EDITORIAL

Sustainability of a national programme for drug-resistant TB: why does a well-designed programme stagnate?

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Sustainability is an important issue in public health programme design and management. After the initial success in reducing TB incidence and improved health outcomes, national programmes for TB control do not necessarily continue to succeed. Likewise, the country-level trend of TB incidence can differ substantially, even within high-incidence countries. Sustainability in case finding and treatment is particularly important for drug-resistant TB (DR-TB) due to the difficulty in controlling outbreaks once DR-TB emerges and spreads. Extensive resources are required for upgrading laboratory testing, drug availability, training health care workers and surveillance.¹

In this issue of *Public Health Action*, Abbas et al. investigate the possible causes of stagnation in the national programme for DR-TB in Pakistan after its initial success.² The authors apply a Practice Theory framework to ethnographic fieldwork at the clinic level. The study found well-structured strategy and rich resource inputs at the overall programme level, in contrast to inadequate implementation at the clinic level.

Using Practice Theory, the authors are able to show that this was because the programme's primary focus was on materialities (materials, infrastructure and technologies) and not on competencies (knowledge, skills, and processes), that is, there was undue concentration on tangible and measurable practices, while intangible and difficult-to-measure practices were being ignored. The clinics appeared to be well-managed: roles and responsibilities were displayed; clinical files were well-organised; the number of staff was adequate; and no major drug shortages existed. However, after detailed analysis, Abbas et al. found inconsistent staff role allocations, a lack of leadership and management, and inadequate skill levels. Supervision and training were a major limitation.

Abbas et al. highlight the mismatch between strategy and implementation and that between programme managers' intention and the reality of service provision.² This mismatch could result in patients' dissatisfaction with services, a lack of knowledge of drug side effects, reduced adherence to

treatment and failures in case finding and treatment. This is a classic but serious example of inappropriate goal-setting, workforce design and monitoring, which failed to address the issue of treatment outcomes, but instead focused on process indicators. Managers may end up being satisfied with process indicators and not adequately motivated to achieve improvements in patients' physical and mental health outcomes if roles and responsibilities are not delegated appropriately.

National programmes should be monitored to ensure that the programme is able to sustain both materialities and competencies. In fact, patient outcomes are part of the monitoring framework in the WHO guidelines for the programmatic management of DR-TB.³ However, this monitoring framework does not define indicators related to competencies among staff. A motivated and trained workforce is an essential component of any health care system.⁴ We can expect managers to pay greater attention to the competencies of their workforce if their clinics are evaluated on the basis of patient outcomes. Competencies should be incorporated into the design of quality health service provision.^{5,6} Practice Theory highlights the importance of balancing materialities and competencies in the design, service provision and monitoring of national programmes.

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