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PROCEEDINGS ABSTRACT

Evaluating the barriers to glycaemic control in Iraqi patients with type 2 diabetes: the impact of lifestyle, medication adherence, and clinical inertia

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Achieving optimal glycaemic control is the cornerstone of effective type 2 diabetes mellitus (T2DM) management, as it is strictly required so as to prevent devastating micro- and macrovascular complications. Despite the availability of diverse therapeutic options, a substantial proportion of patients consistently fails to meet their clinical targets, thereby highlighting a significant gap in care. This cross-sectional study has aimed at determining the prevalence of uncontrolled T2DM among Iraqi patients and at systematically investigating the multi-level determinants contributing to treatment failure, by specifically focusing on lifestyle behaviours, prescribed drug regimens, and distinct barriers to medication adherence. The study took place between November 2025 and February 2026 across specialised diabetes management clinics, endocrinology consultation units, and primary healthcare centers located in the city of Hillah of the Babylon Governorate, in Iraq. Data were rigorously gathered through the use of a structured electronic questionnaire, supplemented by face-to-face interviews conducted during routine clinical visits in order to ensure data accuracy. Our study enrolled 158 adult patients, with an age range spanning from 20 to 60 years, comprising a demographic distribution of 51.9% women and 48.1% men. Strict inclusion criteria mandated that all participants possessed a confirmed, physician-documented T2DM diagnosis for a minimum duration of at least one year. The questionnaire of the study captured demographic data, anthropometric measurements, specific dietary habits, daily physical activity levels, as well as detailed medication-receiving histories. Based on the self-reported glycated haemoglobin (HbA1c) levels, participants were carefully stratified into two comparative cohorts: a "controlled T2DM" group (in which HbA1c levels were <7%) and an "uncontrolled T2DM" group (in which HbA1c levels were ≥7%). All collected data were subjected to rigorous statistical analysis utilizing the Chi-square test in order to determine statistical significance and to assess potential sex-based differences across all of the measured variables. Our analysis has revealed an alarmingly high prevalence of uncontrolled T2DM, negatively affecting 55.7% (N=88) of the total study population. Importantly, statistical evaluation confirmed no statistically significant variance regarding sex differences between the male and female cohorts in relation to their overall glycaemic control status. A detailed analysis of this uncontrolled patient cohort highlighted severe lifestyle-associated deficiencies; more specifically, 89.8% of these patients reported complete physical inactivity, 77.3% demonstrated persistent non-adherence to a low-carbohydrate dietary plan, while 54.5% were clinically classified as "obese". Moreover, the gathered clinical data exposed a substantial degree of clinical inertia that

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was firmly embedded within the local healthcare delivery framework. Despite failing to meet therapeutic glycaemic targets, 44.3% of the uncontrolled T2DM patients were inexplicably maintained on a single-agent (monotherapy) plan, and 44% remained on their currently prescribed drug regimen for over 18 consecutive months without receiving any necessary treatment intensification or dosage optimization. Notably, despite this observed clinical inertia, 64.7% of the uncontrolled T2DM patients expressed willingness to immediately initiate insulin therapy if explicitly recommended by their attending physician. Therapeutic non-compliance was conclusively identified in 35.3% of the poorly controlled T2DM group, driven primarily by unintentional factors like forgetfulness (41.9%), alongside an inability to tolerate bothersome medication side effects (25.8%). In conclusion, our study suggests that suboptimal glycaemic control is highly prevalent among Iraqi patients with T2DM, driven by a complex interplay of physical inactivity, obesity, widespread clinical inertia, and medication non-adherence, which necessitates immediate, collaborative multidisciplinary interventions involving physicians, clinical pharmacists, and dietitians in order to optimize treatment intensification and patient education.

Keywords

clinical inertia; HbA1c; Iraq; type 2 diabetes mellitus; uncontrolled diabetes

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Conflicts of interest statement

None to declare.

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