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The multilingual context of the early care and support of deaf children in Ghana

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ABSTRACT

Understanding the multilingual language context of deaf children's lives provides an essential knowledge base from which to develop the early support of children and families. Current models of early support tend to draw on Euro-Western understandings of the multilingual lives of families of deaf children and assume an established infrastructure around language and communication intervention. This paper examines the multilingual contexts of deaf children in Ghana; a low-resourced country in sub-Saharan Africa where the use of multiple local languages is a part of the eco-cultural context for early development, but where the early support of deaf children is under-resourced, and there is limited understanding of childhood deafness and the potential of sign language communication. Through interviews with caregivers of deaf children and the documentation of language biographies, we examine the proximal and distal influences on multilingual languaging and communication choices. We draw on Bourdieusian social theory to identify ways in which power and agency dynamically shape multilingual communication possibilities for deaf children and their caregivers, specifically in relation to the legitimised use of sign language among other local languaging practices. Implications for the development of context-sensitive models of early support for multilingual deaf children and their families are discussed.

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Introduction

The development of language and communication skills is a cornerstone of the early care and education of deaf children and a central focus of early intervention programmes (Yoshinago-Itano, 2003, 2014). For bilingual and multilingual deaf children, the need for the establishment of a strong primary language – whether this is signed or spoken – as a basis for conceptual development, cognitive growth and literacy development has been well-rehearsed (Cummins 2021). This knowledge base underpins approaches to early intervention and support for young deaf children and their families that facilitate the development of sign language and a supportive bilingual/multilingual development environment. To this end, current models of good practice emphasise the importance of deaf leadership and the role of visual communication in family mentoring and coaching (Gale et al. 2021). However, much of the published research into the early support of multilingual deaf children pertains to economically rich contexts where there are established deaf education resources, early identification and support infrastructures, and professional health and education communities who are academically networked (Brons, Knoors, and Marschark 2019; Collyer 2018).

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This paper examines the multilingual language learning contexts of deaf children in Ghana in sub-Saharan Africa (SSA) that is one of the world's regions with a high prevalence of deafness. Ghana is a low-income West African country where there are more than 70 spoken languages and three sign languages in use (Nyst 2010). Most deaf children are born into families and communities in Ghana where more than one spoken language is in regular use, but where caregivers have little or no previous experience of childhood deafness and sign language communication. The early intervention and support needed to ameliorate this situation is not currently in place (Oppong and Fobi 2019). Consequently, communication barriers exist between deaf children and their hearing caregivers. Children's delayed language development is major source of parental anxiety and a cause for concern in the education sector (Opoku et al. 2020).

We interviewed 12 hearing caregivers of deaf children from Southern, Middle and Northern Regions of Ghana. We gathered information about their experiences of parenting and interacting with their deaf children and the influences on their multilingual communication practices. To provide rich context for the interview data, we also developed four family language biographies. Interview data is analysed thematically to identify proximal and distal influences on family language practices. The relationship between these practices and macro social issues is scrutinised with reference to Bourdieu's take on language on social life (1991).

The research reported here is one of a series of planned and published papers that report on a UK-Ghana collaborative project that examines the early childhood of deaf children in Ghana. Earlier work has focused specifically on caregivers' experience of parenting and provided a critique of western models of models of early support that lead current international practice and expectations (Swanwick et al. 2022). This paper further develops these insights by providing a deep examination of the language learning and development context with reference to understandings of the multilingual experience of deaf children in different global contexts.

Terminology

Throughout this manuscript, we use 'deaf' as an inclusive term to refer to children and adults with various hearing levels, different linguistic and cultural experiences, and communication preferences. Additionally, we focus on the multilingual context of deaf children's language and communication practices rather than ascribe the term 'multilingual' to individuals. In the research context that we describe, where access to sign and spoken languages from an early age is precarious, the use of 'multilingual' to describe young deaf children is potentially 'over-agentive' and obscures the difference between growing up in a multilingual environment and having the opportunities to develop multilingual skills (Marshall and Moore 2018).

The context of early support

Most parents of deaf children have no previous experience of deafness and are unfamiliar with the potential of sign language and deaf community networks. Early support that is informed and family oriented is, therefore, a priority (Moeller et al. 2013). International guidelines recommend that Newborn Hearing Screening (NHS) and diagnosis are completed by three months of age and that intervention is in place before six months (Yoshinaga-Itano et al. 2020). For most economically rich, and some middle-income contexts this is largely achievable. However, NHS – as the trigger for early intervention – is not universally available in low-income contexts due to cost and the lack of joined up health and education infrastructures (Olusanya et al., 2012).

The absence of NHS delays confirmation of childhood deafness (sometimes until school age), that would normally trigger pre-school language and communication intervention. An exacerbating factor is parents' fear of prejudice and stigmatisation that often inhibits attempts to pursue professional (audiological) confirmation and support. Without this disclosure and catalyst for early support, families of deaf children in low-resource contexts are at risk of being insufficiently

informed or empowered to develop agency in relation to communication choices and practices (Störbeck and Young 2016).

Language and communication intervention

A fundamental vulnerability for caregivers' centres on access to support for language and communication development, that should – according to international guidelines – build on the natural language and communication resources of the family (Moeller et al. 2013). Research that identifies early parent–child interaction as one of the main predictors of children's language outcomes has driven extensive work into the evaluation of the quality of parent–child interaction and how it can be defined and measured (Curtin et al. 2021). This research does not however reflect different patterns of language socialisation in multilingual societies and the global diversity of familial and social networks that surround children and families. Specifically, Western models of support emphasise child–parent dyads and a nuclear family structure. Little attention is given to societies that are organised around communal relationships and livelihoods (Kabay, Wolf, and Yoshikawa 2017; Singal and Muthukrishna 2014). In such contexts, the notion of quality interaction needs to be re-evaluated to embrace different caregiver communication practices and the ways in which these are shaped by local understandings of early care and interaction. Research into the multilingual language practices and choices of caregivers is needed that takes account of different cultural contexts, communal intergenerational childrearing practices, and the influencing role of the community.

Professional guidance

Research into early support reveals that professional advice is pivotal in intrafamily language decisions and practices. It is important that this advice is infused with locally based knowledge and expertise and delivered in a way that is sensitive and responsive to different family contexts, values, and cultures. This aspect of best practice is precarious where advice is delivered by those who do not understand the cultural backgrounds of families and are not themselves culturally competent (Yoshinaga-Itano 2014) and where the adherence to language policy overrides the nuances of different family circumstances. Studies of caregiver experience overwhelmingly report the professional advice to use the dominant language of the culture (Batamulu et al., 2020; Crowe and Guiberson 2020). Undiscerning advice can be confusing and disempowering for caregivers who seek a steer from professionals. The wider sociocultural climate for multilingualism and influence of national and local language policies thus needs to be understood as part of the power structure around caregiver language and communication practices (McKee and Smiler 2016).

Caregiver agency

Where multiple languages are in use, including signed languages, families have complex decisions to make about language practices and language development priorities. Different ways in which families approach this is sometimes described as Family Language Planning (FLP). Research into FLP has documented the decisions caregivers make about language use and the processes that legitimise certain language practices in the home (Curdt-Christiansen and Lanza 2018; King, Fogle, and Logan-Terry 2008). This examination of intrafamily communication, that includes multilingual signing, has deepened our understanding of children's repertoires, parental decision-making, and the wider social-cultural dynamics of multilingual language use in mixed deaf and hearing families (Kusters, De Meulder, and Napier 2021; Pizer 2013). However, concepts of agency and choice that pervade the early support and FLP literature warrant further scrutiny. In particular, the extent to which caregivers, across different sociocultural contexts, are utterly free to choose a language approach or ideology needs to be explored (Mitchiner and Batamula 2021), particularly in contexts

where the use of sign language is not socialised as a legitimate choice for caregivers (Lutalo-Kiingi & De Clerk, 2015).

Through an examination of the multilingual context of caregivers of deaf children in Ghana we seek to extend understandings of the relationship between language practices and macro social issues (Salö 2018). These issues need to be understood, we argue, as a basis for the development of contextually sensitive models of early years support for language and communication, that are cognisant of the struggles for power and agency that shape language practices of deaf children and adults (O'Brien, 2021).

Context of the current study

This research takes place in Ghana, where more than 81 different indigenous spoken languages are currently in use and where there are more than 79 different ethnic groups (Ansah 2014). English is the official language in Ghana, a legacy of its British colonial history, and 11 of the indigenous languages are recognised as major languages in Ghana and at least two or three of these are spoken among people in their daily interactions.

Language policy in Ghana reflects government commitment to the development of children's indigenous cultural identities and literacies in their mother tongue. The importance of skills in the child's first or home language (L1) is recognised as the basis for the learning of a second language (Brenzinger 2008). Current policy in Ghana mandates the use of L1 as the medium of instruction for the first five years of school, with gradual exposure to English, before moving to English as a medium of instruction in the upper primary and beyond (Akyeampong, 2009).

Three sign languages have been linguistically documented in Ghana (Nyst 2010). These are Adamorobe Sign Language (AdaSL), Nanabin Sign Language (NanaSL) and Ghanaian Sign Language (GhSL). AdaSL is an indigenous village sign language used by the deaf residents in the Adamorobe community in the Eastern Region of Ghana. AdaSL is used by around 40 deaf people (adults and youngsters) in a community of about 3,000 people representing 1.3% of the total population (Edward 2021; Kusters 2015). NanaSL emerged from a family which was known for its high incidence of deafness in Nanabin, Ekumfi in the Central Region of (Nyst 2010). NanaSL is believed to be the first sign language in Ghana of about 25–30 users.

GhSL is recognised as the main sign language in Ghana among rural and urban deaf communities and it is language of instruction in the schools for the deaf. At this time, GhSL is not officially recognised as one of the languages of Ghana but there is increasing awareness of its use supported by advocacy initiatives among deaf organisations and the deaf community, and through the media. Such efforts to raise the profile of GhSL will ultimately support caregivers of deaf children who may use multiple spoken languages in their daily lives, but have little or no previous experience of sign language communication.

Methodology

The theoretical framework for thinking about multilingualism and the management of early support in this context draws on social constructivist understandings of language as social practice (Heller 2008) that recognise the heterogeneity and flexibility of repertoires (Blommaert and Rampton 2012). The construction of language as practice widens the investigative lens to include the sociohistorical, cultural and economic context of caregivers' multilingual routines, and facilitates analysis of the eco-cultural influences on practice and the relations of power and agency embodied within that practice (Moraru 2020; Salö 2018).

We draw Bourdieusian constructs of 'habitus', 'capital', and 'field' for scrutiny of ways in which power and agency dynamically shape and are shaped by language practice (Salö 2018) and as a means of understanding the interplay between the individual and their social context. Full ethical

approval was granted for this research by the University of Leeds Research Ethics Committee from the Faculties of Business, Environment and Social Sciences.

Participants

Twelve Caregivers of deaf children were recruited from the Ashanti (3), Central (4), Greater Accra (4), and Eastern (1) Regions of Ghana through approaches to three schools for the deaf and two speech and hearing assessment centres. The group of caregivers that came forward to participate included eight mothers, three fathers and one grandmother. Nine of the families had children between the ages of 5–10 years and four families had children between 11 and 15 years comprising 11 males and two females. Due to late identification and lack of reporting, it was not possible to recruit parents of younger, pre-school deaf children. The majority (7) of the caregiver participants were educated to a basic level – that is primary and junior school education. Only four of the participants had further educational experience (up to tertiary level) and one interviewee had no experience of formal education. Three of the caregivers had professional employment and the remaining participants has semi or non-professional sources of income. The case studies provide examples of these livelihoods in more detail.

Data gathering and analysis

In our interviews with the 12 hearing caregivers our aim was to gather information about the language development and communication context and to develop an understanding of caregivers' approaches to interacting with their deaf children and the external influences on their communication practices. Interviews were conducted in spoken English, Twi, or Fante according to caregiver preference. All interviews were audio recorded and transcribed directly into the appropriate local language by members of the Ghanaian research team who are fluent in the local languages. For each of the interviews a translation to written English was prepared. These translated transcripts were sense-checked by the research team members to reconcile inaccuracies and ensure conceptual cohesion (Temple and Young 2004).

We developed short language biographies of each of the families that describe language practices within this sociolinguistic context (Busch 2016). Four of these were selected for reporting in this paper to contextualise the interview data. Interview data was analysed thematically (Braun and Clarke 2006) to describe communication repertoires and strategies, and identify proximal and distal influences on family communication choices and practices (McKee and Simile 2016). Our understanding of repertoires and strategies embraces linguistic and embodied ways of connecting, turn-taking, and making meaning (Bezemer and Kress 2015; Mondada 2014).

Findings

Language biographies

The four selected language biographies provide information about each family, their community and living arrangements, and the ways in which they use different languages and communication strategies in their daily lives. The use of the term 'family' is inclusive of diverse family configurations, guardians, extended members, and siblings. The use of the term 'community' refers to people in a particular geographical area who either use or share the same resources and utilities (such as schools, markets, transport). We use the term 'home' to refer to the living space of the family, recognising that this may be a shared space – such as a compound house – with extended family members or co-tenants. To protect the privacy of the participants, we refer to each family as F1, F2 etc and corresponding use C1, C2 etc to refer to the caregivers in each of the families that spoke to us. Table 1 below shows the makeup of each of the family groupings in the study and

Table 1. Family demographics.

Family	Family members	Caregiver employment
F1	**Mother** H, Father H	Mother is a food seller
	Boy (17) H, Boy (15) D, Boy (11) D	Father is a casual worker
F2	Mother H, **Father H**	Father is a car mechanic
	Boy (15) H, Boy (8) D, Boy (1) H	Mother is small trader
F4	**Mother** H	Mother is a hairdresser
	Boy (8) D	
F6	**Mother** H, Father H	Mother is a senior nursing officer
	Boy (17) H, Girl (10) D, Girl (9) H, Girl (4) H	Father is a banker
F8	**Mother** H, Father H	Mother is a small trader
	Boy (17) D, Boy (12) H, Boy (9) H	Father is a commercial driver
F10	**Mother** H	The mother is a shop keeper.
	Boy (9) D, Boy (7) H, Girl (3) H	
F11	**Father** H, Mother H	Father is a car mechanic
	Girl (9) D, Girl (5) H	Mother is a small trader
F12	**Grandmother** H	Grandmother is a farmer
	Aunt H, Aunt H, Boy (8) D	Aunt 1 is a student teacher
		Aunt 2 is an apprentice hairdresser

identifies which individuals are deaf (D) or hearing (H). The four selected family biographies are shaded. The caregiver within each family that participated in the interview is highlighted in bold and information about their employment is given.

F2 is a family of five who live in a suburb of the Ashanti Region that comprises people from many different ethnicities including Asantes, Fantes, Ewes, Dagombas, Frafras, Hausas, Gas. Both parents are hearing, and one of the three children is deaf. Although Twi is the dominant language of the region not everyone is fluent, and people switch to their local languages (such as Fante, Ewe, Dagomba, Frafra, Hausa, Ga) with community friends and neighbours. They live in their own apartment where some of the rooms are rented to other tenants. The deaf child attends a school for the Deaf in the Ashanti Region. He travels for about 80 kilometres to school and boards during the school term. He is learning GhSL at school. In the home, Twi is spoken by all members of the family. The mother and siblings have also learned some sign language from the school for the deaf. They blend spoken Twi and signs from GhSL to communicate with the deaf child (even though he does not hear or understand the Twi). The father does not know any sign language and relies on the mother or brothers for interpretation between sign language and spoken Twi.

> *I don't usually interact with him. But when I am at home and want to interact with him, he will make the sign and his mother or brother will interpret to me and vice versa* (C2)

Similarly, the deaf child communicates with father through his mother or brothers who interpret in spoken Twi to the father. In the absence of the mother and siblings, the deaf child uses gesture to communicate with his father.

F4 comprises a mother and her deaf child. They live on the outskirts of Winneba in the Central Region of Ghana where Fante and Efutu are the dominant languages although many other spoken languages are used in the community (including Twi, Frafra, Ga, Dagomba, Hausa, English). They live in a compound house. The mother has her own shop at the extended family home (where her mother, uncles and siblings reside) where they spend most days and mealtimes. All the family members are hearing. The deaf child attends an inclusive school in Winneba. He is a day pupil and has a 20-minute walk to school. He was given a hearing aid by a non-governmental organisation but lost it at school. The mother cannot afford the cost of a new one. In the family home, Fante and Efutu are used among family members. They sometimes use both languages interchangeably, for example when they have visitors as Fante is more widely spoken than Efutu. Although Efutu is preferred for daily interactions at home, the mother communicates with her deaf child using spoken Fante along with gestures (pointing and actions) because she believes that Fante is easier for the child to learn

and understand. The mother believes that her son has enough residual hearing to be able to understand her if she speaks loudly and ensures that he is looking at her. She says that she prays to be able to communicate in spoken language him 'as I see other parents communicating with their children in spoken language' (C4).

F8 comprises two hearing parents and three children, the eldest of which is deaf. They live in a suburb of the Greater Accra Region in a compound house. Twi and Ga are the major spoken languages in this community although other spoken languages (Fante, Frafra, Ewe, Dagomba, Hausa) are used among friends and neighbours. The deaf child attends the school for the deaf in the Eastern Region of Ghana. He travels about 80 kilometres to school and boards during term time. He used to have a hearing aid but complained of pain and has stopped using it. In the home, the family blend Twi and English for communication. The deaf child is learning sign language at school, none of the family members use sign language in the home.

Family members communicate with the deaf child using spoken English and Twi with gesture, written English, and sometime drawing. If the child does not understand an utterance in one language they will switch to the other. During our interview with the mother, she told us that her child prefers to use written English for communication with the family unless he is sure of his Twi and/or English pronunciations and that he also supports his speech with gestures.

F10 comprises a hearing mother of three children, the eldest of which is deaf. They live in Winneba in the Central Region of Ghana in a community where Fante and Efutu are the dominant languages although many other spoken languages (Twi, Ewe, Dagomba, Frafra, Hausa Ga, English) are in use. They live in a compound house. The child attends the local inclusive mainstream school that is 10 minutes' walk from home. He is learning GhSL at school and at a local church. He does not use any hearing technology. Fante and Efutu are used among family members. Efutu is their language use of preference although they will switch to Fante (the most shared local language) to accommodate other speakers. The mother has learned some sign language through a local church group and often combines the use of GhSL signs with spoken Fante and includes the use of gesture and touch. The deaf child uses signs that he has learned in school with the addition of gesture to communicate with family. When the mother does not understand, he writes things down in English. Using these strategies, the deaf child helps his mother serve at the shop. The siblings do not know any sign language and so use spoken Fante and gesture to communicate with their deaf sibling.

The sociolinguistic context

The selected biographies give us some idea of the multilingual lives of families; the spoken language environment and interaction between English, what are seen as other dominant languages, local languages, and the opportunities available for sign language use. Combining this information with the interview responses from caregivers provided insights into the factors that guide and influence their language practices.

The lack of infrastructure around early support is an inhibiting factor for caregivers on a number of levels. First, because there are no systematic screening measures a child's deafness is sometimes not picked up until school age. None of the caregivers in this study have experience of early (preschool) support or intervention following confirmation of their child's deafness. For two of the caregivers, there were opportunities for support in connection with the schools for the deaf, but because of late identification this was not available until their child was over five years old and involved prohibitive travel costs.

Second, whilst local languages are promoted in the educational context, GhSL is not officially recognised as one of the languages of Ghana and the education system does not promote bilingual language practices (Opoku et al. 2020). This presents a double bind for caregivers who have to send their deaf child to a school for the deaf where the use of spoken language is not encouraged (irrespective of individual children's different audiological capabilities) to learn a sign language that is

not valorised beyond the school context. The alternative is to send them or to a mainstream school where spoken language is salient but where no sign language support is available (as for F12). Caregivers have concerns about these choices and the influence on their children's' language development.

> *I decided to send him to deaf school. But am a bit disturb because I was told if I send him to deaf school, he might lose the little speech he has because the schools for the deaf only use sign language and gesture as their mode of communication but I also want my son to talk.* C4

Furthermore, although deaf teachers in the schools are fluent sign language users, few of the hearing teachers are. No specific deaf education training is currently available in Ghana and GhSL skills are not an employment prerequisite, although school-based tuition is available once employed. Finally, for most deaf children (as for F2 and F8) attendance at one of the schools for the deaf involves travel and term-time boarding. Caregivers worry about taking and leaving their deaf children in the care of the schools. They are not able to pay regular visits due to the cost and travel time involved.

Societal narratives around multilingualism, being deaf and using sign language are a major influencing factor. Caregivers worry about the impact of the use of multiple languages on their children's (spoken) language acquisition and this influences their choice of language use with their deaf children at home. Five of the caregivers use two spoken languages at home and three prefer to only use one spoken language. Wider attitudes to GhSL also influence caregiver language choice. GhSL is often referred to by caregivers as '*the school sign*' rather than considered as a part of the legitimised home language repertoire. Caregivers want their children to be like other children, and because sign language is not widely recognised or valued, they have little confidence in using it with their deaf child for fear that this will limit communication opportunities and further marginalise their child.

> *I want to interact with my child through spoken language as I see other parents communicating with their children in spoken language.* C4

Caregivers' responses suggest that they are constrained by polarised views of sign and spoken language possibilities. Signing is portrayed as an alternative to speech, rather than an additional resource and most refer to an either/or choice. Caregivers are usually advised by practitioners that the use of sign language is the only way to communicate with their deaf children and bi/multilingual communication, or more general visual communication strategies, are not discussed. Communication in the school for the deaf is understood to be 'only sign language and gesture' (C4). This polemic narrative undermines the rich communication strategies that caregivers are already developing and obscures understanding of the different ways of being deaf, and diverse approaches to communication (Mugeere et al. 2015).

Caregiver choices about their use of language with their deaf children are also influenced by the experience of stigma surrounding deafness in the wider societal context (Baffoe 2013). Seven of the caregivers talk about other adult's behaviours and being singled out as different. C6 talks about the different ways in which people look at you and how this 'breaks your self-confidence'. Stigmatisation extends to teasing or bullying behaviour from children in the community to the extent that caregivers have to make decisions about keeping their deaf children socially isolated. Such societal attitudes can lead to experiences of marginalisation in the local community.

Most caregivers that we interviewed, like many Ghanaians, live in rented houses on a temporary basis where they share common facilities with other tenants who are not their family members. Such a household, that may comprise different ethnic groups, is usually a multilingual space where there are opportunities for interaction in different languages. However, caregivers told us that they, and their deaf children, are sometimes excluded from interaction in these communities. Sometimes co-tenants do not allow their children to play with a deaf child in the compound. The multilingual possibilities of this living arrangement do are therefore always accommodating caregivers and their deaf children.

Caregivers are also disempowered economically. Most of the caregivers that we interviewed are small-scale farmers or small traders (selling food, water or other goods on the roadside or house to

house). In both cases, this implies a hand-to-mouth existence that does not provide for much beyond daily needs. Caregivers with such low incomes are significantly burdened by the need to provide for and support their deaf children's education and hearing health (technology) needs. Additionally, the nature of casual work does not allow caregivers much leisure time for interacting with their deaf children in relaxed ways that are supportive of language and communication development.

Language and communication practices

Families make some choices about spoken language use, according to context and audience, but are not able to do the same for sign language. All the families are hearing, and their only experience of sign language use comes from their child's attendance at the school for the deaf (on the average, not until the child is eight years old). The interview data reveals that families find other ways to communicate using a range of multimodal strategies. For example, by combining 'speech together with gestures and signs' (C12).

> *We communicate with her by speaking and adding gestures. It is not the prescribed sign language but gestures by throwing the hands up and down and pinpointing at objects you may be talking about.* (C11)

Caregivers often talk about the way in which they use mime and demonstration to explain things.

> *I put my hand close to my mouth and close my fingers to mean a cup, this tells him I will drink water. And he will get me some water. If I want him to wash bowls, I do same as I did for water and make a round shape with my two hands like the shape of a bowl, stir with my index finger and he will understand that I am telling him to wash the bowl.* (C12)

Writing and drawing are also mentioned as a means of communication or clarification.

> *He uses sign language but when I am not getting him well, he writes on a paper to tell me what he meant.* (C10)

Caregivers all demonstrate an awareness of the need to engage their child's attention and establish eye contact for communication. However, most seem uncertain of their child's spoken language abilities and lack understanding about how to foster spoken language skills, other than by raising their voices, focusing on speech sounds and the pronunciation of individual words.

> *We communicate through actions and gestures. Sometimes I look straight into his face to make an action when I want to send him on an errand. Sometimes when he is closer to me, I shout a bit louder to call him, he hears.* (C4)

Caregivers are conscious of the difference between 'prescribed sign language' and gesture but have little experience of GhSL to bring to the communicative context. Several caregivers refer to sign language as reserved for the school environment rather than as one among the other home languages. Caregivers also talk about using their own home signs in their communication with their child and make a distinction between the 'language of deaf people' and the 'unorthodox signs' that they use at home (C11) that are 'not his school's signs' (C1).

Caregivers describe the difficulties they experience in relation to communication and language in the home centre on understanding and being understood by their child and the complexities of including them in family and community activities.

> *It's difficult. If it's time for storytelling and you're telling the story, they are all together and you realize that she is not getting it you must use gestures* (…). C6

In F2 for example, the father has no knowledge of sign language. He relies on the mother or siblings to interpret for him. Where caregivers and their children live with extended family and/or other child and adult tenants, the local spoken language prevails. It is usually only the main caregiver (in most cases, the mother) who adapts their communication or has some sign language skills. C10 for example reports that the two siblings of the deaf child are not able to communicate with him in sign language and only use Fante.

Caregivers in this study use their own strategies in communicating with their deaf child. There are no official policies around the recognition or use of GhSL and there is an absence of opportunities for families to learn GhSL. None of the caregivers have previously met a deaf person in a professional or supporting role. Their responses nonetheless demonstrate the ways in which they use the resources and repertoires available to them to engage with their children and encourage reciprocal interaction.

Discussion

Deaf children in Ghana are born into a multilingual culture where at home and in the surrounding community multiple local spoken languages are in use alongside the official language of English. Caregivers move between their spoken languages in the home and use both the local language and spoken/written English with their deaf children alongside different forms of visual communication. For most, this comprises a combination of individual GhSL signs, home signs, writing, drawing, and gesture (pointing, actions, mime, demonstration), and touch. However, caregivers do not recognise these multimodal strategies as a resource and these strategies do not have capital outside of the home environment.

Without early screening and identification and access to maintained hearing technologies or the possibilities of cochlear implants, the importance of visual communication for deaf children in this context is paramount. Whilst children encounter GhSL once in school there are no fluent GhSL speakers at home and the languages of the home other than English are not used in the school context. This is an impoverished language learning experience that excludes deaf children from the multilingual communication practices of family and community and excludes families from the language and culture of the schools for the deaf.

Multilingual language choices

Caregiver decision making about communication is strongly influenced by the wide social-cultural dynamics surrounding language use and deafness where sign language is seen as separate from the multilingual culture of the society. The use of sign language is associated with minoritised individuals and communities, and this is disempowering for families and individuals. Whilst there are increasing initiatives to legitimise and valorise local languages, this does not extend to GhSL.

In addition to this pressure, caregivers do not have manageable access to sign language training, they are physically and culturally disconnected from the school for the deaf, and do not benefit from supportive partnerships with deaf adult role models and mentors, and other professionals. The absence of an external infrastructure around early years support has far reaching consequences for individual development and family relationships as well as language and communication development.

Given these circumstances, the extent to which caregivers have choice about their language practices is questionable, and the relevance of models of early support that conceptualise intervention around family language policies and planning problematic (Curdt-Christiansen and Lanza 2018). Whilst research into family language policies provides a tool for the analysis of diverse social conditions of multilingualism, the use of this model assumes a level of professional interaction with families (Weber 2021) and a certain amount of family agency in 'inviting families to examine and potentially transform their own language ideologies' (Mitchiner and Batamula 2021, 197). This perspective also assumes the availability of language choices for the caregiver whether this be to use sign language as a family (Kanto, Huttunen, and Laakso 2013; Kite 2020), to opt for a CI and focus on spoken language use (Mitchiner 2015) or to pursue a bilingual educational approach (Siran and Dettman 2018). This, and other approaches to family centred intervention are not inclusive of minoritised families, or families in contexts where there is limited agency, choice, and resource.

Multilingualism as social practice

The language and communication challenges for caregivers and their deaf children in this context are social, and not about language alone (Salö 2018). At one level, the multilingual for caregivers of deaf children are about human relationships and understanding. The use of the different local languages in caregiver and family lives embody the inclusion of, and affiliation with others, and as such these practices facilitate a connection between people and mutual understanding (Busch 2016). Conversely, it is the social conditions around deafness and sign language use that ostracise caregivers and their deaf children from community and social life.

At another level, these struggles are a product of societal structures around language, education, disability and inclusion and the resources and experiences of caregivers. In Bourdieusian terms, these interrelated factors can be conceptualised as 'field' and 'habitus' where 'field' denotes the infrastructure, policies, cultural attitudes and ideologies around deafness, language and communication that become socialised in 'habitus', that is individual resources and expectations that shape caregiving (Bourdieu 1990, 1991). Also pertinent to this research context are Bourdieu's constructs of 'linguistic capital' and 'linguistic market' with reference to the ways in which the use of sign languages in society are legitimised (O'Brien, 2021).

Habitus, according to Bourdieu, is a way of thinking and being that we become as a result of social conditioning and socialisation. This is not a one-directional influence but rather an interaction or relationship; we are shaped by, and we shape, our social world: Caregivers are disempowered by the disjuncture between home communication and school signs but at the same time they propagate the separate linguistic markets of home, where the use of sign language is not generally valorised, and school, where its use is legitimised. The habitus of caregivers in this study shapes the way in which they use their multilingual and multimodal resources but at the same time challenges and changes their repertoire: Their cultural day-to-day practice of switching between local languages extends to include signs, gesture and touch with their deaf children and to some extent changes the practices of those around them.

Importantly, in Bourdieu's thinking habitus is a product of field. This relationship denotes a subtle divergence from concepts of environmental influence, that we see in the ecological model, to an understanding of language practice as an embodiment of the terrain or field – 'history made into a body' (Bourdieu 1990, 191). This is significant because of the consequent relationship between individuals and their contexts in terms of hierarchies, power relations, and agency. Caregiver's lack of access to early support and disconnection with school, for example, is historically suited in the colonial history of Ghana. When deaf education was originally missionised in the 1950s through the establishment of a school for the deaf system, the education and care of deaf children effectively became detached from the wider education infrastructure. There is no current legislation for the education of deaf children either as adjunct to, or as part of, the governments inclusive educational for all agenda.

Whilst caregivers have the power to shape the language practices of the home, they lack resources to effect this. For this to change, the value or linguistic capital of GhSL must change beyond the home and school contexts. This requires changes to the way in which disability in general and deafness specifically is viewed in society that would enhance the power of the Ghanaian deaf community to bring sign language into the multilingual repertoire of society. This amounts to a major structural change through which the market value of GhSL is endorsed by those with structural power, that is to say recognised in educational policy, validated as a central part of an inclusive legislation, and legitimised through bilingual education policy development.

Conclusion

Understanding the extent to which caregiver agency and choice is a product of social life is important for the development of early support in different global multilingual contexts.

Multilingualism for these families is shaped by societal and cultural structures and ideologies (Moraru 2020). These insights suggest a move away from purely 'lingual' investments in early support to an emphasis on extending societal structures and ideologies to include deaf ways of being and communicating (Mackenzie and Scully 2007), supported by policy-level actions that legitimise sign language use as part of local multilingual languaging practices.

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