

Increased funding for combatting neglected tropical diseases will not alone make poverty history. The specific contexts of affected areas must be better understood and existing problems dealt with

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*The UK government has recently committed more funds to tackle neglected tropical diseases. While this is a tremendously positive step, there are many issues besides funding that need to be addressed in order to make better headway. In particular, there tends to be overly optimistic assessments of the programmes' effectiveness that runs contrary to the evidence. **Tim Allen** and **Melissa Parker** argue that the incorporation of different disciplinary perspectives and an integrated biosocial approach is essential.*

On Jan 21, 2012, the UK's Department for International Development announced a fivefold increase in its support for programmes to control neglected tropical diseases (NTDs). The department's [press release](#) claimed that the new funding will initially provide 400 million treatments to protect 100 million people from lymphatic filariasis, and to help save 10 million lives that would otherwise be lost to schistosomiasis. Onchocerciasis and dracunculiasis are also to be targeted.

In many respects, these developments are an enormously positive step. However, there is a body of research that highlights hazards associated with current modes of implementing NTD control strategies. These include the undermining of already fragile and overstretched health-care systems with the introduction of large, internationally funded, vertical programmes that are rolling out free drugs to adults and children irrespective of their infective status; difficulties with relying on volunteers to assist with the distribution of drugs in targeted communities; limits in knowledge surrounding the safety and efficacy of combining drugs for some NTDs; and a growing tendency for those promoting mass drug administration (MDA) programmes to overlook the fact that the evidence for how effective they are is more limited than often suggested.

Our research since 2005 echoes some of these points, but it also adds a different perspective. It shows that the specific political, economic and social context in which MDA is rolled out profoundly affects the uptake of drugs for the treatment of schistosomiasis, lymphatic filariasis, and soil-transmitted helminth infections. In some locations, uptake of drugs has been found to be relatively high, but in nearby locations it is very low.

Also, overall drug uptake is almost always overestimated in official reporting. In coastal Tanzania, for example, close scrutiny of ministry of health registers combined with surveys of self-reported uptake of drugs indicated that drug take-up dropped below 26 per cent in several villages whereas in others it had reached 70 per cent. Results from more recent fieldwork have indicated an improved drug uptake in 2010 at some locations, but the average rate across study villages remains well below 50 per cent.

An important issue is that communication about the rationale for MDA with target populations remains a low priority. Local conspiracy theories questioning the "real" purposes of free drug distribution remain unaddressed. After multiple rounds of MDA for lymphatic filariasis, the vast majority of people interviewed in the highly endemic areas in which we have researched are unaware of the link between the disease and mosquitoes and, at best, have a very limited understanding of the rationale for mass

treatment. They ask why people with no visible symptoms should take tablets and why many of those with symptoms take the tablets but seem not to be cured. Similar confusions occur with respect to schistosomiasis. It is thus hardly surprising that rumours circulate about the real purpose of the drugs.

Some parents had become convinced that the tablets had been sent to poison their children. In 2008, there were protests against distributions in various parts of Tanzania. One of our doctoral students observing treatment was attacked by an angry crowd. She had to be rescued by armed police. Elsewhere, teachers involved in handing out tablets were severely beaten.

Many of those involved in implementing MDA programmes are aware of these kinds of issue, but they are reluctant to discuss them too openly or revise policies. Others have set them aside as insignificant. A few passionate advocates of MDA have even gone so far as to misrepresent arguments and insights that we and others have made in an effort to discredit them, occasionally using highly emotive language in the process.

Raising problems with MDA does not mean that we are opposed to NTD treatment—far from it. But we are concerned by the way in which competition for multimillion-dollar grants is closing off debate and restricting critical analysis of what is actually occurring on the ground. The situation is not helped by the fact that intense pressures are placed on institutions responsible for designing, administering, and monitoring MDA programmes to set overly optimistic targets and timelines at the expense of engaging with local realities. Similarly unhelpful is the conflation in medical journals of fine-grained and detailed scholarly research with broad assertions that are best understood as advocacy statements. Sidelining insights from the social sciences is counterproductive, not least because appropriate responses to complex public health problems require a richly textured understanding of the lives of people being targeted.

We have worked with impoverished and politically marginalised Africans for decades and are well aware of the debilitating effects parasitic diseases can have on their lives. The provision of free and subsidised drugs creates a window of opportunity to make a massive difference. However, dealing with NTDs in a sustainable way will involve a range of factors, including behavioural change. The availability of tablets is not enough, and disingenuous dismissal of discomfiting information will not benefit afflicted populations.

In the parts of Africa in which we have worked, imagining that MDA programmes in their current form will, as protagonists suggest, “make poverty history” is unrealistic. More adequate monitoring and surveillance is essential. This entails properly triangulated and evidence-based assessment that draws insights from different disciplinary perspectives. An integrated biosocial approach is essential.

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