

Role of the Red Cross movement in Uganda's Ebola outbreak

Editor – With reference to the news item in the December 2000 *Bulletin* (pp.1476–1477) on the outbreak of Ebola haemorrhagic fever in Uganda in October–November 2000, I agree with the main conclusions about what seems to make a difference in the management of such outbreaks.

Ray Arthur's comments on the correlation between a more vigorous intravenous fluid replacement therapy and the higher survival rate compared with other outbreaks are reasonable. My own thought is that we were probably also dealing with different strains of the virus, some of them more virulent and lethal than others. Additional factors contributing to a better survival rate appear to be the early detection of cases and the tracing of contacts. One particular feature of this latest outbreak is the difficulty of reintegrating survivors into their own communities: they have suddenly become outcasts — expelled from home, their clothes burnt, and with no possibility of finding work.

Your news item mentioned a number of WHO partners as contributors to the relative success of the intervention. The International Committee of the Red Cross (ICRC) is mentioned, but not the International Federation of Red Cross and Red Crescent Societies or the Ugandan Red Cross. Many people do not realize the existence of three different components of the Red Cross movement; the work of national societies and the Federation is very often ignored, albeit unintentionally, so I should like to clarify who does what.

ICRC provides services and health care in conflict zones, while the Federation is the umbrella organization for 176 national societies, representing and supporting them. Such support includes the provision of guidance and standards and coordination of efforts. In emergencies, we support the national societies to do the actual work — and if the task is too big we also provide the necessary resources, as was the case in the Ebola outbreak.

There is one National Society per country, running support programmes that target the most vulnerable people in the population, both under normal circumstances and during emergencies. In this epidemic, the Ugandan Red Cross and the Federation trained scores of volunteers to do much of the house-to-house health information and education campaigning as well as case detection and, when cases were found, to make sure the patients presented for check-up and treatment. From my perspective, based on our previous experience in Gabon and the Democratic Republic of the Congo, this support was crucial and made a major contribution to the better outcome.

The problem with the discharged patients was detected quite early, so the same volunteers, plus additional ones, were trained to provide psychosocial support. This is an ongoing activity and we do not know as yet how effective it is — we are still learning. This is a complex issue, as there are many misconceptions, taboos and traditional belief-related factors to deal with. Once we have analysed the operation, the Federation and the Ugandan Red Cross plan to publish jointly an evaluation of the lessons we have learned. ■

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Applying DALYs to the burden of infectious diseases

Editor – I read with interest the critical examination of summary measures of population health by Murray and colleagues (1). The summary measure, disability-adjusted life year (DALY), that was developed in the Global Burden of Disease Study (2) has made a central contribution to the comparative assessment of disease burden. It is aggregated from disease-specific mortality and morbidity data including an appraisal of the severity of the functional con-

sequences of the disease. The measure makes possible comparisons between health losses due to mortality and morbidity and health losses attributable to different diseases: the addition of disability results in a more realistic measure of disease burden than that obtained from mortality alone. DALYs may be used to evaluate health policies, to compare intervention alternatives, and to assess risk factors. A recent study of the relation between funding by the National Institutes of Health and the burden of disease showed that, except for AIDS and a few other diseases, the size of the burden in the USA was strongly predictive of the amount spent on research and development when disease burden was measured using DALYs (3).

Nevertheless, the limitations of DALYs are also recognized. DALYs do not cover multiple causes and long latency periods, nor do they capture discomfort, pain, suffering, stigma, or the social and economic consequences involved in many conditions, such as the burdens that maternal deaths cause in households and communities. Murray and colleagues acknowledged that certain issues are not reflected, including average levels of population health, reductions in health inequalities, responsiveness of the health system to legitimate expectations of the public regarding the non-health dimensions of its interaction with the system, and the fairness of health system financing (1).

Application of DALYs to burden analysis for infectious diseases may be even more challenging. Traditional mortality or life expectancy measures do not reflect the burden of most non-fatal chronic infectious diseases at all, even though the impact of these diseases is obvious. The DALY measure is a significant step in the right direction as it takes into account non-fatal disease burden, but it fails to address certain unique aspects of infectious diseases so may not necessarily reflect the true picture. First, there are large proportions of asymptomatic infections that may be inaccurately attributed to non-infectious chronic diseases in mortality or even in morbidity data. For example, according to available information, as many as