that to make essential savings at the two large teaching hospitals in Leeds, it might be necessary to axe the posts of 1200 medical, nursing, and ancillary staff.2 As medical and nursing staff are essential for the good care of patients, it would seem inevitable that such cuts will lead to a decline in clinical performance. Outsiders would want to know how such a situation could arise in a health service that has had so much extra money invested in it. Where has that money gone?

It is unlikely, however, to be a simple matter of money, because clinical services have always been starved of resources. Instead the problem may well derive from what might be a deeply mistaken Government ethos: that service quality will be improved if health-care providers are forced to compete for “business” (of which the mantra of “offering choice” to patients is a part). It is the effect of the implementation of this ethos on clinical services, combined with the apparent intention to privatise sections of the NHS,3,4 which conflicts so profoundly with the philosophy of those who have not only given the best part of their lives to their profession but who also, perhaps, know best what the public wants. This conflict is the most likely factor leading to the finding that 41% of hospital specialists have got to the point of despair—through no fault of their own. Using a phrase currently in vogue, Jenni Russell recently referred to health-care professionals as the “canaries in the mine” whose “complaints are often dismissed privately by those in Government, as the whingeing of the selfinterested”.

If the plight of canaries in the mine is ignored, the results can be catastrophic.6

The chances are, however, that the distress being expressed by hospital specialists will be ignored and this raises an even more worrying spectre. If the direction and ethos of restructuring of the NHS continue unaltered, consultants will have to adopt one of two coping strategies: to leave the NHS or to compromise their professionalism. Once again, an outsider would have major doubts about whether either is in the best interests of the NHS and the people for whom it tries to care. But whichever coping strategy is to be adopted, a consequence would be that the prevalence of emotional exhaustion and psychiatric morbidity in hospital specialists in any future survey by Taylor and colleagues would be lower. This apparent improvement would be because hospital specialists would have coped, and their conflict would be less—but it would also mean that they might no longer care. The UK Government would have got the doctors it deserved.

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5 Russell J. When you can’t see a GP. Guardian April 30, 2005: 23.
6 Davis J. As doctors, we see the cancer that eats away at the NHS. Guardian June 27, 2005: 18.

Control of sleeping sickness—time to integrate approaches

Human African trypanosomiasis, commonly called sleeping sickness, remains a devastating disease that kills all those infected unless treated. The disease affects poor marginalised displaced populations, particularly in regions in civil conflict, and control efforts have been focused on screening and treating people in and around known foci of the disease. In today’s Lancet, Eric Fèvre and colleagues1 report on the burgeoning epidemic of sleeping sickness in Uganda. Their study brings out the complicated nature of control by highlighting the many areas where we lack knowledge and the need for integrated intersectoral action to combat the growing epidemic.

A real problem foreseen by Fèvre and colleagues stems from the possible convergence of the two forms of sleeping sickness in Uganda.2 The two parasites involved, Trypanosoma brucei rhodesiense and T brucei gambiense, require different strategies for their control. Uniquely, Uganda has the misfortune of having foci of both forms of the disease which, although today separated by the Great Rift Valley, are converging. Any overlap in distribution would certainly complicate control procedures.

For T brucei gambiense, which causes chronic disease, control activities involve active case-finding and screening

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of populations with the card agglutination test for trypanosomiasis (CATT); for T. brucei rhodesiense, which causes acute disease, passive case-finding is recommended because there is no available diagnostic tool. Drugs are available and, though they are not cheap, are provided free of charge by donation from industry. However, they are toxic, difficult to use (they all require parenteral administration), and most have been in use for a long time. Vector control with tsetse traps is cheap and effective, but has proved difficult to sustain for various reasons, including physical degradation, damage by wind or large animals, theft, and lack of education in use of the traps.3

T. brucei rhodesiense is zoonotic, with game animals and livestock serving as the reservoir of infection, but whether T. brucei gambiens is zoonotic is still a subject of research. The Ugandan epidemic reported by Fèvre and colleagues emerged after the introduction of livestock into the tsetse-belt area, through a restocking project started to encourage people to return to areas they had vacated during the civil unrest of the 1980s.4 Because livestock demography drives the epidemiology of T. brucei rhodesiense (a tsetse fly is five times more likely to pick up an infection from a cow than a human being5), treating the livestock reservoir at the point of origin represents a real opportunity for effective disease management and control. But treating the reservoir has been difficult to implement: Fèvre and colleagues found an insignificant difference in the prevalence of human-infective T. brucei rhodesiense in cattle between the intervention and non-intervention areas. The use of tsetse traps for control of human African trypanosomiasis is particularly critical for the zoonotic T. brucei rhodesiense. In Uganda, responsibility for tsetse control falls under the Ministry of Agriculture.

So what could we do better? Although the lack of adequate tools for disease control and management of human African trypanosomiasis requires urgent attention, activities with the available tools could be much more integrated. Intersectoral cooperation by the veterinary, agriculture, and health services is fundamental. Integrated control starts at national level, but also needs to be implemented at international level, among multilateral and bilateral organisations. Currently, activities are not coordinated, they occur mainly ad hoc, and usually in response to an emergency.6 With intersectoral action, we could better use the tools and funds we have at hand. For instance, control efforts could perhaps be focused around livestock market areas where human cases are concentrated.7

The integration of research with control efforts would bring an evidence-based approach to disease control. Both basic and applied research is needed. Why communities lack adequate knowledge of the disease is a research as well as a control question. What lessons can be learnt from the restocking project? Would implementation research have ensured all aspects were considered before starting the restocking and prevented the epidemic? In a case such as this, implementation research could provide the evidence donors need before committing their support to country control activities.

We need research to develop new diagnostics, including early detection and staging tests, new drugs for treatment, and improved vector-control tools. Given that we now know the genome of the trypanosome,7 and perhaps soon of the tsetse,8 the products we need could be developed. However, realistic funding for research should be made available through national and international cooperation. Better control of African trypanosomiasis requires concerted efforts from the veterinary, agriculture, and health sectors, research organisations, and funding bodies.

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We declare that we have no conflict of interest.