

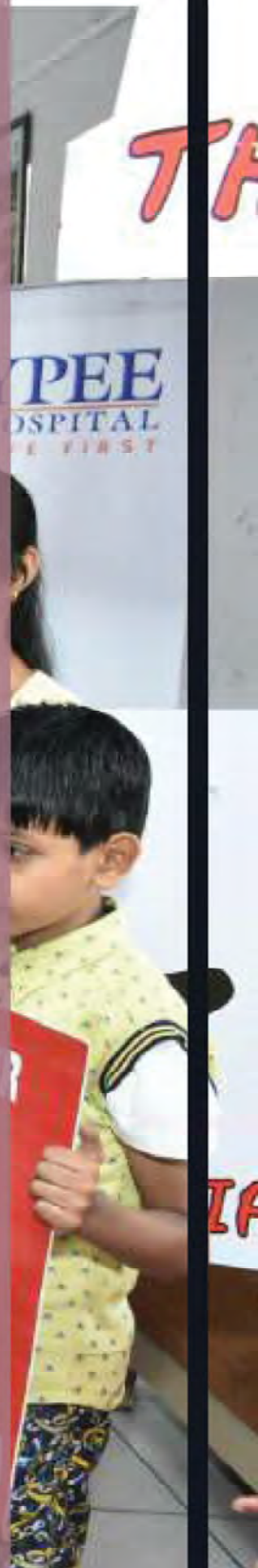


REVIEWING THE  
EFFECTIVENESS  
OF THALASSAEMIA  
PREVENTION  
PROGRAMMES  
TIF'S PERSPECTIVE IN  
A GLOBAL SNAPSHOT

CHECK YOUR  
THALASSEMIA STATUS  
BEFORE MARRIAGE

IT  
IS  
MUST

TO SAVE YOUR  
FUTURE CHILD  
FROM THALASSEMIA



# REVIEWING THE EFFECTIVENESS OF THALASSAEMIA PREVENTION PROGRAMMES

## TIF'S PERSPECTIVE IN A GLOBAL SNAPSHOT

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### INTRODUCTION

Haemoglobin disorders -thalassaemia and, Sickle Cell Disease (SCD), although originally occurring in high frequencies in the countries of the Mediterranean basin, across a belt covering the Arabic countries, the Indian peninsula, the southern countries of the Far East and the African Region (particularly regarding SCD), today these occur widely across the globe as a result of population and/or migration movements. (For more information, see Chapter on Epidemiology).

Regrettably, the global lack of national registries in many countries, in addition to the limited interest to update existing epidemiological data through statistically sound studies, hinder the accurate assessment of the national disease burden carried by these disorders particularly in countries with large populations and/or those with high prevalence of the disease. Such tools would support the investment of national competent authorities in the development and implementation of national control strategies, including prevention (which constitutes the theme of this chapter).

Patients with haemoglobin disorders continue to be born, in small or large numbers as a result of lack of effective control programmes across the world. Moreover, and although improvements to variable extents in medical and public health services have occurred in many countries around the world and which allow better survival of these patients, the suboptimal medical and social care provided to a great percentage of them, perhaps to the majority of them, leads to high levels of early, premature death. The rising number of annual affected births, a major contributing factor to providing suboptimal care services continues to be the case in many, if not most, countries. This poses very serious challenges to health and social care systems, as patients with these disorders, necessitate multiple elements of medical treatment and complex social care. The

provision of care for these patients, is therefore directly related to the level of the Human Development Index (HDI) of each country, the competencies of its healthcare and social welfare systems to address the needs of annually rising numbers of cases in the absence of prevention , as well as other *competing* public health priorities, particularly, but not confined to, communicable diseases. Although a new, long-awaited innovative gene-based curative treatment has been authorised recently (2019) (while others are in advance phase of research), it will take time and immense resources to be widely applied. Bone marrow transplantation on the other hand, has been adopted as a cure of thalassaemia for decades albeit this can only address with sufficient safety and effectiveness to-date only 20 – 30% of the patient population who can secure absolute sibling matched donors. Furthermore, its level of success lies on specific patient criteria and importantly on the quality and experience of the providing transplant centre. Thus, effective prevention programmes still todate, offer the most important solution to achieving advances in the quality of care services.

Over the last 2 – 3 decades the advances achieved in the area of clinical management of patients particularly with transfusion-dependent thalassaemia (TDT) and other haemoglobin disorders have significantly improved the quality of life of patients and impressively extended their life expectancy and these have happened in countries that have implemented effective prevention policies at the national level. Unfortunately however, such results are not seen across all affected countries. In fact, in the majority of countries of the world, where more than 80% of patients with these disorders live, even basic treatment is to-date for a large percentage of them, if not for the majority, sub-optimally provided resulting in the development of many and multiple complications, poor quality of life and premature death. Mortality and morbidity rates are very rarely reported due to the lack of disease specific registries and patient health record systems, and even when these are published, this kind of information comes from countries or centres within a country that are able to provide fairly adequate management data and have adopted registries and surveillance programmes .Such information unfortunately does not come from countries or regions where the greatest challenges exist. Indicators, which may predict in a country poor survival of these patients, include a low HDI and weak economies, a high under-5 mortality rate, inadequate health insurance coverage, poor medical / public health and social service organisation and absence of effective nationally co-ordinated prevention and management programmes. More disease specific indicators related to poor survival include inadequate blood supply and/or blood safety, interrupted and sub-optimally provided specialised monitoring of iron load, iron chelation therapy and lack of

appropriate multidisciplinary care offered by health care professionals with high level of expertise in the field. Moreover the absence of universal healthcare coverage constitutes the one, if not, the most important component that renders a country unable to provide any level of appropriate even basic clinical management, to a chronic particularly genetic disease, such as thalassaemia. Even affluent countries, with their high HDIs, strong healthcare systems and social infrastructures, when addressing the complex needs and high costs of a multi-organ lifelong chronic condition such as thalassaemia, in the absence of effective prevention programmes that achieve reduction of the annual affected births are faced with great challenges. The annual increase in patient numbers particularly in high prevalence countries in the absence of effective nationally co-ordinated prevention programmes, obviously becomes more and more challenging directly impacting on the standards and quality of care services for these disorders.

The direct relation between the reduction of annual affected births and the competency of health authorities to address the huge, many and multiple medical, public health, social and economic repercussions of thalassaemia was first fully recognized in the 1970s by the Southern Mediterranean countries, notably Cyprus, Greece and Italy. These are the first countries in the world where thalassaemia and other haemoglobin disorders (mainly SCD) were recognized to be highly prevalent amongst their indigenous populations and which first recognised their potential severe repercussions if left inappropriately addressed. As a result, their governments, with the support and guidance of the World Health Organisation (WHO), focused great efforts on identifying those elements and policies that could contribute to the reduction of annual affected births – a factor that would facilitate the re-allocation of resources and thus allow the improvement of health and other care of the existing patients as well as engage scientists in more active research with the aim to continually improve patient outcomes.

One must underscore at this point, that the patients and particularly parents in these countries which started establishing support groups and developing strong, united voices, contributed substantially to engaging their governments in promptly developing prevention programmes. They, too, had recognised since then that reducing the annual affected births could indeed support the government to focus attention, research and resources on saving the lives of their children (the majority were children at the time), acknowledging the fact that until then, patients particularly with TDT were dying before reaching the second decade of their life.

**Below are quoted some important guidance by the WHO through its disease specific resolution in support of its country members:**

#### WHO EB 1 18.R 1 THALASSAEMIA AND OTHER HAEMOGLOBINOPATHIES<sup>1</sup>

Article 1 (1). The Executive Board, urges Member States “to design, implement and reinforce in a systematic, equitable and effective manner, comprehensive national, integrated programmes for prevention and management of thalassaemia and other haemoglobinopathies, including surveillance, dissemination of information, awareness-raising and screening, such programmes being tailored to specific socioeconomic and cultural contexts and aimed at reducing the incidence, morbidity and mortality associated with these diseases”

Article 2. The Executive Board, requests the Director-General

“(1) to raise awareness of the international community of the global burden of thalassaemia and other haemoglobinopathies, and to promote equitable access to health services for prevention and management of these diseases;

(2) to provide technical support and advice to Member States in framing of national policies and strategies for prevention and management of thalassaemia and other haemoglobinopathies”.

Cyprus and Greece, initially but later also followed by other countries (including Israel, Thailand and India), fully acknowledged the value of prevention in the safeguarding and continually improving the quality of care of patients and their medical and public health resources (see below historical extracts or country specific statements)

#### CYPRUS: THE CASE FOR IMPLEMENTING A NATIONAL PREVENTION PROGRAMME<sup>2,3</sup>

Prof. George Stamatoyannopoulos, a medical geneticist at the University of Washington was invited in 1972 by the Ministry of Health of Cyprus, in his capacity as a WHO Consultant at the time, to visit the island in order to provide guidance.

Prof. Stamatoyannopoulos stated in his report to the Ministry that “... [by] offering the best available treatment regimens to the current population of patients, each patient would be likely to live into middle age. A not insignificant consequence would be that medical costs would escalate, and would escalate further as [an average 60 – 80] new affected births would be born each year. Absent of a prevention programme, it is estimated that the prevalence of  $\beta$ -thalassaemia would go from 1:1000 to 1:138 in the next 50 years (v.2022), creating an increase of 300 – 400% in the demand for blood and 600 – 700% in the cost of treatment. Cyprus would soon find that the needs of its thalassaemic patients would completely engulf not just the available blood supplies but also the entire budget of the Ministry of Health”.

A series of studies conducted in Greece between 1962 - 1972 by Prof. Christos Kattamis, paediatrician at the University of Athens, showed that 21% of children suffering from congenital diseases who were hospitalised were thalassaemia patients. Prof Kattamis concluded that this *'percentage was extremely high and revealed the gravity of the problem'*.

It was estimated that the number of affected births in Greece between 1980 - 2009 would be more than 10,000. The government of Greece had already invested sufficient annual resources for the treatment programme of thalassaemia (since 1965), and based on this new prospective analysis subsequently ensued a policy (including community awareness) for the prevention of thalassaemia, founding the first Centre for the Prevention of Mediterranean Anaemia 1975 in Athens, and subsequently establishing a premarital certificate policy in 1980.

### ISRAEL & THAILAND: A COST-BENEFIT ANALYSIS OF PREVENTION VS TREATMENT

In more recent times (2014), it has been estimated in Israel, with an anticipated 45 annual affected births that the cost of preventing one affected birth is approximately \$63,660 compared to an investment of \$1,971,380 for treatment of a single patient for 50 years. This is related to a total health resource preservation of \$76 million over ten years.

Respectively, in Thailand it has been estimated that for every affected birth prevented a total of \$1,914.57 is saved, considering that the lifetime cost of treatment of a single patient for 30 years is \$219,759.00. Thus, providing a benefit: cost ratio of 72:1.

This essentially demonstrates that effectiveness in prevention is related to significant resource savings which can be allocated to improve the quality of treatment, social care and many aspects of the public health infrastructure and services provided to existing patients.

### INDIA: ANTICIPATED FUTURE COSTS WITHOUT PREVENTION<sup>1</sup>

It has been estimated that in the absence of prevention the thalassaemia population of India would rocket to a total of 275,000 by 2026.

This would require an annual blood supply equivalent to 9.24 million units and total treatment costs would surpass 19% of the Indian national health budget.

Historically, voluntary avoidance of the birth of new cases of thalassaemia was offered in the early days of the 1970s initially as previously mentioned by countries of high disease prevalence in their indigenous populations such as Greece, Cyprus and Italy. This led to a reduction of annual affected births by more than 70% within 2 - 4 years and in most of them by over 80% within 5 years of implementation of such *efforts* (See Figures 1-4 & Table 1). At first the programmes of prevention addressed the “at-risk” couples as part of a national policy that involved mainly screening. The programme was gradually however and with the guidance of the WHO extended to include additional components (as seen in Table 2) aiming to secure the programmes’ effectiveness and sustainability. This policy was followed in subsequent years by many other countries across different cultures, healthcare and social service infrastructures and economic robustness. Successful implementation of an effective programme, marked by the reduction of annual affected births, has however been quite poor across the world to-date, particularly in countries where political commitment, national organisation and full financial coverage of policies have been absent or suboptimal. In conclusion, a comprehensive control policy should include both the components of provision of quality care for patients and a reduction of annual affected births, if effectiveness of a control programme to address haemoglobin disorders is the target.

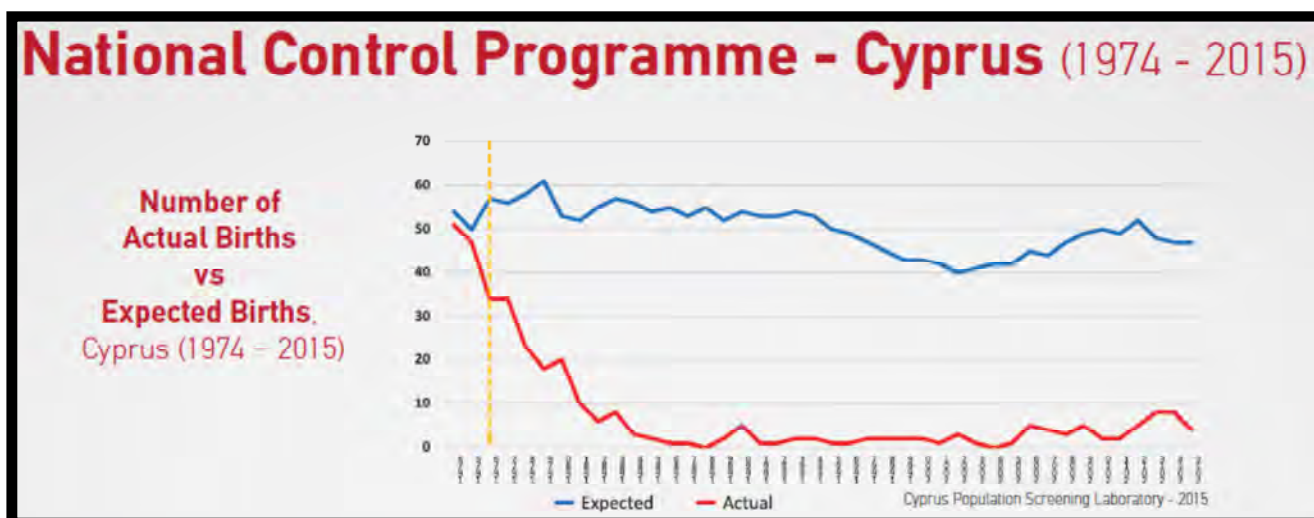


Figure 1. Cyprus National Prevention Programme Results<sup>7</sup>

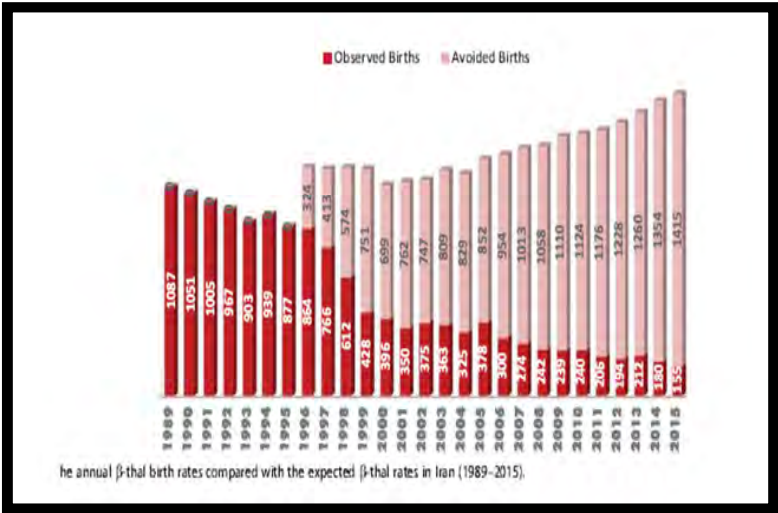
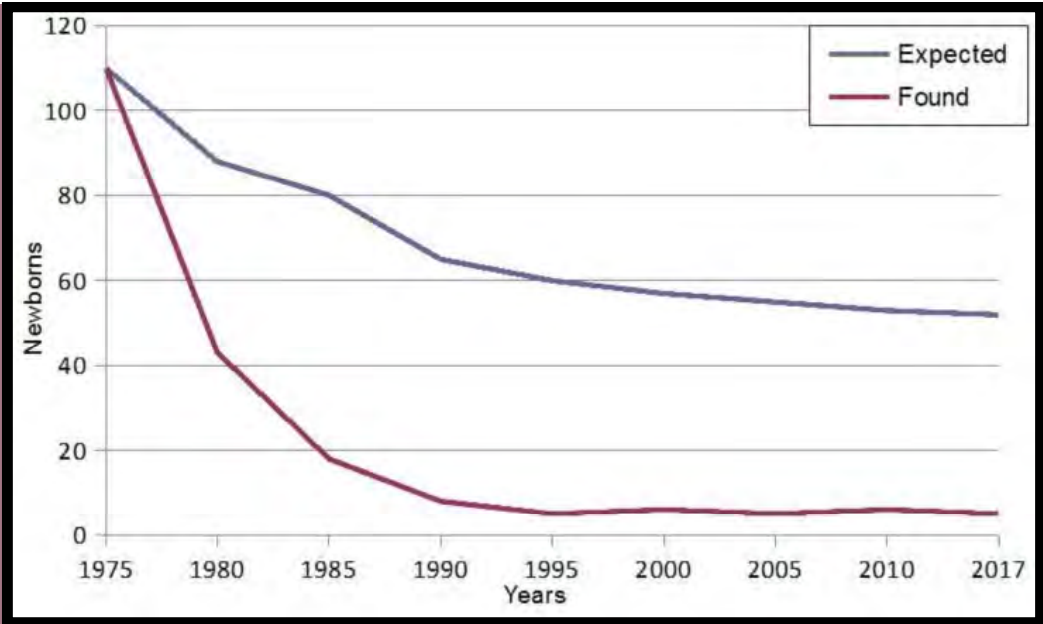
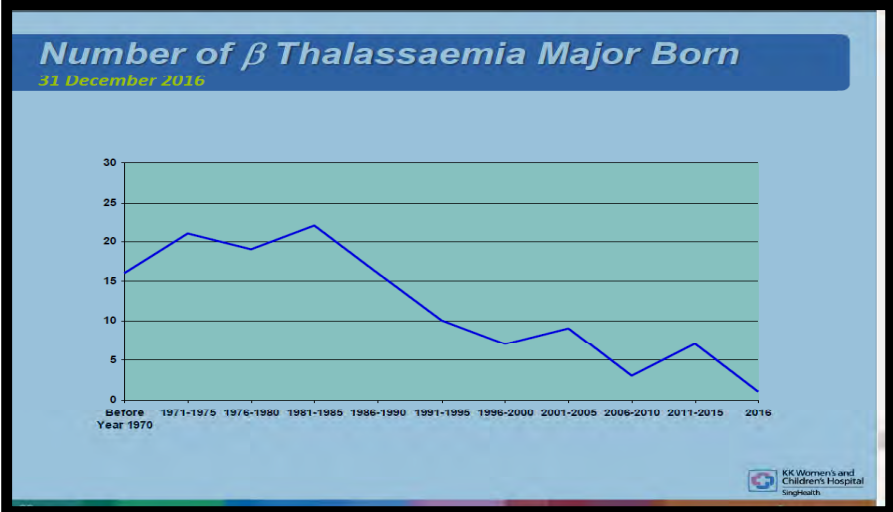


Figure 2. Iranian National Prevention Programme Results (1989 – 2015) <sup>8</sup>

Figure 3. Singapore – Decrease in births (1970 – 2016) <sup>9</sup>



-thalassaemia birth rate in Sardinia (1975 – 2017) <sup>10</sup>



PERIOD	NUMBER OF NEWBORNS WITH B-THALASSAEMIA		
	EXPECTED	OBSERVED	PREVENTED
1980-84	1096	458 (41.7%)	638 (58.3%)
1985-89	872	187 (21.4%)	685 (79.6%)
1990-94	823	145 (17.3%)	678 (82.7%)
1995-99	809	99 (12.2%)	710 (87.8%)
2000-04	831	73 (8.7%)	758 (91.3%)
2005-09	908	48 (5.2%)	865 (94.8%)
1980-2009	5339	1010 (18.2%)	4334 (81.8%)

**Table 1. Longitudinal trends of annual births with  $\beta$ -thalassaemia (in 5 year intervals) during 1980 – 2009 for expected vs observed and prevented births in Greece <sup>11</sup>.**

The Thalassaemia International Federation (TIF) has, as a pillar of its work, the promotion of nationally co-ordinated and fully funded control services (prevention and management) in every *affected* country. As a patient driven organisation, the rationale behind this, is that improvements of medical and social care cannot happen in the absence of effective control of annual affected births.

In this Chapter, we attempt to provide a crude snapshot of the current services and policies in some countries, members of TIF, across the different regions of the world, and their level of effectiveness with regards to prevention mainly of transfusion-dependent thalassaemia. For this purpose a simple scoring system, better described as a '*ladder*' model, was developed where those in the lower scores can rise or climb the ladder (should they wish or decide to do so) to reach higher scores and become more effective. **Such a scoring system, does not aim, under any circumstances, to criticize the policies or results seen in the different countries** across the world and neither can it be considered as an accurate representation of the existing situation with regards to prevention of thalassaemia in a country. It may merely point out basic deficiencies as these have been identified through published literature and/or TIF's work and to assist its members- national patients/parents associations to encourage the health care professionals' community and health care planners to optimize their national strategies related to the prevention of thalassaemia recognising its value and contribution in the improvement of care services for their disorder(s).

## METHODOLOGY USED

### RETRIEVED INFORMATION

Current practices on prevention were investigated through a literature search, using publications recorded in PubMed and Google Scholar. Information from these sources on this theme is often unfortunately limited and/or outdated, mainly as previously noted, due to the absence of national registries and/or updated epidemiological studies and micromapping. Therefore this was supplemented by information contained in reports of TIF developed by advisors and collaborators (a variable group of medical/scientific professionals and expert patients at the national/regional/international level), who have been visiting, in the context of TIF's work and activities, countries across the six Regions of the world over the years. Many of these reports are confidentially prepared by TIF in support of the work of health authorities and/or patient associations and as such, they constitute unpublished information of TIF.

HbE was considered along with  $\beta$ -thalassaemia since it results in a thalassaemia syndrome of variable clinical severity. Other haemoglobin disorders, especially SCD and clinically significant  $\alpha$ -thalassaemia, have been excluded from this discussion since despite their geographical coincidence and the use of the same medical/public health/social services, different policies are usually necessary for their control, including neonatal screening.

### COUNTRIES INCLUDED

A total of fifty one ( 51) countries across the six WHO Regions, with one hundred (100) national patient associations, members of TIF, were selected for this study, with variable estimated birth incidence of  $\alpha$ -thalassaemia. These countries are heterogeneous in culture, needs, health priorities and socioeconomic development.

### IT IS NOTED THAT:

- Those countries which are in active turmoil at this time, namely Syria, Afghanistan and Yemen are included in this list, due their high affected birth incidence. However, it is acknowledged that these have certainly no possibility, today or in the very near future, to formulate or apply any policy while the majority of their patients are displaced and struggling to survive.
- The Democratic Republic of China with its large regional variations, and high prevalence in most of the Southern provinces, is not included in this study, even though in some of these provinces quite successful prevention programmes have been implemented in the last 10 – 15 years.

A small number of both low and high prevalence countries for which reports and contacts are so limited that any data are considered quite unreliable (e.g. Tajikistan, Uzbekistan, Sudan) are omitted from this study.

### SCORING SYSTEM - RATIONALE

TIF has proceeded to develop, based on the rationale described below, a scoring or grading system to crudely assess the level of effectiveness of any prevention programme that exists in each of the countries included in this study. This work aims to provide a tool that may:

1. Support TIF in its work with governments, healthcare professionals' and patients' communities in advocating for the value of an effective national prevention programme and to;
2. Encourage, empower and assist competent national health authorities to engage in a process of self-evaluation in regards to their existing prevention policies, with a view to facilitate the identification of areas for improvement and the better planning of those public health services that will be tailored/ targeted to the country's national needs in the area of prevention.

**Grading is an extremely difficult, challenging, and sensitive task to achieve satisfactorily and will of course never be absolutely accurate as previously mentioned, particularly in the absence of so much significant information and up-to-date data.**

The main components recommended by TIF to comprise a national effective prevention programme (*see Table 2*) are those which have demonstrated to have contributed to the success of the prevention strategies established mainly by the governments of Cyprus, Greece, and Italy back in the early 1970s followed and adopted by a number of other countries through the years. These strategies are primarily related to a significant decrease of incidence of annual affected births (*as seen in Figures 1-4 & Table 1*).

In later years, in the mid-1980s, such programmes began to be adopted by other countries including the United Kingdom and France. These are countries which historically since the 1950s have hosted large numbers of immigrant workers from countries with high prevalence in haemoglobin disorders. Hence, these countries developed at national level either effective disease-specific policies of prevention and

management (v. United Kingdom) or policies in the context of national rare disease plans into which haemoglobin disorders were/are included (v. France).

Strong surveillance programmes were developed by these countries as an essential component of their national programme to closely monitoring the effectiveness of the programme and promoting necessary adjustments, amendments, or corrective measures. The work and experience deriving from successful and effective prevention programmes contributed to the development by TIF and others, of guidelines for the prevention of haemoglobin disorders<sup>2</sup>

Following these countries, several others across the world, including many with significant cultural and religious constraints, have made efforts to develop prevention strategies albeit with largely variable effectiveness.

*Components of a Thalassaemia Prevention Programme considered by TIF in developing its scoring include:*

Political commitment and a nationally coordinated, fully funded programme (policy or strategy) to cover the needs of the whole population is the pre-required component of any effective Thalassaemia Prevention Programme. In addition, any comprehensive prevention programme should encompass the following five (5) pillars:

1. Public awareness & education. Campaigns/programmes;
2. Laboratory Screening programmes (to identify carriers);
3. Prenatal diagnosis/Gynaecological services/molecular studies;
4. Surveillance system and;
5. Genetic counselling services.

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<sup>2</sup> 'Prevention of Thalassaemias and other Haemoglobin Disorders, Vol 1 & 2', 'Prevention and Diagnosis of Haemoglobinopathies: A Short Guide for Health Professionals and Laboratory Scientists' and Prevention of Inherited Diseases – The Example of  $\beta$ -Thalassaemia published by Thalassaemia International Federation). <https://thalassaemia.org/el/publications/tif-publications/>

**Some more explanation on each of the above pillars are provided in Table 2.**

TIF made an effort to ‘grade’ the effectiveness of any programme and/or policies existing in a country with reference to the prevention of thalassaemia.

*The grading methodology used is explained below:*

- The existence of a nationally supported and funded programme (policy or strategy) for the prevention of thalassaemia in a country scores five (5) units, as this alone, underscores the existence of a strong political commitment to address a medical condition that is considered a health priority;
- Next comes the existence of each of the 5 pillars/services, as mentioned above in *Table 2*, Each pillar/service is scored as follows:
  - (i) One (1) unit is allocated for the existence of the pillar/service to any extent;
  - (ii) Two (2) units are added if the pillar/service constitutes part of a national policy irrespective of its effectiveness and;
  - (iii) Two (2) units are further added for effectiveness of the pillar(s)/ service(s) as assessed from documentation (e.g. published literature).

No.	COMPONENT	EXPLANATION
1.	National Programme (Policy or Strategy)	This implies national commitment, budgetary support and quality control.
2.	Public awareness & education	Without an informed and willing participating public any strategy will meet obstacles. Well-coordinated public awareness and educational programmes to reach the society at large constitute an essential component of a national plan.
3.	Population screening	Identification of patients and carriers through quality assured nationally designated laboratories, sufficient in number and with appropriate geographic distribution to cover the needs of the whole population across the country.
4.	Gynaecological and Prenatal Diagnosis services	Competent, well-trained, and sufficient in number gynaecologists and laboratories in nationally assigned centres to cover the needs of those who wish to perform prenatal diagnosis (PND), irrespective of their decision on how to act on the results.
5.	Surveillance system	Policies, which lead to actions at a public health level, require a system of continuous monitoring and systematic evaluation, not only to know the results but also as guides to any necessary upgrades or modifications which the programme may need.
6.	Genetic counselling	To inform and offer choices to “at-risk” couples and carriers is vital to allow couples to make informed choices. In addition, the provision of reliable genetic information is essential to identify / diagnose patients in order to facilitate their decisions on the next steps in life. This service requires experienced, well-trained, and sufficient in number genetic counsellors.

**Note: Pre-implantation diagnosis where technology and cost are available, make it a possible choice. Based on in-vitro fertilisation (IVF), this technology allows the selection and implantation of healthy embryos, not affected by thalassaemia.**

**Table 2. Components of a comprehensive programme on prevention of a genetic disorder.**

In an ideal situation therefore, each pillar could score a maximum of five (5) units and a total maximum of 30 units if and when each pillar/service scores maximum (i.e. 5x6). A

**Effectiveness is defined by TIF in the context of this grading exercise as the competency of the pillar/service to cover the needs of  $\geq 70\%$  of the country's population in the context of a national policy.**

scoring of 30 would indicate a prevention programme that is effective in reducing equal to or more than 70% of the anticipated annual affected births within about 5 years of its implementation. Such information of course should be based on reliable nationwide published data, deriving from the surveillance system component of the programme; otherwise, the additional scoring of 2 units related to the effectiveness of the programme cannot be added to the score (*Table 3*).

OPEN			
No.	COMPONENT	INDICATOR	SCORE
1.	<b>NATIONAL PROGRAMME</b>	A national policy, programme, strategy exists with official status, publicly announced, government-controlled and fully funded	5
2.	<b>PUBLIC AWARENESS/EDUCATION</b>	Exists	1
		Exists within a National Programme	2
		Nationwide or covers at least 70% of the population	2
3.	<b>SCREENING</b>	Exists	1
		Exists within a National Programme	2
		Nationwide or covers at least 70% of the population	2
4.	<b>PRE-NATAL DIAGNOSIS SERVICES</b>	Exists	1
		Exists within a National Programme	2
		Accessible and available to cover $\geq 70\%$ of the needs of the population within the National Programme	2
5.	<b>SURVEILLANCE</b>	Exists	1
		Exists within a National Programme	2
		Nationwide or covers at least 65% of the population	2
6.	<b>GENETIC COUNSELLING</b>	Exists	1
		Exists within a National Programme	2
		Nationwide or covers at least 65% of the population	2
<b>According to the score of each pillar/service a total score is given to each country (as seen in Annex I)</b>			

**Table 3. TIF's Grading System for the Assessment of Thalassaemia Prevention Programmes**

Based on this scoring system four (4) broad categories (A-D) of effectiveness emerged as shown below *Table 4*:

SCORING CATEGORY	INTERPRETATION
A ≥ 20 UNITS	Describes countries which have established a programme that demonstrates a very good effectiveness reflected in ≥ 70% reduction in the annual affected births.
B 19 – 15 UNITS	Describes countries which demonstrate a programme of good effectiveness with considerable but not sufficient national coordination and support but, with a good potential to upgrade its programme to category 'A' with targeted improvements.
C 14 – 10 UNITS	Describes countries which demonstrate a programme with some disease-specific policies but with no national coordination and with weak to poor effectiveness.
D ≤ 9 UNITS	Describes countries which demonstrate serious weaknesses, gaps and challenges calling for many and multiple actions to be taken at the national level.

**Table 4. Scoring interpretation**

## RESULTS

Based on the information and data collected (as previously described) for each of this component/service in each of the 51 countries included in this study (*as shown in Annex I*), TIF's scoring system (*as shown in Table 3 & 4*) was applied and each country was given a grade between A to D (*as shown in Table 5 separated by Regions and in Annex I per country*).

The countries included in this study reflect 51% of the global population in 2019<sup>3</sup>. In addition, the number of thalassaemia patients in these countries, as reported in the literature and by TIF's estimations, constitute about 85% of the global patient community. Therefore, based on the results of the crude Grading System implemented by TIF for the purposes of this study, effective national prevention programmes are implemented in only 12% of the countries examined. The affected annual births in those countries represent only 3 – 4% of the global annual expected births, indicating that a great number of thalassaemia affected births are happening across the world and that effective prevention programmes are still widely lacking.<sup>12</sup>.

The scoring of prevention policies in each of the 51 countries is comprehensively shown in Annex I "justifying", based on TIF's scoring rationale and methodologies used, its grading.

<sup>3</sup> World Bank Data [https://data.worldbank.org/indicator/SP.POP.TOTL?name\\_desc=false](https://data.worldbank.org/indicator/SP.POP.TOTL?name_desc=false)

SCORING CATEGORY / REGION	A	B	C	D
EUROPE	Cyprus, Greece, Italy	Azerbaijan, France, Turkey, United Kingdom	None	Albania, Austria, Belgium, Bulgaria, Germany Romania, Sweden
EASTERN MEDITERRANEAN	Iran, Palestine	Jordan, Kuwait, Lebanon, Oman, UAE	Iraq, Pakistan, Qatar, Saudi Arabia, Tunisia	Afghanistan, Egypt, Morocco, Syria, Yemen
WEST PACIFIC	Singapore	Malaysia	Viet Nam	Cambodia, Lao
SOUTH EAST ASIA	None	Maldives, Sri Lanka, Thailand	India	Bangladesh, Indonesia, Myanmar, Nepal
AMERICAS	None	None	None	Argentina, Brazil, Canada, Trinidad & Tobago, USA
AFRICA	None	None	None	Algeria, Mauritius

**Table 5. Summary of the implementation of TIF's Grading System for Thalassaemia Prevention Programmes in 51 countries (as described in Annex I).**

## DISCUSSION

Disease prevalence, in most cases, has been the driving factor guiding political commitment to address the Prevention of this disorder rather than the national HDI or the level of the country's economy. This contrasts with the area of Management where HDI level has proven to be the decisive factor in the provision of appropriate health and other care.

Through the analysis performed on the existing situation with regards to Prevention in 51 countries members of TIF, across six WHO regions of the world, as shown above, one can evidence the immense heterogeneity; significant success for example has been achieved in areas with high thalassaemia prevalence but with important cultural and religious challenges (e.g. Iran). On the other hand, success has also been achieved in areas with high thalassaemia prevalence but long-term political instability and low HDI (e.g. Palestine). Also, smaller areas with very low prevalence but a robust healthcare infrastructure and a high HDI (v. Singapore) have achieved effective prevention and as such is singled-out in the entire region for its effectiveness.

These, together with the countries in the southern Mediterranean, including Italy, Cyprus and Greece, for which there is ample reference throughout this chapter, are included in



**SCORING CATEGORY A** characterising those countries that have demonstrated effectiveness in their prevention strategies.

The countries in **SCORING CATEGORY B** have also focused appropriate efforts and work on addressing the control of haemoglobin disorders and in their case too, high prevalence has been the key driver for achieving political commitment to develop disease-specific policies. Although published data to-date have not documented the level of effectiveness with regards to prevention (as defined as a decrease by  $\geq 70\%$  of annual affected births at a national level) many and significant steps have been taken through the years in these countries across each pillar (*as described in Table 2*) of the prevention programme. These include for example many public awareness initiatives, large screening studies and implementation of genetic counselling services to a smaller or greater extent. In most of these countries, the services related to the component of PND were not satisfactorily addressed and have not reached neither all those in need nor at least a significant proportion of couples “*at-risk*”. This has happened in some countries as a result of cultural and religious norms; but in many others this has occurred on account of medical and healthcare infrastructure challenges and poor economies in addition to other important health priorities (including communicable diseases) that needed to be addressed.

In some countries of this category, the small to medium geographic size of the country and/or population, good public health infrastructure, and/or strong scientific interest provide significant potential for their programmes to reach effectiveness in the near future, including Malaysia, Maldives, Sri Lanka. The huge steps taken in Thailand over the years, as well as the implementation of many disease related policies, unfortunately have not allowed the country to achieve the goal of nationwide effectiveness of prevention. This has been the result of not only of vast genetic and thus phenotypic heterogeneity of haemoglobin disorders in the country but also on account of the country's size and level of population's health literacy and education in passing out information and awareness in rural or remote parts of the country and the wide and variable distribution of haemoglobin disorders, especially in rural areas. Other countries in this category, mainly in the European Union and across the extended European region, including the United Kingdom, France, Turkey and Azerbaijan have exhibited reasonable effective programmes. The former two (i.e. United Kingdom and France) being countries with robust healthcare infrastructures and strong economies felt that it was essential and cost effective to address the prevention of haemoglobin disorders, which were of high prevalence among their immigrant populations; while for the latter

two, Turkey and Azerbaijan, high prevalence in their indigenous population was the driving element for political commitment for significant steps to be made in order to reduce the annual affected births whilst acknowledging the great benefit this would have on their patients' quality of care and the amelioration of the 'burden' on their public health infrastructures. In countries of Scoring Category B, and although to-date very limited published data is available, reductions of annual affected births have occurred but not quite to levels as those defined by TIF as effective.

**SCORING CATEGORY C** includes countries with a great focus on haemoglobin disorders as well as the existence of strong political interest to address the control of haemoglobin disorders. These have led to the promotion and development of many and multiple disease – specific policies and programmes. However, these countries (including India and Pakistan) on account of either large populations, and/or diverse ethnic backgrounds, and/or geographic challenges (e.g. size, terrain etc.), and/or other *competing* health priorities, and/or weak health and social care infrastructures, and/or weak economies have to-date shown poor results in the prevention component of the control of haemoglobin disorders. In other countries of this category (e.g. Saudi Arabia) cultural and/or religious beliefs to a large extent have perhaps hindered the implementation of a national programme and the achievement of a good level of effectiveness with regards to the prevention of haemoglobin disorders. On the other hand, Iraq – a country with a very long history of interest in haemoglobin disorders and long-term planning for an effective prevention programme, has been unable to adopt a national strategy thus far, due to political turmoil and instability, which has suffocated the country for more than two decades now.

Other countries, including Viet Nam, are still quite in the early stages of planning, however political commitment does exist for such a programme to proceed. Tunisia, included in this category, is a country with a long history of interest and quality work done in the area of both management and prevention of thalassaemia since the early 1990s. Unfortunately, the country has suffered political turmoil in the last 20 years which have not only allowed the strengthening of such strategies, but sadly resulted in their regression. Noteworthy, is the fact that all the countries in this category have made important progress in the clinical management of these disorders.

The countries included within **SCORING CATEGORY D** represent those which have not focused enough efforts and have not to-date prioritised the prevention of haemoglobin disorders at any level. In this Scoring Category many, if not all, countries have focused work only on the clinical management of the disorders; some of them with great, but

many with very limited, success. The countries in this category are of variable levels of HDI, different capacities of medical / public health infrastructures and different levels of thalassaemia prevalence. This category includes the USA, Canada, Austria, Belgium, Sweden and Germany which are all countries of low to medium prevalence mainly within their immigrant population groups, very high HDI and strong and robust medical and public health infrastructures. In two of these countries (v. Austria and Sweden) these disorders have only very recently been introduced and thus constitute very rare disorders. In contrast Bulgaria, Romania, Albania have low to medium thalassaemia prevalence in their indigenous populations but weak economies and healthcare infrastructures. Their focus has been confined to providing medical and public health services to the patients. Morocco with a medium prevalence and medium HDI has also focused more on clinical management and very confined work on prevention strategies. Nepal on the other hand, with medium to high thalassaemia prevalence but fragile economy and weak healthcare infrastructure, coupled with many geographic challenges has focused more, albeit with limited success, on clinical management and not addressed to any extent any of the essential components of prevention. Across the spectrum, Yemen with medium to high prevalence of the disease, very low HDI and almost a completely destroyed healthcare infrastructure consequent to the ongoing civil war, has lost every hope of strengthening and continuing the work it started some 25 years ago on the control of thalassaemia. Finally, Brazil, Argentina and Trinidad & Tobago are countries of the South American region with medium to high HDI and variable prevalence of haemoglobin disorders historically confined to immigrant groups. These, have since become integrated into the respective indigenous populations of each country, thus peaking the interest of governments in addressing as a priority the medical and social care of patients with these disorders and less on the disease(s) prevention strategies.

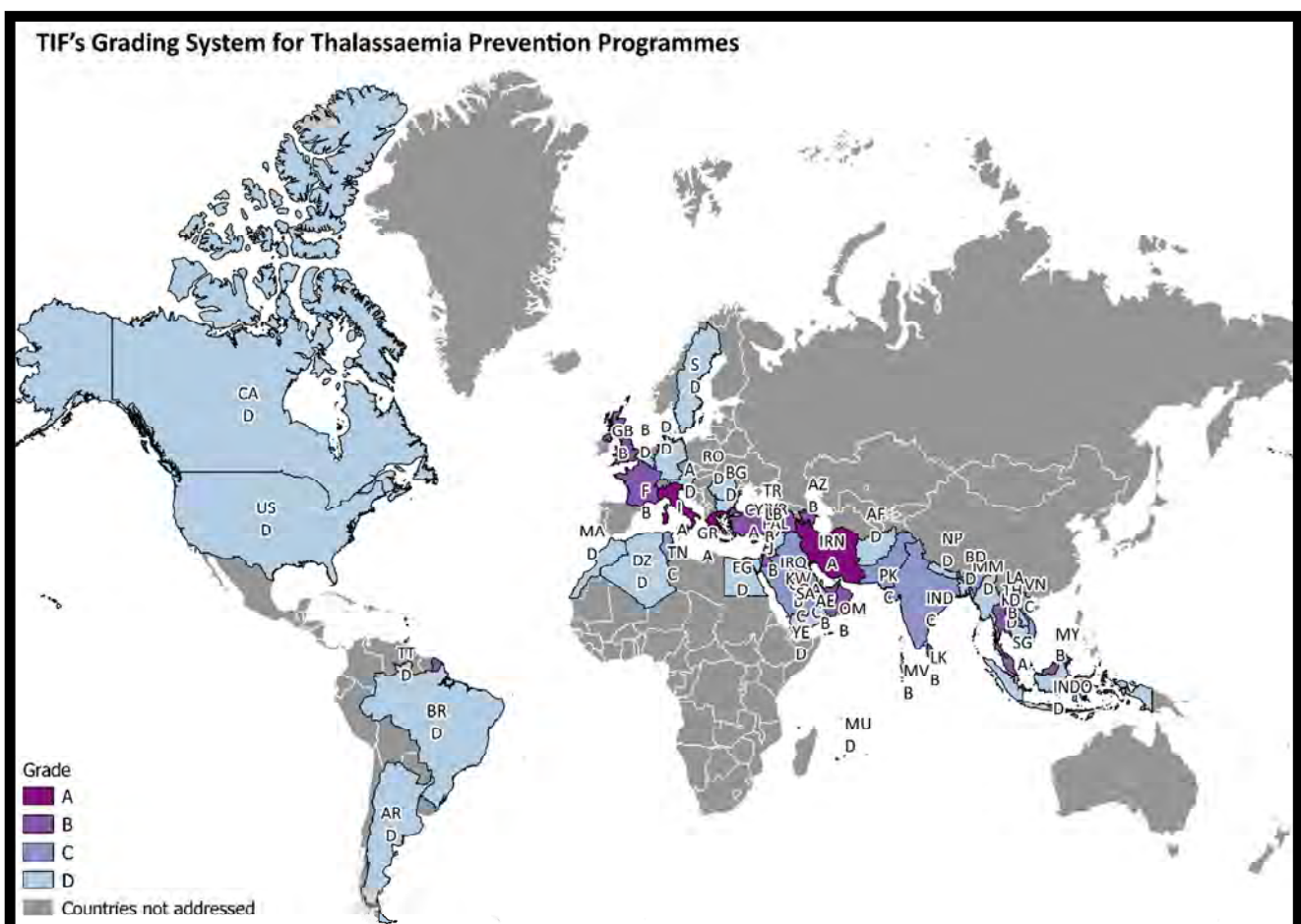
## CONCLUSION

In conclusion, and until other solutions can be offered by science and medicine to decision-makers that can be made readily, easily and without great cost and technological challenges available, preventing annual thalassaemia affected births remains the only effective tool to safeguard both the survival and quality of life of existing patients and the sustainability of medical and public health infrastructures and resources.

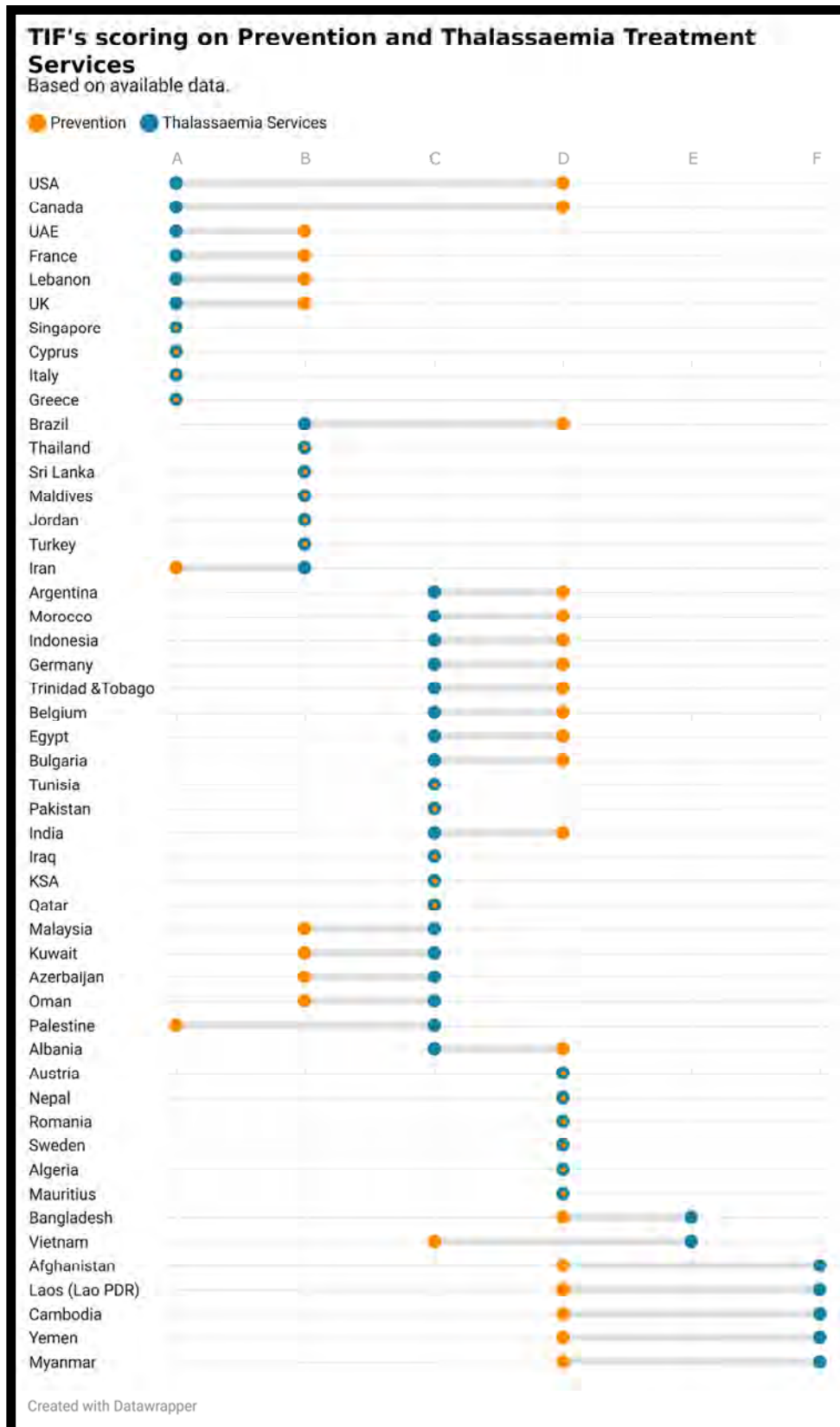
Notwithstanding the existence of a disease-specific WHO Executive Board decision, the ample knowledge and experience available on how to develop an effective prevention programme, the plethora of WHO programmes, resolutions and declarations (including those on non-communicable diseases, blood and patient safety etc), the United Nations Declaration of Human Rights aspiring for equal access to quality healthcare, and the prioritisation of universal health coverage as a Sustainable Development Goal 2030, the global situation calls for more structured actions on behalf of national health authorities. The close collaboration of expert health care professionals, the academia and the patient support groups who are equal and invaluable partners in this effort with the national competent authorities and under the guidance of WHO is urgently needed.

*The global situation at presently regarding the implementation of effective prevention policies for thalassaemia, as seen from this study (please see also map A and Table 6 at the end of this chapter), even grossly assessed, is unsubstantial and this despite the huge work done by the WHO and many national governments across the globe.*

**For TIF, effective prevention programmes remain a necessary tool that has proved beyond any doubt its substantial contribution to achieving better health and quality of life of patients with thalassaemia.** Advocating for the implementation of effective prevention strategies therefore remains a key focus of TIF's work and activities across the world. The Federation's close and productive collaboration primarily with the WHO, but also with other official regional and global health bodies, the medical, scientific/research/, academic communities across the world, the, industry and other relevant stakeholders is indeed regarded essential in achieving advances in this area.



**Map A**



**Table 6**

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**ANNEX I. AN ASSESSMENT OF THE THALASSAEMIA PREVENTION PROGRAMMES IN 51 COUNTRIES ACROSS THE WORLD BASED ON TIF'S GRADING SYSTEM**

COUNTRY + REFERENCE	EXPECTED B-THALASSAEMIA BIRTHS/ YEAR	NATIONAL POLICY	PUBLIC AWARENESS	SCREENING	PND	SURVEILLANCE	GENETIC COUNSELLING	TOTAL / 30	CATEGORY
GREECE <sup>13</sup>	1.64/1000	5	3	5	5	5	5	28	<b>A</b>
ITALY <sup>14</sup>	0.46/1000	5	3	5	5	5	5	28	<b>A</b>
BAHRAIN <sup>15</sup>	0.21/1000	5	5	5	3	5	5	28	
IRAN <sup>16</sup>	0.43/1000	5	5	5	3	5	5	28	<b>A</b>
CYPRUS <sup>17</sup>	5.55/1000	5	2	5	5	5	5	27	<b>A</b>
PALESTINE <sup>18</sup>	0.4/1000	5	3	5	5	3	1	22	<b>A</b>
SINGAPORE <sup>19, 20, 21</sup>	0.2/1000	5	2	5	3	5	5	20	<b>A</b>
OMAN <sup>22</sup>	0.286/1000	5	3	3	1	2	5	19	<b>B</b>
AZERBAIJAN <sup>23</sup>	0.344/1000	5	3	5	3	3	5	19	<b>B</b>
UNITED KINGDOM <sup>24, 25</sup>	0.0018/1000	5	1	1	5	5	2	19	<b>B</b>
LEBANON <sup>26</sup>	0.132/1000	5	2	2	2	3	5	19	<b>B</b>
TURKEY <sup>27</sup>	0.121/1000	5	1	3	3	5	1	18	<b>B</b>
JORDAN <sup>28</sup>	0.306/1000	5	3	3	3	3	1	18	<b>B</b>
MALDIVES <sup>29</sup>	8.97/1000	5	3	5	0	5	1	18	<b>B</b>
FRANCE <sup>30</sup>	0.0016/1000	5	1	2	2	5	3	18	<b>B</b>
UAE <sup>31, 32, 33</sup>	1.8/1000	5	2	5	1	1	3	17	<b>B</b>
SRI LANKA <sup>34</sup>	0.18/1000	5	3	3	3	3	1	17	<b>B</b>
THAILAND <sup>35</sup>	0.21/1000 [AN ADDITIONAL 3.57/1000 WITH HbE/B THALASSAEMIA]	5	3	3	3	3	1	17	<b>B</b>
KUWAIT <sup>36, 37, 38</sup>	0.132/1000	5	2	5	1	3	1	16	<b>B</b>
MALAYSIA <sup>39, 40, 41, 42, 43</sup>	0.58/1000	5	2	2	1	5	1	15	<b>B</b>
QATAR <sup>44</sup>	0.225/1000	5	1	5	1	1	1	14	<b>C</b>
VIET NAM <sup>45</sup>	0.37/1000	0	2	2	3	2	5	14	<b>C</b>
KSA <sup>46</sup>	0.25/1000	0	3	5	1	3	1	13	<b>C</b>
IRAQ <sup>47, 48, 49, 50</sup>	0.576/1000	0	2	5	1	3	1	12	<b>C</b>
INDIA <sup>51</sup>	0.58/1000	0	3	3	2	3	1	12	<b>C</b>

PAKISTAN <sup>52, 53, 54</sup>	1.0/1000	0	3	3	3	1	1	11	<b>C</b>
TUNISIA <sup>55</sup>	0.122/1000	0	2	1	2	3	2	10	<b>C</b>
ALBANIA <sup>56</sup>	0.625/1000	0	1	1	3	3	1	9	<b>D</b>
BULGARIA <sup>57</sup>	0.156/1000	0	2	2	2	2	1	9	<b>D</b>
EGYPT <sup>58</sup>	0.7/1000	0	3	1	1	3	1	9	<b>D</b>
BELGIUM <sup>59</sup>	0.002/1000	0	1	5	1	0	1	8	<b>D</b>
TRINIDAD & TOBAGO <sup>60</sup>	0.3/1000	0	2	2	0	3	1	8	<b>D</b>
BRUNEI D <sup>61</sup>	0.47/1000	0	1	3	0	3	1	8	
BANGLADESH <sup>62</sup>	1.67/1000	0	1	1	2	2	1	7	<b>D</b>
GERMANY	0.0017/1000	0	1	1	3	0	2	7	<b>D</b>
INDONESIA <sup>63</sup>	2.13/1000	0	1	3	1	1	1	7	<b>D</b>
ALGERIA <sup>64</sup>	0.1/1000	0	1	3	0	1	1	6	<b>D</b>
SWEDEN	0.0026/1000	0	1	1	1	1	1	5	<b>D</b>
CANADA <sup>65</sup>	0.006/1000	0	1	1	1	0	1	4	<b>D</b>
USA <sup>66</sup>	0.004/1000	0	1	0	1	0	1	3	<b>D</b>
MAURITIUS <sup>67</sup>	0.371/1000	0	2	1	0	0	0	3	<b>D</b>
MYANMAR <sup>68</sup>	0.66/1000	0	0	1	1	0	1	3	<b>D</b>
ROMANIA	0.025/1000	0	0	1	1	0	0	2	<b>D</b>
YEMEN <sup>69</sup>	0.484/1000	0	0	1	1	0	0	2	<b>D</b>
CAMBODIA <sup>70</sup>	3/1000	0	0	0	1	0	1	2	<b>D</b>
LAO <sup>71</sup>	5.7/1000	0	0	1	0	0	1	2	<b>D</b>
NEPAL <sup>72</sup>	1.28/1000	0	0	1	0	0	0	1	<b>D</b>
AUSTRIA	0.0014/1000	0	0	0	1	0	0	1	<b>D</b>
PAPUA NG <sup>73</sup>	0.65/1000	0	0	0	0	0	0	0	
SYRIA	0.625/1000							0	<b>D</b>
AFGHANISTAN	0.361/1000							0	<b>D</b>
MOROCCO	0.07/1000							0	<b>D</b>
BRAZIL	0.042/1000							0	<b>D</b>
ARGENTINA	0.046/1000							0	<b>D</b>





