Cardio News

National Advisory Committee for the Prevention and Control of Rheumatic Fever and Rheumatic Heart Disease in Namibia

In Windhoek, Namibia, Thursday 23 April 2015 marked a historic milestone for the Pan-African campaign to arrest the march of rheumatic fever (RF) and rheumatic heart disease (RHD) throughout our continent. Under the authority of the Minister of Health and Social Services, Dr Bernard Haufiku, the first meeting of the National Advisory Committee on Rheumatic Fever and Rheumatic Heart Disease began to elaborate on a plan for the prevention and control of a heart disease, which, it is estimated, claims the lives of 1.4 million people in less well-resourced countries globally every year. The prevalence in Africa is as high as 30/1 000 among school children.

Among survivors, RHD is a major cause of morbidity through heart failure, atrial fibrillation and cerebrovascular accidents. RHD results in school absenteeism in about two-thirds of affected learners, and because the disease progresses during early adulthood and causes chronic disability, it has the potential to undermine national productivity. The economic impact of RHD in the African region is profound and was estimated at US$791 million to 2.37 billion in 2010.

Significantly, Namibia is the first African country to tackle the prevention and control of RHD in this manner at a national level. The national programme was launched in March 2014 by Dr Richard Kamwi, the health minister at that time. Advocacy for the national programme had been informed by research conducted by the Namibian National Registry of RF and RHD, which is an important partner in the Global Registry of RF and RHD.

The campaign to eliminate RHD in our lifetime has its origins in the first all-Africa workshop on rheumatic fever and rheumatic heart disease, which was supported by the Pan-African Society of Cardiology (PASCAR) and the World Health Organisation African region (WHO-AFRO), and held in the Drakensberg, South Africa in 2005. At that meeting, four actions were recommended as part of any programme: awareness-raising for both the public and health workers, surveillance (of incidence and prevalence), advocacy for funding and implementing treatment and prevention programmes, and prevention (primary and secondary). From this conversation, the 'Stop Rheumatic Heart Disease ASAP Programme', described in the Drakensberg Declaration, was to emerge.

Clinicians in 12 countries in Africa took up the surveillance challenge and participated in the Global Registry for RHD (REMEDY), which in 2012 collected robust data on 3 066 children and adults (including 266 Namibian patients) with RHD. A strong coalition for RF and RHD prevention developed over this period. Both the knowledge gathered and the collaboration itself established a powerful platform through which the coalition has been able to influence public policy and advocate for the prevention and control of the most common non-communicable disease affecting the heart in our continent.

These intentions were consolidated at the second all-Africa workshop on RF and RHD at Livingstone, Zambia in 2014 and expressed through the 'Mosi-o-Tunya (the smoke that thunders) Call to Action' (2014). This call from PASCAR was endorsed by the WHO-AFRO and called for the elimination of acute RF and control of RHD in Africa in our lifetime.

Delegates of the National Advisory Committee on RF and RHD

Persistent in-country advocacy over four years, together with the momentum created by the Pan-African coalition, led to the creation of the National Advisory Committee on Rheumatic Fever and Rheumatic Heart Disease in Namibia. RHD is the end result of acute RF, a consequence of untreated pharyngitis caused by group A *Streptococcus* (GrAS). Overcrowding, poor housing conditions, under-nutrition and lack of access to penicillin for sore throat are determinants of RHD.

With adequate medical care, RHD is preventable, and it is therefore a litmus test for the efficacy of primary healthcare systems. Penicillin prevents rheumatic fever and is the cornerstone of both primary and secondary prevention. Penicillin supply is dependent on health system infrastructure. Penicillin delivery depends on awareness among healthcare providers of the importance of this strategy.

Recognising these realities, Namibia has adopted the 'ASAP' strategies and will incorporate them into the national programme. The advisory committee will work with the Minister to design the details of the programme, namely raising awareness through public and professional education, establishing a well-tested surveillance system, advocacy work to improve the availability of health services for patients, and promoting adherence to effective measures for the prevention of RF.

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