

Disconnection between guidelines, policy and implementation of Infection prevention and control in Pakistan

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A few months ago, I was engaged by a private university teaching hospital to help pass a Sindh Healthcare Commission (SHCC) licensing audit. I was hired for one week as a consultant; an IPC nurse was brought on for four days — long enough to be present during the inspection, to demonstrate that "processes existed." The hospital's actual interest was not in improving care. It was in the certificate that would let it keep operating for the next two years.

I had, in fact, written IPC policies for this hospital before — properly referenced against National Institutes of Health (Pakistan) and WHO guidelines. I found them again on that visit: bound, shelved, and covered in a fine layer of dust in the ward office. No one had opened them. No one, as far as I could establish, had ever read them — not the policy document, not the underlying national guideline, not the WHO source material it was built on.

When I went for rounds on the wards, another story unfolded. Sharps bins overflowing past their fill line. No functioning hand hygiene station, sanitizer bottles empty. No waste segregation system of any kind — sharps, infectious, and general waste handled identically. Bed railings caked with dirt. Toilets that had clearly not been cleaned that day, or the day before. Bed linens stained and soiled. Curtains between beds, by the nursing staff's own admission, had not been laundered or replaced in years. No isolation facility for a patient with a transmissible infection; no personal protective equipment stock available. A microbiology laboratory so rudimentary it had no functioning reporting pathway. No infectious diseases service, and an IPC committee, an antimicrobial stewardship committee, and a healthcare waste management committee that existed only on paper. This is not an isolated story. This is the situation of IPC in many of our private, public, and academic hospitals.^{1,2}

There is no shortage of technical direction. WHO and NIH guidelines have detailed the requirements of a functioning IPC program.^{3,4} Provincial healthcare commissions have built IPC standards into licensing requirements, and functioning AMR, IPC, and waste management committees are now a checklist item for accreditation. Training follows the same pattern. SHCC, WHO, JHPIEGO, NIH, MMIDSP, the CDC, and others repeatedly gather the same clinicians in hotel conference rooms for content that is genuinely sound, then send everyone home with a certificate and no follow-up. No one tracks whether ward practice changes afterward; no resources accompany the learning, and the next workshop is already being scheduled.^{5,6,7}

I do not think I can write this editorial honestly without turning the question on myself and on colleagues who do similar work. When a hospital's only focus is on "getting through the audit," what is our responsibility? I took the engagement; I wrote what I believed were genuinely useful policies; I cannot say with confidence that the facility is safer today than before I arrived, only that it is licensed.

The responsibility to close the gap between trainings, guidelines, and implementation lies with the regulatory and licensing bodies, and more so with government. This is not because independent agencies such as WHO and JHPIEGO are failing — they are doing a great job — but because sustainability is ultimately a state responsibility, not a donor or NGO one. SHCC and the equivalent provincial commissions should stop treating licensing as a single scheduled visit and instead build sustainability into the license itself: random, unannounced inspections through the license period, and a named facility-level IPC focal person from whom periodic reports are formally demanded, rather than a committee that meets to generate minutes. The National Institutes of Health should run a national surveillance program for healthcare-associated

infections, with the resulting data made public hospital by hospital, so that performance carries a reputation as well as a regulatory consequence.

The guidelines were never the missing piece, and neither, in the end, the policies nor are more training the missing piece: we have run a great many good sessions in conference rooms. The gap between what we know and what we do will not close through another document; another workshop, or another consultant brought in for a week to make a healthcare facility look compliant. It will close only when government allocates a substantially larger share of the national budget to healthcare, and to IPC and infection control infrastructure. Pakistan's public health expenditure has, for years, hovered at roughly 1% of GDP — among the lowest allocations in South Asia, and a fraction of what a health system carrying this burden of preventable, IPC-related infection requires. The government must allocate considerably more.

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