

TIBETANS IN EXILE: A HEALTH PERSPECTIVE

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At the end of October 1994 my wife and I, accompanied by our ten-month old daughter, travelled to Dharamsala in Himachal Pradesh, North India. The purpose of the trip was to work as volunteer medical officers with the Tibetan community-in-exile. Little has been written about the community from a health perspective. Although I have tried to include information already published, much is written from our five months experience of working with the community.

Introduction

In 1950 the People's Liberation Army (PLA) of the Chinese People's Republic invaded the vast, remote land of Tibet. Few people had ever entered this country and little was known of its secrets high up on the Himalayan plateau. The Tibetan people had lived for centuries within a traditional Buddhist system overseen by a large system of monasteries. Their spiritual and political head is His Holiness, The 14th Dalai Lama. The invasion of Tibet was seen by Beijing as a liberation of the Tibetan people from the chains of feudalism. In reality it allowed China to gain a territory the size of Western Europe and a strategic cushion high up in the Himalayas bordering Central Asia, Pakistan, India and the Kingdoms of Nepal and Bhutan spreading eastwards as far as Burma. There followed a systematic suppression of cultural and religious freedom in an effort to assimilate the indigenous population into the greater communist system of China. In 1959, following intolerable oppression and a breakdown in communication between Chairman Mao and the Dalai Lama, there was an uprising. This was swiftly quelled by the PLA and the Dalai Lama was forced to escape across the Himalayas to India. India and Tibet had long been trading partners, and their government under Nehru were quick to offer refugee status to the fleeing Tibetan exiles. The Dalai Lama settled in Dharamsala, a former British hill station, now in Himachal Pradesh.

Since 1959, particularly during the cultural revolution, an estimated genocide of one million Tibetans has occurred from a population of seven million.¹ Numerous monasteries have been destroyed and the Chinese authorities maintain a tight control on religious and political activities within Tibet. Some seven million Han Chinese now live in Tibet and outnumber the native population. Many Tibetans are being held in Chinese prisons, where they are subjected to torture and denied basic human rights.

Since 1959 approximately 110,000 people have followed their spiritual leader into exile. These people are now living in settlements widely scattered around India and Nepal with small communities now in the West. Dharamsala has been established as the seat of the Dalai Lama's government-in-exile, which administers to the needs of the exiled community and as much as possible to the Tibetans inside Tibet. In contrast to the iron-fisted approach of the Chinese authorities, the Dalai Lama has pursued a policy of protest through non-violence. Although it has done little to shift the steadfastness of Beijing it has undoubtedly prevented an

escalation of the oppression within Tibet and help consolidate public opinion in the rest of the World. This recognition was endorsed by the award of the Nobel Peace prize to the Dalai Lama in 1989.

There has been little documentation of the health problems of Tibetan exiles. Prior to the Chinese occupation the availability of health care was limited to traditional Tibetan medicine. This is based on a concept of physiology centred around complex psychological and physical forces intertwined with tantric Buddhist principles and astrology. Diagnosis is largely brought about by examination of the pulse and urine. Treatments are mainly herbal in conjunction with the use of pressure and heat (moxibustion). Allopathic medicine was virtually unknown inside Tibet apart from that provided by a physician who was attached to the British legation in Lhasa.² There is little or no information as to the prevalent health problems that were inside Tibet prior to 1950. It is also difficult to speculate. Because of its isolation and unique geographical features it presumably escaped many of the global pandemics that caused major public health problems in the first half of the 20th century. The single most prevalent public health problem in the exile community today is tuberculosis.

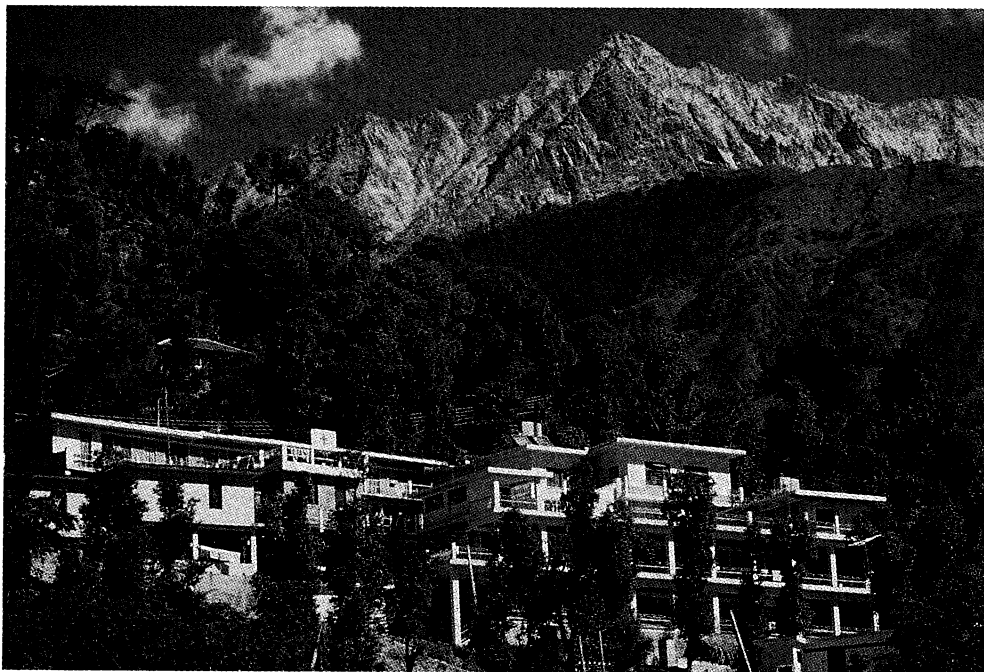
The problems facing the early refugees must have been immense. Crossing the border into India meant a massive geographical and climatic change. The contrast from the icy Tibetan plateau with an average elevation of over 4,800 metres to the stifling heat of the Indian plains could not be greater. I can think of no parallel in other refugee situations, where political borders are crossed but into geographically similar countries. The trek over the Himalayas brought its toll and those that crossed into India and Nepal were weak and exhausted, many with frostbite. Arriving in India undoubtedly exposed them to many diseases for which they had no natural immunity. The health services available to them were those that already existed within the Indian medical system. Following the events of 1959 Tibetan medicine went into decline. Many physicians were imprisoned particularly, during the Cultural Revolution. His Holiness, The Dalai Lama saw a need to preserve this important facet of their culture, and the Tibetan Medical Institute (TMI) was founded. In 1982, after 21 years in prison, Dr Tenzin Chodak, the former personal physician to His Holiness, came to India and brought much needed skills to the TMI particularly in the area of medicinal formulation. Today the Institute is flourishing, training new physicians in the traditional skills, has an expanding herbal pharmaceutical production supplying medicines throughout the Diaspora and has a large following among Westerners.³

The task of co-ordinating health services within the widely scattered exiled community has fallen to the Department of Health (DOH), a ministerial office within the Kashag (government of His Holiness). Most of its funding is provided through western-based aid agencies. It runs a parallel system of traditional Tibetan medicine alongside a structured allopathic health program. There is recognition of the vast disparity between the two systems and no attempt is made to combine them. The main focus of the allopathic system is on providing basic care at community health worker level. Each settlement attempts to have two Community Health Workers (CHWs) who work from small clinics. The CHWs have access to a basic range of drugs and are able to treat the majority of common infections, skin diseases etc. that present to them within the settlements. They are trained in basic laboratory techniques such as haemoglobins, ESRs, urine microscopy and most importantly Ziehl-Neelsen staining of sputum for

acid and alcohol fast bacilli. Tuberculosis (TB) is by far the biggest public health problem facing the Tibetan exile community and the role of the CHW is pivotal in the control programme, both in detection and follow up of cases. Community health workers are not confined to settlements as many Tibetans live within institutions such as monasteries and schools. Many of the larger such institutions have their own CHW. Training of health workers takes place in courses organised in Dharamsala by the DOH in conjunction with staff from the Tibetan Delek Hospital.

The Tibetan Delek Hospital

The Tibetan Delek Hospital is a charity-run organisation which is both administratively and financially autonomous from the DOH. It is a 44-bedded primary health care hospital founded in 1971. It was set up to provide allopathic health care for the Tibetan community in Dharamsala and act as a referral centre for the settlements in Himachal Pradesh. Basic laboratory and X-ray facilities are available. Half of the beds are for TB patients. The hospital runs many health programmes including an under-fives immunisation clinic, antenatal service, and dental and eye clinics in addition to its general medical out-patients and TB clinics. On the clinical side staffing is based on volunteer doctors usually from the West, who work alongside the medical administrator and currently one Tibetan physician who oversees the TB programme as project manager. The nurses are all Tibetan although currently assisted by a volunteer from Australia. The hospital provides a number of satellite services; an out-patient clinic in Mcleod Ganj (a village of Dharamsala) and weekly clinics held at the Jampaling Elders Home,



The Tibetan Delek Hospital with the backdrop of the Dhauladhar Range, Himachal Pradesh, India.
(Photo by Chris Jones.)

Soga School transit camp, Norbulinka Religious and Cultural Institute and the Dolmaling Nunnery. Tri-annual field trips to the various settlements within Himachal Pradesh are also run, mainly to review the TB programme and support the CHWs in any problems they are facing.

For a hospital in a developing country, it is reasonably well equipped. There is a small operating theatre used mainly for minor surgical procedures and a delivery room for obstetric cases. Their use is dependent on the skills and qualifications of the volunteer medical staff. It is not usual to have a volunteer with major surgical skills. Specialist laboratory investigations are available from private Indian doctors in Dharamsala particularly ultrasound. A CT scanning service is available in Pathankot some two hours drive away in the state of Punjab. Referrals of more complex problems are made to either the Indian government hospital in Dharamsala or the postgraduate institute in Chandrigarh, which is about a six-hour drive and represents the nearest teaching hospital. Some referrals are made to Delhi.

Health problems

In order to understand the health problems facing the exile community it is important to have an appreciation of the social fabric within which the Tibetans are living. Of the approximate 3,500 people that arrive from Tibet annually almost all cross into Nepal. From there they make their way to Kathmandu where they are processed by representatives of the government-in exile and the UNHCR by whom they are given official refugee status.⁴ Most then travel to Dharamsala to see the Dalai Lama. Whilst in Dharamsala they are housed at the reception centre for new arrivals. From there they are sent to any number of settlements in India. Most of the children will be sent to one of the Tibetan childrens' villages which are mainly boarding schools. There they receive an education in parallel with the Indian education system, with the addition of learning the Tibetan language and culture which is something that is largely denied them in Tibet. For this reason many Tibetans send their children to India. Unfortunately the Chinese authorities are clamping down on this and penalising parents who send their children abroad by removing their trade licences and inflicting them with higher tax burdens essentially making them *persona non grata* within their own country. Young adults who arrive are usually sent to the Soga School near Dharamsala. This is a temporary corrugated-iron complex which acts as a transit camp. Here the students are educated in the language and ways of their new host country. Others may be sent to similar institutions in Delhi or South India. Monks and nuns are sent to the various monasteries and nunneries. From this it can be seen that many Tibetans are living within institutions. The level of hygiene and sanitation is often poor and accompanied with overcrowding it is not surprising that tuberculosis is common. It is also the condition in which water-borne diseases thrive, especially diarrhoeal diseases and typhoid. Skin infections and pediculoses are also prevalent. Other factors that contribute to ill-health include poor level of health education, the dramatic environmental change, poor nutrition and poverty. The nutritional needs of Tibetan exiles have largely gone unassessed. The locally available food is another of the great contrasts between India and Tibet and for many new arrivals it is largely unpalatable.

Given the huge sense of cultural isolation coupled with personal histories of great suffering and hardship (including torture), psychiatric morbidity is high.

Many physical symptoms have an underlying psychosomatic component but largely go unrecognised. The Tibetan language itself lacks words for psychiatric illness and most conditions get grouped under the term of madness or diseases of the 'heart'. Like most societies psychiatric illness carries a stigma and is seen as a weakness, and many problems inevitably go unrecognised in the community.

The problems of the elderly, as in most developing countries, are emerging as an increasing problem. Many of the original surviving 1959 refugees are now amongst the elderly population. Separated from family still inside Tibet, they lack their usual social structure and extended family support, particularly financial support. They are thus becoming an increasing financial problem to the community. Aid organisations have helped build old peoples' homes, but these institutions are a foreign concept to Tibetans. They provide food and shelter but have major deficiencies from a health care point of view.

The management of chronic problems such as hypertension, diabetes and asthma are particularly difficult to deal with. Little is known of the prevalence of these conditions. Health education is poor and general awareness and patient understanding is low, making non-pharmacological intervention difficult. Drug treatments are widely available but represent a significant financial burden to most patients. Asthma management is particularly fraught with difficulties since steroid inhalers for prophylaxis are unavailable outside the major Indian cities as well as being prohibitively expensive.

A frequent complaint was dyspepsia. A study of exiles living in the south of India⁵ found a prevalence rate of *Helicobacter pylori* infection of 77 per cent in a randomly selected group of Tibetan males with close correlation between infection and chronic gastritis; the incidence of infection did not rise with age but correlated with the proportion of early life spent outside India, presumably in Tibet. Younger people who had been resident in India for 20 years or more had a higher risk of *H. Pylori* infection. The study of population migrations can sometimes provide clues to the pathogenesis of disease and the Tibetan experience may be a further example.

Tuberculosis

One of the key topics of debate regarding tuberculosis in Tibetans is whether, when tucked away in the rarefied atmosphere of the 'Roof of the World' and isolated from outside visitors, they in effect were isolated from the disease? After the Chinese invasion they were exposed to the bacillus as millions of Han Chinese migrated in from the overcrowded People's Republic. No one really knows if tuberculosis was a problem prior to 1950. Certainly, when you read early accounts by westerners who ventured into Tibet, living conditions and personal hygiene were very poor—just the conditions in which tuberculosis thrives.² However many of the community in exile believe that their present problem is due to the dramatic climate change when they moved from the Tibetan plateau to the plains of India. This could lead to the inference that tuberculosis was previously uncommon.

Inside Tibet today pulmonary tuberculosis seems to be as major a public health concern as it is outside. Official surveys performed by the People's Republic of China in 1985 and 1990 have shown an increase in pulmonary tuberculosis rates from 5.5/1,000 to 15–30/1,000.⁶ However, diagnoses were often made without sputum evaluation, and X-ray facilities were limited to fluoros

copy. The aid organisation, Médecin Sans Frontières, in 1992 found a prevalence rate in areas they surveyed less than that shown in the official statistics but it was hard to find data representative of the indigenous Tibetan population, the Han Chinese now being in the majority.

The situation in exile is very different, since more accurate statistics are available. Amongst the Tibetan community there is a programme which runs alongside the tuberculosis control programme for India and is based on WHO guidelines. The programme is currently sponsored by the Basque government of Spain. The current prevalence rate of people on anti-tuberculous treatment is about 1–2 per cent.⁷ This figure is probably an understatement as there are undoubtedly undetected cases in addition to Tibetans who have chosen to get their treatment through private Indian practitioners or from a local Indian government hospital. One unanswered question is whether Tibetans are acquiring the disease in India or whether they are bringing it with them? Unfortunately resources do not allow for mass X-ray and tuberculin testing of all new arrivals.

The programme is fraught with problems although still manages to have a high success rate; about an 80 per cent cure rate compared to about 40 per cent on the overall Indian programme. Although the CHWs maintain a high degree of vigilance, many patients seek alternative health outlets, such as private Indian doctors or traditional Tibetan medical practitioners. Tibetan medicine does not have a cure for the disease and there is a greater acceptance that conventional medicine is necessary to control it. More and more traditional practitioners are now referring patients with symptoms suggestive of tuberculosis to their allopathic colleagues. Unfortunately the programme has met a problem created by private Indian doctors who prescribe unconventional drug regimens, in inadequate doses, for an insufficient duration of time. Multi-drug resistance is now a major problem. Treatment regimens for drug resistant organisms are hugely expensive (an 18-month course of treatment is equivalent to 10 years' salary for the average Tibetan). Fortunately many get part sponsorship from aid charities in conjunction with funding by the DOH. Patient compliance can be a problem. Overall the defaulter rate is low but it is high amongst one group of Tibetans who earn their living by making and selling sweaters. This is seasonal work, and every winter the sweater sellers head off to different parts of India to ply their trade. The financial pressures are great and many are forced to default from the programme. It is difficult to ensure a steady supply of drugs as they wander from place to place. Treatment is often interrupted, and relapse and drug resistance are common.

The extent of association between HIV infection and tuberculosis amongst the Tibetan exiles is unknown for the simple reason that HIV serology is not performed. This is as much a political issue as a lack of resources. However in the small population that has presented to the Delek Hospital in recent years, there have been none with any obvious HIV related diseases, which may suggest that the incidence is very small. Despite lack of HIV testing the DOH and Delek Hospital staff are giving priority to public education regarding the infection. Happily, the Delek Hospital has abandoned its previous habit of steam-sterilising needles for repeated use for streptomycin injections and is now disposing of them after single-use. Unfortunately this policy has not filtered down to the settlements.

There are other limitations to the tuberculosis programme. There are inade

quate resources to undertake a screening programme and routine contact tracing. This becomes particularly difficult in the large institutions, which appear to offer favourable conditions for the spread of *Mycobacterium tuberculosis*. There is now a greater emphasis on health education within the program, and public awareness about the mode of transmission and symptoms seems to be increasing. This will hopefully go some way to improve the situation. There is still much work to be done and tuberculosis control remains an enormous challenge to the Tibetan community.

CONCLUSION

In my short time in Dharamsala I was uniquely privileged to be allowed into the exiled community and to observe the problems they encountered while living in India. They present a tale of enduring hardship coupled with a tenacity for preserving their unique, deep-seated religious and cultural identity. Having emerged from their mountain home they have entered a vastly foreign world. They seem to have embraced our own concept of allopathic medicine and yet retain their own traditional practices in a truly complementary way. The prevalent health problems remain the diseases of poverty, and there is a recognition of the huge task that is required to overcome them. The future for Tibetans is as precarious as it is uncertain. Walking the political tightrope between their masters in China and their hosts in exile is a difficult and dangerous journey. If and when the hard-line approach from Beijing relaxes and Tibet returns to autonomy there will then be the mammoth task of shaping a health programme not in exile but at home.

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PROTECTING TRAVELLERS FROM TROPICAL DISEASES: THE PRESENT POSITION AND FUTURE PROSPECTS

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This paper was written after returning from the fourth meeting in Mexico in 1995 of the International Society for Travel Medicine (ISTM) attended by 900 participants.

Malaria

No significant changes in recommendations for prophylaxis were reported, although since ICTM3 in Paris there has been a move towards more uniform recommendation of mefloquine. There is now a greater acceptance that the rate of adverse effects (AE) is higher for mefloquine than for chloroquine; this in contrast to the results of large retrospective studies published in 1993 which found virtually no difference between chloroquine and mefloquine. Retrospective and prospective studies may lack sensitivity for AE depending on the questions asked and time lapse between the timing of the questionnaire and onset of AE.

In a short term study of Spanish tourists the rate of dizziness, anxiety and insomnia was about twice as great on mefloquine (18 per cent) compared to chloroquine (8 per cent). A British retrospective study examined AE in over 1,000 mefloquine users. The incidence of severe neuropsychiatric symptoms was about 1:170, far higher than the 1:10,000 previously quoted for prophylactic use, compared to zero for chloroquine plus proguanil. Dissociation from reality was the most prominent symptom in severe cases.

Pharmacological studies have not found that AEs correlate with plasma levels. Hearing, postural control and vestibular function did not show any abnormality in ten healthy volunteers given mefloquine 250 mg weekly for 16 weeks, even though some experienced AE. A double blind crossover trial of weekly mefloquine in trainee pilots detected no impairment of performance, although there was a low incidence of sleep related AE. Older travellers tend to have less AE than young adults. There was a report of a patient who had several episodes of paranoid psychosis on mefloquine but only in association with heavy (600 ml of whisky) alcohol consumption. After he ceased his weekly binges he had no further problems. The relationship of mefloquine AE to alcohol needs further study as many tourists increase alcohol intake during vacation.

Multi-drug resistance seems to be increasing in Papua New Guinea with 15 per cent of falciparum cases resistant to quinine, 27 per cent resistance to mefloquine and 31 per cent to halofantrine. These drugs are structurally similar and cross resistance was expected.

Mefloquine seems to be tolerated better in children than in young adults, and the prohibition on the use of mefloquine in children under 15 kg can be viewed flexibly, although with no liquid formulation, compliance with tablets limits its use. Break through malaria during or following mefloquine prophylaxis with its long half life, is likely to lead to both more frequent late recrudescence, and malaria with low parasitaemia. There is some evidence that this is occurring.

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