

Editorial Commentary

Diabetes care at school: The right of all children with diabetes

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In India, there is significant heterogeneity in our population in terms of socioeconomic and educational status as well as access (geographic and financial) to facilities for the management of type 1 diabetes (T1D). There is a similar heterogeneity in the school infrastructure. In government and the private sectors we have a few very well-managed, well-financed schools with all self-care medical facilities for common illnesses; and many schools lack several basic amenities. Still, the core principles of providing an enabling environment and taking adequate care of each child/adolescent with diabetes during school hours should be followed by all schools.

The facilities needed by the child with T1D vary according to age. The most vulnerable are children in playgroups and kindergarten, where the teacher should be well-versed in identifying and managing hypoglycemia. For primary classes, a school nurse should be available to check blood glucose routinely and administer insulin either following a chart provided to them by the treating doctor or in consultation with the parents. The once-a-day checking of blood glucose by the teacher or the nurse at the school will instill confidence among the parents as well. Again, the teachers should be able to recognize symptoms suggestive of hypoglycemia. More importantly, the children should be empowered to speak to the teachers or friends if they feel hypoglycemic or unwell due to any illness. This will happen only when the young kids feel that they will be taken care of with empathy and not be made to feel guilty of disrupting the class or be stigmatized. They should not feel shy if they need to have a snack or visit the washroom. Young children with diabetes may be allowed to carry a phone so that parents and the child feel reassured that they can connect in case of need.

For older children, the primary onus of T1D care can be on the children themselves if they have had diabetes for some time. However, the enabling environment in terms of infrastructure as well as support from peers, teachers, and school management is essential. Another vital issue for adolescents would be to acknowledge and respect their discretion. For example, an adolescent girl once shared with us that she was part of her school team as the lead percussionist for an interschool music competition. After the performance, she was being complimented for her skills among a group of students of different schools; when her teacher said that she plays so well despite being a “diabetic.” She felt that suddenly everyone’s perspective changed from admiration and envy to sympathy for her. “Diabetic” became the defining feature of her identity. Hence, this aspect of being sensitive about not identifying a student by her having diabetes, not mentioning the condition where it is not required, is also to be kept in mind.

In this issue, Virmani *et al.* have highlighted some of the deficiencies in diabetes care that children in urban schools face.^[1] Less than half of the children took insulin before the school

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meal, which we all know constitutes a substantive meal for most children, given the long school hours and a rushed and inadequate breakfast at home. Less than a quarter of the children had their blood sugar checked at least once a week during school hours. The majority of those taking insulin or checking the blood sugar at school were older kids, with self-care.^[1] In younger kids, the parents had to come to the school for these diabetes care activities, further highlighting the lack of adequate infrastructure in most schools. The study population included the children taking treatment at more prominent pediatric endocrinology centers and coming for regular follow-up, thus representing those with a relatively better access to diabetes care. However, such children would probably constitute no more than the upper 25% crust of the total population of children and adolescents with diabetes in our country. The status of the remainder of the children can only be conjectured at this moment. The status of T1D care at schools needs a comprehensive survey which may be conducted as an activity of the Indian Society for Pediatric and Adolescent Endocrinology (ISPAE) with the participation of its members from all parts of the country. In my experience, up to 70% of parents (and/or patients) insist on a regime that does not entail taking injections at school.

It is only in older adolescents who are well-versed in self-injection and use a pen device that there is some acceptance to taking insulin at school.

There is a role for societies such as ISPAE to undertake training activities for teachers to improve awareness regarding T1D management at school. We also need to sensitize the teachers regarding other issues in children with T1D, such as being made to feel different or exclusion from sports, excursions, and co-curricular activities. With inputs from children and young people with diabetes, simple modules can be prepared and shared widely. The ISPAE can undertake “training of trainers” activities to encourage further percolation of these messages at all levels.

REFERENCE

1. Virmani A, Boddu SK, Sarda A, Shukla R, Puri S, Chhabra M, *et al.* Type 1 diabetes self-care in urban schools in India. *J Pediatr Endocrinol Diabetes* 2021;1:8-13.

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