Samoa

National Rheumatic Fever Primary Prevention Policy

Prepared by:
HRPIRD with technical support of the RFAG

29 April 2003
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### ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARF</td>
<td>Acute Rheumatic Fever</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>MOESC</td>
<td>Ministry of Education, Sports and Culture</td>
</tr>
<tr>
<td>HACC</td>
<td>Health Aid Coordinating Committee</td>
</tr>
<tr>
<td>HEAPS</td>
<td>Health Education and Promotion Section</td>
</tr>
<tr>
<td>HPS</td>
<td>Health Promoting Schools</td>
</tr>
<tr>
<td>IEC</td>
<td>Information Education and Communication</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NZAID</td>
<td>New Zealand Agency for International Development</td>
</tr>
<tr>
<td>RF</td>
<td>Rheumatic Fever</td>
</tr>
<tr>
<td>RFAG</td>
<td>Rheumatic Fever Advisory Group</td>
</tr>
<tr>
<td>RHD</td>
<td>Rheumatic Heart Disease</td>
</tr>
<tr>
<td>TOR</td>
<td>Terms of Reference</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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</table>
1.0 INTRODUCTION

Rheumatic Fever and Rheumatic Heart Disease is a debilitating illness that requires complex and costly treatment. Rheumatic Fever is a disease that starts with a sore throat caused by a bacterium called Streptococcus. If undiagnosed and untreated, it can lead to rheumatic heart disease and cardiac complications that can often lead to death, disability often impacting on the patients quality of life. Complications of rheumatic fever are the second most frequent reason for transferal of Samoan citizens overseas for medical treatment. It is also the second most costly episode of care overseas. A recent study of Rheumatic Fever in Samoa raised further concern over the high prevalence of Rheumatic Heart Disease in Samoa particularly amongst the young population (5-15yrs).

The above realities have raised concern within the Ministry of Health and Government of Samoa about the impacts of Rheumatic fever on the health status and quality of life of the affected population. Furthermore, there is growing concern over the cost implications of acute and long term treatment for Rheumatic fever related illnesses to the Government of Samoa and the families of the patients.

The Ministry of Health and the Government of Samoa have responded to these issues and concerns by identifying Rheumatic Fever as a priority issue to be addressed in the Ministry of Health’s national and development programs. The Government of Samoa in collaboration with the Government of New Zealand through its development program NZAID in 1999 established a Fanau ma Aiga Manuia Project to address child health issues in Samoa with Rheumatic Fever as one of the priority issues to be addressed.

Various broad national strategies identified to address rheumatic fever issues are; the prevention and reduction of the number of Samoans affected by Rheumatic Fever; improving awareness of the public on the impacts of Rheumatic Fever; improving surveillance, diagnosis, treatment and management of identified patients.

The Government of Samoa identified the prevention of rheumatic fever as the first step in its response to the issues identified above. It also identified the most affected age group (5-15 yr) as the priority target population for prevention and treatment programs.

There are three levels of prevention of Rheumatic Fever:

- **Primary Prevention**: raising awareness of the importance of sore throats, and skin sores early treatment of all streptococcal sore throats and skin sores with penicillin
- **Secondary Prevention**: raising awareness of the signs of rheumatic fever, early identification of cases of rheumatic fever and providing long term penicillin prophylaxis to prevent recurrences and progression of rheumatic heart disease (RHD)
- **Tertiary Prevention**: quality management of the cardiac sequelae of RHD
This policy paper focuses on the primary prevention of rheumatic fever (RF). The purpose of the paper is to provide policy options for consideration of the Ministry of Health (MOH) and the Ministry of Education, Sports and Culture (MOESC) in the provision of primary prevention programs and activities for rheumatic fever in Samoa.

2.0 GOAL

To reduce the prevalence of Rheumatic Fever in children aged 5 – 15 years.

3.0 OBJECTIVES

1. To increase Rheumatic Fever awareness among the public and school communities (teachers, students and parents)
2. To promote early and appropriate treatment of sore throats, skin sores and sore joints.
3. To strengthen collaboration between the Ministry of Health and the Ministry of Education, Sports and Culture in the planning and provision of primary prevention activities for Rheumatic Fever.

4.0 BACKGROUND OF THE RHEUMATIC FEVER PROGRAM IN SAMOA

Samoa first established its acute rheumatic fever (ARF) Prevention Program in 1984 with the assistance of the Remuera Rotary Club and the Harold Trust Foundation of New Zealand. The program was coordinated by retired Pediatrician Dr Kuresa and a fulltime nurse funded by the Harold Trust Foundation. The number of patients on the Rheumatic Fever register in 1984 was 134. As of December 2000, there were 1618 names on the main Rheumatic Fever Register.

The operations of the Rheumatic Fever Prevention Program was taken over by the Samoa Health Department in 1988 and the World Health Organization (WHO) gave assistance in 1991 by donating a project vehicle.

The New Zealand Aid (NZAID), at the request of the Samoan Government, gave further assistance to strengthening the Rheumatic Fever Program in 1995. Part of this assistance included funding a large prevalence survey, which generated some very interesting data. Furthermore, it was the data generated from this study that led to the establishment of the more comprehensive Fanau ma Aiga Manuia Project of which the Rheumatic Fever Prevention Program is now part.

The Rheumatic Fever Advisory Group was established by the Ministry of Health in April 2000 to provide policy advice to the Chief Executive Officer of the Ministry of Health through the Health Aid Coordinating Committee on rheumatic fever issues and future developments on rheumatic fever services. The RFAG also provides technical and policy advice to the development of national Rheumatic Fever Policies. The RFAG is chaired by the Head of the TTM Hospital Paediatrics Unit with members that include doctors, nurses, health educators and a policy analyst.

The RFAG, in collaboration with the Ministry of Education, Sports and Culture was instrumental in the planning, development and implementation of the Rheumatic Fever School Prevention Pilot Program. The pilot program was implemented in 12 randomly selected schools between October 2000 and October 2001.
5.0 Primary Prevention of Rheumatic Fever

Primary prevention activities aim to prevent streptococcal pharyngitis from progressing to Acute Rheumatic Fever. The 1996 Rheumatic Fever research study clearly showed the need for a more aggressive approach to preventing and controlling ARF. The following Rheumatic Fever primary prevention activities took place over the last five years:

- Rheumatic Fever information needs analysis conducted in 1999
- The Rheumatic Fever mass awareness media campaign in 2000
- Rheumatic Fever mass media awareness campaign evaluation in 2001
- Re-run of the Rheumatic Fever awareness media campaign in 2001

5.1 The Rheumatic Fever School Pilot Program

The overall aim of the pilot program was to test the hypothesis that a school-based rheumatic fever program can prevent and control rheumatic fever in school-aged children (5-15 years). A sample of 2,000 students was drawn by the RFAG to test the effectiveness of the pilot program - 1,000 students in the intervention pilot schools matched against 1,000 in the control schools. The pilot program involved:

- Pre and post-screening (A pre-and post screening of pilot school students was conducted by the RFAG doctors and nurses to identify students with RHD symptoms at the beginning and end of the pilot program to measure the effectiveness of the pilot program at controlling and preventing rheumatic fever in the intervention schools)

- Rheumatic Fever training for teachers (RFAG medical personnel provided the training for all the classroom teachers of the six intervention schools' teachers. The training aimed to inform the teachers of the six intervention pilot schools about rheumatic fever, the three key rheumatic fever-related symptoms and the classroom procedures required during the 12-month pilot program.)

- Rheumatic Fever training for nurses (The RFAG medical personnel also provided training specific to the pilot program for the hospital and community-based nurses in the intervention school areas. Rheumatic fever identification and referral guidelines for nurses were distributed to all nurses attending the training sessions. The training aimed at providing community nurses with information about the school rheumatic fever pilot program, the classroom and referral procedures)

- Intervention schools’ classroom procedures (The main objective of the intervention schools’ classroom procedures was to raise rheumatic fever awareness, identify self-identified symptomatic children and to notify and advise parents to take their children to the nearest hospital / health centre for follow-up care.)
• Child Health Project Team support procedures (The MOH's Child Health Project Team aimed to engage and maintain the intervention schools' involvement and commitment to the pilot program.)

5.2 Key School Pilot Evaluation Findings and Recommendations

• Discontinue post and pre screening – out of 2,503 children sampled, just 2 of the 15 children identified with possible RHD were confirmed to have RHD. The costs of screening were considered high in relation to the benefits gained.

• Strengthen community nurse involvement – despite the training provided for nurses, the school pilot programme failed to fully engage community nurses in the referral and follow-up procedures

• Strengthen follow-up procedures – follow-up and referral documentation were inadequate due to failure to establish strong linkages between (1) the schools and community nurses (2) between the community nurses and the hospitals

• Strengthen quality of the data collection – there were major gaps in monitoring and collection of classroom registers by the Child Health Project Coordinator and failure of manual rheumatic fever paediatric register to enable measurement of the impact of the pilot program.

6.0 POLICY ISSUES

6.1 Lack of coordination between funding and implementing agencies

Because the majority of the target population of 5-15 year olds are in primary and secondary schools, any health program that targets this population will need to work closely and collaboratively with the Ministry of Education, Sports and Culture (MOESC). Currently, the Ministry of Health collaborates with the Ministry of Education on an ad hoc basis when the Ministry of Health needs to implement a program in schools.

There is a formal mechanism for more regular collaboration between the two ministries through the Health Promoting Schools Council. Unfortunately, the council has not been very active over the last few years. In addition, there is a Rheumatic Fever Advisory Group that advises the Ministry of Health on secondary prevention. This RFAG consist of Ministry of Health officials only. Given the significant role of the MOESC in the early prevention and secondary prevention programs for rheumatic fever, it would be advisable to have a representative of the MOESC on the RFAG.

Long-term sustainability of the RF Program will be dependent upon the integration or institutionalisation of the Rheumatic Fever program within the regular school health programs in schools. For this reason, there needs to be a memorandum of understanding between the MOH and MOESC on the Rheumatic Fever Program and the roles of each ministry in implementing this program. The on-going maintenance of the Health Promoting Schools Council and RFAG will also be essential in ensuring regular communication between the two ministries on health and rheumatic fever related programs. In particular, the school primary prevention project will be greatly assisted by having oversight and support from the HPS
Council. It will be important for the Child Health Policy Analyst to be in attendance at HPS Council meetings.

**Lack of coordination in implementation**

There are several donor agencies assisting the MOH in rheumatic fever related programs. The NZAID over the last decade and through the Fanau ma Aiga Manuia program has been the lead agency in providing the MOH support for Rheumatic Programs. In addition, the WHO has provided technical and financial support over the past decade and the French Government has provided human resource development support for Samoan nurses and doctors.

Unfortunately, these donor assisted programs are not well coordinated and there is limited communication and understanding internally of the roles and activities of the various donors with regard to rheumatic fever programs. Whilst the MOH has a Rheumatic Fever Advisory Group, it was established by the CEO to look specifically at rheumatic fever activities of the Fanau ma Aiga Manuia Project. It does not have jurisdiction over the other donor assisted rheumatic fever programs. It is important that the terms of Reference (TOR) and membership of this group be reviewed and expanded to ensure the group has an oversight role regarding rheumatic fever related programs and activities within the MOH and amongst donors and that there is improved communication amongst key rheumatic fever stakeholders.

### 6.2 Sustainability of RF primary prevention program

Sustainable program delivery will be difficult after the Fanau ma Aiga Manuia project finishes. It will be necessary to identify those who are willing to assist with program delivery over the long term. Sustainable approaches may include incorporating program content into the routine information, education and communication taking place within radio, television, newspapers, schools, churches, women's committees and health centres.

The development, maintenance and distribution of the health education resources will be a challenge. Recurrent budget allocation is required to ensure that reprints of all rheumatic fever resources can be made annually. The MOH will either need to make additional annual budgetary allocation or to get sponsorship from the business or NGO community for the HEAPS for Rheumatic Fever related IEC materials.

A reliable system is needed to ensure ongoing distribution of new resources and replacement of damaged resources.

### 6.3 Discrepancies in Rheumatic Fever Information

There is discrepancy in the information from two rheumatic fever surveys undertaken by the Ministry of Health in 1996 and another survey in 2000. The earlier survey indicated a very high prevalence rate of rheumatic fever in Samoa whilst the more recent survey noted a lower prevalence rate. The RFAG decided to use the results of the more recent survey due to the fact that the 1996 survey did not provide echocardiographs for the suspected cases of Rheumatic Fever.

To improve planning and policy development for rheumatic fever programs and activities, the Ministry of Health needs to produce more reliable information.
Late diagnosis of children with Acute Rheumatic Fever
One of the major rheumatic fever issues is that children are being diagnosed late when they have already progressed to acute rheumatic fever (ARF). A considerable number of young children are sent overseas for heart surgery as a result of complications of rheumatic fever. Early diagnosis and treatment of children with rheumatic fever can prevent them from progressing to acute rheumatic fever thus saving government money in sending children overseas for heart surgery. Implementing the pilot rheumatic fever program in school will assist in identifying children with symptoms of rheumatic fever and thus reduce the problem of late diagnosis of rheumatic fever children.

7.0 STRATEGIES AND POLICY OPTIONS
7.1 Improved Coordination in RF Program Planning and Implementation
The Ministry of Health and MOESC to work together to revive and re-establish the Health Promoting Schools Council as the leading body for multi-sectoral collaboration amongst government and non-government agencies in advocating and implementing the Healthy Schools concept and approach in Samoa. The integration of the Rheumatic Fever program activities under the Health Promoting Schools umbrella will greatly improve collaboration and integration of rheumatic fever programs into the health and education regular school programs.

The expansion of the role, functions and membership of the Rheumatic Fever Advisory Group (RFAG) to include other key stakeholders such as the MOESC, the Ministry of Women, Community and Social Development, the Komiti Tumama to assist in providing advise on appropriate strategies that will be supported by the community and is feasible for implementation.

7.2 Institutionalisation of RF Program into MOH and MOESC annual programs/ budgets
If this program is to be sustainable, it needs to be integrated and institutionalised within the MOH and MOESC regular school health programs within the health promoting schools umbrella. Human resource cost will be the major cost to the MOH and MOESC in implementing and integrating the RF Program into their annual work programs.

In addition, the MOH will have to allocate additional recurrent resources to the HEAPS for the reprinting of rheumatic fever IEC materials and Television and radio spots produced under the Fanau ma Aiga Manuia Project.

7.3 Improved Rheumatic Fever information for planning
The Ministry of Health in collaboration with the Health Research Council and Ministry of Finance (Statistics Division) will need to improve methodology for future research into Rheumatic Fever in Samoa. Accurate and timely information is essential to the development of health service options to improve rheumatic fever health services and outcomes for the Samoan population.

7.4 Improved early diagnosis of children with Rheumatic Fever
Because the majority of the affected population will be in schools, it is necessary that any direct intervention program be focused in the school setting to improve efficiency and effectiveness of program implementation. Three options were provided for consideration; and the MOH has opted for Option 2; Incrementally
introduce and implement the RF School Early Detection and Treatment Program

Section 7.4.2 provides an analysis of option 2 according to selected criteria. (Annex 3: Three options and analysis)

**7.4.1 OPTION 2: Incrementally rolling out the pilot school program**

This option proposes that the Ministry of Health and the Ministry of Education Sports and Culture consider implementing the program but incrementally rolling it out a few schools at a time prioritised according to the schools with high prevalence of rheumatic fever cases. The Ministry of Education Sports and Culture will decide on the number of schools to start the program with and add other schools every calendar year. The mission/church and private schools will be integrated into the program by the MOESC in the second year of implementing the roll out program. The Ministry of Health will provide training for teachers of the selected schools and the community nurses of selected areas.

The timing and frequency of the classroom rheumatic fever identification procedure will be changed according to the results of the teachers’ Rheumatic Fever Program evaluation report. The rheumatic fever classroom register, notification and follow-up process will also be refined.

Linkages between various stakeholders will be strengthened. Key liaison people within the Ministry of Health and the Ministry of Education Sports and Culture; teachers and parents; parents and community nurses/doctors/health centers; community nurses/health centers and paediatrics clinic/RF register will be identified.

It is also important to raise the awareness of the public and the school communities about rheumatic fever, its symptoms and complications when its not treated by frequent screening of rheumatic fever television spots, reprinting and distributing rheumatic fever health education resources, rheumatic fever education programs in the community.

**7.4.2 Option Analysis**

Following is an analysis of option 2 according to the following criteria of: effectiveness, cost to the MOH and MOESC, sustainability of each option, resource required, political acceptance and feasibility of implementation.

<table>
<thead>
<tr>
<th>OPTIONS</th>
<th>Does it solve the problem?</th>
<th>Cost to the MOH</th>
<th>Cost to the MOESC</th>
<th>Sustainability</th>
<th>Resource requirement</th>
<th>Politically acceptable</th>
<th>Feasibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incrementally rolling out program</td>
<td>Yes</td>
<td>Low</td>
<td>Medium</td>
<td>Yes</td>
<td>Low to medium</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Option 2 proposes the incremental introduction of the Rheumatic Fever School Program according to high risk schools identified by the 1996 and 2000 surveys. This option addresses the problem of late diagnosis by early intervention in the schools, it is also less resource intensive than Option 3 which proposes the national introduction of the program; it will also be politically acceptable since it is practical and will not demand too much resources from the MOH and MOESC and
if there is commitment by the MOH and MOESC, it can be sustained over the long term.

8.0 RECOMMENDATIONS

The recommended option by the MOH as mentioned above is the incremental introduction of the Rheumatic Fever School Program in schools selected by the MOESC and the MOH.

The RFAG and the MOH need to consult with the MOESC and the Health Promoting Council on the details and costs of implementing the recommended option.

9.0 CONCLUSION

From the findings presented in this paper, it is clear that deciding on a primary prevention policy for rheumatic fever involves taking into account a number of complex variables. In addition to the potential for resource mobilization, one needs to keep in mind issues of collaboration, sustainability and coordination. However it is very important that everyone works together to prevent rheumatic fever from affecting our children’s lives. The best alternative to go for is to get the teachers at schools to pick up the symptoms of rheumatic fever and refer the symptomatic children to see a nurse or doctor.

Early detection and treatment of rheumatic fever makes a big difference to the lives of those infected and the country as well in terms of financial costs of overseas treatments. It is recommended that the Rheumatic Fever School Program can become an effective and efficient intervention to ensure the early detection and treatment of rheumatic fever in the Samoan community that can in the long term lead to reduced complications from Rheumatic Fever.
Annex 1: ACTION PLAN

1. Submit RF Primary Prevention Draft Policy to RFAG, HACC and CEO
2. Sign off of Policy
3. RFAG to prepare a detailed Action Plan
4. RFAG to review referral protocol
5. Plan training workshops for teachers and nurses
6. Re-run awareness campaign
7. Evaluation
Annex 2: RFAG Members

1. Lauano Dr. Herbert Peters (Chairman) - Head of Paediatrics Unit
2. Dr Satupaitea Viali - Dean of Oceania Medical School
3. Lemalu Dr Limbo Fiu - Head of Medical Unit
4. Leo’o Dr John Adams - Paediatrician/Director – MedCEN Hospital
5. Maatasesa Matthes (Urban/Rural) - Principal Community Nurse
6. Faranise Wright - Registered Nurse – Paediatrics Unit
7. Perive Lelevaga - Senior Health Educator - HEAPS
8. Diana Roma HRPIRD - Senior Health Policy Analyst –
Annex 3: Three options and analysis

Option 1: Do nothing for now
This option suggests that the Ministry of Health continue with its existing program of giving penicillin to people with symptoms of rheumatic fever who visit the hospitals and health centers. No other additional activities are recommended.

OPTION 2: Incrementally rolling out the pilot school program
This option proposes that the Ministry of Health and the Ministry of Education Sports and Culture consider implementing the program but incrementally rolling it out a few schools at a time prioritised according to the schools with high prevalence of rheumatic fever cases. The Ministry of Education Sports and Culture will decide on the number of schools to start the program with and add other schools every calendar year. The mission/church and private schools will be integrated into the program by the MESC in the second year of implementing the roll out program. The Ministry of Health will provide training for teachers of the selected schools and the community nurses of selected areas.

The timing and frequency of the classroom rheumatic fever identification procedure will be changed according to the results of the teachers' Rheumatic Fever Program evaluation report. The rheumatic fever classroom register, notification and follow-up process will also be refined.

Linkages between various stakeholders will be strengthened. Key liaison people within the Ministry of Health and the Ministry of Education Sports and Culture; teachers and parents; parents and community nurses/doctors/health centers; community nurses/health centers and paediatrics clinic/RF register will be identified.

It is also important to raise the awareness of the public and the school communities about rheumatic fever, its symptoms and complications when its not treated by frequent screening of rheumatic fever television spots, reprinting and distributing rheumatic fever health education resources, rheumatic fever education programs in the community.

OPTION 3: Implement the program nationally
This option is similar to option two however the program will cover all schools in Samoa. A key concern will be the practicality of implementing this program nationally which will be a massive undertaking by the MOH and MESC. The MOH and MESC currently are working under increased work strains due to declining workforce numbers but increasing demand for services. Implementing the rheumatic fever school project nationally will significantly increase the workload of teachers, nurses and doctors.

Option Analysis
Following is an analysis of the three options according to the following criteria of: effectiveness, cost to the MOH and MESC, sustainability of each option, resource required, political acceptance and feasibility of implementation.
<table>
<thead>
<tr>
<th>OPTIONS</th>
<th>Does it solve the problem?</th>
<th>Cost to the MOH</th>
<th>Cost to the MESC</th>
<th>Sustainability</th>
<th>Resource requirement</th>
<th>Politically acceptable</th>
<th>Feasibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do nothing for now</td>
<td>No</td>
<td>Very high</td>
<td>None</td>
<td>Yes</td>
<td>None</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Incrementally rolling out program</td>
<td>Yes</td>
<td>Low</td>
<td>Medium</td>
<td>Yes</td>
<td>Low to medium</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Introduce the program nationally</td>
<td>Yes</td>
<td>High</td>
<td>High</td>
<td>No</td>
<td>Very high</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

According to the selected criteria, option one should be disqualified or disregarded by virtue that it does not address or solve the problem at hand. This policy paper is developed because of the need to address and solve the very serious impact (social, health, financial) and implications of Rheumatic Heart illnesses on the Samoan community. Furthermore, the cost of doing nothing to the MOH will be very high given that if we do not improve the early diagnosis of Samoans with Rheumatic Fever, there will continue to be an increasing number of Samoans with Rheumatic Heart Disease that will require high cost tertiary care that can only be provided overseas.

Option 2 proposes the incremental introduction of the Rheumatic Fever School Program according to high risk schools identified by the 1996 and 2000 surveys. This option addresses the problem of late diagnosis by early intervention in the schools, it is also less resource intensive than Option 3 which proposes the national introduction of the program; it will also be politically acceptable since it is practical and will not demand too much resources from the MOH and MESC and if there is commitment by the MOH and MESC, it can be sustained over the long term.

Option 3 proposes the introduction and implementation of the Rheumatic Fever School Program nationally. As mentioned before, this will be very resource intensive and can have a significant impact on the workload of the teachers who will be doing the surveillance and referral work, increase the work load of the nurses who will be providing treatment as well as increasing the work load of doctors and nurses at the Rheumatic Fever Clinic who will be dealing with increased number of complications of rheumatic heart disease. In addition, it will be impossible to provide the necessary training and awareness programs for all the teachers and the nurses to nationally implement the Rheumatic Fever School Program.