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CAPACITY-BUILDING AND ADVOCACY TO IMPROVE ACCESS TO QUALITY KIDNEY CARE IN DEVELOPING COUNTRIES

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There are 850 million people with kidney diseases globally, twice the number with diabetes, 20 times the number with cancer or with HIV. Almost 200 million people have catastrophic personal health expenditure due to kidney disease. Kidney disease is currently the 11th leading cause of death worldwide, and it is estimated that by 2040 if will be the 5th leading cause of death. Yet, despite these alarming figures, there is poor recognition of kidney disease as a major health problem, either globally (it is not considered to be one of the major NCDs by WHO) and in many countries.

Gross inequities in access to quality kidney care exist across the globe, and within individual countries. This occurs especially for endstage kidney disease (ESKD), and in particular in low (LIC) and low-middle income countries (LMIC). As a consequence, between 2.5 and 7 million people die annually due to lack of access to kidney replacement therapy (KRT) for ESKD, and another 1.7 million with acute kidney injury (AKI) for want of KRT. In Africa <10% of those requiring KRT receive it, and in Asia <20%. In low resource settings provision of kidney care and especially KRT needs to be prioritised against other fundamental health care needs, including sanitation, clean water, nutrition, infectious diseases & reproductive health.

To address this need, the International Society of Nephrology (ISN) directs the majority of its revenue and other resources to capacity-building programs, esp. in LIC and LMIC. These programs include fellowships, sister renal and transplant centre pairs, educational ambassador visits, clinical research support, CME and training in interventional nephrology. The 0by25 and Saving Young Lives programs of ISN are expanding access to care of patients with AKI, and through a new broad initiative ISN aims to increase global access to integrated ESKD care. As a developed country, South Korea has little need for external capacity-building support, however it is well-placed to help build capacity in emerging nations, by training and supporting kidney healthcare workers and their kidney units.

ISN's Global Kidney Health Atlas collects data from the majority of countries, and can be used as a scorecard to track progress in kidney care needs and provision. The latest survey was published this year and includes data on the availability, accessibility and affordability of high quality care for patients with kidney failure, from 160 countries, representing 98% of the world's population. It reveals substantial disparities in key components of high quality kidney care, including public and private healthcare financing, workforce numbers, surveillance systems, policies to prevent development and progression of CKD, and promotion of integrated ESKD care. Key recommendations have been made to close the gaps in care of patients with kidney disease.

Improving global access to quality kidney care requires a multi-pronged approach. Local and global advocacy must engage key governmental & non-governmental stakeholders, and national governments should be held to account. ISN is involved in local and global (via WHO and the UN) advocacy to improve kidney care worldwide. ISN has hosted 2 Global Kidney Policy Forums, the first in Latin America in 2017, and the second in OSEA in April 2019. These meetings bring an international perspective on key health issues related to the prevention and management of kidney diseases, as they impact particular countries or regions. They bring together, high-level decision-makers and stakeholders, including health ministry officials, WHO representatives, key opinion

leaders, and representatives of the wider health community such as nurses, patients and other international health NGOs. As the only kidney organisation in official relations with WHO, ISN is in an ideal position to influence global policy, and is making steady progress as evidenced by the recent naming of kidney disease as a major contributor to the 4 major non-communicable diseases.
Early detection and prevention of kidney disease must be prioritized to reduce the burden of ESKD and AKI. Rationing of access to KRT is politically and ethically unacceptable, yet universal access to KRT, as currently practised, is unaffordable in many countries. Transplantation must be encouraged as current rates (<100,000 pa) cater for a tiny portion of the global ESKD need. Conservative care needs to be applied as a positive alternative to KRT, especially in the elderly and those with substantial comorbidity. Peritoneal dialysis (PD) is a cheaper option used effectively in many countries, yet it is underutilized in others. Simple technical solutions could allow local production of dialysate for haemodialysis (HD) and PD, and affordable machines for HD in remote settings.

As a result of these and other efforts, kidney care has been improved substantially in a number of countries and regions. However, many countries still have poor access to quality kidney care. Methodical, persistent and resolute action could within a couple of decades bring universal global access to quality kidney care.