UWE HEALTH AND SOCIAL CARE Nursing Elective: India Report for the Gane Trust 2010

PSG charitable trust is committed to social improvement and empowerment through education in India (PSG). They provide a teaching hospital and a private nursing college, affiliated to DR M.G.R University. Having spent four weeks on a student-nursing elective programme with PSG, this report will detail some of the experiences and comparisons and contrasts of, as well as the socio-economic context for healthcare delivery in India. It will pay specific attention to the training, government and private initiatives as well as complementary therapies and the belief systems, inherent in traditional forms of healthcare. Community healthcare delivery and acute care will also be considered.

Nursing Education: Private & Public

Undergraduate studying for a bachelor of science students study for four years to qualify with both registered nurse and registered midwifery status. These students complete 3760 hours in clinical practice. In comparison, UK students must work 3200 hours to qualify for registration (NMC, 2004). Students come straight from school, having majored in chemistry, biology and physics. Mature entry and flexibility in learning routes are not options. Self-directed learning is not emphasised due to the intense nature of the programme. Diploma nursing is considered lower status within the nursing hierarchy, as the course is shorter and more practically based. Diploma graduates are not able to administer medication, comparable to health care assistants in the UK. There are six master's level programmes offered. Nurse lecturers need no clinical experience to teach, but need to have studied at postgraduate level, which has the potential to lead to a theory/practice gap (Chapman and Clegg, 2007). Due to the image of nursing and stigma in society there are few male students or lecturers.

The Indian Nursing Council (INC) regulates the nursing register and course syllabus. Each state has a nursing council, which the nurse must register with in order to work within that state at a small fee. All state councils are affiliated to the INC, in a similar

to the UK NMC (2010). Nurses become members of the Trained Nurse Association India on qualifying, which is a professional body. The Student Nurses Association (SNA) is a subdivision of this body. This is similar to the UK's national union of students (NUS, 2010) although very nursing specific, similar in aspects to the work of RCN Students (2010). Nursing students tend to socialise together and there is a strong sense of community between each academic cohort. An inter-nursing college events programme is run under the SNA to develop networking, raise social consciousness and to fund raise for charity. There is a high sense of pride and moral prestige amongst students and their involvement with the SNA. They had several events during the elective, including the SNA graduation ceremony, farewell and cultural events. It was fascinating to see the magnitude, humour and confidence with which these events were delivered.

Due to the demand for nurses, private institutions are quickly being established across the country. The are not necessarily affiliated to a University, nor do many have access to clinical skills training environments. They are thought to be diluting the quality of graduate nursing and this is an issue under consideration by the INC audit (Nirmala, 2010).

Government universities offer more opportunity than private ones. The fees are less due to the scholarship provisions. Only students with the best grades are selected. The facilities are reported to be poor, due to lack of funding but there are a wider variety of cases available for students to observe.

People attending PSG hospital tend to have private health insurance but the PSG charity works on a number of outreach programmes enabling subsidised payment for many below the poverty line. The government have also introduced a scheme in Tamil Nadu where people are given money to have surgery in the private sector due to long government hospital waiting lists.

Belief & Complementary Healthcare

The World Health Organisation (WHO, 2010) defines health as a holistic approach to wellbeing, not just as the absence of disease. In India, amongst there is a connection between spiritual belief, use of natural medicines and wellbeing. Religion and belief systems are an important and heavily practiced aspect of the culture. The Catholic Church has a large investment in healthcare provisions (CBCI, 2010).

There are six traditional Indian systems of medicine practiced in Tamil Nadu; ayurveda, siddha; a hindu, state specific version of ayurveda, homeopathy, unani; an urdu version of homeopathy, naturopathy and yoga. Historically, the longevity of the India people has been said to reach 100-120 years (Hari, 2010), but today the life expectancy is 64 years (WHO, 2009). Cultural development, weight gain and stress are contributing factors.

Theirs is an evolving perception that medication is the best route to recovery, which has created some social stigma towards complementary practices. Allopathic medication provides a quick but perhaps temporary fix (Hari, 2010). Complementary systems require cooperation and active participation. There is growth in this consumer market as knowledge is packaged at a premium, to re-educate people with traditional skills in self-healing, lost through Westernization. Dr Hari (2010) from Roots Ganapathy, a private natural cure centre, suggests equilibrium can be a vicious cycle, as people spend more time at work they spend their earnings on their health. Investment of time is low on health so, people who run behind money pay for this stress through poorer health.

PSG is one of few hospitals in India to offer in-house complementary therapy. Used as a preventative treatment to help the body heal naturally. The practitioners concentrate on chronic diseases and weight management, which can sit independently or alongside allopathic medicine. Health insurers consider this therapy a luxury; so do not cover the costs. Similar services are offered at Roots Ganapathy. Treatment is based on teamwork and faith; 25% doctor, 25% nurse/therapist, 25% patient and 25% god (ibid).

Both naturopathy and ayurveda are considered a way of life, Arya means life and veda means knowledge (Arya Veda, 2010). They are based on plants and their effect on the five elements of, space, air, fire, water and earth, which need to be in balance with the spiritual forces of the body and structural elements of the body for optimal health (Hari, 2010). There are seven essential structures; food which affects the plasma and enables life energy, blood in the vital organs, flesh and muscles for movement, fat for lubrication, bones for structure and support as well as bone marrow and nerves, and reproduction (ibid).

Treatment available includes diet and lifestyle guidance, massage and reflexology to increase blood flow, relieve tension and improve strength and yoga to aid weight loss, flexibility and to maintain health. Hydrotherapy is offered, using water at different temperatures and mud therapy is also used to increase circulation and relieve joint pain.

The objective of attaining good health is to achieve harmony, through awareness of the stages of existence, physical, vital energy, mind, intellect and bliss. The five senses are considered the houses of god in naturopathy, which need to be controlled with the intellect, in order to reach a higher state of being (ibid, Prasad, 2010). It is thought the senses affect perception, so must be kept clean through treatment (Prasad, 2010). To achieve this, concentration needs to be paid to breathing. It is thought a lower respiration rate enables a person to predict the future and maximise their life expectancy as more oxygen reaches the vital organs at a slower speed (ibid).

The Arya Vaidya Chikitsalayam, is a private, complementary hospital, which focuses on chronic disease ranging from orthopaedics, respiratory disorders, vascular, neuro-muscular, auto-immune and progressive conditions which require regular oil and preparation, both internal and external. They also focuses on preventative health through seasonal routine, consumption, sleep patterns, daily activity, and spirituality.

The gaps between the three seasons of winter, summer and monsoon are considered major disease cultivating phases (ibid). It is further believed that what and how we eat cause disease (ibid). Treatment plans are based on; rejuvenation and elimination, purification and purgation, to induce vomit, clearing nasal cavities and improving blood clotting. As the treatments are herb based, contraindications are considered minimal (ibid).

The body uses vital energy for digestion. Dr Hari (2010) advised that fasting and rest enables the release of toxins. Fever is considered a healing crisis; fasting demands rest and reduces fever, thereby helping the body's natural healing process (ibid). When food is consumed, raw food is considered to provide more energy to the cells. A pure vegetarian diet is recommended. Every life form is thought to have a purpose, so if dead flesh is consumed, the animal's purpose will affect the energy of the perpetrator (ibid). Unhealthy diets can affect weight and blood proteins such as cholesterol, creatin and urea (ibid). Dr Hari (2010) also discussed auto-urine therapy, whereby the patient drinks their own urine; of which it is thought 37 enzymes can break down cell damage, used to treat cancer.

Ayurvedic and Siddha treatment is offered free of cost in many of the rural health centres. The government recognises its value for many people. The treatment is not seen as a cheaper alternative to allopathic medicine, as the various plants are costly to grown and prepare (Siddha Doctor, 2010). It can be used to treat a range of chronic conditions, with current research being undertaken at the Siddha Central Research Institute (2010), Madras.

The Arts Research Institute is a charitable organisation dedicated to rediscovering the art and science of varmam. Hidden on palm leaf manuscripts during the English occupation, when European systems of medicine were imposed on the natives (Danino, 1996). Training is delivered to volunteers, mainly healthcare professionals. It is considered an affordable treatment for the lower socio-economic groups. The objective of the institute is to impart knowledge and ensure varmam remains established as an Indian system.

There are many types of varmam energy, including touch, speech and movement. Pathways connect the physical and energetic body. Similar to Chinese acupressure, pressure is applied to points, which tunes the energy channels to cure disease. Pressure comes in many forms, including kneading, slapping, blowing air and licking (ARI, 2010).

There is currently limited clinical evidence on the health benefits of complementary therapies. A number of institutes are conducting research, including Svyasa (2010) in Bangalore and Kaivalyadama (2010) in Pune. Case studies and continued custom provide the main evidence of therapeutic benefit. Dr Hari (2010) suggests that one can't necessarily prove results but can feel the benefits, thereby highlighting the importance of belief in wellbeing.

Community Healthcare & Socio-Political Factors

India is striving to become a developed country, governed by the United Nation's development index (2010), which measures income, education and health, per capita. However, there is fear that welfare and capital growth is not relative to the size of the population (Aram, 2010). Historically, politics and social trends have influenced healthcare. In the seventies there was government investment in family planning and the right for women's choice (Ledbetter, 1984). There was the abolition of child marriage, which took time to become socially accepted (Aram, 2010). The nineties saw the right to women's inheritance and widows pension (ibid), providing much needed financial support, as often these women are not respected in society (ibid).

Urbanisation has meant urban slums are on the increase. 25% of people are living below the poverty line, however the country's development in sciences and medicine provides a dichotomy (Subramanian, 2010). A common phenomenon for many nurses is emigration, to earn higher salaries abroad (Thomas, 2006). Indeed, PSG Offshore Health Management Services runs a courses to help prepare nurses looking to emigrate. Although this isn't the direction the hospital wants to be

focusing on at the moment due to the recession and need to retain nurses within the country (Nirmala, 2010). Emigration brings prospects to the Indian economy through money transferring but is a threat to the social structure, which impacts on family members being unavailable to look after relatives in times of need, such as ill health (ibid). Many parents leave their children with their grandparents in India, sending money for private education; meaning globalisation and capitalization are impacting on educational disparities, the social culture and family bonds (Thomas, 2010).

The Shanti Ashram is a non-government organisation (NGO). It works with poverty stricken villages in a social, economical, political and skill development context, to translate and deliver evidence based, quality care, which is effectively audited for future development (Aram, 2010). There was opportunity to learn about the mobilisation and delivery of service, and how they utilise a variety of people and resources across their projects. Including community health promotions, screening, immunisations and poverty elevation.

Visits were made to a variety of rural women's enterprises, set up under government microcredit programmes. Enabling economic empowerment for women. Food distribution programmes were organised similarly, to provide those most at need with food rations, in a village centric way, thereby avoiding corruption (Subramanian, 2010). Despite their poverty it was endearing and humbling to be welcomed so warmly by the local villagers, snacks, drinks and meals were often provided along with a willingness to communicate and share experiences despite the language barrier.

Opportunity was made available to participate in a cervical screening camp. Sixty-seven women were screened in a village school over two hours, conducted after a women's forum meeting. Many were not aware of the symptoms of cervical cancer. Ashram field teams go out to villages to motivate and counsel service-users to continue treatment, helping to reduce barriers to treatment such as shyness, transport and cost.

There was fear amongst the women at the clinic and the environment proved difficult to keep service-user confidentiality. Consent and information was given at time of registration. There was an abruptness amongst the healthcare team, keen to see as many service-user as quickly as possible. With regards to infection control, there was no cleaning of the examination table. Personal protective clothing was used intermittently. Swabs that fell on floor were picked up and used. It appeared to be a case of making best use of available equipment, cost effectively.

The Ashram supports pre-schools, and delivery of health vaccines and nutritional advice. Particularly needed amongst the illiterate and uneducated. Although the government provide some immunisations they do not support the MMR vaccine. The Ashram runs a subsidised scheme. A doctor and two nurses from PSG delivered the clinic in a village schools. The family are provided with the used syringe after inoculation, to verify that it is single use. The children were frightened and the numerous flies, rickety, portable wooden table and dirty environment added to the atmosphere. Regardless, the villagers were pleased the MMR was affordable at 20 rupee instead of 200 rupee in the hospital.

A variety of schools were visited during the community placement. Many children were fascinated and excited to meet a foreigner and practice their English. Schooling is compulsory, free bikes and bus passes are given to encourage teenagers to attend. The government also provide nutritional supplements through the school for undernourished families. Health promotion is encouraged in the village schools; PSG nursing students runs several camps to improve knowledge and understanding, often using puppets to communicate effectively. Pictures in the school depict ten actions of hygiene a child should perform every day. The Ashram also runs a project under the World Day of Prayer and Action for Children scheme (GNRC, 2010), which encourages schools to organise programmes on ethics education. The school syllabuses do not include humanities, only the essential subjects of maths, language and sciences.

PSG nursing students run activity based programmes at a home for the mentally and physically handicapped. Their daily routine includes chores and yoga. The home is an enclosed environment, which contrasts with the UK integration and delivery of care to people with learning disabilities in the community (DH, 2009). A common problem in the home is violence, in which case the person is isolated, calmed down and administer psychiatric medication and behavioural change therapy.

Several rural, primary health centres (PHC) were visited, which provide twenty-four hour care for geographical regions at minimal or no cost. The centres are staffed with doctors and laboratory technicians who perform routine diagnostics. Nurses, field staff and pharmacists are available as are specialists in optometry, podiatry, naturopathy and siddha. Routine surgery is undertaken as well as triage, treatment rooms and in-patient wards. Although the government has a no needle stick injury policy and therefore provide disposable syringes it was occasionally observed that needles were being sterilized and reused, to save cost.

There is a free blindness control programme (DHFW, 2007) in place to reduce blindness from 2% to 0.7% at rural level. It is thought that vitamin-a deficiency in 0-5yrs can result in under 8's developing refractory error. For those aged 50+ cataracts are common, both can cause blindness (Optician, 2010).

Service-users are seen on the same day meaning turn around is quick and waiting lists low. Clinics include ear-nose-and-throat, family planning, maternal, diabetes and anti-leprosy/malaria/tuberculosis programmes. Cases signifying an overnight stay include; diarrhoea and vomiting, maternal cases and those with fever. Acute incidences are referred to hospital. Emergency ambulances are available through the hospitals or directly from the PHC.

The field team are responsible for village health promotion including contraception, and outreach work, compiling a year census and working in partnership with and village health nurses (VHN's), to undertake surveillance work on potential epidemics. The VHS's travel great distance by foot or bus and are familiar with 15,000 service-

users each. In remote areas, on location village nurses carry government funded mobile phones to ensure open communication with the PHC's. They carry out multi-purpose visits, including, iron deficiency tests, dressings, inoculations, healthy living, dietary and anti-natal education. They also provide education in local schools. They are similar to district nurse in the UK but different in setup due to the geographical and funding structure in India.

A pancheayet is a local village government. Villagers elect leaders to run the village in line with government work-streams. Projects include community development, housing, road improvements and water sanitation; of which, since 1992 there has been an increase in protected drinking water but the tap may be in the street as opposed to individual houses (Mekala, 2010). The Assure village is currently building 100 free, government funded houses, for villagers below the poverty line, in order to move them out of mud huts. This is a key government mission (ibid).

India is a beautiful country, spoilt by an abundance of litter and lack of civic pride. There are no collection systems in place, so non-biodegradable material infiltrates every surrounding. Some people collect and burn the litter in piles, but this has environmental and health implications (Aram, 2010). People urinate and defecate publicly in open spaces, raising sanitation concerns. Certainly, there were concerns before the Commonwealth Games regarding sanitation and health threats (Overdorf, 2010). The Ashram has worked on a project to support villagers, in installing toilets within their homes, however due to inflation, the work became unfeasible (Subramanian, 2010).

Allopathic Healthcare & Infection Control

Both leprosy and tuberculosis (TB) are thought to be prevalent due to the overcrowded population. Transmitted though spitting, which is common in India and through airborne modes of transport. The Coimbatore Urban Leprosy Eradication Scheme (CULES) is a government-funded institution in partnership with PSG. The government are hoping to eradicate leprosy by 2020. In Tamil Nadu it is nearly eradicated, with diagnosis rates being 1-2/10000 (CULES Doctor, 2010).

The centre offers health promotion initiatives and treatment provided by doctors, pharmacists, physiotherapists and field staff. Leprosy is a preventable and curable disease. It causes loss of sensation on the peripheral tissues, skin and nerves. Anaesthetic-pigmented factors are common, including platelet lesions (elevation), skin lesions and satellite lesion. It's treated with steroids and physiotherapy to keep the skin supple.

Screening and early diagnosis are key. Leprosy causes absorption and osteomyelitis, which affects the cartilage and small bones and causes fat loss and weakening of muscle dexterity. The impact on the nervous system can lead to deformity of the hands, feet, nasal bridge and pressure ulcers. Rehabilitation programmes include education on ulcer management and adapting to deformity. Drug therapy lasts between six and twelve months and can have contraindications to the kidneys and liver. Field teams are used as a surveillance measure to supervise treatment delivery and ensure service-users keep up with the treatment plans, and for auditing purposes.

Tuberculosis (TB) is easily infected, can develop drug resistance and can be fatal (CULES Doctor, 2010). There are two types of TB, pulmonary, which affects the lungs and presents respiratory symptoms including coughing up consolidated blood or yellow sputum lasting more than two weeks. The second is extra-pulmonary, which can affect the affects testis, abdominal, lymph nodes and blood capillaries. Fever, weight loss and decreased appetite are common symptoms. Skin smearing and x-rays are used in diagnosis. There are two stages, the first is treatable, and the second affects the nervous system and causes irreversible damage (ibid). Treatment involves anti TB therapy medication. TB and HIV are common, as TB affects the least resistant, when a person presents with one, they will be tested for the other.

Diabetes is a significant chronic condition in India (Diabetes India, 2009). The development is thought by some people to be related to rapid cultural changes, more stress and diets rich in salt and sugar. Doctor Prasad (2010) form the Ayra Veda

centre is of the view that if people are susceptible to disease, their body craves that which it should not have, so in times of stress people move closer towards the danger, such as sugary food consumption. The predominance of the condition appears to be type 2 related. Knowledge and awareness is growing, through health promotion work delivered by the PSG student-nurse camps, however, people are reluctant to omit sugar from their diet leading to potential complications (Mekala, 2010). On investigation, few understood the function of their medication or the benefits of insulin therapy or dose adjusting regimes such as DAFNE (2010) for type 1/juvenile diabetes, available in the UK.

HIV has apparently decreased in India due to the health promotional practice and awareness (Aram, 2010), there are reported to be over two million people currently affected (Avert, 2010). People are only given antiretroviral therapy when their CD4 count is below 300, it is thought they can build resistance if given beforehand and it is costly for the government but potentially gives rise to opportunistic infection (ibid).

HIV clinics supported by NGO's in the PHC provide instant screening and counselling services. In Tamil there are eleven HIV awareness buses supported by the National AIDS Control Agency (2007). This service reaches people in remote areas to educate and help them deal with discrimination. Outreach programmes focus on control and prevention of infection, address stigma and seek to understand the experience and demographics of service-users/carers in order to provide better service (Aram, 2010). The Ashram are particularly interested in working with children and understanding their perspective and feelings on their condition in order to better serve them, this is a current area of focus in government lobbying (Sharma, 2010). Within schools and families, male children with HIV are apparently treated preferentially, with a higher abortion rates if couple's know they are carrying a female (Aram, 2010).

Maternal health is based on cultural upbringing and tradition. Breast-feeding is recommended for first 6 months but women are only given three months maternity

leave causing a dilemma for many families. The government has a number of incentives for supporting maternal health including cash and nutritional packs for attending check up appointments. Contraceptive cash incentives are given to those below the poverty line, for sterilization and population control. If a family has only female children, and limits the number of children they have to two, the children are given bonds as a dowry when they reach eighteen years.

PSG hospital is authorised to practice under the National Accreditation Board for Hospitals (2010). Nurses appear to follow similar shift patterns and dress codes to their counterparts in the UK. The work ethic amongst the health care professionals (HCP's) is strong, although observations amongst the rest of the population showed a divided approach to work, there appears to be a reactive rather than proactive focus in many cases.

The hospital offers an intensive care unit (ICU), cardiac, coronary care unit (CCCU) and neurology ward, one to one nursing care is provided. All medical cases arrive into these wards for triage and observations, where specialist equipment and experienced technically proficient staff are available. General wards are not fit to deal with critical cases. Maintenance of chronic conditions is undertaken on the general wards. If financially viable, service-users have the option to be placed in semi-private rooms with specialist nurse care.

Within the trauma ICU there is a postoperative ward, surgical observations area, head injures unit and trauma ward for septic cases. There is also a cardio-thoracic ICU and Burns ICU. Along with ten operating theatres each for specialities and radiology suite. Five days were spent observing these departments.

There were few sedated service-users on these wards and many were ventilated whilst awake. Only neurological, gastro and large cases such as laparoscopy are ventilated under sedation, this gave rise to questions regarding service-users comfort and dignity in care..

Much of the equipment was similar in function to that in the UK although older in design and more manual in function. Non-invasive blood pressure is monitored continually in ICU, similar to the UK, and hourly vital signs taken. The nurses are not provided with manual handling training or equipment, although the nursing college advise they do provide basic training at undergraduate level. Judging from ward activities, few follow manual handling precautions, hence many have back problems (ICU-Nurse, 2010). Restraints are used with consent of the next of kin in a variety of situations, including restlessness. It was frightening to watch the forceful manner in which the HCP's handled service-users without consent, causing shock and agitation for the patient. This gave me an opportunity to consider the benefits of informed consent, patient centred care and dignity, as delivered in the UK.

Personal protective clothing was available although not visible, worn mainly for sterile procedures. Hand hygiene is gaining use throughout the hospital although equipment such as taps and bars of soap differ to UK measures. Flip-flops are worn in ICU for infection control, although this poses a manual handling risk. There was an infection control specialist nurse who visits the ward to undertake daily audits. Observation of their role gave an appreciation as to why infection control nurses in the UK carry out so many audits; to ensure nurses trained from many different locations all abide by the same standards to ensure quality care can be delivered to the service-user (DH, 2010). Interestingly, for infection control reasons, unlike some government hospitals, the patients keep no belongings inside the hospital and family cannot bring in food. Families are allowed to visit at specific times as per the UK.

Evidence based care is hard to gauge amongst nurses as healthcare is doctor led, although, responsibility lies with the nurse for continuity of care (Nirmala, 2010). HCP's speak to the patient in their local language but English is used as the communication language between professionals and within the medical notes. Meaning the patient has limited opportunity to participate in discussions about their care. It was interesting as a foreigner to be aware of non-verbal cues in certain contexts, which led to much understanding of the situation, dialogue and opportunity to partake in conversations, however there were many times where the

language barrier proved frustrating and aided to a sense of lack of control and inability to make preferential choices. In itself, this was a learning opportunity, finding new ways to express or contain oneself, remaining patient in the process.

Conclusion

This experience has enabled a greater appreciation of the socio-political influencers to the delivery of healthcare in India. Opportunity was made available to spend time in some fascinating environments, welcomed by so many to learn from complementary, acute and community practitioners in order to draw comparisons and contrasts to UK nursing care. Knowledge and appreciation for the spiritual and traditional importance placed on wellbeing has also deepened. Ultimately, to develop professional and collaborative practice in the future, to deliver better patient care.

The experiences provided an incentive to reflect on healthcare delivery in terms of access, investment, and standards of care, waiting times and efficiency for delivery. Exposure was given to tropical, infectious diseases, immunisation programmes, women's health projects, chronic disease management, nutrition and social uplifting schemes. The disparities between the rich and poor are vast. Through the government, NGO's and private sector there are a range of programmes in place to support those most at need, but often education and geographical access is a barrier. Opportunities have also been relevant to consider the EU criteria, involving children's, maternal, learning disabilities and mental health.

Cultural differences have provided dynamic challenges to develop communicate skills through a variety of mediums. Being in an ethnic minority didn't come without frustration, often experiencing the sense of feeling like a silent feminist. Enthusiasm, assertion and motivation were employed to share knowledge. Unexpectedly, the objectivity gave some wonderful opportunities to take new perspectives of understanding. The greatest lesson's learnt were the simple, perhaps obvious ones in relation to Maslow's hierarchy of need (Psychology, 2010); to be happy, clean and well balanced is considered the best route to health.

In conclusion of the experience, here is an excerpt taken from my journal,

> India is a chaotic mix that conjures a colourful presence, which touches every sense. Anything truly is possible. There are a thousand million woven stories that resemble the mayhem of the roads. Not always in unison, rarely following the rules, if there are any, but surviving, somehow.

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Appendix A.

Self constructed feedback form to help PSG develop the programme in the future.

PSG Elective Feedback
Claire Barber 13/9/10 – 07/10/10

Situation	Suggestion
Pre-arrival	• Copy of programme sent by email so that relevant preparation can be made; e.g visiting website of Shanti-Ashram, preparing questions, gathering useful material that could be shared – eg photographs or useful gifts for schools and villages. • Details on distance between airport / train station / bus station and PSG Guest house, best mode of transport and approximate cost (for initial arrival). • Small gym, shop and beauty centre on the PSGIM site and free use of washing machine and outside area to dry clothes. • Any information on tipping protocol • Rupees cannot be exchanged outside of India. They can be exchanged at the airports (expensive rate) or taken out of the ATM's on arrival. • Vaccinations: check with doctor pre travel. Consideration might want to be given to buying malaria tablets, rabies and Japanese encephalitis vaccines although not essential if contracted in an at risk area, insurance may be void if not inoculated against. • Visa type: Entry visa requiring invite letter from PSG College. • Climate information • Mosquito repellent (50% DEET)
Introduction Pack	• Named contact of person at the guest house (pref English speaking) who can address questions relating to accommodation orientation/facilities, meal times & protocol or any relevant concerns. • Map of Coimbatore. • Route map from guest house to hospital campus. • Information on the inter-site bus • Key places of interest; post office, bank, pharmacy, browsing centres, religious buildings, opticians, various cafes & restaurants in the area, ATM's. • Some useful Tamil words

	• Taxi number • Information on sites and attractions and best way to travel to them: Within bus reach: VOC park, Ootys food store. Further afield; temples, Isha yoga centre, Sirivani falls. Ooty (Mountain railway from Mettepalyam) • Codes re accommodation curfew (this isn't held for international students but it would be useful to know so that students can respect the rules for others). • Hospital orientation to also include a written copy of useful names and organisation chart if one is available? Guidance on the cafeteria facility and how to place orders, location of outdoor coffee shop area's • Contact details of chief librarian & opening hours. • Overview of how transport works for community placements; dedicated driver, will have been pre-booked for trips by college, in some instances the vehicle will wait, in others pick up needs to be arranged via the PSG contact on the day.
Clinical placement in acute setting	• It would be really useful to follow the shift patterns of one staff nurse for one week. This would enable a relationship to be built and opportunity to practice more clinical skills. The expectation of nurses in India is based on the Indian nursing training and I spent much of my time explaining my UK training and background in order to build confidence with the nurses. Having a one 1/1 relationship may provide more learning opportunities and enable a sense of participation for the student nurse as opposed to being an 'observer'.
Photography	• A consent form to be signed by any community patients / villagers / sc teachers, who agree to have their photo's taken may be a valid way to ensure that photo's can be used in presentations etc at a later date back in the UK.
Useful suggestions / information	• Buy an Indian sim card for mobile phone use (can be bought in PSGIM site shop or the phone shop just off campus) • PSG IM has a computer room on the 2nd floor, the technician was able to put an IP address on my laptop which meant it could be used within the IM building to access the University internet. • Don't store food in room, keep cupboard doors looked as this will attract vermin.
Useful items to bring	• Continental two pin adaptor plug • Laptop, paper notebook & pen • Reading book, Uni work • Tupperware lunch box to store food in room / packed lunch • Toilet roll / tissues • Torch • Sleeping bag inside liner to sleep in • Knife, fork & spoon / or learn to eat with hand • Camera

	• Flip-flops for indoor use – in the Guest house and perhaps even a personal pair for use in the hospital; ITU/Trauma • Many items can be bought in India at a much cheaper cost and will save on carrying too many items, e.g toiletries, clothes, washing powder etc.