Clinical Training and Supervision Governance for Novice Graduates in Communication and Swallowing Sciences and Disorders in Botswana: A Retrospective Dyadic Professional Narrative Inquiry

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ABSTRACT

Documentation of the development of professional clinical training institutional and administrative manuals for communication and swallowing sciences and disorders (Swallowing and Speech Language Pathology/Therapy – SLP/SLT) in Africa is of high interest, in relation to ongoing national SLT developments and global findings. In this retrospective qualitative inquiry, our aim was to establish the existence of guidelines that govern clinical training and supervision of novice/newly qualified Speech-Language Therapists (NQSLTs) in Botswana. The specific objectives were to (1) identify the guidelines for clinical training in dysphagia available for NQSLT graduates to transition from academic to professional practice during their first year post degrees and (2) establish the supervision guidelines for training newly qualified SLT graduates in dysphagia during their first year post-graduation. We conducted a qualitative collaborative narrative inquiry with a single lead speech therapist in Botswana to capture their collective memory of SLT practice in the country through their expert insight and lived experiences. A content analysis of the discussion isolated four major themes related to training and supervision: the Motswana perspective (a missing link), the Health Professions Guide Act, an incongruence paradox, and a classic cyclical dilemma relating to supervision guidelines. We concluded that these four factors combine to undermine clinical training and supervision for NQSLTs in Botswana, and consequently, their scaffolding from graded academic clinical training to professional practice.

Keywords*:* Botswana, guidelines, novice/newly qualified speech-language therapists, supervision, training

1. INTRODUCTION

Dysphagia (swallowing/deglutition disorder) is a widespread condition associated with increased hospital stays and compromised quality of life. It is also a significant risk factor for many life-threatening complications, such as malnutrition, severe dehydration, aspiration pneumonia, and asphyxiation (Adkins et al., 2020). According to some estimates, about 8% of the general adult population globally has dysphagia, with a prevalence above 80% reported in some patient populations (Leira et al., 2023; Adkins et al., 2020; Ndiema et al., 2023). The high prevalence of dysphagia and the associated complications underscore the need for effective management strategies. Frameworks for dysphagia management generally include client background, clinical observation, screening, appropriate functional feeding attempts with liquids/solids based on diet modifications, professional development, and instrumental swallowing tests such as Fiberoptic Endoscopic Evaluation of Swallowing (FEES), Videofluoroscopic Swallowing Study (VFSS) and High-Resolution Manometry (HRM) (ASHA, 2019).

Typically, Speech-Language Pathologists/Therapists (SLPs/SLTs) primarily conduct the assessment and management of dysphagia. Speech-Language Therapists are clinicians trained to support individuals with dysphagia across a wide range of patient categories, from pre-term neonates to end of life among geriatrics, irrespective of their primary conditions (RCSLT, 2014). Effectively meeting the needs of patients with

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dysphagia requires SLTs to have an intricate combination of specialized scientific knowledge in core areas (including anatomy, physiology, linguistics and phonetics, speech/language development, and pathology), clinical tools, and interpersonal skills. In countries with established dysphagia management practice, such as the United Kingdom, the United States, New Zealand, Singapore, and South Africa, a SLT graduate degree in a related field and a supervised novice clinical training full-time year or a SLP master's degree with completed clinical fellowship are mandatory components of scaffolding into licensure for SLT independent practice (AHPC, 2022; Signatory Associations, 2022; HPCSA, 2014). This training is designed to equip SLTs with specialised knowledge and skills to enable them to provide high-quality care to patients/clients with communication disorders and dysphagia (Human resource development council of Botswana – HRDC, 2025; Etter et al., 2021).

Newly qualified SLTs (NQSLTs) require adequate guidelines and supervision post-graduation to help them transition efficiently into autonomous practice (RCSLT, 2014). In the United Kingdom, to align with the developing need to structure dysphagia training among the revised undergraduate programs, a guideline for training and competency in dysphagia was developed for SLT degree students and graduates (RCSLT, 2018; RCSLT, 2014). Similarly, ASHA, 2020 and the Speech Association of Canada (SAC, 2016) require supervised clinical fellowship training for SLPs after their master's coursework, including a clinical practicum. The Singapore Allied Health Professionals Council (AHPC, 2022) also dictates that Effective supervision ensures SLPs adhere to established protocols and competency frameworks. Elsewhere, the Health Professions Council of South Africa (HPCSA, 2014) provides that an NQSLT is first registered into a community service year. The South African ethical guidelines for management of dysphagia among adults further state that before independent practice, a degree holder in a community service year requires at least six months of dysphagia training under the supervision of a specialist/senior SLT or a close or distant mentor, where one is unavailable during this professional training (SASLHA, 2011).

According to MRA- PAC Signatory Associations (2022), ASHA (2019) and RCSLT (2014), to independently conduct dysphagia screening, assessment, diagnosis, FEES, VFSS, HRM, competency levels review and specialization and professional development, a SLP must attain at least the foundational level post-degree or specialist level in each stage of interest to provide supervision during training. The Singapore AHPC (2022) also emphasises that after one year of SLT supervised training by novice graduates, supervision skills in dysphagia can be obtained after about three years of continuous practice and regular planned mentorship. This is equivalent to about two years, post-completion of at least 36 credits of master's coursework, including clinical practicum and at least nine months of fulltime clinical fellowship required in the USA (ASHA, 2020). According to AHPC (2022), Signatory Associations (2022), Lancaster et al. (2017) and RCSLT (2014), an overtime development of core national SLP career guidelines to streamline (post)graduate academic to professional clinical training and supervision in dysphagia can be summarized through the tabulated synthesis: the elaborated 10 Step levels outlining general SLP stages with a focus on dysphagia in Table 1.0 below. The structured guidelines for dysphagia training, supervision, and general transition from graduates in professional clinical training to practice form part of the SLT clinical framework.

In contrast, in countries where SLP professional clinical training and practice guidelines are relatively new like Tanzania, Ethiopia and Kenya, such standards are either lacking or in the process of being established (Mang'ombe et al., 2026; Smaoui et al., 2025; Ndiema et al., 2025; Coutts, 2019; Kamal et al., 2012). This creates a practice gap, where NQSLTs have inconsistent oversight and stewardship to help them transition efficiently into independent practice. The Republic of Botswana currently holds a handful of SLT graduates who are internationally trained. The public health personnel report indicated that among the 9,651 health professionals employed by the ministry of health within the 13, 378 public service providers, only 11 are audiologists and speech therapists (Statistics Botswana, 2024). Botswana initiated its first, four-years Bachelor of Science in Speech and Language Therapy program in 2023 (Botswana Qualification Authority [BQA], 2023). This indicates that the program will ideally graduate its first locally trained clinicians in the 2027 - 2028 academic year, thus creating the locally trained SLT career pool. Part of the SLT degree program focuses on training professionals to screen, assess, and manage dysphagia across all age groups (Boitekanelo College, 2026). The effective transition into independent SLT practice hinges heavily on the availability of adequate guidelines for

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training and supervision during the first-year post-graduation. At the time of this writing, the HRDC, (2025) recognized SLT as a scarce skill in the nation.

Table 1: Overall outline of SLP/T clinical training levels and the italicised dysphagia stages as outlined by various professional bodies

Level	Description
Elementary (Basic) Steps/Levels	
1. Pre-qualifications: undergraduate theoretical & clinical training (Dysphagia level A)	Mandatory coursework in SLP/T before independent practice. In undergraduate, a minimum of 400 hours SLP academic: clinical training/on-the-job training/internship/practicum is a must (HPCSA, 2014). To qualify for *student-level* clinical training in dysphagia, at least 100 hours are completed (ASHA, 2019)
2. Clinical Professional training I: Newly qualified speech-language therapist-NQSLT/*assistants*/on-job training/community year – paid. (Dysphagia level A, Yr. 1)	For degree holders, at least a full time year of 1000 hours is required with about 35-40 hours weekly of supervision in SLP as the transitioning to entry level solo SLP/T practice. Full-time dysphagia training for at least 6 months or equivalent is required in the training duration (RCSLT, 2014, SASLHA, 2011). Which further continues in blocks of 3 years while retaining a certificate of maintenance with a degree in SLP/T (ASHA, 2020).
3. National examinations, ASHA equivalent standards	A standardized electronics exam to validate SLP knowledge and skills as a partial fulfilment for licensing to practice as a SLT graduate (Prometrix: Assistants Certification, SLP-A**)** or masters finalist/graduand/graduate level (PRAXIS: CCC - SLP**)**
Intermediate Steps/levels	**Descriptions**
4. Master's/Postgraduate theoretical and academic practicum training (Dysphagia level B, Year 1-2)	Academic training in SLP offered in a university. Graded in credit hours, such as (a) dysphagia coursework, (b) at least 400 hours of supervised graded full-time SLP internship/ clinical practicum/ training – 25 hours of observation and 50 hours may be from supervised undergraduate training. Complete at least 100hrs in dysphagia. Training may be extended, also known as (c) externship (ASHA, 2020).
5. Clinical Professional training II: Clinical fellowship year for postgraduates (Dysphagia level B, Year 2 - 3). A paid supervised training position.	Completion of *foundation level* on RCSLT- DTCF for trained SLPs./at least 100 hours of dysphagia training during 400 hours in SLP practicum at master's level (ASHA). After postgraduate graded internship and coursework, while ongoing with academic research project/ have graduated from a 24 months SLP master's program; complete at least 1260 hours full-time general clinical training fellowship in SLP for at least 9 months – a maximum of 35 hours weekly/ 48 months per 5 hours weekly minimum.
6. *Practitioner* (Year 3, Dysphagia level B-C)	Required 2 years of independent practice with structured mentoring. Monitored training for improving SLP practice,
Advanced Steps/levels	
7. Supervision (Dysphagia level C, Yr 4) Conducts referrals.	For supervision in specialized areas such as dysphagia, a supervisor requires at least 3 years of independent practice in the focus area post-master's graduation. With at least 420 hours completed during ASHA fellowship/RCSLT - level c *specialist* stage in dysphagia from the required total general SLP hours.
8. *Consultant* (Year 4-5, Dysphagia level D)	Trainer: conducts complex instrumental exams that otherwise a specialist may need assistance with/not qualified to conduct.
9. Continuous Professional Development - CPD in dysphagia	At least 2 CPD credit hours completed for supervisors to effectively oversee trainees in assistant and foundation levels. (b) Leadership, administration, training, research & innovation

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training and/or in Supervision	to develop core areas that complement indirect practice hours for careers and capacity building in dysphagia).
10. Continued Competency Review	

Sources: ASHA, 2020; ASHA, 2019; HPCSA, 2014; RCSLT, 2014; SASLHA, 2011

Unlike countries with well-established frameworks for dysphagia training and competency, SLP education in the Republic of Botswana is still in its early development phases. The SLT curriculum approved by the Botswana Qualification Authority (BQA, 2018) indicates that one of the career pathways for SLT graduates is to pursue a master's programme in Speech and Language Pathology/Therapy. This is supported by the Human Resource Development Council – HRDC of Botswana, 2025, "Recommendations for external postgraduate training, including masters, doctorate and other professionals." Yet, there is limited empirical evidence of training structure and support systems available for the upcoming SLTs who are expected to graduate from the bachelor's degree programme. This, therefore, calls for a look into the republic's available and accessible guidelines for post-graduation SLT clinical training in dysphagia. In this paper, we report the findings of a study on the availability of guidelines for professional clinical training and supervision of NQSLTs in Botswana, with a focus on dysphagia. The study had the following objectives:

1. To identify the guidelines for clinical training in dysphagia available for NQSLT graduates in Botswana to transition from academic to professional practice during their first year post degrees.
2. To establish the supervision guidelines for training newly qualified SLTs in Botswana in dysphagia during their first year post-graduation.

The remaining sections present the methodology employed, the results and discussions, and major conclusions. The results underscore the need for relevant stakeholders to ensure that NQSLTs in Botswana have adequate support to help them transition to independent practice.

2. METHODOLOGY

The study was a retrospective qualitative inquiry into the available guidelines on training and supervision for NQSLTs in Botswana. The study involved an in-depth narrative inquiry in collaboration with a single lead speech therapist in Botswana to share their expert insights and experiences in SLT practice in the country. At the time of the inquiry, the principal investigator (PI) was a lead independent academic and a doctoral candidate researcher (with private experience in Botswana) specializing in health education governance post higher-education and global healthcare partnerships. She was, at the time, developing a study on professional clinical training in dysphagia for SLP master's degree holders in Kenya, as part of the requirement to fulfil a Doctor of Philosophy program. To add, the PI was dual certified in leadership development and mentorship, and in strategic management of organizational conflict using mediation as an alternative dispute resolution (coupled with a higher diploma in Psychological Counselling); a postgraduate senior clinician (deglutologist and Speech-language pathologist - SLP), a basic-education specialist graduate in Secondary, Special Needs Education focused on Emotional behavioural disorders and on hearing impairment (coupled with a diploma Early Childhood Development Studies).

The key narrative expert is a Motswana lead SLT practitioner with a Bachelor of Science degree in Speech and Language Therapy from Europe. The key expert was a private SLT, incumbent head of SLT in the public sector, with over 15 years of SLT experience in the public and private sectors in Botswana. To add, the key expert is among the very first SLT practitioners to practice in the country's public service. After completing the SLT degree, the key expert returned to Botswana and was at the forefront of efforts to initiate formal recognition of local SLT training in Botswana. The expert formed part of Botswana's founding SLT practitioners and was part of the board that was appointed to facilitate the recognition of speech therapy into the nation's health professions body. The expert later played a direct leading role as a technical task force that co-developed the first government-approved Bachelor of Science (SLT) curriculum in Botswana. The expertise, proactive skills in the formalization of SLT practice programmes in the country and international experience in SLT training positioned this expert as a key resource in this study.

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Prior to the discussion, the PI engaged the key expert in a preliminary mobile consultation to build rapport, seek consent, request participation and arrange for the actual discussion. The discussion was conducted over the phone by the PI using adapted narrative inquiry cues emerging from the discussion to support free-flow of expert thoughts and living experiences. The cues included eight prompts that solicited the expert views on the SLT clinical training and supervision guidelines in Botswana, mainly, the requirements for NQSLT that describe the scaffolding process from academic to professional training and practice during the first year post degree graduation.

To achieve substantive trustworthiness and credibility, the PI scheduled a one-hour live-transcribed telephone call. Besides the eight guiding inquiries, some follow-up inquiries were posed as appropriate. The discussion was transcribed digitally, as the first author also made notes on key points. At the end of the session, the principal investigator summarized the key points and shared with the expert to verify whether their views were captured correctly.

Data analysis was thematic and followed Braun and Clarke's (2006) six-step framework. The analysis was conducted by the principal investigator. The call was transcribed live and it was edited manually verbatim to preserve the intended meaning. The investigator began the analysis by first carefully reading through the transcript and reviewing the personal notes to familiarize with the text. The text was then systematically broken into initial inductive codes, which were then scrutinised to identify initial themes. These initial themes formed the initial template. They were reviewed thoroughly against the codes and the original text for accuracy and consistency. They were then refined into a final set of themes that were synthesised into a narrative using codes. The discussion transcript was sent to the expert for verification. The study was conducted as a co-dependent, professional, retrospective research and it did not involve any clinical trials or interventions, client data files or external human subjects.

3. RESULTS AND DISCUSSION

The narrative inquiry discussion with the expert generated several views related to the availability of guidelines for professional clinical training and supervision of NQSLTs in Botswana. In this section, these views are presented and discussed as per the two objectives.

3.1 The guidelines for clinical training in dysphagia for SLT graduates

A scrutiny of the discussion isolated three major themes related to training: the Motswana perspective as a missing link, the nation's Health Professions Guide Act, and an incongruence paradox. As a note, while these themes are discussed under training, as shown later, they also apply to supervision.

3.1.1 The Motswana Perspective: The missing link

The first theme captured the expert's view that the current training and supervision structure did not fully integrate the local aspects of SLT. This theme emerged right from the start of the discussion and resonated throughout most of the conversation. For instance, when asked about the availability of professional clinical training guidelines for NQSLTs in Botswana, it was noted that,

> Prior to SLT programme approval, a workshop was conducted by a Botswana higher education institution, the national qualification and the health professions authorities. To address the level of qualification at the honours degree level through benchmarking with selected universities in South Africa.

Looking at this response, the establishment of the SLT training programme was a Botswana initiative involving local stakeholders (a higher learning institution, the qualification and the health professional authorities) and "through benchmarking" with foreign universities, especially South African universities. Aside from this "benchmarking, there was no indication in the response of how local contextual settings influenced the programme's development. This pointed to a key missing link: the voice of the Motswana. Indeed, when prompted on the perspectives of the Batswana during the initial phases of the SLT programme's development,

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the response was categorical: "There is nothing. Honestly, I don't think there is anything written from the SLT Botswana aspect." The respondent added,

> "Maybe I need to pursue my thoughts on doing a publication to try and address areas like dysphagia patients as a follow-up on this publication to link my perspectives from the Botswana side. Based on the influence of the professors coming from South Africa to support the development, the Botswana SLT program was heavily biased towards SA SLT programs."

What stands out from the above sentiments is that the development of SLT training in Botswana was and continues to be heavily influenced by the South African models. Although not directly implied, the above response reflects a limited voice of the locals. It is noteworthy that this response came from an actively involved expert in pioneering SLT training in Botswana and co-developing the country's first-ever undergraduate programme in SLT. This heavy leaning towards South Africa has a two-sided implication for the development of SLT training in the country. Partnering with well-established South African universities puts Botswana's SLT field in an elevated position to gain immediate international credibility and subsequently, rigorous qualification and internationally recognised standards for graduates and practitioners. It also offers local higher education institutions a platform to gain access to advanced SLT research and resources that are yet to be available domestically.

On the other hand, SLT is deeply tied to language, dialect, and culture (Khoza-Shangase & Mophosho, 2018). A curriculum with a heavy foreign influence, therefore, risks difficulty in capturing the local national language (Setswana) dynamics and contexts that may be key to optimal patient outcomes. There is also the risk of healthcare model incongruence and epidemiological mismatches (Huwyler et al., 2021; Staley et al., 2021). More clarity is needed on whether and how these potential bottlenecks were factored in during the development of Botswana's SLT training framework, which was not discussed. There's a need to refer to the curriculum and recommend adaptations to the upcoming 2028 program review date (BQA, 2023) to ensure that it adequately captures the local voice.

3.1.2 The Health Professions Guide Act

Throughout the discussion, the National Health Professions Guide Act emerged as a core primary and guiding framework for SLTs' clinical training and its specificity in dysphagia post-graduation. During the conversation, the expert was asked whether there was a structure to guide SLT graduates in their first year post-graduation, and whether the guideline covered dysphagia. The respondent said that,

> It would be good to refer to the Botswana Health Professions Act. Prior to the inception of the SLT field in the Republic's Health Professions body, it was something discussed when we were sitting among the Act stakeholders about post-graduation vision. The team recommended that everybody, local and internationally trained, first sit for an exam prior to registration.

The expert also made it clear that the Act stipulated several training requirements for SLTs, such as examinations and mandatory internship (graduate professional clinical training - GPCT). Beyond these broad requirements, however, there were no references to specific guidelines on SLT clinical training post-graduation, especially in dysphagia, similar to those available in Singapore (AHPC, 2022), the United Kingdom (RCSLT, 2014; 2020) and the United States (ASHA, 2019). For example, when asked whether there were specific guidelines or pathways in Botswana for SLT in dysphagia, the response was, "Previously, not yet. Am glad that you're doing research and bringing in Botswana as well, because we will definitely benefit from that. I will definitely inquire about the current health professions Act and confirm the present status."

The Botswana Health Professions Act (*BHP Act, 2001*) establishes a legal framework for allied health professions. The BHP Act sections 2 and 9, for example, stipulate mandatory internship prior to registering as a health professional for the first time. According to the *Botswana Health Professions* Act (2001), "intern" means a person registered as an intern as per section 9, who is required to complete a period of internship training in an approved hospital or institution to acquire practical skills and experience before becoming entitled to practice

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his profession without supervision". It is unclear when referring to the NQSLT training whether the "intern person" has graduated or not.

The Act further mandates all health professionals to complete a period of supervised training in an approved healthcare setting. This training, according to BHP council should prepare graduates to acquire practical skills before they can practice (*Botswana Health Professions Act*, 2001). The BHP Act further provides for continuous training to ensure that health professionals remain proficient and competent throughout their career. However, unlike traditional fields, such as medicine, which have highly structured governance structures, there is yet to be a clear guidance for SLTs to transition to practice post-graduation. The Act is heavily skewed towards policing and minimum compliance, such as exams and licensing, rather than facilitating specialised graduate professional clinical training or clear career progression paths for locally trained SLTs.

Botswana is, however, far from being a unique case. Unlike pronounced SLT professional training frameworks in countries with well-established SLP programs, for countries such as India (Rangarathnam et al., 2021) and Kenya (Ndiema et al., 2024; ASLTK, 2020) which are undergoing SLP development, the national guidelines for SLP professional development support, especially in dysphagia training among NQSLTs or clinical fellows are unclear. There is a need for such countries to invest in a standardized framework to support SLT clinical training during the first year post-graduation.

3.1.3 Practice Incongruence

This theme referred to an appearance mismatch between anticipated and actual states in training and supervision. Throughout the conversation, the expert clearly concurred that the development of the Botswana SLT training programme was heavily biased towards the South African programmes. The expert was also of the view that Botswana relied heavily on external standards to guide its local SLT training. The expertShe asserted, "Previously, for Botswana, the health professions body trusted the credibility of the external training facilities since there were no training programs in the nation yet. Therefore, the government would take into consideration the university credentials of a graduate from international programs and proceed to directly register the SLT graduate without a domestic internship. At the time, there was no SLT system. Hence, it would have been unfair to require in-country training because who would have been supervising them with no speech therapists on the ground?" Some points stand out from the expert. Firstly, during the initial development of SLT, Botswana relies heavily on external partners to support local training programmes (BQA, 2018). The expert reported, "The government would take into consideration the university credentials of a graduate from international programs" and use these qualifications as the basis for directly registering a SLT without a local GPCT. Secondly, reliance on external training, according to the expert, was primarily because at the time (1) Botswana had inadequate facilities – no SLT system and (2) It would have been unfair to require in-country training process with no qualified trainers on ground to supervise graduate interns. Comparing SLT with other healthcare fields, the expert said,

> In relation to the initiation of the medical program in Botswana, because there were already doctors in place, medical students from a Motswana public university would be enrolled in an internship, especially at the public national hospitals for about one year prior to deployment to other hospitals across the country.

This further stressed the view that the overreliance on external support was primarily because of inadequate local capacities. Although the expert referred to a "previous" period, there was limited evidence from the responses that things have changed much. As noted by Statistics Botswana (2024), only 11 audiologists and SLTs are recorded to be in the public sector. Indeed, when asked about the existence of guidelines to support the transition of the upcoming, approximately 23 local SLT graduates into practitioners post-graduation, the expert reflected,

> This is a gap. I think it is a very good question because it is something I have been thinking about. Like, *what is going to happen to our students cause of the system we had before, and now that we are starting to graduate them locally?*

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Thus, according to the expert, even at the time of the discussion, there was a considerable "gap" in terms of the available guidelines and supervision to support SLT graduate transition. These findings concur with those reported from other countries where SLP clinical training especially in dysphagia is still in its early development phases (Ndiema et al., 2024; Rangarathnam et al., 2021). At the same time, the expert made it clear that there is a significant deviation in what is practiced in Botswana in terms of professional training and what is done in countries with well-established SLT programmes. The expert said,

> As an alumnus from a SLT degree program in Europe*, a one-year internship (GPCT) under supervision post graduation was a requirement. I know it's also a requirement in South Africa.* For instance, from one of the SA universities used to benchmark the SLT program in Botswana, SLT graduates are required to complete one-year internship as well.

Herein lies the incongruence. While Botswana relies heavily on external support for guidelines on training, its standards and practices deviate considerably from countries with established SLT programmes, even South Africa, which it uses as the benchmark. From the previous discussion, this deviation is primarily due to inadequate local capacities – facilities and qualified trainers. The overreliance on external support could also be detrimental because it could limit the development of a sustainable, localised postgraduate pipeline (Sebothoma et al., 2021). Here is evidence of a cyclic problem, where inadequate local resources and trainers compel Botswana to rely on external support, which, in turn, hinders the development of local experts.

3.2 Supervision Guidelines for Professional Clinical Training: A Classic Cyclical Dilemma

The issues highlighted above apply to both training and supervision. Besides these three, the expert mentioned issues that are specific to supervision, which mirrored the classic cyclical dilemma. Throughout the inquiry, the expert made it clear that there were no adequate guidelines on the supervision of SLTs post-degree graduation. For example, commenting on the availability of guides for training, the expert clarified,

> It's something that I would need to confirm with the current Health Professions Act. Before, *SLT graduates would go straight into practice without that structured supervision and training hours*, *unlike what is required in the UK or maybe SA.*

Further scrutiny revealed that the inadequate supervision was due to cyclical problems. The first one was the lack of qualified trainers to supervise graduates. When prompted on the availability of supervision post-graduation, the expert rhetorically asked, "Realistically, who was going to be supervising them and following up on them?" The position was that in the absence of qualified supervisors, it was *unrealistic* to expect adequate supervision. This is a sharp contrast to most Global North countries with established SLP/T practice. In England, for example, Guthrie et al. (2017) observed that nearly all SLTs had no major difficulties finding a supervisor. The majority had access to at least weekly support from a dysphagia specialist.

Closely related to inadequate supervisors was the issue of guidelines for supervisors. During the inquiry, the principal investigator asked, "What guides you to qualify as a supervisor and to know the required supervision hours?" When this prompt was floated, the expert remarked,

> Those are very good questions. Definitely, there are gaps that need to be addressed so that they can be researched and worked on. I appreciate that because they have been questions that have been on my mind. *What is the future of the profession if we do not align with international standards to a certain level?*

From this response, it was apparent that, from the expert's knowledge, no guideline was available for supervisors in graduate SLT clinical training, especially in dysphagia. A picture that emerges here is that of a classic cyclical dilemma. There is a need for guidelines on SLT supervision, which is currently lacking in Botswana. At the same time, there are only a few qualified SLT supervisors, in the first place, to use such guidelines. A supportive environment is crucial for developing confidence and competency among health professionals. For SLT clinical training in dysphagia, this support may take various forms, mostly the availability of opportunities for professional development, such as effective guidelines and supervision training (Peters et al., 2019). The

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supervision gaps reported here, therefore, imply that although SLTs in Botswana may have limited opportunities to advance their competence in dysphagia management post-graduation, their leveraging of academic and clinical global collaborations provides the nation room for domestic development while appreciating international standards.

CONCLUSION

Designs and organization for dysphagia management, as a core basic task for SLTs, can be advanced by interested clinicians into their practice through specialised training and supervision. This recognition has been and continues to be established globally through professional associations. Specialised training and supervision are, in turn, usually achieved through structured degree and/or postgraduate and/or continuous professional development study processes. However, the clinical dysphagia training structure and core requirements embedded in SLT training post-degree in Botswana is translucent. In this study, we investigated the availability of guidelines for professional clinical training and supervision of NQSLTs in Botswana, with a focus on dysphagia. The objectives were to (i) identify the guidelines for clinical training in dysphagia available for SLTs to transition from academic to professional practice during their first year post-graduation and (ii.) establish the supervision guidelines for training NQSLTs in dysphagia in the first year post-graduation. Our study showed that the current undergraduate training and supervision structure for SLT in Botswana tends to be highly foreign-aligned and may not fully integrate the local aspects of SLT. Currently, the BHP Act, council and the qualifications authority are core primary guides on SLT training and supervision for dysphagia post degree graduation. The *BHP Act (2001)*, establishes a general legal framework for post-graduation training of allied health professionals, thus portrays the needed emphasis on available specialised clinical training guidelines and access to clear career progression paths for the upcoming SLT graduates. We also found evidence of an apparent practice incongruence, where although the SLT training programme in Botswana relies heavily on external support for guidelines, its practice standards deviate considerably from countries with which it benchmarks. This mismatch appears to be rising primarily from inadequate local capacities, namely facilities and qualified trainers. The incongruence also points to a cyclic problem between inadequate local capacities and external support. We also found evidence of a classic cyclical dilemma on inadequate guidelines in SLT supervision. Finally, to prepare specialists such as deglutologists for clinical supervision, lecturer, research and policy roles across Botswana and the broader African continent, the study pointed to a critical need for the development of SLT postgraduate programs. By laying out this pathway, Botswana could demonstrate its strong position as a solution-based career footprint by adapting to an Africa-relevant, advanced structured training in communication and swallowing sciences and disorders. This is crucial for not only the higher education institutions postgraduates professional development task force (the prospective – 2027 - 2028, the first Batswana SLT degree graduating cohort), but also improved allied healthcare systems for graduate professionals (like nurses, nutritionists and dietitians), medical specialists (like otorhinolaryngologists, gastroenterologists and neurologists), rehabilitation scientists (like psychologists, occupational therapists and Physiotherapists) and education sectors across early childhood development, special needs education with background in hearing impairment and/or general educators in English-linguistics.

Overall, this study was conducted to recognize and appreciate the growth of SLT in Botswana, and to be part of the solution by creating more room for further constructive criticism, in-depth local research and development of resources for quality SLT graduate - professional clinical training and supervision in like dysphagia. Speech-language therapy is reported as a priority skill in the HRDC, 2025. To align with the vision 2036, while there is need to recognize and uphold international structures, localization of designs and procedures to meet the domestic needs of SLT clinical training and practice in Botswana is inevitable.

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carrying too much." Senior manager. "No matter how good you are, in the wrong place, even if you give your best, you will never be enough! In the right place, just your mere presence is celebrated. You don't lose your worth and value just because its unseen", unknown. . Maya Angelou, "Do the best you can until you know better, and when you know better, do better."

Competing Interests

The authors confirm that there was no conflict of interest during the composition of this article. The primary author/contributor of this article is the principal investigator/corresponding author.

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All relevant data to this study has been included in the article.

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Authors' Contributions

*The primary author developed the article content (the overall structural writing) and the layout. The co-author provided domestic clinical expert insights, baseline data and context from institutional memory regarding the foundation of SLT in Botswana.

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