

Renal services in Iraq

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In this issue of the Iraqi new medical journal, three papers about different aspects of renal services are published. Iraqi nephrology as a medical discipline started in 1970s when first dialysis machines has been installed in Baghdad Teaching Hospital for the first time. Shortly after that, in 1973 the first renal transplant surgery was performed at Al-Rasheed Military Teaching Hospital.¹ There was neither proper nephrology job description nor a nephrology training program at that time. The progress in Iraqi nephrology continued slowly and the provision of renal services largely maintained in the capital city of Baghdad and large governorates. In 1998, the Iraqi Board for Medical Specializations established three-year nephrology fellowship program which had led to the graduation of nephrology specialists whom started nephrology services in other governorates. In those years, haemodialysis was unable to keep pace with patients' number and thus acute intermittent peritoneal dialysis continued to be part of Iraqi dialysis practice. In 2004, nephrology candidates and the recent graduates started the practice of inserting dialysis catheters through conjoint training with the vascular surgeons. In the last fifteen years, there were a noticeable increment in the prevalence of chronic kidney disease/ end stage renal disease (CKD/ESRD) but without proper records. Haemodialysis continued to be the most common form of chronic renal replacement therapy.² With such increment, many issues surfaced like how to improve the services, how to combat such increase, and how to achieve adequate dialysis and quality of life at an acceptable cost.

In 2013, the National Haemodialysis Leasing program has been launched. In this program the provision of dialysis service was subcon-

tracted by the Ministry of Health to three international speciality companies with expertise in the management of the dialysis units and the production of devices and material used in that service. Certainly, infrastructures and dialysis logistics had been improved but still there are many gaps to be filled.

In this issue, Majeed et al (See page 91) applied field epidemiology to have situation analysis for Iraqi haemodialysis service through a survey done in 2012. The reported prevalence of Iraqi ESRD-HD patients in 2012 was 74/1000000 PMP (2445 patients) which is still underestimating the real prevalence taking in consideration the population of Iraq in 2012. By June 1, 2018 the total number of patients on haemodialysis (HD) in Iraq is about 5500 patient with a prevalence of 139.8 patients per a million and there are 5400 patients living with functioning kidney transplants. Here, it is worth mentioning that we are lacking records about the number of patients with CKD or non-dialysis dependent ESRD. With an estimation of Iraqi population of about 39 millions, the total prevalence of ESRD is expected to be more than that of nearby countries.³

Majeed et al has described the infrastructures of haemodialysis in Iraq in 2012. Still the ratios of units, and machines to the population and patients are less than standards. The adoption of the National haemodialysis leasing program has improved the number of the functioning units and their quality but this needs revision to meet the standards of renal care in such fluctuating economy and financial crisis. All efforts needed to keep the standard at an acceptable costs.

The nephrology workforce in Iraq is among

the lowest in the Middle East with a 1.03 nephrologist per a million of population according to the International Society of Nephrology report, 2018. This is consistent with the 2012 Majeed et al's report. Indeed, Iraq's health system and renal services does not only need nephrologists but also well trained and dedicated nephrology and dialysis nurses. This should be a target for policy makers as well as planning and human resources departments in the ministry of health. In addition, Iraq reported to have very low nephrology trainee densities of 0.32 trainee per a million of population in the Middle East.⁴ In order to start and implement new renal service programs, nephrology should be made a more appealing program to promote junior physicians, and nurses to increase nephrology efforts, reduce workload and certainly improve quality.

The surgical perspectives of Sabah N. Jaber (See page 84) about vascular access in haemodialysis casts the light about the increasing challenges for managing haemodialysis patients in Iraq. Late nephrology referral and delayed creation of dialysis fistulas made it difficult to mind the gap with the international standards. From nephrology perspectives, formal training program of interventional nephrology should be an integral part of nephrology curriculum and may represent a future super speciality. Increase of awareness among primary care physicians, nephrologists and vascular surgeons to have early referral for primary dialysis fistulas is of paramount importance.

This issue is also containing another important part of promoting nephrology services in Iraq that is the renal transplant registry. Elzein et al (See page 86) presented the history and the current status of the Iraqi renal transplant registry (IRTR). It's a good example of the partnership between the ministry of health, Iraqi society of nephrology and transplantation and big pharma. The future hope is to include all pa-

tients with ESRD whether treated by haemodialysis and renal transplantation in the registry. Such a comprehensive approach empower the renal care in Iraq through a better planning, proper implementation and with less costs.

It's important to note that Iraq didn't establish a chronic peritoneal dialysis program; a therapy which prove beneficial for at least patients who are not able to get haemodialysis therapy for one reason or another. Copying the haemodialysis leasing experience for chronic peritoneal dialysis may be a good start to have well established services which comprises patient's education and provide dialysis consumables and to have a centre of excellence as a starting point.

Acute kidney injury (AKI) is an overlooked issue in Iraqi renal services. It's a common problem of daily nephrology practice and it's potentially preventable. Primary health care units which are the sites of primary prevention of diseases, early detection, and proper interventions, are invaluable to prevent the need for dialysis therapy, prevent serious complications including death and to minimize the cost. It is prudent to say that dialysis therapy in an intensive care unit is a big and costly intervention for critically ill patients with AKI.

Many gaps in the Iraqi renal services are still existing. Their identification and proper planned management need a teamwork between the Ministry of Health, Nephrology units and the professional scientific societies to promote better attitudes and higher standards. Proper documentation is mandatory. Dialysis referral, delivery and management should be regulated through a nationwide accepted guidelines and protocols. Transplantation needs better governmental, society and religious supports. The aim is to have a well-led, responsive, effective, and safe renal services.

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