Rheumatic fever and rheumatic heart disease know no boundaries

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Background: State and territory borders do not exist for Aboriginal and Torres Strait Islander people; boundaries are drawn according to birthplace and the relationship to those places. Programs working in Aboriginal and Torres Strait Islander communities need to acknowledge this and accommodate accordingly.

Despite it being a rare disease in industrialised countries, some of the highest rates of rheumatic fever (RF) and rheumatic heart disease (RHD) in the world are found in Aboriginal and Torres Strait Islander communities in central and northern Australia. RF and RHD affect young people in their most productive years and can have devastating effects. A prevalence study in SA in 2011 estimated almost 200 documented cases of RHD, with approximately 85 of these living in the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands, with underreporting of cases likely.

Coordinated RHD control programs can assist in the prevention of RHD through identification of cases, improving clinical follow-up and encouraging adherence to secondary antibiotic prevention.

Method: The NT RHD control program has been running since 1997 and has successfully built up strong networks across the territory that facilitate the implementation of the control program. Since its commencement in 2012, the SA RHD control program has worked closely with the NT program. The two programs are working towards providing a service that is seamless for health services and patients in cross-border region of central Australia. This is achieved through close coordination of education and sharing the same electronic platform for the RHD Register, which records cases of ARF and RHD.

Benefits of working together have included the sharing of experiences, improved follow-up of patients, and improved awareness of the disease among health professionals in the region. Challenges of working across two jurisdictions have included negotiating the different practices and delivery of services within each health system, ensuring confidential sharing of patient information across jurisdictions and working within the time constraints of those involved.

Conclusion: Collaboration between and commitment from organisations is fundamental for the improvement of the health and wellbeing of individuals and communities. With the support of the NT, the SA RHD control program is laying the foundation for improved health outcomes for RHD patients across SA.