Challenges Facing Optimum Care of Diabetic Children in Iraq

Sir,

Type 1 diabetes mellitus (T1DM) is one of the important public health problems worldwide. In developed countries, the incidence rate of pediatric T1DM continues to rise by an average of approximately 3%–4% per annum, but the increase is not necessarily uniform, showing periods of less rapid and more rapid increase in incidence in some registers. Over the past several decades, a global rise in the prevalence of T1DM in the pediatric population has been noted. The alarming increase in the prevalence is predicted to occur due to multiple genetic and environmental risk factors. The economic burden for children with T1DM is substantial.

In Iraq, no recent data are yet present on the exact prevalence of pediatric T1DM. However, the available data on the pediatric TIDM estimates in 2010 pointed out to the 2.8/1000 prevalence. In Iraq, children with newly diagnosed T1DM are included into the database of health-care system. They are treated and followed up at the level of primary health-care centers (PHCs). Through the ration system employed in Iraq since 1990, they are provided with drug dispensing cards (DDCs) and monthly offered their required need of insulin therapy and injection equipment (e.g., needles and syringes, insulin pens).

Optimum care of diabetic children in Iraq currently faces challenges in the aspects of treatment and follow-up. After decades of war, sanctions, occupation, administrative corruption, and poor governance, the health-care system in Iraq is eroded and under-resourced. This along with organization mismanagement makes it fruitless. It is based on the PHCs and majority of diabetic patients are treated and followed up at this level, referring the complicated cases to secondary or tertiary hospital care or specialized diabetes centers (SDCs). Most of the time, the provision of insulin and injection equipment by DDCs is irregular, and it is not prescribed according to the patient’s need. Glucose strips for home testing are not provided free by
the PHCs. Regrettably, many patients have low incomes to buy them. Glycosylated hemoglobin measurement is not done in PHCs and patients have to be referred to the nearest tertiary hospital or SDCs for testing which is costly. This might delay the results, and ultimately affects the follow-up. It is obvious that diabetes needs a multidisciplinary team for better care of patients. The team should consist of a pediatric diabetologist, a diabetes educator, a dietitian, a social worker, and a psychiatrist. It should have an attachment within the health-care system and the community. This team does not exist in Iraq owing to the lack of human resources or unavailability of the services. Consequently, diabetic patients mostly see only the treating PHC physician for the treatment and follow-up. I presume that organized strategy tailored by health-care policymakers is needed to improve the current disorganized practice. The strategy should focus on improving financial resources, professional human resources, laboratory support, provision of treatment, and preventive measures as well as increasing the awareness of PHCs physicians, and public on diabetes.

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There are no conflicts of interest.

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