



A FIRST IN AFRICA

NATIONAL ADVISORY COMMITTEE FOR PREVENTION AND CONTROL OF RHEUMATIC FEVER AND RHEUMATIC HEART DISEASE IN NAMIBIA

In Windhoek, Namibia, Thursday 23 April marked a historic milestone for the pan - African campaign to arrest the march of Rheumatic Fever (RF) and Rheumatic Heart Disease (RHD) through 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 a plan for the prevention and control of a heart disease which it is estimated claims the lives of 1.4 people in less well-resourced countries globally every year. The prevalence in Africa is as high as 30/1000 amongst school children. Amongst survivors, RHD is a major cause of morbidity through heart failure, atrial fibrillation and cerebra-vascular 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 estimated at US\$791 million – 2.37 billion in 2010. Significantly, Namibia is the first African country to tackle the prevention and control of RHD in this manner at 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 much 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 (REMEDY).

The campaign to eliminate RHD in our lifetime has its origins in the 1st 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 (WHO-AFRO) and held at 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, prevalence); Advocacy for funding and implementing treatment and prevention programs; and Prevention (primary, and secondary). From this conversation the “Stop Rheumatic Heart Disease A.S.A.P. Programme”, described in the Drakensberg Declaration, was to emerge. Clinicians in twelve countries in Africa took up the surveillance challenge and participated with the Global Registry for RHD (REMEDY) which through 2012 collected robust data on 3066 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 2nd 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 World Health Organisation Africa Region (WHO-AFRO) and called for the elimination of ARF and control of RHD in Africa in our lifetime.

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 rheumatic fever (ARF), a consequence of untreated pharyngitis caused by Group A Streptococcus (GAS). 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 is therefore a litmus test for the effectiveness of primary health care systems. Penicillin prevents recurrent rheumatic fever and is the cornerstone of both primary and secondary prevention; however penicillin supply is dependent on health system infrastructure. Furthermore, penicillin delivery depends on awareness amongst health care providers of the importance of this strategy. Recognising these realities, Namibia has adopted the “ASAP” strategies and will incorporate them into its national programme. The advisory committee will now 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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