

Acute rheumatic fever— a preventable, inequitable disease: a call for action

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Acute rheumatic fever (ARF) is a preventable autoimmune response to group A *Streptococcus* (GAS) infection.¹ In an estimated 60% of ARF cases, carditis progresses to chronic rheumatic heart disease (RHD) and permanent heart valve damage.² Unless treated with intramuscular injections of benzathine penicillin G (BPG) every 28 days for a minimum of 10 years, ARF patients are likely to experience worsening cardiac damage and increasing chances of heart failure, stroke and early death.³

ARF and RHD have all but disappeared from high-income countries. Yet here in Aotearoa New Zealand they remain an alarming and inequitable cause of preventable suffering and death for Māori and Pacific peoples. Over the 2000-2018 period, Pacific children (5–14 years of age) were 80 times more likely, and Māori children were 36 times more likely, to develop ARF compared with European/other children (based on initial ARF hospitalisations).⁴ The ethnic inequity of distribution continues to drive elevated rates of RHD and premature death across the lifespans of Māori and Pacific peoples.

In April 2018, member states of the World Health Organization unanimously adopted the Global Resolution (A71/25) on Rheumatic Fever and Rheumatic Heart Disease⁵ (the Resolution), which is a call for national, regional and global actions to prevent and control ARF and RHD.⁶ The New Zealand Ministry of Health were world leaders in this achievement, initiating the drafting process to develop the Resolution and setting out the case for taking action. However, despite this global success and a 2020 pre-election promise for a national ARF/RHD patient register, the New Zealand

government has not yet taken action to fund or implement such a register that could help monitor and reduce ARF/RHD.

By supporting the health workforce to maximise the likelihood of adherence with long-term antibiotic therapy,^{7,8} patient registers are instrumental in helping to organise the medical care of patients with ARF/RHD.^{7,8} Registers facilitate monitoring of disease burden and progression, providing epidemiological data that can be used for planning prevention and control programmes.^{9,10} The World Heart Federation (an association of international heart foundations and medical societies) recommend the use of comprehensive register-based ARF/RHD control programmes, and the New Zealand ARF/RHD sector have called for a national register numerous times over the last two decades.¹¹⁻¹⁶

Pū Manawa, a recently formed, sector-wide network of health practitioners, researchers and key stakeholders, including ARF/RHD patients, whānau and non-governmental organisations, is advocating for the immediate establishment of a long-overdue national ARF/RHD register as an important step towards disease control and the reduction of ethnic inequities in New Zealand. The inequitable rates of ARF and RHD in Aotearoa are shameful. They clearly breach of te Tiriti o Waitangi and demand a strong government response. There is an urgent need for leadership, coordination and an adequately resourced national strategy for the prevention and control of ARF/RHD. As a core component of such a strategy, an immediate action that the Government can take is to support and fund the implementation of the national ARF/RHD register as promised.

Competing interests:

Nil.

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