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**HEALTH SEEKING BEHAVIOURS OF TIBETAN REFUGEE
COMMUNITY IN DHARAMSALA, INDIA.**

By

Jurme Wangda

A thesis submitted to the School of Rehabilitation Therapy,
in conformity with the requirements for
the degree of Master of Science

Queen's University
Kingston, Ontario, Canada

June 26th., 1996

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ABSTRACT

This study examined the health seeking behaviours of the Tibetan refugee community in Dharamsala, India. Both qualitative and quantitative data were collected on 46 members of the community randomly chosen from five stratified groups. Subjects were divided into two age groups; 15 - 35 and 36 - 60.

The Tibetans in Dharamsala have the benefit of three health-care models. These are Tibetan traditional systems Tibetan traditional medicine (TTM) and Spiritual healers (SH) and one Western allopathic medicine (WA) adopted in exile. The three systems are well integrated into the community and cross refer to each other, based on their expertise. All systems are accessed depending on the differing needs of the community.

The Tibetans of Dharamsala generally found TTM to be the best health system, because of the caring nature of the care-giver and safeness of the medications. Their initial-utilization patterns depended on the nature of their medical problem. For curative procedures, TTM and WA were chosen while SH was chosen for preventative measure. It was apparent that the younger Tibetans in Dharamsala were more comfortable and familiar with WA concepts. As well, compared to the older Tibetans, younger Tibetans were more aware of the possibilities of side-effects and transmittable diseases related to WA treatment.

The initial-decision making process of the Tibetans in Dharamsala for their health related problems were made on the basis of their previous experience of treatments. Another notable aspect of the decision-making process, was the decision to seek consultation of Spiritual Healers to determine their health care choices.

In general all the three main health-care models were effectively utilized. WA was most frequently accessed for 'acute/trauma cases', TTM for 'chronic disorder/diseases' and SH for 'psychological or spiritual related disorders/obstacles. This study is an initial examination of Tibetan health seeking behaviour in Dharamsala and remains an interesting subject for further research.

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CHAPTER I: INTRODUCTION

1.1 A Brief History of Medicine

Health is very important to the individual and to society. In fact, without health, wealth is almost meaningless. This concept denotes that health is related to every aspect of a person or a community. Health according to the World Health Organization (WHO) is defined as " a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (Helman, 1994 p.92).

Twenty-five hundred years ago, Buddha Shakyamuni taught that birth, aging, disease and death are the processes of life (Men-Tsee-Khang, 1995) and that the root of disease is three poisons; lust, anger, and ignorance. These are believed to be the essence of all health problems in Tibetan traditional medicine. In the seventh chapter of 'Bodhisattvacaryavatara', Shantideva states, " Evil deed inflicts harm against body and mind' (p.27).

Nearly 2400 years ago, Hippocrates, the master physician of Greece, taught that illness has natural rather than supernatural causes. He implemented the theory that the human body has the power to heal itself (Albright and Bets, 1980).

"There was a time when all healers were priests and all priests were teachers. It may seem archaic to turn to a religious leader for treatment of the body, or think that an educator is concerned with physical health

of spiritual well-being. Yet there is the holistic principle; man is a triune being. He thinks of himself as body, mind and spirit" (Solomon, 1989 p.3-4).

This philosophy is not unlike the concepts within traditional Tibetan medicine. This latter approach identifies the Spiritual Healer and use of the Oracle in determining treatment needs.

The French philosopher Descartes (1596-1650), influenced the development of the Western medical model and scientific thought by promoting the theory that the body and mind are distinctive entities which can be dealt with in separate ways. Descartes' theory encouraged specialization, ultimately leading to a significant emphasis on the treatment of symptoms, syndromes, and dysfunctions of physical organ systems (Albright and Bets, 1980).

Notable medical advancements in Western Medicine include the following discoveries. Around 1800, Jenner discovered small pox vaccination; in the 1850s, Schlieden and Schwann developed a theory that living things were composed of cells; in the late 1880s, Pasteur had discovered a correlation between the presence of micro-organisms (germs) and disease; Koch had identified the tubercle bacillus; Roentgen the X-ray, and by 1900, the Curies' had identified the properties of radium. Chemotherapy, the treatment of disease by chemicals, also began to be used at about this time. Ether and other substances were in use, thereby facilitating the utilization of surgical treatments (Albright and Bets, 1980). These and other western discoveries

influenced the direction of Western medicine in the late 19th. and early 20th. centuries.

Support was given to the drug industry by the petroleum industry (Albright and Bets, 1980). This was due to the fact that a large proportion of the drugs undergoing research, and in production, were derived from petrochemicals, such as plastics. The most popular drugs were in the classes of tranquillizers, antibiotics, and drugs to lower blood pressure and diuretics. The rapid expansion of technology ran a course parallel to the rapid development of drugs (Albright and Bets, 1980).

In our present age of specialization, modern man has entrusted his 'three selves' (body, mind and spirit) to specialists (Solomon, 1989). Western man decided to separate these 'three selves' restricting an understanding of diseases and illnesses. Health professionals and scientists are now beginning to appreciate the fact that there are human or spiritual dimensions to health and healing in addition to the scientific basis of western medical practice. This healing factor goes beyond all the techniques, all the chemical constructs of the physical body, and gives a wholeness to the healing process (Solomon, 1989).

In this study, the investigator believed it would be possible to demonstrate that 25 centuries of tested knowledge of Tibetan Buddhist culture would be of benefit to the Western cultures as an option which is timely and appropriate, both in terms of the 'philosophical framework' it has to offer and the 'promotion and restoration of health and well being'.

1.2 Statement of the Problem:

The Tibetan people in Dharamsala, India have three health-care options available to them.

- 1) Spiritual Healer (SH),
- 2) Traditional Tibetan Medicine (TTM), and
- 3) Western Allopathic Medicine (WA).

There is little understanding of how or why the Tibetan community choose one particular approach to health care over another. An understanding of why Tibetans choose one system over another is important in the development and allocation of health care resources and the provision of facilities and programs in the future.

1.3 Research Questions

The primary research question is to determine which approaches to health the Tibetan community in Dharamsala consider to be the best and why this is the case. The explicit purpose of this study is to enhance our understanding of Tibetan health seeking behaviour. The following topics were explored as part of the research:

- i) Tibetan health and illness beliefs;
- ii) The initial decision-making process for seeking treatment;
- iii) The factors that influence how Tibetans choose between the three types of

treatment available to them, namely Spiritual Healers , Traditional Tibetan Medicine and Western Allopathic Medicine.

- iv) Tibetan beliefs surrounding the appropriateness of certain types of treatment for specific types of health problems;
- v) The usage of the three treatment types;
- vi) The satisfaction with the three treatment types.

1.4 Limitations of the Study

The study originally intended to include 50 participants. Due to social and community constraints, only 46 participants were available. Constraints that influenced an individual's participation in the study included:

- i) The Tibetan New Year occurring at the same time as this study
- ii) Participants attending the teaching session of H.H. the Dalai Lama
- iii) The beginning of the school year in Dharamsala
- iv) A number of annual activities of the Tibetan Government-in-exile, such as the 10th. of March, i.e. the Uprising Day, Tibetan Women's Movement and International Women's Day.
- v) Some of the ages of the community members in the taxation books where the participants were selected from were not accurately recorded.
- vi) Limited time and resources due to financial constraints.

1.5 Limitations of the Approach

There has been little Western research on Tibetan health care issues. In addition, the Tibetan people are not familiar with the Western research approach, which uses sets of questions in an interview format administered on a specific schedule. The fact that subjects may not have been familiar with these research constructs may have introduced cultural based limitations. The personal independence of Tibetans makes it difficult for them to understand or appreciate why someone would need to follow specific sets of procedures as used in a questionnaire. Although the investigator was born and raised in Tibet, half his life has been spent in a western environment; in effect this has resulted in the investigator having a sense of his 'muscles' being Western, while the 'bones' are still Tibetan. This may introduce researcher bias. The result of the study cannot be generalised to all Tibetan communities in India, but may help future studies of this kind.

1.6 Purpose of the Study

This study focuses on the Tibetan refugee community of Dharamsala, Himachal Pradesh, India, which is located approximately 535 kilometres northeast of Delhi. The purpose of the study is to provide a baseline of information regarding the health seeking behaviour of Dharamsala Tibetans that can be used in developing a

more comprehensive and effective health care system for the Tibetan community. The study includes a description of how persons monitor their bodies, define and interpret their symptoms, take remedial actions, and utilize the health care system (Mechanic, 1982). This baseline data will be valuable for other researchers studying health system use in Dharamsala.

1.7 Hypotheses

The hypotheses in this study are;

- i) Exposure to alternative health-care systems will influence health seeking behaviour.
- ii) Tibetans born and raised for at least 15 years in Tibet will have different health seeking behaviour than those born outside of Tibet, e.g. in India.
- iii) Experience and personal knowledge of health care systems will influence health seeking behaviour.

1.8 Definitions of Terms

This study frequently uses the term **health and illness beliefs**. To understand what is meant by health beliefs, one must consider that believing that one is presently healthy does not presume that one would remain healthy forever. Therefore, any intentional activities taken as a measure to prevent any foreseeable health concern is

defined as 'health beliefs'. When one refers to illness beliefs, it means any individual who becomes ill wishes to eliminate that particular cause. Therefore, any intentional activities taken as a measure to cure that illness is defined as 'illness beliefs'. In another words, prevention relates to health beliefs and cure is related to illness beliefs.

Western Allopathic Medicine: This term, which originated in Europe, refers to what is generally known as modern medicine which is practised in urban oriented health care systems. The methods are bio-scientific. Treatment principles are scientific and fractional. The diagnoses include the use of mechanical devices, and treatment practices include chemicals or drugs.

Traditional Tibetan Medicine: Traditional Tibetan Medicine, literally called "the science of healing" was taught by the Buddha in India around 500 B.C. It was introduced into Tibet in the 7th. Century, and is practised there to this day. The method is psycho-physiological. The treatment principle is natural and holistic. Diagnosis is made mainly through sphygmology, and urine-examinations. The treatment practices through herbal and mineral ingestion and application.

Spiritual Healers: There are two kinds. One is a *lama* (Rinpoche); the spiritual masters, originated in Buddhism. The method is to use spiritual insights, the treatment principle is compassion and altruism, the diagnoses are achieved through empathy and listening, and the treatment practices include benediction, blessings,

precious pills, pujas and rituals.

The other kind is the *oracle* (Lha); who seeks help from the spirits while a person is in a trance. The oracle (Lha) is primarily based on prediction from a specific spirit while an individual is in a trance. This is a shamanistic approach which is practised in many other cultures, such as jakri, buji, in Nepal; rei no tatsune, kami-danomi in Japan; and is also found in other regions including Thailand, India, Native Australia, and Spain.

Interdependedness: Those who practice Traditional Tibetan Medicine believe that phenomena do not exist by themselves, but are just dependently arisen in the sense of being dependently imputed (Dalai Lama, 1984; Tarthang, 1989). An example of this was explained by Buddha in detail in the 'Rice Seedling Sutra' and was recorded in Yeshi and Russel (1990 p.27) " Due to the existence of this, that arises; due to the production of this, that is produced".

Karma: Karma is a Sanskrit term that denotes action and its fruits; the totality of all virtuous or non-virtuous actions and their fruits (Rigzin, 1994). For example, positive actions bring positive results and negative actions breed negative fruits. One cannot get a banana from an apple tree.

Evil Spirits: This term refers to force/energy that is believed to be harmful or obstructive to living beings. In summary, there are 23,900 diseases and disorders commonly spoken amongst the Traditional Tibetan health experts/Spiritual healers.

Those diseases and disorders are roughly sub-divided into six main categories listed as follows in both English and Tibetan.

- (a) 1,080 kinds of demonic harms/evil spirits (bGegs-rigs),
- (b) 404 different kinds of diseases (ned-rigs),
- (c) 21 bad omens (lTas-ngan),
- (d) 360 distractions (Ye - 'Brog.),
- (e) 21,000 unfortunate conditions (rKyen-ngan), in this case 'conditions' refers to conditions/circumstances which are a prerequisite for a cause to produce an effect, and
- (f) 15 infant gDons/demonic harms (byis-pai-gDon-chen) (Das, 1970).

Those 23,900 diseases or disorders are summarised in three groups;

- (i) Diseases of longevity/ of lifespan, that of thoroughly established phenomena.
- (ii) Diseases of karmic results, that of dependent phenomena. (iii) Diseases of gDons (demonic harms or evil spirits), that of conceptual imputation which means taking things as having a truly existent nature, generally known as 'reality' (Kaba-Paltsek, 1992; Rigzin, 1994)

Three Poisons: Desire (lust), Anger, and Ignorance which are believed to be the central cause for misery and lamentation and suffering including diseases. The three poisons give rise to three humours. For example, Desire causes Wind/Air (rLung); Anger causes Phlegm (mKhris-pa); and Ignorance causes Bile (Bhad-kan) (Rechung,

1973; Rapgyal, 1981; Donden and Kelsang, 1983, Clifford, 1984; Dash, 1985; Men-Tsee-Khang, 1995).

Puja: An offering; this constitutes all types of offerings such as worship, rituals, religious ceremony or service, recitation of sacred texts, and visualization of deities.

Mantra: Words of power; single or series of sanskrit syllables repeated as invocations, based on the power of sounds. Continuous repetition of mantras is also used as a form of meditation.

Wheel of life: A pictorial representation of Buddhist teachings showing the nature of samsara (cyclic existence).

Shamanism: A traditional belief that world is pervaded by good and evil spirits who can be influenced or controlled only by the shamans (practitioner). Many traditional healers in many parts of the world use this means to help prevent or cure diseases (Schuhmacher et al., 1989).

CHAPTER II LITERATURE REVIEW

2.1 Pre-Dharamsala History

2.1.1 The Origin: History of Tibet

History of Tibet goes back to five hundred years before Buddha Shakyamuni came into this world, i.e. circa 1063 B.C., to a semi-legendary figure known as Lord Shenrap Miwo who reformed the primitive animism of the Shen race and founded the Tibetan Bon religion (Scientific Buddhist Association, 1986; Beckwith, 1987). As further proof of the longevity of Tibet, Herodotus the celebrated Greek historian, and geographer, living in the fifth century B.C., made a reference to Tibet in his works (Saklani, 1987 P. 60). However, the present official Tibetan Royal Year of the modern Tibetan calendar is dated from the enthronement of King Nyatri Tsenpo in 127 B.C.

2.1.2 The Land of Tibet

The Tibet, often referred to as the Roof of the World, is a vast country which is more than two and half times the size of Austria, Denmark, France and Germany put together (Mitter, 1964). Tibet lies roughly between the 28th. and 36th. parallels of north latitude and 79th. and 99th. of east longitude. The entire area is over 2.5 million square kilometres and is composed of a plateau averaging some 3,650 metres

above sea level surrounded by the Himalayas, Karakorum, Kunlun and Altya-tagh mountain ranges. The area stretches some 2,500 kilometres from the west to the east and is the source of many great rivers of Asia such as the Ganges (Tibetan: Ghang-ga) Brahmaputra (Tibetan: Tsangpo), Mekong (Tibetan: Zachu), and Yangtse (Tibetan: Drichu) (Scientific Buddhist Association, 1986; & Mitter, 1964)).

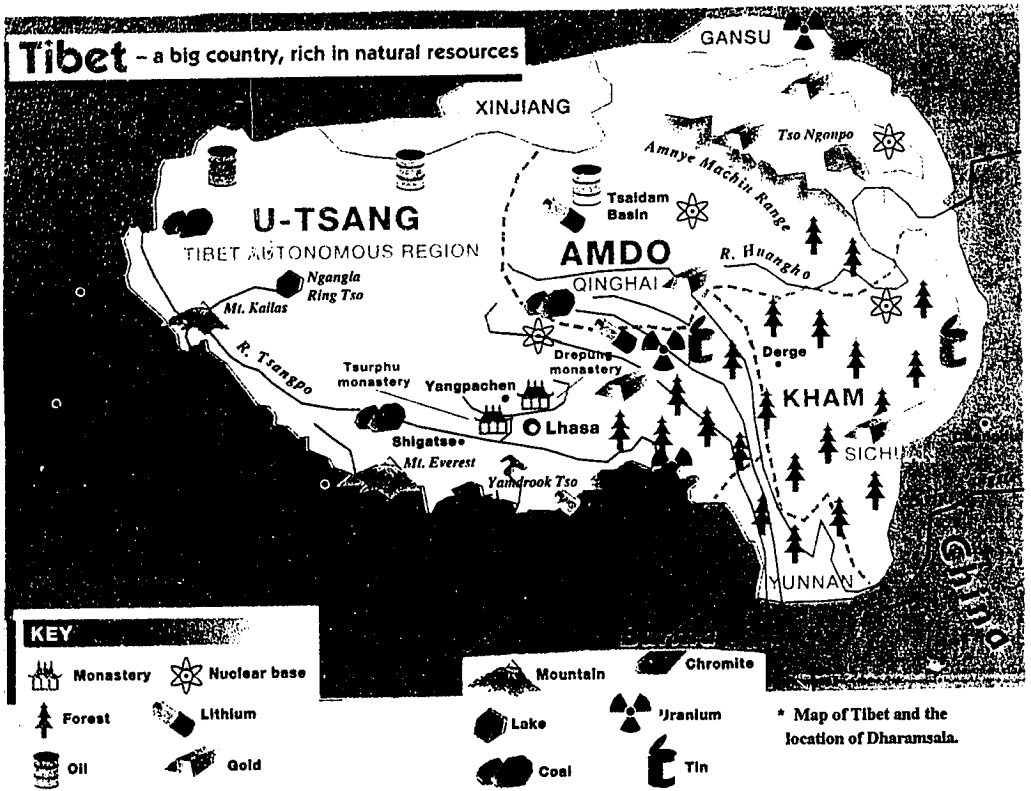


FIGURE 1: MAP OF TIBET AND ITS SURROUNDINGS

* Adapted from New Internationalist, No. 274/Dec. 1995.

2.1.3 The People and Language of Tibet

The Tibetan people are a distinct race with their own spoken and written language. This language is Tibeto-Burmese and is quite distinct from the idiographic Sino-Thai language group. It has its own culture, traditions, food and dress. In 1959, the population of Tibet was estimated at six million. Since then, there has been no reliable means of assessing the size of the population. However it has been estimated that 1.207 million Tibetans have died as a result of Chinese atrocities. This was recorded between 1950 and 1984 by Scientific Buddhist Association, Department of Information and International Relations (1986).

2.2 The Setting in Dharamsala

2.2.1 Tragedy and the New Environment

China invaded Tibet in 1949 and the Tibetan people were forced to leave their country in 1959. Approximately 100,000 Tibetan refugees have escaped to different parts of the world, mainly India, Sikkim, Nepal and Bhutan. Tibetans have set up their 'government-in-exile' in Dharamsala, in the Kangra District of India since 1960, when His Holiness the Dalai Lama their beloved leader, moved to this place.

Until the Dalai Lama, his attendants and a few Tibetan refugees first moved to Dharamsala in 1960, it was largely an unpopulated area. There was a military base a small market place and a few Indian government offices with very few visitors. There were only a couple of public buses coming to Dharamsala each day. Now, Dharamsala is a very busy place with more than eighty buses coming from all major cities in northern India including two daily public bus services and a couple of direct privately owned bus services from New Delhi which is approximately five hundred thirty five kilometres away from Dharamsala. Prior to 1980, the Dharamsala Tibetan population was quite stable, being around seven thousand. Since then, China opened up the Tibetan boarder into Nepal for foreign tourists, Tibetan refugees have flowed steadily so that the population of Dharamsala has been very unpredictable. Besides, now there are many foreigners visiting the place. It has grown into a tourist attraction. People can even go to Dharamsala by air from Delhi. The local government has built an airport just near to Dharamsala.

2.2.2 Demographics

Tibetan refugees have established about 80 communities in South Asia; approximately 60 of them are scattered throughout India (Landis, 1992). Dharamsala is one of them. It functions as the pre 1959 capital, of Lhasa. Here in exile, people call it "the little Lhasa" to conform and recognize this as that of pre 1959 (Saklani, 1987). Dharamsala is an Indian town, in the Kangra District of Himachal Pradesh. The jurisdictional capital of the district is Simla, about 200 km. from Dharamsala. Both Simla and Dharamsala are hill stations or summer retreats, which were in their peak time of usage during the British rule of India (Crowther and Wheeler, 1987). This is the reason why many of the places have foreign (English) names, for example 'McLeod Ganj' and 'Forsyth Ganj', named after British army officers of that era. Dharamsala was predominantly a military base, whereas Simla was more of a summer resort. In Dharamsala, there still exists a heavily armed Indian military camp, due to the proximity of Pakistan.

The population of Dharamsala in 1993 was recorded at 17,320 by the Dharamsala Municipal Committee. The population of the Tibetan community in Dharamsala in 1993 was estimated by the Dharamsala Tibetan Welfare Office and Freedom Movement Office as approximately 7,300, of which about 6,540 were between age 15 - 60. The local people of Dharamsala called 'Gadhia', are a hill people who are gentle in nature and rather innocent. Today the majority of the

population of Dharamsala is of Indian origin (including Panjapi, Marwari, Kashmiri, Nepali, Gujrati). The Dharamsala municipal region is sub-divided into three main areas; Upper Dharamsala, Lower Dharamsala, and Kachari. The Tibetan community is predominantly in Upper Dharamsala (McLeod Ganj and Forsyth Ganj), and the Indian community lives in Lower Dharamsala. Kachari is the location of the local Indian government offices, such as the Police Office, Foreign Registration Office, Main Post Office, Jail, and the Public Hospital.

The Tibetan refugees within the Dharamsala Tibetan Welfare jurisdiction are located in Yole, Telugpur, Lower Dharamsala, Ghangchen Kyishong, Forsyth Ganj and McLeod Ganj. Much of these are grouped into five Blocks A through E. The principle institutions of value to the Tibetan refugees can be found within the following communities.

(a) McLeod Ganj (Blocks: B,C,D)

The majority of the Tibetans within Dharamsala region reside in McLeod Ganj. The community has the following primary components: His Holiness (H.H.) the Dalai Lama's Resident palace, Namgyal Monastery, Dialectic School and Main Temple, Tibetan Handicraft Centre, Tibetan Institute of Performing Arts, Tibetan Welfare Office, Branch Security Office, Refugee Reception Office, Tibetan Freedom Movement Office, Tibetan Youth Congress, Tibetan Women's Association, Hotel Tibet, a branch of Tibetan Medical and Astrological Institute, a branch clinic of Delek

Hospital, two Private Traditional Tibetan Medicine clinics, two convents, and a number of monasteries, shops, and restaurants.

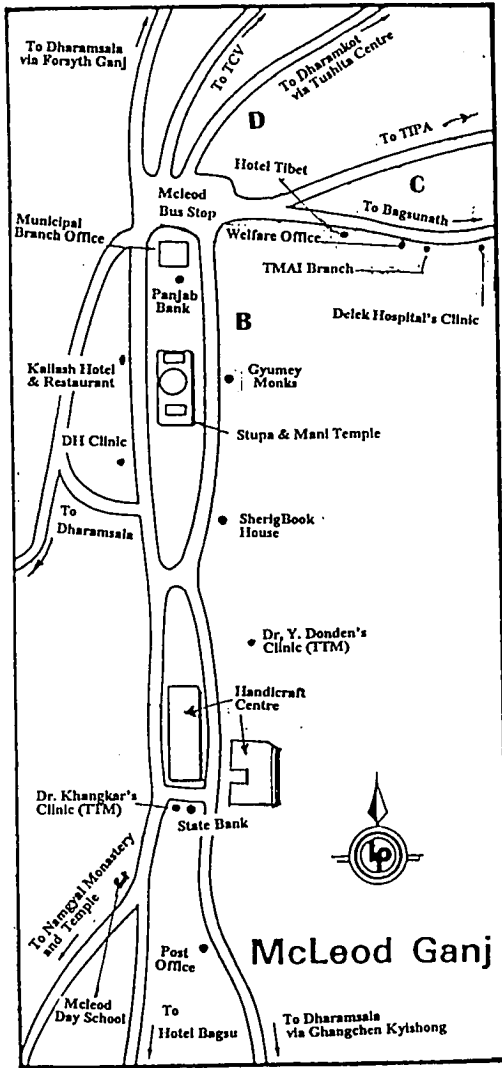
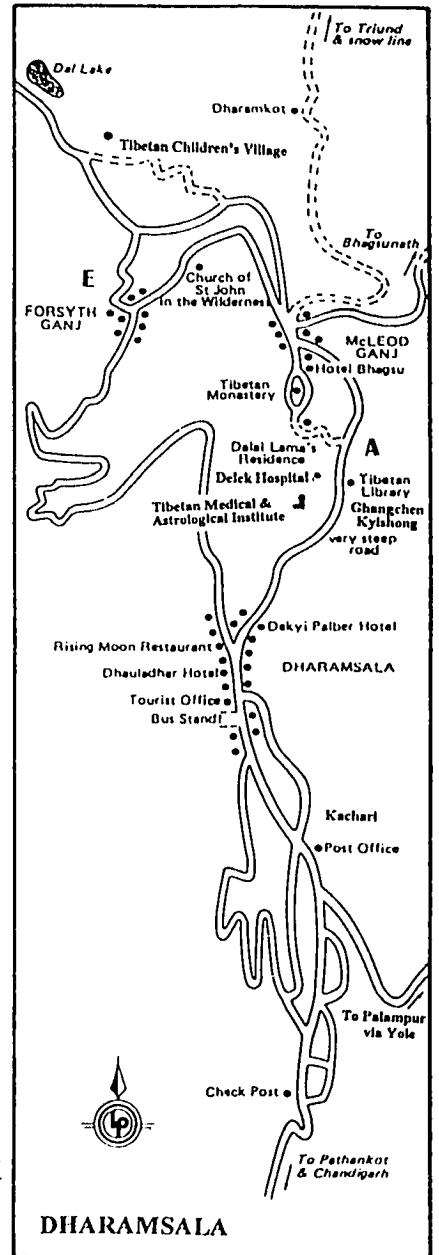


FIGURE 2: MAP OF DHARAMSALA AND MCLEOD GANJ

* Adapted from; India: survival kits, 1987.



(b) Ghangchen Kyishong (Block: A)

This region includes the Secretariat, the Central Administration of Tibetan Government-in-exile, the Library of Tibetan Work and Archives, the Tibetan Medical and Astrological Institute, the Delek Public Hospital, the Nechung Monastery (National Oracle), and the Amnye Machen Institute.

(c) Forsyth Ganj (Block:E)

This area includes the Tibetan Children's Village (TCV) School up to grade 12. and a vocational training centre for Tibetan Arts and Handicrafts.

2.3.1 Political Structures

In 1960, the first Tibetans to appear in Dharamsala were His Holiness the Dalai Lama and his entourage. Over the subsequent 37 years the Tibetan refugee population grew, and Dharamsala became the political centre for Tibetan people and the seat of Tibetan government-in-exile (Organizing Committee of Information Office, 1984). The Tibetan community in Dharamsala started like an ordinary refugee camp, with the exception that it was also the location of His Holiness the Dalai Lama the political and spiritual leader of the Tibetan people.

In 1959, the Dalai Lama re-established his Government in India. Soon after his flight from Tibet a series of democratic changes in Tibetan Government were initiated. A parliament-in-exile was constituted of a popularly elected body of people's representatives. In 1961 the H. H. the Dalai Lama prepared a draft constitution for the future Tibet and sought the opinion of Tibetans on this matter. In 1963, a detailed draft constitution for a future Tibet was promulgated.

The basic fundamentals established by this Government included;

Upholding the principles of non-violence, as laid down in the teachings of Tibetan religious traditions;

Commitment to the social welfare and a Federal Democratic Republic;

Adherence to the Universal Declaration of Human Rights, specified by the United Nations on 10th. December, 1948 (Department of Information and International Relations, 1994);

Promotion of the moral and material welfare of the Tibetan people to achieve their common goal of independence;

Endeavouring to conform to the generally accepted principles of international laws of host countries;

Provision to all Tibetans of equality before the law, and the enjoyment of the rights and freedom set forth in the Charter without discrimination of Sex, race, language, lay or ordained, social origin, rich or poor, as well as other fundamental rights and freedom (Kumar, 1994).

2.3.2 Tibetan Government-in-exile

In order to provide management and administrative functions, the Tibetan Government-in-exile was organised on a departmental basis. The following departments were made responsible to the Central Political Authority.

(a) Government-in-Exile Departments

Inside Tibet, the Tibetan religious and cultural heritage has been endangered due to the military invasion by China. H.H. the Dalai Lama established the Council for Religious and Cultural Affairs (now the **Department of Religion and Culture**) in 1959 to preserve and promote understanding of Tibetan religion and culture. The **Department of Home Affairs** is responsible for all social rehabilitation schemes for the Tibetan refugees. The **Department of Finance** is responsible for the budget, loans and business operations. The **Department of Education** is responsible for the provision of both traditional and modern education for Tibetan children. The **Department of Health** is responsible for the provision and promotion of health care. The **Department of Security** was established in 1959, soon after the formation of the Central Tibetan Administration (CTA). Its primary duty was to ensure the personal security of H.H. the Dalai Lama. The **Department of Information and International Relations** was established to disseminate information about Tibet to

the rest of the world through special publications and audio-video material. It also prints and publishes journals and other publications on Tibet in four different languages, English, French, Tibetan and Hindi.

Recognising the need to improve the use of its human, physical and financial resources in the development of the Tibetan refugee community, the CTA established the **Planning Council** in 1988. This was chaired by a member of the Kashag (cabinet) and comprised the secretaries and other heads of most of the Constitutional Commissions and CTA Departments.

Reception facilities have existed since late 1979 when the first refugees arrived from Nepal. With the increasing number of new refugees from Tibet, an **Office of the Reception Centre** was established in 1990 to provide reception facilities. The Office has branches in Kathmandu, New Delhi and Dharamsala.

The CTA has overseas **Offices of Tibet** under the charge of the Kalon (Minister) for the Department of Information and International Relations. These Offices are in United States, Europe, Asia and Western Pacific regions (Department of Information and International Relations, 1993, 1994; Kumar, 1994).

(b) Structures of Decision-Making in the Settlements

The settlement is described as a self-reliant Tibetan refugee community organized and managed under the Department of Home Affairs, Government-in-exile,

Dharamsala. There is a Representative of the CTA in each settlement who is responsible for the welfare of the refugees. In each settlement there is a registered cooperative or society. One of the main objectives of the cooperative or society is to procure and supply consumer goods to its members, to procure and supply materials for agriculture or handicrafts, and to identify commercial markets. The cooperative or society plays a very important role in determining the socio-economic conditions of the settlers.

H.H. the Dalai Lama planned the settlements as a long term strategy. The settlements were especially established for the purpose of the preservation and promotion of the Tibetan way of life as it was believed that this was the only possible way to keep Tibetan issues alive. Therefore, almost every settlement has at least one monastery, a traditional Tibetan medical clinic as well an allopathic clinic. All the documentation related to CTA are written in the Tibetan language. The Tibetan Freedom Movement (TFM), Tibetan Youth Congress (TYC) and Tibetan Women's Association (TWA) have formed a network of local chapters in most settlements and are actively involved in the Tibetan cause.

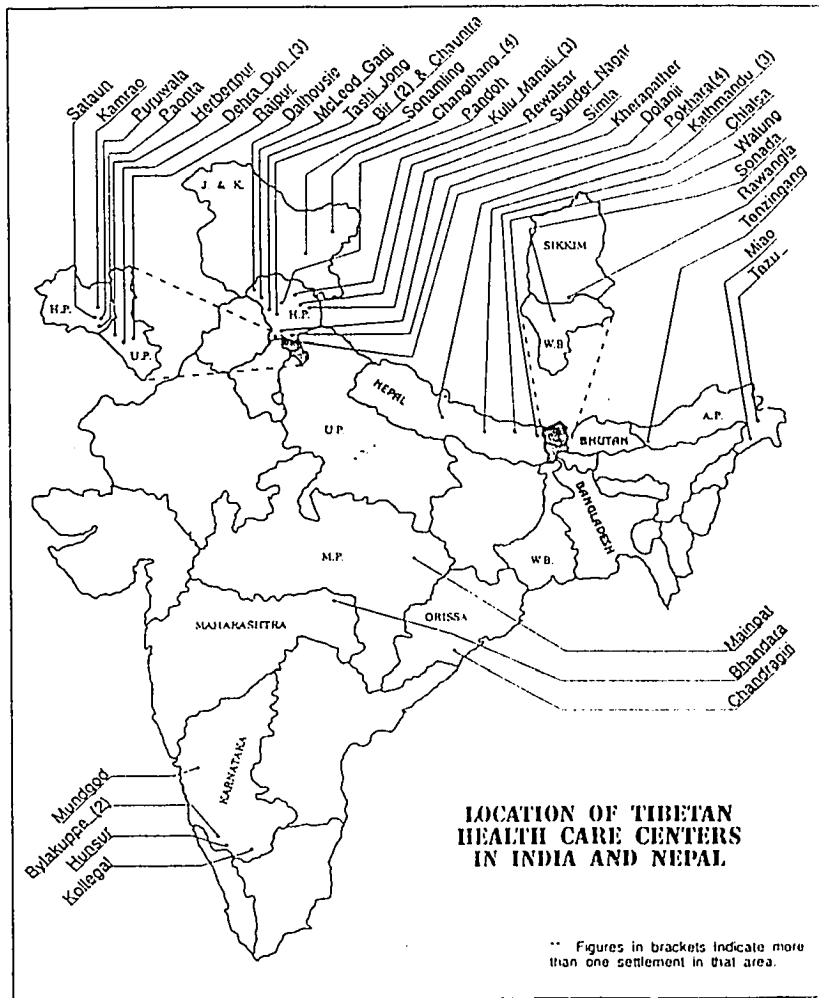


FIGURE 3: LOCATION OF TIBETAN HEALTH CARE CENTRES IN INDIA AND NEPAL

* Adapted from Tibetan Health (1981-1991). Central Tibetan Administration, Dharamsala.

2.3.3 Religion

Approximately 95% of the total population in Tibet is Buddhist. The remained are Bon (indigenous faith), Muslim or Christian (Department of Information and International Relations, 1993; Kumar, 1994). This balance of religions is also reflected in refugee communities in foreign lands.

Although Buddhism was taught by Gautama Buddha and flourished in India around 560 B.C., it was only introduced in Tibet by Songtsen Gampo; the 33rd. King of Tibet in 633 A.D. (Wangda, 1976). It continues to be practised and promoted in Tibet. The most effective way to communicate the basic philosophy of Buddhism is to study the "Wheel of cyclic existence" (Wheel of Life) as shown in Figure 4. This illustrates the nature of the 'twelve links of dependent arising'. Prior to being able to understand that a phenomenon is empty because of being dependently designated, one has to fully understand the aspects of cause and effect. In order to do that one has to identify the subject or the phenomena that produces pleasure and pain, or that harm and help. These phenomenon lack inherent existence, so they are interdependently arisen, or otherwise defined as voidness or emptiness (Dalai Lama, 1991).

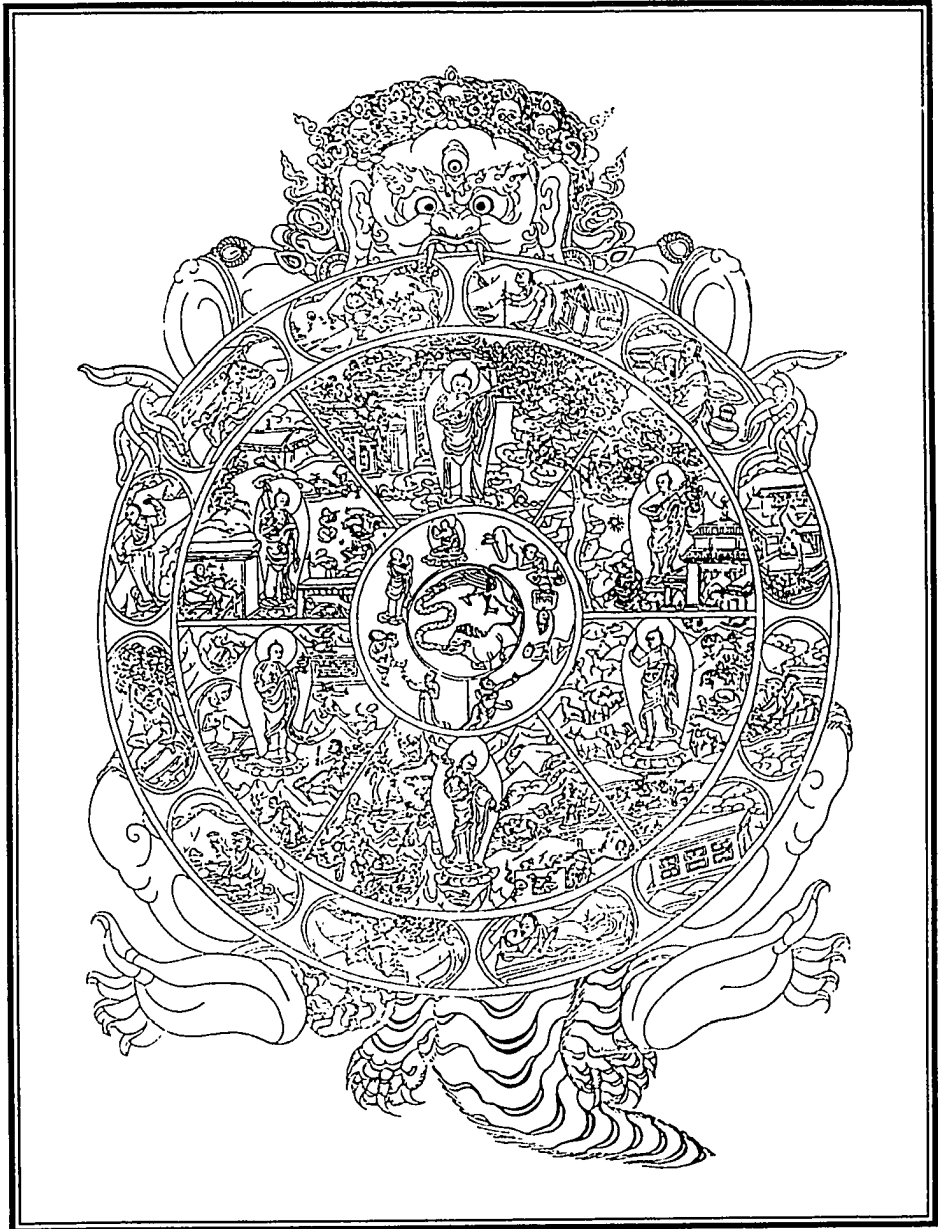


FIGURE 4: WHEEL OF LIFE

• Adapted from Cho Yang: the Voice of Tibetan Religion and Culture No.3.

THE DRAWING OF THE WHEEL OF CYCLIC EXISTENCE

In the middle, three animals representing three poisons:-

- 1) Pig: Ignorance <gTi-mug> (ti-mug)
- 2) Rooster: Attachment <'dod-chags> (do-chag)
- 3) Snake: Aversion <she-sDang> (she-dang)

The second circle is the six realms:-

- 1) gods <Lha>
- 2) semi-gods <Lha-ma-yin>
- 3) animals <dud-'Gro> (du-do)
- 4) hell <dMyal-bo> (nyal-wa)
- 5) petal gods/hungry ghosts <yi-dags> (yi-dag)
- 6) human <mi>

The outer circle is the twelve links of interdependent origination:-

- 1) Ignorance <marig-pa>
- 2) Compositional action <'du-byed> (du-je)
- 3) Consciousness <rNm-shes> (nam-she)
- 4) Name and form <ming-dang-gSugs> (ming-dang-sug)
- 5) Sources <sKye-mChed-drug> (kye-che-dug)
- 6) Contact <reg-pa>
- 7) Feeling <'Tshor-ba>(tsor-wa)
- 8) Attachment <sred-pa> (se-pa)
- 9) Grasping <len-pa>
- 10) Existence <srid-pa> (si-pa)
- 11) Birth <sKye=ba> (kye-wa)
- 12) Aging and death <rGa-shi> (ga-shi)

A fierce looking deity behind the wheel, represents the nature of impermanence, indicating that all phenomena are impermanent and subject to decay.

Note: Inside the <> are Tibetan names and within the () are how to pronounce in roman English.

FIGURE 5: KEY TO WHEEL OF LIFE

2.3.4 Socio-Economic Structure

In the early stages, Dharamsala was a refugee camp, its people were without direction. With strong effort and insightful leadership, Tibetans soon stood on their own feet and became independent. Without the generosity of many organisations and individuals this development would have been impossible. The Tibetan community is now socially stable and economically viable.

2.3.5 Economy

As a refugee community, the economy is stable. Religion is a vital component of this culture and as Mahmoudi K. M. of the University of Northern Arizona stated, the indigenous Tibetan network established by refugees themselves provided not only a foundation for cohesive communities, but also contributed to the economic well-being of the host community (Landis, 1992). The Tibetan communities in southern India are agricultural based settlements while in northern India they are traditional handicraft production based. Carpet weaving is of the highest employment, particularly in Nepal. Initiated by the Tibetan refugees in early 1960s, today the carpet industry is Nepal's top export item and largest source of employment. For example, in the first six months (mid July to mid December) of the fiscal Year 1989-90 the exports was 37.9 million US Dollars (Adhikary, 1990). In India, although the unemployment rate among settlement populations between the ages of 16 and 50 is

18.5 percent, in scattered Tibetan communities the unemployment rate was recorded as low as 1.8 percent, with the average of 9.9 percent (Department of Information and International Relations, 1995).

2.3.6 Education

Education for the Tibetan children was the first priority set by H.H. the Dalai Lama. He decided to set up a centre to take care of the sick and the destitute children, most of whom were orphans or within single parent homes. In fact, the Tibetan Children's Village (TCV) was initiated on March 17th, 1960 to care for 51 starving, ill and sick children brought to Dharamsala from Jamu (North India). The late Mrs. Tsering Dolma Takla, elder sister of H. H. the Dalai Lama volunteered to look after the children. Now, it is the largest autonomous institution in Dharamsala, with branch schools in TCV Lower Dharamsala, TCV Bylakuppe (South India), TCV Leh (Ladhak), and TCV in Kulu. Initially, the program was mainly for orphans and children of one surviving parent. Since the end of 1979, due to open frontiers between Nepal and Tibet, many children were sent from Tibet to Dharamsala for education. Although the program is meeting its original objectives, priority is given to children from Tibet.

According to statistics compiled by the Planning Council in Dharamsala, the number of monks and nuns who have relocated to India to pursue religious studies between 1979-93 was about 5,000, with an addition of over 3,000 new refugees in the

age group of 5 to 14. Another group of more than a thousand youngsters aged between 15 - 25 have been admitted to various schools in India (Department of Information and International Relations, 1993).

The Education Department is responsible for all educational activities except those falling under the autonomously constituted Tibetan Children's Village in Dharamsala, and Tibetan Homes Foundation in Mussoorie. The Department oversees 84 schools in India, Nepal and Bhutan serving about 24,000 children. Out of these, 63 schools are in India. Thirty schools under the Central Tibetan School Administration (CTSA), run by the Government of India and 33 schools are under the direct administration of Education Department of the Government-in-exile of which the teachers' salaries are granted from the CTSA (Kumar, 1994).

According to Tsering Shakya, a historian based in London, who compared those in exile to those living in Tibet under Chinese rule, the country has been left with a 75% illiteracy rate and over 60% of school-age children have never had the opportunity of attending school (Tibetan Bulletin, 1996). These statistics were provided by the Planning Council of the CTA. Altogether about 92 % of Tibetan children in exile, age 6 to 17 are attending schools. Approximately 82% of them are enrolled in Tibetan schools in Nepal, Bhutan and India. The total number of teachers in these schools is 1,280 with an average teacher-student ratio of 1:20 (Department of Information and International Relations, 1993).

2.3.7 Health in Dharamsala

In Tibetan culture the health programs are guided by Buddhist concepts. Buddha said, "Health is the highest gain". Without health, one is unable to fully contribute to society. Therefore, health is important in terms of social function and for the further development of community services. In the Tibetan community, particularly in Dharamsala, this responsibility is met by the Department of Health.

The Department of Health was established in 1980. It is responsible for the provision of health needs for the Tibetan refugee community in India, Nepal, and Bhutan. The Department is also responsible for meeting the costs of emergency health services and treatment of indigent Tibetans. In collaboration with the Tibetan Medical and Astrological Institute, the Department is seeking to integrate modern allopathic medicine with the traditional system of Tibetan medicine (Kumar, 1994).

2.3.8 Disability

Disability as defined in terms of impairment and handicap is a new concept amongst Tibetans. Most Tibetans view disability as related to karmic consequences (as something that results from action by motivation), or as something not unusual. For example, a man with an amputated leg is looked upon as an individual whose disability is caused by either his carelessness or karma. Either way, the conclusion is that he brought it on himself. Exact data on the demographics of disability in the

Tibetan community is not known.

Internationally, people with disability are estimated to be 10% of the world's population. Twenty-five percent of the world's population including family/caregivers are directly affected by disability. Eighty percents of the world's people with disability live in isolated areas in which no more than 2% receive rehabilitation services of any kind (Helander, 1992).

(a) General Disability and Rehabilitation

The World Health Organization (WHO, 1980), classified Impairment, Disability and Handicap as:

Impairment: loss or abnormality of psychological, physiological or anatomical structure or function; for example, that of an individual with a leg amputation.

Disability: any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being. For instance, due to a leg amputation, one is restricted from walking as a normal person does.

Handicap: a disadvantage for a given individual, resulting from an impairment or a disability, that limits or prevents the fulfilment of a role that is normal (depending on age, sex and socio-cultural factors) for the individual. As a result, the restriction caused by a leg amputation, one is disadvantaged in getting a job, in a normal

setting/situation that does not account for special needs.

2.3.9 Health Seeking Behaviour

Health seeking behaviour is the range of activities that individuals undertake to restore or promote health, including health protective activities, self management of health problems, use of informal resources such as the family network, and use of formal professional resources. Life style, health beliefs, and resource availability affect health perception and health-related behaviours (Long & Weinert, 1992).

Health seeking behaviour could be better understood by realising the basic idea of "health behaviour". In the western world, the study of health behaviour is a newly emerging interdisciplinary field (Gochman, 1988). According to Gochman, health behaviour means actions and habits concerning health restoration, health improvement, health maintenance, and emotional states and traits. Furthermore, personal attributes such as beliefs, expectations, motives, values and other cognitive elements and personality characteristics are included as well (Gochman, 1988, P.169). In fact, health behaviour in Western terms seems to represent almost an entire quality of a person. A further description by Calnan states that:

"Health behaviour is any activity undertaken by a person believing himself to be healthy, for the purpose of preventing disease or detecting it in a symptomatic stage" (Calnan, 1987).

According to the traditional Tibetan medical beliefs, there are three types of health behaviours.

(a) Continual Behaviour

This can be defined as the worldly activities performed during ones life time. Emphasis is on happiness and living a long life and the notion is that no one wants sorrow, suffering or disease. In Tibetan beliefs, there are various ways one can look for health without relying on medicine. For example, wearing various precious stones, practising secret mantras, seeking help from certain protector deities, doing meditation, and performing religious rites and rituals.

It is also believed that illnesses can be caused by exposing the 'sense' faculties to "extreme conditions". For example, it is regarded as dangerous to gaze too long at very attractive elements, to smell bad odours for long periods, or to listen to loud sounds for any length of time. At the other extreme, silence or a total separation from stimuli can also cause illness (Donden, 1986).

(b) Seasonal Behaviour

This concept emphasizes the influence on the body of the sun, moon and stars at different times of the year. This includes the influence of the relative amount of night and day on body strength. It is believed that the physical body and outer physical world are formed by the same elements. Therefore, changes in the outer

world influence health status and well being. Those changes can be detected and understood through the reaction of bile, wind and phlegm.

(c) Occasional Behaviour

There are thirteen different occasional behaviours (temporary in nature) which are believed to influence health status. Some examples of these are forceful suppression of hunger, thirst, sleeping, urination, and emitting semen (Donden, 1986).

In addition to continual, seasonal, and occasional behaviours, there are other related issues of a religious nature, which significantly influence Tibetan health and illness beliefs. For example, telling lies, killing other beings, stealing others possessions are against the Buddhist philosophy and Tibetan Buddhist believe will adversely affect ones health.

2.3.10 Healing Practices

The success of health decisions rests on the ability to listen and respond appropriately to concerned people (Crawshaw, 1993). By listening, we can better appreciate the contributions of traditional Chinese and Tibetan medicine, ayurvedic medicine, tribal healers, and many other practices. These systems, along with western medicine, are fingers on the same hand or tributaries of the same river. All are aspects and means of restoring health (Steward, 1993).

All systems have their limitations. For example, the Western Allopathic medical system is in great demand because of its wide range of services but it is almost impossible to provide high technology and resource intensive service in a small town where there is a lack of electricity and other services, and medical devices necessary to detect the cause of illnesses and to treat patients (Wangda, 1993). In the current situation, the majority of the world's population resides in rural areas (Izhar, 1987). According to Yoder (1982), biomedicine is relatively effective in the task of diagnosis and treatment, but is weak in being accessible and in ascribing meaning to illness. In the case of the Tibetan Traditional Medicine, it is well regarded in Dharamsala and continues to be used by the community and also by many Indians and Westerners who come to the area (Donden, 1986). Traditional Tibetan Medicine lacks the pursuit of the Western scientific approach. Therefore, it is difficult to encourage its use in other cultures at this stage. TTM also lacks effective treatment in acute illnesses and does not encourage complex surgery, including organ transplants.

This traditional Tibetan medicine is not only a holistic approach for health care provision, but provides a complete angle of perspective both in terms of philosophy and clinical assessment and the understanding of nature of diseases and their causes (Khangkar, 1991).

Clifford (1984) has suggested that Traditional Tibetan Medicine (Tibetan: Gyu shi) is perhaps the oldest and complete tradition of medical psychiatry in the world,

being more than a thousand years old. One also learns from our own cultural and ethnic backgrounds how to be healthy and how to recognize illness (Spector, 1991).

"In western societies, relief from disease and the restoration of health and healing are often considered to come from professionals, trusted community representatives, hospitals, pharmaceutical agents, and technological devices and maneuvers. Yet, we know from our own experience and the experiences of other cultures that diet, movement, touch, aroma, sound, quiet, solitude, light, beauty, plants, animals, and prayer also have healing effects" (Steward, 1993 p.629).

The basis of Traditional Tibetan Medicine is the Tripod Theory of Humours. They are i) Wind/Air (rLung), ii) Bile (mKhris-pa), and iii) Phlegm (Bhad-kan) that are the essential components that prolong and maintain the mystical balance, rendering the individual free from any disorders. According to Dr. Changbar S. Wangdu, a well known traditional Tibetan physician, the tripod theory holds that the cause of most diseases lies in the mind and since then the impact of mental factors related to promotion of health has been inseparable in terms of traditional Tibetan medicine (Department of Health, 1993).

The first international debate on Tibetan medicine took place during the reign of King Tisong Deutsen, 38th. King of Tibet (Khri-srong lde'u-btsan AD 755-797) when skilled doctors from Mongolia, China, India, Persia, Eastern Turkistan, Nepal, Kashmir, Dolpo and Afghanistan among others, participated at Samye, the first monastery in Tibet. The Tibetan King promulgated four basic ethical responsibilities of a physician, known as 'The Four Vows'. Those were that a doctor must

- (1) be altruistic,
 - (2) abandon sloth and procrastination,
 - (3) abstain from intoxicating drinks, and most importantly
 - (4) make a patient feel at ease and relieved through compassion and love
- (Khangkar, 1991).

Since then, these ethical principles have been promoted with care and great respect by Traditional Tibetan Medicine.

In the West, from the mid-1970s there was wide-ranging discussion and limited action over the move away from secondary, hospital-based treatment to primary, community-based, health promotion and care. The shift away from secondary care was partly a reaction against high-technology medicine (Jones, 1994). The shift toward primary, community-based health care was facilitated by an increasing sense that certain ancient and esoteric healing practices, long ignored by Western science, may in fact represent profound insights into the very nature of well-being (Moffitt et al., 1990).

In 1978, the World Health Organization recommended that traditional healing be integrated, where possible, with modern medicine and stressed the necessity of ensuring respect, recognition and collaboration among the practitioners of the various systems concerned. The manpower resources that WHO had hoped to enlist included the folk Unani or Yoga practitioners and Chinese traditional healers, such as acupuncturists (Helman, 1994).

WHO's hope in integrating medical services was to address the considerable health needs of developing countries. With inadequate financial and professional resources and insufficient geographical coverage, no single approach to health care is sustainable (Izhar, 1987). Facing these realities, many countries adopted an inclusive health care system that integrated various approaches into their formal health structures (Phillips, 1990). In the Asia region inclusive systems have generally evolved where the traditional systems have had a long and popular history and where they have had formal medical tradition, literature, training and research (Phillips, 1990).

The Tibetan Government-in-exile has embraced the integrated approach to health care and has enacted legislation to legally regulate Western Allopathic and Traditional Tibetan medicine within the Tibetan communities throughout India Bhutan and Nepal. Health services provided by spiritual and faith healers, although obviously not amenable to regulation, have nonetheless thrived within the Tibetan culture for centuries and continue to provide an option for health services.

ORGANIZATIONAL STRUCTURE

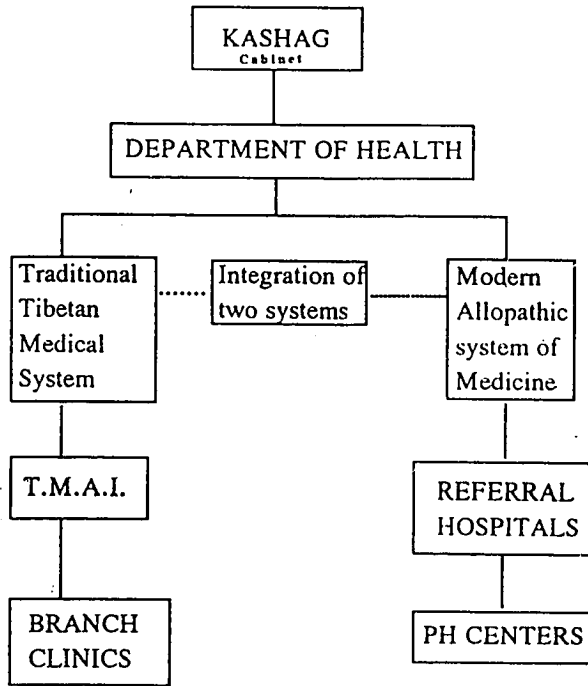


FIGURE 6: ORGANIZATIONAL CHART, DEPARTMENT OF HEALTH

DHARAMSALA

* Adapted from Tibetan Health. (1981-1991). Department of Health, Central Tibetan Administration.

2.3.11 Tibetan Health and Illness Beliefs

When one dies, in Tibetan belief, it is not the end of that particular individual, because rebirth is inevitable. This is the law of karma. When a birth take place, there follows the death. The end of birth is death and the end of death is birth. There are (7x7) 49 days for the preparation and journey towards the next rebirth. Timing is very important. When a person dies, each seventh day a specific puja is performed. The last day of the seventh week, which is 49th day, the 'visa' of the departed consciousness (soul) expires for this intermediate state. One would have to be transcended according to ones past karma (activities). There are beliefs and procedures related to the disposal of the corpse in the period immediately following the death (Evans-Wentz, 1960). This is one of the main reasons why Traditional Tibetan Medicine and Astrology are closely inter-connected. There are specifications when to remove the corpse and in which direction. Various pujas are performed to ease one's journey towards the next birth or next beginning. Whether that particular individual had a fully matured life, or death could have been prevented by other spiritual means such that the individual died before the expected life span was completed will direct the spirit to the next destination/life. In the case of someone who died prematurely the expected life, this individual would return in the next life only to fulfill this short-fall of time.

Regarding one's life span, Tibetans believe that every being has accumulated merits that determine each individual's life span according to one's past deeds, which is not a concept of destiny but one of karma. For instance, if someone gained merit to live up to 80 years of age, there still exist the possibilities of other causes for untimely deaths. Such obstacles are preventable through various pujas or other spiritual or moral actions done during a lifetime for others' benefit. In other words, although one has had karma to live for 80 years, there are various causes for untimely death due to the lack of awareness or force of other related accidents. Tibetans believe that these are preventable through proper spiritual practices. The spiritual healers play a strong role in these pujas and practices by defining what needs to be done in each case.

This practice of spiritual input is based on Buddhist philosophy which is inseparable from the Traditional Tibetan Medicine. The Traditional Tibetan Medicine is not only believed to be taught by Buddha, who emanated as the Buddha of medicine, but Buddhism itself born through the ardent investigation of concerns regarding sickness, old age and death. Both health and illness are rooted in terms of causation, karmic results, and spirits (negative, neutral or positive).

(a) Causation

When one has health or illness concerns, one wants to know what is the cause of those particular problems. It could be due to anything; including biological, physiological, sociological, or psychological causes. Searching for cause of health

or illness problems is common to all of the three treatment types. The difference is that the Western Allopathic Medicine looks primarily at the present physical/mental - combination of states, while Traditional Tibetan Medicine looks beyond this, to past karmic causes. Buddhism emphasizes that every phenomenal existence is led by a specific cause. Without cause there exist no effect, therefore no existential phenomena. Karma is the law of cause and effect (Kongtrul, 1986).

(b) Karmic results

"Karma means actions. From the viewpoint of how actions are done, there are physical, verbal, and mental actions. From the viewpoint of their effects, actions are either virtuous, non-virtuous, or neutral. In terms of time, there are two types - actions of intention which occur while thinking to do something and the intended actions which are the expressions of those mental motivations in physical or verbal action" (Dalai Lama, 1984 p.26).

Karma is a Sanskrit term that denotes actions and its fruits; the totality of all virtuous or non-virtuous actions and their fruits (Rigzin, 1994). The karmic results can be discussed in relation to ill-health which is termed as obstacles. In this regard, karmic results are believed to be one's negative willed actions that committed towards others directly or indirectly, in the process of one's continuation of lives. These causations could be in words, actions or thoughts which are driven by motivations

that spring from: Attachment, Anger, or Dullness,(Kalu, 1985).

These are the three roots of negation which eventually characterize the 84,000 affliction emotions for which Buddha had provided the antidote of 84,000 dharma bodies to eliminate all and to reach the state of enlightenment (Kalu, 1985).

In general, the treatment of karmic-results would be to perform certain acts of charity, such as giving alms to the needy or saving lives of other beings. Other actions might include social services, such as building bridges, making new roads and cleaning the environments, placing the benefit on others. It is said that 'I' conveys a single number and 'others' means infinity (Dalai Lama, 1993).

(c) Spirits

According to TTM, the spirits are discussed in the context of psychiatric disorders (Tibetan: Gyu-shi). The Traditional Tibetan Medicine is sub-divided into many characteristic forms, or forces related to spirits. There are various ritualistic approaches to deal with these differences. For example, attachment to material wealth at the time of death can keep a spirit earth bound in ghost form and they will be unable to move on through their journey towards the next rebirth. In this case a specific puja or mantra may be performed by the living to help the dead move on. The time and the place could also be a conditional force. For example, if it is something to do with serpents; water could be of importance, or if something has to do with earth-guardians; rocks or mountains could be of importance.

There are many ways of dealing with the evil spirits. At this stage, four basic approaches would be most appropriate. Those are through pacification, empowerment, initiation and wrathfulness. The main key is to find the right spiritual healers. Each spirit has its own specific pujas, or rituals, that can be performed, as directed by the spiritual healers or astrologers. These will result in the elimination of the cause of certain problem.

CHAPTER III METHODOLOGY

This study focused on the Tibetan refugee community of Dharamsala, Himachal Pradesh, to provide a baseline of information regarding the health seeking behaviour that could be used in developing a more comprehensive and effective health care system for the Tibetan community.

3.1 Planning Phase

The Tibetan Medical and Astrological Institute (TMAI) of Dharamsala approved a visit by the investigator to collect data in Dharamsala. Upon reaching Dharamsala on the 21st. of January, 1993 at 8:15 AM, the investigator met with the key people who had experience and knowledge in the area of health and beliefs, including :

- ▶ Dr. Wangyal, Physician of H.H. the Dalai Lama
- ▶ Mrs. T. N. Lhamo, the director of Department of Health
- ▶ Professor Jampa Gyaltzen of the Astrological Department, Tibetan Medical and Astrological Institute (TMAI)
- ▶ Mr. Tinley Woesser, the general secretary of TMAI,

The investigator was free to access the Department of Health and to participate in health-care related workshops. Other visits were made possible that were very beneficial to this project. They included visits to the

- the Planning Committee,
- Security Department,
- Home Department,
- Library of Tibetan Works and Archive,
- ▶ Welfare Office,
- ▶ Office of Reception; and
- ▶ Freedom Movement Office.
- ▶ Tibetan Children's Village, personnel here were also very cooperative.

3.2 Introduction to the Community

Introduction to the interviewees was made through the Tibetan Welfare Office during their public meetings. Both the Tibetan Welfare Office and the regional Freedom Movement Office helped by introducing the investigator to the interested individuals and officials, such as block leaders and school administrators. The investigator was known to most of the interviewees prior to this introduction.

3.3 Instrument Design

The interview instrument (Appendix A) was developed by the principal investigator in consultation with advisors within the School of Rehabilitation Therapy, Faculty of Medicine and Department of Psychology at Queen's University, Kingston, Ontario, Canada. The questionnaire was developed specifically to address

the needs of this particular study. Item construction was aided by several archival resources (Cook, 1989; ICACBR Research Group, 1992; Yaker, 1970).

To ensure the instrument was as appropriate as possible, the principle investigator made some minor changes in idioms and expressions following recommendations by the local experts in Dharamsala. Those individuals were physicians, both WA and TTM, and researchers from the Department of Health, Tibetan Medical Institute, Astrology Department and Delek Hospital. The questionnaire was translated into the Tibetan language by the researcher and was re-translated into English by a second person in Dharamsala who had some experience in dealing with scientific research in Tibetan herbal medicine to check for accuracy and linguistic appropriateness.

The interview instrument consisted of a combination of fixed response and open-ended questions. The fixed responses were designed in order to provide consistency in the focus of questions and to provide a basis for comparability of the responses. Open-ended questions were provided to gain an in-depth understanding of responses. It was intended that the interviews would provide rich detail and context, individual variation and causality would be appropriate to the description of health seeking behaviour.

In addition the investigator used archival documents, interviewed key informants and kept field notes of personal observations in the community and points offered by the interviewees during the three months of data collection.

3.4 Consent

As the age range of the participants extended from 15 to 60 years old, the investigator found that there were a number of people in the sample population who were unable to read. Since the majority of the sample population knew the principle investigator, it was culturally inappropriate to ask for written consent. The content of the consent form was explained verbally to each participant and verbal consent was obtained. The concept of consent was presented together with the letters of support given from the three main offices, the private office of H.H. the Dalai Lama, Department of Health (Government-in-exile) and Tibetan Welfare Office of Dharamsala. (See Appendices B, C & D)

3.5 Interview Process

Each interviewee was assigned a code number in order that the confidentiality of the informant be ensured. The maximum duration of the interview was 180 minutes, with a minimum time of 35 minutes, and a mean time of 74.09 minutes. After making sure that the interviewee understood the purpose and the content of the study and their contribution in time and energy, the investigator administered the interview questionnaire. Each question was repeated twice in Tibetan and the interviewee was asked how the respondent interpreted the given question. When the specific question was relayed and understood, then the interviewee was asked to

answer each item. After answers to the specific question were provided, the investigator repeated each answer in Tibetan to the interviewee to check the accuracy of each response. Over 21 (45%) of the total sample population responded in English. While subjects answered the questionnaire, the investigator did not intervene unless an interviewee asked for clarification of a specific item.

3.6 Sample Population

Although the initial proposal indicated that the subject pool would be chosen from the annual population survey of the Tibetan Welfare Office of Dharamsala, no survey of the Dharamsala annual population had been conducted within the last five years. The reason for not completing the annual population survey was that the Department of Health and Planning Committee were planning to develop and implement a comprehensive cross-sectional health survey of Dharamsala. The Welfare Office did not want to inconvenience the residents of Dharamsala with additional surveys.

The investigator was given access, however, to the voluntary-taxation name list of the Tibetan Freedom Movement Office as a population data source. This is a census of the Tibetan community and is renewed annually. From that list the participants were randomly selected and assigned to one of two groups. It was expected that most people under the age of 35 would be born outside of Tibet as the main exodus

of people from Tibet was between 1959 and 1960. Thus one group was aged 15 - 35 years (born outside of Tibet) and the other aged 36 - 60 years (born inside of Tibet). Prior to the random selection, the geographical and groups of particular social status were stratified. The balance between older age group and younger age groups and gender in each age group was considered.

3.7 Method of Data Collection

All data was obtained through one-on-one interviews conducted by the investigator. The time and place were based on the availability or convenience of the participants. The interview schedule was designed to elicit information relating to:

- i) socio-demographic background;
- ii) health seeking behaviour;
- iii) illness beliefs;
- iv) treatment beliefs; and
- v) community support.

A structured interview format was utilized to provide consistency in the focus of questions and comparability of the responses (Hungler & Pilot, 1987) and, therefore, the majority of the questions were close-ended. However, in order to have some in-depth information several open-ended questions were included.

Section I of the interview questionnaire was designed to gather socio-demographic information and was aimed at establishing a data base by which the participants responses may be compared. Sections II to V were adapted from a previous study of health seeking behaviour in India (Cook, 1992) with the addition of questions specific to this study.

3.8 Pilot Test

The pilot test was completed as soon as the investigator reached Dharamsala. A pilot test was necessary, in order to strengthen the instrument which was developed in Canada. This allowed for the incorporation of local suggestions. The investigator was unable to access any Tibetan group while in Canada. Nine subjects were interviewed in the pilot test. Preview of the results indicated that the questionnaire design was appropriate since the only adjustment to the instrument was related to a small modification of language.

3.9 Strategies for Analysis

All survey data was coded, analysed and organized using the statistical software package SyStat (1992); and the software Quattro Pro (QPRO) (1991). In addition to the above, frequencies and percents have been presented in the form of tables and figures.

Context analysis was used to understand the meanings, motives, values, and intentions tacitly woven into Tibetan health care behaviour. A qualitative interpretation was derived from the in-depth interviews, consultation with some of the knowledgeable individuals in this regard, and the field notes taken after each interview had been completed. My experience and understanding of the culture was used to give context to the data. This is not only my traditional culture, but also a community where I lived for many years.

3.10 Ethics Review

The study design was approved by the Queen's University and Affiliated Teaching Hospitals Health Science Human Research Ethics Board in August, 1993. The study was designed to be carried out in the Dharamsala Tibetan Refugee Community with consideration for the Tibetan people and customs. Nothing was done in this study that presented risk or that would jeopardize the people. It was important for the community to be informed of the purpose of the study and to be assured that there would be no repercussion to answering the questions candidly and expressing their views honestly. Every possible effort was made to maintain the privacy of the interview situation. All data and identifying characteristics have been kept confidential to protect the identity of any of the subjects.

CHAPTER IV RESULTS

The results section is divided into a number of sub-sections. The first sub-section focuses on the sample population of this study which includes the demographic characteristics, gender and age groups, marital status, country of birth, family status, household status, duration of Dharamsala residency and daily activity. The second part emphasizes the community support and indicates the nature of the community and community's main health concerns; the religious affiliation, education, and gender roles. The third part presents health seeking behaviour; including responsibility for maintaining good health, illness beliefs, concept of disability, choice of treatment, preventative and curative issues and negative effects of treatment. The fourth part deals with physician/expert and patient inter-communication. This looks into the degree of satisfaction, feeling at ease, respect and listening in a caring manner. Also included are, comprehension of diagnostics, comprehension of treatment and treatment confusion. The fifth part outlines what the Tibetans in Dharamsala perceived to be the best health-care models and why.

The results are presented in tables with frequencies and percents. A number of tables are presented using a 5 point scale. Most of the 5 point scale results are presented on a scale of 5 to 1, while some of them are presented in combination of two units, for example collapsed 1+2 or 4+5. The rationale for the latter is that in some cases such comparison showed more clear readings of the data in terms of general tendencies or flow.

4.1 Demographic Characteristics

4.1.1 Gender and Age

Table: 01 Ratio of Gender and Age Groups

N=46	Males		Females	
	Freq.	%	Freq.	%
Age 15-35	10	21.8	14	30.4
Age 36-60	12	26.1	10	21.8
TOTAL	22	47.8	24	52.2

Out of 46 total sample population, 24 (52.2%) were females and 22 (47.8%) were males. Twenty four (52.2%) subjects; 14 (30.4%) females and 10 (21.8%) males were in the younger age group while 22 (47.8%) subjects; 10 (21.8%) females and 12 (26.1%) males were in the older age group.

4.1.2 Marital Status

Table: 02 Marital Status

N=46	Married with spouse		Married without spouse		Single	
	Freq.	%	Freq.	%	Freq.	%
	18	39.1	4	8.7	24	52.2

Twenty two (48%) subjects were married while 24 (52%) were single. Out of married couples, 18 (39%) were married with spouse and 4 (9%) were married without spouse.

4.1.3 Country of Birth

The subjects were asked to identify their country of birth.

Table: 03 Country of Birth

(N=46) Countries	Birth Places	
	Freq.	%
Tibet	29	63.0
India	16	35.0
Nepal	1	2.2

Twenty nine (63.0%) were born in Tibet while 17 (37.2%) were born in exile.

4.1.4 Family Status

Subjects were asked to indicate the number of people living with them.

Table: 04 Number of people living in the house.

(N=46) Number of people	Sample Population	
	Freq.	%
1	8	17.4
2	10	21.8
3	9	19.6
4	9	19.6
5	3	6.5
6	4	8.7
12	1	2.2
13	1	2.2
43	1	2.2

Ten (21.8%), almost one fifth of the sample population confirmed that they lived with one other person. There were 9 subjects (19.6%) each living (3 or 4 together). Four subjects stated that they had 6 members in their household. The individuals who live with 12 or more people were from the TUV school dorms.

Subjects were asked the number of rooms in their home.

Table: 05 Number of Household Rooms.

(N=46) Number of rooms	Sample Population	
	Freq.	%
1	22	48.0
2	11	24.0
3	9	19.6
4	2	4.4
7	2	4.4

Almost half of the sample population 22 (48.0%) lived in one room. Followed by 11 (24.0%) subjects who lived in 2 rooms.

4.1.5 Household Status

Subjects were asked who they perceived as the head of their household.

Table: 06 Head of Household

N=46	Head of the Family	
	Freq.	%
Myself	21	45.7
My wife/husband	7	15.2
My father	5	11.0
My father in law	1	2.2
My mother	1	2.2
My mother in law	0	0
my daughter	0	0
my daughter in law	0	0
my son	0	0
my son in law	0	0
others	11	24.0
Total	46	100

Twenty one (45.7%) subjects indicated that they (interviewee) were the head of the family. The second most common answer was the wife/husband, 7 (15.2%). 11 (24.0%) were others.

The subjects were asked to identify their relationship to their respective heads of household.

Table: 07 Relationship to head of the family

N=46	Relationship to the Head of the House	
	Frequencies	Percents
Self	20	43.5
Wife or husband	7	15.2
Father	0	0
Father in law	0	0
Mother	0	0
Mother in law	0	0
Daughter in law	5	10.9
Daughter	1	2.2
Son	1	2.2
Son in law	0	0
Others	12	26.2
Total	46	100

Twenty (43.5%) subjects revealed that their relationship to the head of the family as 'Self'. Second most frequent answer 7 (15.2%) was either wife or husband. Twelve (26.2%) indicated others.

4.1.6 Duration of Dharamsala Residency

Subjects were asked how long they have been living in this community. (N=46)

Table: 08 Duration of Dharamsala Residency

Number of years	Freq.	%	Number of years	Freq.	%
6	1	2.2	19	1	2.2
7	3	6.5	20	3	6.5
8	1	2.2	21	1	2.2
9	2	4.4	22	1	2.2
10	5	10.9	23	1	2.2
11	4	8.7	25	1	2.2
12	2	4.4	27	1	2.2
13	2	4.4	28	3	6.5
14	1	2.2	29	1	2.2
15	3	6.5	30	1	2.2
16	1	2.2	32	2	4.4
17	2	4.4	34	1	2.2
18	2	4.4			

The least number of years was 6 and the maximum number was 34 years. The most frequent answers was 10 years (5 subjects). There were 25 different durations indicated. The average number of years was almost 17.

4.1.7 Daily Activity

The subjects were asked during the last few years what did they do most of the time.

Table: 09 Daily Activity

Type of works (N=46)	Frequencies	Percents
Work in a paid job	17	37.0
Work in the family business	6	13.0
Go to school/college	9	20.0
House keeping/child care	1	2.2
Others	13	28.3

Work in a paid job was the most frequent response 17 (37%). Going to school/college chosen by 9 (20%) subjects. 'Others' was chosen by high number, 13 (28.3%) compared with the rest. House keeping/child care was only one.

The subjects were asked for the duration of their activity per day.

Table: 10 Hours per day of major daily activity

Number of hours per day	Persons executing the activities (N=46)	
	Frequencies	Percents
4	1	2.2
5	2	4.4
6	2	4.4
7	1	2.2
8	8	17.4
9	6	13.0
10	7	15.2
11	12	26.1
12	5	11.0
14	1	2.2
15	1	2.2

Twelve (26.1%) executed their activities 11 hours per day. Followed by eight individuals (17.4%) who worked eight hours per day. One individual indicated 4 hours/day. Overall work or activities per day can be divided into two groups. One that ranges between 5 to 10 hours per day and another that ranges between 12 to 15 hours per day.

4.2 Community Support and Characteristics of the Community

4.2.1 Community Support

Participants were asked to state to what extent the following statements were true for their community.

Table: 11 Community Support

		Not True at all					Very True					Don't Know
(5 point scale; N=46)		1	2	3	4	5	1	2	3	4	5	
1 .	meet often, discuss	2	6	13	11	13	1					
2 .	all knows each other	1	16	16	7	5	1					
3 .	solve conflict together	3	7	12	14	10	0					
4 .	everyone help out a person	3	8	16	13	6	0					
5 .	a lot of sharing	3	9	16	12	5	1					
6 .	everyone joins in celebration/festivals	0	0	1	11	34	0					
7 .	suspicious of each other	7	16	11	5	4	3					
8 .	no unity in my community.	27	6	6	4	3	0					

Twenty four (11+13) (52%) of the total sample population responded that people meet very often to discuss various aspects of community life. Twelve (7+5) (26.1%) responded that everyone knew each other and that in cases of conflict 24 (14+10) (52%) would collaborate in reaching a resolution,

("helping out"). The community response to how they would 'help out' if a person in the community had a problem was mixed with responses ranging from 'not at all' to 'very true'. The largest response was between those two extremes 16 (34.8%). Similarly in sharing with community there was no clear response with the largest group again between the 'not true' and 'very true' responses 16 (34.8 %). However, when asked about participating or sharing in festivals and celebrations, the community agreed 45 (11+34) (97.8%) that this occurred. The community largely did not believe that people were suspicious of each other with the responses falling within the 'not true' category 23 (7+16) (50 %). This was supported by the strong response to the suggestion that there was no unity in the community when 33 (27+6) (71.7 %) disagreed with this statement.

4.2.2 Community's Main Health Concerns

Subjects were asked to describe what was their community's main health concerns and the qualitative answers were grouped by theme.

Table: 12 Community's Main Health Concerns

Community's main health concerns (N=46)	Frequencies	Percents
No main health concerns	3	6.5
Needed environmental cleanliness	11	24.0
Lack of sanitation	9	19.6
Plastic bags are bad	7	15.2
Tuberculoses	6	13.2
Lack of toilets and water	3	6.5
Scabies	2	4.4
Not knowing why health is important is a problem	1	2.2
High blood pressure	1	2.2
Lack of hospital	1	2.2
I do not know	2	4.4
Total	46	100.0

Eleven (24.0%) subjects indicated a 'need for environmental cleanliness' as a health concern. Nine (19.6%) subjects identified 'lack of sanitation' and then 7 (15.2%) subjects confirmed that 'plastic bags are bad'. Six (13.2%) indicated TB a community health concern.

Subjects were asked to describe what their main health concern and the qualitative answers were grouped by theme.

Table: 13 Individual's main health concern

Individual's main health concern (N=46)	No of people in Frequencies and percents	
	Frequencies	Percents
No main health concerns	23	50.0
Stomach-ache	3	6.5
Pollution	2	4.4
Cannot eat cold food	2	4.4
Cultural-based habits	2	4.4
Having no bathroom & room	1	2.2
Cannot eat fats	1	2.2
Cough and fever	1	2.2
Physically weak	1	2.2
Diet	1	2.2
Gastric	1	2.2
Can't get weight down	1	2.2
Head-ache	1	2.2
Back pain	1	2.2
Neck pain	1	2.2
Coughing and breathing	1	2.2
High blood pressure	1	2.2
Eye sight problem	1	2.2
Having no nutritious food	1	2.2
Total	46	100

Twenty three (50%) subjects stated that they had no main health concerns. The second most common answer was stomach-ache 3 (6.5%).

Subjects were asked if they have any health concerns today (at the time of interview).

Table: 14 Health Concerns Today

(N=46) Types of health concerns	Frequencies	Percents
No health concerns	32	69.6
Yes (not specified)	3	6.5
Stomach-ache	2	4.4
Cannot quit smoking	2	4.4
Next door's toilet smell	1	2.2
Jaundice	1	2.2
Breathing problem	1	2.2
Gastric	1	2.2

Thirty two (69.6%) confirmed that they do not have any health concerns at the time of interview. Three subjects said 'YES', but did not specified, followed by 'Stomach-ache' or 'Cannot quit smoking' scored 2 (4.4%) each.

4.2.3 Religious Affiliation and Shrine/Altar Usage

The participants were asked to indicate their religious affiliation.

Table: 15 Religious Affiliation

(N=46)	YES	Percents	NO	Percents
Religion (Buddhism)	46	100%	-	-

As indicated in Table 15 all participants responded that their religion was Buddhism.

Individuals were also asked to report whether they possessed a shrine/altar and the usage of shrine /altar. These results are presented in Tables 16. and 16.1.

Table: 16 Possession of Shrine/Altar

(N=46)	YES	Percents	NO	Percents
Shrine room/altar	45	97.8%	1	2.2%

All except one person possessed a shrine/altar. The person who indicated that she did not possess one lived in a school dormitory.

Table: 16.1 Usage of Shrine/Altar

(N=46)	Frequencies	Percents	No Ans.	Percents
More then once a day	34	73.9%	1	2.2%
Once a day	11	23.9%	-	-
Total	45	97.8%	1	2.2%

Forty five (98%) participants used the shrine/altar at least once a day, while 34 (74%) used it more than once a day.

4.2.4 Education

Results on the education obtained by participants are reported in Table 17.

Table: 17 Educational Background

Level of education obtained N= 46	Frequencies	Percents
no regular schooling	3	6.5
some primary schooling	2	4.3
completed primary schooling	5	10.9
some secondary	7	15.2
completed secondary	11	23.9
vocational/technical	1	2.2
some university	1	2.2
completed university	4	8.7
others (monastery/nunnery etc.)	12	26.1
Total	46	100.00

Of the sample population only 3 (6.5%) had no regular schooling or education. Therefore, 43 (93.5%) had received education ranging from primary to university and monastery/nunnery. The largest group in the education category were those who completed secondary education 11 (23.9%) and the 12 (26%) who were educated in a religious institution. One person selected vocational/technical education.

4.2.5 Gender Roles

Results of the responses about whether or not women should do office work are presented in Table 18.

Table: 18 Appropriateness for Women to Do Office Work

In frequencies and percents	Age 15 - 35 (N=24)				Age 36 - 60 (N=22)			
	YES		NO		YES		NO	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
MALE	10	41.7	0	0	12	54.6	0	0
FEMALE	14	58.3	0	0	10	45.4	0	0
TOTAL	24	100	0	0	22	100	0	0

All the 46 sample population strongly agreed that it was appropriate for women to do office work.

Responses to whether it is appropriate for men to do household work or not is reported in Table 19.

Table: 19 Appropriateness for Men to Do Household Duties

In Frequencies and Percents	Age: 15 - 35 (N=24)				Age: 36 - 60 (N=22)			
	YES		NO		YES		NO	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
MALE	5	20.8	5	20.8	11	50.0	1	4.2
FEMALE	13	54.2	1	4.2	10	45.5	0	-
TOTAL	18	75.0	6	25.0	21	95.5	1	4.2

A total of 18 (75%) between the age of 15-35 agreed 'Yes' the men can do household duties and 6 (25%) of them indicated 'No', that it is not appropriate for men to do household duties. Twenty one (95.5%) of the 36-60 age group responded 'Yes' and only one that is (4.6%) said 'No'. As for the younger group half of the males said 'Yes' and the other half of them said 'No' while almost all the females responded 'Yes'. In the older group almost all the males said 'Yes' and all the females responded 'Yes'.

4.3 Health Seeking Beliefs and Behaviours

4.3.1 Concept of Good Health and Health Maintenance

Subjects were asked to describe what they felt 'good health' was.

Table: 20 Concept of Good health

N=46	Idea of Good Health	
	Frequencies	Percents
clean food, water, clothing & environment	20	43.5
being in good shape; having no major illness or worry	10	21.8
gentle with compassion healthy physical body	6	13.0
try to keep happy have good food & keep clean	1	2.2
state of person's physical, mental and social well-being	5	10.9
balance of energy and channel	2	4.4
that which provide fundamental happiness to oneself and others	2	4.4

Good Health' according to 20 (43.5%) subjects was 'clean food, water, clothing and environment', followed by 10 (21.8%) subjects who indicated that 'being in good shape and having no major illness or worry' was good health. Another 6 (13.0%) subjects agreed that 'inner good quality (compassion) and outer healthy physical body', and 5 (10.9%) subjects confirmed that 'state of person's physical, mental and social well-being means 'good health'.

Subjects were asked to describe what they do to keep in good health and answers were grouped by theme.

Table: 21 What people do to keep in good health

Way of keeping in good health (N=46)	Frequencies	Percents
Eat nutritious food and keep in mental peace	5	11.0
Try to keep surroundings clean	20	43.5
Eat well and keep clean	10	21.8
Proper balanced diet, do exercise and work hard	5	11.0
Praying for others need keeps me in healthy state	1	2.2
Do not think of such in particular	2	4.4
Make sure to clean myself and surroundings before water-offerings	1	2.2
Cannot do much about it	1	2.2
Try to practice hard and try to avoid eating fats	1	2.2
Total	46	100.0

Twenty (43.8%) subjects indicated that 'they kept surroundings clean' in order to 'keep in good health'. Ten (21.8%) subjects stated they 'ate well and kept clean'.

Five (10.9%) subjects each stated they 'ate nutritious food and kept in mental peace' or 'ate proper balanced diet, exercised and worked hard' to keep their good health.

4.3.2 Responsibility for Maintaining Good Health

Table: 22 Responsibility for Maintaining Good Health

(N=46)	Responsible					Don't Know
	Not Responsible			Responsible		
5 point scale	1	2	3	4	5	
Myself	0	0	2	8	36	0
Family members	0	2	8	12	23	1
Friends	1	11	15	9	8	2
Government	1	5	10	9	21	0
Foreign Aid	2	8	13	12	10	1
God/Karma	6	5	6	10	15	4

Overall, the subjects regarded that all of the individuals/groups included in the list held some responsibility for maintaining good health. Those that were believed to have the greatest responsibility were the individuals themselves, as seen by the responses of 36 (78.3%) who chose the answer 'myself', 23 (50%) 'family members' and 21 (45.7%) 'government'.

4.3.3 Illness Beliefs

Table 23 shows responses to the question regarding the cause of various illnesses.

Table: 23 Cause of Various Illnesses

5 point scale (N=46)	Not True At All					Don't Know
	1	2	3	4	5	
Poor Nutrition	1	2	12	12	19	-
Work stress	1	9	14	13	8	1
Fate/Karma	3	9	8	7	17	2
Conflicting emotions	14	14	9	3	6	0
Genes/inherited	2	17	10	11	3	3
Chemical imbalance in the body	1	5	19	12	8	1
Germes	0	4	15	16	11	0
Evil spirits	4	18	8	6	4	6
Lack of exercise	1	8	19	12	5	1
Family stress	1	10	16	14	5	0
Part of natural cyclic of life and death	1	3	8	12	17	5
Body organ not functioning	0	9	15	10	11	1
Unhealthy environment	0	3	9	18	16	0
Result of previous wrong action	1	10	13	6	15	1
Break down the body defence	1	5	11	15	13	1
Allergies	0	6	21	12	7	0
Weight problem	1	16	17	7	3	2
Virus	0	3	18	12	13	0
Emotional imbalance	1	16	14	11	1	1
Season of the year	4	10	16	12	3	1

There are a number of factors which are perceived to be related to the cause of illness. Nineteen (41.3%) subjects listed 'Poor nutrition' as the most likely cause, followed by Karma and part of natural cycle of life death with 17 (37%), and unhealthy environment with 16 (34.8%). Previous wrong moral actions was chosen by 15 (32.6%), with virus 13 (28.3%), and germs 11 (23.9%) also identified as probable causes. The remaining possible causes produced a range of responses within the mid range between 'Not true' and 'Very true'.

4.3.4 Concept of Disability

When asked how the respondents defined disability, the answers were grouped according to five main themes. The results are presented in Frequencies and Percents next to each main themes.

- i) Physical disability, eg. "One who does not possess organs or limbs". 8 (39.1%).
- ii) Disability not being able to produce income generation activities, eg. "One who cannot work". 9 (19.6%).
- iii) Concept of 'Karma', eg. "Disability caused due to previous non-virtuous actions". 8 (17.4%).
- iv) Disability that stress mental and physical balance, eg. "Mentally unable to understand positive knowledge, physically unable to perform duties". 6 (13.0%).
- v) The functional restriction in Activity in Daily Living (ADL). eg. "One who cannot take care of oneself". 5 (10.9%).

When asked which of the following would be considered a disability, the responses from the interviewees as below.

Table: 24 Which Diseases are Considered a Disability

(N = 46)	YES Disability		NO Not Disability	
	Freq.	%	Freq.	%
High blood pressure	13	28.3	33	71.7
Deafness	37	80.4	9	9.6
Feeling giddy	3	6.5	43	93.5
Blindness	42	91.7	4	8.3
Breathing or coughing problems	5	10.9	41	89.1
Paralysis	39	84.8	7	15.2
Epilepsy	28	60.9	18	39.1
Mental problems	24	52.2	22	47.8
Diarrhoea	4	8.7	42	91.3
Memory problems	23	50.0	23	50.0
Physical abnormality	27	58.7	19	41.3
Malaria	5	10.9	41	89.1
Movement problems	32	69.6	14	30.4
Leprosy	34	74.0	12	26.0

When asked to order those disabilities from most to least serious the some of the striking responses are as listed in Tables 25, 26, and 27 respectively.

Table: 25 Diseases Most Considered a Disability

DISEASES (N=46)	FREQUENCIES	PERCENTS
Blindness	42	91.3
Paralysis	39	84.8
Deafness	37	80.4
Leprosy	34	73.9
Movement Problems	32	69.6
Epilepsy	28	60.9
Physical Abnormality	27	58.7

A great majority of the sample population, 42 (91.3%), agreed that 'blindness' is the most serious disability, followed by 'paralysis' 39 (84.8%), and then 'deafness' 37 (80.4%).

Table: 26 Were Mental Disorders Considered Disability

(N=46)	YES	YES
DISEASES	FREQUENCIES	PERCENTS
Mental Problems	24	52.2
Memory Problems	23	50.0

A little more than half of the total sample population indicated that mental or memory problems were considered to be a disability.

Table: 27 Conditions Least Considered a Disability

(N=46) DISEASES	FREQUENCIES	PERCENTS
Feeling Giddy	4	8.7
Diarrhoea	4	8.7
Malaria	4	8.7

Three least conditions least considered a disability were feeling giddy, diarrhoea, and malaria. Each scored up to 4 (8.7%).

The subjects were asked whether disability could happen before/during/shortly after birth.

Table: 28 Possible Occurrence of disability

(N=46) Disability	YES Could happen		NO Couldn't happen		Don't know
	Freq.	%	Freq.	%	
Before birth	44	95.7	1	2.2	1
During birth	42	91.3	2	4.4	2
Shortly after birth	42	91.3	4	8.7	0

One interviewee did not agree that disability could happen before birth and another answered, "I don't know". The rest of the subjects, 44 (95.7%) agreed that disability could happen before birth.

Forty two (91.3%) agreed that disability could happen during birth. Two did not think that disability could happen during birth. Another two answered "I don't know".

Forty two (91.3%) agreed that disability could happen shortly after birth. However, 4 (8.7%) did not think that disability could happen shortly after birth.

4.3.5 Health Seeking Behaviour

Subjects were asked where would their family take them first for treatment.

Table: 29 Family's First Choice for Medical Treatment

Family's first choice for treatment (N=46)	Frequencies	Percents
WA	14	30.4
TTM	19	41.3
SH	6	13.0
No Preference	1	2.2
Don't Know	2	4.4
No Answers	4	8.7
Total	46	100.0

TTM scored the highest with 19 (41.3%), followed by WA 14 (30.4%) and then SH 6 (13.0%).

Table: 30 Where Respondent Would Go First for Medical Treatment

(N=46)	FREQUENCIES	PERCENTS
Western Allopathy	18	39.1
Tibetan Medicine	18	39.1
Spiritual Healers	8	17.4
Others	2	4.4

The above table shows that an equal number of participants responded that they would seek first medical treatment from both Western Allopathic and Tibetan Medicine treatments. Spiritual Healers were least likely to be the first source for medical treatment.

Table: 30.1 Access to First Treatment by Age Groups

In frequencies and percents	Age 15 - 35 (N=24)		Age 36 - 60 (N=22)	
	Freq.	Percents	Freq.	Percents
Western Allopathic	15	62.5	3	13.7
Traditional Tibetan	6	25.0	12	54.6
Spiritual Healers	2	8.3	6	27.3
No Preference	1	4.2	1	4.6

Fifteen (62.5%) younger Tibetans preferred Western Allopathic as a first medical treatment, while the older Tibetans prefer Traditional Tibetan Medicine 12 (54.6%). Spiritual Healer were the least choice in first access point for medical treatment for both age groups.

Eighteen subjects chose WA or TTM as their first medical treatment.

Table 30.1 represents a breakdown of this data according to gender and average age.

Table: 30.2 First Medical Treatment According to Gender and Average Age

(N = 36)	Western Allopathy		Tibetan Medicine	
	Male	Female	Male	Female
Number	7	11	6	12
Average Age	26.1	25.2	50.1	33.9

The choice by gender indicated that for the first access to both Western Allopathy and Tibetan Medicine, the ratio of females to males was very similar. The average age between the younger and the older female groups was much closer than the average age of the two male groups. In both Treatment Types, females chose treatment more than males.

Subjects were asked to describe the basis for making their decision.

Table: 31 Rationale for Making the Decision

Rationale for Making Decisions on Where One Would Go First for Medical Treatment (N=46)		
Western Allopathy	Frequencies	Percents
For immediate pain relief	11	24.0
My own beliefs	1	2.2
I was exposed to WA only	2	4.4
Better education and facilities	1	2.2
More scientific	1	2.2
Pills are easier to eat	1	2.2
My mind tells me	1	2.2
Traditional Tibetan Medicine	Frequencies	Percents
No side effects and cures the cause of diseases	9	19.6
More natural and less side effects	7	15.4
Medication will not harm at all, incase doesn't help	1	2.2
Only TTM could cure me well	1	2.2
Spiritual Healers	Frequencies	Percents
More correct decision	4	8.7
I go for a Mo (Spiritual advice)	2	4.4
It worked and it works	1	2.2
I trust in the Lama	1	2.2
No Preference	Frequencies	Percents
Depnds on the nature of the illness	2	4.4

Eleven (24%) subjects would go to WA for first treatment, because WA was good in 'immediate pain relief'. With TTM two main reasons, 9 (19.6%) agreed 'no side effects and eliminates the cause of diseases' and 7 (15.4%) subjects agreed that 'more natural and less side effects'. Although WA and TTM had same numbers of subjects, the rationale for choosing the particular health models were quite different. In SH 4 (8.7%) subjects agreed 'for better decision'.

The subjects were asked to inform their usage of the Three Medical Models in the last 6 to 24 months.

Table: 32 Usage of Medical Models for Duration of 24 Months

Duration (Months)	Health Models	(N=46)			
		YES		NO	
		Freq	%	Freq.	%
Past 6 months	WA	25	54.4	21	45.7
7 - 12	WA	23	50.0	23	50.0
13 - 24	WA	24	52.2	22	48.0
Past 6 months	TTM	30	65.2	16	34.8
7 - 12	TTM	33	71.7	13	28.3
13 - 24	TTM	34	73.9	12	26.1
Past 6 months	SH	24	52.2	22	48.0
7 - 12	SH	25	54.4	21	45.7
13 - 24	SH	32	69.6	14	30.4

All the three health models were used by the subjects in a similar fashion during the last 6 months. TTM 30 (65.2%), followed by WA 25 (54.4%) and then SH 24 (52.2%).

Treatment used between 7 to 12 months were recorded as TTM 33 (71.7%), followed by SH 25 (54.4%) and then WA 23 (50%).

Those who sought treatment between 13 to 24 months was recorded as TTM 34 (73.9%), followed by SH 32 (69.6%) and then WA 24 (52.2%).

Subjects were asked whether they will re-use any of the three medical models in future.

Table: 33 Re-use of the three medical models in future

(N=46) Health Models	Re-use of Medical Models in Future				Don't Know	No Ans.
	YES		NO			
	Freq.	%	Freq.	%		
WA	41	89.1	1	2.2	2	2
TTM	40	87.0	4	8.7	1	1
SH	38	82.6	5	10.9	1	2

With regards to re-use of treatment, the results were very close with WA 41 (89.1%), followed by TTM 40 (87%) and then SH 38 (82.6%). The additional data and Field note suggested an interesting dimension that will be presented in Table No.33.1.

Table: 33.1 Conditions for Re-use of Medical Models.

(N=46)	Unconditional		Conditional		TOTAL
	YES		YES		
	Freq.	%	Freq.	%	
WA	22	47.8	19	41.3	41
TTM	29	63.1	11	24.0	40
SH	34	74.0	4	8.7	38

Of the 41 (98.1%) 'yes' responses for WA, 19 (41.3%) subjects included a conditional 'yes'. These subjects mentioned that it depended on the situation. They also said that the future was unpredictable, so they could not give an affirmative answer. Some even said it was not a well thought out question. The same trend went with TTM of which 40 (87.0%) agreed they would re-use TTM, yet 11 (24.0%) were conditional. Interestingly, regarding SH, out of 38 (82.6%), only 4 (8.7%) suggested conditional use.

4.3.6 Treatment Beliefs and Choices

Subjects were asked to what extent the following statements were true for them, related to long lasting illness, injury or bodily ailment.

Table: 34 Where Consultation is Sought

Five point scale (N = 46)	Not True At All					Very True		Don't Know	No Ans.
	1	2	3	4	5				
Consult WA	0	4	14	20	7	-	1		
Consult TTM	0	2	8	19	16	-	1		
Consult SH	1	8	8	7	20	1	1		
Consult a Parent	15	14	7	2	7	-	1		
Consult a Friend	19	10	9	3	4	-	1		
Consult Brother & Sister	21	13	8	3	0	-	1		
Use Home Remedy	18	11	7	7	1	-	2		
Do Nothing	39	3	1	1	-	1	1		
Prayer / Meditation	12	9	9	9	5	1	1		

The results of the Table: 34, indicate that the spiritual healer was consulted the most 20 (43.4 %), followed by Tibetan medicine with 16 (34.8%) western allopathic medicine with 7 (15.2%). If one collapses the two final columns, that of 4 & 5 of the 5 point scale, then TTM scores up to 35 (76.1%), then the WA and SH in equal frequencies of (27) that is (58.7%). 'Do Nothing' scored none. People do not seem to consult their brothers and sisters which scored the second least.

Subjects were asked if it was difficult for them to pay for medical treatment.

Table: 35 Difficulty of Paying for Treatments

5 point scale (N = 46)	Not Difficult		Very Difficult			No answer
	1	2	3	4	5	
Western Allopathy	18	6	6	5	7	4
Tibetan Medicine	28	10	2	2	0	4
Spiritual Healers	27	7	4	0	0	8

Twenty eight (60.9%) agreed that it was not difficult to pay for TTM treatment, followed by Spiritual Healers 27 (58.7%) and Western Allopathic with 18 (39.1%). All were in agreement that overall it was possible to pay for medical treatment, even Western Allopathic treatment, where 12 subjects (26.1%), felt that it was difficult or very difficult, 24 (52.2%) felt that it was not difficult, while 6 (13.1%) were not inclined either way.

The following table shows the results of the questions which asked if it was appropriate for 'poor people' to get the different kinds of treatment. In this context, the word appropriate was taken to mean suitable or fitting.

Table: 36 Appropriateness of Treatment for Poor People

(N = 46)	YES	NO	No Answer	Don't Know
Western Allopathy	34	9	2	1
Tibetan Medicine	46	0	0	0
Spiritual Healers	41	4	1	0
Others	2	0	0	0

The above table suggests 46 (100%) agree that Tibetan medicine is appropriate for the poor people, followed by Spiritual healers with 41 (89.1%) and Western allopathic 34 (78.3%). The others scored only 2 (4.4%).

Subjects were asked if three options of treatment made them sicker.

Table: 37 Do Various Treatments Make One Sicker

(N=46)	YES				NO			
	DEFINITELY SICKER	POSSIBLY SICKER	TOTAL	%	DEFINITELY NOT SICKER	POSSIBLY NOT SICKER	TOTAL	%
WA	2	12	14	30.4	14	18	32	69.6
TTM	1	4	5	10.9	26	15	41	89.1
SH	0	6	6	13.0	34	6	40	87.0

The overall response of subjects was that no one medical treatment made them sicker. Within the responses to each treatment, the most frequent answers that treatment make one possibly or probably sicker was Western Allopathic medicine 14 (30.4%), followed by Spiritual Healers 6 (13.0%) and then traditional Tibetan medicine scores 5 (10.9%). The opposite responses that the treatment makes one possible or definitely not sicker, corresponds to their negative response, with TTM 41 (89.1%), followed by SH with 40 (87.0%) and by WA with 32 (69.6%).

Table: 37.1 Treatment Makes One Sicker by Age

(N = 46)	AGE:15-35 (N=24)				AGE:36-60 (N=22)			
	YES	%	NO	%	YES	%	NO	%
Western Allopathic	11	45.8	13	54.2	3	13.6	19	86.4
Tibetan Medicine	4	16.7	20	83.3	1	4.6	21	95.5
Spiritual Healer	5	20.8	19	79.2	1	4.6	21	95.5

Eleven (45.8%) of the younger group considered that WA treatment made people sicker, followed by SH with 5 (20.8%) and TTM 4 (16.8%). Only 3 (13.6%) of the older group considered that WA treatment made people sicker, followed by TTM 1 (4.6%) and SH 1 (4.6%) each.

4.3.7 Choice of Treatment by Condition

Subjects were asked to choose the most appropriate treatment for the following given conditions.

Table: 38 Choice of Treatment by Conditions

(N = 46)	WESTERN ALLOPATHY		TRADITIONAL TIBETAN MED.		SPIRITUAL HEALER	
	Freq.	%	Freq.	%	Freq.	%
HEALTH CONCERN						
Burns	43	93.5	1	2.2	2	4.4
Birth defect	31	67.4	6	13.0	8	17.4
Other deformity	35	76.1	5	10.9	1	2.2
Paralysis	9	19.6	27	58.7	10	21.7
Arthritis	6	13.0	35	76.1	2	4.4
Amputation	43	93.5	1	2.2	0	0
Anxiety	2	4.4	15	32.6	26	56.5
Depression	5	10.9	13	28.3	26	56.5
Psychosis	11	23.9	6	13.0	24	52.2
Heart problem	26	56.5	14	30.4	2	4.4
Breathing and coughing	35	78.3	7	15.2	1	2.2
High blood pressure	24	52.2	19	41.3	1	2.2
Blindness	39	84.8	2	4.4	4	8.7
Deaf/Mute	31	67.4	4	8.7	7	15.2
Epilepsy	6	13.0	23	50.0	15	32.6
Fever	41	89.1	5	10.9	0	0
Leprosy	28	60.9	6	13.0	5	10.9
Tuberculosis	45	97.8	1	2.2	0	0
Hepatitis/Jaundice	3	6.5	43	93.5	0	0
Diarrhoca/Vomiting	38	82.6	8	17.4	0	0

The following are major results from the Table 38 representing the choice of treatment for specific health concerns. Western Allopathic treatment was chosen as the preferred treatment for burns 43 (93.5%), amputation 43 (93.5%), tuberculosis 45 (97.8%), fever 41 (89.1%) and diarrhoea 38 (82.6%). The Traditional Tibetan Medical treatment was favoured for paralysis 27 (58.7%), hepatitis 43 (93.5%), epilepsy 23 (50%), and arthritis 35 (76.1%). Spiritual Healers were preferred for the treatment of anxiety 26 (56.5%), depression 26 (56.5%) and psychosis 24 (52.2%).

4.3.8 Curative and Preventative Beliefs

Table: 39 Treatment Used for Curative or Preventative Purposes

(N = 46)	CURATIVE	PREVENTATIVE	NO ANSWER
Western Allopathic	36 (78.3%)	10 (21.7%)	2 (4.4%)
Traditional Medicine	39 (84.9%)	5 (10.9%)	0
Spiritual Healer	12 (26.1%)	30 (65.2%)	4 (8.7%)

Both Traditional Tibetan Medicine with 39 (84.9%) subjects and Western Allopathic with 36 (78.3%) subjects, were selected as a curative approach to illness, while Spiritual Healers were selected 30 (65.2%) as being more preventative in approach.

Table: 39.1 Treatment Used for Curative or Preventative Purposes by Age

(N=46)	Age: 15 - 35 (N=24)			Age: 36 - 60 (N=22)		
	CURATIVE	PREVENTATIVE	No Ans.	CURATIVE	PREVENTATIVE	No Ans.
WESTERN ALLOPATHIC	19 (79.2%)	5 (20.8%)	2 (8.3%)	17 (77.4%)	5 (22.7%)	0
TRADITIONAL TIBETAN MEDICINE	20 (83.3%)	2 (8.3%)	0	19 (86.4%)	3 (13.7%)	0
SPIRITUAL HEALERS	7 (29.2%)	15 (62.5%)	2 (8.3%)	5 (22.7%)	15 (67.1%)	2 (9.1%)

Both younger and older age groups responded that TTM and WA were used principally for curative treatment while SH were seen by both groups to offer preventative treatment.

Table: 40 Treatment Most Commonly Sought

(N = 46)	Frequencies	Percents
Western Allopathic	16	34.8
Traditional Tibetan Medicine	23	50.0
Spiritual Healers	3	6.5
No Preference	1	2.2
Home Remedy	3	6.5

Twenty three (50%) of the respondents most commonly sought TTM, while 16 (34.8%) commonly sought WA treatment. SH and Home Remedies were the most common choice each of three persons (6.5%).

Table: 40.1 Most Commonly Sought Treatment by Age

(N = 46)	Age :15 - 35 (N=24)		Age: 36 - 60 (N=22)	
	Frequencies	%	Frequencies	%
Western Allopathic	12	50.0	4	18.2
Traditional Tibetan Medicine	7	29.2	16	72.7
Spiritual Healers	1	4.2	2	9.1
No Preference	1	4.2	0	0
Home Remedy	3	12.5	0	0

Twelve (50%) of the younger age group most commonly sought WA treatment while the older age group most commonly sought TIM 16 (72.7%). Interestingly, the home remedies were used only by the younger age group with 3 (12.5%) subjects listed in this category.

4.3.9 At Ease While Seeking out Treatment

Table: 41 Degree of Ease While Seeking Out Treatment

In five point scale (N= 46)	Not at Ease		Very much at Ease			No Answer	Don't Know
	1	2	3	4	5		
Western Allopathic	2	10	19	8	1	5	1
Traditional Tibetan Medicine	2	7	9	15	9	3	1
Spiritual Hcalers	2	6	7	8	14	8	1

Fourteen (30.4%) subjects responded that they felt very much at ease seeking Spiritual Healers followed by 9 (19.6%) who felt very much at ease seeking Traditional Tibetan Medicine. Only one person (2.2%) felt very much at ease seeking Western Allopathic treatment. Both Spiritual Healers and Traditional Tibetan Medicine scored higher on the 'very much at ease' side of the scale, while Western Allopathic were in the mid range leaning towards the 'not at ease' side of the scale.

4.3.10 Respectful in Treating

Table: 42 Degree of Respectful Treatment of Subject by Practitioner

(N = 46)	Very Respectful					Very Disrespectful					No Ans.
	1	2	3	4	5	1	2	3	4	5	
Western Allopathic	22	5	12	3	0						4
Traditional Tibetan Med.	32	6	2	1	1						4
Spiritual Healer	30	2	4	1	1						8

Although all three treatment types scored highly regarding the respectful treatment, 32 subjects (69.6%) believed that Traditional Tibetan Medicine treatment was provided by the practitioner in the most respectful manner, followed by Spiritual Healers with 30 subjects (47.8%), and Western Allopathic Medicine with 22 subjects (47.8%).

4.3.11 Listening in a Caring Manner

Table: 43 Degree to Which Practitioner Listens in a Caring Manner

In five point scale (N = 46)	Very Caring Listener					Not Caring Listener	No Answer
	1	2	3	4	5		
Western Allopathic	19	11	7	1	3	5	
Traditional Tibetan Medicine	34	3	2	1	2	4	
Spiritual Healers	31	1	2	1	3	8	

Thirty four subjects (73.9%) scored Traditional Tibetan medicine treatment as having practitioners who listen with care, followed by Spiritual Healers with 31 (67.4%) subjects, and Western Allopathic treatment with 19 (41.3%). Overall, the results show that practitioners in all three treatment types listen in a caring manner. Negative scores were similar for all three treatment types as having been treated by practitioners who did not listen caringly.

4.3.12 Comprehension of Diagnostics and Treatment, and Treatment Confusion

Subjects were asked if they understood the diagnostic procedure.

Table: 44 Comprehension of diagnostics

N=46	(In 5 point scale)					No Ans.
	Difficult			Easy		
	1	2	3	4	5	
WA	8	15	12	5	2	4
TTM	7	8	13	9	5	4
SH	5	5	6	10	12	7

Twelve (26.1%) agreed that SH was easy to follow for the diagnostic procedure. For TTM, 13 (28.3%) respondents were at the mid range and then numbers spread over the 5 point scale. Fifteen (32.7%) respondents indicated that WA was difficult to follow for the diagnostic procedure at level 2 in 5 point scale and 12 (26.1%) were in the middle of the scale.

Subjects were asked to indicate whether they understood the treatment protocol explained to them.

Table: 45 Comprehension of treatment

N=46	(In 5 point scale)					No Ans.
	NO		YES			
	1	2	3	4	5	
WA	2	3	5	9	23	4
TTM	1	7	1	7	26	4
SH	6	5	4	3	21	7

Results were quite similar in three models; TTM 26 (56.5%) followed by WA 23 (50%) and then SH 21 (45.7%) respondents agreed that they understood the treatment protocol that doctor or practitioner explained to them.

Subjects were asked if they felt confused by the treatment they received at the three respective health-care models.

Table: 46 Treatment confusion

N=46	(In 5 point scale)					No Ans.
	Confused			Clear		
	1	2	3	4	5	
WA	9	8	11	9	4	5
TTM	1	5	10	18	8	4
SH	2	3	7	9	18	7

Eighteen (39.1%) respondents agreed that SH was clear to understand, followed by

TTM 8 (17.4%) and then WA 4 (8.7%). Overall SH was more 'clear', indicated by the scores being further towards the '5' end of the point scale. TTM was towards the 'clear' side of the 5 point scale. WA indicated more in the middle and 'confused' end of the scale.

4.3.13 Satisfaction

Subjects were asked to describe their level of satisfaction with the various treatments.

Table: 47 Degree of Satisfaction with Treatment

(N = 46)	Not Satisfied		Very Satisfied			Don't Know	No Ans.
	1	2	3	4	5		
Western Allopathic	2	3	13	18	4 8.7%	1	5 10.9%
Traditional Tibetan Medicine	0	3	7	18	13 28.3%	0	5 10.9%
Spiritual Healers	1	2	9	7	18 39.1%	1	8 17.4%

Regarding the satisfaction for treatment, 18 (39.1%) suggested SH were most satisfactory, followed by TTM treatment with 13 (28.3%) subjects indicating total satisfaction, followed by WA with only 4 (18.2%) subjects indicating total satisfaction. The range of responses indicated little difference when columns 4 and

5 were combined, with 31 (67.4%) of the sample showing total satisfaction with Traditional Tibetan Medicine treatment, followed total satisfaction with Spiritual Healers by 25 (54.4%) subjects, and Western Allopathic with 22 (47.8%) subjects indicating total satisfaction..

4.3.14 Choice of Medical Models for Treatment

Table: 48 Which is the Best Treatment

(N = 46)	FREQUENCIES	PERCENTS
Western Allopathic	12	26.1
Traditional Tibetan Medicine	19	41.3
Spiritual Healers	13	28.3
Other	2	4.4
Total	46	100

When best was defined as the “most safe and effective” form of treatment 19 (41.3%) of the total respondents found Traditional Tibetan Medicine offered the best treatment, 13 (28.3%) subjects believed that Spiritual Healers offered the best while 12 (26.1%) believed Allopathic Medicine provided the best treatment.

Table: 48.1 Which is Best Treatment by Age

(N = 46)	Age: 15 - 35 (N=24)		Age: 36 - 60 (N=22)	
	Frequencies	%	Frequencies	%
Western Allopathic	9	37.5	3	13.6
Tibetan Traditional Medicine	7	29.2	12	54.6
Spiritual Healers	7	29.2	6	27.3
No Preference	1	4.2	1	4.2
Total	24	100	22	100

The results show that the older age group found Traditional Tibetan Medicine to be the best treatment 12 (54.6%) subjects , followed by Spiritual Healers with 6 (27.3%) subjects. The younger age group felt that Western Allopathic treatment was the best treatment with 9 (37.5%) subjects, followed by Traditional Tibetan Medicine and Spiritual Healers each with a score of 7 (29.2%) subjects.

CHAPTER V: DISCUSSION

5.1 Demographic Characteristics

5.1.1 Ratio of Gender and Age Groups

The sample population for this study was almost evenly distributed between male and female as well as young and old age groups. The data grouped by age showed many interesting differences in health seeking behaviours which will be discussed in later appropriate discussion sections.

5.1.2 Marital Status

Almost half of the sample population indicated they were married with only a small percentage living without their spouse. These people were separated due to the need of one of the partners to migrate for work. The marital status indicated that more than half of the sample population were single. This was mainly due to the inclusion of monks, nuns, and students beside the usual lay single persons. In fact, being political refugees, many of them were parted from their family as well. Having more single individuals than married ones suggests that population control may not be a worry for this community. In this sense, monks and nuns, beside their spiritual pursuit, do contribute a great deal in the stabilization of the population growth of which it has been a major economical obstacle and may cause political instability in

many nations across the globe. Moreover, no one indicated they were widow or widower. This may be explained partly by the fact that once freed from the family responsibilities, many older people will adopt a monastic lifestyle spending their time in prayer to prepare for their ultimate transaction, death.

5.1.3 Country of Birth

Two thirds of the subjects were born in Tibet while one thirds were born in exile. The higher number of people who were born in Tibet is evidence of the increasing numbers of 'new comers' to Dharamsala. The investigator was surprised at the number of Tibet-born Tibetans. Although the subjects were not stratified on birthplace, it would have been interesting to do so and compare these to see if there was a difference in beliefs and behaviours between pre and post Chinese-occupation of Tibet.

5.1.4 Duration of Dharamsala Residency

The duration of Dharamsala Tibetan residents ranges from 6 to 34 years in 25 different chronological orders. During the last 13 years, there seems to been relatively more people migrating to Dharamsala than other times which supports the influx of 'new-comers' from Tibet, since 1980's timing matched when the records indicated that the first new comers showed up in Dharamsala in 1980.

5.1.5 Family Status

(a) Number of people living in house:

More than one fifth of the sample population agreed that they lived two people together. Those who lived in households of 3 or 4 scored almost one fifth each. Eight of the subjects were single. The field notes indicated that all except one of the single subjects were monks or nuns. Although, traditionally Tibetans lived in extended families, the data suggests that there were fewer extended families. This could be due to their refugee status, or the change of social environment where people were forced to support themselves through employment opportunity rather than self-reliance through nomadic or agricultural work. Now in exile, as a necessity, schools were turned into extended family where the children had step parents and lived together in groups of 12, 13 or 43 as a family.

(b) Number of household rooms:

Here one room indicated a room/cell, not 1 bed-room apartment in Canadian sense, which means living room, kitchen, toilet/bathroom and the bed room. Two rooms in this study was a living/sleeping room plus either kitchen or shrine room. There were common toilets or bathroom or one had to use the public toilets which were built nearest to one's residential area. Almost half of the sample

lived in 1 room, 1/6 of them were monks or nuns. Close to one quarter subjects possessed 2 rooms. This state is not unusual for Tibetan refugees. If such condition were to exist in their country, it would be considered a major problem. In Tibet a typical house would be 2 stories with a shrine room on top (3rd. floor), made out of clay and stones. The nomads are the exceptions those who live in black yak haired tents called, 'ba'. Generally, animals are kept on the first floor of the Traditional Tibetan house and people live on the second floor, of which heat is generated not by electricity but by animals. This way animals were protected from predators as well.

5.1.6 Household Status

Half of the subjects indicated that they (interviewees) were the head of the family, followed by a quarter of the subjects who indicated 'others'. The subjects that chose 'others', included monks, nuns and students in dormitories. Traditionally the head of household would be father and mother combined with the father responsible for outside and affairs and mother for inside affairs. Half of the subjects stated that their relationship to their head of the family was either wife or husband, again a quarter of them stated 'others' while another quarter indicated that they were the father or mother in law of the head of the household as well. This is not surprising as traditionally as the Tibetans get older they pass the family responsibility on to the younger generation, freeing themselves for spiritual practice. This does not mean however that they are not consulted in the decision making process.

5.1.7 Daily activities

A paid job was defined as any job for which they received payment by others for work in places as in an office, school, restaurant, handicraft centre, carpet factory, clinic or shop. More than 1/3 of the subjects were working in a paid job, while another 1/4 chose the 'others' category which included the monastic life. One fifth of the subjects went to school/college. Compared to traditional Tibet, the percentage of the population in monasteries would have been similar, but the paid job would be replaced by self sufficient nomadic and agricultural work.

(a) Activities per day in hours

Monks and nuns described longer activity hours than the rest of the lay population, except those who worked in restaurants or were step parents in school. Over a quarter of the subjects worked 11 hour/day. These long days were not specific to any one particular job but seemed to reflect the community activity. The community was an early riser and food and daily requirements were bought daily from early morning to late evening. This was partly because not all households had such conveniences as refrigerators. The office workers by contrast appeared to have shorter working day. As for why the longer day was a norm, it was because everything was done manually. For example, laundry was done by hand, food was bought and freshly prepared each meal and generally speaking life in Dharamsala was labour intensive, similar to many refugee communities.

5.2 Community Support and Nature of the Community

A community is like a field. The quality of soil and its condition will have a significant impact on what is in the field. In this analogy, the soil is the Tibetan people in the Dharamsala community. The investigator believes that in order to know a community, its character must be studied. In order to learn about the existing community support of Dharamsala, the investigator included in the survey questions to help reflect some of the character and characteristics of this community.

From the 1960s until the end of 1970s, Dharamsala was quite a settled community. Its population was stable and predictable, people were quite knowledgeable about each other. When China opened the border between Tibet and Nepal in October, 1979, many new Tibetan refugees poured into Dharamsala. Since then, the Dharamsala Tibetan population has been continuously changing. More than half of the sample population in this study indicated that people often met each other to discuss various issues of common interest, yet only one fourth of the sample population stated that they actually knew each other. Although the residential Tibetans seemed to be somewhat disoriented by the flux of arriving new Tibetan refugees ('new-comers' is the term they used) nearly half of the sample population agreed that when there is a conflict, everyone participated in its resolution (Table 11).

Slightly less than half of the subjects indicated that they would assist another person who had a problem, and only one third of the sample population indicated that

they believed there was sharing within the community. Unlike when I lived there in the 1970s and early 1980s where people were more likely to help out 'new-comers', the response shows that people were now more reluctant to assist them. Perhaps it is a natural by-product of a situation where there were many 'new-comers' leaving and arriving regularly, which has overwhelmed the community to the extent that people were less willing to help. Approximately half of the sample stated that there was no suspicion in their community, with the next most substantial number of answers occurring in the mid range. This would indicate that generally the people of the community were trusting. The current officer in-charge of the Reception Office, since 1993, who is responsible for assisting the new-comers in Dharamsala, Mr. Kunphel said, "...the people of Dharamsala are not very sure who some of those new comers really are. It may be that the Dharamsala Tibetan people are suspicious that some of these new-comers are sent by the Chinese authorities".

Almost all of the sample population agreed that they did participate in celebrations and festivals. Also, the results show that more than two thirds of the respondents strongly believed that the community was united. It is fair to say that although the Tibetan Community in Dharamsala is not in as stable condition as it was in the 1980's, it still is well integrated in terms of public participation in community activities, while at the same time maintaining a distinct Tibetan cultural identity.

5.2.1 Community's Main Health Concern

The subjects were more concerned about community health rather than their own individual health concerns. Almost all subjects indicated they had community health concerns, the majority being environmental conditions. Communicable diseases were also a concern. These indicate a sophistication of understanding of the relationship between diseases, environment and people. Even under an individual's main health concern, environmental issues were mentioned. These relationships can be explained in two ways. First, Buddhism stresses the interdependence of nature and living beings, and secondly, western thoughts stress the importance of cleanliness to combat viruses and germs.

5.2.2 Religious Affiliation

One hundred percent of the randomly chosen sample population in Dharamsala in this study were Buddhist. This is not surprising as the literature review indicated that the overwhelming majority of Tibetans are Buddhist. Being a Buddhist requires that every family have their own shrine room or at least an altar. Each individual, if not the family, uses the shrine/altar each and everyday. This observation was reflected in the sample population studies. Although there are many rituals and pujas, Buddhism stresses the importance of daily offerings and these are normally conducted at least twice a day. Offerings are made in the morning and then taken away in the evening. This traditional practice appears to have continued for the Buddhist Tibetan-

in-exile. The significance of this particular daily usage of shrine/altar is important since this practice emphasizes altruistic attitude and behaviour of an practising Buddhist towards other sentient beings. Daily practices are generally based on the so called 'Four immeasurable' which are to pray and meditate on immeasurable love, immeasurable compassion, immeasurable joy and immeasurable equanimity. All of these are connected to and influence health and happiness. Buddhism also teaches that one's personal environment must be maintained in a neat and clean manner, therefore emphasizing the importance of sanitation and hygiene.

5.2.3 Education

Education is one of the most important elements in the modern world. Particularly, in the monetary social system, education can increase the income generating potential of an individual and in turn, this is often used to measure the degree of success or the achievement of an individual. Traditionally in Tibet, education was perceived as a scholastic measure for the spiritual practitioners, monks, nuns, lay religious persons or the sons and daughters of aristocratic families. For the general population, education had less significance, for the life was largely nomadic, agricultural or mercantile. In those latter groups, understanding how to barter and trade was more useful than the need to acquire 'money'.

Today, with the advancement of technology, the world is becoming a 'Global Community'. In essence, the world seems to have become smaller and in the current

environment, no country can exist just by itself. Therefore, the need for education is crucial. The modern day Tibetans-in-exile are not exceptional in this regard. It appears as if the Tibetans are advancing towards the ideal of the 'education for all'. Unlike Tibetans in Tibet, where the majority of the people are illiterate, in the exiled community of Dharamsala, few individuals indicated that they had 'no regular schooling' (Table 17). Most of them (93%) had the opportunity for some degree of education. This relates well to the statistics compiled by the Planning Council in 1993, that suggested that 92% of Tibetans-in-exile were attending schools.

5.2.4 Gender Roles

As human history is nearing the twenty first century, gender equality has received increasing attention. Traditionally, many cultures have diversified the roles of men and women in the family, as well as in society (Solomon, 1989). In the Tibetan-in-exile community of Dharamsala, all the men and women suggested that it is appropriate for women to do office work. Although the type of work may have changed for this group of Tibetan women in exile, their traditional philosophy of helping support the family along side their husbands has remained. Such a position suggests a change in philosophy that differs from other cultures. It is conventionally believed by Tibetans that men and women naturally have equal rights regarding their societal roles. As more than two thirds of the total respondents indicated that 'A home is built by both men and women', this traditional belief still persisted. This belief can

be better understood from the statement made by Yeshi Lhamo, one of the first generation of Tibetan women to grow up in exile (Tibetan bulletin, 1996).

"Speaking as a Tibetan woman, compared with other women I think our values are mostly good. We work in the household and also along side our men in business or farming or whatever - and this is not because men force us to go out and earn money as well as work at home. We think it is our responsibility to help earn the family income" (Lhamo, 1994 p.26).

In the home however, gender role changes are not so clear. Although the majority of the respondents (88.6%) agreed that it is appropriate for men to do household duties, a notable percentage (12.4%) did not. Interestingly, among the younger age group, one quarter of them said it was not appropriate for men to do household duties. When asked why, they suggested that men had more responsibility for obtaining economic resources and working outside the home, while women were more patient and persistent in working in the home. Perhaps this change in view by the younger Tibetans is because they have lived in India and have been exposed to other cultures and this has influenced their traditional view.

5.3 Health Seeking Behaviour:

Responsibility for health does not only affect the individual, but also the society as a whole. A working society is only as strong as its functional components, the people. It is possible to create an enlightened society only through the acts of responsible individuals. When the investigator asked the respondents who was most responsible for maintaining good health, the majority (78.3%) of the respondents answered that they themselves were mostly responsible. It was clear from the results that Tibetans believed that the individual bore this responsibility. However, families were felt to be critical contributors to maintaining good health. In addition, the role of government was identified as having a responsibility and respondents acknowledged the influence of God/Karma.

Since the respondents were all Buddhist, the concept of God was inappropriate for inclusion in the questionnaire. The principle investigator included this concept to familiarize the audience with the western point of view. It was later realised as the study progressed that using the term 'karma' alone would have been most appropriate for this type of study. In future studies it is recommended that Tibetan survey questions related to God use the term 'karma'.

5.3.1 Concept of Good Health and Health Maintenance

Good health in general terms was defined as good food, clean environment, low stress, happiness, good mental physical balance and good energy balance in the body. The responses on maintaining good health reflect the same general trends. These same trends were reflected in values of community health. This is not surprising as the refugee community had congested living quarters and cleanliness and mental balance is imperative to maintain health in such situations. It also reflects their Buddhist beliefs that body, mind and speech must be balanced and a clean environment for spiritual practice is a must.

5.3.2 Illness Beliefs

The Tibetan community in Dharamsala believed that illness was the result of several factors such as poor nutrition and karma, that illness was part of the natural cycle of life and death, and lastly, that illnesses were related to the presence of an unhealthy environment. Tibetans in Dharamsala considered that poor nutrition was believed to be the most likely cause for illness. The investigator experienced the life of a refugee, and understands that this would be a likely statement from people who are refugees who have suffered from lack of food and subsequent illness during their flight.

Of interest was the inclusion of the belief that disease is part of the natural cycle of life and death. This relates to the traditional Tibetan belief of karma, which

is the continual cycle of cause and effect throughout the cycle of life and death.

An unhealthy environment also ranked high as a cause of illness. This view could also be explained by the traditional Tibetan belief regarding the nature of 'interdependentness'. Perhaps from a Western perspective, the term 'food chain' comes closest to explaining this concept. It is believed that whatever the phenomenon may be, it does not have an inherent existence on its own, but is dependent on other phenomenal existence. An example of this would be to imagine a bowlful of apples. Apples cannot be reproduced by themselves as they sit in the bowl because the apple has no inherent-existence. In order to reproduce more apples certain other conditions of cause and effect must exist, such as soil, light, air, water and minerals. The concept suggests that “because of this...that arises” or “because of this product...that produces” (Gawkie, 1982).

Tibetans in Dharamsala also seem to believe that germs and viruses to be the significant cause of disease, followed by a lack of exercise and weight problems. Other causes of disease included genetics and the presence of evil spirits. The terms 'germs' and 'virus' were not commonly known to ordinary Tibetans, as they are not terms that are used in other treatments, such as in Spiritual Healing. Many common people did not have access to a Western knowledge-base and had to be introduced to these terms. During this study the investigator explained the terms to approximately one quarter of the sample population, mainly older respondents.

5.3.3 Concept of Disability

According to this sample in the Tibetan community in Dharamsala, the most disabling conditions were blindness, paralysis, deafness, leprosy, movement problems, epilepsy, and physical abnormality. From the results, two things were worth noting. First, blindness is the most concerned disability. This is consistent with other research. According to the Gallup Surveys, (1988) blindness is the worst disability that can happen to someone, a belief that is also held by this Tibetan community. The second interesting result is that a physical abnormality was considered to be a less serious disability than movement problems. The sample of Tibetan people in Dharamsala believed that a physical abnormality was not necessarily a devastating condition. In other words, if someone had a congenital physical abnormality of the hand, then that person had a disability that created few difficulties. Yet, if a person had a disability that restricted movement, then the disability was troublesome to that individual. According to the results, the least disabling conditions were feeling giddy, diarrhoea, and malaria, in rank order. Field notes suggested that as the population had personal experiences of these, they rated them as valid health and disability related concerns as they prevented them from doing what they wished to do. This concept of disability did not differ from international understanding of disability, which states that disability means any restriction or lack of ability to perform an activity within the range considered normal for a human being (WHO, 1980).

It was also interesting to note that the Tibetans in Dharamsala considered mental problems (52.2%) and memory problems (50%) to be disabilities. Tibetans believed that the mind or mental factor is the forerunner of all intended deeds. That is, when one acts, the core cause comes from within rather than from an external agent. Therefore, mental commands are more powerful than the physical nature. If a physical abnormality occurs, one has a greater chance of dealing with it than if one has a mental problem. A further example of this concept is seen in a popular Tibetan saying extracted from Times of India, "Thou shalt not make thy senses a playground of thy mind" (Wangda, 1973-1995).

The subjects had a good understanding about the possibility of disability occurring at any time before, during or shortly after birth. The investigator's understanding of this result is that everyone experiences reality in a similar fashion and has had some experiences to warrant these views.

5.4 Decision-making Process to Seek Treatment

5.4.1 Seeking First Treatment

A number of factors influence the initial decision-making process to seek treatment. "First treatment" was defined as where one would go to seek treatment immediately. Of the total sample population, 18 respondents (39.1%) sought first treatment from Western Allopathic Medicine (WA) and an equal number (18 respondents) sought treatment from Tibetan Traditional Medicine (TTM). The

younger age group preferred WA, while the elder group preferred TTM. It is interesting to note that almost half of the population sample preferred to seek consultation regarding health professionals from a SH. Field notes confirmed that from both age groups, people consulted SH not only to determine which medical treatments to seek, but also from which practitioner to take treatment. Therefore, although Spiritual Healers are consulted about the nature and providers of treatments, first access is to Western Allopathic treatment with SH as the third option. The two respondents on Table 30 listed as “other” provided an interesting fourth option. This fourth option was to seek treatment according to one’s need. The choice varied depending on the nature of the illness. Perhaps, such integrated choices may increase in future when people are more informed about multi-level treatments and how they work.

In answer to the question that asked which health care models were most commonly sought out for the treatment of health problems, half of the population sample sought TTM and more than one third sought WA. Only 3 (6.5%) sought SH or home remedies. When the age was taken into consideration, it was clear that younger Tibetans commonly sought WA while older people preferred TTM. Interestingly, only younger respondents mentioned a preference for home remedies. In addition, field notes documented that a number of respondents mentioned that they switch between health care models, if the 'first treatment' did not help them as expected they would pursue a second course of action.

The open ended question on this subject revealed that the majority of respondents preferred WA for the immediate pain relief and emergency acute care and preferred TTM for further elimination of the disease and for the safety of treatment. The SH was thought to be of greatest value for preventative measures.

The rationale for making decisions for choosing which health care models to use for the first medical treatment was very similar to that of which of the three health models was best: WA for immediate pain relief; TTM for no side effects and cures the cause of diseases and SH for assessing the worthiness of decision option given.

5.4.2 Consultation

Consultation with legitimate spiritual masters seemed to be one of the main processes for making a decision to seek treatment. As a main consultation procedure, people had the most faith in consulting with SH. This was followed by TTM, and WA. Prayer or meditation and consultation with one's family was seen as less appropriate.

5.4.3 Payment

Affordability is one of the most important factors of health care provision. It is even more critical when related to a refugee community. Payment would be one of the major criteria when governing the decision to seek health care and treatment. For the respondents in the Tibetan community in Dharamsala, WA appeared to be less 'accessible' than the other two systems. This was due to instances where consultation

was required with several specialists, as specialists were rarely located in the same place as the original physician. To obtain specialized Western Allopathic treatment for certain diseases, one has to go further than the community or the country where one is living to obtain it. This was a financial concern for the patients and their families.

5.4.4 Medical Treatment for Poorer People

The responses to the question regarding the appropriateness of treatment models for poor people, all of the sample population agreed that TTM was the most appropriate. This was followed by SH (89.1%) and then WA (78.3%). One fifth of the total sample population suggested that WA was not appropriate for poor people. The main reason for this may be that WA treatment required money in payment for services. In addition, the treatment procedures were complicated and it was possible that one had to deal with treatment side-effects.

5.5 Characteristics of the Three Types of Medical Treatment

5.5.1 Does Treatment Make One Sicker?

This particular question was included in order to learn and understand the respondents' beliefs and knowledge regarding the safety, side-effects, and the effectiveness of treatment received. A 'yes' answer implying that treatment made one sicker, was given to WA 14 (30.4%) followed by SH 6 (13.0%) then TTM 5 (10.9%).

Saying no, it doesn't make one sicker, the responses were TTM 41 (89.1%) followed by SH 40 (87.0%) then WA 32 (69.6%). The respondents in the Tibetan community in Dharamsala believed that Tibetan Traditional Medicine was safer than either Spiritual Healers or the Western Allopathic Medicine. According to information gathered in field notes, Traditional Tibetan Medicine had few if any side effects, was effective in rooting out the cause of diseases, dispensed medications based on herbal materials and promoted healing through natural balance. In a state of natural balance there is no danger of transmitting communicable diseases. The community also believed that Spiritual Healers had amassed centuries of experience to draw upon, especially when it came to mental disorders or psychological problems. Yet, it was also mentioned by some respondents that if one was driven by blind faith, there was a danger of not accepting alternative treatment, and so one could miss the opportunity for curing one's disease appropriately. There are examples in the west as well that some individuals such as Christian Scientists have refused blood transfusions and have died as a result (Henderson, 1981).

The respondents in the Tibetan community in Dharamsala also felt that Western Allopathic Medicine had many good qualities, especially as it had a scientific base. But, they felt that there was an increased risk of transmitting other diseases through such techniques as blood transfusion or improper injection. The Tibetans tended to believe that Western Allopathic Medicine was limited, especially in terms of the an 'intangible syndrome'. For instance, if one was unable to identify

the cause of a syndrome, then it was unlikely that one will find a proper solution. The Tibetans also believed that WA was very dependent upon mechanical assistance rather than human caring.

5.6 Tibetan Beliefs Surrounding the Appropriateness of Certain Types of Treatment for Specific Types of Health Problems

According to Professor Jampa Gyaltzen, Head of the Astronomy and Astrology Department, the most tangible integration between the Delek Hospital (WA) and the Tibetan Medical Institute (TTM) was that any patients with tuberculosis were directed to Delek Hospital. This was the result of both institutions' experts having frequent meetings to coordinate services in order to minimize the pain that their patients bear. Similarly, any patient who complained of hepatitis was sent to the Tibetan Medical Institute. Generally, for acute diseases such as 'fever' or tissue-trauma, including burns, amputation and intestinal disorders, people selected WA.

In this Tibetan sample, the above trend was evident. For chronic illness such as arthritis, hepatitis, they preferred TTM. Both the WA and TTM were regarded as curative in their approach. The Spiritual Healer was sought for the management of mental health problems including anxiety, depression and psychosis. In fact, diseases or disorders caused by 'spirits' are far greater in quantity than traditional Tibetan medical based causation. "According to the traditional Tibetan medical text by G. Sangye, (Wangdu, 1983) there are 404 different kinds of diseases caused by

unhealthy food, improper behaviour, and unbalance of three humours. There are another 1,080 different kinds of diseases or disorders caused by various kind of 'spirits'. In addition there are 12 different kinds of 'spirits' that harm only infants. Each of these 'spirits' has a name and a consistent pattern of harmfulness and a treatment procedure of specific rituals or pujas undertaken by Spiritual Healers.

The results clearly indicate that in the case of anxiety, depression or psychosis, people sought treatment from SH. Most of the diseases or disorders related to 'spirits' are undertaken by SH. The Tibetan terms for these evil spirits is 'gDons' and there is no direct English equivalent. There are 1,080 evil spirits (gDons) which literally means evil spirit that extracts the essence of life, soul or longevity from an individual. Those 1,080 can be subdivided into three categories: 360 female gDons which originate from Attachment (lust) and that produce Wind (energy); and 360 male gDons enumerated from Aversion that extract vileness and germs; and 360 neutral gDons that comes from Closed-mindedness (ignorance), producing phlegm, malignant spirits, and earth guardians.

The existence of those above mentioned gDons can be divided into three realms or worlds:

- ▶ the planets of the upper world,
- ▶ the mountain gods of the intermediate world, and
- ▶ the nagas and earth lords of the subterranean world (Wangdu, 1983).

5.7 Usage of the Three Treatment Types

5.7.1 Curative or Preventative

Both the TTM and WA were used by the respondents for curative purposes. Eighty five percent of the total sample population indicated that they used Traditional Tibetan treatment for this purpose, followed closely by WA (78.3%) and then SH (26.1%). When it came to preventative, however, it was the other way round. The results were: SH (65.2%) followed by WA (21.7%), then TTM (10.9%). Clearly, SH was seen as a major preventative strategy. But in the preventative use of SH, there were a number of preventative measures which are based on beliefs and holistic approaches with multiple objectives. There are those which dealt with various spirits and obstacles which are not based in logic as Western medicine. Therefore, it is difficult to understand how they work or why they work explicitly.

People were also aware of effectiveness of WA preventative measures, such as immunizations and vaccinations. In WA, all the prevention measures have clear goals such as BCG for TB, measles vaccine for measles, meningitis vaccine for meningitis prevention. Preventative health behaviours are also included such as voluntary checkups and immunizations.

For the Westerners, who are more oriented to the WA model, other medical options may pose some difficulties. For them, TTM and SH are not well understood options. For the Tibetans in Dharamsala, however, having multiple options for health

care made perfect sense. For them deciding where to go for treatment, and when to commonly go for treatment, and whom to seek treatment from were very different questions. The first question related to behaviour. When one had a certain health problem, they chose where they would go for emergent care and relief of pain. The other question was related to choosing treatment based on the type of conditions and where one went most frequently for that condition. Although half of the sample most commonly sought treatment from TTM and almost one third most commonly sought treatment from WA, it was the younger Tibetans that preferred WA while the older ones preferred TTM.

5.8 Satisfaction of the Three Types of Treatments

For any treatment approach, patient satisfaction is the ultimate goal. In this study, patient satisfaction was measured in four specific ways:

- ▶ did they feel at ease
- ▶ were they treated with respect
- ▶ were they listened to in a caring manner; and
- ▶ did they receive treatment satisfaction.

5.8.1 Ease at Seeking Out Treatment

In this study, the phrase 'feel at ease' was defined in terms of the environmental relationship between the healer and the patient, and not the mode of treatment. A

physician must make a patient feel at ease and provide relief through compassion and love (Khangkar, 1991). People were most at ease with TTM, followed by SH and WA. TTM is based on a person-to-person relationship between the doctor and the patient in which each are more or less on equal footing. SH is also based on a person-to-person relationships however, in this case the relationship is one of master and follower. This person-to-person relationship of TTM appears to provide people with a more relaxing environment than the one with SH.

WA often utilizes experts along with various technological activities with which the Tibetan people were unfamiliar. The WA doctor/patient relationship in the community of Dharamsala did not place the two on equal footing, because there were no similar values to be shared by the two participants in this relationship, nor an ultimate goal to be achieved by both in a common ground. WA doctors are not required by written vow to treat with compassion and love and therefore were considered more separated and aloof from patient. WA practice tended to create a certain degree of anxiety or uncertainty for patients, or perhaps a better expression of this state would be that patients were in some confusion about the process.

5.8.2 Treated Respectfully

A TTM physician must abandon sloth and procrastination (Khangkar, 1991). According to the Tibetan respondents in Dharamsala, Tibetan Traditional Medicine treated them with the greatest degree of respect, followed by Spiritual Healers and

Western Allopathic Medicine. There may be many reasons for this, however, the most likely reason is that TTM doctors spend more time with their patients. Field notes suggested that Tibetan doctors were not obliged to 'fiddle' with complicated machinery and were empowered by other forces. A simple human contact provided with a sense of understanding that is needed for a vulnerable individual to gain more respect. For the Tibetan respondents, this seemed far more important than having a knowledgeable expert determine what needed to be done.

5.8.3 Listening in a Caring Manner

A TTM physician must abstain from intoxication drinks (Khangkar, 1991). Having intoxicating drinks decreases one's awareness capability of listening. When we check into a dictionary, the differences between hearing and listening is marginalised by 'concentration' (Collins, 1991). To hear means to perceive sounds, and to listen means to concentrate in what one hears. Listening is a very important part of a treatment-diagnosis in Tibetan Traditional Medicine. Almost three-quarters of the total sample valued that the TTM practitioners listened in a caring manner, followed by more than two thirds of the subjects that valued SH and then WA by 19 (41.3%). Listening is the gateway to correct understanding. In fact, a correct understanding is the awareness which lies in the wake of listening. Listening in a caring manner helps both the expert and patient to minimise confusion and uncertainty in dealing with health problems.

5.8.4 Comprehension of Diagnostics and Treatment, and Treatment Confusion

Despite approximately half the subjects indicating they understood the protocols that was explained to them by the three types of medical practitioners, the actual treatment caused more confusion. Again the subjects generally felt less confused with SH treatment when compared to WA. The specialized nature of WA confused people. Both the TTM or SH are vehicles that render holistic treatment. When someone seeks treatment, TTM or SH diagnose the patient's health problem and prescribe what should be done. With WA, although specialized experts may be able to diagnose and treat health problems, these experts were rarely found all in an accessible location. TTM treatment confused them slightly more than SH. This showed again the importance of their spiritual beliefs on their health and well being. The Tibetan Buddhist culture was common to everyone as it was taught and practised since childhood. Therefore, this familiarity with spirituality allowed for comprehension of the practice of SH. Both WA and TTM are academic disciplines and this understanding was not pervasive to all Tibetans.

5.8.5 Satisfaction

A TTM physician must be altruistic (Khangkar, 1991). So far as satisfaction is concerned, more than one third of the total sample population agreed that SH was most satisfactory, followed by TTM with (28.3%) and then WA with (8.7%). This outcome was not the result of superior medical knowledge but rather of greater kindness or concern for the patient.

5.9 Which Treatment Did Tibetan Respondents Consider to be Best

The respondents in the Dharamsala Tibetan community believe that TTM was the best health care approach, followed by SH and WA Medicine. The reasons given were as follows. When investigating what treatment is best for each age group, the older people preferred TTM while the younger ones preferred WA. The SH for both age groups overall had equal support. One important factor was that TTM treatment had no side effects and, according to information gathered, it cured the cause of diseases. It was beneficial in the long term and had a simple diagnostic procedure, confirming for the patient what was wrong. It was safer, since its basic philosophic view point conveys 'health through balance'. TTM was considered age old knowledge, wherein experience and confidence were valued.

WA, was perceived by many as effective for emergent care and immediate pain relief. Some were able to appreciate the tangible nature of detecting illness using technology such as X-rays, cardiograms and catscans. Western Allopathic medicine was recognized as having better facilities, practitioners with more education and a scientific base.

For the SH, the reasons given for its popularity were related to one's own beliefs and trust. Field notes indicated that at first, it was best to consult a Spiritual Healer for advice in order to determine which medical model to choose. SH was best for preventing obstacles and other harms. As well, the notes indicated that for them it worked, so they had faith in the treatment.

CHAPTER VI: SUMMARY AND CONCLUSIONS

Demographics

The ratio between male and female as well as age groups were distributed approximately evenly. However, due to the continuation of exodus from Tibet, almost two thirds of the sample population were born in Tibet. This brought forth a new interest of future research to investigate whether there is a significant differences in health seeking behaviour or health beliefs between those who were born in Tibet or in exile.

Regarding the marital status, slightly more than half of the sample population were single. Although, little less than half of them were married, only a few of them were living without their spouse despite the harsh reality of getting a stable job as a refugee. This indicates that the family bondage was strong and they faced their struggle against difficult situations together as a family rather than an individualistic approach. The traditional extended family of Tibet was not evident in Dharamsala due to the splitting up of families during the exile process.

Although in general, the family status of Dharamsala Tibetan community did not paint a rosy picture at all, people did not complain about their personal needs. For example, more than 2/3 of the subjects were living in just a 1 or 2 room living space of which almost 2/3 of them have 2 to 4 family members living together. This

is an indication of the density of the population of Tibetans living in the small area of Dharamsala. This also highlights the importance of having a clean environment to live in.

Community

Dharamsala, in Kangra District, Himachal Pradesh, is a town of about 170,320 Indians and approximately 7,300 Tibetans. One portion of the hill-side of Dharamsala is the seat of H.H. the Dalai Lama and the Tibetan government-in-exile and is a well established Tibetan community. In Dharamsala, there are various other Tibetan institutions such as the Library of Tibetan Works and Archives, the Tibetan Medical and Astro. Institute, Tibetan Performing Arts, Monasteries, Nunneries and schools and so on. It is an interesting community that attracts tourist and Tibetan scholars. Because of this, both the Tibetan and the Indian communities prosper economically. Despite the Tibetan exile community being surrounded by the Indian community and culture, the Tibetans-in-exile have been able to keep their culture intact. As well even with the changing environment of many new comers from Tibet, there was still good integration within the community.

Religion

All of the sample of this study were Buddhist. This provided common psychological and religious understanding among all subjects which encourages the Dharamsala Tibetan community to evolve towards a well integrated community. Although the Tibetans were driven into two groups due to the military invasion of Communist China in 1950, Buddhism as a common philosophy has helped the Tibetan refugee community in Dharamsala to resolve their problems. The two distinctive Tibetan groups are those who, through domination and abuses of the Chinese communist culture were forced into exile and, those who were born in exile in a democratic society. Both groups are struggling to preserve the original Tibetan culture with respect to fundamental human rights and with a sense of universal responsibility.

Education

Although the exile community has experienced hardship and humiliation initially, the Tibetans in Dharamsala have turned this to a positive situation. Ninety three percent of the sample had some degree of formal education thus indicating that this community had a high literacy rate. According to the Department of Education, the school enrolment between 1993-1994 was 22,886 students located in the 85 Tibetan schools in India, Nepal, and Bhutan. Female students constituted 51% of the

total number of students (Department of Information and International Relation, 1995). This state is quite different from the current situation inside Tibet. According to the 1993 official statistics, 33% of Tibetan children in Tibet cannot go to school at all. Furthermore, 45% of Tibetans age 15 and above are completely illiterate or semi-illiterate which is three times greater than the average Chinese rate of 15% (Wells, 1995).

Even though the system of education in the exile Tibetan communities is well established and the young Tibetans in-exile, are benefiting from this system, a new problem seem to be appearing. That is, how will the Tibetan community employ those who have been educated. This should be a significant concern to those who are both developing education policy and managing employment issues. It is not too late to prepare for educational renovation to ensure an appropriate balance between educational input and employment opportunity.

Household

The traditional extended family of the Tibetans is also missing in Dharamsala. Most households have two to four household members.

Gender Roles

Although Gender roles are seldom discussed in Tibet, generally women undertake the domestic activities while men take charge of the external work, but women also help men with tasks outside the home. It is usually the case that a

Tibetan woman is always there where work is to be done, especially in nomadic life. From a Japanese perspective, a member of a film crew who spent an entire year in Tibet in 1983, filming the Tibetan nomad life uttered, "Tibetan women work so hard, I thought, that without them men would not survive." From Tibetan point of view, it is a matter of karmic relationship based on eons of interdependent lives. Back in Tibet, people did not inquire what are the gender roles, but rather how to live in harmony. For example, in Tibet people did not bother very much about their age. Many people are unaware of their birth day or even month, although their year of birth was generally known through the twelve astrological zodiac signs. For the Tibetan people, birth, old age, and death are a natural part of existence. The birth is not a crucial matter; instead, how one lives is important. People believe in the continuation of ones life after life until one reaches the state of enlightenment.

Even in the religious or spiritual realm, male and female are perceived as equals. Soul or mind has no gender. It is not the gender that leads to enlightenment, but the wisdom that experience the nature of mind into bliss; the state of voidness. However, based on historical facts and the cultural milieu, males in Tibet dominate community affairs and females manage the home. A popular Tibetan saying, " A father may be empowering, yet home is owned by mother", provides an idea of how Tibetans perceive gender roles.

The environment shapes living beings. Those who live in a 'desert' and those who live in a rain forest have more differences in their mode of livelihood than

similarities. This is not because the living beings themselves wanted it that way, but because they have had to adapt. This particular environment could be called, 'culture'. Culture resembles the colours. Whether one will recognize it or not, the colour will eventually soak unto those who dwell with the colours. In this study the older Tibetans hold an 'equal rights' attitude between male and female while a notable percentage of younger Tibetans suggested that it is not appropriate for men to do household duties. This suggests that the colour of the inhabitant culture stained the original culture. However, the older Tibetans have less flexibility in the process of acculturation than the younger Tibetans.

As mentioned above there are substantial differences between the older Tibetans and the younger Tibetans in almost all aspects of health values, beliefs, and practices, with the younger Tibetans preferring WA, while the older ones prefer TTM treatment. But when it comes to the question asking, "does the treatment make one 'sicker'?" almost half of the younger Tibetans agreed that WA treatment does make them 'sicker' while only one eighth of the older Tibetans suggested that WA treatment make them 'sicker'. This could be interpreted as meaning that the younger Tibetans have more knowledge about WA than the older Tibetans and were more aware of the possible side effects and transmittable diseases.

Concept of Good Health

Tibetans in Dharamsala indicated good health was a good mental and physical balance maintained by a clean environment, good food, happiness and low stress.

Responsibility in Maintaining Good Health:

Self discipline is a tool for the development of inner qualities of an individual. These inner qualities encourage one to avoid the comfort of selfishness, and to seek a way to benefit others. Therefore, self responsibility is the measurement instrument that leads an individual to act and behave in an altruistic fashion. Such a concept is inspired through the Buddhist culture, by accepting the law of 'karma' and the nature of cyclic existence. These basic ideas of self-discipline and responsibility appear to be demonstrated in 'maintaining good health' as well. Most of the sample population agreed that maintaining good health is a personal responsibility.

Illness Beliefs

Tibetans in Dharamsala believe that the cause of illnesses are the result of multiple factors. 'Poor nutrition', 'karma', 'part of the natural cycle of life and death' and 'unhealthy environment' were stressed more than 'germs', 'virus', 'weight problems', 'lack of exercise' or 'genes/inherited'. It could be concluded that this set of beliefs are mainly due to the status of material development/comfort level in the west.

When the material needs are advanced, the comfort level that comes along with it, encourages lack of discipline and creates a 'state of laziness', instead. This condition results in an emphasis of the importance of physical fitness rather than keeping ones body and mind in a balanced state.

Concept of Disability

The concept of disability has not been yet fully recognized in the Dharamsala Tibetan community. This is perhaps the result of differences in educational philosophy between East and West. In the East, life is looked on as an 'ever changing phenomenon' that exists for a long, long time, having it's past, present and future aspects. Steward (1994) stated it this way:

"In the eastern traditions, death tends to be viewed as leaving or dropping the physical body. It is as much a beginning as an ending and is seen as another self in the mysterious journey on which the bodily existence is only a part" (p.274).

Therefore, disability is seen and understood as a part of an individual. It can happen to anyone at any moment. Be it even before, after, or during ones birth. Since the disability is an unavoidable part of an individual, we should and must tackle this situation not as a concern for a specific group, but as part of our very own nature.

In the West, life is generally understood as a static phenomenon, having a beginning

(birth) and an end (death). Existence of an individual is measured as 'one life span'.

Again Steward 1994 stated:

"Our western concept of death profoundly affects the health care system. We tend to see death as an end, a terminal event, a tragedy, a failure, and a loss. This view point helps explain why high percentage of health care dollars is spent in the first and last months of life" (p.274).

Therefore, disability seems to be an issue for someone else's concern rather than looking at oneself as an impermanent being, momentarily changing and constantly moving. Because of this, the solution for the betterment of the people with disability tends to be neglected.

As such, the approach differs drastically. This is a very important point to be realised and understood. The people with disability in the west are now viewing able bodied people as "temporarily able bodied people". Perhaps they are coming closer to the Tibetan way of thinking.

In this study, the respondents' definition of 'disability' could be categorised into five main themes. i) Physical disability, ii) disability not being able to produce income generating activities, iii) concept of 'karma', iv) disability that stress mental and physical balance, and v) the functional restriction in Activity in Daily Living (ADL). It seemed questionable that although, spiritual development or mental factors are considered to be more important than physical factors, the concept of 'disability' slants

towards 'physical disability' rather than towards the 'mental disability'. But in the Buddhist idea eyes (sight), ears (auditory), nose (olfactory), tongue (gustatory) and body (tactile) are an inseparable part of the mental factors/mind. For instance, if one cannot see at all, the perceiving function of the eyes will be non-existent, hence, this relates to a partial loss in the 'mental cognizance'. If one reasons in this way, the 'physical disability' could well be put together in the context of both 'karma' and mental/physical disability' which gives an interesting perspective on how Tibetans perceive 'disability'. The above interpretation comes from the findings that 32 (70%) of the sample agreed that disability is a problem of mental and physical well being, rather than just a functional disadvantage. In addition, disability concern is a human concern in the process of the cyclic condition of birth and death, because it is an inevitable part of our lives and without a part we cannot achieve wholeness.

Decisions to Seek Treatment

In the decision making process, more than one third of the sample agreed to seek treatment from WA or TTM respectively, in equal numbers. In the majority of the cases, the younger Tibetans preferred WA while the older Tibetans preferred TTM. The availability of more education for the younger Tibetans-in-exile about different alternatives in treatment would obviously affect the numerical distribution between treatment possibilities.

Curative and Preventative Options

The issue of 'curative' and 'preventative' showed that both the WA and TTM were perceived as curative while SH is perceived as being a preventative measure. Many of the respondents agreed there was a preventative component to WA as well, based on their personal experience, for example, vaccines for TB, polio, meningitis measles and other preventative (immunization) programs. But, the nature of the 'preventative' differs from that of SH preventative strategy.

Although the 1080 different kinds of evil spirits or demonic harms (disorders) have been identified and solutions developed, people depended on the empowerment of spiritual blessings and rituals that have provided a reliable healing solution for centuries rather than taking a medicine or vaccine.

Costs of Treatment

Everyone desires the best possible health care provision, but the selected option is more or less governed by 'affordability'. In addition, the most expensive treatment may not necessarily be the most effective. In this study, the total sample population agreed that the TTM was the most accessible treatment for poor people.

Satisfaction with Treatment Process

To feel at ease, is an important element in any social encounter. Whether it is a pleasant encounter or an unpleasant one makes a difference in how one could, or would, deal with certain given conditions. This is specially applicable to health related issues. In this study, in order to understand such conditions, the investigator decided to investigate into four characteristics of the patient doctor relationship environments. These characteristics were, when one goes to seek treatment, i) did you feel at ease; ii) did the healer/expert treat you with respect; iii) did the healer/expert listen in a caring manner, and iv) was the treatment selected considered satisfactory.

Three out of four subjects agreed that TTM created the best patient-doctor relationship. With respect to 'satisfaction' SH was considered to be the best. In all four of the above mentioned categories, WA was perceived as the least desirable option. Although, Dharamsala Tibetan community seem to value WA the least out of the three treatment types. The results also seem to support or reinforce their treatment choice of WA for acute/trauma situations where the experts must react quickly to ensure good treatment out come. In conclusion, the Tibetans in Dharamsala believe that in 'acute cases' WA was best, in 'chronic cases' TTM, and in terminal/preventative cases SH was best.

Original Hypotheses

Considering the above results, the hypotheses were supported. The following are the summaries of the supporting data:

- (i) *Exposure to alternative health-care systems influences health seeking behaviours.*

Due to exposure of WA as an alternative health care provision, the basic framework of the Health Care Provision (HCP) of Health Department of Tibetan Government-in-exile went from a single organizational structure to two branched organizational structure. Prior to the introduction of WA, the people depended on a single structured health-care system, the TTM (including SH). Today, the organizational structure of health care provision in the Tibetan community in-exile has two systems with three aspects; TTM, WA and integration of the two. WA treatment is best in providing solutions for acute health problems. The exposure to WA health care not only has influenced the Tibetan people's health seeking behaviour, in as much as the results indicated that the younger Tibetans prefer WA, but TTM has been introduced to the Indian people as an alternative to their existing WA system, thereby creating an impact on their health seeking behaviour.

- ii) Tibetans born and raised at least 15 years in Tibet will have different health seeking behaviour than those born in India.

All 'new comers' from Tibet, between the ages of 15-35 in this study had no previous contact with TTM. Therefore, when they are sick, they seek treatment from WA because of their exposure to only WA. Nonetheless, there had been an obvious difference between the older and the younger Tibetans. The older Tibetans preferred TTM while the younger Tibetans preferred WA. The results of the study indicated that the younger Tibetans were much more aware of the possibility of 'side effects' and the need for 'safeguards' associated with WA, than are older Tibetans.

- iii) Experience and knowledge of health care systems will influence health seeking behaviour.

In any given condition, experience and knowledge make a big difference. The results of this study suggesting that those who were more knowledgeable about a specific health care model were most likely to choose that particular model. Some made their choices based on previous experiences; others chose to seek treatment according to their own knowledge or through knowledgeable spiritual consultants.

Future Research

The data contained in this study could be used as a basis for further studies, not only to further investigate greater accessibility to different health care systems, but also as a basis for studying sustainable health-care provision, and developing strategies to meet the needs of the exiled Tibetans in India, Nepal and Bhutan. This could also lead to a second stage, which would include defining and developing an improved and viable health-care system for Tibet.

Since this is just an initial study, investigating the 'health seeking behaviour' of the Tibetan community in Dharamsala, the sample size was insufficient to generalize findings of this study to all Tibetans. However, it encourages the pursuit of future studies relating to the health care issues in Tibetan communities in various locations. It would be ideal to initiate an integrated research program so that the positive features of WA, TTM, and SH may be understood. This could lead to the enhancement of a sustainable health care provision of community-based rather than institutional based services. Community based programs would include the management and promotion of health care, where patients would be able to make knowledgeable choices. Ideally, the best conditions for health care are those in which people are free to select preferred options, rather than being given no choice at all. This could only be possible with the emergence of a multiple options for health care provision.

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APPENDIX A

HEALTH SEEKING BEHAVIOUR IN A TIBETAN REFUGEE COMMUNITY
(DHARAMSALA, INDIA)

Jurme Wangda
School of Rehabilitation Therapy
Queen's University
1993

Respondent Code _____
Interview Date _____
Interview Duration _____
Other Person(s) Present _____
Role Played _____

Interviewer Comments:

PART I: DEMOGRAPHICS

1. Respondent Code _____
2. Gender (circle) M F
3. Age (approx. years) _____
4. Marital Status (check **one** only)
- _____ married and living with spouse
- _____ married and not living with spouse
- _____ single
- _____ widow or widower
5. What is the highest level of education you have attained?
(check **one** only)
- _____ no regular schooling
- _____ some primary schooling, not completed
- _____ completed primary schooling
- _____ some secondary (not completed)
- _____ completed secondary
- _____ vocational/technical
- _____ some university
- _____ completed university
- _____ other (specify) _____
6. Religion (check **one** only)
- _____ Bon
- _____ Hindu
- _____ Muslim
- _____ Buddhist
- _____ Christian
- _____ Other (specify) _____
7. Do you have a shrine room?
- _____ yes
- _____ no

8. If you have a shrine room, how often do you use it?
(check **one** only)

more than once a day
 once a day
 once a week or more
 less than once a week
 Not applicable

9. How many people live in your house? _____

10. Who is the head of your household? (check **one** only)

Myself
 my wife /husband
 my father
 my father in law
 my mother
 my mother in law
 my daughter
 my daughter in law
 my son
 my son in law
 other (specify) _____

11. What is your relationship to the head of your household? (check **one** only)

" I am their _____ ".

Self
 wife/husband
 father
 father in law
 mother
 mother in law
 daughter
 daughter in law
 son
 son in law
 other (specify) _____

12. In which country were you born?

13. How long have you lived in this community?

Approx. years: _____

14. During the last few years, what did you do for most of the time? (check one only)

_____ work in a paid job Specify: _____

_____ work in the family business Specify: _____

_____ work on the family farm

_____ go to school/college

_____ look for work

_____ housekeeping/child care

_____ too old or ill to work/retired

_____ other (specify) _____

15. How many hours/day do you do this activity?

_____ hours/day.

16. Is it appropriate for men to do household duties?

Yes ___ Because, _____

No ___ Because, _____

17. Is it appropriate for women to do office work?

Yes ___ Because, _____

No ___ Because, _____

PART II: HEALTH SEEKING BEHAVIOURS

1. How would you define disability?

2a. Which of the following would you consider a disability...?

- | | |
|--------------------------------|--------------------|
| a) high blood pressure | b) deafness |
| c) feeling giddy | d) blindness |
| e) breathing/coughing problems | f) paralysis |
| g) epilepsy | h) mental problems |
| i) diarrhea | j) memory problems |
| k) physical abnormality | l) malaria |
| m) movement problems | n) leprosy |

2b. Please order those disabilities from most to least serious.

3. Do you think that disability could happen before birth?

4. Do you think disability could happen during birth?

5. Do you think disability could happen short after birth?

6. What is **good health**, according to you?

7. What do you do to keep in good health?

8. Do **YOU** have any health concerns today?

9. What is your main health concern?

10. What is your community's main health concern?

11. You can get different kinds of treatment when you are sick. Which one do you most **COMMONLY** seek out? (check **one** only)

- Western/Allopathic treatment
 Traditional Tibetan treatment
 Spiritual treatment
 Aryurvedic
 Home remedy
 other (specify) _____

12. If you were sick, where would **YOU** go first for treatment? (check **one** only)

- Western/Allopathic treatment
 Traditional Tibetan treatment
 Spiritual treatment
 other (specify) _____

12a. How did you make that decision?

13. If you were sick, where would your **FAMILY** want you to go first for treatment? (check **one** only)

Western/Allopathic treatment
 Traditional Tibetan treatment
 Spiritual treatment
 other (specify) _____

Please indicate how often you have used these treatments in the past and if you will again in the future?

Frequently : 75 - 100% of the time needed for medical care
Sometimes : 45 - 74% of the time needed for medical care
Infrequently: Less than 44% of the time needed for medical care
Never : Nil

14. Use of Western/Allopathic treatment in the past.

In the last 6 months:

Yes - Frequently___ Sometimes___ Infrequently___
 No

7 to 12 months:

Yes - Frequently___ Sometimes___ Infrequently___
 No

Between 13 to 24 months:

Yes - Frequently___, Sometimes___ Infrequently___
 No

_____ never

15. Will you use Western/Allopathic treatment again?

Yes - Frequently___ Sometimes___ Infrequently___
 No

16. Use of Traditional Tibetan treatment in the past.

In the last 6 months:

Yes - Frequently Sometimes Infrequently
 No

Between 7 to 12 months:

Yes - Frequently Sometimes Infrequently
 No

Between 13 to 24 months:

Yes - Frequently Sometimes Infrequently
 No

never

17. Will you use Traditional Tibetan treatment again?

yes - Frequently Sometimes Infrequently
 no

18. Use of Spiritual treatment in the past.

In the last 6 months:

Yes - Frequently Sometimes Infrequently
 No

Between 7 to 12 months:

Yes - Frequently Sometimes Infrequently
 No

Between 13 to 24 months:

Yes - Frequently Sometimes Infrequently
 No

never

19. Will you use Spiritual treatment again?

yes - Frequently Sometimes Infrequently
 no

20. For what do you use Western/Allopathic treatment the most? (check **one** only)

_____ curative treatment
_____ preventative treatment

21. For what do you use Traditional Tibetan treatment the most? (check **one** only)

_____ curative treatment
_____ preventative treatment

22. For what do you use Spiritual treatment the most? (check **one** only)

_____ curative treatment
_____ preventative treatment

23. Is it appropriate for **POOR** people to get the following kinds of treatment?

	Yes	No
Western/Allopathic treatment	_____	_____
Traditional Tibetan treatment	_____	_____
Spiritual treatment	_____	_____
other (specify) _____	_____	_____

24. Do you think that Western/Allopathic treatment could make you sicker?

_____ yes... definitely _____ possibly _____
_____ no... definitely _____ possibly _____

25. Do you think that Traditional Tibetan treatment could make you sicker?

_____ yes... definitely _____ possibly _____
_____ no... definitely _____ possibly _____

26. Do you think that Spiritual treatment could make you sicker?

_____ yes... definitely _____ possibly _____
 _____ no... definitely _____ possibly _____

27. Do you ever feel confused by the treatments you obtain?

	confused			clear	
	1	2	3	4	5
1. Western/Allopathic	1	2	3	4	5
2. Traditional Tibetan	1	2	3	4	5
3. Spiritual	1	2	3	4	5
4. Other _____	1	2	3	4	5

28. Were you able to follow the diagnostic procedure?

	difficult			easy	
	1	2	3	4	5
1. Western/Allopathic	1	2	3	4	5
2. Traditional Tibetan	1	2	3	4	5
3. Spiritual	1	2	3	4	5
4. Others _____	1	2	3	4	5

29. Did you understand the treatment protocol that doctor explained to you?

	Yes			No	
	1	2	3	4	5
1. Western/Allopathic	1	2	3	4	5
2. Traditional Tibetan	1	2	3	4	5
3. Spiritual	1	2	3	4	5
4. Others -----	1	2	3	4	5

30. How satisfied are you with the treatments you have obtained?

	not satisfied			very satisfied	
	1	2	3	4	5
1. Western/Allopathic	1	2	3	4	5
2. Traditional Tibetan	1	2	3	4	5
3. Spiritual	1	2	3	4	5
4. Other _____	1	2	3	4	5

31. Were you treated respectfully?

	Yes			No	
	1	2	3	4	5
1. Western/Allopathic	1	2	3	4	5
2. Traditional Tibetan	1	2	3	4	5
3. Spiritual	1	2	3	4	5
4. Others _____	1	2	3	4	5

32. Did the practitioner listen to you in a caring manner?

	Yes			No	
	1	2	3	4	5
1. Western/Allopathic	1	2	3	4	5
2. Traditional Tibetan	1	2	3	4	5
3. Spiritual	1	2	3	4	5
4. Others _____	1	2	3	4	5

33. How at ease are you seeking out treatment?

	not at ease			very much at ease	
	1	2	3	4	5
1. Western/Allopathic	1	2	3	4	5
2. Traditional Tibetan	1	2	3	4	5
3. Spiritual	1	2	3	4	5
4. Other _____	1	2	3	4	5

34. Is it difficult for you to pay for treatment?

	not difficult			very difficult	
	1	2	3	4	5
1. Western/Allopathic	1	2	3	4	5
2. Traditional Tibetan	1	2	3	4	5
3. Spiritual	1	2	3	4	5
4. Other _____	1	2	3	4	5

35. Is it difficult for you to travel for your treatment?

	not difficult			very difficult	
	1	2	3	4	5
1. Western/Allopathic	1	2	3	4	5
2. Traditional Tibetan	1	2	3	4	5
3. Spiritual	1	2	3	4	5
4. Others _____	1	2	3	4	5

35a. Please explain the difficulties _____

36. Which kind of treatment do you think is **BEST**? (check **one** only)

- Western/Allopathic treatment
- traditional Tibetan treatment
- spiritual treatment
- other (specify) _____

37. **WHY** do you think its best? _____

38. How responsible are the following for maintaining good health?

	not responsible at all			very responsible	
	1	2	3	4	5
a. Myself	1	2	3	4	5
b. Family members	1	2	3	4	5
c. Friends	1	2	3	4	5
d. Government	1	2	3	4	5
e. Foreign Aid	1	2	3	4	5
f. God/Karma	1	2	3	4	5

Some people believe that some kinds of treatment are better for certain kinds of health concerns. Please indicate which type of treatment you think is best for each item.

HEALTH CONCERN	WESTERN ALLOPATHIC	TRADITIONAL TIBETAN	SPIRITUAL	OTHER
PHYSICAL DISABILITIES				
Burns				
Birth Defect				
Other Deformity				
Paralysis				
Amputation				
Arthritis				
MENTAL/EMOTIONAL DISABILITIES				
Anxiety/Nervousness				
Depression				
Psychosis				
CARDIORESPIRATORY DISABILITIES				
Heart Problems				
Breathing/Coughing Problems				
High Blood Pressure				
SPECIAL SENSORY DISABILITIES				
Blindness				
Deaf/Mute				
OTHERS				
Epilepsy				
Leprosy				
Fever				
Tuberculosis				
Jaundice				
Diarrhea/Vomiting				

PART III: ILLNESS BELIEFS

Below is a list of statements describing some causes and consequences of illnesses, injuries, and bodily ailments. Please try to remember when you last had such a problem and after hearing each statement, please state to what extent these statements are true for you.

Long lasting illnesses, injuries, or bodily ailments are usually caused by:

	not true at all			very true		don't know/ understand
	1	2	3	4	5	9

1. Poor nutrition	1	2	3	4	5	9
2. Work stress	1	2	3	4	5	9
3. Fate	1	2	3	4	5	9
4. Conflicting emotions	1	2	3	4	5	9
5. Genes/inherited	1	2	3	4	5	9
6. Chemical imbalance in the body	1	2	3	4	5	9
7. Germs	1	2	3	4	5	9
8. Evil spirits	1	2	3	4	5	9
9. Lack of exercise	1	2	3	4	5	9
10. Family stress	1	2	3	4	5	9
11. Part of natural cycle of life and death	1	2	3	4	5	9
12. Body organ not functioning	1	2	3	4	5	9
13. Unhealthy environment	1	2	3	4	5	9
14. Result of previous wrong moral action	1	2	3	4	5	9

Long lasting illnesses, injuries, or bodily ailments are usually caused by: (continued)

	not true at all				very true	don't know/ understand
	1	2	3	4	5	9

15. Breakdown in the body's defenses	1	2	3	4	5	9
16. Allergies	1	2	3	4	5	9
17. Weight problem	1	2	3	4	5	9
18. Virus	1	2	3	4	5	9
19. Emotional imbalance	1	2	3	4	5	9
20. Season of the year	1	2	3	4	5	9

PART IV: TREATMENT BELIEFS

Below is a list of different therapies that people would use with long term illnesses, injuries, and bodily ailments. Again, after hearing each statement, please state to what extent these statements are true for you.

With a long lasting illness, injury, or bodily ailment I would most likely:

	not true at all			very true		don't know
	1	2	3	4	5	9

1. Consult Western Allopathic treatment	1	2	3	4	5	9
2. Consult Traditional Tibetan treatment	1	2	3	4	5	9
3. Consult Spiritual healers	1	2	3	4	5	9
4. Consult a parent	1	2	3	4	5	9
5. Consult a brother or a sister	1	2	3	4	5	9
6. Consult a friend	1	2	3	4	5	9
7. Use a trusted family remedy	1	2	3	4	5	9
8. Do nothing (wait and see)	1	2	3	4	5	9
9. Turn to private prayer/meditation	1	2	3	4	5	9
10. Other _____	1	2	3	4	5	9

PART V: COMMUNITY SUPPORT

Now we will ask you a few questions about the community (village) you come from. Please state to what extent these statements are true for your community.

	not true at all			very true		don't know
	1	2	3	4	5	9
1. People meet very often to discuss various things.	1	2	3	4	5	9
2. Everyone knows about everyone in this community.	1	2	3	4	5	9
3. In cases of conflict, people sit around to solve it.	1	2	3	4	5	9
4. If a person has a problem, everyone in my community helps out.	1	2	3	4	5	9
5. There is a lot of sharing in my community.	1	2	3	4	5	9
6. Everyone joins in celebrating the festivals.	1	2	3	4	5	9
7. In my community, people are suspicious of each other.	1	2	3	4	5	9
8. There is no unity in my community.	1	2	3	4	5	9

THIS CONCLUDES THE SURVEY. THANK YOU VERY MUCH FOR YOUR PARTICIPATION!

I am Jurme Wangda. At present I am studying at Queen's University, Kingston, Canada. My special interest is to know how and why we Tibetan people willingly choose one health care model over another, particularly here in the Dharamsala community where we are able to access multiple health care opportunities. At least far as I know there are the following three alternatives:

- a) Tibetan Medical & Astro. Institute.
- b) Delek Hospital
- c) His Holiness the Dalai Lama or Nechung Dratsang and others.

This survey is to understand the public/patients perspective towards treatment they receive, and their knowledge of the alternative approaches. I believe that understanding of the needs of medical care of persons who are sick is important in our development of our health care service.

Therefore, by understanding of my own view as such, I would like to have your honest and valuable opinions or suggestions through this survey. Now, the conditions are as being explained to you with the consent form. Thank you.

VITA

- Name:** Jurme Wangda
- Place; Year of Birth:** Nhenang, Toelung, Tibet; 1951
- Education:** M.Sc. (Rehabilitation Therapy) 1996 (Candidate)
Queen's University, Kingston, Ont., Canada
- B.A.B.Ed.(Physical Education) 1975
Nippon Health and Education University, Tokyo, Japan
- Teaching License Completion 1975
Tokyo Board of Education, Japan
- Buddhist study (Graduate Level)
Komazawa University, Tokyo 1972-1975
- Work Experience:**
- * 1991 - 1996
Lecturer/Instructor in Mind and Meditation at
Community Centre
 - * 1986 - 1990
Coordinator/Language Instructor for School for International
Training (St. Vermont USA) Nepal, India.
 - * 1984 - 1985
Tibetan Government-in-exile:
In Bomdila; Administration of education and community
integration programs for refugee settlement. Responsible for
resolution of community conflicts
 - * 1979 - 1984
Organization and security of Dharamsala Tibetan community
activities.
Provision of security for H.H.the Dalai Lama in Dharamsala
and India at public and private events.
- Awards:**
- * 1992/1993; 1993/1994
International Centre for the Advancement of Community
Based Rehabilitation Fellowship

APPENDIX B



ཏཱ་ལའི་བོ་ལཱ་མཆོག་གི་འཕེལ་བའི་འཕྲིན་ལུགས་ཀྱི་འཕྲིན་ལུགས་ཀྱི་འཕྲིན་ལུགས་

OFFICE OF HIS HOLINESS THE DALAI LAMA

།ངོ་སྤྱོད།

༄༅། འགྲུ་ར་མེད་དབང་གྲགས་ལགས་ནས་དེ་སའི་ཁྲུལ་གནས་
འཁོད་བོད་རིགས་འགའ་ཞིག་ལ་འཕྲོད་བསྟེན་དང་འབྲེལ་བའི་བྱི་
བ་བྱ་རྒྱུ་ལ། འབྲེལ་ཡོད་སྤྱི་མཆིས་ནས་བྱི་བར་ལན་འདེབས་
གསལ་པོར་གནང་རྒྱུ་མཚོན་མཐུན་འགྲུ་ར་གནང་འོས་ཅི་
མཆིས་དམ་དོན་གནང་ལུགས་ཀྱི་ངོ་སྤྱོད། ལྷ་སྤེལ་ཡིག་ཚང་ནས།
༡༩༩༥ ལྷ་ ༣ ཆེས་ ༣ ལ།།

Thekchen Choeling McLeod Ganj 176219, Dharamsala Himachal Pradesh.
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APPENDIX C

Phone : (01892) 2718



འོ་ཤེས་ལྷན་ཁག་གི་ཤེས་པ་ལྟུང་།

DEPARTMENT OF HEALTH

CENTRAL TIBETAN ADMINISTRATION OF HIS HOLINESS THE DALAI LAMA
GANGCHEN KYISHONG, DHARAMSALA-176215 KANGRA (H. P.) INDIA

Ref. No. :

Date :

TO WHOM IT MAY CONCERN

This is to introduce Mr. Jurme Wangda, at present studying at Queen's University, Kingston, Canada. He is making a survey to understand the patients perspective towards their treatment and doing a research among the Tibetans in-exile, your co-operation is requested.

Dated: March 3th, 94.

A handwritten signature in black ink, consisting of several loops and a long horizontal stroke at the end.

Namgyal L. Taklha
Secretary



APPENDIX D

Phone : 2560



དུ་ས་བོད་མིའི་བདེ་དོན་ལས་ཁང་།
TIBETAN WELFARE OFFICE
Department of Home
(Central Tibetan Administration of H. H. the Dalai Lama)

Handwritten text in Tibetan script, consisting of approximately 10 lines of cursive writing.



VITA

Name: Jurme Wangda

Place; Year of Birth: Nhenang, Toelung, Tibet; 1951

Education: M.Sc. (Rehabilitation Therapy) 1996
Queen's University, Kingston, Ont., Canada

B.A.B.Ed.(Physical Education) 1975
Nippon Health and Education University, Tokyo, Japan

Teaching License Completion 1975
Tokyo Board of Education, Japan

Buddhist study (Graduate Level)
Komazawa University, Tokyo 1972-1975

Work Experience:

- * 1991 - 1996
Lecturer/Instructor in Mind and Meditation at
Community Centre
- * 1986 - 1990
Coordinator/Language Instructor for School for International
Training (St. Vermont USA) Nepal, India.
- * 1984 - 1985
Tibetan Government-in-exile:
In Bomdila; Administration of education and community
integration programs for refugee settlement. Responsible for
resolution of community conflicts
- * 1979 - 1984
Organization and security of Dharamsala Tibetan community
activities.
Provision of security for H.H.the Dalai Lama in Dharamsala
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Awards:

- * 1992/1993; 1993/1994
International Centre for the Advancement of Community
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