

R25 International Practicum Final Report

Angela Palmer-Wackerly, M.A.

The Ohio State University

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Author Note

Angela L. Palmer-Wackerly is a doctoral student in the School of Communication at The Ohio State University.

I am grateful for the R25 International Practicum grant award sponsored by the National Institutes of Health Fogarty International Center and the OSU Health Sciences Colleges to help fund my participation in a study abroad program focused on health and mental health in India. While in India, I created a blog *India Traveler* (www.tumblr.com/blog/indiatraveler) to document my thoughts and serve as a foundation for this paper.

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In July, I spent three weeks in India enrolled in a study abroad program through The Ohio State University. Sponsored by the OSU Department of Social Work, the program focused on health and mental health in a developing country and the ways in which culture impacts health and mental health. This program fit nicely with my interdisciplinary interest of health communication, culture, and public health.

When I had applied to the study abroad program, I had only heard of Mumbai and New Delhi. My port-of-entry into India was Mumbai, but unfortunately, I did not have any time to visit there. My final destination was Chennai, which is on the southeast coast of India. We spent 1.5 weeks there, then took the train to Bangalore for the second half of the program. After a few days in Bangalore, we had a 3-day mini-break, and we flew to Trivandrum in the region of Kerala and took an hour-long taxi to Varkala, also in Kerala. Then, we returned to Bangalore for the rest of the program. We stayed in a YWCA in Chennai and university dorms in Bangalore. Studying abroad in India was a life-changing cultural experience, and one that will continue to fuel my research in international sexual and reproductive health.



Responsibilities During the Practicum

The program schedule consisted of morning lectures, afternoon fieldtrips, and evening cultural experiences. Our responsibilities included actively participating in lecture and on the fieldtrips, while also keeping a daily journal and writing a final comparative paper for the course (due Sept. 1). We attended lectures at the Madras School of Social Work in Chennai the first

week and at the Richmond Fellowship Postgraduate College for Psychosocial Rehabilitation in Bangalore the second week. Our lectures included topics that impact Indian culture and health decision-making, such as religion, the caste system, astrology, crimes against women, gender concerns, child rights, gay rights, the health care system in India, HIV/AIDS, mental health services in India, meditation, and the family role in psychosocial rehabilitation.

My Favorite Lecture: Violence Against Women

Every morning in Chennai, we had the national paper *The Times of India* and the local paper *Chennai Times* delivered to our room door. One day, one of the main headlines was about an acid attack on a Delhi woman in Mumbai and the fact that the government is not doing enough to prohibit these attacks or the sale of this cheap acid, which can be bought for as little as 5 to 30 rupees (10 to 60 cents) at any Indian grocery store. These attacks, as was in this case, were often brought about because of a declined marriage or dating proposal. The result is severe disfigurement or death. Here is a link to the story:

http://articles.timesofindia.indiatimes.com/2013-07-10/india/40491054_1_acid-attack-apex-court-supreme-court

This article was a sober lead-in to that morning's lecture: Violence Against Women, given by a women's rights female attorney, who had presented to the U.N. about women's rights in India. She presented to the UN to advocate for international pressure to improve India's current situation despite receiving threats from some Indian government officials. She was unequivocally outspoken that India's women are treated as second class citizens and that she will spend the rest of her life trying to improve the status of women. When we asked her if she worried about her safety (in another case, an activist who protested child marriages was gang-raped as a lesson to others), she said no. Because she is from a high caste and class, she is protected.

She divided her lecture into ‘Crimes Within the Home’ and ‘Crimes Outside of the Home’. The violence against women in the home isn’t just from a woman’s husband; it’s from her mother-in-law, her father-in-law, her brother-in-law, and her sister-in-law. Even though the dowry practice in India was prohibited in 1961, most citizens continue to do it but label it as “gifting”, which serves as an effective loophole. As our instructor said, “We can change the law, but we haven’t been able to change the custom”. When a family is financially struggling, the in-laws often pressure the wife to go back to her family for more money. They know that the more they physically and emotionally abuse the wife, the more her family will try to stop it by giving more money. Because it is illegal to give and receive dowry funds, people are reluctant to go to the police for fear of prosecution.

The most common type of violence toward women is physical abuse and burning with kerosene and fire. Physical abuse and burn deaths are not confined to the uneducated, powerless, rural villagers; they exist among doctors and lawyers too—all classes and castes. She said, women are told they must adjust to the situation—by family members, in-laws, friends, politicians, and police; violence is a part of a man’s right within marriage. There is a local Tamil (the language spoken in Chennai) saying: “The arms that hold you are the arms that hit you.” If a man hits another man, it is a crime; if a man hits his wife, it is as it should be. Little did I know that just two weeks later, I would witness a domestic abuse situation coming from the shack below my dorm balcony in Bangalore in the middle of the night. The son, known to be an alcoholic, was physically assaulting his mother. The social workers in our school said this family often argues, and it is common for sons to physically abuse elderly women when the women will not turn their pensions over to the sons for alcohol. They said the police will not come because the mother will not prosecute. In India, domestic violence is still largely viewed as a private, family matter.

Perhaps the most disturbing part of the lecture was the information on female feticide and infanticide. Beginning at 6 weeks, many women in India receive an ultrasound scan to confirm the sex of the baby even though this is illegal. Most people in India have 2 children; if the first child is a girl, no problem. If the second child is a girl, it is a big problem. The average woman in India rarely goes to the doctor by herself; her mother-in-law and husband often attend. In the cases where the second child is a girl, we were told it is not uncommon for the in-laws to pay the doctor to give the woman an abortion without the mother's knowledge immediately following the scan. One study estimates that more than 10 million female fetuses are missing from India as a result of feticide and 90% of all aborted fetuses are female. Should the fetus survive, infanticide is next and disturbingly easy to do with poison, a cloth, and many other ways. An estimated 3 million female infants are missing as a result of this practice. This, too, is rarely done by the mother, and instead done by the in-laws. One recent story featured a mother whose female child died immediately after birth so she was convicted for 5 years for murdering her daughter. The girl maintained it was her in-laws and that she had no idea it was happening. After she served 5 years, she came out of prison beaming with a child on her hip. She told the court system, "Thank you for putting me in jail because my daughter would have been killed." She had been unknowingly in early pregnancy with another child at the time of her conviction.

Violence outside of the home is also a problem in India. This violence is the reason girls receive curfews and are told to avoid places where a lot of men hang out. Last year, the Delhi gang rape in a private van that resulted in the death of the female victim was well-publicized. Another case we talked about involved a girl who walked into a hotel at 11:30 pm after work to speak to a friend. She didn't drink (98% of the women in India abstain from alcohol), and left on her moped to go home. Five boys left the bar in a car and began chasing her on her moped. An auto-shaw driver called the police to inform them that this girl was being chased and was trying

to escape the men. The police arrived too late; she was rammed by the car and killed. Just like with the Delhi case, many people asked, “Why was a girl out so late?”, “Why did she go to a bar?” and “What was she wearing?” The primary focus was on her behavior instead of the murder.

Field Trips

The daily field trips consisted of site visits to addiction facilities, elderly care homes (including dementia patients), psychosocial rehabilitation in-patient and out-patient centers, village schools (based on India’s belief that education is improving health), local hospitals, and the National Institute of Mental Health and Neurosciences (NIMHANS). We were fortunate enough to talk with a professor/researcher at NIMHANS who advises the government on national drug addiction policies. Photos of some of the above field trips are included below:

India has a three-tier healthcare system, starting with the primary care centers for a block of villages. We toured a primary health center, responsible for treating 30,000 people with very few staff, in a village outside Bangalore (pictured right).



I had my mini-practicum at the KIMS (Kempegowda Institute of Medical Sciences) multi-specialty teaching hospital and research center in the family planning clinic. It was the craziest process that I have ever seen. Patients were seen by first-come, first-serve; however, people were still coming into the consultation room to try to cut in front of the patient to whom the doctor was talking. No privacy existed between patients and patients were seen for a maximum of five minutes with a constant revolving door of patients. No time for chit chat; patients explained their problem, the doctor sort of examined the patient, and then gave them a prescription. And, in these five minutes, the doctor

was multi-tasking between talking to the patient, talking to other patients who were waiting, answering her cell phone, talking to nurses who came in to talk about other cases, and trying to instruct a medical student. I have never seen anything like it, and I had a massive headache when I left.

Another field visit was TTK hospital in Chennai, a top drug and alcohol rehab facility in India. It is actually certified through the U.S. because India does not certify rehab facilities, which leads to a lot of abuse in rehab facilities (e.g., chained to beds, locked in rooms). In India, every state has a different alcohol policy and alcohol can only be bought in government-owned facilities. Alcohol, cannabis, narcotics, and inhalants are the most popular drugs. Injection drug use, cocaine, and meth are rare. A residential counselor at TTK started the AA program in Chennai. Because so many people in Tamil Nadu cannot afford to travel to Chennai, TTK has started an outreach program where the hospital goes to treat people in need.

One of my favorite visits was to a gypsy camp. Before going, we had gypsy customs and



their cultural preference for women being dirty explained to us: To protect themselves from men outside the community. Things are changing for gypsies much like the rest of the Indian population in which some are following traditional ways and others are becoming modernized (some even have flat screen TVs in their homes). Some gypsy women still hand sew only two skirts in womanhood, which they wear one at a time, without washing or removing until it falls off of their bodies. Others now wear saris or other traditional Indian clothes.

The adults all seemed clean while the children were unbelievably dirty (one of my favorite girls' heads was filled with what looked like lice).

Other favorite visits included the three free government schools where students are given a free education, free meals, free supplies, and free clothing because they are all living below the poverty line (\$1 per day). All of the children were excited to see us, and they sang songs and recited poems to us. They were not fluent in English yet, so when they asked us to sing a song to them, we sang the *Hokey Pokey* in order to involve them and they loved it. We also taught them O-H-I-O.



As for my overall favorite visit of the trip, I will explain below in the next section.

Accomplishment of Goals and Objectives

My objectives for this trip as it related to my research in women's sexual and reproductive health are listed below with an explanation of my exploration of these questions.

(1) What are the critical areas of women's health and mental health in India where communication could assist in the improved delivery of social services?

One critical health area is infertility awareness and support. While working at KIMS hospital, I primarily worked with a medical social worker, whose job it was to counsel couples about pregnancy, family planning, infertility, HIV/AIDS, and STIs. She told me myths that are very common among the middle class, the primary constituency of the hospital. For example, the culture looks down on women masturbating because they believe it will lead to infertility during

marriage because the sperm will fall out. We also discussed stigma and social support related to infertility: Still today outside of the big cities (so 70% of the population), when a couple is infertile, a biological child is still preferred. So if it is a female issue, the husband can take a second wife (the first wife understands that it has to be this way), and if they still do not conceive, the wives live together with the husband. If it is a male issue, the couple can adopt. Further, if a newly married woman is not working, she is considered infertile after the first month of marriage if she does not conceive (regardless of whether it is a male issue), and will not take part in a naming ceremony for newborns or be allowed to stand next to a bride and groom during a wedding because she is considered 'inauspicious'. She said India needs a public awareness campaign for infertility.

(2) What is a feasible dissertation project that could offer value to Indian communities and organizations as well as inform our scientific knowledge of health communication and culture?

The idea I am most excited about involves an HIV/AIDS child/adolescent facility outside of Bangalore. It is a non-profit organization run by a Catholic order that focuses on healing the sick. Because the stigma is so great surrounding this disease, the facility asks to remove the children from their homes or the homes of their extended families and they bring them to the facility to care for them and to ensure they are fed properly and receive their medication. They are allowed two home visits a year, and their families can visit them on Sundays only. It is such an interesting model for HIV/AIDS care for children—making sure their needs are met while giving them multiple types of social support from multiple types of people. In June, the facility moved 25 adolescents from the children's facility to a new adolescent facility for the first time. They are not sure how this program is going to work since it is so new, so they need more research. I believe this could be a perfect research partnership.

I loved this facility and these children. All classes are taught in English and they understood our accents better than some of the doctors we had met. The children took turns putting on dances for us according to their dorm assignment. The songs and dances were Bollywood and the children taught us how to dance to a song. They were also little charmers—silly and sarcastic already. I did not want to leave. Out of respect for their privacy due to the stigma, we did not take any pictures, but below are pictures of the exterior as well as some of the classrooms. It is easy to feel the positive energy here:



(3) Who are possible collaborators among host institutions and health care organizations for my future research in India?

I plan to apply for grants, including a Fulbright grant, to support my dissertation research. I would like to explore the socio-cultural and communicative aspects of HIV/AIDS in India while also partnering with a non-profit organization to improve social support for adolescents who are among the first cohort of Indian adolescents to survive. The facilities consist of Sneha Care Home, which is home to 100 Indian children living with HIV/AIDS, and the Shining Star School, which is the educational part of this program. The organization began in 2008 and is located in Bangalore on the Snehadaan (“Gift of Love”) campus. It is run by the Catholic Camillians, an international faith-based order which focuses on quality health care for the poor and sick. At this facility, the children are given an education, counseling, medical and nutritional care, spiritual support, and life skills and enhancement training. Approximately 60 percent of the

students are orphans because of HIV/AIDS; however, a main part of the program is to continue to develop the relationships with immediate and extended family members. Ultimately, the goal is to reintegrate them into society as productive members.

In June 2013, Sneha Care Home began an adolescent program for 25 students who are 13 years and older. The goal is to provide vocational training and perhaps a college education, depending upon student aptitude. This is the first cohort of adolescent students for whom the staff at Sneha Care Home is educating and caring; thus, uncertainty exists in how these young teenagers are approaching decision-making about their futures. The model of live-in care and education that Sneha Care Home has created for adolescents with HIV/AIDS is exciting and relatively new. The results of my project will improve communication and resources available for adolescent patients with HIV/AIDS and their families and peers while also helping the students, school staff, and family members manage their uncertainty about the students' futures.

The main objective of my proposed study is to gain information about the messages that the students receive about their futures and how it impacts their decision-making about their careers, health, and relationships. In India, family members are the main decision-making partners in these areas; yet, the staff at Sneha Care Home has been largely responsible for students' education and care, and students have lived with peers, creating a family away from their family. Thus, my research project seeks to answer the following question: *How do the messages that students receive from school staff, family members, and peers impact their decision-making about how to attain future success and well-being?*

Negative and Positive Aspects

Negative Aspects

Even though I miss India, I do not miss the constant noise; the garbage strewn all over the street, sidewalks, and yard; the cow waste on the sidewalk; my digestion issues; no hair dryer;

the dorm shower (hot water was not plentiful); and the confrontation with sadness many, many, many times a day. However, surprisingly, with the exception of the last one, I really did get adjust to it.

One of the most difficult aspects for me was seeing poverty so close and all around us. Shacks were situated next to well-kept, gated houses, and even next to our dorm in Bangalore. We also learned that water is a precious commodity and many people do not have access to safe, clean water. Those residents without drinking water are able to line up two hours in the morning and two hours in the evening with jugs for “corporate water” or government-filtered water that is safe to drink. As hot as it is in India, people have gotten used to conserving drinking water and drinking it very slowly. Even the restaurants/airlines give tiny glasses of water that I easily finished in two gulps. I realized how lucky we are in the U.S. to have the concern that we are not drinking enough water by choice, not by necessity. I also realized how much water we waste in everyday activities, such as washing dishes and brushing our teeth.

Another difficult aspect was coming into contact with street dogs, which were often starving. Animal rights in general were lacking in India. In addition to the dogs, the cows were often tied to street posts for the majority of the day, where they were only able to stand and sit. I enjoyed seeing the cows whose owners allowed them to roam; however, because they would often lie down in the middle of the road. Because they are such sacred animals, it is interesting to see people move out of the way for them—more so than for people.



Finally, one of my fellow students who visited a local Hindu temple in a rural area saw an elephant, one of the holiest of animals and who lives in this temple, shackled with all four legs in the courtyard, only able to sway back and forth. Whenever I would become depressed about the state of the animals, I would reflect on what one of my professors from the Global Health Specialization had said: “If a country’s animals are starving, so are its people.” This would allow me to focus on all life in India and reflect upon the realization that America’s pets eat better than the majority of India’s citizens.

Positive Aspects

As much as sadness became a part of my daily life, so, too, did happiness. There was so much stimulation at all times that everywhere existed something fascinating to watch. I will miss our cultural consultants (we had two students hired to guide us through the culture at each location); the coffee; riding a two-wheeler; the monkeys outside my window (see right for a photo of one eating a coconut); the coconut palms all around us (one of my favorite sounds: the wind through the palm leaves makes it sound like it’s raining) (see right); the kids; and the people, the people, and the people.



Just when everything seemed hopeless there, I saw people giving everything they had to improve lives for other less fortunate people. That is what I will miss most of all: the friendliness, generosity, hospitality, and warmth of the people in India. Perhaps the best example of this is a gift given to each of us by one of our cultural consultants, Christina. She gave us all of the glass paintings that she had made, which were the only decorations in her home (except an enormous picture of Jesus). We saw them when we went to dinner at her house and she said at the time that they were the things she loved most. The



generosity is astounding—I cannot believe she gave us what is most special to her. She matched each painting to our personality: Mine was a picture of Jesus holding a lamb in front of a wooden door—the good shepherd. I will keep it forever as a reminder of hope, comfort, and kindness.

Unique experiences or events

Indian culture was different than American culture in almost every way possible; thus, nearly every experience was unique. However, my favorite events were attending an Indian wedding, attending a classical Indian dance recital, learning to wash clothes in a bucket, and drinking coffee and eating Indian food.

Indian Wedding

I loved this ceremony. It reminded me of Catholic and Jewish ceremonies, where there are certain traditions that occur at certain times. A fire is lit in front of the couple to signify the sun, and that the most important part of the earth is blessing the couple. Other important parts included the father of the bride washing the groom's feet; the groom placing the wedding necklace on the bride (what they use instead of a ring); the groom grabbing the big toe of the bride and walking seven steps with her; and the groom tying a string around the bride's waist to signify that she is his "property" while she is standing on a bowl of white rice to neutralize negative charges and place positive energy around the couple. Here are pictures of the event, including one of the bride and groom, the caterers, and us with the bride's family:



Indian Dance

Girls interested in dance begin taking classical dance lessons around 8 years old, and they must complete five years of training before they can even participate in a recital. The performance that they created for us included various dance numbers, where they not only explained the history of this style, but they also explained how a dancer progresses through the years if dancing this style.

As far as training in the early years, the dancers first focus on their foot work, which consists of a series of moves that involve slamming their heels to the floor and then lifting their toes and doing squats with their toes pointed sideways (a position they hold forever). Just watching it made me cringe because I could feel the pain in *my* body as a result of their hard work. Then, they gradually progress to working on arms and fingers (they have very specific positions for their fingers) and eventually to face and eyes. It is a very expressive and elegant dance, and it is very hard on their bodies. One of our cultural consultants was a professionally trained classical dancer and she said the training is meant to be gradual so that it does not damage their joints. But, the heel slams were so loud, it is hard to imagine it does not damage at least a little bit.



Everyday Activities

Even the everyday activities were interesting and unique. Before going to India, I had heard that every bathroom is equipped with a multi-use bucket which could be used to wash our clothes. I did not want to do this so I brought enough clothes to last for my trip. However, after experiencing two days of the intense heat and humidity of Chennai, I heartily embraced the



custom and began washing my clothes every other day (see left for picture of typical bathroom and bucket).

Another favorite daily activity of mine was drinking morning and evening coffee. South Indian coffee is some of the most delicious coffee I have ever had. It is made with ground coffee beans and chicory. Its frothy deliciousness tastes more like a latte and is meant to be drunk from a metal cup and cooled with a saucer. Before you drink it, you pour the coffee back and forth into each container until the coffee cools. Holding the metal cup is like touching hot coals, but you eventually get used to it and just jump right in, numb fingertips and all (see above for a picture of Christina demonstrating how to cool the coffee).

And, finally, eating was also an adventure. On the plane ride over, a man told me that most South Indians eat with their fingers and if I wanted to fit in, I should do the same. I immediately jumped in and although I never enjoyed the messiness of it, cleanup was easy. For special occasions or dinners in traditional restaurants, we ate on banana leaves and piles of food were continually placed out of buckets onto our leaf until we folded to signal that we had had enough (see below for a picture of me eating at a restaurant a picture of wedding caterers serving food).



Overall Assessment of the Practicum

My overall assessment of India is best expressed by describing one of my favorite nights in India. We attended a dinner at both of the homes of Christina and Shiya, our cultural consultants in Chennai—two recently graduated Masters social work students. We sat on the floor on blankets, and were welcomed in the traditional South Indian way (jasmine for our hair, and sandalwood paste for our foreheads). These girls did not go out to eat “because it’s too costly”; yet, they shared everything they have with us in order to make us feel comfortable. Christina and her mother shared a double bed (her dad is an alcoholic and lives apart from the family). They are not concerned with impressing others or trying to attain more; they are grateful to enjoy middle class status, receive a BA and MSW, and find jobs so that they can help support their parents. With 2/3 of India living on less than \$2 a day, Christina and Shiya’s middle-class families are the fortunate ones. However, looking at the tiny rooms (their apartments are approximately 400 square feet each) and the lack of conveniences that we enjoy back in the states, such as a shower or bathtub, a washing machine, and a TV, I realized that they, not things, sustain each other, their family, their friends, and their community. I am a better person for having met these two young women—as well as many, many others in India—and for their generosity, kindness, and openness in welcoming us so warmly to India.

I am grateful for this study abroad experience because now I know, not just think, that I want and can do health communication research in a developing country. I am sure I have changed already, but I look forward to also noticing the changes that are yet to come. In India, people do not say goodbye. Instead, they say, I will go and come back. I cannot wait.

