Pakistan Picaresque

A surreal encounter in an Islamabad office reveals in an instant why billions of dollars spent on aid to Pakistan have made so little difference in the lives of the country's poor.

BY SAMIA ALTAF

For our meeting with the director of the Pakistan Nursing Council, we arrived punctually at a small two-room office tucked away in a corner of the National Institute of Health's campus in Islamabad. In the center of one room was a table covered with a flowered plastic tablecloth, as if awaiting a picnic. Resting on it were a pencil holder, some writing materials, and a telephone. On one side of the table was a rather ornate chair, and on the wall behind it was a framed photograph of Muhammad Ali Jinnah, the man credited with creating Pakistan, in his signature oval cap and a severe black *sherwani*, a formal knee-length coat. Four rickety chairs, a bit dusty, lined the other side of the table. In the adjoining room were more rickety chairs and another table, on which an elaborate tea service was arranged. A small man wearing stained clothes sat on a stool by the door, and mumbled something as he rubbed sleep deposits from his eyes.

"She's what?" I heard my companion ask in a panic-stricken tone. "Dead! Oh, my God, do you hear that?" she said to me. "The director of the nursing council is dead." She stood still for a minute, as if paying her respects. "How did she die?" she said, again turning to the fellow.

The man looked offended at our misapprehension. "Late. Mrs. S.," he said. Ah, Mrs. S. wasn't dead. She would be late.

My companion, a Canadian, was new to this part of the world and understandably confused by the way Urdu, the national language, is translated into English, the "official" language, especially by people who have minimal schooling. Mrs. S. had gone from merely being late to being "the late Mrs. S." In a way, this slip of the tongue—or of the ear?—was quite symbolic. For in its efforts to make any effective contribution to the changing needs of the health care system, the Pakistan Nursing Council—the federal institution that oversees nursing and all related professions—might as well have been dead.

We told the man that we would wait.

For the past several weeks, my Canadian colleague and I had been traveling through Pakistan as we prepared recommendations for a technical assistance program funded by the Canadian government. She was the external consultant on this project, and I was the local consultant. A pale woman in her early forties, she was dressed that day in loose trousers and a neutral-color top. Privately, I had taken to calling her "Lucymem-sahib," after a character in Paul Scott's novel of post-colonial India, *Staying On* (1977), who exemplifies the imperialist attitude of British hangers-on. True to this

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Students at a nursing school in Chakwal, in Pakistan's Punjab province, take the Florence Nightingale Pledge in November.

model, Lucy had been undergoing a memsahib-like change by barely perceptible degrees each day. Both of us were at times in each other's way, at times at cross-purposes. We were unsure of who was actually in charge—she, by virtue of her status as "lead" consultant, or I, more experienced, though a "local" and hence inferior.

Mrs. S. arrived an hour later quite flustered. She was a shy-seeming, slightly built woman in her fifties wearing a flowery *shalwar-kameez*. On her head was a starched *dupatta*—a long scarf—from which raven black hair peeked out. Dyed, no doubt. She looked a bit startled to see me in a sari, wrinkling her nose delicately in what I interpreted as disapproval as she adjusted the *dupatta* with an elaborate gesture.

"You are not a Pakistani?" she asked, affecting nonchalance.

I told her that I was, and could see that she did not believe me. Why, then, was I wearing a sari? The traditional sari—a single piece of cloth wrapped around the body—is worn by subcontinental women of many religious and ethnic backgrounds. Pakistani women wore saris until the 1970s, when in a period of Islamo-nationalist fervor, and with the tacit encouragement of the government, they adopted the *shalwar-kameez–dupatta* ensemble—loose, baggy pants and a long tunic with two yards of loose cloth that drape the shoulders. The rejected sari acquired an "Indian" tinge, and came to be seen as vaguely "Hindu" as well as anti-Islamic, a sentiment that hasn't entirely disappeared.

Mrs. S. apologized for the delay, telling us that she had been called away unexpectedly. "Must have been something important," I said conversationally, for she was quite out of sorts. I worried that my sari-clad personage was a contributing factor. This turned out not

to be the case. A World Bank delegation was visiting, and she had been called to meet them "right away."

Couldn't she say that she had an earlier meeting and have them wait? Lucymemsahib wanted to know.

"How can you do that?" Mrs. S. asked. "They are the World Bank."

And now, she asked, what could she do for us?

The year was 1992, and Lucymemsahib and I were helping the government of Pakistan prepare a grant proposal for the country's Social Action Program (SAP)—a comprehensive effort to renovate Pakistan's health, education, and water sanitation systems that the World Bank and a consortium of other multinational development organizations had pledged to support. Specifically, we were looking into ways to attract more women to provide midlevel health services in rural areas. As head of the Pakistan Nursing Council, Mrs. S. presided over the governmental organization responsible for the recruitment, training, and certification of nurses at Pakistan's 60 civilian nursing schools and a handful of specialized military institutions.

The SAP we helped prepare, which ran from 1993 through 1998, turned out to be a dismal failure, as was the one that followed in 1999–2003. Subsequent programs, especially since 9/11, show every indication of being as unsuccessful. The critical indicators of maternal and child health tell it all. Estimates of Pakistan's maternal mortality ratio since 1990 range from 300 to 800 maternal deaths per 100,000 live births; even the low end of this range is unacceptable. By contrast, Sri Lanka, another South Asian country, with an income per capita that was roughly comparable to Pakistan's at the beginning of the 1990s, saw its maternal mortality ratio fall from 92 per 100,000 in 1990 to below 50 today. The infant mortality rate in Pakistan in 2003 was 76 per 1,000 live births, as compared with 11 in Sri Lanka. In the developed countries, the infant mortality rate is only about five per 1,000 live births.

Beyond the health care sector, the story is much the same. A report published in 2007 by the Center for Strategic and International Studies in Washington, D.C., concluded that the $1 billion in development and humanitarian assistance the United States has poured into Pakistan since 9/11 has saved lives in areas affected by a massive 2005 earthquake and has improved the lot of a small number of people, but "has done little to address the underlying fault lines in the Pakistani state or society." Assistance from other institutions such as the World Bank and the Asian Development Bank has been equally ineffective.

These stories of failure are nothing new. They have been repeated over the years in numerous programs all over the developing world. The interesting question is why.

Some of the reasons are familiar. Developing countries—often beset by political instability, outmoded institutions, meager resources, and a host of other woes—are desperate for money. (When, in a conversation with a Pakistani official, I predicted the failure of the SAP, he replied that at least it would bring in "foreign exchange for the national kitty.") At the same time, international lending organizations such as the World Bank are under pressure to make loans; otherwise they are out of business. Some baseline "tangible" results are expected when the project ends, but these mainly take the form of documented capital outlays (schools built, computers purchased, etc.) and published reports. There is little interest in assessing whether the projects have actually had an impact on people's lives.

The development history of Pakistan, long before the first SAP, was full of hastily assembled programs that lacked adequate support institutions or other infrastructure. The legacies of this haphazard approach are everywhere. Health centers cobbled together sit locked and empty—sometimes because they lack staff and supplies, sometimes for reasons that aren't readily apparent. The situation in education is at least as dire. "Ghost" schools, which show enrollment figures higher than the number of malnourished, bedraggled students living in the whole village they supposedly serve, are documented as major achievements.

The specialists who design the programs work for and are answerable to distant development agencies. Most are narrowly trained technicians from Europe or the United States who have very little understanding of the social conditions and institutions in the country they are dealing with. At a personal level, they bring with them something more destructive than ignorance: a certain kind of palpable arrogance. They have been designated "experts": foreigners who represent high-profile donors and who command exorbitant salaries. Most are white, which, given Pakistan's colonial experience, imbues them with a tincture of superiority in the minds of the general public. White Europeans were, after all, the colonial "masters." Being human, these experts very quickly gain an exaggerated sense of their own authority and a disinclination to entertain ideas divergent

from their own. Consequently, they end up using their sometimes considerable financial decision-making power not to benefit the country they're supposedly there to serve, but in the interest of their own institutions or to protect their jobs.

Present in the country for a short period of time, they are focused on the product—an impressive report, expenditures made—they signed up to deliver. They favor technocratic "solutions." Sickness is to be combated with clinically skilled people, for example; to deal with illiteracy, it is assumed, you need teachers and reading materials. The relationship between problems and their social context is left unexamined. Grandiose, fuzzy, and unrealistic plans that rely on capital outlays and numbers of people to be trained are quickly drawn up with the representatives of the host government, which participates happily—for this will bring in money—or unhappily, because there is no other option. Most funding agencies work on a short budget cycle, so even if some die-hard planner wants to, there is no time to consider larger issues and long-term solutions.

Yet those who give aid and the governments that receive it have the feeling they are "doing something" to respond to the nation's ills. Most specialists do their jobs to the best of their abilities. People with experience know full well that most of the time they are just muddling through, trying to meet deadlines. In the end, government officials, technical consultants, and aid agencies all hope that "some" good comes out of the muddle. Alas, when muddle goes in, muddle comes out, as we have seen in the years since that afternoon in Mrs. S.'s tidy little office, where we witnessed that muddle with our own eyes.

Mrs. S. started by telling us about the background of Pakistan's nursing system, which was inherited from British colonialists.

"We use the same curriculum that was used to train British nurses during World War II," she said with obvious pride.

"Surely it has been updated since then," said Lucymemsahib jokingly.

"No."

"You really mean it has never been updated since then? Why not?" asked Lucymemsahib, quite aghast.

"There was no need to," replied Mrs. S. "Only recently, after all this Alma-Ata business, there is pressure to change it," she added, sounding as if this were completely unnecessary.

That "business" was an international conference held in the city of Alma-Ata, in what is present-day Kazakhstan, in 1978. Considered a watershed event for the design of health delivery systems in developing countries, the conference decreed that services based on the Western model were inappropriate for these countries. Since most health problems in developing countries were believed to be the result of environmental problems such as poor sanitation and malnutrition, it was decided that they should be tackled by making improvements in the environment. Any remaining medical needs could be addressed by minimally trained local health workers.

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The wisdom or folly of this policy and the tale of its selective implementation are matters for another time. Most of the developing countries, including Pakistan, signed on to the resulting Alma-Ata Declaration, promising to reorient their programs according to a primary health care (PHC) model introduced at the conference. Since there was little discussion of how this was to be done, however, each institution in Pakistan translated the model as it saw fit.

"To meet the needs of the PHC model, we are going to stress more community medicine and family planning in the nursing curriculum. Nurses will be doing all this

along with their regular work," said Mrs. S.

"Why?" asked Lucymemsahib. "Nursing is, as its name says, nursing. And equally important. What hospital can function without good nurses?"

"That is true. But it is in the declaration. We have to do community medicine."

"But what about nursing?" insisted Lucymemsahib, clearly not happy about nurses' involvement in this community medicine business.

"What particular aspects of community medicine?" I asked, knowing full well the many colors and constructions of this much-maligned term.

"Oh, just some things to do with the community," offered the director nonchalantly.

After completing a 24-month curriculum, including a practicum rotation in a hospital, nurses take the examination administered by the Pakistan Nursing Council. Once they pass, they are certified and registered by the council. Sounds good. This means there are standards that can be monitored.

"But it does not matter," our good Mrs. S. said, "whether they are certified or not. A lot of organizations hire nurses without any certification and registration. Especially the private hospitals and clinics. And since these institutions pay a lot more money than does government service, the nurses prefer to work for them rather than for the government. Many do not even wait to complete the training program."

"Do these organizations then train these people themselves?" asked Lucymemsahib.

"Oh no, there is no need to train them. They can work." At least Mrs. S. was honest.

"What do you mean, there is no need?"

"Well, they do know the work."

"What work do they do?" Lucymemsahib was genuinely confused.

"Nursing work," responded our hostess calmly, adjusting some papers on her desk.

"But nursing is a skilled profession. A nurse, to be effective, has to perform certain tasks which are technical, and many times critical." Lucymemsahib looked at me, her face flushed and eyes shining with indignation. She was a registered nurse herself. In Canada, nursing is a highly skilled, well-organized, and respected profession.

"Ah, but you see, there is no rule which says that you are not allowed to work as a nurse without certification," Mrs. S. explained patiently. "And practically speaking, even if there were, there is no way we can reprimand them. There is no way to enforce this rule."

"Can you not change the rules and put in regulations?" Lucymemsahib turned again to Mrs. S.

"What rules?" asked the lady mildly.

"The rules regarding the employment of people who are not properly qualified to do the job."

"No, no, rules should not be changed, for this would lead to a lowering of standards, and it is very important to maintain high standards." Mrs. S.'s voice rose with emotion. For all her life, she told us, she had fought to adhere to standards "against all odds."

"What standards are you talking about?" Lucymemsahib's voice was also high.

"The standards of nursing, the noblest profession in the world. It must have the highest standards in the world." Mrs. S.'s voice cracked on the high note.

And, just as suddenly, both ladies stopped talking. Their faces were red and they were out of breath.

Lucymemsahib's worry was justified. Even today, one need only visit any facility in the large cities to see what is going on. "Nurses," whose only claim to the title is their little starched uniform, are blundering through people's lives. I saw a nine-year-old boy die after a routine appendectomy because a nurse did not know that she needed to give him a test dose before administering penicillin, to check for allergic reaction. A hypertensive man had a stroke because the nurse who was monitoring his blood pressure did not think she had to alert the doctor when it became dangerously high. There are nurses who do not know how to read a thermometer.

At the same time, nurses have thriving private practices in towns where they are called "doctor." They dispense medicines, suture wounds, treat ingrown toenails, perform abortions. One enterprising young lady was doing outpatient cataract removals in a small town just 50 miles from where we sat. Her name came up again and again whenever the subject of private medical care or palatial houses—the two go hand in hand in Pakistan, as in other countries—was under discussion. She had done well enough to build a mansion within two years of opening her "practice," complete with marble foyer and imported toilets, which, though completely unusable because of the inadequate water supply, were

nevertheless the cause of much envy.

"Why do employers hire unregistered nurses, when they know that these women might not be adequately trained?" My friend was persistent.

"Because there is an acute shortage of nurses in the country, and no clinician can work without nurses," replied Mrs. S. This, too, was a fact, consistently documented. "To date, 19,000 nurses are registered with the council, and given the population, this is an extremely poor nurse-to-population ratio. This means we have one nurse for 6,000 people. On top of that we think that easily half of these 19,000 are out of the country, and the other half are trying their best to get out too. As you can see, there are just not enough nurses to meet the demand. That is why even untrained girls are hired. That is why we need to train more nurses." (According to the World Health Organization, Pakistan had 48,446 registered nurses in 2004—though there is no way to know how many of these nurses were actually in the country—and the fact that health indicators have barely budged shows this is mostly an improvement on paper.)

"This situation exists only in urban areas, does it not?" I asked, for Pakistan is certainly more than its three large cities; almost 70 percent of the population is rural, and rural-urban disparities are a major hurdle in developing standard programs or uniform employment salaries, benefits, etc.

"Of course. What need is there for nurses in rural areas where there are no hospitals? As it is, we do not have enough nurses for urban areas," said Mrs. S.

"Why do you then not increase the output? Surely in a country where there is a shortage of jobs, this should be a very attractive option for women." Lucymemsahib was being logical, applying the law of supply and demand. But this was Pakistan, and there were yet another 10 layers to the problem.

"This is easier said than done," Mrs. S. replied, with a pursing of her lips. "It is not easy to attract girls and women to go into the nursing profession, especially if they come from good families."

"What on earth do you mean!" Lucymemsahib was horrified. "Is it because of poor salaries? Is the pay that low?"

"Oh, no, pay has nothing to do with it," replied Mrs. S. "Girls prefer to go into teaching, although that has still lower pay. It's just that nursing is not considered a . . . a decent profession."

Lucymemsahib looked from me to Mrs. S. and back again, her mouth opening and closing like a fish's.

"But *you* are a nurse, aren't you?" she said, once she got her breath back.

"Oh, no, no I am not." Mrs. S. was quick to correct her.

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She was from the federal bureaucracy, a civil servant. Down to the present day, no nurse has served as the director of the Pakistan Nursing Council.

The institution of nursing in Pakistan is a strange hybrid. It is built on the foundations of the health and medical system created by the British in the 19th century to serve the colonial and local elite. Initially, nurses came from Britain. Later, especially during World War II, nursing programs were set up in local hospitals, and, as in Britain, women were recruited. This was a challenge. Educated women from middle-class households, who had some schooling, were reluctant to go into professions. Those that required close contact with people, especially males who were not part of a woman's immediate family, were even less attractive. At the same time, Christian religious missions were well established on the subcontinent, and they had their own schools and hospitals. The missions also took in abandoned infants and children,