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School Children and Healthcare in Porvorim, Goa, India

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Editorial

The nearby government's Primary Health Centre (PHC) is doing a good job of periodically checking the medical status of students in the three school units where I work: two primary schools and one high school. We have about seven hundred children attending, ages ranging from four to fourteen years. Many students are first-generation school-goers. The parents are often daily-wage laborers, migrants from neighboring states like Karnataka and Maharashtra. Of the three school units, in two, no fees are charged as they are aided by the state government. Many parents have come from faraway Bihar, Uttarakhand, Jharkhand and even the remote north-eastern regions like Assam, Meghalaya and Manipur, in search of work. All these migrants are from rural areas. The Indian sub-continent is large and geographically varies drastically from district to district. The school population comprises Dravidian, Aryan, Mongolian and mixed 'races', too. Besides, they belong to various 'castes' (a social hierarchy common and rigid in India), communities and religions. This context is important as it means their levels of hygiene; food habits and personal discipline are not restricted to poverty alone. Culture plays a huge role in healthcare in India. Superstitions have to be overcome, habits changed, mindsets channelized. Unlike many villages in India, Goan villages are more accessible and better organized/connected. I like to call them 'rural urbania' for they are never more than a couple of kilometers from a town have internet connectivity, and although the electricity supply is erratic, it exists. Education and healthcare, both closely related, are considered important in Goa, again uncommon in other parts of India. The government-aided school that I work in, and its neighbourhood, is an example of what happens in a Goan village, in healthcare.

Once a year, the PHC sends us de-worming tablets. Parents' consent is taken and on the National Deworming Day, February 10, all students who are present, and the teachers, are made to consume the tablets. Those absent are given the same on 'mop-up' day which is about a week later. The record of the tablets and consumers is submitted to the PHC. The problem with this method is that there is no post-event stool-check to know the efficacy of the medicine. Nevertheless, even assuming it works at thirty per cent., it's worth the effort as it is a country-wide exercise. We teach the children to wash their hands after they use the toilet and before they touch food.

Indian children, especially those coming from rural-poor homes, have been found to be anemic. Which is why the government is now supplying free of cost iron and folic-acid tablets (syrup for pre-primary age group 3-5) to be given to students. Formerly, this was restricted to the government-run and government-aided schools, but from this year, even the unaided schools under the Goa Board have also been covered. One tablet per month has to be taken, a total of three tablets to be taken over three months. Good idea. According to me, like the de-worming tablets, these should also be given to the students in class, in school so we can monitor their consumption. The government order came late and the PHC had to distribute the tablets at a time when school was about to have exams and then close for the summer vacation. We have no way of monitoring whether the parents would conscientiously give their wards the medicines at all. So we had to convince the children that it was their responsibility and we made them mark the dates on which they would have to take the medicine and remind their friends to do the same. Such schemes, if properly run, can have an impact on public healthcare in the long run.

Students get prophylactic treatment against tetanus, measles, polio, diphtheria, etc., under another government scheme, mostly through school. What happens in cases where a child does not attend school for any reason, I don't know, but herd immunity would help anyway. Separate records are maintained by the parents and the school.

The PHC does not cover dental health. Our children suffer from ailments arising from poor oral hygiene and we invited a local dentist to take a look at our student's teeth and gums. His time was sponsored by the local Rotary Club. (In the coming semesters, I will tap the Corporate Social Responsibility (CSR) funds of wealthy industries and banks and call it an exercise to 'invest in future customers/staff'.)

The teachers have to swallow a de-worming tablet themselves in front of the class, as a demonstration. Then, they actually put the tablets into the mouth of each child. Their hands are clean and dry. I mention this because this year, along with the tablets, one pair of rubber-gloves was provided by the PHC. I didn't understand the need. If every teacher was to use gloves, to protect her/himself against infections from the children, or allergy arising from touching the tablets, they should have provided one pair per class-teacher. Were the gloves for preventing transfer of infection from child to child? If so, we needed a glove per child. We kept the single pair of glove in the cupboard, ensured that the teachers had thoroughly washed and dried their hands and kept handy many clean paper napkins when the children were being given the tablets.

No scheme will work in India unless potable, pathogen-free water is freely available to all. We are still dependent on water of questionable quality bought in recycled-plastic bottles.

Water-borne diseases in India are rampant.

"Towns and cities with an abundance of water struggle to manage the water efficiently, often leading to water collecting in potholes and or in the surrounding areas and going unused. This can have severe consequences as water-borne diseases, such as cholera, malaria and diarrhoea can spread as a result of improper management of the water supply as well as discharge. … Water contamination often occurs due

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to inadequate and incompetent management of resources as well as inflow of sewage into the source" .

In spite of getting very heavy rains through the monsoons, Goa has a problem of water scarcity. Some areas of the state have suffer because of misuse of ground water (for swimming-pools, for example) which means there is insufficient water for the fields and treated water for drinking is also scarce. Quite often, the water treated by the Public Works Department is unfit for drinking because of poor quality of pipes and leakages/leaching from sewage, sewage pipes, or other polluting areas.

Water-borne diseases like gastroenteritis and diarrhoea erupt every year during the summer and rainy seasons. School teachers play an important role here. More than posters and pamphlets (such a waste of paper), it is the teachers who can impress upon the children the importance of filtering/boiling water to keep healthy. It is the teacher who can tell stories about malaria and dengue and how to avoid them. If a child in a particular class has had a bout of typhoid, his/her story is what can educate his/her mates more than any text they are given to read. Healthcare awareness can be spread in many ways. Also, children make an impact on the adults at home.

Leptospirosis, filariasis and other parasitic diseases, which are rampant in people who live near unsanitary or stagnant water bodies or sewages, are another problem our students' families face. On one hand, we teach our children that water is a life-giving liquid. On the other hand, we know that 'bad' water kills. Water-borne diseases caused by bacteria, viruses, protozoa and intestinal parasites invariably have diarrhea as a symptom. Washing hands after defecation, preparing/handling food with unwashed hands and other matters of personal hygiene are important. A large population defecates in the open, and the micro-organisms from the fecal matter contaminates well-water. Systems for disposal of human waste matter are still poor.

All the de-worming tablets consumed will not help if access to safe potable water is not easy. We're still waiting for a Free From Amoebiasis/Bacillary Dysentery Day. Or a National Paratyphoid Day. Or a Hepatitis Day. Or a more pompous sounding Dracunculus medinensis Day. None of these celebratory days will work unless we get clean, pathogen free water. We aren't touching dangerous chemicals in water here.

The burden of waterborne diseases is underestimated and probably something to be feared more than the Corona virus.

Another vital area covered by a government scheme is malnutrition, through its mid-day meal scheme. This is for students (from ages five till twelve) in government and government-aided schools. Our schools get the meals from a self-help women's group. Some of the children actually come to school only because they get something to eat. The daily meal is monotonous. It comprises two pulses and two vegetables cooked in a coconut or onion-based gravy, accompanied by bread (some schools opt for rotis or rice). Mid-day meals are not compulsory, so many children carry packed lunch from home. All in all, this scheme, if well executed, will do more for healthcare and education (a child with nutritional deficiencies is unlikely to do well in school) than most others. Sadly, in some districts in India, this 'meal' consists of thin gruel or undercooked bread (rotis) and salt. Cases of food-poisoning leading to death are also not unknown. The best monitors of such programs are the parents of the students, who can make random visits to the kitchens where such meals are prepared.

To conclude: posters and jingles may work up to a point, but for a State to get results in healthcare, on the ground execution has to be meticulous and sustained. When it comes to pediatric health and schools are to be involved, teachers have to be trained. Merely attending workshops is not enough.