# Physiotherapists in Afghanistan

## Exploring, encouraging & experiencing professional development in the Afghan development context

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Göteborg 2010

Cover illustration: Ester Svensson

The illustration is a representation of the Afghan proverb, ‘a mountain cannot reach a mountain, (but) a man can reach a man’, decorated with inspiration from *suzani* patterns. Suzanis are embroidered fabrics with distinct, colourful patterns made in Afghanistan and other Central Asian countries.

Physiotherapists in Afghanistan: Exploring, encouraging & experiencing professional development in the Afghan development context

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ISBN 978-91-628-8167-2
http://hdl.handle.net/2077/22922

Printed by Intellecta Infolog AB
Göteborg, Sweden 2010

کوه به کوه نمی رسد آدم به آدم میرسد

*A mountain cannot reach a mountain*
*(but) a man can reach a man*

Afghan proverb

# Abstract

The aim of the thesis is to analyze the matter of supporting professional development of physiotherapists in Afghanistan, and the issues involved in expatriate physiotherapists working with professional development cross-culturally in development contexts. The thesis is based on two field studies, aspects of which are reported on in four papers. The first field study aimed at analyzing and describing the physiotherapy component of a disability programme. The aim of the second field study was to explore the process of a development project, in order to gain understanding of how such work can be done in a better way. Participant observation was used for the data production of both studies. The adult learning theories of transformative learning and situated learning were used as a theoretical framework in the thesis.

Paper I describes the situation, needs and challenges for developing physiotherapy in Afghanistan. The therapists worked in isolation with little opportunity for further education or professional development. Their approach was mainly medical, where the work was dictated by the patients' expectations and doctors' recommendations. They used primarily passive methods of treatment, and their work was affected by cultural, religious and situational factors and they demonstrated a basic capacity of clinical reasoning.

Paper II explores factors that impacted learning and professional development of the Afghan physiotherapists in the development project. Examples of these factors were: a pattern approach to treatment, linear thinking, and socially oriented decision-making that affected how new things learned were put into practice; concrete representations and an instrumental view of knowledge characterized learning approaches; language barriers, different interpretations of meaning and cultural codes challenged communication; and a prescriptive, encouraging approach of the expatriate physiotherapy development worker affected teaching and learning.

Paper III explores professional ethics for Afghan physiotherapists and identifies two ethical tensions for the professional practice of Afghan physiotherapists: between individualistic and communitarian ethical perspectives, and between normative ethics and local morals.

Paper IV is a critical reflection over the expatriate development worker's development process through, and impact on, the development project. The perspective of the development worker is transformed from an idealistic helper to an enterprising learner as a consequence of active participation in and a self-critical reflection of the process.

Working with and researching professional development cross-culturally and in development contexts is complex and requires consideration of many different factors. Cultural competency is essential, where to understand others one needs to first understand oneself, and oneself in relation to others. This requires support when in the field. Physiotherapy theory and practice must be adapted to the local context. Actions taken towards promoting learning and professional development must be firmly rooted in the Afghan context, and investigated, planned and implemented together with Afghan physiotherapists. The professional development of Afghan supervisors and teachers should be a priority. To encourage reflection of both Afghan and expatriate physiotherapists a communicative learning approach could be taken, where ethical challenges and disorienting dilemmas can form the basis of a reflective discourse and lead to increased understanding.

**Key words** Afghanistan, collaboration, culture, development project, ethics, field study, learning, physiotherapy, professional development, reflection

# Abstrakt på Svenska

Syftet med avhandlingen är att analysera professionell utveckling av sjukgymnaster i Afghanistan, och vad det innebär att som utländsk sjukgymnast att arbeta med och stödja professionell utveckling över kulturella gränser i utvecklingssammanhang. Avhandlingen baseras på två fältstudier som redovisas i fyra artiklar. Den första fältstudien syftade till att analysera och beskriva sjukgymnastiken i ett rehabiliteringsprogram i Svenska Afghankommitténs regi. Syftet med den andra fältstudien var att utforska processen i ett treårigt utvecklingsprojekt som hade som syfte att utveckla Afghanska sjukgymnasters professionella kompetens. Deltagande observation användes för data produktion i båda studierna. Som teoretiska referensramar i avhandlingen har 'Transformative learning' och 'Situated learning' använts.

Artikel I beskriver utgångsläget 2004, behov och utmaningar för att utveckla sjukgymnastik i Afghanistan. Sjukgymnasterna arbetade isolerat med få möjligheter till vidareutbildning eller yrkesutveckling. Deras arbetssätt var främst medicinskt och arbetet styrdes av patienternas förväntningar och läkarnas rekommendationer. De använde främst passiva behandlingsmetoder och deras kliniska resonerande var begränsat. Arbetet var påverkat av kulturella, religiösa och situationella faktorer,

Artikel II analyserar faktorer som påverkade lärande och professionell utveckling hos de afghanska sjukgymnasterna i utvecklingsprojektet. Exempel på dessa faktorer var: ett 'kokbokstänkande' i behandlingen och ett socialt orienterat beslutsfattande som påverkade hur nya tekniker användes i praktiken; en instrumentell syn på kunskap och behov av konkreta representationer kännetecknade deras lärandestrategier; språkbarriärer, olika tolkningar av innebörd och kulturella koder var utmaningar i kommunikationen; och en instruerande och, uppmuntrande approach hos den utländska sjukgymnasten/utvecklingsarbetaren påverkade både undervisning och lärande.

Artikel III analyserar yrkesetik för afghanska sjukgymnaster och identifierar två etiska spänningar i professionell praxis för afghanska sjukgymnaster: mellan individualistiska och kollektivistiska etiska perspektiv samt mellan normativ etik och lokal moral.

Artikel IV utgör en analys och kritisk reflektion över den egna rollen som utvecklingsarbetare, egen utveckling och påverkan på utvecklingsprojektet. Det egna meningsperspektivet förändrades från en idealistisk hjälpare till en aktivt lärande utvecklingsarbetare. Att arbeta med och forska om professionell utveckling över kulturella gränser i ett utvecklingssammanhang är komplext, och hänsyn måste tas till många olika faktorer. Kulturell kompetens är avgörande, i det att man först måste förstå sina egna motiv och referensramar och sig själv i relation till andra, för att kunna förstå andra. Detta kräver handledning i det praktiska utvecklingsarbetet i fält. Sjukgymnastisk teori och praktik måste anpassas till de lokala och kulturella förhållandena. Åtgärder för att främja lärande och professionell utveckling måste förankras i det afghanska sammanhanget. I det fortsatta arbetet bör detta utforskas, planeras och genomföras tillsammans med afghanska sjukgymnaster. Kompetensutveckling för afghanska handledare och lärare bör prioriteras. Kommunikativt lärande kan vara ett medel för att uppmuntra till reflektion av både afghanska och utländska sjukgymnaster, där etiska utmaningar och 'disorienting dilemmas' kan utgöra grunden för en reflekterande diskurs som leder till ökad förståelse.

# List of Papers

This thesis is based on two field studies, various aspects of which are described in the following papers. They are referred to in the text by their Roman numerals. Published and accepted papers have been re-printed with the kind permission of the journal publishers.

I Wickford J, Hultberg J & Rosberg S (2008) Physiotherapy in Afghanistan – needs and challenges for development. *Disability and Rehabilitation.* 30, 305-13.

II Wickford J, Edwards I & Rosberg S (2010) Exploring learning and professional development of Afghan physiotherapists. *Submitted, in review process.*

III Edwards I, Wickford J, Ahmed Adel A & Thoren J (2010) Living a moral professional life amidst uncertainty: Ethics for an Afghan physical therapy curriculum. *In press, Advances in Physiotherapy.*

IV Wickford J & Rosberg S (2010) The physiotherapy development worker identity – critical reflections on experiences from Afghanistan. *Submitted, in review process.*

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# Abbreviations

| | |
|---|---|
| AAPT | Afghan Association for Physical Therapy |
| BPHS | Basic Package of Health Services |
| CPD | Continuing Professional Development |
| EBP | Evidence Based Practice |
| ET | Expatriate teacher |
| FN | Fieldnote |
| GIHS | Ghazanfar Institute of Health Sciences |
| HI | Handicap International |
| IAM | International Assistance Mission |
| ICRC | International Committee for the Red Cross |
| MOPH | Ministry of Public Health |
| NGO | Non-governmental organization |
| PNF | Proprioceptive Neuromuscular Facilitation |
| PT | Physiotherapist |
| PTI | Physical Therapy Institute |
| RAD | Rehabilitation of Afghans with Disabilities |
| SCA | Swedish Committee for Afghanistan |
| SGAA | Sandy Gall's Afghanistan Appeal |
| TENS | Transcutaneous Electrical Nerve Stimulation |
| WCPT | World Confederation of Physical Therapy |

# Key Definitions

*Adult learning* is concerned with both social interaction and the external environment, and internal processes of the learner, where the adult learner takes responsibility for their learning, and is bound by what they see as meaningful to learn (Illeris 2006).

*Communicative learning* is the creation of meaning based on mutual efforts to understand each other. It is concerned with understanding what others mean, as well as making ourselves understood, where "the process of understanding involves claims to rightness, sincerity, authenticity, and appropriateness rather than assessing a truth claim" (Mezirow 2003, p.59).

*Context* is the environment or social world in which we live, work and interact (Lave 2009, Merriam-Webster 2010).

*Culture* is a complex, diverse and dynamic system of meanings, or social frame of reference, constructed by groups of people, which affects and is affected by the practices of these people. "Culture is to a human collectivity what personality is to an individual" (Hofstede 2001, p.10).

*Development* is used in three main senses, "a vision or measure of a desirable society; an historical process of social change; deliberate efforts at improvement by development agencies" (Thomas 2000, p.48), where the last is the one of relevance for this thesis.

*Development project* is a specific intervention within the development context aimed at improving the situation of people (Thomas 2000).

*Development worker*, often synonymous to volunteer, is an expatriate who participates in and gains experience of development work. Their primary role is to advise, but often they also provide some measure of technical expertise (Eriksson-Baaz 2005).

*Meaning perspective* is the frame of reference which guides our intentions and how we interact and communicate with others, how we interpret others actions and intentions, and how we validate the meaning that we perceive behind these (Mezirow 1991).

*Professional development* a life-long process of learning and refining practice and skills to ensure the best possible care for patients (Aslop 2000, Swisher & Page 2005).

*Reflection* is an intentional, critically analytic process where intellectual and affective processes are used to create meaning and lead to understanding through problem solving, rational discourse, and interpretation and validation of experiences and knowledge (Donaghy & Morss 2000, Mezirow 1991, Rodgers 2002).

# Preface

My interest in Afghanistan has grown out of a general interest in the region due to growing up in Pakistan. My years in Pakistan have had a major impact on inspiring the steps taken to exploring physiotherapy in Afghanistan, and on the desire to gain understanding of how expatriate physiotherapists can support the professional development of Afghan physiotherapists in a contextually and culturally relevant manner. This desire was reinforced as I realized how little explored this is within physiotherapy; although there is much experiential knowledge from all those who have worked in developing countries, there is comparatively little documented, and even less researched.

This journey has been a challenge. There are many people who have contributed extensively along the path that has lead to this final thesis, and I am deeply grateful to each and every one. There are a few in particular whom I would like to mention, and without all of you, the research and this thesis would not been possible.

First, my deep and sincere gratitude goes to the *Afghan supervisors, physiotherapists* and *physiotherapy assistants* who welcomed me and worked with me during my years in Afghanistan. I would like to mention you by name, but there are too many of you to fit in this space! I am not the same person that came to Afghanistan in 2004, and I will forever be in your debt for all you have taught me, for your generosity, hospitality and friendships. I hope that the future will bring many long years of continued collaboration and joint learning!

Next, I want to thank my main supervisor, *Susanne Rosberg*, senior lecturer in physiotherapy. It has not been an easy road, but you've put up with the winding and changing paths. Thank you for daring to take on this challenge, for your dedication, sincere interest and encouragement along the away. This thesis would not have happened without you. I hope you will make it to Afghanistan eventually, and meet the wonderful people that I had the privilege to work with.

I thank my assistant supervisors, *Jane Carlsson,* professor in physiotherapy, and *John Hultberg,* senior lecturer in the theory of science. Jane, thank you for your support and for making it possible to explore a new field at the physiotherapy department at the Sahlgrenska Academy. John, thank you for epistemological discussions, and your feedback on the manuscripts of this thesis. Special thanks goes to *Ian Edwards*, senior lecturer in physiotherapy at the University South Australia, and co-author: your interest in and support in this research process has taught me so much, and challenged me to new perspectives. Your dedication to and interest in the Afghan physiotherapists is inspiring. I also thank *Jan Gustavsson,* senior lecturer at the department for education and special education, for invaluable feedback and discussions during the process of writing the frame of this thesis, and *Anette Olin*, senior lecturer at the same department, for methodological discussions. Thanks also goes to *Bengt Kristiansson,* previous Secretary General of the Swedish Committee for Afghanistan, for your

openness towards the idea of including research in our development project and for your interest in this project.

There are also a number of people in Afghanistan, or who have worked in Afghanistan, to whom I am indebted. First, my previous colleagues in the RAD programme, *Zemarai Saqeb, A Malik Halim, Amin Qanet, Atiqullah Namati, Samiullah Mahmoody* and *Dr Ghani Amin.* Thank you for putting up with our incessant ideas, for the discussions and the open constructive atmosphere in RAD. I thoroughly enjoyed working with you all, and am grateful for all you organized and put up with as we worked together. My office-buddies, *Anne Hertzberg* and *Fiona Gall:* you both were great sounding boards, and supportive in all our activities. I loved going on fieldtrips with you, and am amazed at your energy and rigour in tackling the never-ending challenges. *Jeanne Hartley,* you are a role-model. Your trips to Afghanistan were so encouraging, and I would love to be in Afghanistan at the same time again, and go on joint field trips to visit and work with our Afghan physio colleagues! *Heather Dawson,* your happy smiling face and attitude have been a constant encouragement, ever since I first met you on the Amani football pitch! I have enjoyed the continued discussions, and I hope we will have the possibility of working together again. I also want to thank *Zara Pennicook*, for all the talks, your encouragement, your professional guidance and inspiration – and for home-made fig-and-walnut spread. It was great having you in Kabul, and your trainings were a fantastic contribution. Maybe we can meet again in some joint venture. Thank you *Chiara Retis,* for discussions and collaborations with all the bits and pieces that needed attention. It was so good to have a friend to share professional issues with! *Judy Thoren,* your gentle and deep understanding of the situation of Afghan physiotherapists is something I hope I can come to gain. Thank you for sharing your wisdom and insight.

I thank the reading group at the physiotherapy department, *Carin Willén, Anna-Lisa Thorén-Jönsson,* and *Margareta Kreuter,* for constructive input into aspects of the frame of this thesis. Also, thank you *Fredrik Bertz,* for proof-reading the frame. *Ester Svensson,* thank you for the beautiful cover illustration! You're the most talented and thoughtful artist I know.

Finally, my family. *Mam, Pap, Ester, Marcus* and *Anna:* I know of none who have such a supportive family. Your understanding and unquestioning support in encouraging me to go a place most people would never dream of going to. Your visits and excitement in sharing the Afghan chapter of my life. Your belief in me through the lows. Thank you for more than I can say.  Ni är helt enkelt bäst.

# 1 INTRODUCTION

This thesis is based on two field studies, various aspects of which have been described in four papers. These four papers explore and discuss different factors related to professional development of physiotherapists in Afghanistan. They have by no means covered all aspects related to this, but they are a start in providing greater understanding of what needs to be considered when working with professional development in a country where physiotherapy is still young and faces many contextual challenges.

The first field study spanned three months in 2004, and aimed at analyzing and describing the physiotherapy component of a disability programme, Rehabilitation of Afghanistan with Disabilities (RAD). Based on this, the needs and challenges for developing physiotherapy in Afghanistan were established, described in paper I. Meeting the physiotherapists, seeing the complex reality of their practice and hearing about their hopes and dreams as professionals compelled me to return in 2006, and from 2006-2009 I worked, lived and researched in Afghanistan. For the first two years I conducted a development project together with a group of Afghan physiotherapists, which aimed to strengthen and improve the clinical practice of the physiotherapists in RAD as well as encourage a greater responsibility of the supervisors in taking charge of their own professional development. In order to understand how to do this in a better way, a second field study was conducted of the work. Based on this second field study, paper II explores factors that impacted learning and professional development of the Afghan physiotherapists in the development project, and paper IV is a critical reflection over my development process through, and impact on, the development project. The experience from the second field study also feeds into paper III, which explores professional ethics for Afghan physiotherapists.

## Aim & Outline of the Thesis

This thesis describes the paths taken in the studies above. With a critical perspective on the work that was done, the overarching aim of this thesis is to analyze the matter of supporting professional development of physiotherapists in Afghanistan, and the issues involved in expatriate physiotherapists working with professional development cross-culturally in development contexts.

Although the more traditional form of presenting ethnographic research is as a monograph, this is a thesis by portfolio. The reason for choosing this format is that peer-reviewed articles are more easily accessible to a broader public, which is of value due to the paucity of accessible research regarding physiotherapy in developing countries. There is also the value of the peer-review process of publishing articles. However, the nature of the ethnographic approach and the theories used requires ample descriptions of both the context and the

research process that is not possible in the limited space of the articles, hence the length of the thesis.

Proverbs, stories and folk legends have an important place in Afghan culture, to convey moral messages and societal values, and to humour and entertain (Dupree 2002). Thus, each chapter is introduced with an Afghan proverb that illustrates a main theme in the chapter. In the second chapter the context of the thesis is described, which includes physiotherapy in developing countries, aspects of the Afghan context, and physiotherapy in Afghanistan. The third chapter outlines the theoretical perspectives that have been used in this thesis. The fourth chapter describes the methodological approach, the research context and the research processes, followed by a methodological discussion. The findings of the four papers are summarized in chapter five. Based on the discussions of the four papers, chapter six discusses various aspects related to promoting professional development for Afghan physiotherapists, as well as what it means to work as a physiotherapy development worker in such endeavours. Chapter seven brings this thesis to a close with a conclusion of the main messages of this thesis.

# 2 BACKGROUND

باصلح گفتن دنیا آرام نمی شود

The world will not find rest by just saying "peace"

Afghanistan will not find rest by just saying “peace”. Numerous wars have ravaged the country where one conflict has paved the way for another. The Afghan people have endured tremendous challenges and hardships. And despite all the resources that have been poured into the country, the situation is not improving. There are concerns about much of the development work being conducted. Has the work been more about external interests than solutions rooted in local needs? In this complexity, where does physiotherapy fit in?

To understand the matter of promoting professional development of physiotherapists in Afghanistan, the Afghan development context must be described, as well as the role of physiotherapy in this. First, physiotherapy in the developing world will be presented. The context in which Afghan physiotherapists work, and in which expatriate physiotherapists participate, will be described, followed by physiotherapy in Afghanistan. The chapter concludes with the aims of the four papers and of this thesis.

## Physiotherapy in Developing Countries

Physiotherapists are proposed as important for rehabilitation services in developing countries (Kay et al. 1994). In these nations physiotherapy is suggested as valuable beyond providing pain relief and promoting mobility: Landry et al. state that “the direct and indirect loss of human potential due to disability and poor health is a financial expense” (2007, p.234) which directly impacts developing nations possibilities for human development. They call upon physiotherapists and health professionals to address the issues of disability through advocacy, research and action on a local and global level.

Physiotherapy is practiced in a wide range of countries across the globe (Crompton et al. 2001, Higgs et al. 2001). It is at different stages of development in different countries; with base similarities and a common definition and aim of practice, there are local variations and traditions affecting its practice and development (Higgs et al. 2001). Physiotherapy practice and education has thus followed different development processes in different countries (for example, see Chipchase et al. 2006, CSP 1994, Dunleavy 2007, Echternach 2003, Irwin-Carruthers 1988, Kay et al. 1999, Lundbladh 1993, Moffat 2003, Swisher & Page 2005, Werner 1987). There are differences pertaining to local conditions in each country, and distinctions can also be made between Western and developing nations.

In Western countries, the development of the physiotherapy profession spans the last century into the 1800’s and has been shaped by major events in

history. For example, the poliomyelitis epidemic and several major wars were directive in the development of physiotherapy in America (Moffat 2003). In developing countries, by contrast, the profession is often introduced by Western funded and -run organisations, such as in Cambodia (Dunleavy 2007) and Afghanistan (Lammi 1997). The important difference here is that physiotherapy in Western countries has developed in accordance with historical events and is related to the countries' cultural contexts, while in many developing nations it is introduced, taught and developed by external physiotherapists, often as a direct result of considerable health-care needs, wars or natural catastrophes. Since physiotherapy has its roots in Western ideology (Norris & Allotey 2008), the development efforts tend to be based on Western notions of physiotherapy practice and ethics.

At the same time, the development, education and practice of physiotherapy in these countries are affected by local cultural norms, for example in Palestine (Dawson 1999). Also, there are particular challenges to developing physiotherapy in developing nations that differ from those in Western countries, such as in Cambodia (Dunleavy 2007). This has direct implications for teaching and professional development in these countries.

## Physiotherapy education & professional development in developing countries

There is much work being done with developing physiotherapy services in developing nations, and there is considerable experience regarding training needs and approaches (Horobin & Naughton 2008). But accessibility to this knowledge and experience is limited, and there is a paucity of research available regarding how physiotherapy is best taught and developed in these countries.

The research considers various other factors. There is a recognition of the personal and professional benefits of working in developing countries for physiotherapists (Humphrey & Carpenter 2010) and physiotherapy students (Dupre & Goodgold 2007, Sawyer & Lopolo 2004); there is recognition of the problematic issue of stemming from Western-developed theories regarding physiotherapy practice in non-Western contexts (Norris & Allotey 2008); there is an increasing understanding of the consequences of cultural differences in physiotherapy practice (Noorderhaven 1999), and of the importance of cultural competency for physiotherapists (Black & Purnell 2002, Lazaro & Umphred 2007, O'Shaughnessy & Tilki 2007). The research literature is weighted towards the rewards for the expatriate physiotherapists and students in terms of the potential for developing cultural awareness and competency through engaging in clinical practice in a developing nation (Dupre & Goodgold 2007, Humphrey & Carpenter 2010, Sawyer & Lopolo 2004). There is comparatively little discussion of the implications of Western physiotherapists promoting, practicing and teaching a Western-developed profession in a country with a cultural context and history (sometimes radically) different than their own. Whatever the reasons for

living and working in developing nations, these are important issues to consider. Thus the context in which professional development is promoted is central:

> Physiotherapy practice is international, but the context of practice is not. … It dawns on us that the delivery of physiotherapy services cannot be the same in all countries. We know there are different health needs, different economic, health care and educational systems, and different demographic characteristics. Yet rarely do those outside the country concerned, and sometimes even those inside it, appreciate how those differences affect physiotherapy practice (Williams 1985, p.3).

These words, written 25 years ago, still hold sway. Much has been done and gained in developing the physiotherapy profession internationally. But there is more to be investigated concerning how this is done in developing countries, about how expatriate physiotherapists engage in this work. To explore this in terms of professional development of physiotherapists in Afghanistan an understanding of "the context of practice" in Afghanistan is needed.

## The Afghan Context

Afghanistan has over the past 30 years been a recurrent focus of international media, and various images of this landlocked country have been broadcasted across the world. Surrounded by Pakistan, China, Tadjikistan, Uzbekistan, Turkmenistan and Iran, it holds a strategic position and has been, and still is, the playing field for many mighty powers. With numerous wars, humanitarian crises and droughts, the country has moved from one tragedy to the next. Being largely mountainous with stretches of plains and of desert, large areas are inaccessible and inhabitable, and it appears barren, rugged and difficult. Yet things are never only as they first seem. The dusty brown hills and expanses give way to green valleys where local apricots and almonds have never tasted better. Drab, brown, dirt walls hide carefully tended gardens, where grapevines climb the trellises and roses scent the air. The Afghan context has many sides, and what will be described here covers only a few of them.

### Afghanistan today

Almost 10 years after the fall of the Taliban the situation in Afghanistan is far from stable. Due to many years of drought and destruction the country is dilapidated on all levels, and it is rearing a generation that has known only war and displacement. In 2002 Afghanistan was considered a "profound humanitarian crisis" (Sharp et al. 2002, p.215). Since then it has been – and is – the recipient of massive military intervention and support, humanitarian aid, emergency relief and development efforts, all from a broad array of international governments, donors, agencies and non-governmental organizations (NGO). Although there has been progress in many sectors since 2001, Afghanistan remains one of the

least developed countries in the world with low social indicators of food and housing, health and education; 70% of the population are severely vulnerable in terms of health and poverty (WHO 2007). Living standards remain low, human rights are abused, corruption flourishes. The Afghan government steadily loses public legitimacy as the country deteriorates, and it remains highly dependent on outside resources and support (HRW 2009). In 2009 Afghanistan's Human Development Index (HDI) rated 181 out of 182 countries (UNDP 2009). Furthermore, despite massive international development, peacekeeping and military efforts, insurgent groups and the Taliban are on the rise and the security situation has steadily deteriorated; it was in 2008 the worst since the fall of the Taliban. The fighting has increased at the expense of civilians, especially women and children (HRW 2009). Through all this, the majority of Afghans want only to get on with a normal life and tend to their own business (Johnson & Leslie 2008).

## Ethnicity, collectivism & honour

There are approximately 30 million people living in Afghanistan (UI 2007). The Afghan social structure is composed of a number of different ethnic groups, and Afghan culture is a rich milieu of traditions stemming from these, and from the many people and groups who have passed through (Dupree 2002). The largest ethnic group are the Pashtun, which represents approximately 50% of the population; they are politically dominant and live in the western, southern and eastern parts of the country. The Tadzjek, Uzbek, Turkmen and Kirgis live in the north, the Hazara people live in the central highlands, the Baluch in the south and the Aimac in the west. Historically, a geographical spread and limited means of communications has isolated the groups, and given rise to individual ethnic and cultural characteristics (Forsberg 2005, UI 2007).

Thus there are differences between the groups, but also similarities. A common trait is the centrality of the family and the clan, which function within a patriarchal system (Forsberg 2005, UI 2007). Afghanistan is a collectivist society, where the welfare of the group goes before that of the individual. Although the fighting, the massive displacements of the past decades, and the migrations to larger cities have caused splitting of families and a mixing of the different groups, the element of group belonging and of Afghan identity is still strong (Forsberg 2005): "key to understanding the Afghan notion of identity is that it is formed in relation to others: to family, to community, to tribe or ethnic group. A person's sense of self and place in the world works from the family outwards through ties of kinship and other networks" (Johnson & Leslie 2008, p.48). Linked to this, hospitality and social life is central to Afghan culture (Dupree 2002).

Another key concept that runs deep is honour: "Honour is the rock upon which social status rests" (Dupree 2002, p.978). This is particularly strong in Pashtun culture, and defending one's own or the family's honour is done at any cost (Forsberg 2005, Johnson & Leslie 2008). Honour is intertwined with moral actions, not the least when related to gender roles (Karlsson & Mansory 2007): a

proper behaviour of men and women is directly linked to notions of shame and honour. A man's honour is linked to how he takes care of and treats his family, and how his family behaves is reflected on him. A woman's honour is damaged if she does not carry out her duties properly, such as mothering or housekeeping.

## Men & women

All societies have gender stereotypes, where children are socialized into roles through schooling and the environment in which they grow up. As such, a collectivist society holds certain implications for the roles of its members, men and women alike. Also, Afghanistan is an Islamic country, and roles of men and women are coloured by Islamic traditions. However, when discussing perceptions of gender roles one must take care not to confuse religion for culture or tradition. For example, 40% of gender discrimination was seen to be related to tradition while only 25% stemmed from a strict interpretation of religion (Brieger 2005). The roles of men and women in Afghanistan have deep roots in their traditions and their ethnicity, and they have been further impacted by the many years of war and insecurity.

The gender relations are complex. The man has the overall decision-making power as the head of the family. Men function in the public sphere whereas women are restricted to the private sphere of the home (Karlsson & Mansory 2007). Women can within this sphere have considerable power. Women are the nucleus of the family, and the status and honour of the family is tightly linked to them. An important role for the men is to protect their home and family, and their women – this includes respect for women. Since the women carry the honour of the family, this protection also means protecting the family honour. This relationship must be understood in its broader context: when there have been no national rules of law due to weak social welfare and state institutions, it is up to the community and extended family to protect its own. The male members of the family, the husband, father or brother, shoulder this responsibility. Furthermore, the many ethnic and social groups have their own traditions and values concerning the roles of men and women, whereby these vary within the country. The roles also depend on social status and the age of men and women, and there is often a distinct difference between the rural and urban lifestyles and values where the rural areas are generally more conservative than in the cities (ibid).

## Islam

Afghanistan is an Islamic republic, where all laws and regulations – on local as well as national level – are based on Islam. Virtually all Afghans are Muslim. Most of these are Sunni, the largest Islamic branch, and 15-20% are Shia. Smaller groups of other religions exist and are permitted, as long as they practice their faith in discretion (UI 2007, Utas 2005). According to Dupree, there is a general tolerance, where "Afghans have a profound belief in the humanitarian, egalitarian teachings of Islam. They do not make an issue of being Muslims, of

exhibiting proof of their muslimness, and abhor any tendencies toward fanaticism. This is the pillar on which Afghan culture rests" (2002, p.980).

As with the centrality of the family, Islam is a common denominator between the different ethnic groups and colours all areas of the society, from everyday activities to the political arena: "it is impossible to imagine an Afghanistan without Islam" (Johnson & Leslie 2008, p.47-8). The society is also built on tradition and in many cases, tradition and religion become merged which can be misleading in the interpretation of what is what (Utas 2005).

## Education

During the second half of the 20th century, and before the wars, considerable developments towards a modern educational system were made, but during the conflict-filled decade following the Soviet invasion in 1979 the education sector suffered tremendously (Samady 2001). At present, increasing insecurity and insurgence is severely compromising children's education, particularly in the south and southeast. In 2008, 46% of girls and 74% of boys were enrolled in primary school, and only 8% of girls and 18% of boys were enrolled at secondary level (HRW 2009). Apart from the insecurity and lack of accessibility, there are a number of challenges for the educational system: large classes, poorly educated teachers (with little or no formal education), lack of resources and teaching materials, and inconsistency in students' attendance in the classes (Karlsson & Mansory 2007).

Education is highly valued by Afghan parents, and teachers traditionally have a central role and a respected status in the Afghan community (Karlsson & Mansory 2004, 2007). Boys and girls are generally considered to have equal rights to education, but there is a catch: girls, particularly older (nearing puberty) ones, should not be taught by male teachers. As there are limited numbers of female teachers, this is a considerable challenge for girls' education.

Memorization and imitation have been, and are, central components of teaching and learning in Afghanistan (Karlsson & Mansory 2007). The practice of memorization or rote learning stems from the Islamic schools where reading and writing was a rare skill, and the Quran was learned by heart (Boyle 2006). Still, there is some variation in the educational methods, where teachers with higher education from teacher training colleges and Western-type schools do not lean so heavily on memorisation and imitation (Karlsson & Mansory 2007).

## Medical services & health-care issues

The present medical and health-care scene in Afghanistan is complex. As a result of a long-standing, ill-functioning health care structure, and due to the years of fighting and drought, dire consequences are suffered by the Afghan people. One in five households has a disabled person (Trani & Bakhshi 2006) and the increasing instability in the country is continuing to reap victims of war. Women and children's health is among the worst in the world: maternal mortality is extremely high with 25,000 deaths per year, and infant mortality is 129 per 1000

live births. The prevalence of communicable diseases is still high. The long years of conflict have led to the development of depression, anxiety and post-traumatic stress disorders, especially amongst women. Poor education, low economic status and inadequate nutrition all contribute to widespread ill health. There is not enough medical staff and facilities to answer to the needs of the people: there are only two physicians, five nurses/midwives, 4.2 hospital beds, and 0.6 primary health care units and centres per 10,000 inhabitants (WHO 2007, 2009).

Many educated Afghans – including health professionals – fled the country during the years of war and insecurity (Sharp et al. 2002). Since the fall of the Taliban in 2001, much effort has been put into re-building the health-care structure, and the past few years have seen considerable improvements in the health-care system (Waldman et al. 2006). However, the issue of providing adequate medical services is still crucial. The international community has poured resources and funds into the country, and virtually all medical care is supplied or supported by NGOs and international donors. Progress is slow and complicated, as it is often disrupted and prolonged by the post-conflict instability and insecurity (WHO 2007). The challenges facing medical and health-care professionals are broad and considerable; they must be tackled on many different levels and require the co-operation of different actors.

## Development work in Afghanistan

The development context in Afghanistan is complex and challenging. The continued deterioration in the country suggests that the mark has been missed: despite the billions of dollars that have been spent on rebuilding Afghanistan and promoting peace, the security situation is getting progressively worse, and reconstruction is proving to be a painstakingly difficult and slow process.

Afghanistan is dependent on international aid for 90% of its national expenditures (Waldman 2008). Positive developments have been made, but they are not in proportion to the billions of dollars that have gone into the country, aimed at security, reconstruction and development (ibid). There are a large number of different organizations, agencies and companies working in Afghanistan. For example, the Agency Coordinating Body for Afghan Relief (ACBAR) has registered 193 Afghan NGOs/civil society organizations, 113 international NGOs, five international organizations, 27 private companies, and 19 United Nations (UN) agencies (ACBAR 2010), and these are not all. The different organizations and agencies compete for funding and for the implementation of projects. Projects are on constant deadlines, bound by work plan objectives and indicators. There is a constant issue and challenge of coordination of efforts between the different organizations, and there is the problem of providing services that are needs-based rather than project- or donor-driven.

Development, where the West comes in and brings progress to the developing world, has been criticized for doing the opposite, where aid and development provide a cover for the new world's colonialism (Goldsmith 2002). 'The White man's burden' is a legacy from colonial times: based on the notion

that Western culture is the standard by which others should be moulded, the developed White man is obliged to bring development and improvement to Others (Easterly 2006, Eriksson-Baaz 1999). This is of course not true for all who work in developing countries, and there are many sides to the issue, but there is a history and complexity to development work that one cannot overlook when being part of it. Engaging with development and humanitarian work is an intricate matter, where there are often numerous – and hidden – agendas, not the least political ones. This is unfortunately also seen in Afghanistan, where aid has suffered due to international interests and political strategies (Donini 2004): "Far too much aid has been prescriptive and driven by donor priorities – rather than responsive to evident Afghan needs and preferences. Too many projects are designed to deliver rapid, visible results, rather than to achieve sustainable poverty reduction or capacity building objectives" (Waldman 2008, p.2). The accountability towards Afghans and to national authority has been undermined and second to the accountability towards international donors (Johnson & Leslie 2002). Johnson and Leslie state that "Afghanistan comes with a history, and unless this history is understood and taken into account, both the political process and reconstruction are likely to end in failure" (2002, p.861).

These are overwhelming claims of complex problems on high levels. There are issues closer to the ground, in terms of attitudes in the work of expatriate development workers. For example, in terms of NGOs and organizations working in Afghanistan, Coleridge (2000) states that although there is an expressed agreement that development work needs to be culturally sensitive and adapted, this fall short in practice as local values and ethics clash with those of the development workers. Ethical issues are difficult to address and traverse, and in the end, development efforts are directed by expatriates, based on their values and ideas. Neill (2000) discusses how many international health care assistance and development programmes are sorely lacking in culturally sensitivity and responsiveness with regards to recipients. There is recognition and acceptance of these issues, but this is far from enough if programmes are to be successful. There is also a risk of culture being used as a shield or excuse from taking responsibility for actions. The key question to consider is: "who is serving whom within the context of international health care programs?" (ibid, p.170)

The development of physiotherapy is a very small drop in the larger complex situation of national reconstruction of Afghanistan. However, the context is the same, and it is within this complex Afghan- and development context that the physiotherapy profession is being developed. It is in this context that Afghan physiotherapists practice and learn. And it is in this context that expatriate physiotherapists work for longer or shorter periods of time to support the continuing development of the profession and the physiotherapists in Afghanistan.

# Physiotherapy in Afghanistan

The physiotherapy profession is a developing subculture within the Afghan health-care structure. It was formally introduced in the early 1980s by the International Assistance Mission (IAM), who together with the Ministry of Public Health (MoPH), opened the Physiotherapy School in Kabul (now renamed PTI) (Lammi 1997). The profession has through the years been developed by various different NGOs and organizations, such as IAM, Sandy Gall's Afghanistan Appeal (SGAA), the International Committee for the Red Cross (ICRC), Handicap International (HI), and the Swedish Committee for Afghanistan (SCA). Having for a number of years developed mainly within the smaller framework of these organizations, it is expanding and there is an increasing interest in the profession within the national health-care structure. This structure forms a complex network comprising the MOPH, Ghazanfar Institute of Health Sciences (GIHS) along with the myriad of organizations, donors, hospitals and clinics that are to a greater or lesser degree striving to build a functioning system of health related services.

A number of recent developments have been made. Physiotherapy is presently included in the Basic Package of Health Services (BPHS) (MoPH 2005), which is a standardized package of health services that aims to ensure various levels of health service provision to the whole country; the Afghan Association for Physical Therapy (AAPT) became a member of the World Confederation of Physical Therapy (WCPT) in 2007; there has been a national upgrading of the physiotherapy curriculum from two to three years; and there are increased demands for services, as well as needs for monitoring and improving quality as the profession becomes nationally recognized. The profession is being moulded by these expectations, together with a number of other factors: the influence from various national and expatriate teachers and advisors; the complex needs of patients and a relatively ignorant medical and health care system regarding the benefits of physiotherapy; and the rigid bureaucratic frameworks that exist in the national health-care structure that the physiotherapy profession is ultimately striving to become a greater part of – while simultaneously striving towards professional autonomy and independence.

Assessments of the situation of physiotherapy in Afghanistan have been made (Armstrong & Ager 2006, Lang 2006). Core conclusions are that practical-, clinical reasoning- and problem solving skills of Afghan physiotherapists are basic. There is a dependency on external input for training and professional development, and a need to improve the physiotherapy education. The treatment approach reflects a medical model, with lesser consideration given to the specific functional problems of the individual patient. A contextually relevant professional development is a central need in strengthening the physiotherapists in terms of these factors.

## Professional development of physiotherapists in Afghanistan

Mirroring the claim of Landry et al. (2007) stated in the beginning of this chapter, in the long-term rehabilitation of Afghanistan the participation of a strong and healthy population is vital. The physiotherapy profession holds considerable potential for the health-care structure of Afghanistan and for the rehabilitation of Afghans who have endured many years of war and displacement. The Afghan physiotherapists have much to offer in out-patient and hospital care as well as in community rehabilitation, through treatment and rehabilitation services, prevention of developments of disability and other complications, and by assisting in promoting a healthier population. To provide the most suitable services, the profession must keep abreast of changes within the country, as well as with the obligations of professionalism as members of an international community of physiotherapists. All this puts particular demands on physiotherapy training and professional development, and requires understanding of how to best adapt physiotherapy for the Afghan people. It has implications for how expatriate physiotherapists engage in their work in Afghanistan.

The situation in Afghanistan is complex and multi-facetted and does not lend itself to quick fixes. It entails numerous challenges for the physiotherapy cadre. There are practical challenges in working with professional development, such as a large geographical spread of the physiotherapy clinics combined with transportation and security issues, and limited resources for training and access to information. As mentioned in the beginning, there are issues related to expatriates promoting approaches to treatment in a context different from their own. Many NGOs bring physiotherapists from other – often Western – countries to do training and capacity building and to provide monitoring and supervision. These physiotherapists often stay for a (relatively) short time, which is one factor that limits opportunities to understand the many layers of the Afghan context. This triggers a number of questions regarding cultural sensitivity, contextual awareness, and how well activities are adapted. Furthermore, the deteriorating security is making recruitment of expatriate physiotherapists more difficult.

For the Afghan physiotherapists, and in the extension, for the patients they treat, a suitable and contextual development can have a considerable impact. Hence, for a long-term sustainability of the professional development of Afghan physiotherapists, there must be a better understanding of how physiotherapy can best be adapted to fit the Afghan context, with a focus on strengthening the Afghan physiotherapists' capacity to continue their own development efforts. For this, there must be a greater understanding of how professional development of physiotherapists should be approached in the Afghan context, as well as a greater understanding of, and appreciation for, the impact of the expatriate development workers, physiotherapists and teachers who come to support and teach the Afghan physiotherapists. These are questions that will be addressed in this thesis.

# Aims

The overarching aim of this thesis is to analyze the matter of supporting professional development of physiotherapists in Afghanistan, and the issues involved in expatriate physiotherapists working with professional development cross-culturally in development contexts.

This builds on papers I, II, III, and IV, where the specific aims are:

I to describe and analyze the current situation of the physiotherapy component of RAD in order to identify and discuss the needs and challenges for the further development of physiotherapy in Afghanistan (I, p.307).

II to explore factors that impacted learning of Afghan physiotherapists within the context of a development project.

III to discuss the dilemmas and possibilities for an ethics curriculum for Afghan physical therapists.

IV to describe my learning and development process in terms of changes in my meaning perspective and the impact of this on the work with the Afghan therapists.

Based on these four papers and almost four years of exploring, encouraging and experiencing professional development in the Afghan development context, this thesis takes a critical perspective on the work that was done.

# 3 THEORETICAL FRAMEWORK

جوینده یابنده است

The seeker is the finder

As stated in the proverb above, to find the best approach to training and supporting the professional development of physiotherapists in a context different from one's own, one must actively seek a deeper understanding. The theoretical perspectives presented in this chapter have underpinned this process.

First, professional development as understood in physiotherapy will be described. Since professional development is centrally concerned with learning, and is affected by both personal and contextual factors, adult learning theories which cover these have been employed. The transformative perspective on learning has been used in the exploration of how to understand learning on the individual level, and situated learning has been used to consider contextual factors. The chapter concludes with a summary of these theories as relevant for this thesis.

## Professional Development in Physiotherapy

Physiotherapists' professional development is considered an important part of working as a responsible health-care and rehabilitation professional, and it refers to a life-long process of learning and refining practice and skills to ensure the best possible care for patients (Aslop 2000, Swisher & Page 2005). Physiotherapists, as autonomous professional practitioners, are obliged to keep abreast of changes of a dynamic work field and profession, and monitor and develop their skills and behaviour accordingly (Higgs et al. 2001). The process of physiotherapists' professional development starts in physiotherapy undergraduate training, as physiotherapy students are socialized into their roles as professionals and members of a professional community (Richardson 1999a). As such, professional education plays a vital role in laying the base for a professional identity, after which the professional development process becomes a lifelong endeavour of striving towards professional goals, and professional competence and expertise: physiotherapists' "professional development is dependent upon their ability to be situationally responsive and continually to review and evaluate their work through critical thinking, clinical reasoning and processes of reflection" (Richardson 1999b, p.467).

As a life-long process of learning, professional development is commonly discussed in terms of Continuing Professional Development (CPD) (CSP 2003, French & Dowds 2008). Key principles of CPD include individual responsibility in learning, and a continuous and systematic learning process with clear learning objectives that is planned and based on outcomes of learning (CSP 2003). The

professional development process requires skills of reflection, and conscious effort through a structured approach can help practitioners develop a reflective practice (CSP 2005, Donaghy & Morss 2000). CPD includes work-based and informal learning as well as institutional, formal learning (Eraut 1994). The work-based or situated learning is of great value for physiotherapists' learning and professional development (Richardson 1999b). As physiotherapists engage in the context of their working lives, their professional knowledge is tested and further developed through reflection on, and evaluation of, practice (CSP 2005). Learning thus occurs as knowledge learned in courses is tested and applied in practice, and valuable learning also occurs in the workplace itself.

Just as physiotherapists professional development is affected by their workplace and culture, the manner in which physiotherapists approach professional development also feeds back into how the profession is shaped in that particular culture (Richardson 1999b). Furthermore, the workplace, such as the clinical setting, is part of a larger context, which is constantly changing. The context is thus of considerable importance for physiotherapists professional development.

Finally, there are the personal, intrinsic factors of each physiotherapist that will affect how he or she develops professionally. Professional development is each individual physiotherapists' responsibility: "learning must be planned and negotiated personally rather than be structured and assessed by others" (Aslop 2000, p.4). This is a challenge, when work and personal life put many other demands on both time and energy. Important personal skills needed are reflection and critical thinking (Donaghy & Morss 2000, Richardson 1999b), a will and desire to learn (Illeris 2006), as well as a well-rooted professional identity (Richardson 1999b).

Professional development is thus impacted by both personal and contextual factors. These factors are interlinked and to understand how expatriate physiotherapists can encourage and work with professional development of physiotherapists in Afghanistan, a different context than their own, these factors will be important to explore. They will here be considered from the perspective of relevant adult learning theories.

## Adult Learning

The term adult learning is broad and encompasses a diverse field of different clientele, contents and delivery systems (Merriam 1993). It is complex, and there are a range of different theories and approaches to understanding how adults learn (Illeris 2009). From this broad expanse of theory and knowledge about learning, two approaches have been chosen. But before describing these, there are a few general conceptions about adult learning that are useful to consider.

Much of adult learning theory stems from the first half of the 20$^{th}$ century, developed by educational and developmental psychologists (Merriam 1993). Early focus was on measuring learning capacity through the aging process, as well as the measurement of intelligence, how aging affects memory, and abilities

to problem solve and process information. More recent developments take a broader approach, where the social and cultural context of the learners, as well as their experience and personal histories are considered in relation to how adults learn (ibid). Thus adult learning includes two different but integrated processes, one which is concerned with social interaction and the external environment, and one which focuses on internal processes (Illeris 2006). Adult learning also includes formal and informal processes, which can occur in every-day life, in institutionalized settings and in the workplace. A basic concept of adult learning as opposed to child learning is that this is a life-long endeavour where adults take control over and responsibility for their learning. The basic concept is that adults' learning is bound by what they are interested in, and what they see as meaningful to learn: teaching or "outside influence … will always be received in the light of the individual's own experience and perspectives" (ibid, p.17).

As stated, there are both internal and external factors that impact professional development processes. The added dimension of working cross-culturally and in a development context makes this even more important. The perspective we stem from is developed within our own particular contexts, and when we engage in new contexts with people from a different culture, this will impact how we interact, how we communicate, and how we understand each other. Thus, in terms of professional development of Afghan physiotherapists in a development context, the internal and external processes will be considered based on transformative learning and situated learning, respectively. The over-arching aim with using these theories is to facilitate a comprehensive perspective on what it means to work with and experience professional development with physiotherapists from different backgrounds and cultures.

## Transformative Learning

All learning entails change, and this is particularly true in transformative learning in that it "*shapes* people" (Clark 1993, p.47, italics in original). Transformative learning is part of both personal and professional development processes, it can be both educationally structured and part of every-day life (Clark 1993). Transformative theory is related to contextual theories of adult learning and stems from a humanistic understanding of the person (Clark 1993, Mezirow 1991). Transformative learning holds that prior experiences shape who we are, and who we are directs our intentions and our interpretations of experiences. As such, learning is described as "the process of using a prior interpretation to construe a new or a revised interpretation of the meaning of one's experiences in order to guide future action" (Mezirow 1991, p.12).

In childhood, learning occurs formatively through both socialization – informal learning of social norms through interaction with parents, friends and mentors – and through formal schooling. We are socialized into particular roles, and into particular ways of seeing the world. Even though as adults we are more self-directed in our learning, our understanding is invariably shaped by these ways of seeing, and we are continually influenced by our culture, language and

experiences. “Culture can encourage or discourage transformative thought” (Mezirow 1991, p.3), so where, what, and how we learn is directly related to the culture in which we have grown up, as well as in which we continue to learn. Expatriate physiotherapists’ participation in the work with Afghan physiotherapists is directly affected by their culture and prior experiences, and this will have an impact on the work. Understanding this for oneself is of central importance for both work and research in a different culture and context than one’s own. This is one of the aspects being considered in this thesis.

Beyond recognizing the importance of context in shaping meaning perspectives, transformative learning in general gives less attention to the matter of context. It is aspects of the individual processes of learning that will explored from the transformative perspective.

## Transformative learning process

Transformative learning builds on the assumption that meaning exists within individuals rather than in literature or other external representations of knowledge (Mezirow 1991). Learning involves using this meaning to understand our experiences, where meaning is an interpretation of the experience. The interpretation is validated based on what we know from before, and meaning is validated through interaction and communication with others. Our interpretation of experiences is directed by particular frames of reference that are shaped as we grow up, also called meaning perspectives, mindsets, or habits of mind (Mezirow 1991, 2009); the term meaning perspective will be used henceforth. Meaning perspectives form the structure for interpretation and learning and are the basis of the transformative theory: “[they] are the structures of culture and language through which we construe meaning by attributing coherence and significance to our experiences” (Mezirow 2009, p.92). The meaning perspectives of both Afghan and expatriate physiotherapists have been shaped in relation to the environment in which they have grown up. Since these environments are often very different, it becomes essential to be aware of the different approaches to learning that may result, but which are less obvious than the differences of culture and context.

The manner in which we define and solve problems directs much of what we learn, and since our meaning perspectives define our approaches in problem solving, they will dictate how we learn and what we are open to learning. This is of relevance for understanding learning of Afghan physiotherapists, but it is also relevant for expatriate physiotherapists: how open are they to understanding local beliefs and practices? Their meaning perspectives will set the boundary for how competent they are in noticing and adapting to cultural nuances in interacting with the Afghan physiotherapists, and in participating in their practice.

There are five interacting contexts in which the transformative learning processes takes place: *meaning perspectives,* as described above; *communication*, which represents skills in language, and the ways in which statements are made, understood and validated; *line of action,* which is the intention or purpose of the learner, and their desire and will in learning; *self-image of the learner,* i.e. how

the learners perceive themselves and their role, how they view the learning process and their situation; and *the external environment*, the particular situation or circumstance in which where all interpretations are made and remembered (Mezirow 1991, p.13-14). These highlight several important factors when analyzing what impacts learning, and have enabled a structured approach for exploring learning and professional development of the Afghan physiotherapists in paper II.

In transformative learning, an old – or new – experience is reinterpreted through a new set of expectations. A new meaning, or perspective, is given to the old experience. Thus, through the transformative learning process meaning perspectives are changed or transformed, enabling the learner to view and comprehend the world from a new perspective (Mezirow 2000). This transformative learning can take place on different levels, within meaning perspectives, or through change or transformation of meaning perspectives (Mezirow 1991). The highest level of transformative learning involves a complete shift where the previous perspective is re-organized into a new one. The transformative learning process usually requires a strong stimulus – a "disorienting dilemma" (ibid, p.168) – to trigger the transformation and enable a move away from old habits of thinking. The process requires self-awareness, reflection and critical thinking (ibid). This transformation aspect was not the focus in the field studies of this thesis, in that it was not an aim to encourage a transformation of meaning perspectives of the Afghan physiotherapists. However, as will be described in chapter five, the process of researching and working with the Afghan physiotherapists and critically reflecting over experiences, entailed a personal transformative learning process for me as the development worker (IV).

## Reflection in transformative learning

In defining reflection Mezirow refers to John Dewey, describing it as "the process of rationally examining the assumptions by which we have been justifying our convictions" (1990b, p.5), and "the central dynamic in intentional learning, problem solving, and validity testing through rational discourse" (1991, p.99). Reflection enables us to see through the way we normally interpret experiences: we reassess the validity claims that were made by meaning perspectives formerly unchallenged (ibid). Importantly, this is done through discourse with others. This communicative, reflective process is a "critical-dialectical discourse" (Mezirow 2003, p.60) where the dialogue stems from each person's meaning perspective and involves their beliefs and feelings. Carr and Kemmis (1986) describe dialectical thinking as the process by which the opposition of two poles leads to a reconstruction of thinking and acting.

A critical reflection on assumptions and a full participation in dialectical discourse are thus two main elements of the transformative learning process. Communicative with others, where we all stem from our own meaning perspectives, which may be contradictory, it is a critical reflection over the

differences that can lead to learning, and potentially to transformation. This is the essence of communicative learning, which will be described below.

## Instrumental & communicative learning

Following Jürgen Habermas, a German philosopher and sociologist who stems from the tradition of critical theory and pragmatism, Mezirow (1991) makes a distinction between instrumental and communicative learning. Instrumental learning is concerned with controlling and manipulating the environment and other people, and learning 'how to do' things. It often takes a cause-and-effect approach where instrumental action is empirically based and follows technical rules – "it centrally involves assessing truth claims – that something is as it is purported to be" (Mezirow 2003, p.59). Instrumental learning is based on a hypothetico-deductive developmental logic (Mezirow 2009), in other words, knowledge is constructed or confirmed based on the testing of hypothesis; this is a common approach in scientific research.

Communicative learning is concerned with understanding others, and what they mean, as well as making ourselves understood: "the process of understanding involves claims to rightness, sincerity, authenticity, and appropriateness rather than assessing a truth claim" (Mezirow 2003, p.59). Communicative learning is thus analogical-abductive (Mezirow 2009), which means that the validity of knowledge, beliefs and ideas are tested through informed discussion leading to a consensual best explanation. In the process of transformative learning, it is through communication and dialogue with others that we can validate our experiences. We attempt to understand others through validating their assertions, and harmonizing these with our own (Mezirow 1990a). Transformative learning can occur in both instrumental and communicative learning, and reflection is required for both (Mezirow 2003).

Instrumental learning is a traditional educational approach in physiotherapy through the teaching of established approaches, techniques and treatments, as well as in the approach to research in evidence-based practice that is common in physiotherapy (Herbert et al. 2001) which largely involves processes which follow along the lines of the hypothetico-deductive model. Physiotherapy is also a social practice, and there is an increasing focus on the relationship between the patient/client and the professional, which requires communication skills in the professional and an understanding of patients' ideas, beliefs and expectations for treatment (Atkins & Ersser 2008). Narrative reasoning, for example, is not concerned with validating hypotheses by testing as in instrumental learning, but rather by mutual agreement between the patient and therapist (Edwards et al. 2004). Both instrumental and communicative learning are required in the process of learning to be a physiotherapist and in subsequent professional development. Instrumental learning has been the main focus in teaching of physiotherapists in Afghanistan (II), but what is being discussed in this thesis is a more communicative learning approach for both Afghan and expatriate physiotherapists (II, III, IV).

Communicative learning is inherently a social interaction that is impacted by each person's meaning perspective. Since these meaning perspectives are contextually formed, it is of relevance to consider the contextual factors of learning. This brings us to the next theoretical perspective that has been used, i.e. situated learning.

## Situated Learning

Fuller et al. state "that without a contextualized analysis, the treatment of questions of access to and control of learning opportunities, as well as what is learned and how, is likely to be limited" (2004b, p.4). Working with an international NGO in Afghanistan, teaching, researching and promoting professional physiotherapy development, this statement is very relevant. Coming as foreigners into a post conflict/ongoing conflict context, teeming with development agencies and donors, it is impossible to ignore the impact of the development context on the work, of how different cultures impact participation, interaction and communication, or of how knowledge is used. Expatriates understanding of the learning and professional development of both the Afghan physiotherapists and of themselves must consider the context in which they collaborate, learn and develop. Due to this, situated learning has been used as the other theoretical stepping-stone for the exploration of promoting professional development of physiotherapists in Afghanistan.

Situated learning is important for the professional socialization of physiotherapy students and in the professional development of physiotherapists (Richardson 1999a, b). In particular, situated learning is of relevance for expatriate physiotherapists who enter a new context, whether it be to work, teach or research, in order to learn what it means to participate in this new context. Thus, the relevance of situated learning for this thesis is two-fold: 1) expatriate physiotherapists coming to teach and develop physiotherapy in Afghanistan need to consider the social relationships and cultural context in which they are working, in order to teach and promote physiotherapy in a suitable and relevant manner. Through critically participating in this context they can challenge their preconceived ideas about what it means to be a physiotherapist and to practice physiotherapy in a different culture, and they can develop their cultural competency; and 2) physiotherapy is a profession that has been developed in the West, is underpinned by theories developed in Western countries, and has been introduced to Afghanistan by foreign organizations and then developed and promoted with considerable input by expatriate teachers. Physiotherapy needs to become contextualized, adapted to the Afghan context.

Situated learning is where knowledge is gained through specific activity in the authentic context where it is to be applied and practiced (Billett 1996): "learning is not merely situated in practice – as if it were some independently reifiable process that just happened to be located somewhere; learning is an integral part of generative practice in the lived-in world" (Lave & Wenger 1991, p.35). Similarly, the practice or workplace itself is both situated in and affected

by particular contexts. The practice will have particular traditions by which it functions and it will affect the learning and development of its members, but it is also shaped by the individuals who comprise the community of practice.

Communities of practice are not the same as groups or social categories, and they are broader than those only related to work or schooling (Wenger 1998). They are not always defined but collectively perceived by its members; they are comprised of a shared repertoire of routines, actions and discourse, with mutual engagement of its members in practice in the pursuit of shared enterprises. Communities of practice can be large or small, they are constantly changing and they are part of larger contexts; they are not self-contained units but interlink with others through individuals moving between different communities of practice (ibid). One such community of practice related to the research of this thesis is within the clinical setting of the Afghan physiotherapists; another is within the development programme the Afghan physiotherapists and I worked with. These are both part of and impacted by the larger Afghan context and the larger development context, and they interlink with other communities of practice to which the Afghan and expatriate physiotherapists belong.

Communities of practice are dynamic, they are comprised of and shaped by its members, with all their beliefs, intentions and experiences (Wenger 1998). As members learn and develop through participation in the communities, so also will the communities shift and develop (Lave & Wenger 1991). Introducing new people into a community of practice can be a way of triggering change and development as members are introduced to new ways of thinking. For example, expatriate physiotherapists who come to teach or promote physiotherapy in Afghanistan will have an impact on community of practice in which they participate and intervene.

Communities of practice also affect the identities of its members. Identity is directly linked to the community of practice and the larger context in which it has been constructed: "building an identity consists of negotiating the meanings of our experience of membership in social communities" (Wenger 1998, p.145). Our identities are shaped as we enter new and unfamiliar communities of practice, with a lack of competence regarding its practices. Becoming a member in a community means developing an identity therein, and our membership in this community is related to how competent we become in the ways of the community. This is of direct relevance and import for cross-cultural work and research, in terms of the cultural competency of the expatriate physiotherapists, and how this competency is developed as they engage in new contexts and communities of practice. In participatory observation, which was the main method used in the studies of this thesis, this affects access to the field, and the possibilities for production of data and understanding in the research.

Our identity will dictate learning experiences, or how knowledge is constructed (Wenger 1998). How others perceive our identities will dictate how we are treated, the manner of interactions, and how learning is encouraged or discouraged. Furthermore, the identities that are formed will have different connotations in different contexts and in different cultures. This has particular

relevance for this thesis, where the identity the expatriate physiotherapist perceives for him- or herself may be perceived differently by those with whom he or she interacts. This has further implications in terms of the expatriate physiotherapist being associated with the development context of which he or she is a part (Eriksson-Baaz 2005). This adds another dimension to the process, in terms of participation – for both development work and research.

## Participation – learning in practice

Participation is a key prerequisite for learning in practice. It can be described as an "encompassing process of being active participants in the *practices* of social communities and constructing *identities* in relation to these communities. … Such participation shapes not only what we do, but also who we are and how we interpret what we do" (Wenger 1998, p.4, italics in original). Through this participation, learning occurs through creating meaning of our experiences, and it is a direct result of participation in practice, of understanding gained in practice (Lave 2009). Participation is affected by both the cultural norms, traditions and goals of the practice, and by the agency of the individual him/herself, and their interest and engagement in learning (Billett 2004). Just as there are many different contexts, there are many different forms of participation, and the nature of the participation is dependent on both the characteristics of the practice or workplace and of the individual, and the possibilities for, and interest in, the individual to exercise their agency (ibid). The practice can either restrict or promote participation, as can its members: new-comers participation in a new practice or context are dependent on the old-timers 'taking them in', which is described in Lave and Wenger's (1991) concept of legitimate peripheral participation.

Legitimate peripheral participation relates to the learner entering into a new context, and how learning occurs as they become a part of this context (Lave & Wenger 1991). The learner is a novice in relation to the new context: their knowledge and skill, no matter how well-developed, must be tested in relation to the new setting, and it is through participation and interaction that old knowledge can be validated and new knowledge gained. Thus an expatriate physiotherapist or researcher, no matter how skilled as a professional, is a novice in the local Afghan context. They must learn what it means to be a physiotherapist, what it means to participate and observe as a researcher, in this particular context.

The process of participating in a new context is interactive and the influences between the individual, other members of the community and the community flow back and forth with the resulting outcome being knowledge and change for all involved (Lave & Wenger 1991). But such participation and change cannot be taken or forced. To enter into a new community, to engage in legitimate peripheral participation, requires access and transparency (ibid). For a new-comer to participate in a community of practice such access must be given by the members of the community, and this can be a tricky and sensitive endeavour. This issue of access entails particular challenges when considering both development work and field research. Cross-cultural communication, power

and hierarchies will directly affect what and how knowledge is gained, as will be discussed in chapter six. Also, it should be noted that not all participation will lead to learning that is positive and beneficial to the individual (Fuller et al. 2004a). Participation is complex and subject to a number of impacting factors. It is of central importance for both the research and the development work being described in this thesis. As such participation in terms of the research will be discussed in the next chapter, and in terms of the development project in chapter six.

## Contextual learning & knowledge transfer

The contextual nature of knowledge is another factor that must be considered in terms of promoting the professional development of a Western-developed profession into a developing country with a different cultural context, using professional theories and teaching practices that are based on Western concepts of clinical practice and learning. Situated learning critiques the idea of generalizability of knowledge, that knowledge gained from one context is directly applicable in a different one, including between work-place and educational settings (Billett 1996, 2004). All learning and knowledge is proposed to be socially and culturally influenced, since the contexts in which learning occurs and knowledge is developed is socially constructed (Eraut 2004). This is of import when introducing, promoting and teaching a profession cross-culturally, when the knowledge being taught, and the manner of teaching, has roots in a different cultural context. It is essential to consider when seeking understanding of how this can be done in the best way.

Thus the idea of knowledge transfer. Transferability of knowledge can be described as near or far transfer (Billett 1996). In near transfer, knowledge is applied between contexts or communities of practice that are closely related. Far transfer involves the opposite: the greater the difference and distance between communities of practice, the lesser the likelihood for the knowledge to be directly applicable. Transfer of knowledge also relates to the type of knowledge (Eraut 2004): some forms of knowledge will be more transferable than others, and some are easier learnt in an educational setting than in the workplace. For example, in physiotherapy the body of professiosnal knowledge is broad, it is practical and theoretical, social and academic, and it is under constant development. Certain things are less dependent on cultural factors, such as particular treatment techniques, anatomy and biomechanics. Certain things can be learned theoretically in more formal educational settings, such as physiology. Other aspects of physiotherapy, such as clinical reasoning, skills of communication, collaboration, patient education etc., need to be developed in relevant contexts. It is these aspects of the profession that are harder to both research and teach, without an understanding of the local context. Thus these aspects are a challenge for expatriate physiotherapists teaching or researching the practice of Afghan physiotherapists.

Finally, there are concerns with the idea of knowledge transfer in terms of development work, where Western norms form the framework for the practice.

van der Velden has discussed the use – and abuse – of knowledge in development work: "what is knowledge? Who decided what knowledge is? Whose knowledge matters?" (2004, p.75). She advocates "knowledge sharing (and learning) [which] is more than knowledge transfer – bringing knowledge from where it is available to where it is needed. Sharing takes place within a dialogue of knowledges in which knowers exchange experiences, values and ideas" (ibid, p.78). This links back to communicative learning, and part of the process of successful knowledge transfer requires an understanding of the new situation or context into which one enters (Eraut 2004). In relation to working and researching in other countries and with other groups of people, this necessitates a consideration of culture, and is a matter of cultural competency. Thus, a definition of context and culture is in order.

## Context & Culture

When talking about working and researching cross-culturally, it becomes essential to establish what is meant with the concept of culture, as part of the context in which learning and professional development occurs. Context and culture are interlinked, hence context must first be defined. There are two uses of the word: 1) "the parts of a discourse that surround a word or passage and can throw light on its meaning"; and 2) "the interrelated conditions in which something exists or occurs", i.e. the environment or setting (Merriam-Webster 2010). The second definition is how context is used in this thesis. Lave further suggests that a context is "a social world constituted in relation with persons acting" (2009, p.201). Thus a working definition for this thesis is that context is the environment or social world in which we live, work and interact.

To define culture is more difficult, since culture is a broad term that can mean different things to different people, and in different settings. Hofstede has given an apt description: "culture is to a human collectivity what personality is to an individual" (2001, p.10). Cultures are dynamic and interdependent: they are learned and can be re-learned, and they impact individuals by comprising a framework within which individuals interact and learn social codes. Cultures are thus viewed as complex, diverse and dynamic systems of meanings, as social frames of reference that are both constructed and affected by groups of people, and affect the practices of these people. Culture is the medium through which people act and interact within the social world or context of which it is a part.

The importance of appreciating culture has been recognized in physiotherapy: "everyone has a culture which influences all aspects of daily life. Culture should not be seen as something external to a person; rather it is an integral part of each person. … it is critical to put practice and models of practice into context" (Henley & Twible 2008, p.462). Physiotherapy in itself is proposed as a particular culture (Norris & Allotey 2008). Just as culture has direct links to the particular contexts in which it has developed, physiotherapy culture is interlinked with Western ideology, and this colours both its theory and practice. For example, in physiotherapy discourse, "concepts such as *individualism,*

*personhood, autonomy, responsibility for action* and *human rights* are understood to be universals which are rarely acknowledged or questioned" (ibid, p.153, italics in original). However, these concepts may have a very different meaning in cultures that are collectivistic, and where autonomy and responsibility for action stem from different social norms (Noorderhaven 1999), such as in Afghanistan.

To describe Western or Third World culture is an impossible and presumptuous task, as each in itself is highly diverse. Physiotherapy culture will also differ from one country to the next. To describe Afghan culture is also a bold endeavour, as it is comprised of many subcultures, and efforts of understanding and describing it in this thesis are from the perspective of an outsider. Main strains that are apparent in the literature, and which were experienced when living in Afghanistan, have been presented in the previous chapter. For the purposes of this thesis, some key cultural differences will be considered in chapter six, in relation to particular dimensions that have been developed to enable comparisons between cultures (Hofstede 2001). In doing this, there is a fine line between highlighting and using commonly stated characteristics of Afghan culture to aid the understanding of own experiences and reflections, and using these to put unwarranted labels on behaviours and incidents based on personal perspectives of that culture. This must be considered when being both an outsider and member of the development context, within which the work and research of this thesis was conducted.

In this development context, culture is not an unproblematic concept (Eriksson-Baaz 1999). A nuanced strategy is needed, with balanced critique directed towards concepts of the West and the Third World, where an overall view recognises the "hybridity of cultures", and that cultures are constantly being re-shaped in relation to different development discourses in the Third World as well as in the West (ibid). A critical reflection over culture and what culture means – both one's own, and that of others – is an essential prerequisite for physiotherapists working cross-culturally. One must strive to develop cultural competency. To understand a person, one must strive to understand their personality, views and opinions; to understand a group or collectivity, one must strive to understand its culture. Having said this, the base-line to which one must constantly return is that cultures are comprised of individuals, individuals have their own personalities, beliefs and ideas, and understanding a culture does not automatically mean that one can understand the individuals of that culture. These issues are of central importance when coming as an expatriate physiotherapy development worker to work in Afghanistan. As Afghan and expatriate physiotherapists work together, they will impact each other's views on what it means to be a physiotherapist, but also, their interactions will impact the view of the own culture and context, and they will participate in these in a new way.

## Summary of the Theoretical Perspective

The transformative perspective on learning and situated learning are in this thesis considered to be relevant theoretical approaches that complement each other. Mezirow is critiqued for not giving enough consideration to contextual factors, while situated learning puts less focus on the individual aspects of learning. Combined they provide a useful theoretical framework for this thesis, for understanding processes of professional development of physiotherapists and of teaching and promoting physiotherapy in different cultures.

The theoretical point of reference in this thesis is thus that context, communities of practice, culture, meaning perspectives and identities: they are all intertwined, and one cannot be considered without considering the other. Whether working with or researching professional development, consideration must be given to meaning perspectives and identities of both expatriate and local physiotherapists, to their manner of participation and interaction, and to the context they participate in. The contextuality of physiotherapy theory and practice as developed in the West, and the transferability of this to a non-western culture, must be considered. And ultimately, the position of expatriates as new-comers into the new context, and what this means for their participation, understanding, cultural competency and access to the field, is of central importance.

Thus, tying it all together, I refer back to the proverb at the beginning of the chapter. To truly seek understanding and knowledge related to others one must consider these different factors. One must critically reflect over both one's own and others actions and the context in which they take place. The seeker who is able to do this is well on his or her way to developing new understanding and knowledge.

# 4 METHOD

**تا شمال نباشد درخت شور نمیخورد**

A tree doesn't move unless there is wind

Change requires a trigger, a wind, as is implied by the Afghan proverb above. Professional development and learning is about change, and the research of this thesis has been concerned with exploring the process of such change for physiotherapists in Afghanistan, in two field studies. The first field study aimed at analyzing and describing the physiotherapy component of a disability programme, RAD. The aim of the second field study was to gain knowledge and understanding of how to work with professional development of Afghan physiotherapists in a contextually relevant way, by exploring the process of a development project. Aspects of these studies are reported on in four papers highlighting different aspects of professional development and learning.

This chapter will describe the process of knowledge production in the two field studies. First the methodological approach will be presented. The setting and the participants will be described, then the focus, aim and activities of the two studies. This is followed by a description of the methods of data production of the studies, and the analysis of the four papers. Ethical issues are discussed, and the chapter ends with a discussion of various methodological issues, such as contextual factors, access to the field and field roles, pre-understanding and reflexivity, the process of analysis, and issues of validity.

## Methodological Approach

### Ethnographic field work

The knowledge generating procedure of the two field studies was grounded in the epistemological ideas of ethnography (Bailey 1996, Bernard 2002). Ethnography is a legacy of anthropology, which builds on a committed search for all forms of knowledge concerning the situations and lives of people, striving to gain and portray a complete image of these (Bernard 2002). Human action must be explained and understood based on the context in which it has occurred, and the researcher strives to experience the reality of the people being studied by participating in their daily lives and in their communities. As such, ethnographic field work is described as “a form of inquiry in which one is immersed personally in the ongoing social activities of some individual or group for the purposes of research. Field work is characterized by personal involvement to achieve a level of understanding that will be shared with others” (Wolcott 2005, p.58). As fieldwork requires an active involvement of the researcher, his or her field roles, access to the field and pre-understanding is of great interest in order

to understand the conditions for data production and the picture portrayed of the context and phenomenon being studied (Bernard 2002).

Ethnographic data production is based on interaction, participation and observation of the individuals and context being researched, where the researcher takes a systematic approach in documenting, and striving to understand and portray what is observed (Bernard 2002, Fangen 2005). Commonly used methods are participant observation and interviews. In the two field studies of this thesis, participant observation – including informal dialogues and conversations – was the main method used, complemented by semi-structured interviews and photographs in the first field study.

## Participant observation & fieldnotes

Participant observation is a method of social research where the researcher interacts with the people, and lives and works in the field being studied (Bernard 2002, Fangen 2005). It is a continual process of recording the field of interest while actively being in it, and then taking a step back to make sense of what has been seen; in other words, moving back and forth between an emic and etic perspective (Bernard 2002). This is an important part of the process of continuous reflection and analysis of ethnographic data production, and it places requirements on the researcher's capacity for reflexivity. Reflexivity is the critical examination of the researcher over the relations between his/her perspective, conditions for seeing/observing and assumptions about what is being observed, how (s)he affects the research process and is affected by it, the methods used, and the data that is produced. Reflexivity is what enables researchers to be instruments of data production (Hammersley & Atkinson 2007). It is a skill that is developed over time as the researcher becomes more at home in the field, and can look beyond first impressions and preconceptions. Thus we go back to the importance of emic and etic perspectives, of nearness to and distance from the field, where removing oneself from the field becomes essential for gaining perspective on experiences.

Participant observation entails different levels of both participation and observation. These can be distinguished as (i) the complete participant, (ii) the participant as observer, (iii) the observer as participant, and (iv) the complete observer (Hammersley & Atkinson 1983). Fangen (2005) adds an additional level to this, with the intervening participant. The researcher often moves between different levels of participation and observation. In certain circumstances, one will be more of an observer, at other times, more of a participant. But whichever level of participation or observation one develops, the data production will be an interpretation of the researcher, guided by his/her pre-understanding (ibid). Again, reflexivity is key in enabling the researcher to develop an understanding of the observations, while considering their own impact and influence on both the observations and interpretations. Furthermore, this is dependent on the ability of the researcher to access the field. In field research, the researcher will essentially be a legitimate peripheral participant, as described in the previous chapter. It takes time to gain legitimacy, and the extent

to which one is given access lies in direct correlation to ones cultural competency and ability to adapt to the local cultural customs.

Participant observations are documented as fieldnotes, which are the raw data of the research from which ethnographies are built (Walford 2009). Just as there are different levels of participation and observation, there are different forms of writing fieldnotes. These range from the strict objective representations of what was observed, as in realist ethnography where there is as little influence of the researcher as possible and a control of bias, to the radical participatory, critical and feminist traditions where the presence of the researcher's feelings and emotions are positively recognized as part of the data (Clifford 1990, in Beach 2005). The perspective in this thesis is that an acknowledgement of the researcher in the fieldnotes is a marker of validity, as long as the positioning of the researcher is made clear. This enables us to know from what perspective the observations were made, which is essential for understanding the findings.

The production of data in participant observation can thus be seen as an interpretative act where the pre-understanding of the researcher guides the whole process from openness and sensitivity in observations, the selection of events and phenomena being documented, the transcription and interpretation of fieldnotes, to the textual representation of observations and experiences through descriptions and stories.

## Setting & Participants of the Field Studies

Since participant observation is centrally concerned with engaging in and observing every-day life, what every-day life represents must be defined; the setting of the research must be described. The first field study was conducted in the clinical context of the Afghan physiotherapists, whereas the second field study took place in the broader Afghan development context, of which the clinical context was one part. The general context being considered in this thesis is that of the Afghan- and development context. An introduction to this was given in chapter two, which serves to give a general picture of the environment in which the research was done. Further specifics regarding the field and the participants of each study will be given here.

### The field

Both field studies were conducted within the physiotherapy component of the RAD programme. RAD is the largest disability programme in Afghanistan, implemented by the SCA, and the SCA is the second largest employer of physiotherapists, after the ICRC. RAD is a Community Based Rehabilitation (CBR) programme that is implemented in the north, north-east, east and south-east and hence has a wide geographical spread (shaded areas in figure 1, next page). It is an extensive programme in terms of the different services provided: physiotherapy, orthopaedic aid, information and communication, employment support, vocational training, provision of revolving loans, education in CBR, and

special education for disabled. The RAD physiotherapy clinics are situated primarily in rural areas, and physiotherapy services are provided in the clinics as well as in the homes of patients who cannot easily come to the clinics.

Figure 1. Map showing 13 provinces + Kabul where the Rehabilitation of Afghans with Disabilities programme is implemented. The light gray zones are the provinces that were included in the first field study, while the second field study incorporated all the shaded provinces.

The first field study was conducted in the physiotherapy component in the northern region of RAD (Balkh, Samangan and Jowzjan provinces, light gray areas in figure 1). There were seven clinics, with ten male and/or female physiotherapy departments. In 2004, the eastern region was not a part of RAD, and the northern region was recommended as the most suitable place for the study: the security was good, there was a room in the office where I could stay, there was a female interpreter and better transport facilities. Although all the clinics in the region were visited, the majority of the time was split between the male and female departments in the Mazar-e-Sharif clinic. There were no other expatriates in the office or clinic, hence I spent most of my time with Afghans. I met comparatively few expatriates, as opposed to when I returned in 2006, was employed by the SCA, and had my base in Kabul.

The second field study encompassed the whole physiotherapy component of RAD, with all four regions. There were 37 districts in 13 provinces (gray and light gray areas in figure 1), with 37 physiotherapy clinics. The clinics comprised a male and/or female physiotherapy department. Also included was Kabul (dark gray area in figure 1), where the RAD Technical Support Unit is based in the

SCA management office, and where I gradually became more involved in PTI, AAPT and with other disability and physiotherapy organisations. Importantly, this project was done within the development context of which both the Afghan therapists and I are a part, being employed by the SCA, an international NGO.

## The participants

The group of physiotherapists and physiotherapy assistants working with RAD will be referred to collectively as therapists, since in practice the assistants worked independently in the same way as the physiotherapists. These comprise a large portion of the physiotherapy cadre in Afghanistan working with different NGOs and organizations (80 out of approximately 325). Of the RAD therapists, there was one male and one female physiotherapy supervisor in each of the four regions (in Ghazni there was only a male supervisor). There was also the national Physiotherapy Technical Officer, my counterpart, who was based in Kabul and had an overall responsibility for the physiotherapy component. The three female supervisors were recruited during 2006, and hence did not exist at the time of the first field study in 2004. I was the only expatriate physiotherapist in the programme.

In the first field study, the 11 physiotherapists and two physiotherapy assistants (eight men and five women) working in the Northern region of RAD were included. One of the men was the physiotherapy supervisor. Although I participated in their clinical work, I was very much an observer, taking notes and photographs, asking questions. I assisted when requested, we discussed cases, but I was not their colleague and not a part of the work as when in the development project.

In the second field study, the participants included the Afghan therapist on two levels: there were key participants, and general participants. The key participants were the seven supervisors and my counterpart, the Physiotherapy Officer. These made up the physiotherapy core group, of which I was also a part. The general participants included the 8o physiotherapists and physiotherapy assistants (50 men and 30 women) working with RAD, who participated in trainings, and were supervised and observed in the regions. Also, collaborations and interactions included other Afghan physiotherapists, and the few other expatriates working with physiotherapy in Afghanistan.

The core group planned, monitored and evaluated the development project. The supervisors were recommended for the core group by the RAD Programme Coordinator, as this fit with their responsibilities, and it was a way of enhancing and strengthening their roles and their collaboration. There was less consistency in the female participation for the first half of the project; when there were difficulties for the female supervisors to participate, others were sent in their place. In the southern region the programme was not able to find a female supervisor during the time of the project, and for some of the meetings different therapists from this region participated.

In the first field study, the therapists were given written information about the study, translated into Dari when necessary, and they gave oral consent to

participate. Permission was always asked before taking photographs of the therapists and the patients. Permission to record the interviews was also requested and given. In the second field study, the therapists were given oral information, and gave oral consent. During the first meeting with the physiotherapy supervisors, the research was explained and discussed. For the remainder of the therapists in the programme, this was done during the first trip to the regions, where almost every therapist was visited, as well as in the first training. It was explained at the start that they could chose to not participate. The participants have been given acronyms in the articles, and only dates have been given when referring to incidents that occurred since it is possible to trace places to individual therapists.

## Gender & participation of women

In Afghanistan, men are treated by men, and women by women. Thus, the men and the women had separate departments in the clinics, and time was spent in both male and female departments. At the beginning of the second field study there were only male physiotherapy supervisors in each region, despite the fact that over one third of the therapists in the programme were women. Female supervisors were recruited during 2006 to ensure that the female therapists in the programme were given the same support as the men. Activities and trainings strove to respect cultural norms regarding men and women. I was assured that it was not a problem to conduct trainings in a mixed gender group, thus the theory parts were held jointly for men and women, but they worked separately for the practical parts and when with patients. The exception was the manual therapy training: due to the nature of the training it was held separately for the men and the women. The opportunities for women to participate in trainings were limited by their restricted possibilities to travel. Most of the women were not able to travel alone without their *moharram* (male relative who acts as a chaperon).

## Language

A number of languages and dialects are spoken in the country. The two official languages are Pashtu, spoken mainly by the Pashtuns, and Dari. Dari is spoken – with variations in dialect – by other ethnic groups, although these also have their own languages (UI 2007). Dari is the main language used at PTI.  However, a large number of the therapists had a better understanding of Pashtu than Dari, as Pashtu is the mother tongue of the therapists who come from the eastern and south-eastern regions of the programme.

In the northern region, where the first field study was conducted, Dari is more common. In this study, a female translator (non-physiotherapist) joined me in the female department in Mazar-e-Sharif, since the two female therapists spoke very little English. The three male therapists spoke fairly good English, and since the translator also worked in the RAD office, we managed with no interpreter during the days I was there. The translator also joined me when I travelled to the districts one day a week, and she translated for the interviews.

The second field study of the development project entailed larger challenges regarding language and communication. Three of the physiotherapy supervisors had a good grasp of English, three could communicate fairly well, and two knew very little, but they took lessons and their English improved over the span of the development project. In the regions very few therapists knew English well. I learned basic Dari, but was not fluent. Thus all trainings and meetings were translated between English and Dari or Pashtu, and translation was done in the clinics when necessary/possible. The translations during trainings were for the greatest part done by the Physiotherapy Officer. He also translated during the first observation trip to the regions. One of the female supervisors with good English skills translated during the evaluation trip, to ensure translations even when in the female departments. This supervisor also translated for the manual therapy training for one of the female groups, while the other was translated by my counterpart for the theoretical parts, and by the translator from the first field study for the practical parts. Teaching handouts were provided in Dari, and in English for those who wanted; monthly newsletters were translated into Dari and Pashtu. The aim was to translate other training materials into Pashtu also, but finding suitable translators who could translate physiotherapy texts was a major challenge and frustration for the therapists and teachers alike.

# The Field Studies

## Ethics

The project proposals of both field studies were approved by the Institute of Neuroscience and Physiology at the University of Gothenburg, and by RAD and the SCA, within whose structure they were carried out. The SCA General Secretary at the time had considerable experience from both research and doing ethical assessments of research projects, and from living and working in Afghanistan.

## First field study

### *Focus & Aim*

The focus of the first field study was the physiotherapy component of the northern region of RAD. The aim of the study was to analyze and describe the physiotherapy component of RAD. This aim was re-formulated from the initial aim during the first week in Kabul, based on discussions with a number of people who worked with physiotherapy in Afghanistan. The reason for this re-formulation was that my initial aim focusing on physiotherapy treatment for mine injured children proved irrelevant to the situation.

Table 1. Activities of the first field study

| Week | Activity |
|---|---|
| **1** | Kabul: planning study, meeting people involved in physiotherapy in Afghanistan |
| **2-3** | Visits to the different physiotherapy clinics in the region, getting acquainted with the therapists and the programme |
| **4-7** | 4 days in male & female departments in Mazar-e-Sharif; 1 day in districts, each week |
| **8** | Kabul: short break from the field & further data collection about physiotherapy in Afghanistan |
| **9** | Taloqan: RAD Workshop (with representatives from all the RAD regions) |
| **10-12** | 4 days in male & female departments in Mazar-e-Sharif; 1 day in districts, each week |
| **13** | Mazar-e-Sharif: gathering last bits of data and tying the study together |

### *Activities*

The first field study was conducted over a period of 13 weeks, as shown in table 1. The time in the field was intense where I lived in the regional office of the programme, spent as much time as possible in the clinics, and visited all the clinics and therapists in the region. During the days spent in the Mazar-e-Sharif clinic, mornings were spent in the clinics with the therapists, and the afternoons were devoted to writing up fieldnotes, transcribing interviews and coding the photographs of the day. This set-up worked well, since the mornings were the busiest in the clinics. In the districts (to a lesser extent in Mazar-e Sharif) the therapists went on Home Based Training (HBT) in the afternoons. Opportunities to join these HBT visits in the districts were restricted due to travel limitations.

### *Field roles*

My role in this first field study was predominantly that of a foreign observer, but I was also a physiotherapy colleague and through the expectations of the Afghan therapists – even before arriving I was told that they were anticipating me teaching them new things – I was treated as a teacher. There was a constant dialogue about patients, where I asked questions about what they did and why, and the therapists asked about patients and different types of treatment, and how things were done in Sweden. At times I was requested to treat patients, which I strove to do together with them. Thus in the first field study, I was largely an observer as participant (Hammersley & Atkinson 1983).

## Second field study

### *Focus & Aim*

The focus of second field study was a development project aiming to improve the professional practice of Afghan therapists within RAD. The aim of the field study was to explore the process of the development project in order to gain understanding of how such work can be done in a better way. The development project was based on what was observed, experienced and recommended in the first field study, and on requests of the therapists for more training and support in their work. The specific aim of the development project was to strengthen and improve the clinical practice of the physiotherapists in RAD, as well as encourage a greater responsibility of the supervisors in taking charge of their own professional development. The time in Afghanistan was from 2006-2009.

### *Activities of the development project*

The development project spanned 2006-2007. The project consisted of three modules aiming at particular areas of physiotherapy that were considered relevant and in need of strengthening and improvement. The core group planned and evaluated these modules; an overview is shown in table 2, next page. The initial themes chosen for the modules were assessment and documentation, clinical reasoning, and CBR. Discussions during the first module, however, led to a revision of these, as it was decided that more practical themes should be chosen. Although they used exercises and manual methods to a lesser extent in their treatment, the Afghan therapists claimed these to be central to physiotherapy practice. Manual methods of treatment could potentially be more relevant in a country with limited resources than electrical equipment (requiring electricity and expensive equipment). Hence exercise therapy and manual therapy were chosen for the second and third module.

The development project and its impact were evaluated by the core group. The supervisors were given evaluation sheets to practice evaluations during the span of the project, and the whole process was evaluated, both orally and in writing, in the final core group meeting after the participants had evaluated the results of the actions in their regions (see Appendix 1 for the evaluation form). The supervisors presented evaluations of their regions at the final core group meeting in August 2007 (table 2).

*Core group meetings* Core group meetings were held at the start and end of the project, and three meetings were held per module, with an overlap of the exercise therapy and manual therapy modules (table 2). I led the meetings in 2006, and in 2007 other members of the group chaired the meetings. The initial plan was to rotate the meetings to different regions. However, this was discontinued after the first year due to limitations in the female supervisors' abilities to travel, and subsequent meetings were held only in Kabul.

Table 2. Overview of the activities of the development project (II, p.4)

| | | |
|---|---|---|
| Initial Physiotherapy Core Group Meeting: 060201, Kabul. Introduction to and planning of project | | |
| Observation field trip: 060205-0307, Ghazni, Taloqan, Mazar-e-Sharif and Jalalabad | | |
| **Module 1** | Assessment & documentation | Physiotherapy Core Group Meeting 1: 060202, Kabul<br>Physiotherapy Core Group Meeting 2: 060404-05, Jalalabad<br>Education field trip: 060507-0608, Taloqan, Mazar-e-Sharif, Kabul (Ghazni therapists) and Jalalabad (Trainer: JW)<br>*Additional training supervisors:* supervisory issues, 060614-15, Kabul (Trainer: JW)<br>Physiotherapy Core Group Meeting 3: 060813, Taloqan |
| **Module 2** | Exercise therapy | Physiotherapy Core Group Meeting 1: 060814, Taloqan<br>*Additional training supervisors:* Transcutaneous Electrical Nerve Stimulation (TENS) training 060815, Taloqan. Requested by the supervisors (Trainer: JW).<br>Education field trip: 060930-1122, Taloqan, Mazar-e-Sharif, Kabul (Ghazni therapists) and Jalalabad (Trainer: JW)<br>*Additional training supervisors:* Supervisory training 061204-06, Kabul (Trainer: senior British physiotherapist and consultant to the programme).<br>Physiotherapy Core Group Meeting 2: 070416-17, Kabul<br>Physiotherapy Core Group Meeting 3: 070820-21, Kabul |
| **Module 3** | Manual therapy | Physiotherapy Core Group Meeting 1, 2 and 3: same as for exercise therapy<br>Extra Physiotherapy Core Group Meeting: 061204, Kabul<br>Education field trip: 070216-0307 Taloqan, Mazar-e-Sharif, Jalalabad, Kabul (Ghazni therapists) (Trainer: external Australian physiotherapist)<br>*Additional training supervisors:* Proprioceptive Neuromuscular Facilitation (PNF) 070418-19, Kabul. Requested by the supervisors (Trainer: Italian physiotherapist working with ICRC) |
| Evaluation field trip: 070506-23, Jalalabad, Mazar-e-Sharif and Taloqan (Ghazni by Physiotherapy Officer) | | |
| Final Physiotherapy Core Group Meeting: 070820-21, Kabul. Evaluation, conclusion of project, discussion about ideas for future work. | | |
| *Additional training supervisors:* PNF training follow-up 070822-23, Kabul. (Trainer: Italian physiotherapist, ICRC) | | |

*Trainings* Trainings were held as part of each module (table 2). These were conducted in the field, except for the Ghazni therapists who had to come to Kabul due to the deteriorated security in this region. I conducted the trainings for the first two modules, while the third was done by an Australian physiotherapist. The first training covered assessment and documentation procedures in physiotherapy, and revised assessments sheets and registers were practiced, to be further tested by the therapists in their clinics. The exercise therapy training covered basic exercise physiology and how to use exercise as treatment, with specific programmes with examples of back, shoulder, knee, balance and coordination exercises. This training also included basic nutrition. The manual therapy training focused on peripheral joint mobilization, based on a distance-learning manual that the Australian physiotherapist had written for physiotherapists working in remote areas with little opportunity for CPD. It was impossible to cover everything in the one training, whereby it focused on peripheral joints since this was considered suitable to start with compared with spinal mobilization.

Each training consisted of practical and theoretical components, and patient work was included in the trainings as much as possible, in order to tie the training to their normal clinical practice. Active approaches to treatment were encouraged, and although clinical reasoning was not taught specifically, the therapists were encouraged to discuss, and were constantly asked “why” they chose a certain treatment, or what they meant with an answer to a question.

Additional trainings were held for the supervisors, as extra support and based on specific requests (table 2). This was also intended as a means for them to practice taking what they learned back to their regions, to teach their colleagues. The extra trainings were given in combination with core group meetings to minimize the supervisors’ travelling and time away from their regions.

*Observation & evaluation field trips* In addition to travelling to the field for the trainings, there were two other field trips (table 2). The first was an observation trip was done at the start of the project, to introduce me to the field and all the therapists, and to make an initial assessment of the situation together with the Physiotherapy Officer. All four regions were covered, and as many of the clinics as possible. There was also an evaluation trip at the end of the project, where the aim was to evaluate changes in the therapists’ clinical work in the regions, how they were implementing things they had learned. As stated, it was not possible for me to go to Ghazni; this was done by the Physiotherapy Officer. My evaluations complemented the individual evaluations that each supervisor made from their region.

## *Field roles*

My role in this second field study was different from the first field study. Here I became a part of the development context in that I had an official role and I was employed with the specific aim of improving the physiotherapy practice in RAD.

I was also employed with the understanding that the work with the Afghan therapists would include research, in order to understand how we could do such work in a better way. Being both the researcher exploring the development project, and the development worker leading the project and promoting change, I weighed heavily on the participation side of the participant/observer scale, being essentially an intervening participant (Fangen 2005). This idea of taking a more active role as a participant and simultaneously documenting the process as a researcher was inspired by action research (Reason & Bradbury 2006), although it was not an action research study.

*Additional work in the field*

After completing the development project, I continued working in Afghanistan for another year-and-a-half. In 2008 I worked part-time with AAPT, and part-time with RAD, with the supervisors and the therapists in the regions. In 2009 I left the SCA but worked part-time in a clinic as a physiotherapist, and continued an informal support to the AAPT. This enabled further reflections over what had been experienced and observed in the development project.

## Data Production in the Two Field Studies

### Participant observations & fieldnotes

For both field studies participant observation was the main method used to explore various aspects of the work, including the discussions and dialogues that were part of the work and interactions. In the first field study, observations were made in the physiotherapy clinics and the occasional visit to patients' homes during Home Based Training. In the second field study the participant observation was much broader and included meetings, trainings, field trips and practical/clinical work.

Observations were recorded as fieldnotes. In the first field study, notes were written into a notebook during the mornings spent observing in the clinics, and re-written into the computer during the afternoon of the same day, while the information was still fresh. In the second field study, the days were busier. Field notes were written into notebooks, and re-written into the computer in the evening. During some of the meetings and in trainings where I was not teaching notes were written straight into the computer.

As stated earlier, in different traditions of ethnography, the presence of the researcher in fieldnotes is treated differently. In the first field study, the fieldnotes were mainly inscriptive where what was recorded was my interpretation of what was observed (Clifford 1990, in Beach 2005). Although I included recordings of my thoughts that were triggered by what was observed, the fieldnotes were more objective compared with the second field study. In this, the nature of my fieldnotes was both inscriptive and descriptive in the more complex sense (ibid), where my presence was acknowledged in the fieldnotes.

As inscriptions, my interpretations were inscripted in the observations, for example see the episode below from a visit to a clinic in the northern region:

> When the supervisor and I come into the room there is a patient on the exercise machine, a fancy construction with multiple components, including a revolving plate. A patient is standing on this plate, rotating her body to and fro. I ask the therapist (PT) what the patient's problem is, and she says that the patient has "limited movement in all her spine". I continue questioning, asking why she came to the physiotherapy department. "She has DJD [degenerative joint disease]". But what was her complaint when she came? "She has low back pain, and has had this for three years". The supervisor asks the PT to do the assessment of this patient again. She does this, but haltingly so, she acts unsure in the presence of both me and the supervisor. She seeks confirmation for what she is doing, asking if what she is doing it right. She has a hard time summarizing what she sees, and bringing it together to a concluding diagnosis. Although she states her observations orally, she does not write them down in the patient's journal.
>
> When she starts the assessment of another patient, also with back pain, she focuses on details. She states that there is a "lateral shift" (which I cannot see) and "muscle spasms". (These are recurring findings that the therapists state when it comes to back patients.) She asks the patient to bend over, which she does with no problem. She does not ask about pain when she does this, so the supervisor and I ask, and there was no pain in her back when bending, and she has no radicular pain. The PT does Babinski's test, and I ask her why she is doing this:
>
> PT: Just I want to test it.
> JW: But why?
> PT: In history she said she had numbness and tingling, and the problem is CNS [central nervous system].
> JW: How do you think it is a problem in the CNS?
> PT: I want to find out the reason for the neurology pain.
>
> She cannot say more specifically what the Babinski's test shows, and when it should be used. (The patient has not presented any symptoms that indicate central damage, has had no trauma, and there were no other neurological findings in the assessment.) She then tests SLR by lifting the leg briskly up to 90°, and does not ask the patient about pain (re-written from FN080216).

I made interpretations of the way the therapist was acting based on my understanding and beliefs about physiotherapy. In the episode above, I perceived that the therapist was uncertain in her assessment and treatment of the patients. However, her actions must be understood in light of the female supervisor, a translator and myself being present and watching her, asking her questions. Furthermore, the therapist in question gave the impression of being a shy and quiet person, which further would have impacted her actions. Thus, it cannot be assumed that she was less competent merely on the basis of what was seen here.

As descriptions, the fieldnotes included a record of personal reactions and feelings as I observed, partook in, and was affected by, the work and the therapist's context, as well as new ideas or thoughts that were stimulated by what I had observed. An example of this is given below:

> I have for the past couple of days felt that there is a gap or something, in relation to X. I feel I cannot completely connect to him. He simply agrees with things that I say, and I wish that we could have more of a discussion about issues. I wonder if he feels that I am encroaching on his expertise or territory, or what the matter is… He simply accepts things that I say, and says that everything is fine, agrees with my ideas. I don't really know what to do to change things. Maybe X is simply a quiet person, as I have understood both from experience and from comments from others. Maybe he also feels that it is a little strange to have a foreign young female have so much to say about his area of work… The other thing that is a little hard, is that there have been so many times when X should have done things, and they have not been done. So I feel obliged to follow up on everything, and I don't like nagging and constantly checking. This might be chipping at his pride, I don't know. That X previously was used to doing everything himself. I will simply have to keep asking his opinion about things, and run things by him. I am not in a position to question him about this (FN 060802).

My observations were guided by the aims. In the first field study the aim was to describe and analyze the situation of the Afghan therapists, hence observations were made from a broad perspective; this was also my first visit to Afghanistan and I wanted to take in as much as possible. In the second field study, the observations were affected by the aim of the development project, i.e. to strengthen and improve the clinical practice of the physiotherapists in RAD as well as encourage a greater responsibility of the supervisors in taking charge of their own professional development.

The recording of observations was dependent on practical possibilities for taking notes: when there was more time, the fieldnotes were fuller and more descriptive; when there was less time, the focus was on issues that seemed relevant to the aims. For example, when I conducted trainings, there was less time for this, although I had a note pad at hand, and made jottings when possible. The notes were also affected by my degree of participation. There was more personal input into the data when I was actively engaged, such as when conducting trainings, compared with when someone else was doing the training.

## Photography & interviews

In the first field study photographs and semi-structured interviews complemented the participant observations. The photographs served as a mode of documentation and stimulated recall for the description of the physiotherapy in RAD, the physical environment and the physiotherapy treatment methods. The photographs were coded and organized daily, parallel to the fieldnotes.

The semi-structured interviews covered basic information about the therapists, and their views on physiotherapy. These were tape-recorded and then transcribed in verbatim, and as they were translated between English and Dari as we spoke, it was only the English from the interviews that was transcribed. Informal follow-up discussions were also conducted in 2009 with five physiotherapy teachers to answer questions that had arisen in the second field study in relation to ethics and Islam. The interviews and discussions were not analyzed in-depth but provided complementary information to the observations.

## Analysis of the Four Papers

During and after engaging in field work analysis aims to make sense of the field experience, to "search for patterns in data and for ideas that help explain why those patterns are there in the first place" (Bernard 2002, p.429). This happened both formally and informally. I alternated between observation and reflection when in the field, where preliminary analyses were done continuously as the fieldnotes were written out in full. Then, specific steps were followed for the analysis for each paper, where the steps are summarized in table 3, next page. A combination of inductive and deductive reasoning was used in the analysis. Through inductive reasoning, understanding is allowed to emerge from the texts, while deductive reasoning stems from a hypothesis (Bernard 2002). The deductive analysis was influenced by the theoretical framework chosen. The inductive analysis was affected by my own process of development through the project; the analyses that were done towards the end were more nuanced compared with my first analyses. This will be further discussed in the methodological considerations, page 52.

The various steps and processes of the analyses have been inspired by qualitative procedures described by Bailey (1996), Bernard (2002), and although having not done grounded theory research, initial inspiration was also taken from Strauss and Corbin (1998). In paper I the initial analysis of the data from the first field study aimed at providing a descriptive account of the therapists' situation, based on the steps described in table 3. From this, the next step involved a further analysis focusing on the needs and challenges in developing physiotherapy in Afghanistan.

For paper II the analysis of the data from the second field study had a cyclical nature which consisted of three phases, where each phase led to a deeper understanding. The first phase involved a structured analysis of the fieldnotes in September 2007, to identify key themes as related to the aims of the project; see table 3 for the different steps of this. The second phase spanned 2008 and part of 2009, where continuing the work with the therapists enabled a deeper understanding of the data to develop. It was during this time that 'learning' stood out as a central and cross-cutting theme, in relation to gaining a better understanding of professional development of the Afghan physiotherapists. The third phase took place after leaving RAD, and involved interpreting factors that impacted the therapists learning in the project from a perspective inspired by the

transformative perspective of adult learning described in chapter three. This again opened up new insights into the data. Through this cyclical nature of analysis and reflection, new dimensions, or a further understanding of these dimensions, unfolded: with each phase new sides to the themes that had been identified became apparent.

Table 3. Analyses of the four papers

| | |
|---|---|
| **Paper I** | **Phase 1** The fieldnotes were read several times in order to grasp their meaning as a whole.<br>Coding, where themes, sub-themes and significant aspects of the themes were identified in the texts.<br>Memoing – thoughts evoked by the fieldnotes were recorded.<br>The sub-themes and significant aspects were then organised into the larger themes.<br>Re-grouping the data: through mind-mapping of the larger themes patterns in the sub-themes and significant aspects of the larger themes were identified.<br>**Phase 2** Further analysis focusing on the needs and challenges in developing physiotherapy in Afghanistan. |
| **Paper II** | **Phase 1** Open reading of the fieldnotes to grasp their meaning as a whole. Thoughts that arose were noted.<br>Themes and significant aspects of the themes were identified in the text. From these, preliminary key themes were developed.<br>Mind maps were created to organize and give an overview of the key themes, and aid further reflection.<br>Episodes/incidents illustrating the themes were identified in the fieldnotes.<br>**Phase 2** Continued work and reflections in the field<br>**Phase 3** Interpretation of factors that impacted learning of Afghan physiotherapists from a perspective inspired by transformative learning |
| **Paper III** | Reflections and discussions between the co-authors based on their different experiences focusing on professional ethics for Afghan physiotherapists, where my input was based on understanding gained from the analysis of paper II, and my cumulative experience from working, living and researching in Afghanistan. |
| **Paper IV** | Re-reading of the fieldnotes, and memoing of thoughts triggered when reflecting over the fieldnotes.<br>Identification of themes and significant aspects of themes.<br>Identification of key themes from these, and organizing these into categories with the help of mind-mapping.<br>Further reflection over the key themes and categories in relation to my development process and impact on the study and work with the Afghan physiotherapists, using the combined theoretical perspective of transformative learning and situated learning. |

Paper III considers professional ethics for Afghan physiotherapists based on the experience and reflections of three expatriates and one Afghan who have worked with teaching physiotherapy in Afghanistan. The context and rationale for this paper was the perceived need by AAPT and PTI to introduce professional ethics to the curriculum. My contribution to the paper stemmed from the understanding that has developed through the analysis described for paper II, and from my cumulative experience of living, working and researching in Afghanistan. We – the authors – reflected on and discussed ethical dilemmas and possibilities for teaching ethics for Afghan physiotherapists. This took place during 2008 and 2009, via Skype, email and in person.

The final paper grew out of a need to establish my own development process through the work with the Afghan therapists, as a means of understanding the process and the resulting outcome (Thomas 1993). The reason was also to balance the discussion of my Afghan colleagues and their learning, where it is of ethical importance to also critically reflect on my own learning. This new analysis basically followed the same structure described for paper II, albeit with a different focus: this time it was on my learning and development process, and impact on the project. The process of the analysis was influenced by the combined perspective of transformative learning and situated learning. Appendix 2 shows a couple examples of the themes and memos from this analysis.

## Ethical Considerations

The field studies described were considered useful for gaining understanding of the situation of the Afghan therapists, and for how professional development of physiotherapists in Afghanistan could be supported in the best way. The knowledge gained could challenge the ways in which physiotherapy development work is presently being done, and stimulate reflection over ways of working, for Afghan and expatriate physiotherapists alike.

However, the nature of the studies puts particular requirements on how the research is carried out. Furthermore, there are issues of concern in terms of researching and working in a development context. Participating in the lives of others, the researcher and development worker must consider their role, and factors such as power, cross-cultural communication, and their own cultural competency. These factors will bear directly on how the researcher acts and interacts with the other participants. There are risks involved: if the researcher is not able to handle the cultural differences, or abuses their position, this could undermine the therapists. There is a risk in how the data is presented, where sensitive issues could be personally destructive for the individuals involved.

In the second field study, although all the therapists gave consent to participate, there are dilemmas in this. How much of a choice did they have? The focus of the study was the development project that aimed at improving practice, which they wanted and had requested. The study was endorsed by their employer as part of the development project, and I, who promoted the project, was doing

the research. Also, although I was a volunteer during the time of the development project, I still had a position with the potential of power. Although I did not get the impression that the supervisors or therapists were adverse to the research, these matters raise ethical concerns and place particular requirements on how the data is handled and presented.

The knowledge and understanding gained from ethnographic research is to be shared with others (Wolcott 2005). This means representing those that have been studied, creating an image of them, as has been done with describing the Afghan therapists in papers I and II. Creating representations is a “complicated and contentious undertaking” (Madison 2005, p.3-4). What has been described stems from a desire to understand, not to value, so as to help increase awareness and understanding. Yet the meaning that is intended may not be thus perceived by the reader, since the image portrayed will be interpreted based on the reader’s prior conceptions of physiotherapy, the theory used, and of Afghanistan. Saving face and maintaining honour are important in Afghanistan, and it is not my meaning to exploit or demean the therapists I worked with. Thus there were situations that I have chosen to not write about, such as ethnic issues, conflicts and personal interests between different therapists and colleagues. For example, in paper IV no details regarding the disorienting dilemma described are given. Disclosing details about these issues could be helpful for outsiders to better understand the whole context, but to do so would abuse the trust of the Afghan therapists, and it could be personally destructive for the individuals concerned.

The ethical issues involved when the researcher is actively involved in the process often do not fit into the formats of traditional ethical guidelines and may be overlooked by review boards, yet there are a number of ethical dilemmas that should be addressed (Zeni 2001). The plan and methodological approach may be fine, but it is in the manner in which the researcher engages with the people and in the work that ethical dilemmas can arise. Thus, the key lies in how the researcher acts. I aimed to conduct the research in an informed and ethical manner – indeed, it was a desire to gain understanding of how to conduct development work in the best way that spurred the whole idea of the second field study. Doing a research study of the development project further raised the quality of the work by providing a structure for reflection that would not have been done to the same extent otherwise. This does not mean that ethical dilemmas did not arise; an example will be described in the next chapter (paper IV). Zeni states that “collaboration and communication are the best guides to preventing the ethical dilemmas of practitioner research” (2001, p.164). And this is easier said than done. The experiences from this research have impressed upon me the importance of critically reflecting over one’s own role and position in participating in and researching others practice. It is not enough to consider the issues before-hand, but a constant reflection must be done when in the field. Ones attitude and cultural competency lies at the heart of being able to conduct both research and development work in an ethical manner. This, and other related issues will be further discussed in the methodological considerations below.

# Methodological Considerations

Fieldwork generally means staying in the field for a considerable length of time (Bernard 2002). With the two field studies described and the collective period of working in Afghanistan, the time spent in the field was almost four years from 2004-2009. However, the key to good ethnography is not measured by the time spent in the field, but how that time is spent (Beach 2005). This is what will be considered in this section. Just as in learning and professional development, the data production of the studies described here was impacted by both contextual and personal factors. This will be considered in terms of context and participation. Related to these is the matter of pre-understanding and reflexivity, which will also be discussed. The process of analysis will be discussed, and the chapter concludes with a discussion about validity.

## Contextual factors impacting the data production

The context set the scene for the studies. There were a number of practical and situational factors that had a direct impact on the access to the field, what was possible to do, and which impacted on roles and manner of participation.

### *The development context*

In chapter two various sides of the Afghan context was described, including the development context. Becoming a member of the development community had implications for my participation and access to the field as a researcher, as well as the identity I developed as a development worker (IV). There was a distinction between the Afghans and the expatriates working with the organization. The number of expatriates was small in relation to the number of Afghan staff: there were between 8-14 expatriates, and around 4000 Afghans. Apart from three-four of us who were development workers, the rest of the expatriates had managerial, administrative and advisory positions. In working terms development workers had no more contact with the management than anyone else in the organization. Socially, we did, and being expatriates, we were automatically associated with the management team. Expatriates travelled in chauffeured land cruisers or the like, whereas the Afghan staff travelled separately in large staff busses. Expatriates also lived in expatriate compounds or housing, with a very decent standard of living. Due to security reasons, we were chauffeured wherever we went – local taxis were out of bounds, and walking was strongly advised against – which limited ease of movement. There was a whole expatriate social scene that generally excluded Afghans, including restaurants that were out of bounds for Afghans (due to alcohol). These are just a few examples, but all in all, being a part of the development context directly impacted access to and participation in the Afghan context by creating boundaries and reinforcing hierarchies.

### *Security issues*

The general post conflict/ongoing conflict status of Afghanistan had a considerable impact on the access to the field in the studies. From arriving the first time in 2004 to leaving in 2009, the security situation became steadily worse. Bomb-blasts and warnings of suicide bombings became a part of life. The menacing presence of tankers and armed military became disturbingly natural, part of the back-drop. The whole situation was part of the thrill and challenge of the work, and it added meaning and determination to do as much as possible.

However, the deteriorating security was – naturally – a direct hindrance to both the work and the research. Being employed by an international NGO meant being subject to security guidelines and recommendations, and combined with being part of an international development community, this effectively created boundaries that had a hampering effect on being able to engage fully, and in a more natural way, in Afghan society. After a first trip to the south-eastern region in the Spring 2006, I (as an expatriate) was not permitted to travel south of Kabul. Therefore all trainings for the therapists from this region were held in Kabul, which meant limited follow-up or supervision could be done – none by me, although the Physiotherapy Officer was able to go a few times. There were a few incidents during trips to the regions where security prohibited movement to certain areas, most often in certain districts in the Eastern region.

### *Practical challenges*

RAD is a large programme, with rural and urban clinics. The 80 therapists spread out over almost a third of the country gave a broad representation of the physiotherapists in Afghanistan, entailing a representative view of Afghan physiotherapists' situations in a country of many different ethnic groups. However, for what we tried to do it was too large and too spread out. It was easier to limit the breadth of the first field study, whereas this was not possible in the second field study and development project; I was employed to work with the whole physiotherapy component. The large geographical distribution and number of therapists further meant that it was impossible to provide more extensive follow-up to trainings, or sufficient in-field support of the supervisors, which would have been preferable. This impacted how they did their evaluations and the manner in which they practiced the new things that had been taught. It also limited how often the core group could meet, and hence, during the times we did meet, there were other practical issues that had to be addressed which were not directly related to the development project.

The breadth of the endeavour was personally challenging. Apart from the large number and geographical distribution of therapists, I was expected to teach and supervise, do this in a relevant manner, try to understand and make myself understood, and simultaneously document observations. Being in the regions was stimulating and these times comprised highlights in the work. When visiting the therapists in their regions issues were brought to our attention, which would not have petered down to Kabul. But they were also taxing. Being an independent individual who loves the freedom of moving around at will outdoors, being in the

regions meant even more restrictions than usual. Being confined to one room, dependent on others for meals and for transport entailed a loss of personal space and consequently sapped energy. Balanced with the inspiration and stimulation it was manageable. But each month spent travelling in the regions was exhausting, with the intense engagement in the therapists and their work and the lack of normal routines for re-charging energy levels. This had a limiting impact on reflection over observations and experiences.

Communication and the language barrier was another major challenge, and this directly impacted the process of data production. It hampered the natural flow of conversation and exchange of ideas, and limited how much I could participate in the discussions. At the same time, my efforts to learn Dari and use what I knew were greatly appreciated, and it was a means of showing interest. And although not fluent, my grasp of the language was sufficient enough that I could follow the general gist of what was being said, which was helpful in a number of ways, such as following how things were translated. Cross-cultural communication will be further discussed in chapter six (see page 85).

## Gaining access to the field

Participant observation must always consider the impact of the researcher due to his or her active engagement in the field and with the people being studied (Fangen 2005). Understanding my manner of participation is essential for understanding the process and the production of data, since what I saw and perceived as meaningful was directly related to the understanding and meaning perspective I had at the time. As Mezirow says, "we are caught in our own histories. However good we are at making sense of our experiences, we all have to start with what we have been given and operate within horizons set by ways of seeing and understanding that we have acquired through prior learning" (1991, p.1). Thus there are a few factors to consider.

There were a number of different field roles that I held in the field, including being a white foreign young woman, a physiotherapist and physiotherapy teacher, a development worker and a researcher. Each of these had various dimensions, and central to them all, to my manner of participation, was cultural competency.

### *Cultural competency*

Participating as a researcher in others' practices involves gaining access. Using Lave and Wenger's (1991) term, the researcher could be seen as a legitimate peripheral participant, striving to become a member of the community in order to gain an emic, or insider perspective. As described, the context of the studies was not an easy one to enter. A vital component to enable access was cultural competency. Cultural competency for an ethnographer entails being able to read and adapt to local cultural codes in any given situation, and adapt the level of participation accordingly. It entails being able to be near or distant, as appropriate. My cultural competency has its roots in an international upbringing,

where interacting with people from other countries and cultures has been a natural part of my life.

I have Swedish parents, but spent my first 19 years in Pakistan. I passed the majority of my school years in an international boarding school with people from many different countries. My parents worked closely with Pakistanis, lived in Pakistani communities, learned their language, culture and customs. The experience of growing up in Pakistan has had a major impact on the way I view development work. It also had a major impact on the manner in which I interacted with my Afghan colleagues. I consider it as a key factor that enabled me to gain access, and to shift between roles as appropriate depending on whether I was in the female or male physiotherapy department, and on whether I was in Kabul or the more conservative regions. It facilitated finding common ground with the therapists beyond our professional commonality.

This cultural competency can be considered as an embodied state of being that was developed as I grew up in Pakistan, and through the values and way of living of my family. It is a natural part of who I am, and being in the environment in Afghanistan triggered behaviour that was learned in Pakistan. Hence cultural codes such as avoiding eye contact with and maintaining distance to men, and traditions such as wearing a head-scarf, were not unnatural and did not require conscious effort. This cultural competency was invaluable for what I was able to gain access to and observe, for the relationships we formed, which opened up new spaces for me to enter. This cultural competency was of particular import in that I was a young foreign female (24-29 years) in a culture where women and men are largely separated (in the public sphere), and age is a social indicator for respect.

### *Being a white young female physiotherapist*

As a young foreign white female and physiotherapist I was able to work with and observe both the men and the women. As a physiotherapist the Afghan physiotherapists and I shared common professional ground and a common goal in striving to improve their practice. Being an expatriate physiotherapist/teacher was a legitimate reason for being present for the treatment of both male and female patients. As a woman I was able to be in both male and female departments (I cannot vouch for the situation in the southern parts of the country, which are reportedly more conservative), while this would not have been possible for a man; they would not have been able to observe the treatment of Afghan women. In fact, it was jokingly stated in expatriate circles in Afghanistan that white women are the third sex: they look like women, but act like men. However, this was not to be taken for granted or abused, and a respectful attitude and adapting to the cultural codes for proper behaviour was essential for working together and for gaining respect in return. Thus, an important factor facilitating access in this regard was my cultural competency, as described.

### *Balancing field roles*

There are different levels of participant observation, and these are linked to the role of the researcher (Fangen 2005, Hammersley & Atkinson 1983). In the two field studies, I had various different roles, and these roles affected my manner of participation and observation. In the first field study, I was a researcher and a physiotherapist, and my identity as such was highly coloured by my Swedish university education and clinical experience. My short stay in Afghanistan meant that the influence of the context was not extensive, as compared to the second field study. As described, in the first field study I was mainly an observer as participant (Hammersley & Atkinson 1983), whereas in the second field study I was an intervening participant (Fangen 2005). I will henceforth be discussing primarily the field roles in the second field study.

Participating in others practice as a researcher means finding a role that suits ones personality and skill-set (Fangen 2005). As a physiotherapist I issued from an understanding of what it means to be a physiotherapist, based on my educational and clinical experience from Sweden. I entered a scene where there were expectations on me to bring new knowledge, changes and development. I was given – and took – the role of a teacher in trainings and in supervisory visits to clinics in the regions, provided training and information concerning the physiotherapy profession. This role of physiotherapy teacher was one I was comfortable with, due to an interest in teaching, and stemming from the enjoyment and stimulation I find in working as a physiotherapist.

The first field study was valuable for the start of the second study: I already knew several of the Afghan physiotherapists, and returning to the field and following up on the first field study was a positive note to start on in terms of my relationship with the therapists. Being employed by the organization enabled access in that I had a given place in the group. I was not just an outsider striving to gain entrance, I had a legitimate reason for being there and I was welcomed due to the fact that I was coming to work with the Afghan therapists to improve their clinical practice. It enabled an insider's perspective on what it means to engage in development work. But this also impacted the data production. My role as an expatriate physiotherapist and teacher, and my position as a development worker, assumedly affected how the therapists acted while I was observing them, and thus the data production. Furthermore, my role and active participation in the development project entailed responsibility towards my colleagues and my organization. This responsibility meant that I was concerned for the project, for how it was conducted, and for the outcome; I was keen that the work should be done well. It also meant that it was harder to take a step back and remain objective when peering through my researcher glasses. This placed particular requirements on my reflective capacity and impacted what I was able to see in the observations I made.

Another dimension related to what I was able to see was self-preservation in light of the general pressures of the work, research and environment. To maintain levels of function, protective barriers limited my insight but enabled me to continue with the work and research despite feelings of inadequacy in meeting

the requirements of both. It was not until after leaving Afghanistan in 2009 that I was able to start to critically analyze what I had experienced and address issues that were lurking at the edges, but which I had not had the energy or capacity to deal with when participating in the field. It was during this process that a more critical perspective was developed towards both my approach in the work and research, and the matter of engaging in development work.

Overall, I was neither neutral nor an equal co-participant. Although we shared professional ground, as a physiotherapist I had a different educational background and different future educational possibilities, which I felt placed obligations on me to share what knowledge I had. I was not a member of the therapists' clinical community of practice, but I had a position within the RAD physiotherapy cadre, and I became a member of the development community. And although I was an outsider, as time passed I gained more and more access to the field, as I developed relationships with my Afghan colleagues and gained more insight into their lives and practices.

My field roles and the issues of access can be exemplified by Goffman's (1990) metaphor of front and back stage performances. He suggests that all actions are social performances, and we act and interact in different ways depending on which stage we are on. The front and back stages entailed different roles for both the therapists and me, and different degrees of access.

The front stage represented the trainings, meetings, and clinical practice. Front stage, we all had particular roles, both through our formal positions, but also that we created through our interactions and expectations. On the front stage, I was an expatriate physiotherapist, development worker and participant observing the activities taking place. The back-stage represented the times in-between that were not officially part of the project. For example: travelling together for long hours when visiting the regions, visiting homes, sitting down for lunch, sharing stories and discussing favourite Bollywood movies over numerous cups of *chai* (tea). As I gained more access as a legitimate participant, I also gained more access to the therapists' back-stage. Although I documented primarily the activities of the front stage, the interactions of the back-stage were of great value for the collaboration on the front-stage, and for deepening my understanding of the therapists and their work. What should be clarified here is that I accessed the back-stage of the women, but not of the men. My interactions with the men were restricted to the activities in the clinics and of the development project, i.e. the front stage.

There was also my front and back stage, between the work and research, and personal time. The way we expatriates lived was a way of taking a step back from the field, of going back-stage. My apartment was a small haven for me in the midst of the restrictions and the busyness of the work, and my expatriate friends were an important part of social life. Here I could take a break from my role of teaching and observing, from being an expatriate. At the same time, living like this very effectively set expatriates apart from the Afghans, and meant that it took longer to get to know my colleagues and the Afghan culture. In this regard, I was grateful for the experience from my years in Pakistan. As described earlier,

when travelling to the regions, I did not have my personal back stage, and thus did not have the same possibility for taking a pause from and gaining perspective on the work.

To summarize, I was overall more comfortable as an active participant than a passive observer, and my role as a researcher was not as strong as that of a development worker or physiotherapist; it was a constant balancing act, maintaining the two. The development project impeded on the research, and the research was also a limiting factor in the development project since this took extra time and energy, and where the felt pressures of documenting observations restricted my engagement both professionally and socially. As a development worker I developed in my role while in Afghanistan, while I was less confident as a researcher while in the field. It was not until I left Afghanistan, gained perspective on my experiences and critically reflected over these, that I started developing more as a researcher.

## Pre-understanding & reflexivity

Field work is a personal experience (Madison 2005), observations are always going to be interpretations, and what is observed is directly coloured by the perspective of the researcher. My prior experiences shaped my pre-understanding and prejudices, and this affected the manner of my participation, my observation and interpretation, and my reflexivity. My upbringing in Pakistan facilitated a greater openness towards the diversity of different cultures which is more difficult for those who have lived in only one cultural environment (Hofstede 2001). However, despite prior experiences, there is always a risk of ethnocentrism when working cross-culturally (ibid). Also, as well as being an asset, my experience from Pakistan at times led to overconfidence in understanding the Afghan culture; there are similarities, but there are also differences.

Various measures were taken to adapt to and gain a better understanding of the Afghan context. I strove to adapt to the local dress and customs; I learned basic Dari and tried to use what I could when communicating with the Afghans. Literature about Afghanistan was read prior to entering, and when in, the country. Regular breaks were taken from the country, which was necessary for re-charging energy and for gaining perspective on the work. This included a number of trips to Pakistan: travelling between Pakistan and Afghanistan added dimensions to my perspectives on both countries. Trips were also made to India, where I participated in physiotherapy courses. This gave personal experience of being a student in physiotherapy courses in the same region: although India is different from Afghanistan, I perceived similarities in the trainings, and I experienced how different the teaching approach was compared to Sweden. I continually reflected over personal reactions to what I observed and experienced, and discussed and reflected upon these with other expatriates working in the field, both physiotherapists and non-physiotherapists. Finally, and importantly, there were countless informal discussions with the Afghan therapists regarding their practice and experiences, culture and traditions, which were invaluable in

helping me understand the things that happened. These efforts were of import for my reflexivity.

Data production through observations documented as fieldnotes requires a critical view, in all stages of the process (Fangen 2005). My reflexivity set the parameter for what was possible to see and understand; it was in direct relation to my pre-understanding, to the context, to how I participated in and was given access to this context. Being actively involved in the work impacted my observations, where my interpretations were inscripted in the fieldnotes and my feelings and reactions to what I was seeing and experiencing was recorded.

To understand others actions one must also try to understand their meanings and intentions with the actions, as well as the context in which the actions are made and in which the intentions were formed (Mezirow 1991). This will entail challenges in homogenous situations, but it is magnified when working across cultural borders and when one cannot communicate fluently. The actions described that were taken to deepen my understanding helped in this regard, and there were further factors that were of import. The work outside of RAD, with AAPT and PTI was valuable since the physiotherapy group in Afghanistan is small, and engaging in work outside of RAD enabled me to see issues from the perspectives of physiotherapists outside my own programme. It enabled insight into various intrigues and power plays that affected the work of the physiotherapists generally. The informal follow-up discussions with physiotherapy teachers in 2009 gave further insight. Importantly, the myriad of other activities and incidents involved in living for three-and-a-half years in Afghanistan impacted my understanding of the country and facilitated a more nuanced perspective of what it means to live and work there as an expatriate and as a physiotherapist.

## The process of analysis

Just as when considering participant observations, the analysis of the data must consider the perspective of the person doing the analysis (Fangen 2005). My analytic ability was both limited and assisted by my pre-understanding, as well as by the roles I had in the research. These roles enabled an emic understanding of what it means to be an expatriate development worker, but an emic understanding of the Afghan therapists was in many respects hampered by the development context we were in, our roles, and particularly by the communication barrier. Furthermore, the active participation in the development project as an intervening participant hampered the possibility to develop a more etic perspective in the process of analysis. It was not until leaving Afghanistan end of the summer of 2009 that a more critical, etic perspective was developed.

As I continued to reflect on the work I had participated in, my perspective on this changed, I became more critical, and through this greater insight was gained. In paper I the analysis is basically descriptive. In paper II the analysis went deeper than in paper I, guided by the theoretical framework of transformative learning, which helped in developing an understanding of what impacted the therapists' learning and professional development in the project. In

paper III, discussing ethical issues with the other authors sharpened and increased insight. Finally, in paper IV, re-analyzing the fieldnotes from the second field study more than two years after the first analysis of these notes was enlightening. Critically reflecting over my experiences, I found that my perspective had changed, and new things were seen in the data. This enabled an analysis of how my meaning perspectives had changed. Not until the preparation and related reflective processes of the final paper and in the writing of the frame in this thesis was I able to acknowledge how my "ideological preferences" (Thomas 1993, p.9) impacted the research and work in Afghanistan, and how it impacted what I saw in the analyses. This reflective process over experiences has given substance to my ideological conceptions – it was like a 2D image transforming into a 3D figure, with sides and angles that I had not been aware of before.

## Validity

Validity in participatory observation concerns trustworthiness with aspects such as credibility, transferability and confirmability (Fangen 2005, LeCompte & Goetz 1982). The credibility of the data is established by positioning the researcher in relation to the field, and the findings must be viewed in light of the context and manner of participation. This has been described earlier in this section. To consider transferability, one must also consider the contextuality of knowledge, as described in terms of knowledge transfer in chapter three. Professional development and learning of Afghan therapists is specific to the Afghan context. However, the need to contextualize physiotherapy theory and practice is relevant for any context. Furthermore, what will be presented concerning working as an expatriate physiotherapist and development worker is considered relevant for anyone – not only physiotherapists – working in development contexts anywhere.

Confirmability will be considered in terms of communicative validity. Communicative validity is the validation of experiences, observations and interpretations both by others, and through discussion with others (Fangen 2005). This is part of the process of data production, where observations are constantly being validated by reflecting them in what others say, and with what one reads and experiences. It is thus often unstructured and the sum of the experiences becomes an embodied understanding in the researcher, which are hard to describe but which directly colour what is seen.

Communicating what one has perceived to the participants is an important part of the validating process (Fangen 2005). During the studies there were numerous conversations, with both Afghans and expatriates, where experiences and observations were shared. Many were not documented, but they helped to create an image of the larger picture, and balance what I thought I was seeing. In terms of the findings of the papers, regrettably, the findings of paper I were not shared with the therapists prior to publication. For paper II, a specific discussion and sharing of ideas with the supervisors post-data analysis was hampered by my leaving the SCA; this was unfortunate since considerable insight was gained after

leaving Afghanistan. However, another expatriate physiotherapist working with RAD, with considerable experience of working with and teaching Afghan physiotherapists, discussed the findings with the Afghan supervisors and the themes therein were confirmed. Even though this was not optimal in terms of communicative validity, presenting the findings to the Afghan therapists and asking for their opinion was also of ethical value. For paper III, the interpretations of the expatriate authors were challenged and balanced by the Afghan author. Finally, paper IV was read by a senior Afghan physiotherapist, with considerable experience of working with expatriates, who recognized the issues raised and endorsed my reflections:

> I have read your paper. It is wonderful! You really thought very deeply into the Afghan context and describe your experience in Afghanistan in a good manner. I accept your understanding of Afghanistan and Afghan people. You really had the privilege to go to many part of Afghanistan into the physiotherapy clinics and see the reality of profession there. Your presence, as a development worker and physiotherapist was very helpful in Afghanistan and I can hear that from PTs at SCA and others. When I read your experience, I thought that I was a witness of what you say. Sometimes in reading I moved my head and said yes, that is right. … I learn from your paper and I read this part maybe 5 times repeated (Adel A, personal communication, July 21, 2010).

Peer-reviewing is also part of communicative validity (Fangen 2005). The findings of paper II were corroborated by six relevant expatriates who had worked within the fields of physiotherapy and disability in Afghanistan. Experiences were discussed with my supervisor and co-author Susanne Rosberg in Sweden, by e-mail, Skype, and in person when in Sweden. Having not been to Afghanistan, her outsider perspective challenged me to question what I was experiencing. The co-author Ian Edwards (papers II and III) was a valuable sounding board and contributor to the interpretation of my experiences. He lived in Afghanistan from 1983-1987 where he was involved in the initial development of physiotherapy, and he has returned on a number of teaching trips in more recent years. Finally, the papers have been (I, II and III) and are being (IV) rigorously reviewed in terms of scientific quality as part of the publication process of peer-reviewed journals.

Having said all this, there are a number of concerns with communicative validity. First, the day-to-day discussions I had with the supervisors were impacted by our roles in the programme. Particularly, understanding was impacted by the cross-cultural communication and my non-fluency in Dari or Pashtu. Discussions between expatriates were helpful and supportive, and we could share experiences without language barriers. However, this did not always lead to enhanced understanding, since what was validated was based on our perceptions at the time, which in hindsight was not always very nuanced, and biased towards our own opinions.

In the end, it is not possible to obtain complete consensus regarding ethnographic data due to the different beliefs and understandings we may have of the world (Fangen 2005). Rather, one of the strengths of exploring life with an ethnographic approach is that through presenting our perceptions for others' consideration, we can challenge each other's perceptions, and come to new understanding. Thus we engage in a continual process of gradually developing greater knowledge and understanding of ourselves in relation to the people whose lives we engage in. In this case, possible explanations are suggested which contribute to enhanced understanding that can guide constructive actions in further development work together with the Afghan therapists, and from this, yet greater understanding can be gained.

Finally, although the length of the field work does not entail validity as stated at the beginning of the methodological considerations, the length of my time in Afghanistan was invaluable in building relationships, enabling access to the field, and ultimately developing insight. The level of participation enabled an emic perspective of what it means to be a development worker, although this was at the expense of a more etic perspective when in the field. This etic perspective has developed over the past year, through a critical perspective on the wealth of experiences from the collective period of almost four years of both studies. The time-limits of doctoral research have drawn a line for the present reflective process of this thesis. However, it is believed that this process will continue, through further critical reflections, and hopefully, through further work with the Afghan physiotherapists.

## A tree doesn't move unless there is wind

Field work is a craft (Bernard 2002) and an art (Wolcott 2005), and as such takes time and practice to learn how to do well. What has been described in this chapter is my first shot at doing ethnographic field research. My participation, observations, fieldnotes, and analysis reflect learning in progress. Furthermore, as has been experienced throughout the processes described in this chapter, the only thing that has been constant is that things rarely go as planned. The journey followed a constantly changing path and brought me to a different place than expected. And this is what makes the whole process so interesting: what we thought we knew can be up-turned in a moment, and it is in the breaking point that new understanding can be gained. Thus, as stated by the Afghan proverb, a wind is certainly needed if the tree is to move, but the wind blows where it will, and we cannot know beforehand the direction it will take.

# 5 FINDINGS

مشک آن است که خود ببوید، نه که عطار بگوید.

A good perfume is known by its own scent
rather than by the perfumer's advertisement

As is implied in the proverb above, a true representation can only be given by the person him- or herself. This chapter is a summary of the findings of papers I, II, III and IV, and being largely based on the interpretation of outsiders, these findings are but one representation. To gain a more complete picture, one must work with the Afghan therapists, and gain understanding as they 'spread their own scent'; one must engage in development work and discover one's own scent. That being said, the hope is that the findings presented will inspire greater reflection over the factors involved when promoting professional development in Afghanistan.

## Paper I: Physiotherapy in Afghanistan – Needs & Challenges for Development

The findings in paper I present an overview of the situation of the Afghan therapists working in the northern region of RAD. The following section describes the main themes in the findings.

### The physiotherapy component

The RAD therapists worked primarily in rural settings, where men and women were treated in separate departments. They treated patients of all ages. There was a large span of conditions that required treatment, where the most common complaints were "back problems, arthritis, 'other' conditions, cervical problems, cerebral palsy (CP), spinal cord injury (SCI), polio and hemiplegia" (I, p.307). The following is a summary of a fieldnote from a day in a female physiotherapy department:

> It is only 8:30 in the morning, but the air is already warm and the sun is bright. Sitting on a bench outside the female department a few women have pulled back their corn blue *chadaris*; there is a child playing on the floor. In the physiotherapy room the two physiotherapists are preparing for the day, ironing their white coats; one of them tends her baby daughter whom she has brought to the clinic. Afghan music is playing on the radio, and the fan in the roof churns and drones in the background. My translator and I are served green tea as we wait for the day to start.

The first patient is a 1½-year-old boy with torticollis. The mother explains that she had a very difficult pregnancy, and after he was born he always lay with his head to the right side. The physiotherapist holds the child in her lap and massages the sternocleidomastoid muscle with talcum powder, and then stretches it by pulling it back and forth. The next patient is a 3-year-old girl, referred by an orthopaedic doctor. The mother says she has trouble walking and always falls down. The doctor suspected rickets, and recommended physiotherapy. An older lady is getting infrared treatment for her neck and shoulder, followed by cervical traction, and two other ladies, also with neck pain, are waiting their turn. A young lady with polio limps in, her right leg is affected. She is treated with hot pack and rigorous stretching of her contractures. A lady with chronic back and neck pain has been waiting for some time. The physiotherapists tell me that she has been discharged but returns regularly, wanting infrared treatment for a number of complaints.

The stream of patients lessens before lunch, and as we wait, we have another cup of tea. The physiotherapists and I discuss our profession; we compare experiences regarding how physiotherapy is practised in Sweden and in Afghanistan. The differences are many, yet we share common professional ground (summarized from FN040530).

## Isolation

Most of the therapists worked in isolation: in the rural centres there were one or two therapists (often one male and one female), and they met their colleagues once a month, during On-Job Training and payday. The supervisor visited each clinic once a month. There was little collaboration with therapists outside the programme, such as with the ICRC. They had very little access to information, especially not new developments in physiotherapy. At the time of this study, they did not have Internet access.

## Gender & cultural aspects

Men and women were treated separately. The patients often did not remove their clothing during assessments, never their trousers. Children, women and older men were often accompanied by a family member. There were difficulties for female therapists to travel to the patients for Home Based Treatment, as well as to other regions for trainings or workshops. It was also more difficult for female patients to access the clinics, due to transport issues and having to leave their responsibilities at home.

## Passive treatment

The treatment was dominated by passive methods, often with various modes of electrotherapy: hotpacks, infrared light and electric massage were common. A few departments had TENS apparatus and ultra-sound, but these were used to a lesser degree. They advocated active and manual treatment but these methods figured less often in practice. Stretching was common for contractures, and

traction for back pain and neck pain. Exercises were used for some patient-groups, particularly hemiplegic patients. They explained that the patients wanted electrical treatment. They also gave advice to patients, ranging from using local materials for various activities to nutritional advice.

### Physiotherapy assessment & documentation

The patients' medical diagnoses formed the basis for the treatment rather than a functional and symptomatic assessment. Assessments were stated as important. The range of assessment skills varied, and assessments were carried out according to three formatted sheets: 'Musculoskeletal', 'Neurological' and 'Spinal'. Daily recording of treatment given was sporadic, with little documentation of the effect of the treatment. The reporting system for monitoring the activities of the physiotherapy component was quantitative, focusing on the number and type of patients treated.

### Role of the therapists

The therapists perceived their role to be one of taking care of the patients, having good behaviour. They had expectations from the patients and their families to live up to. They followed doctors' recommendations in the treatment before their own ideas. They were prescriptive, and seldom discussed treatment plans with the patients.

### Knowledge & clinical reasoning

There were variations in how they viewed their own professional knowledge: some thought it was adequate, others were able to identify areas where they needed improvement. Most wanted more courses and further education, and a few were particularly keen to progress professionally. They showed considerable theoretical knowledge, which was based on the courses they had taken and the information available. This knowledge base had not been updated, and with limited supervision and input, there was a risk of treatment being based on habit and the patients' expectations. Through their practical work they conveyed difficulties with clinical reasoning, where treatment was based on cause-and-effect thinking dictated by diagnoses.

## Paper II: Exploring Learning & Professional Development of Afghan Physiotherapists

Paper II explores various factors that impacted the learning of Afghan physiotherapists in the development project. The different contexts of transformative learning described in chapter three have served as a theoretical inspiration in the interpretation of these factors (see page 17).

## Expressions of meaning perspectives in the Afghan therapists' practice

Based on only the participant observations, it is not our place to define the meaning perspectives of the Afghan therapists. However, various expressions of these were seen in their clinical practice and participation in the trainings. These impacted how they used the new things learned, where these were practiced with a pathology-focus and a recipe-based approach, and following habitual structures of practice. The different expressions identified were:

*Pattern approach* Certain methods were used for certain conditions, and new techniques were adapted to old habits of practice. Patients were treated with several different methods for the same condition, in one treatment session.

*Linear thinking* Basic skills of critical reflection and analysis were perceived, where things were described as they were seen. A challenge for the supervisors was to reflect on suitable approaches when in the abstract setting of a core group meeting. This was easier in clinical settings and when discussing patients, where they showed greater interest in and skills of reflection.

*Socially oriented decision-making* Social and traditional norms governed the roles of patient and therapist, and how treatment was administered. The expectations and desires of the patients impacted the choice of treatment. This was also true with the medical doctors, where doctor's prescriptions carried considerable weight in their clinical decision-making.

*Equipment preference* The therapists explained that patients wanted treatment using sophisticated apparatus, and it was perceived that they would look more professional with such tools. Methods, such as electrotherapy, were often used. These also made practice easier and enabled more patients to be seen.

*Religious dimension* A belief in *Allah* (God), and living as honest Muslims, were seen as a natural part of professional practice. The therapists were tools through which healing was given by Allah, and they had a responsibility to give the best treatment they were able to give.

> A patient is receiving TENS combined with hot pack over the erector spinae muscles. The patient has back-pain "due to DJD [Degenerative Joint Disease]". The treatment plan is "TENS, hotpack, mob (grade 1-2), strengthening ex". I watch as the physiotherapist mobilises, pushing down over the lumbar spine with the ulnar border of her hand, in an oscillating movement: "I am doing for each joint for 30 seconds", she explains. I ask the patient how she is feeling, she says she feels no change, she has pain.
> JW: Why are you doing mobilisation for DJD?

PT: She has no x-ray, but because she has pain I should start with grade 1-2, tomorrow I will see how she is, if she is better I will increase the grade. The patient said at first there was pain, now it is a little better.

After completing the mobilisation, the physiotherapist shows the patient an exercise: she tells her to lift her bottom into a bridge, and hold for 10 seconds. The patient does this four times before the physiotherapist tells her: "You are tired, it is enough for today. Do this at home as much as you can."

Later when we are discussing the combined use of TENS and hotpack, she says she uses these "because I don't want to waste time."

JW: What is the aim of using hotpack?

PT: Before because we are used to using hotpack, and all patients are used to hotpack, people will be unhappy if we stop using. We stopped gradually with infrared and massager, we will stop gradually with hotpack. The reason is for muscle relaxation. Some people who have joint problems, I will do correction and then give hotpack, I don't want to make them unhappy (re-written from FN070521).

## Cross-cultural communication in the core group & trainings

Communication was a major challenge and barrier in the project. There were two levels of communication: language and the meaning behind what was being said.

*Language* New treatment methods or upgrading courses were often taught by expatriates, and translators had to be used since they most often did not speak Dari or Pashtu. For many of the therapists the ability to partake of and understand physiotherapy literature was impacted by limited or no English skills, and by the levels of their primary education. These factors entailed challenges for expatriate physiotherapists to provide suitable training materials and it challenged teaching. The lack of information, and the quality of translations, was a frustration for therapists and expatriate teachers alike.

*Meaning* Expatriate teachers' and Afghan therapists' cultural norms and expectations impacted how meaning was conveyed and interpreted. The meaning behind what expatriates said was interpreted first by a translator, and this translation was then interpreted by the students. This also affected the expatriates understanding of what the Afghan therapists meant. These factors at times led to misunderstandings.

*Saving face* Critique was challenging to handle, and the matter of keeping face had an impact on their actions.

During a period of clinical work with the PT supervisors we talked about how they could continue developing professionally in the field, when there were few courses and they did not have someone to teach or supervise them. We talked about learning from difficult cases, about discussing with colleagues and sharing ideas and learning from each other. I suggested that if they had a patient

> that they did not know what to do with, they could ask their colleagues, and discuss the case together. To this I was told: "Afghan people cannot ask a question and show that they do not know" (Supervisor 2, FN080416).

However, when discussing with the supervisors, they shared recounts of difficult patients and situations. It should be stated that discussions took place between the supervisors and the expatriate physiotherapist/development worker, and how this occurred between the therapists is not known.

## Approaches to learning

*Concrete operations* Handouts and written materials were highly valued, and the therapists wanted a format or demonstration to copy and follow. Listening to a lecture without a practical demonstration was more challenging. This approach could also be related to communication, where by receiving handouts they would not miss any information from what the teacher was trying to say.

*An instrumental approach* There was an instrumental view of knowledge and of learning new things. Technical skills learned were then perceived as easily passed on to others.

## Roles of the physiotherapy supervisors in the development project

The supervisors were teachers/supervisors and students, as well as participants involved in implementing the project; these roles had implications for their learning. As students, they were keen to learn; they conveyed a pride in the knowledge they had and eagerly demonstrated their skill. They also conveyed expectations on the development worker to bring changes and teach them new things. As supervisors, their managerial responsibilities of organising and hosting the trainings impeded on their participation in these. As teachers, they instructed more than discussed how the therapists should work. Their roles as participants changed over the project where they became more active and showed an increased interest in supervising their colleagues.

## The development project as a context for learning

*Approach of the researcher/development worker* The researcher/development worker in the project had a direct impact on the outcome of the project; this is described more in paper IV. The trainings included many discussions and were interactive, but the teaching tended to be prescriptive and instructive.

> Half a year after the exercise therapy training, during the manual therapy training, the question of how to instruct patients to do exercises arose. The expatriate teacher (ET) and I (JW) talk to a group of female therapists (PT) about the necessity to include exercises as part of the manual therapy treatment,

particularly home exercises. When one therapist states that they see the patients six days per week, and asks about mobilisations, she is told that she cannot do mobilisations on the patient on a daily basis:
PT1: If the patient does not come every day, the patient says they become worse. We learnt in physiotherapy training that the patient must come every day.
PT2: If the patient does not come every day, they will not do their exercises
ET: The patient is also responsible for the treatment
PT2: We check if the patients are doing their exercises correctly.
ET: Before my patients go home, they show me what they should do. I ask them to write down what they are to do.
PT1: But our patients are illiterate.
The expatriate teacher draws some stick drawings to illustrate that they can use drawings to show the patients, to which another PT responds:
PT3: Not possible.
PT2: When they learn it, that day they do it correctly, then they forget. If that patient comes back to a different physiotherapist they will show the exercises wrong.
PT4: It is better to give all the pictures to the patient, so they can use these.
JW: Do your patients understand pictures?
PT1: A few, but most do not understand pictures.
PT3: We show them, and then when they come back and are asked to demonstrate, they do it incorrectly.
ET: Maybe the patient can teach their relative, they have learned it from you, they have to think about it, and explain it to their relative.
JW: Would it be possible to have exercise groups?
PT3: But we have individual treatments, not groups.
JW: Yes, but if you have a lot to do, working with groups can be a way of easing your workload.
PT1: But maybe the patients have different problems, and cannot work in a group.
JW: You can have patients working individually, but they are all exercising together in a group.
PT1: We are doing this, having several people at a time (re-written from FN 070227).

*Core Group* The supervisors' active participation in the project was perceived as a positive change, they appreciated the core group and the possibility of meeting together to discuss work issues, and the method of working with the modules.

*Restrictions & challenges* Both the supervisors and the development worker had other demands on their time, apart from the activities of the project and the research. Language barriers, the considerable spread of the core group and the large number of therapists, power and hierarchies related to the Afghan and the

development context, were some of the practical and contextual issues that affected how the work and the research could be conducted.

*Achievements of the development project* The supervisors' evaluations of the project were basic and descriptive, but commendable in proportion to the limited support they had received in carrying them out. Apart from critique regarding not enough supervision and problems with the handouts and information, their evaluations were positive: the trainings had been useful and they were happy with the project. They felt that the therapists had made considerable improvements, they were interested in, and were practicing the new methods, although there remained difficulties in how they used the new techniques.

The changes were also commended by an external consultant: compared with an evaluation done in 2006 (Hartley 2006) which correlated with the start of the project, Hartley stated that the therapists were working with "new treatment concepts, improved patient assessment and treatment records, [they have] done away with passive and electrical treatments leaving behind a motivated, hands on and much improved and strong physiotherapy workforce, who very obviously get much satisfaction from their work" (2008, p.5). Compared with the start of the project, their standards of assessment, documentation and treatment were improved. This being said, there is a need for ongoing follow up and for a repeat of some of the trainings (Dawson H, personal communication, May 2, 2010).

As described in chapter three, adult learning and professional development necessitate responsibility in learning. The participatory approach of the development project was a considerable change to how things had been before. Actively seeking the supervisors' ideas and showing an interest in their work and their concerns encouraged them in their responsibilities. Observing the supervisors their interest in their profession was perceived, and the way they took on their responsibilities with increased rigour suggested that they had grown in their roles. One of the female supervisors is presently the president of the AAPT, and the Physiotherapy Officer sits on the AAPT Executive Board for the second time around. The supervisors have continued to meet in the core group; however, how these meetings are conducted, and what they contain in terms of proactive action towards continued professional development, is not known. The supervisors have skills and influence, and a keen interest in continuing what the project started, but they have many demands on their time and often shoulder several responsibilities (Dawson H, personal communication, May 2, 2010).

## Paper III: Living a Moral Professional Life Amidst Uncertainty: Ethics for an Afghan Physical Therapy Curriculum

Physical therapy training in Afghanistan has been based on Western teaching materials translated into local languages since most Afghan physical therapists have little or no comprehension of English. This translation of normative,

evidence-based practice underpinning physical therapy was found to be inadequate when it comes to the issue of en ethical physical therapy practice in Afghanistan. Two ethical tensions are identified: 1) between individualistic and communitarian understandings of ethics, and 2) between normative ethical theory and 'local moral experience' (Kleinman 2006).

## Two ethical tensions

As members of the international physical therapy community through membership in WCPT, there are increasing obligations for the Afghan physical therapists to set professional standards. Ethical principles commonly employed in Western countries are based on a more individualistic approach. For example, informed consent of the client is an expected ethical pursuit in a collaborative approach to services. Afghan society and culture, however, is communitarian, where decision-making is also subject to the wills and expectations of those around the individual. This entails an ethical tension in balancing obligations for professional ethics with what works 'on the ground'. The second tension relates to balancing what the Afghan physical therapists are taught that they should do, and want to do, with the expectations placed on them from their communities leading to actions that may not follow this. Living and working in Afghanistan entails numerous challenges, not the least in terms of the moral challenges that arise in face of the huge and varied demands of clinical practice.

## Local moral experience

There are numerous challenges that Afghan physiotherapists face in their practice, where the tension between normative ethics and their local moral experience is a very real part of their clinical practice. An example of such a tension was exemplified by an incident related at a workshop at the AAPT General Assembly in 2008, where the normative ethical notion of informed consent clashed with the context:

"A well respected physical therapist posed this question to his colleagues: 'Do you think that therapists should tell the patient (or care giver) the truth?' He then went on to relate a story of a mother with a baby girl who had hydrocephalus. The mother had asked him regarding the child's prognosis and how disabled the child was likely to be in the future. The physical therapist related his response to the group and it sounded like a very well balanced, informative and educative explanation to the mother as what the child and the family could expect. He had been realistic, but not overly bleak or pessimistic, offering hope of a life, which, whilst probably constrained in some ways, could nevertheless see the development of a child who could be an active and loving part of the family. The next day the baby was found early by the staff, left at the gates of the hospital. The question was repeated 'So should I still tell the truth in the future?'" (III, p.4)

### Narrative reasoning: interpretation & reflection

We suggest that strengthened reflective skills can help Afghan physical therapists tackle the ethical tensions, particularly through a narrative approach through discussion of ethical dilemmas which arise in their practice. Narrative reasoning can be used by the physical therapists both to actively strive to understand their patients and also to understand the contextual factors which influence positively or adversely ethical decision making and action in professional practice (i.e. local moral experience).

### Identity, voice & power

Narrative reasoning also considers notions of ‘identity’, ‘voice’ and ‘power’, which makes it further relevant for Afghan physical therapists who are in the process of forming their professional identity in the larger Afghan social and medical community.

### Narrative ethics & stories: telling & listening

Narrative reasoning as a practice of listening and telling stories fits well with the strong Afghan oral tradition. Afghan physical therapists have many personal stories to tell which illustrate the challenges involved in working as a physical therapist in Afghanistan, but also personal experiences of what it means to live in a country ravished by war. These can be used in a collaborative effort to explore and develop ethical practice, and to teach those of us (expatriates) who do not share these experiences, what it means to work in such a context. Through telling and listening to these narratives, critical reflection can be facilitated, for expatriate and Afghan physical therapists alike.

### Narrative ethics & social concern

Through narratives ethics and the telling and sharing of experiences, the decision-making process can be shifted from an individual to a more social perspective. What ethical principles mean for the particular situations can thus be explored, rather than being simply prescribed based on normative, Western traditions.

## Paper IV: The Physiotherapy Development Worker Identity – Critical Reflections on Experiences from Afghanistan

This paper takes a critical view of my participation as a development worker/physiotherapist/researcher in the development project. My participation in the project had a direct impact on the outcome. From a perspective inspired by transformative learning and situated learning (see chapter three), I describe the meaning perspective that I had in the work, how through a critical reflection over experiences and disorienting dilemmas my perspective came to be changed, and how my approach and perspective impacted the outcome of the project.

## The Idealistic Helper

*Own background* With Swedish parents, I grew up in Pakistan, and attended an international boarding school from the age of seven. My upbringing was infused with core values of doing good to others. I am a conscientious do-er, problem solver and idealist, with a positive approach and high expectations on myself and others. My experience from growing up in Pakistan, combined with my first trip to Afghanistan in 2004, shaped my view of the way in which developed countries engage in the developing world. A participatory approach was taken in the development project, with the hope that this would encourage the Afghan therapists' responsibility for their own professional development. Although inspired and keen, I was young and inexperienced and did not anticipate the complexity of what it means to participate in development work; I did not expect the extent of the impact it would have on me, both personally and professionally.

*Attitude – encouragement & instruction* There were two main sides to my attitude and approach in the work. I was interested in, and strove to encourage, the therapists' in their work and situation. In trainings and meetings I tried to stimulate their thinking about what they said and did, and encourage an active participation and interactive discussions over what was being taught. At the same time I issued from my ideas of what professional physiotherapy practice entailed, and what I and other expatriate physiotherapists thought they needed to know. I strove for collaboration, but projected my ideas about what needed to be done. Furthermore, the courses were not adequately adapted to their habits of learning, and were too compact in relation to the limited opportunities for follow-up. This being said, the courses were greatly appreciated, and the therapists made considerable changes in their clinical practice. But the courses were taught based on my understanding of teaching and learning, and I had not understood the manner by which they learned best. The attitudes and expectations of the therapists also impacted my role. Through our attitudes and expectations towards each other we were mutually responsible for the resulting collaboration. This was further impacted by the situational interests of the context we were in – comprised of both obligations of Afghan communitarian society, and the hierarchy of the development context.

*Collaboration & participation – relationships & power* Constructive relationships were important for the collaboration, and my hopes for equal participation in the work were affected by both my attitude (as described above), by the expectations of the therapists, and by the larger context we were in. Having a sensitive nature, the state of my relationships with the Afghan therapists and how I perceived that the work was progressing and being received, directly affected my emotional state of being. I was disappointed and disheartened when I felt misunderstood, frustrated with our communication, or that all the work being done was not leading to useful change. Similarly, feelings of encouragement and inspiration were directly linked to seeing the therapists' progress, or to experiencing positive developments in our relationships.

Our relationships and collaboration were affected by the context we were in. The physiotherapy profession in Afghanistan has been introduced, supported and developed by international organizations, and despite national developments it remains largely dependent on these. We all worked for an international NGO, but with different positions and roles, and different levels of dependency. The Afghan therapists' relationship to me was impacted by my being an expatriate development worker within the development system on which they were dependent. There were various power-plays, both between expatriates and Afghans, and between Afghans, which to a smaller or greater extent affected the work. These were mutually constructed by the attitudes we had towards each other, and the goals and hopes we had for the work we engaged in. These issues were part of the disorienting dilemma that will be described further on.

*Communication – bridges & barriers* Communication served both as an asset and a hindrance in the work. Although I was not fluent, through my efforts to learn the language and to communicate with my colleagues, I showed an interest that was valuable in building relationships. My basic understanding enabled me to grasp the general gist of what was being said in conversations and during trainings. However, my non-fluency also separated me from the group, and there was much information that was not translated and which affected the picture I constructed of the situations. The need for translations during trainings and of training materials had a direct effect on what was being taught.

What was communicated and taught was also affected by our cultural norms and behaviour, such as what a professional attitude entails, and what the roles of patients and physiotherapists should be in a clinical situation. Finally, my interpretation of what was communicated was affected by my perspective and pre-conceived ideas about the Afghan therapists and their situation, as was the Afghans understanding of what I communicated to them. Our roles in the development context, as mentioned earlier, also had an impact, which is exemplified in the disorienting dilemma described below.

## Disorienting dilemma

"During my third year of working in Afghanistan as a development worker promoting professional development of Afghan physiotherapists, I participated in a meeting with representatives from some of the main organizations and institutions working with physiotherapy. These different organizations were collaborating in improving the physiotherapy curriculum. Suddenly there was an uncharacteristic, angry eruption from a normally respectful Afghan member of the group, accusing the three expatriates present of having double agendas, and that one of the non-governmental organisations (NGOs) represented was pushing its own agenda in our mutual efforts of improvement, ultimately seeking to destroy the national institution we were working to support" (IV, p.1).

This incident is an example of a disorienting dilemma, as described in chapter three. It was a painful experience, and one of the key incidents that opened my eyes to the different perceptions of what we expatriates were doing

and why. It could have left me with an unbalanced understanding of the person involved. However, every person has a story, and hearing the perspective of the person in question, and then the stories of others, the incident made sense. The angry accusation was rooted in a history of expectations, interests and disappointments, and directed towards one particular person. It impressed upon me the complexity of what it means to work together, both from different cultures and backgrounds, but also within the complex development context. The longer I stayed, and the more I got to know people and heard their stories, the more I started understanding the dynamics that were in play. And through it all, my story, my meaning perspective, was a part of the picture and had a direct impact on the outcome of the work.

## Impact

The meaning perspective described affected how I taught and interacted with the Afghan therapists. My desire to encourage them to develop as professionals, my interest in their work and situations, my efforts towards cultural sensitivity and to learn the language: all formed an important base in the work. Less constructive was my prescriptive attitude of what I thought they needed to know, and how this could be learned, and an insufficient understanding of their needs in and approaches to learning. Yet in the end the project entailed considerable changes, and the therapists and supervisors experienced improvements in their work. I believe the reason for this was our relationships and the attitude of interest and dedication shown towards them and their work.

## The Enterprising Learner

Leaving Afghanistan in 2009, my meaning perspective as an Idealistic Helper was still in place, although sufficiently undermined by my experiences and reflections to be unstable, leaving me less confident in my role and regarding the work we had done. As I continued reflecting, with a more critical perspective over what I had been involved in, this Idealistic Helper has given way to a tentative Enterprising Learner. A self-critical reflection over the experiences of teaching and working together with therapists who live and work in a considerably different context taught me much about collaboration. As such, I have a more nuanced view of what it means to engage in professional development efforts in development contexts, and with people who have different views, beliefs and backgrounds.

# 6 DISCUSSION

صدا از یک دست نمی براید

You can't clap with one hand

One cannot clap with one hand when working with professional development over cultural borders; our concepts of truth are not absolute, nor are our concepts of professional practice and learning the golden standard. Thus we need to share our experiences and learn together. Clapping with two hands requires coordination, and to clap together with others requires an ability to listen in and adapt to their rhythms. Teaching and working with people from other cultures is not only about understanding them so that we can teach them in a better way; rather it is about how we work together, understand and learn from each other.

These are some of the base concerns of this chapter. First a summary of the discussions of the four papers is given. Based on these, the matter of promoting physiotherapists' professional development in the Afghan context will be discussed. Then various aspects related to working as an expatriate physiotherapist and development worker in developing countries will be considered, including cross-cultural communication, power, and cultural competency. The chapter concludes with thoughts of what it means to collaborate with people from different cultures.

## Summary of Discussions, Papers I-IV

The four papers discuss various aspects related to professional development of physiotherapists in Afghanistan. Paper I describes how the context in which Afghan physiotherapists work and learn is a challenging environment for both clinical practice and professional development, on several different levels. Some particular challenges are identified: moving away from a medical model and individualizing treatment based on thorough assessments; adapting a more active approach in treatment to the Afghan context, including exercise therapy; updating knowledge according to EBP; developing both greater skills of clinical reasoning, and a greater understanding of clinical reasoning in the Afghan context; improved skills of assessment and documentation; and finally, developing a system to encourage and support the professional development of the rural-based therapists. In striving to meet these challenges it is stated that it is essential that the Afghan therapists have an active and participatory role in development efforts in order for these to be sustainable and culturally relevant.

Paper II discusses factors that impacted the learning of the Afghan therapists as observed and perceived in the development project. Technical, instrumental approaches to learning are linked to the therapists' educational background where memorization and imitation are common methods, to teaching methods in their primary education as well as at PTI, and to the teaching of

expatriate physiotherapists keen to impart as much knowledge as possible within limited time-frames. The instrumental approach to learning is important, but should be balanced with more communicative learning, which could help in developing skills of clinical reasoning. This entails challenges for expatriate teachers in terms of how they teach, it requires insight into how the Afghan therapists learn, as well as skills of cross-cultural communication. It also requires personal insight and skills of reflection. Being limited by communication barriers, it was not possible to explore in depth the skills of reflection or clinical reasoning of the therapists. One cannot assume that the therapists' approaches to learning do not lead to deeper understanding, and we have made no assumptions about a greater understanding of their skills of reflection. There is thus more to explore with regards to learning and professional development of Afghan therapists. A communicative learning approach, for example peer learning, could be useful for both Afghan and expatriates to explore learning and meaning perspectives, to facilitate mutual understanding, and to stimulate reflection.

Paper III gives an example of professional physiotherapy practice that cannot be directly applied in a new context: professional ethics cannot be cut and pasted from a Western context into the Afghan one, due to differences in the societies. The discussion about professional ethics for Afghan physiotherapists proposes a narrative approach to resolving ethical dilemmas and tensions between what the physiotherapists are expected to do as professionals, and the expectations perceived by their communities. The ethical tensions between normative ethical theory and local moral experience, and between individualistic and communitarian ethical imperatives must be addressed by teachers of professional ethics for Afghan physiotherapists. Engaging in moral dialogue in the teaching of professional ethics holds value in facilitating increased understanding of others.

Finally, paper IV is a critical reflection over my identity in the development project. This included being a development worker, physiotherapist and researcher; these were interrelated and directly impacted by the development context in which I lived and worked. My identity in this context was also impacted by how my Afghan colleagues perceived my identity in relation to their understanding of the West, of development and of other expatriates. As a physiotherapist I adhered to professional principles learned from study and work in Sweden, which reflected a Western professional ideology. As a researcher with limited experience I relied on structure and theory, much in the same instrumental way that I perceived the Afghan therapists to approach learning new things. Although critical of the development context from the start, I was a part of it and I was affected by its influences. My experiences and a critical reflection over these has challenged and changed my meaning perspective. The sum of my resulting view is that we need to understand ourselves before we can hope to understand others, and a healthy dose of critical self-reflection enables us to see where we stand in relation to the people we work with. Reflecting together over disorienting dilemmas can be a way to learn more about ourselves and about others.

There are a couple common themes in the four papers. A mutually reflective, communicative learning approach should be taken in the collaboration between Afghan and expatriate physiotherapists, where ethical challenges and disorienting dilemmas can be used as basis for a reflective discourse. Furthermore, Western approaches to physiotherapy practice and to learning may not always be directly applicable in the Afghan context, and physiotherapy knowledge must be locally situated. These are base concerns that will be elaborated upon in this discussion.

## Professional Development in the Afghan Context

The general context in which the Afghan therapists live and work was described in chapter two. This presentation is by no means complete, but together with what has been described in papers I-IV it provides a contextual backdrop for the present discussion. The clinical and learning environment of Afghan physiotherapists is different from that which is found in modern Western educational and clinical settings. The range of patients is broad and diverse, and the medical and health-care sector struggles to meet their needs. There are limited resources and possibilities for supervision and for CPD; there are different views of knowledge and on how knowledge is gained. The physiotherapy practice is affected by the roles of therapists and patients, by their community, and by the medical- and healthcare system. There are challenges related to a limited understanding of the profession and its benefits. There is the additional dimension of the development context, with which the profession is interlinked. Physiotherapy has been introduced and developed by international organisations, the major employers are international NGOs and organizations, and local organizations and institutions (such as PTI and AAPT) are dependent on external funding and support. Finally, there is the factor of expatriate physiotherapists who primarily work with training and professional development, as well as in managerial, administrative and advisory positions. These are just some of the contextual factors that must be considered.

As described in the previous chapter, there were positive outcomes as a result of the development project. However, these outcomes do not reflect deeper understanding gained, nor do the discussions in the papers sufficiently cover the different layers involved in promoting professional development in Afghanistan. Thus there are a number of issues to consider in terms of the work that was done, and the recommendations given.

### Evidence based practice

In paper I we state that the physiotherapists' practice needs to be rooted in EBP. EBP is a central concept in modern medical- and health care, and is a requirement for professional physiotherapy practice. It encompasses research, clinical experience, and the beliefs and values of the patient (Bury 2003). Other expatriate physiotherapists and I told the Afghan therapists that they should use

methods which are proven to be effective, and that they should move away from treatment modules such as infra-red, electric massagers and an extensive use of hotpacks. The Afghan therapists often explained their use of these methods as answering to patient desires, although they recognized that this was not always in line with what they thought were more effective approaches (II). Their clinical reality is complex and not always easy in terms of balancing expectations with what they have been taught is the best approach and what they think is morally right (III). Here one must consider the matter of patient collaboration and the relationship between the physiotherapists and the patients.

In modern physiotherapy practice, the patient is expected to take an active role in the treatment situation (Higgs & Jones 2008). The Afghan therapists approach to patients was instructive and reflected the attitude of a parent to a child, and at the same time they wanted to please the patient (I, II). Patient collaboration was a group matter: members of the family often came with the patient to the treatment session, and were involved in the process (in the case of women, children and the elderly or severely disabled, seldom with men). Communication and decision-making thereby included not only the patient. The collaboration was also impacted by the social status of the patient: a patient coming from a high position could demand extra attention, and the physiotherapists had social obligations to oblige. Their reputation would be affected by how they respected these obligations, and their reputation in the community as respectful Muslims and members of the community was thought to directly impact their practice. Collaboration with other actors reflected the physiotherapist-patient relationship. Collaboration between the supervisors and students was dominated by instruction rather than discussion. Collaboration with medical doctors was dictated by hierarchical positions, where the therapists were obliged to follow the instructions and recommendations of the doctor. All this directly impacted how the physiotherapists practiced, and were expected to practice. It directly impacted how new things learned were put into practice, and their learning in practice (II). When teaching evidence-based approaches to treatment these factors must be taken into consideration, and herein is a challenge. EBP is important, but encouraging EBP for Afghan physiotherapists one must consider the contextuality of knowledge. As described in chapter three, knowledge that has been developed in one context cannot necessarily be directly translated into another. This will be discussed more below.

## Approaches to learning

Just as the context affected the physiotherapists' practice, it had an impact on their approaches to learning (I, II). This is natural, and learning styles of physiotherapy students also differs between Western countries (Mountford et al. 2006). For example, the Afghan therapists' instrumental approaches to learning, and the roles of the teachers and students, can be linked to educational methods used in Afghan schools. Karlsson and Mansory describe how the teacher was seen as the expert: "the teacher was the director of the play and in addition, the main actor. S/he took the major role while the students had the walk-on, non-

speaking parts" (2007, p.246). They describe how the teaching was not individualized, and activities were directed towards all and expected to be done by all. The teachers had the students repeat, in chorus; they often asked questions requiring a yes or no response, and did not ask questions where the students were expected to reason or explain. The students did not want to make mistakes: it was shameful to not know the answer when questioned by the teacher (Karlsson & Mansory 2007). These educational approaches of memorization and imitation can be perceived as old-fashioned and non-reflective from a Western perspective. However, one cannot on this basis simply assume that they cannot lead to a deeper understanding:

> Memorization and understanding are often considered to be opposites. Memorization without comprehension is mindless rote learning, and comprehension is not automatically associated with prior memorization. However, in Islamic education, memorization of the Qur'an is generally considered the first step in understanding (not a substitute for it), as its general purpose was to ensure that sacred knowledge was passed on in proper form so that it could be understood later. ... Memorization of the Qur'an (and other sacred texts) is meant to be the first step in a lifelong enterprise of seeking understanding and thus knowledge. The objective is not to replace understanding with dogmatism but to plant the seeds that would lead to understanding (Boyle 2006, p.488).

Referring again to the concept of knowledge transfer (Billett 1996, Eraut 2004), it is hence suggested that when teaching Afghan physiotherapists, one cannot use teaching approaches developed in Western contexts, simply because they are believed to be better for stimulating clinical reasoning or skills of reflection. Doing so may promote learning, but it can also lead to frustration or simply a waste of time. Furthermore, there is a value in the imitation of experts, when combined with discussions and stimulated reflection in practice – in other words, where observation is part of an active participation in practice (Lave & Wenger 1991). Similarly, memorization can serve as the stepping-stone for subsequent reflection over experiences and over what one has memorized.

Another factor that can impact Afghan therapists' learning relates to how expatriates teach. Although striving towards active approaches to learning, where students are encouraged to discuss and participate, expatriates who come for a short time may feed into the instrumental approach in their keenness to impart as much knowledge and information as possible, in the short time available (II, IV). Also, when there are barriers in communication, it becomes easier to work with a technical approach, and handouts naturally hold value in ensuring that no information is missed in the translations. The teacher has a particular responsibility in learning situations, in enabling the students to explore self-analysis (Molloy 2009). However, both teachers and students are responsible for how students are allowed to participate in learning activities (ibid), and this is of

central import if there are different ideas about the roles of the teacher and the student.

Wenger states that “our perspectives on learning matter … If we proceed without reflecting on our fundamental assumptions about the nature of learning, we run an increasing risk that our conceptions will have misleading ramifications” (1998, p.9). This was the whole point with trying to gain a better understanding of what impacts learning of Afghan physiotherapists (II), and of my own approaches to learning in the development project (IV). It was a goal in the project to adapt treatment approaches to the needs and context of the Afghan physiotherapists. But this was easier said than done. When teaching physiotherapy techniques and approaches, my teaching was based on theory and knowledge rooted in Western research and clinical practice, although I consciously tried to adapt this to what seemed relevant for the Afghan context. We discussed the trainings in the core group, but I made the handouts and content of the trainings, hence my adaptations were based on my perceptions. This is not to say it was unsuccessful, as suggested by the outcome of the project, but some things worked better than others. One example is exercise therapy.

Movement, mobility and function are at the core of physiotherapy (WCPT 2009), and exercise and physical activity are important parts of this. Exercise therapy is effective for a range of chronic disorders and diseases (Pedersen & Saltin 2006, Smidt et al. 2005), and exercise and physical activity is an essential part of strengthening the body and maintaining health (Galloway & Jokl 2000, Henriksson & Sundberg 2008). The Afghan therapists claimed exercise to be central to physiotherapy practice (I, II), they were keen and interested in this module and in making changes in their practice. In the exercise therapy module, the exercises taught were based on EBP, and as relevant for particular patient groups that were common in the clinics. Yet there were difficulties in putting these into practice – many of the therapists struggled in doing them, and in teaching them comprehensively to patients in the way they had been taught. Also, the use of illustrations or pictures, such as to explain an exercise for a home programme, was not always understood by patients. This could be related to the challenge of knowledge transfer.

Eraut suggests five interrelated stages that are involved in the knowledge transfer process: “1) The extraction of potentially relevant knowledge from the context(s) of its acquisition and previous use. 2) Understanding the new situation, a process that often depends on informal social learning. 3) Recognizing what knowledge and skills are relevant. 4) Transforming them to fit the new situation. 5) Integrating them with other knowledge and skills in order to think/act/communicate in the new situation” (2004, p.212). We touched on these stages in the development project, but did not go deeply enough into them. There was also too much information in the trainings in relation to the time available to cover it all sufficiently (IV). Thus, there was limited time for practice of the exercises for the therapists, and for them to explore how these could be better adapted to the needs and possibilities of the patients.

Eraut (2004) also suggests that transfer not only involves moving knowledge from one context to another, it also entails a learning process in itself. An example of this is given in paper III. Professional ethics is an example of Western concepts – normative ethics – that cannot simply be cut and pasted, but where one must consider the ethical and moral norms, or local moral experience (Kleinman 2006). What is suggested is a narrative approach to exploring ethical dilemmas that the physiotherapists encounter in their practice, where this can be a means of facilitating increased understanding about others and of ethics as relevant for the Afghan physiotherapy practice (III). This stems from the concepts of narrative reasoning and ethical reasoning, which are two models of clinical reasoning.

Narrative reasoning is reflective of communicative learning (Edwards et al. 2004). It involves understanding patients' experiences, as well as the patients' understanding of their experience, through what they are saying. Ethical reasoning involves decision-making concerning various dilemmas of moral, political and economical nature which are part of clinical practice (Higgs & Jones 2008), but it is also suggested to be a part of everyday practice rather than only for ethical dilemmas (Edwards et al. 2005). A combination of ethical principles and of patient values and contexts are needed for sound ethical judgements in physiotherapy practice (Edwards & Delany 2008).

Both narrative and ethical reasoning require skills of reflection: reflection enables the therapist to interpret and understand what the patients mean in their stories, to see the larger picture of the story (Mattingly 1994), and it helps physiotherapists to traverse between deductive and inductive ethical reasoning enabling sound ethical decision-making (Edwards & Delany 2008). Afghan physiotherapists' skills of clinical reasoning and reflection are suggested as skills needing strengthening (Armstrong & Ager 2006, Lang 2006), and this was reinforced in papers I and II. However, there are a number of issues to consider in this regard.

## Clinical reasoning & reflection in the Afghan context

As a key component of professional physiotherapy practice, clinical reasoning was a buzz-word in trainings for the Afghan physiotherapists, where expatriate teachers returned to the importance of Afghan physiotherapists developing skills of clinical reasoning. Clinical reasoning is anticipated as a central skill for modern, professional physiotherapy practice (Jones et al. 2008). It is "a context-dependent way of thinking and decision-making in professional practice to guide practice actions" (Higgs & Jones 2008, p.4). Clinical reasoning develops through interaction with others – peers and patients – and it is affected by each individual's frame of reference (Edwards et al. 2004, Higgs & Jones 2008). It was a term I often referred to, but we did not target it specifically enough in the development project. Furthermore, due to cultural and communication barriers, establishing levels of clinical reasoning becomes more difficult (II).

Higgs and Jones state that "one of the greatest challenges of clinical reasoning is to harmonize generally accepted healthcare practices and evidence

for practice with patient-centred practice" (2008, p.11). Thus there are a few things to consider in terms of teaching clinical reasoning for Afghan physiotherapists. Firstly, clinical reasoning is a Western concept of professional practice that has been developed in line with developments in Western countries, and this must be considered when promoting it in a different context. For example, in teaching clinical reasoning one must consider the roles of the patient and the physiotherapist. In the modern concept of clinical reasoning, the role of the patient or client is a critical aspect. Instead of being a passive recipient in the treatment encounter, the patient is expected to play an active role in maintaining health, and participate in decisions made regarding their health (Higgs & Jones 2008). This view issues from Western informed society where medical- and health-related information is readily available via media (Internet, television, magazines etc). Afghanistan presents a different situation. Although technology is making a breakthrough and information is becoming more easily available, its use is limited; even if the information is available in local languages, illiteracy is a major factor. The concept of informed consent of patients must be mirrored in the communitarian context of Afghanistan (III). Furthermore, the patients generally have a more submissive role to the therapists (I, II), which impacts how they collaborate in the treatment situation. This does not mean that patient responsibility is less valid for Afghan patients, but it must be viewed in light of local cultural practices and the roles of the patients and therapists.

Secondly, as obvious as it may seem, clinical reasoning should not be confused with reflection. Clinical reasoning skills have been perceived as basic, but this does not mean that skills of reflection are basic. The therapists reflected over aspects of their practice, and reflection was particularly stimulated, and perceived as important, when discussing clinical cases and ethical dilemmas in practice (II, III). Here the matter of cross-cultural communication becomes of great import. What expatriates – physiotherapists and researchers – perceive is affected by their understanding of the way things are, and limited by both language barriers and differences in interpretation of what the other person means with what they are saying. It is impacted by their cultural competency and the extent to which they are able to participate in the field. This raises concerns regarding how Western physiotherapists teach clinical reasoning. How clinical reasoning should be manifested and taught for Afghan physiotherapists must be more collaboratively explored.

Finally, clinical reasoning cannot be learned from books or lectures. It is a social and contextual process that needs to be understood and explored within the specific context (Higgs & Jones 2008). The manner in which clinical reasoning is taught must stem from the Afghan therapists approaches to learning (II), and this is not something that can be learned within the short span of a development project. Perhaps there should be less talk about clinical reasoning, which can easily become too abstract, and more emphasis on encouraging reflection as part of a collaborative, communicative approach between Afghan physiotherapists, and between expatriate- and Afghan physiotherapists. Discussing experiences with others aids the process of reflection, where expressing ones thoughts and

ideas to others in a comprehensible manner helps clarify these (Rodgers 2002). This takes us back to the communicative, narrative, and reflective approaches suggested in papers II, III and IV.

## Communicative learning in the Afghan context

The Afghan physiotherapists exhibited an instrumental approach to learning and practice (II). Much of Western physiotherapy teaching and research also stems from instrumental learning and action, where techniques are developed, tested and taught on a basis of easing pain, increasing mobility and improving function. This is an important part of practice and of research. However, there is also the social side of physiotherapy practice: with the increasing appreciation for the impact of ideas and beliefs of the patient in the treatment situation, communicative learning becomes highly relevant. In their study of reasoning of expert physiotherapists, Edwards et al (2004) found that cause and effect reasoning (instrumental learning) was accompanied by narrative reasoning (communicative learning) and that the capacity to utilize both forms of learning was a feature of professional expertise. Thus, both instrumental and communicative learning are needed, and in both reasoning and reflection are important components (Mezirow 1991, 2009). Here, however, the focus will be on communicative learning.

As described in chapter three, communicative learning means striving to comprehend what the other person means, and making ourselves understood. This is valid for the interaction between Afghan physiotherapists, between them and their patients, and between Afghan and expatriate physiotherapists. Communicative learning can enable insight for all involved, through the sharing of different perspectives that challenge beliefs and pre-supposed ideas. Here the roles of Afghan and expatriate physiotherapists will be more obscure: both will be learners and teachers within the hierarchical Afghan- and development context. This places particular challenges on the expatriate physiotherapist or development worker. Taking a practical approach to this, peer learning is a well-documented approach in physiotherapy education that can be explored.

### *Peer learning*

Through participation in learning groups and discussion with peers, greater emancipatory learning can be promoted. Peer learning is described as "an education procedure in which peers coach one another through clinical experiences using demonstration, observation, collaborative practice, feedback/discussion and problem solving" (Ladyshewsky & Jones 2008, p.433). It is suggested as a tool for encouraging clinical reasoning skills in novice practitioners: often physiotherapy students or novice practitioners do not learn as much as they could through their clinical practice of working with patients, and this can be enhanced through discussion with other physiotherapists – either fellow students or colleagues, or supervisors and teachers (Ladyshewsky & Jones 2008). Peer learning has been seen to improve skills of physical examination,

communication and clinical reasoning to a greater extent compared with individual learning (Ladyshewsky 2002).

A form of learning with peers is already used by the RAD therapists as they meet for their monthly On-Job Trainings, where they take turns in teaching various subjects related to physiotherapy (I). Thoren (2007) reports that Afghan physiotherapists valued presentation of what they have learned to others as an important method for maintaining quality. This was reflected in the development project, were the supervisors were keen to pass on to their colleagues what they had learned (II). What should be considered here is: how is this being done? Instruction will not develop skills of reflection, and teaching peers does not automatically mean that peer learning takes place.

Meeting in small groups to discuss and learn together is not a foreign concept. According to Afghan tradition, problems are discussed and solved together; (male) leaders meet together to make decisions in *jirgas* (traditional councils): “the successful resolution of problems does not come from confrontation but from negotiation, from a recognition that no-one must lose face, from the crafting of a solution designed to appear as if everyone has 'won'. A change of position is not acknowledged, because that would be to admit fault” (Johnson & Leslie 2008, p.93). Here are important cultural nuances that must be considered by expatriate physiotherapists who encourage or participate in such groups, such as respect, honour and saving face.

The suggested approach necessitates that the therapists bring difficult cases to the group, or are able to share problems that challenged them in their practice. Learning from mistakes, or being able to critically look at ones practice without losing foothold or risk losing face, is considered paramount to developing as professionals. Brookfield (2008) states the importance of teachers, educators, or leaders being able to make mistakes and show them in order to lower the bar and encourage students, or novice practitioners, to learn from their own mistakes, and to question what has been their norm in terms of clinical practice. Yet this is easier said than done. There are several issues with peer learning which will hamper its effectiveness in promoting skills of reasoning and reflection, such as lack of skills for reviewing and a reluctance to be honest in appraisals in case this compromises working relationships (Swisher & Page 2005). The supervisors did not want to appear incompetent in front of their colleagues (II), and being evaluated by peers or students is a sensitive issue for Afghan physiotherapists (Thoren 2007). Along the same line, when considering professional knowledge of Afghan surgeons, Foster (2009) found that students were rarely failed, even if they performed very poorly; peer reviewing or critiquing was avoided for fear of being critiqued at a later stage. At the same time, it should be mentioned that although mistakes were not readily owned up to amongst the therapists in the development project, there were situations where senior Afghan physiotherapists were able to stand in front of a group and tell of difficult, ethically challenging cases where they had not given the best treatment (III). Such cases were also discussed with me, when I brought up the subject. In terms of Afghan and expatriate physiotherapists working together, cultural differences in approaches

to giving and handling critique must be remembered; there are issues of communication, power and how culturally competent the expatriates are. These are important to consider, as they will directly affect both communicative learning and collaboration.

This section has discussed a few of the challenges involved in, and suggestions for, promoting professional development for Afghan physiotherapists, as related to the Afghan context. There are further factors to consider that relate to the development context. Thus we need to take a closer look at the dilemmas and possibilities associated with expatriate physiotherapists working in Afghanistan, and what it means to work as a physiotherapy development worker in a development context.

## Working in a Development Context

It is a complex scene that greets a Western development worker entering Afghanistan. Hundreds of NGO's – most of who are based in Kabul – vie for their piece of the development cake; there is competition for work, for suitable employees, for donations and funding. For many, tight security measures restrict social activities and local engagement, limit movement, and dictate living conditions. Along with this, there are moral and ethical challenges intertwined with the development work. There is the risk of over-confidence in ones role, and in ones knowledge and usefulness in relation to the Afghans. There is a risk of being presumptuous about Afghan culture and traditions, based on biased depictions provided by international media. With preconceived ideas it is easy to make generalizations, and this will affect the work and interactions. Afghanistan is comprised of many different ethnic groups, and although there are many similarities between the groups, there are also differences. Geographically, the groups have been separated and historically they have had little contact with each other. This has led to the evolution of different traditions and subcultures within the Afghan borders. Some have their own interpretations of Islam – a few have their own religions – and they have their own traditions and languages. There is also the matter of rivalry and dissent between people groups that may be difficult for a Western development worker to comprehend. There is the central matter of honour, and of defending that honour at whatever cost.

These are tricky factors, and ones that were faced in the work with the Afghan therapists. As described in chapter two, there is critique towards the way in which much development work is conducted, and Afghanistan is no exception. Having lived in a development context for a few years, having experienced the challenges and benefits of this context, I have come out the other end with a more nuanced perspective of what it means to be a development worker (IV).

### The physiotherapy development worker

In paper IV my identity as a physiotherapy development worker has been described. This development worker identity will be different for every person,

depending on his/her personality, experience and interests. This identity will be shaped by what each person bring with them into the interactions, by those they work with, and by the context they are in.

Participation in communities of practice means investing in the practice, in others, and being changed through interactions with others (Wenger 1998). It necessitates being given access and legitimacy, as a 'peripheral participator', and developing an identity as part of a community of practice reflects a sense of belonging (ibid). Expatriate physiotherapists working in developing countries enter into particular communities of practice in a different cultural context than their own. Barring those who commit their lives to the work, they stay for some months or a few years, and in this time make recommendations and bring changes. They then leave and someone else comes, who has different experiences. There are benefits in this, since the input becomes broader and more diverse. But it can also become wearying for the local physiotherapists, who have to constantly adapt to new people and to new ideas. Furthermore, it means there is inconsistency in the work, since few projects can be wrapped up within a few years. Communities of practice are "shared histories of learning" (Wenger 1998, p.103) and to what extent can expatriates become a part of a community of practice, when they are there for a short time and do not share the local histories of learning?

The is also a risk of being ethnocentric (i.e. "the belief that one's own culture is superior to others and is the standard by which other cultures should be judged" (Loveland 1999, p.16)) when coming to teach and help develop professional skills in a country where the profession has not come as far. It is reinforced by attitudes and expectations; it is emphasized by hierarchies and power, and by a hospitable culture where guests are treated with respect and honour. To avoid ethnocentric pitfalls, a continual reflection upon actions, reactions and interactions is essential. This necessitates awareness of one's meaning perspectives and of what directs ones actions. Becoming aware of this is difficult, yet this is an important component of learning and teaching. Physiotherapists engaging in cross-cultural practice must establish what they believe and know where they come from before they can truly start to understand someone else (IV). Teaching over cultural borders is essentially an ethical pursuit in ensuring that interventions are suitable and stem from felt needs of the people and not from what expatriates think is the best way to approach learning or clinical practice. This has direct implications for participation.

## Participation in development work

The nature of participatory philosophy and practice is complex. Despite knowing that things would be different due to different backgrounds, education and cultures, not enough consideration was given to the fact that the Afghan therapists and I might have different definitions of participation: "participation is a rich concept that means different things to different people in different settings. For some, it is a matter of principle; for others, a perspective; and for still others, an end in itself" (Hayward et al. 2004, p.98). In the development project I viewed

participation both as an end (increased responsibility of the supervisors = less dependency on expatriates) and a means (facilitating improvement of their clinical practice that was suited to the Afghan therapists' context). As the development project progressed, I perceived that there were different expectations on our – the therapists and my – roles; this had direct implications for our participation. I came from my Swedish perspective of striving towards equality, participation and responsibility in the project. I entered a hierarchical context where I was met by expectations to bring new techniques, new knowledge and skills. It was explained to me, and I experienced in practice, that patients had a greater belief in treatment suggested or given by an expatriate physiotherapist. Similarly, I felt that I was expected to be the expert, with my Western education and degree. Although I started as a volunteer (and thereby on the lowest rank amongst the expatriates), I was treated as an advisor. I was part of the Technical Support Unit for the programme, based in the central management office in Kabul. Together with the Physiotherapy Officer I held a position of responsibility in the physiotherapy component. I was expected to solve problems and lobby for the therapists, as well as teach and supervise. All of this led to a particular place in the hierarchy. On the other hand, my younger age and unmarried status demanded less respect compared with older colleagues, which was felt to be an asset.

Participatory approaches in development work are a growing trend, yet this does not annul the risk of Western concepts of development directing the participation, or the issue of power. There is a sneaky backside to participatory approaches. Although sounding noble in its efforts to empower and lift up the Other, this approach has been criticized for being just another way for Western organizations to direct development efforts, while gaining credit and honour in the process (Kapoor 2005). In employing a participatory approach in the development project, I did not fully comprehend the complexities of what such work entails as part of the development context. My manner of participation was central, yet I was less critical of this when in the field. Hence one of the reasons for writing paper IV, and taking a critical look at my participation in the work. When working cross-culturally, it is important that expatriate physiotherapists and development workers take the time to try to understand their position in relation to the local context.

## Cross-cultural physiotherapy practice

Culture is not a static construct, it is constantly changing in response to input and stimulation from the people involved, just as people engaging in a new culture will be impacted by this and by the people of that culture. Norris and Allotey (2008) appeal for greater humility towards the issue of culture and how this will impact on how physiotherapy is practiced and spread in developing countries.

Afghanistan is firmly rooted in its history, traditions and culture, but due to the long-standing presence of foreign influence and the years during which many Afghans lived as refugees, the recent decades have brought tremendous changes to the country. The growth of modern technology has brought new opportunities:

the mobile phone is a necessity for most Afghans, computer literacy is on the rise, and Internet cafés open up a whole new world which was previously largely unknown and inaccessible for many. The influx of foreign actors in the country is bridging an agricultural community with the highly developed modern systems of the developed world. At the same time, there are deep cultural traditions and religious beliefs that dictate how people should live their lives. Modern developments are predominant in the cities whereby the gaps between rural and urban society is growing. Add to this scene the large international presence and influence in restructuring and rebuilding the country. The implications of all this, the joining of so many different cultures and ideas with the common goal of rebuilding a country, is understandably rife with pitfalls. The development world has opened up new arenas for power-plays, where traditional systems shift and face an uncertainty over which rulebook applies. It is within this larger context that expatriate and Afghan physiotherapists' work, in practicing, teaching and in developing the physiotherapy profession. In this cross-cultural collaboration there are both similarities and differences to be considered.

### *Professional commonality*

Factors related to being professional physiotherapists are the same in Afghanistan and in developed countries. There are the professional characteristics and human traits of caring for others that span cultural borders and unite the international physiotherapy cadre. The Afghan therapists that I worked with were keen to help their patients. They wanted to give treatment that would decrease pain and improve function, and they wanted to make the patients happy. They wanted to improve as professionals; they were eager to learn new techniques and approaches in treatment. The value of discussing and working together expressed by the Afghan physiotherapists is seen to be appreciated by Western physiotherapists also (Graham 1996). The instrumental (hypothetico-deductive) approaches to learning and clinical reasoning are not unlike those exhibited by Western physiotherapy students (Doody & McAteer 2002). Ethically challenging situations have to be dealt with, no matter what culture or context, and ethical practice is highly relevant for both developed and developing countries (III, Begum 2001, Swisher 2002).

The education of Afghan physiotherapists has been affected by the state of their country, directly impacting what they have learned and how they learn. Considering resources and possibilities, the professional base is not so different. The differences lie in the societies, cultures and contexts. Heather Dawson, an Australian physiotherapist working in Kabul, expressed the perception of sameness and difference as follows: "we are on the same page, but the expatriates write from left to right, and the Afghan physiotherapists write from right to left" [1] (Dawson H, personal communication, November 21, 2009).

[1] Roman script is written from the left to the right. Arabic script is from right to left.

### *Cultural diversity*

The context in which the Afghan therapists study and practice is different from the Swedish one in which I was trained and where I worked. Although the aim of this thesis is not to compare Afghanistan and, for example, Sweden, there are some points that can aid an understanding of the diversity that exists and that impacts cross-cultural work. Hofstede (2001) has rated a number of countries based on different dimensions: power distance, uncertainty avoidance, individualism versus collectivism, masculinity versus femininity, and long-term versus short-term orientation[2]. Afghanistan is not included in his list, however, various neighbouring countries have been rated, three of which are Islamic: Pakistan, Iran, India and the Arab Emirates. To exemplify differences, we can look at the Power Distance Index (PDI). Power distance is "the difference between the extent to which [the boss] B can determine the behavior of [the subordinate] S and the extent to which S can determine the behavior of B" (ibid, p.83). The countries mentioned rate high on the scale: India (PDI 77), Pakistan (PDI 55), Iran (PDI 58) and Arab countries (PDI 80). Sweden, on the other hand, has a low PDI of 31, as do various other European countries (ibid, p.87).

By considering Afghan culture according to Hofstede's dimensions, Afghanistan could be described as collectivist, masculine and with large power distances; Sweden, on the other hand, has an individualistic, feminine, small power-distance culture (Hofstede 2001). To illustrate this contrast in terms of my role, I was a young unmarried female physiotherapist and research student who had left her family and travelled alone to the other side of the world to live and work in Afghanistan where age is honoured, collectivity is valued, marriage is the norm, and where women at large are not highly educated or proactive in the public or work arena. Considering the theme of this thesis, another example of differences is power distance as exhibited in learning situations, which shows how different the approaches to teaching and learning can be based on cultures. The large power distance situation described below reflects what has been stated regarding education in Afghanistan, and is recognized in the approaches to teaching and learning exhibited by the therapists (II):

> […] the parent-child inequality is perpetuated by a teacher-student inequality that caters to the need for dependence well established in the student's mind. Teachers are treated with respect (and older teachers even more so than younger ones); students may have to stand up when the teacher enters the room. The educational process is teacher centered; teachers outline the intellectual paths to be followed. In the classroom there is supposed to be a strict order, with the teacher initiating all communication. Students in class speak up only when invited to; teachers are never publicly contradicted or criticized and are treated with deference even outside school. … The educational process is highly personalized; especially in more advanced subjects at universities, what is

[2] A discussion of these dimensions in relation to physiotherapy is given by Noorderhaven (1999).

> transferred is seen not as impersonal 'truth,' but as the personal wisdom of the teacher. … In such a system the quality of an individual's learning is virtually exclusively dependent on the excellence of his or her teachers (Hofstede 2001, p.100-101).

The low power distance situation looks quite different, and is recognized from my own higher education in Sweden:

> […] teachers are supposed to treat their students as basic equals and expect to be treated as equals by the students. Younger teachers are more equal, and therefore usually more liked, than older ones. The educational process is student centered, with a premium on the students initiative; students are expected to find their own intellectual paths. Students make uninvited interventions in class and are supposed to ask questions when they do not understand something. They argue with teachers, express disagreement and criticisms in front of teachers, and show no particular respect to teachers outside school (Hofstede 2001, p.101).

Considering this, clashes in how teaching and learning are approached when coming from high- and low power distance contexts are inevitable. Ladyshewsky (1999) addresses the differences that exist concerning cross-cultural supervision of students who come from a different cultural background than the clinical supervisor. Without an adequate understanding of where the student or learner is coming from, the clinical education can become ineffective and lead to distorted assumptions about the learner's ability. His perspective is on Southeast Asians who come to learn in the Western Australian context, whereas our situation is the reverse: Western physiotherapists who come to teach Afghan physiotherapists in the Afghan context. Yet his discussions are relevant. For example, "a westernized clinical educator would typically expect a student to take responsibility for his own learning and to be self-evaluative and questioning of all practices. In contrast, an Asian student would prefer to be guided by the instructor so that no mistakes occur" (Ladyshewsky 1999, p.165). Similarly, I expected the Afghan supervisors to participate actively in the project and evaluate their own participation and actions, whereas they wanted me to confirm that what they had seen or done was correct.

The manner of giving feedback is another typical example where problems can arise, which reflects what was mentioned earlier about the challenge of handling critique. Giving direct feedback can be perceived as threatening or even offensive for non-Western students, and negative feedback can lead to 'losing face' (Ladyshewsky 1999). The matter of 'saving face', i.e. maintaining a public self-image, carries different meaning in collectivistic and individualistic cultures, and is another important factor to consider when working cross-culturally:

> In collectivistic cultures, the concern for face is predominantly other-oriented. In individualistic cultures, the concern is self-oriented. Misunderstandings may

> occur when individualists fail to give face to collectivists when they interact. The issue of giving face, especially to people of higher status, is important in collectivistic cultures. When people from individualistic cultures violate this expectation, it can have major consequences for their relationship (Gudykunst 1991, p.93-94).

A few words should also be stated regarding gender, as the roles of men and women in Afghanistan differ from, for example, Sweden, and there can be preconceived ideas and misconceptions about these roles. The Afghan gender roles cannot be interpreted based on Western norms, which have a different cultural basis. An example is how the men and the women participated in the trainings. The trainings in the development project were held in mixed groups, apart from the manual therapy training due to the nature of the course. The women were more submissive and less proactive compared to the men in the mixed trainings, but when separated the women became much more interactive and participatory. A lesser participation could be understandable in light of women being placed in a context in which they were less comfortable. In Afghanistan women traditionally function within the homes whereas the men function in the public sphere. The trainings and courses would fall under the public sphere, and Afghan culture would here dictate that women maintain a lower profile.

These are just some examples, but it suffices to say that there are particular responsibilities and challenges for expatriate physiotherapists coming to teach and supervise learners in a cross-cultural context. There are a few further issues to consider, which are of central importance for both work and research, and hence require particular attention. These are cross-cultural communication, power and cultural competency.

## Cross-cultural communication

Communication had a direct impact on the work and the research with the Afghan therapists (II, IV). Beyond the obvious language barriers between Afghan and expatriate physiotherapists, there were verbal nuances, such as metaphors, and non-verbal communication, such as tone of voice and body language. What we communicated was based on underlying assumptions and expectations of both speaker and listener, which were not always perceived. It had direct links to cultures, roles and hierarchies. At the same time, how we communicated fed back into how we shaped our roles and interactions. The sum of it all made for a challenging situation in which to work and research.

Communication is viewed as “a process involving the exchange of messages and the creation of meaning” (Gudykunst 1991, p.24). First, “the exchange of messages” (ibid), i.e. verbal communication or language, was an obvious challenge. I tried to learn Dari and to use what I could. However, the work and research left little time for language lessons or energy for language study, and although I managed on a conversational level, I never reached fluency. I thus taught in English through a translator, as did most of the

expatriate physiotherapists, and the degree of understanding of what was said had to pass through a number of translational efforts. Ladyshewsky describes the different mental processes when a student is asked a question in a language not his own: “First, the learner hears the question and translates it into his own language. Second, he thinks of an answer in his own language. Third, he translates the answer back into the host language. Fourth, he has to think about how to structure the answer appropriately using correct conversational grammar. Fifth, he has to articulate the response” (1999, p.166-167). The teacher’s interpretation of this response is affected by his or her awareness of the impact of this process on their communication. There is an additional dimension to the translation issue, when the expatriate development worker does not come from an English-speaking country. Thus both the Afghan and the expatriates communicate in a language they may not be entirely comfortable with. This may hamper communication, but it may also help: when speaking in a second language, one may use simpler language and speak more slowly.

Although communication was a limiting factor when working with the Afghan therapists, it was also a means of showing interest and gaining access. While I was not fluent, I managed basic conversation and comprehension, which was both useful and appreciated by the Afghan therapists. This enabled me to grasp the general drift of conversations in Dari, to catch when there was a miss in translations, or if something needed to be clarified. Although fluency would be ideal, striving to learn the language of the learners has its own worth, as it shows an interest in the local culture, and a desire to want to understand and be understood. Furthermore, language and culture form a complex relationship, where language is impacted by culture, and vice versa (Risager 2006). Striving to learn the language can thus open up greater possibilities for cultural understanding to be developed. However, learning a language does not automatically mean that one becomes more culturally competent: “If we understand other’s languages, but not their cultures, we can make fluent fools of ourselves” (Gudykunst 1991, p.2).

This brings us to the other aspect of communication, the non-verbal component and the underlying meanings that we attach to what we say. Although learning a new language takes time and effort, this non-verbal communication adds a significant challenge which is just as important, if not more so. We convey considerable meaning through our actions, tones and manners of speaking, which surpass the mere content of the words. The meaning we convey has links to our communication behaviour, which is based on habit, intentions, feelings and emotions (Gudykunst 1991). This is also linked to our meaning perspectives, where these direct the meaning we intend to convey, and how we interpret the meaning of others (Mezirow 1991). This has very real implications when the meanings we think we communicate are misunderstood, or when we interpret others’ meanings differently than they were intended. The disorienting dilemma described in paper IV is a good example of where we came from different perspectives in the communication, and interpreted each other’s meanings differently based on our understanding of ourselves in relation to each

other, and our (mis)perceptions of each other's intentions. As stated, this incident also had links to the issues of power and the larger development context, and these factors are of import for how we communicate.

Our cultures and the social groups to which we belong form and impact the meanings that we relay and interpret in our communications (Gudykunst 1991). Differences between different cultures can lead to misunderstandings. An example of this can be seen between collectivistic and individualistic societies:

> […] in a situation of intense and continuous social contact, the maintenance of *harmony* with one's social environment becomes a key virtue that extends to other spheres beyond the family. In most collective cultures, direct confrontation of another person is considered rude and undesirable. … In individualist cultures, on the other hand, speaking one's mind is a virtue. Telling the truth about how one feels is seen as a characteristic of a sincere and honest person. Confrontation can be salutatory; a clash of opinions is believed to lead to a higher truth. … Adult individuals are expected to have learned to take direct feedback constructively (Hofstede 2001, p.228-9).

Thus, when people from individualistic and collectivistic cultures work together, problems or issues that arise can lead to misunderstandings and unintended insults if these differences are not understood or at least considered. Conflicts are inevitable in any interaction, and they can be complicated by people coming from different cultural perspectives. The development of mutual trust in the work will be paramount to how communication takes place, how the work is handled, and particularly, how conflicts can be solved (Brice & Campbell 1999). Striving to understand what colours communication in the host culture should be a priority, as it should be the goal to be clear in the meanings we attach to the messages we convey.

The interaction of people from different cultural backgrounds thus "contains the possibility of miscommunication and misunderstanding", but also "the potential for enhanced communication and understanding" (Loveland 1999, p.15). Misunderstandings can lead to greater understanding, if handled correctly; a reflection over who we are in relation to others, and over how we interpret others behaviour is essential. Learning a new language is a considerable job, and often not possible in light of time limitations and workloads in development work, and in the end, the attitude in the communication is the most important. An understanding and awareness of how I communicated would not have been possible without a critical reflection over my own perspective in the work (IV). And this requires an understanding of the larger context with its related influences on how the Afghan therapists and I interacted. On this note it becomes relevant to also consider the role of power in our interactions.

## Power

Power is an inescapable component of social interactions, and it must be considered in terms of the aim of this thesis, for several reasons. Power relations

between the members of a collectivity is an intricate trait of cultures (Hofstede 2001); in development work, development is fundamentally linked to progress, and progress is the imperative of power in a modern globalized, economy-driven world (Abrahamsen 2000, Sbert 1992); and in education, adult educators must recognize the implications and impact of the knowledge-power relationship on learning situations (Pietrykowski 1996). All these factors are relevant for the present discussion: as an outsider or new-comer from a rich developed country and with a privileged education, I engaged in teaching and promoting professional development of physiotherapists from a different culture, religion and background, all within the Afghan development context.

It was suggested earlier that Afghanistan falls on the high end of Hofstede's PDI, which entails respect for those in higher positions, associated privileges and status symbols, and little collaboration between levels of the hierarchy (Hofstede 2001). Furthermore, the development context reinforced the hierarchical systems. Being part of this context, the potential of power that came along with my position naturally had consequences for my role and identity. As a development worker I was employed to teach and work with improving and strengthening the physiotherapy services in the programme, and this placed me in a particular position in relation to my Afghan colleagues. I had knowledge to share and I was treated as a teacher, traditionally a respectful position in Afghanistan. We were all employed by the same NGO, but the Afghan therapists were dependent on the NGO in a different way than I was. As an expatriate within the development context I was set apart. Although 'only' a development worker, and thereby on the bottom rung of the expatriate ladder, I was still in a position of power. I perceived expectations that I could access the management, where the core was largely comprised of expatriates. This management was at the top of the hierarchy and inaccessible to the therapists. As discussed in chapter four, this had implications for the research; it also had implications for how we all participated in the development project.

Power must be understood in context. Power is a natural part of interactions between humans, but the understanding of it, the authority and expectations related to it, will differ in different cultural contexts, such as between high and low power distance cultures (Hofstede 2001). This has ramifications for development work, where different cultures meet and people interact based on different perspectives on what power means for the roles and positions of expatriates and locals. Related to this there is a link between power and identity: "[r]ooted in our identities, power derives from belonging as well as from exercising control over what we belong to" (Wenger 1998, p.207). If this is not understood, when given the potential of power through the expectations placed on expatriate development workers, there is a risk of weaving further the hierarchical web that shapes roles and identities in both work and relationships. Being in a development context where money and power speak the loudest and where hierarchy is a given norm (and where the goal is to climb higher on the hierarchical ladder) there is an even greater need for humility and sensitivity to the power factor.

And this is not a simple feat. Plays of power can be deviously obscure. A common term in development work is capacity building, with the aim of strengthening locals to be able to take responsibility and ownership of the work. However, this in itself suggests a power imbalance, where the expatriate advisor teaches and instructs how things should be done in a better way. This is described by Wadsworth who states that the concept of capacity building "has tended to come from professionals rather overly keen to *provide* that capacity rather than draw it forth by assuming it is already latent in people" (2005, p.423, italics in original). She discusses the dilemmas of Western aid agencies that want to help people in developing countries, but where efforts are based on an assumption that the helper knows best what is needed, and dictates efforts since the helped don't know how to help themselves (ibid). This has implications for collaboration in development contexts, and for the proposed approach of communicative learning described earlier.

Although in his initial works Mezirow has been critiqued for not giving enough consideration to the impact of power in learning situations (Pietrykowski 1996), he has more recently countered that the essence of transformative learning is about reassessing problematic meaning perspectives that adhere to, for example, systems of power (Mezirow 2009). He has also recognized the dilemma of power imbalance in communicative learning (Mezirow 2003): unequal power in a dialogical relationship will impact how the other person is understood, and the knowledge that is gained: "As the goal in communicative learning is mutual agreement rather than knowledge of an object or testing a truth claim, power relationships and cultural inequalities can distort the validity of a reasoned outcome" (Mezirow 2003, p.61). This is of considerable import when considering the interactions between expatriate and Afghan physiotherapists, but also between Afghans. The communicative approach is all very well in theory, but its applicability in a context such as in Afghanistan must take many factors into consideration. Every context comes with a history, and every individual comes with an intricate collection of past experiences that has shaped who he or she is. As I experienced and observed, personal agendas could get in the way of the larger goal and thwart collaborative efforts – with both Afghans and expatriates. Understanding this, as part of the larger complex picture of what it means to work in another culture, or with people from another culture, is one of the aspects that are required in developing cultural competency.

## Cultural competency for physiotherapy development workers

There has in recent years been an upswing in the interest for cultural competency for physiotherapists (Black & Purnell 2002, Lazaro & Umphred 2007, O'Shaughnessy & Tilki 2007). The majority of literature is concerned with physiotherapists in the West working with patients from non-English countries and different cultural backgrounds (Jaggi & Bithell 1995, Lee et al. 2006a, Lee et al. 2006b), or how Western physiotherapists and physiotherapy students engaging in clinical practice in developing countries develop professionally,

personally, and increase their cultural competency (Dupre & Goodgold 2007, Humphrey & Carpenter 2010, Sawyer & Lopolo 2004). Practitioners engaging in international practice need to consider cultural differences in service delivery, and be able to adapt to the local culture (Bourke-Taylor & Hudson 2005, Humphrey & Carpenter 2010).

A culturally competent physiotherapist is one who has a sound self-critical understanding of him- or herself, who actively seeks knowledge about and experiences of the culture in question, who constantly seeks to develop an understanding of that culture, and then to adapt services to needs in accordance with that understanding (Leavitt 1999). Henley and Twible suggest that the focus be on similarities: "an important aspect of effective multicultural interaction is consideration of the extent of similarity between people's cultures" (2008, p.461). It is all too easy to stereotype, especially when working with people whose ideas and beliefs do not correlate with one's own. It should be remembered that all individuals, not matter what culture, have their own meaning perspectives and understanding of the world. There are characteristics that pertain to cultures, but there are also personal characteristics that can easily be misinterpreted or mislabelled as 'cultural'.

As was presented in chapter two, the physiotherapy profession has its roots in Western countries, and has developed in the cultural contexts of and through historical events in these countries. As Western physiotherapists travel to developing nations to work and to research, cultural competency will be essential, but what are the implications of where they are coming from on how this is developed? What does it actually mean to develop cultural competency in a developing country and development context?

### *Developing cultural competency*

Developing cultural competency is not something that can be learned apart from cultural experiences, from actively participating with others and in their practices. It is in essence a form of situated learning, where one has to become competent in the ways of the new context (Lave & Wenger 1991, Wenger 1998). Both didactic and experiential learning experiences are recommended, such as learning a new language or learning about the culture in question, combined with engaging in cultural situations that differ from one's own (Leavitt 1999). Leavitt (2002) presents a two-part continuing education article covering the basics of cultural competency, where the aim is for the physiotherapist to, upon completion, be able to apply the concept to their own behaviour and in their professional practice. There are also different theoretical models aimed at developing cultural competency, some of which have been tested for physiotherapists. O'Shaughnessy and Tilki (2007), for example, use a model proposed by Papadopoulos et al., presented as a cyclical process of cultural awareness, cultural knowledge, and cultural sensitivity, which culminates into cultural competency. This gives increased awareness, and the cycle continues. The continual process requires dedicated reflection. Based on the Purnell model of cultural competence, Black and Purnell (2002) describe four steps for the

development of cultural competency for physiotherapists: identifying personal cultural biases; understanding general cultural differences; accepting and respecting cultural differences; and finally applying cultural understandings and skills in practice. Central to these models is the necessity of establishing personal prejudices and biases and of exploring one's own identity through self-critical reflection.

### *Cultural competency in practice*

My background was described in chapter four. My base cultural competency was developed while growing up in Pakistan and this was essential for the work and the research. Knowing the importance of appropriate social behaviour, I actively sought to adapt according to my understanding of this. I tried to learn the language, I strove to adapt to local customs and to be culturally sensitive. I read extensive literature about Afghanistan, both prior to, and when in, the country. I reflected on what was happening and on my own actions. Yet I had preconceptions, I made mistakes and misinterpretations about things that happened. It was disorienting dilemmas and clashes with my own beliefs that forced me to look beyond my preconceptions, such as that described in paper IV. A critical reflection over my own views in relation to what I had experienced was central in deepening my understanding of my Afghan colleagues and of Afghan culture. Thus there are a number of things to consider related to developing cultural competency.

Developing cultural competency is difficult, takes time, and is not without ethical dilemmas. Interacting with people from other cultures can lead to differences and clashes in opinions and beliefs. No matter how well-developed models are for developing cultural competency, the core of the matter is one's ability to deal with the challenges to one's own perception of the world. Clashes, such as the dilemma described in paper IV, may hit on ethical and moral cords that lie at the root of our beliefs and understanding of ourselves, and of the world. Consequently, these clashes become more troubling and difficult to deal with. At the same time, it is through these clashes, or disorienting dilemmas, that we can see ourselves in a different light. Through critically reflecting over these we can come to develop our way of viewing the world, and transform our meaning perspectives.

There are also ethical twists to consider. Cultural exchange is encouraged in development discourse, where the development worker has a cultural experience, learns about another culture, and takes this back to share with others in his own context (Eriksson-Baaz 2005). This is also reflected in the physiotherapy literature mentioned earlier (page 89), where the focus seems to be on the Self gaining a cultural experience about the Other[3]. But what about the Other? If cultural exchange is the aim, then the cultural experience should occur for both

[3] The Self and Other are terms in development discourse, where the Self is the expatriate development worker or donor, and the Other is the recipient, participant or partner in the development efforts (Eriksson-Baaz 2005).

parties. We can also turn the perspective around: I place myself as the Other and the Self is the Afghan physiotherapist. This makes more sense: I am the outsider, coming into a context not my own; I am the minority, the Other, perhaps the one with the strange ideas and concepts that do not fit, that are outside the norm. But either way, a cultural exchange requires an active involvement of both the Self and the Other, with a mutual desire to explore each other's perspectives. This takes us back to communicative learning, where increased knowledge and understanding is the aim for all involved in the exchange. A glitch in terms of such an exchange however, is that since cultural competency must be developed in context, the scales are already tipped in favour of the expatriate development worker. The Afghan therapists will never be able to gain the same understanding of where expatriates are coming from, unless they travel to the expatriates' countries. Thus there will inevitably be an imbalance in the understanding that can be developed about the other.

The context we are in, our meaning perspective and that of the person we are communicating with, will affect how competent we are able to be in any given situation, and to what extent we are perceived as competent. Who establishes how culturally competent we are? Obviously, we ourselves perceive that we are more or less culturally competent. But, this is based on our understanding of the other's culture, and of ourselves in relation to this culture. And we may not be as culturally competent as we think. We base our understanding of how suitable our actions are based on how they are received. However, when communicating cross-culturally as discussed before, we may be basing our understandings on meanings that we have construed, and that were not intended. Thus, cultural competency must consider the perspectives of both others and myself, situated within a particular context.

### *The transformative situated nature of cultural competency*

Cultural competency is inherently social, in that it has no function apart from social relationships. From what has been described, and based on the theoretical framework presented in chapter three, developing cultural competency could be viewed as an ongoing, situated, transformative learning process. Transformative learning enables us to challenge our preconceived ideas about other people and their beliefs and practices. Communicative learning enables us to mutually explore each other's similarities and differences. Situated learning puts what we thought we knew to test in contextual practice, and knowledge about ourselves, those we work with, and the new culture is gained through interacting in it. If we let it, engaging in a different cultural context forces us to look beyond the normal and comfortable perspective and understanding we have of the world. It is through uncomfortable situations and experiences in life that we are challenged as human beings, and pushed to the brink of our capacity (Kleinman 2006). It is in these moments, these disorienting dilemmas, that we have the chance to either grow or to cement ourselves more deeply in our present view of the world.

Cultural competency also involves knowledge transfer, as described in chapter three, of applying what we know in a new situation in a relevant manner.

The transfer of knowledge requires action and participation, and conscious testing and application of what we know. It requires a distancing from what we know in relation to the new context, and regarding what is needed in that new context – is what we know relevant? Ultimately, transfer of knowledge requires critical reflection over ones actions and theoretical applications, and the ability to meet ones shortcomings and fears. The challenge is that this cannot be learned before-hand, it must be learned in practice and with people in the new culture.

So what is it that enables us to participate in other cultural contexts in such a way that we can develop cultural competency through our experiences? Leavitt (1999) suggests a list of personal characteristics that can help rehabilitation professionals develop a successful cross-cultural experience:

> High on the list are a sense of humor, a sense of adventure, patience, flexibility, tolerance for ambiguity and difference, and cultural sensitivity. Being perceptive, empathetic, innovative, organized and committed to sharing knowledge and skills are also important. Working in a cross-cultural setting means being able to cope with the unexpected, and being prepared for situations never previously encountered (Leavitt 1999, p.379).

These characteristics are idealistic: few will present all of these, or all the time. Implied but not stated is imagination. This is important, helping us to see things from the other person's perspective and to understand what it means to be a part of his or her context and community of practice. As Wenger says, "[i]magination is an important component of our experiences of the world and our sense of place in it. … the concept of imagination refers to a process of expanding our self by transcending our time and space and creating new images of the world and ourselves" (1998, p.176). Over-arching all this, cultural competency is an attitude and a state of being, rather than a skill; it is not a final goal but a continual process; it is an actual change of perspective. It is reflective, respectful curiosity towards otherness. It is an attitude of self-awareness and self-critical reflection; an attitude that seeks to encourage and build on collaborative understanding, that seeks to learn as well as to share knowledge.

Various aspects of cultural competency have been discussed, and there are more sides to this than can be covered here. On a final note however, there is a fine line between acknowledging that we have different cultures and practices, to assigning values and judgments to these differences. In development contexts, cultural racism lies deceivingly close when issuing from a perspective of differences due to different cultures, where one culture (the Western) sets the norm for and defines development (Eriksson-Baaz 2005). The differences that have been highlighted in this chapter are part of a process of gaining further understanding. Furthermore, differences should not be seen as a problem: rather than create rifts and boundaries, cultural differences can be an asset in broadening understanding. Thus, cultural competency is an essential skill for physiotherapists participating in both development work and field research.

## Cross-cultural collaboration – clapping together

This chapter has discussed factors that impact learning and professional development of Afghan physiotherapists, and that affect expatriate physiotherapists' work in development contexts. Considering all this, how do we work together in the best way? A shared practice does not automatically imply collaboration (Wenger 1998), so what is needed?

There is no easy or single answer to how to work well in developing countries, or to cross-cultural collaboration. What has been suggested is a mutual, reflective communicative approach to developing professional skills and to adapting physiotherapy practice to the needs and context of Afghanistan. This is relevant for both expatriate and Afghan physiotherapists in terms of developing skills of reflection, and for developing a greater understanding of each other. This necessitates cultural competency, and awareness of the challenges involved in terms of cross-cultural communication and power. The base-line is that awareness and understanding of oneself is essential in order to understand others, and this applies to all involved in the collaboration, expatriates and Afghan therapists alike. This applies for participation both in terms of field research and development work, where our ability to be self-critically reflective and our attitude and approach to each other will make all the difference:

> Encouraging self-critical reflection, but not dominating it, matters. So does the explicit recognition that we are here to do good in a practical way in the world as part of our moral self-fashioning. To accomplish that, we need to risk openness to being changed by others (Kleinman 2006, p.194).

On this note I conclude this chapter by referring back to the Afghan proverb at the beginning. As a child I used to play different clapping games with my friends, where we would face each other and clap our hands together according to specific patterns and rhythms that accompanied various singing rhymes. It took practice to learn the routines that went with each rhyme. Some of my friends were easier to coordinate with than others. But it was particularly the ability to adapt to each other's skills that made for a well-coordinated clapping rhyme. This may be a simple metaphor, but it exemplifies the point: to do the job, we cannot clap with one hand. To do it well, we need to do it together, and both need to listen in to the other. This is easier said than done when we have different rhymes and rhythms to our actions and intentions. But we all have hands, and with mutual will and effort we can learn each other's rhymes and rhythms, and even create new ones.

# 7 CONCLUSION

قطره قطره دریا میشود

Drop by drop a river is made

What has been presented in this thesis reflects small steps towards a better understanding of how to support and encourage professional development in the context of Afghan physiotherapists. The work and research that have been described are but a few drops in the stream of efforts made towards improving the lives of the people of Afghanistan. And these drops are just a start.

Just as disability needs to be approached in the three ways mentioned by Landry et al. (2007) in chapter two, so should the situation of Afghan physiotherapists be approached. Through advocacy, research and the right action, steps can be taken towards supporting a stronger physiotherapy cadre, equipped to meet the challenges in their country. So what is the right action?

As has been explored in this thesis, there are numerous factors that impact the support of and approach to professional development when collaborating cross-culturally. Care should be taken to acknowledge the myriad of understandings that are – sometimes unconsciously – being communicated under the surface, and which cannot be immediately understood when viewed from an outsider's perspective. There must be a sincere sensitivity to the differences in communication and culture with attitudes of mutual respect and trust forming the basis for collaboration. The main points are as follows:

- Cultural competency is essential, where to even start to understand others we need to first understand ourselves, and ourselves in relation to others. This requires skills of critical reflection.
- Physiotherapy theory and practice must be adapted to the local context. Actions taken towards promoting learning and professional development must be firmly rooted in the Afghan context, and investigated, planned and implemented together with Afghan physiotherapists.
- The professional development of Afghan supervisors and teachers should be a priority.
- To encourage reflection of both Afghan and expatriate physiotherapists a communicative approach could be taken, where ethical challenges and disorienting dilemmas can form the basis of a reflective discourse and lead to increased understanding. This will require support, and merits further exploration.

The theories of transformative- and situated learning that have been used hold potential for physiotherapy practice, education and research, in both developed and developing countries. All of us, expatriate and Afghan physiotherapists,

physiotherapists and patients, have our own meaning perspectives that have been shaped and formed by our cultures, circumstances and the different people who have crossed our paths. Every individual sees the world in different colours, depending on their perspective. We can never see the colours that others see, but we can appreciate and respect the diversity of the palette.

Being a fleeting part of the context of the Afghan physiotherapists, working and learning with them, has been a tremendous experience; it has been challenging and rewarding far beyond my expectations. I have made mistakes and I have stepped on toes; I have encouraged colleagues and watched them grow. I have been both humbled and encouraged; I have taught and I have learned. Participating in the lives of other people, with the inevitable ups and downs, is an intricate business and a moral endeavour. Moving outside of our comfort zone, becoming involved in others' concerns, will include challenges and can lead to personal discomforts and sacrifices. Yet this is also a privilege.

Many times during the writing of this thesis I have longed to sit down with the Afghans therapists and discuss different issues. This will have to wait until a later stage. For now, this thesis will have to suffice as a presentation of my experiences, interpretation and understanding of what it means to work with developing physiotherapy in Afghanistan. Finally, there is no one way of understanding practice. This thesis is one representation of the situation of physiotherapists in Afghanistan, of the experiences of working together from different cultures and backgrounds. It is my interpretation of the theory used, the practice observed and the action taken, and the experiences and reflections presented herein are open for critical examination, validation or reconstruction by others working in similar situations.

## Next Steps

More research is needed within this field, both in terms of how physiotherapy can best be adapted to other cultural contexts, and in terms of the cross-cultural collaboration between physiotherapists from different countries. There is a need for greater discussion about the issues related to promoting Western-developed practices in different cultural contexts, and about the ethical challenges and dilemmas that are involved in such work. Just as there is a need for Afghan physiotherapists to develop their skills of reflection in practice, there is a need for expatriate physiotherapy teachers and development workers to self-critically reflect over their role and impact on the work. More attention needs to be given to this by employers, with support and guidance as expatriate development workers participate in the new context and in their work.

Much of what has been described is linked to the Afghan context, or rather, a sliver of that context. Considering the contextuality of knowledge, factors that impact learning and professional development must be explored for each particular setting. However, communicative- and situated learning is important for anyone teaching or promoting professional development of physiotherapy in countries with different cultural contexts. Furthermore, there is a need for more

discussion and research regarding the transferability of physiotherapy as defined by Western norms. The aim should not be to cut and paste what we know, but to take our knowledge, and then work together with local physiotherapists, assistants or trainers to develop a profession that stems from their particular context.

A common saying states that “the more you learn, the more you realize what you don’t know”. The further down the road I have come, the more I realize the complexity of the context I was in, and the naïvety with which I started the work and research. There is much still to be known: "[t]here is never enough time to realize the infinite potential of fieldwork; by constantly threatening to run out on us, time forces us to recognize limits on what we can accomplish. In that important sense, our works are never 'completed'" (Wolcott 2005, p.35). Our work, as described in this thesis, is not completed. The more I learn about Afghanistan, about learning and physiotherapy, about ethnography and development work, the more I am able to reflect upon my experiences and gain new insights into these experiences. The more I learn about myself, the more I am able to see why things turned out the way they did based on my expectations, beliefs and attitudes, experience and competence. The cycle of reflection could go on forever! However, this thesis must come to a close, and to conclude I refer back to the Afghan proverb given at the beginning of this thesis:

A mountain cannot reach a mountain, (but) a man can reach a man

The challenges involved in developing the physiotherapy profession in Afghanistan can seem overwhelming, and some impossible, to overcome. For both expatriate and Afghan physiotherapists to aim for a mutually reflective and communicative collaboration requires work and conscious effort. But this is the key: the mountainous task will remain so unless all who are involved reach out to each other, to work and learn together. Coming from different backgrounds and contexts can be the catalyst that pushes us to look beyond what we thought we knew. Thus there is potential for considerable development as we collaborate from different perspectives and ways of viewing the world: through reflective discourse and action with others, no matter where we are from, we can collaboratively question what we thought we knew, and come out as stronger, more empathic individuals and professionals.

# REFERENCES

Abrahamsen R (2000) *Disciplining democracy. Development discourse and good governance in Africa.* London, Zed Books.

ACBAR (2010) ACBAR directory of addresses. Retrieved 17 August, 2010, from http://www.acbar.org/index.php?option=com_sobi2&sobi2Task=search&Itemid=4

Armstrong J & Ager A (2006) Physiotherapy in Afghanistan: an analysis of current challenges. *Disability and Rehabilitation.* 28**,** 315-22.

Aslop A (2000) *Continuing professional development: a guide for therapists.* Oxford, Blackwell Science.

Atkins S & Ersser SJ (2008) Clinical reasoning and patient-centred care. In: Higgs, J, Jones, MA, Loftus, S & Christensen, N (Eds.) *Clinical reasoning in the health professions.* 3rd ed. London, Butterworth-Heinemann.

Bailey CA (1996) *A guide to field research.* Thousand Oaks, Pine Forge Press.

Beach D (2005) From fieldwork to theory and representation in ethnography. In: Troman, G, Jeffrey, B & Walford, G (Eds.) *Methodological issues and practices in ethnography.* Oxford, JAI Press.

Begum H (2001) Poverty and health ethics in developing countries. *Bioethics.* 15**,** 50-56.

Bernard HR (2002) *Research methods in anthropology: qualitative and quantitative approaches.* Lanham, MD, AltaMira Press.

Billett S (1996) Situated learning: bridging sociocultural and cognitive theorising. *Learning and Instruction.* 6**,** 263-280.

Billett S (2004) Learning through work: workplace participatory practices. In: Rainbird, H, Fuller, A & Munro, A (Eds.) *Workplace learning in context.* London, Routledge.

Black JD & Purnell LD (2002) Cultural competence for the physical therapy professional. *Journal of Physical Therapy Education.* 16**,** 3-10.

Bourke-Taylor H & Hudson D (2005) Cultural differences: The experience of establishing an occupational therapy service in a developing community. *Australian Occupational Therapy Journal.* 52**,** 188-198.

Boyle H (2006) Memorization and Learning in Islamic Schools. *Comparative Education Review.* 50**,** 478-495.

Brice A & Campbell L (1999) Cross-cultural communication. In: Leavitt, RL (Ed.) *Cross-cultural rehabilitation - an international perspective.* London, W B Saunders.

Brieger N (2005) Bilden av kvinnan. In: Sundelin, A (Ed.) *Afghanistan.* Stockholm, Svenska Afghanistankommittén och Premiss förlag.

Brookfield S (2008) Clinical reasoning and generic reasoning skills. In: Higgs, J, Jones, MA, Loftus, S & Christensen, N (Eds.) *Clinical reasoning in the health professions.* 3rd ed. London, Butterworth Heinemann.

Bury T (2003) Evidence based practice - an overview. *WCPT keynotes.* London, WCPT.
Carr W & Kemmis S (1986) *Becoming critical: education, knowledge and action research.* London, Falmer Press.
Chipchase LS, Galley P, Jull G, McMeeken JM, Refshauge K, Nayler M & Wright A (2006) Looking back at 100 years of physiotherapy education in Australia. *Australian Journal of Physiotherapy.* 52**,** 3-7.
Clark MC (1993) Transformational learning. In: Merriam, SB (Ed.) *An update on adult learning theory.* San Fransisco, Jossey-Bass.
Coleridge P (2000) Disability and culture. *Asia Pacific disability rehabilitation journal.* Selected readings in CBR series 1, CBR in transition**,** 21-38.
Crompton S, Myers B, Teager D & Tuckett N (2001) WCPT: the first 50 years. London, World Confederation for Physical Therapy.
CSP (1994) 100 years. The Chartered Society of Physiotherapy 1894-1994. *Physiotherapy.* 80**,** 1A-104A.
CSP (2003) Continuing Professional Development (CPD) briefing and policy statement. *CPD Information Paper No 29.* London, The Chartered Society of Physiotherapy.
CSP (2005) Workplace learning. Evidencing through reflection and evaluation. *CPD Information Paper No 11.* London, The Chartered Society for Physiotherapy.
Dawson L (1999) Professional development, personality and self-esteem of Palestinian physical therapists. In: Leavitt, RL (Ed.) *Cross-cultural rehabilitation - an international perspective.* London, W B Saunders.
Donaghy ME & Morss K (2000) Guided reflection: A framework to facilitate and assess reflective practice within the discipline of physiotherapy. *Physiotherapy Theory and Practice.* 16**,** 3-14.
Donini A (2004) An elusive quest: integration in the response to the Afghan crisis. *Ethics & International Affairs.* 18**,** 21-27.
Doody C & McAteer M (2002) Clinical Reasoning of Expert and Novice Physiotherapists in an Outpatient Orthopaedic Setting. *Physiotherapy.* 88**,** 258-268.
Dunleavy K (2007) Physical therapy education and provision in Cambodia: A framework for choice of systems for development projects. *Disability and Rehabilitation.* 29**,** 903-920.
Dupre A-M & Goodgold S (2007) Development of physical therapy student cultural competency through international community service. *Journal of Cultural Diversity.* 14**,** 126-134.
Dupree NH (2002) Cultural heritage and national identity in Afghanistan. *Third World Quarterly.* 23**,** 977-989.
Easterly W (2006) *The white mans burden.* Oxford, Oxford University Press.
Echternach JL (2003) The political and social issues that have shaped physical therapy education over the decades. *Journal of Physical Therapy Education.* 17**,** 26-33.
Edwards I, Braunack-Mayer A & Jones M (2005) Ethical reasoning as a clinical-reasoning strategy in physiotherapy. *Physiotherapy.* 91**,** 229-236.

Edwards I & Delany C (2008) Ethical reasoning. In: Higgs, J, Jones, MA, Loftus, S & Christensen, N (Eds.) *Clinical reasoning in the health professions.* 3rd ed. London, Butterworth Heinemann.
Edwards I, Jones M, Carr J, Braunack-Mayer A & Jensen GM (2004) Clinical reasoning strategies in physical therapy. *Physical Therapy.* 84**,** 312-330.
Eraut M (1994) *Developing professional knowledge and competence.* London, RoutledgeFalmer.
Eraut M (2004) Transfer of knowledge between education and workplace settings. In: Rainbird, H, Fuller, A & Munro, A (Eds.) *Workplace learning in context.* London, Routledge.
Eriksson-Baaz M (1999) Culture and the eurocentrism of development: The noble Third World versus the ignoble West and beyond. *Journal of International Relations and Development.*
Eriksson-Baaz M (2005) *The paternalism of partnership: a postcolonial reading of identity in development aid.* London, Zed Books.
Fangen K (2005) *Deltagande observation [Participant observation].* Malmö, Liber.
Forsberg A (2005) Folk, stammar och livsmönster. In: Sundelin, A (Ed.) *Afghanistan.* Stockholm, Svenska Afghanistankommittén och Premiss förlag.
Foster K (2009) Surgical training in Afghanistan: an attempt to elucidate the role of professional knowledge. Toronto, University of Toronto.
French HP & Dowds J (2008) An overview of Continuing Professional Development in physiotherapy. *Physiotherapy.* 94**,** 190-197.
Fuller A, Munro A & Rainbird H (2004a) Conclusion. In: Rainbird, H, Fuller, A & Munro, A (Eds.) *Workplace learning in context.* London, Routledge.
Fuller A, Munro A & Rainbird H (2004b) Introduction and overview. In: Rainbird, H, Munro, A & Holly, L (Eds.) *Workplace learning in context.* London, Routledge.
Galloway MT & Jokl P (2000) Aging Successfully: The Importance of Physical Activity in Maintaining Health and Function. *J Am Acad Orthop Surg.* 8**,** 37-44.
Goffman E (1990) *The presentation of self in everyday life.* London, Penguin Books.
Goldsmith E (2002) Development as colonialism. *World Affairs.*
Graham CL (1996) Conceptual Learning Processes in Physical Therapy Students. *Physical Therapy.* 76**,** 856-865.
Gudykunst WB (1991) Attributing meaning to strangers behavior. In: Gudykunst, WB (Ed.) *Bridging differences: effective intergroup communication.* Newbury Park, Sage.
Hammersley M & Atkinson P (1983) *Ethnography: principles in practice.* London, Routledge.
Hammersley M & Atkinson P (2007) *Ethnography: principles in practice.* London, Routledge.
Hartley J (2006) Report from visit to SCA RAD programme April 2006. Consultant report.
Hartley J (2008) Report of the visit to SGAA/SCA RAD 13th October-7th November 2008. Consultant report.

Hayward C, Simpson L & Wood L (2004) Still Left out in the Cold: Problematising Participatory Research and Development. *Sociologia Ruralis.* 44**,** 95-108.
Henley E & Twible R (2008) Teaching clinical reasoning and culture. In: Higgs, J, Jones, M, Loftus, S & Christensen, N (Eds.) *Clinical reasoning in the health professions.* 3rd ed. London, Butterworth Heinemann.
Henriksson J & Sundberg CJ (2008) Allmänna effekter av fysisk aktivitet [General effects of physical activity]. In: aktivitet, Yff (Ed.) *FYSS - Fysisk aktivitet i sjukdomsprevention och sjukdomsbehandling [physical activity in the prevention and treatment of disease].* Stockholm, Elanders.
Herbert RD, Sherrington C, Maher C & Moseley AM (2001) Evidence-based practice -- imperfect but necessary. *Physiotherapy Theory and Practice: An International Journal of Physiotherapy.* 17**,** 201 - 211.
Higgs J & Jones MA (2008) Clinical decision making and multiple problem spaces. In: Higgs, J, Jones, MA, Loftus, S & Christensen, N (Eds.) *Clinical reasoning in the health professions.* 3rd ed. London, Butterworth Heinemann.
Higgs J, Refshauge K & Ellis E (2001) Portrait of the physiotherapy profession. *Journal of Interprofessional Care.* 15**,** 79 - 89.
Hofstede G (2001) *Culture's consequences: comparing values, behaviors, institutions, and organizations across nations.* Thousand Oaks, Sage.
Horobin H & Naughton C (Eds.) (2008) *ADAPT Newsletter: Training and education edition.* CSP Interest group.
HRW (2009) *World Report 2009. Events of 2008.* New York, Human Rights Watch.
Humphrey K & Carpenter C (2010) Experiences of the voluntary physiotherapist role in developing nations. *International journal of therapy and rehabilitation.* 17**,** 150-157.
Illeris K (2006) What is special about adult learning? In: Sutherland, P & Crowther, J (Eds.) *Lifelong learning. Concepts and contexts.* New York, Routledge.
Illeris K (2009) Introduction. In: Illeris, K (Ed.) *Contemporary theories of learning. Learning theorists ... in their own words.* Oxon, Routledge.
Irwin-Carruthers S (1988) Physiotherapy practice in South Africaâ€"yesterday, today and tomorrow. *Physiotherapy Theory and Practice.* 4**,** 207-212.
Jaggi A & Bithell C (1995) Relationships Between Physiotherapists' Level of Contact, Cultural Awareness and Communication with Bangladeshi Patients in Two Health Authorities. *Physiotherapy.* 81**,** 330-337.
Johnson C & Leslie J (2002) Afghans have their memories: a reflection on the recent experience of assistance in Afghanistan. *Third World Quarterly.* 23**,** 861-874.
Johnson C & Leslie J (2008) *Afghanistan: The mirage of peace.* London, Zed Books.
Jones MA, Jensen G & Edwards I (2008) Clinical reasoning in physiotherapy. In: Higgs, J, Jones, MA, Loftus, S & Christensen, N (Eds.) *Clinical reasoning in the health professions.* 3rd ed. London, Butterworth-Heinemann.
Kapoor I (2005) Participatory development, complicity and desire. *Third World Quarterly.* 26**,** 1203 - 1220.
Karlsson P & Mansory A (2004) Islamic and modern education in Afghanistan - conflictual or complementary. Stockholm, Institute of International Education, Stockholm University.

Karlsson P & Mansory A (2007) An Afghan dilemma: education, gender and globalisation in an Islamic context. *Faculty of Social Sciences, Department of Education.* Stockholm, Stockholm University.

Kay E, Huong NT & Minh Chau NT (1999) Upgrading physical therapy education in Vietnam. In: Leavitt, RL (Ed.) *Cross-cultural rehabilitation - an international perspective.* London, W B Saunders.

Kay E, Kilonzo C & Harris MJ (1994) Improving rehabilitation services in developing nations: the proposed role of physiotherapists. *Physiotherapy.* 80**,** 77-82.

Kleinman A (2006) *What really matters: living a moral life amidst uncertainty and danger.* Oxford, Oxford University Press.

Ladyshewsky R (1999) Cross-cultural supervision of students. In: Leavitt, RL (Ed.) *Cross-cultural rehabilitation - an international perspective.* London, W B Saunders.

Ladyshewsky R & Jones MA (2008) Peer coaching to generate clinical reasoning skills. In: Higgs, J, Jones, MA, Loftus, S & Christensen, N (Eds.) *Clinical reasoning in the health professions.* 3rd ed. London, Butterworth-Heinemann.

Ladyshewsky RK (2002) A quasi-experimental study of the differences in performance and clinical reasoning using individual learning versus reciprocal peer coaching. *Physiotherapy Theory & Practice.* 18**,** 17-31.

Lammi H (1997) Negotiating a competence-based transfer plan for a physiotherapy training programme in Afghanistan. Dundee, University of Dundee.

Landry MD, Dyck T & Raman S (2007) Poverty, disability and human development: a global challenge for physiotherapy in the 21st Century. *Physiotherapy.* 93**,** 233-234.

Lang C (2006) Physiotherapy in Afghanistan – a situational analysis. Unpublished report to the Directorate of Human Resources, Ministry of Public Health, Islamic Republic of Afghanistan. Kabul, United Nations Development Programme/United Nations Programme for Action on Disability.

Lave J (2009) The practice of learning. In: Illeris, K (Ed.) *Contemporary theories of learning. Learning theorists ... in their own words.* Oxon, Routledge.

Lave J & Wenger E (1991) *Situated learning. Legitimate peripheral participation.* Cambridge, Cambridge University Press.

Lazaro RT & Umphred DA (2007) Improving cultural diversity awareness of physical therapy educators. *Journal of Cultural Diversity.* 14**,** 121-125.

Leavitt R (1999) Moving rehabilitation professionals toward cultural competence: strategies for change. In: Leavitt, RL (Ed.) *Cross-cultural rehabilitation - an international perspective.* London, W B Saunders.

Leavitt RL (2002) Developing cultural competence in a multicultural world. Parts I & 2. *PT Magazine.* APTA.

LeCompte MD & Goetz JP (1982) Problems of reliability and validity in ethnographic research. *Review of Educational Research.* 52**,** 31-60.

Lee TS-M, Sullivan G & Lansbury G (2006a) Physiotherapists communication strategies with clients from cultural diverse backgrounds. *Advances in Physiotherapy.* 8**,** 168 - 174.

Lee TS, Sullivan G & Lansbury G (2006b) Physiotherapists' perceptions of clients from culturally diverse backgrounds. *Physiotherapy.* 92**,** 166-170.
Loveland C (1999) The concept of culture. In: Leavitt, RL (Ed.) *Cross-cultural rehabilitation - an international perspective.* London, W B Saunders.
Lundbladh K (1993) Sjukgymnastikens ursprung och fäste. In: Holmström, E, Johnsson, B & Lundbladh, K (Eds.) *Sjukgymnastik i historisk belysning.* Lund, Studentlitteratur.
Madison DS (2005) *Critical ethnography: method, ethics and performance.* Thousand Oaks, CA, Sage.
Mattingly C (1994) The narrative nature of clinical reasoning. In: Mattingly, C & Hayes Fleming, M (Eds.) *Clinical reasoning: forms of inquiry in a therapeutic practice.* Philadelphia, F.A. Davis Company.
Merriam-Webster (2010) Context. Retrieved 28 July, 2010, from http://www.merriam-webster.com/dictionary/context
Merriam SB (1993) Adult learning: where have we come from? Where are we headed? In: Merriam, SB (Ed.) *An update on adult learning theory.* San Fransisco, Jossey-Bass.
Mezirow J (1990a) Conclusion: Toward transformative learning and emancipatory education. In: Mezirow, J (Ed.) *Fostering critical reflection in adulthood: a guide to transformative and emancipatory learning.* San Francisco, Jossey-Bass Publishers.
Mezirow J (1990b) How critical reflection triggers transformative learning. In: Mezirow, J (Ed.) *Fostering critical reflection in adulthood: a guide to transformative and emancipatory learning.* San Francisco, Jossey-Bass Publishers.
Mezirow J (1991) *Transformative dimensions of adult learning.* San Francisco, Jossey-Bass.
Mezirow J (2000) Learning to think like an adult. Core concepts of transformation theory. In: Mezirow, J (Ed.) *Learning as Transformation. Critical Perspectives on a Theory in Progress.* San Fransisco, Jossey-Bass.
Mezirow J (2003) Transformative Learning as Discourse. *Journal of Transformative Education.* 1**,** 58-63.
Mezirow J (2009) An overview on transformative learning. In: Illeris, K (Ed.) *Contemporary theories of learning. Learning theorists ... in their own words.* Oxon, Routledge.
Moffat M (2003) The history of physical therapy practice in the United States. *Journal of Physical Therapy Education.* 17**,** 15-25.
Molloy E (2009) Time to pause: giving and receiving feedback in clinical education. In: Delany, C & Molloy, E (Eds.) *Clinical education in the health professions.* Sydney, Elsevier.
MoPH (2005) A basic package of health services for Afghanistan 2005/1384. Kabul, Islamic Republic of Afghanistan, Ministry of Public Health.
Mountford H, Jones S & Tucker B (2006) Learning styles of entry-level physiotherapy students. *Advances in Physiotherapy.* 8**,** 128-136.

Neill KG (2000) In the Shadow of the Temple: Cross-cultural Sensitivity in International Health Program Development. *Ethnicity & Health.* 5**,** 161-171.
Noorderhaven NG (1999) Intercultural Differences: Consequences for the Physical Therapy Profession. *Physiotherapy.* 85**,** 504-510.
Norris M & Allotey P (2008) Culture and physiotherapy. *Diversity in health and social care.* 5**,** 151-9.
O'Shaughnessy DF & Tilki M (2007) Cultural competency in physiotherapy: a model for training. *Physiotherapy.* 93**,** 69-77.
Pedersen BK & Saltin B (2006) Evidence for prescribing exercise as therapy in chronic disease. *Scandinavian Journal of Medicine & Science in Sports.* 16**,** 3-63.
Pietrykowski B (1996) Knowledge and Power in Adult Education: Beyond Freire and Habermas. *Adult Education Quarterly.* 46**,** 82-97.
Reason P & Bradbury H (2006) Inquiry and participation in search of a world worthy of human aspiration. In: Reason, P & Bradbury, H (Eds.) *Handbook of Action Research: concise paperback edition.* London, Sage.
Richardson B (1999a) Professional Development: 1. Professional socialisation and professionalisation. *Physiotherapy.* 85**,** 461-467.
Richardson B (1999b) Professional Development: 2. Professional Knowledge and Situated Learning in the Workplace. *Physiotherapy.* 85**,** 467-474.
Risager K (2006) *Language and culture. Global flows and local complexity.* Clevedon, Multilingual Matters Ltd.
Rodgers C (2002) Defining reflection: another look at John Dewey and reflective thinking. *Teachers College Record.* 104**,** 842-866.
Samady SR (2001) Modern education in Afghanistan. *Prospects. Quarterly review of comparative education.* XXXI**,** 587-602.
Sawyer KL & Lopolo R (2004) Perceived impact on physical therapy students of an international pro bono clinical experience in a developing country. *Journal of Physical Therapy Education.* 18**,** 40-47.
Sbert JM (1992) Progress. In: Sachs, W (Ed.) *The development dictionary. A guide to knowledge as power.* London, Zed Books.
Sharp Trueman W, Burkle JFrederick M, Vaughn Andrew F, Chotani R & Brennan Richard J (2002) Challenges and Opportunities for Humanitarian Relief in Afghanistan. *Clinical Infectious Diseases.* 34**,** S215-S228.
Smidt N, de Vet HC, Bouter LM & Dekker J (2005) Effectiveness of exercise therapy: A best-evidence summary of systematic reviews. *Australian Journal of Physiotherapy.* 51**,** 71-85.
Strauss A & Corbin J (1998) *Basics of qualitative research.* Thousand Oaks, SAGE Publications.
Swisher LL (2002) A Retrospective Analysis of Ethics Knowledge in Physical Therapy (1970-2000). *Physical Therapy.* 82**,** 692-706.
Swisher LL & Page CG (2005) *Professionalism in physical therapy: history, practice and development.* St. Louis, Elsevier.
Thomas A (2000) Meanings and views on development. In: Allen, T & Thomas, A (Eds.) *Poverty and development into the 21st century.* Oxford, Oxford University Press.

Thomas J (1993) *Doing critical ethnography.* California, Sage.
Thoren J (2007) Quality in physical therapy - first steps. Kabul, International Assistance Mission
Trani JF & Bakhshi P (2006) Understanding the challenge ahead. Executive summary report. National Disability Survey in Afghanistan 2005. Lyon, Handicap International.
UI (2007) *Länder i fickformat nr 911 Afghanistan.* Stockholm, Utrikespolitiska Institutet.
UNDP (2009) Human Development Report 2009 - Afghanistan. Retrieved 18 November, 2009, from http://hdrstats.undp.org/en/countries/country_fact_sheets/cty_fs_AFG.html
Utas B (2005) Islam. In: Sundelin, A (Ed.) *Afghanistan.* Stockholm, Svenska Afghanistankommittén och Premiss förlag.
Wadsworth Y (2005) 'Beloved Bangladesh': A western glimpse of participatory action research and the animator-resource work of Research Initiatives Bangladesh. *Action Research.* 3**,** 417-435.
Waldman M (2008) Falling short. Aid effectiveness in Afghanistan. IN ACBAR (Ed.) *ACBAR Advocacy Series.* Kabul, ACBAR.
Waldman R, Strong L & Wali A (2006) Afghanistan's health system since 2001: condition improved, prognosis cautiously optimistic. *AREU Briefing paper series.* Kabul, AREU.
Walford G (2009) The practice of writing ethnographich fieldnotes. *Ethnography and education.* 4**,** 117-130.
van der Velden M (2004) From communities of practice to communities of resistance. *Development* 47**,** 73-80.
WCPT (2009) Position statement. Description of physical therapy. Retrieved January 26, 2010, from http://www.wcpt.org/sites/wcpt.org/files/files/WCPT_Description_of_Physical_Therapy-Sep07-Rev_2.pdf
Wenger E (1998) *Communities of practice: learning, meaning and identity.* Cambridge, Cambridge University Press.
Werner S (1987) The development of physiotherapy in Israel. *Physiotherapy Theory and Practice.* 3**,** 85-88.
WHO (2007) Country cooperation strategy at a glance: The Islamic state of Afghanistan. Retrieved 13 November, 2009, from http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_afg_en.pdf
WHO (2009) WHO country profiles: Afghanistan. Retrieved 13 November, 2009, from http://www.emro.who.int/emrinfo/index.asp?Ctry=afg
Williams J (1985) Physiotherapy - An international profession. *Physiotherapy Theory and Practice.* 1**,** 3 - 5.
Wolcott H (2005) *The art of fieldwork.* Walnut Creek, AltaMira Press.
Zeni J (2001) A guide to ethical decision making for insider research. In: Zeni, J (Ed.) *Ethical issues in practitioner research.* New York, Teachers College Press.

# APPENDICES

## Appendix 1: Final evaluation of the development project

For all physiotherapy supervisors. (Answer in Dari or English)

Name:

1. What went well with the Action Research[*] development project?
2. What did not go well?
3. What do you think about your own participation?
4. What did you learn from working in this way?
5. What should we think about for the future when doing this kind of work?
6. What do you think about this method of working?
7. What do you think about the Core Group?
8. What should the Core Group be?

[*] The use of the term here reflects the understanding at the time. It turned out that an action research approach was not feasible, and as stated on page 38, what was done was not action research. This did not affect the content of the evaluations.

# Appendix 2: Example of analysis

| Code | Excerpt field note | Theme | Significant aspect(s) | Memo |
|---|---|---|---|---|
| A82 (060802) | "How can [exercises] be incorporated in the best way in the Afghan context? … They have bought these fancy exercise machines, yet don't really know how to use them. They profess exercise as an important part of physiotherapy, yet do not show this in their practice. Regarding clinical reasoning, it says that students should have an active part in shaping their learning environment and teaching is an interdependent thing where both the teacher and the student learn. Also, clinical reasoning is highly contextually dependent. And students tend to learn things better which are within their belief system. Are exercises truly within their belief system? In the belief system of the patients? … It is hard enough to make patients in the West do their exercises at home, so how will it work here?" | Effort to contextually adapt actions | Clinical reasoning<br><br>Meaning perspectives<br><br>Relevance? | I was touching on the idea of meaning perspectives and learning already, without realising it. I was questioning how clinical reasoning could fit into their way of thinking, when I didn't really know what that was. I have a lot of reflections over how to adapt exercises to the Afghan context in the right way. It was all my reflecting however, and it could have done with more reflecting together with the supervisors, even if it was with only one or two and not in the whole group. I should have had a reflection partner. There were a couple who could have been this, but they were either working in another organization, or were not in Kabul, and so meeting would be very sporadic. |

| B172 (070516) | [The PT] says that she does [exercises], but what I see does not reflect very extensive usage. She might give one or so exercises, one on the gymball for example, but not really know how to do it right or show the patient how to do it right. She writes a lot about ex in her plans, but how there are done in practice, I find questionable, judging from what I see in the practice, and from her comments. | My versus their understanding of what was taught | Contextually related<br><br>For them probably true<br><br>Related to training | There seems to be an issue with what they write and what they do. However, this should be understood in context. What we thought we were teaching was not necessarily what they understood. So we cannot interpret their resulting action based on what we thought we taught, but rather try to see it from their perspective and consider what they heard and understood. This is related to both the large amount of information they were given, but also that this information passed through a translation filter, which means that exactly what we said and meant might not have been transferred. |
|---|---|---|---|---|
| B200 (070521) | There is a large room [being used] for special ed, and [the PT supervisor] says this would be great for physio. She says if I mention it, she will talk to [the regional manager]. I say she does not need to wait for me to say something, she is the supervisor and can also make recommendations. | Role (given me) | Hierarchy<br><br>Expectations on me | The expectations the supervisors have on me, is exemplified by what the supervisor says here: she wants me to recommend what they need, then she can take my word to the regional manager, and then it will carry more weight. |