

Public Sector Prevention of RF and RHD in South Africa

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This gOPINION is adapted from a speech by Gwen Ramokgopa, MBChB, MPH, the Deputy Minister of Health South Africa, delivered at a rheumatic heart disease (RHD) event held during the 2013 World Health Assembly in Geneva.

This is the first time that a clear statement has been made by the government highlighting the importance of this disease in Africa. It is heartening to note that there are countries in high RHD-prevalence regions that are recognizing the public health importance of the disease, and implementing strategies for control. We are publishing this statement in the interest of raising awareness among policy makers pertaining to the importance of RHD and its control.

—Editors

Acute rheumatic fever (ARF) and rheumatic heart disease (RHD) are estimated to affect 15.6 million people globally and cause 350,000 deaths every year; and even this is thought to be an underestimate [1]. It is clear, however, that low- and middle-income countries bear the highest burden of this condition.

South Africa is in the process of introducing national health insurance (NHI). At this juncture, the Ministry of Health recognizes that a key factor for the success of NHI will be the reduction of disease burden through concerted programs around preventable diseases. RHD is a key preventable condition that has national priority. South Africa's data on RHD are poor, but in 2010, the incidence of RHD in persons older than 14 years in Soweto was 23.5 per 100,000 [2].

In the absence of a vaccine, prevention of ARF/RHD depends on preventing the initial attacks of ARF through short-term prophylactic penicillin treatment of patients presenting with acute sore throat based on clinical signs and symptoms.

Primary prevention of RHD therefore requires well-functioning primary health care services, including school health services where children with streptococcal throat infections can be adequately identified and managed. Communicable and noncommunicable diseases do not fit neatly into distinct categories and hence primary prevention of a number of diseases requires a combination of interventions. Although RHD cannot be “transmitted,” group A streptococcus (GAS), which is the underlying cause, can. This problem is compounded in conditions of poverty, making primary prevention central to our strategy [3].

It is clear that there are significant barriers to primary prevention of ARF/RHD that depend on access to quality primary health care services. Barriers to access include lack of sufficiently skilled personnel at the primary level; the

high cost of microbiological diagnosis; poor awareness of the condition among the public and community; and even insufficient knowledge of the condition among medical staff. There is also the concern that a high percentage of ARF patients present without a sore throat.

Future actions relating to ARF/RHD that will be taken by the Department of Health include finalization of guidelines for prevention and management of ARF and RHD. These are currently being updated in line with the latest research findings, and will be adopted for focused implementation at the primary health care (PHC) level. In expanding our program, we will build on the lessons and successes from the recent HIV and AIDS campaign and treatment roll-out and the platform being developed through our primary health care re-engineering process. This has 3 pillars: establishment of district clinical specialist teams; strengthening of the School Health Programme; and establishment of municipal–ward-based outreach health teams.

PHC doctors, nurses, and community health workers will be trained on the guidelines. The School Health Programme is currently being substantially strengthened and includes a focus on identification of all children with chronic diseases. The school health system will also review the current patient management plans of children identified with chronic diseases. In the case of RHD, this will include ensuring that children with ARF are referred for treatment while those with previously diagnosed RHD are adherent to secondary prophylaxis. The School Health Programme is a unique program in sub-Saharan Africa and will focus on RHD as one of the important chronic diseases of childhood and adolescence.

Imitating the Nurse Initiated Management of ART administration (NIMART) model, PHC nurses are to be trained in the diagnosis and treatment of ARF to affect early and effective interventions. Public awareness campaigns, especially among children, through the School Health Programme, as well as for parents and guardians, will be conducted in order to ensure that sore throats are taken seriously and people with sore throats seek and receive help. The perspective of “live with the sore throat and it will go away” needs to change given that in some cases the consequences of nontreatment can be very serious.

The government and Department of Health are committed to the intensification of efforts to address ARF/RHD on all fronts. Primary prevention of ARF is now firmly embedded in national health policy, and chronic disease management will also be integrated within the School Health Programme. Together with our scientific colleagues and academics, we need to continue efforts to develop an effective vaccine through international collaboration so that in the long term we can eliminate RHD.

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