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# Safeguarding dialysis services during the COVID-19 pandemic

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Interruptions to dialysis services in resource-limited settings, like India, amidst the COVID-19 pandemic has highlighted our ill-preparedness. We need alternative plans to safeguard the provision of this life-sustaining treatment and protect our vulnerable patients.

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> Back-up systems are urgently needed to ensure the uninterrupted provision of life-sustaining treatments

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The second wave of COVID-19 that is currently surging in India evokes memories of the nightmare that was 2020. The first wave subsided inexplicably, leaving behind a false sense of security. Unfortunately, the second wave seems to be fiercer than the first. Working as a nephrologist in a tertiary care public hospital in Mumbai has been an eye-opening experience.

In India, a nationwide lockdown and re-allocation of limited medical resources were initially adopted as the two main strategies to tackle the increasing number of patients with COVID-19. However, we were not prepared for the effects of lockdown. Transport services collapsed, which not only prevented patients from reaching dialysis centres but also caused shortages of dialysis consumables, medicines and personal protective equipment (PPE). The loss of income also forced many migrant workers to return to their hometowns, which often lacked dialysis facilities. The need to mobilize staff to COVID-19 care units also reduced the availability of trained dialysis staff, and many feared contracting the illness, especially when access to PPE was inadequate. The initial confusion surrounding testing guidelines also led many centres to refuse dialysis unless patients had a negative COVID-19 test but these tests could not be easily obtained. Moreover, the cost of testing and additional PPE was borne by patients, furthering inequities in access to care. The shortages in consumables and staff forced some dialysis centres to shut down, further burdening the health-care system, especially public hospitals. Patients were left without support and struggled to find appointments in COVID-19-dialysis facilities, which led to many missed dialysis sessions. Increasing the use of peritoneal dialysis might have extended dialysis services but was limited by the high costs involved. A halt on elective surgeries, including the creation of arteriovenous fistulae and kidney transplantation, further jeopardized the care of patients with kidney failure.

A strong social stigma associated with COVID-19 also made patients reluctant to seek medical help and many presented late in the course of infection, which worsened outcomes. Infrastructure shortfalls, including the lack of ventilators and dialysis facilities led to nearly 30% mortality among patients with kidney failure in 2020. Alarmingly, the incidence of life-threatening and fatal violence against doctors by patient relatives in the face of poor patient outcomes increased dramatically during the pandemic. In one instance, my team of four health-care workers and I had to face down a menacing crowd of more than 50 people. Dealing with numerous unclaimed deceased individuals and abandoned critically ill patients, combined with unhealthy work hours and hostile work conditions compounded our physical and emotional exhaustion.

Over time, we managed to adopt reliable isolation, PPE and sanitization procedures, and standardized dialysis protocols. The city of Mumbai created the COVID dialysis website (https://covidialysis.in/) to coordinate dialysis care for patients who test positive or are suspected to be infected with SARS-CoV-2. This resource reduced the number of skipped dialysis sessions considerably. Regrettably, patients with kidney diseases are still not on the priority vaccination list in India, despite their increased risk of infection and adverse outcomes.

The pandemic did not break the kidney health-care system — rather, it exposed a system that was already broken and highlighted how patients with chronic kidney disease are too often forgotten when health-care resources are distributed, especially marginalized individuals living in poverty. Back-up systems are urgently needed to ensure the uninterrupted provision of life-sustaining treatments, such as dialysis, in the context of disasters. We need policies that deal with the inequitable access to vaccines. Addressing fatigue among health-care workers, protecting their physical and emotional wellbeing is also indispensable. As the pandemic continues to rage, we need to push for policies that are inclusive and equitable for patients and health-care staff to help us navigate these difficult times.

**Competing interests**
The author declares no competing interests.