Australia's rheumatic fever strategy three years on

In November 2020, the *MJA* published a supplement[1] that showcased key elements of the RHD Endgame, which aims to eliminate rheumatic heart disease (RHD) by 2031. As Australia's peak First Nations health body, the National Aboriginal Community Controlled Health Organisation (NACCHO) welcomed its call for Aboriginal and Torres Strait Islander leadership. Consistent with the terms of the National Agreement on Closing the Gap,[2] NACCHO and the Australian Government have now embarked on the first-ever Aboriginal and Torres Strait Islander sector-led initiative to combat acute rheumatic fever (ARF) and RHD across the country.

To our knowledge, this partnership that shares control and sustains sector leadership is a global first. In Australia, it is overwhelmingly Aboriginal and Torres Strait Islander people who are affected by ARF and RHD. This new approach, of interest to many who seek to work more effectively in advancing the health and wellbeing of Aboriginal and Torres Strait Islander peoples, shifts power and decision making to community control. This is sovereignty in action.

A critical role for NACCHO early in the partnership was to co-design a national governance structure. Service delivery models, funding arrangements and accountability are also co-designed at multiple levels of action and reform. A national Joint Advisory Committee has met six times, co-chaired by NACCHO and a senior government health executive. NACCHO also appointed an RHD Expert Working Group comprising experts with significant expertise in Aboriginal and Torres Strait Islander service delivery. The Expert Working Group provides evidence-based medical and health advice articulating requirements for holistic, patient-centred care and optimising health outcomes for Aboriginal and Torres Strait Islander communities accessing the national network of Aboriginal and Torres Strait Islander Community Controlled Organisations (ACCHOs). The Expert Working Group further addresses actions to secure culturally safe pathways with mainstream services, tertiary care interfaces, and appropriate access to health professionals. Innovative strengths-based preventive health messaging is developed by Aboriginal and Torres Strait Islander practitioners with cross-cultural skills.

New funding announced by successive Australian governments is expanding local capacity for ARF and RHD activities. The priority for investment, mutually agreed by the Commonwealth, NACCHO and funding partners, is to invest in expanding a community-based ARF and RHD workforce. Funds are prioritised based on need, using a process informed by NACCHO's expanding experience in developing and applying a decision matrix with sector support.

To date, 15 ACCHOs have secured funding and commenced activities supported by the NACCHO ARF and RHD program. There is a particular emphasis on Aboriginal health workers, practitioners, community-based workers and environmental health workers to lead local health promotion, community development, and program coordination activities.

Participating ACCHOs join the ARF and RHD Community of Practice, a national network for primary health care workers in any region with significant burdens of ARF and RHD. This peer network is vital for ACCHOs where the impacts of health workforce shortages and high staff turnover continue to impede outcomes. Topics already tackled include recommendations for proactive health checks, integrating RHD care plans with existing chronic disease management mechanisms, supporting ARF and RHD clinical audits, and positioning RHD echocardiographic screening within a community-driven population health approach.

Over 40 years ago, the *MJA* first reported unprecedented rates of hospitalisations of Aboriginal children in the Kimberley with ARF in the 1970s.[3] It has taken too long to secure its prescient recommendation for "a comprehensive system for future prevention of rheumatic fever and rheumatic heart disease at a community level". As described in our sector's core services framework,[4] such a system is most effectively implemented through comprehensive community controlled primary health care firmly in the hands of Aboriginal and Torres Strait Islander communities. Additional investment from BHP will expand the number of services participating in the program.[5] We also look to the tertiary health system to address its own shortcomings: long term survival of Aboriginal people with RHD valve replacements in the Northern Territory has not improved from 1964.[6]

ARF and RHD are entirely preventable conditions occurring in high income countries when social and cultural determinants of health are not equitably addressed. We know what needs to be done, and we know that it can be done.[7] NACCHO is now responsible for dispersing over $30 million in service enhancement grants to enable Aboriginal and Torres Strait Islander communities and their community controlled health services to address their local priorities, building on their own strengths and assigning resources to strategies they know will work. Our monitoring and evaluation framework being developed from the ground up provides a guarantee to communities that data sovereignty is secure, as well as reassurance to our Australian Government partnership that effort is aligned with agreed long term outcomes.

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