Community Health Dimensions

of work in

Tibetan Settlements of Karnataka

particularly

Doeguling Settlement, Mundgod

COMMUN' 'EALTH CELL

A report of a participatory reflection on the 'Community Health' dimension of the existing and ongoing health programmes in the Tibetan Settlements in Karnataka State particularly, the Doeguling Settlement in Mundgod.

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Bangalore
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Preamble

The Community Health Cell is an informal resource group and network of individuals interested and involved in community health initiatives, particularly in Karnataka. It brings together a wide range of professional and field based experience and promotes sharing and learning through participatory interaction and critical analysis of grass roots field experience. It seeks to reflect with all its contacts and associates on the 'enabling dimension' of health care and explores alternatives in health action which are rooted in the socio-economic-cultural-political context of the project/process reality free of the constraints of models, text book solutions and borrowed ideas. It facilitates the project team to explore their own solutions to local problems, offering suggestions as a stimulus not as an expert body. The enclosed report is to be, therefore, seen as a product of such a process not as an outside Expert's report.

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The background

The Health Department of the Central Tibetan Secretariat at Dharmsala got in touch with the Community Health Cell in August 1988, as a follow up to a recommendation made by Dr Prem Chandran John, Coordinator of Asian Community Health Action Network (ACHAN) and Consultant to BREAD FOR THE WORLD, a funding agency that supports the Tuberculosis Programme and Primary Health Care activities in the Tibetan Settlements in Karnataka State.

After a preliminary phase of communication, in which the principles of Community Health Cell involvement (outlined in the preamble) were explored, it was decided to hold a 'brainstorming' session at the Community Health Cell along with representatives of the Health Department and the Medical Officers of the Tibetan Settlements.

The Process

This session was held at the Community Health Cell on 10 November 1988. Mr Thupten Phuntsok, Deputy Secretary to the Department of Health and Drs Passang Norbu and Tsewang Ngodup of the Mundgod and Kollegal settlements attended. The Community Health Cell team consisted of

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Ravi Narayan (a Community Health Physician with Public Health and Industrial Health experience); Shirdi Prasad Tekur (a Paediatrician with Community Health background); K Gopinathan (a management resource in the Community Health Cell team); H Sudarshan (a doctor involved in community health/development project in B.R. Hills, Mysore District); and Gerry Pais (a doctor involved in community health/development project in Hunsur, Mysore District).

At this initial session, an outline of the existing health care services and programmes in the Tibetan settlement was presented by the medical officers. In addition, Mr Thupten, explained the administrative structure and decision making process in the Health Department. Various important socio-epidemiological issues relevant to the Tibetan settlements were then explored. These included the socio-cultural factors, the effects of migration and a 'society in transition', the socio-economic situation, the special importance of the sweater seller phenomenon, the lama system, the interactions of the allopathic and Tibetan systems of medicine and the community/settlement organisation and process of governance and decision making. Some aspects of the important public health problems of Tuberculosis and the problems encountered in its control were also discussed.

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Shirdi Prasad Tekur and K Gopinathan then visited Mundgod settlement for two days (12 & 13 November 1988) along with Mr Thupten Phuntsok, and Dr Passang Norbu. During this visit, they made certain observations on various aspects of health services exploring available details through discussions with local team and community representative and a perusal of records and documents. A report of their observations was then presented at a series of informal meetings with Drs Tsewang and Passang and Mr Thupten and among the Community Health Cell team members themselves. The recommendations and possible options for action emerged through this dialogue process.

The entire process has been a very interesting and encouraging one and both the Tibetan Medical Team and the Community Health Cell have mutually benefitted from it. The enclosed report incorporates the observations of the Community Health Cell team that visited the settlement as well as the action alternatives that have emerged in the dialogue.

For purpose of meaningful communication, these are presented point by point in the enclosed format.

We hope this dialogue report is a beginning of a process through which the health teams of the Tibetan settlements and their Community Health Cell colleagues can follow up on action alternatives through further interaction and dialogue.

4. OBSERVATIONS and RECOMMENDATIONS/POSSIBLE ALTERNATIVES FOR ACTION

OBSERVATIONS	RECOMMENDATIONS/POSSIBLE ALTERNATIVES FOR ACTION
I. HOSPITAL	
A. General	
The Doeguling Tibetan Resettlement Hospital has 30 beds. Its average occupancy rate is 6-8 beds. It is well equipped with X-ray, ECG, Laboratory and other necessary equipment. The hospital has adequate facility for performing minor operations. It has specialist facility for eye problems with the help of a local opthalmologist. The hospital has acquired the necessary dental equipment for future use.	A well equipped library and current medical periodicals will help in updating of medical knowledge especially in the area of community health; it will also be useful to the para medical workers in strengthening the primary health care activities.
The hospital services are well utilised by nearby 5 villages and 2 lama camps. There seems to be under-utilization by 4 distant villages due to transport problems.	Administrative routine to include visit to these villages by competent staff on a regular schedule could be considered.
The hospital is self-sufficient for water and sanitation.	
There is a large out-patient load with general and tuberculosis follow-up cases.	Separate TB follow-up clinics on specified days in addition to the already allotted Saturday afternoons could be considered.

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OBSERVATIONS	RECOMMENDATIONS/POSSIBLE ALTERNATIVES FOR ACTION
Record keeping is up-to-date. It is adequate for the TB control programme only. The Hospital follows the National Tuberculosis Programme regime.	Adequate record keeping to reflect the amount of activity being undertaken in the areas of primary health care such as Maternal and Child Health (MCH), under-5 care etc., could be started.
A good referral system with the Medical College Hospital at Hubli for specialist services not available except on the personal liaison of the medical officer.	A formal arrangement with the Medical College Hospital, Hubli and the National Tuberculosis Institute, Bangalore, could be considered.
B. <u>Staff</u>	
The medical officer is overloaded with preventive, curative and till recently administrative activities at the hospital level.	It may be a good idea to induct additional manpower support for community health activities.
An administrator has joined the health team recently.	
The two trained staff nurses are fully involved with hospital out-patient and in-patient activities and are unable to devote time to community health.	A trained community health nurse is required for better utilization of MCH and under-5 activities by the community.

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OBSERVATIONS	RECOMMENDATIONS/POSSIBLE ALTERNATIVES FOR ACTION

c. Administration and funds

The budget of the hospital is prepared by a Committee consisting of the Representative of the Settlement, Village Leaders and the Medical Officer.

About 25% of the funds are met by the Health Tax, Bed Charges and OPD charges at present. Free treatment is given to deserving patients.

It is proposed to collect further 25% from the same resources. This community participation will meet a major part of the health budget apart from TB control programme.

Decisions are made with the participation of the community (represented by the leaders) with adequate flexibility for the medical officer's functioning in medical matters.

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OBSERVATIONS	RECOMMENDATIONS/POSSIBLE ALTERNATIVES FOR ACTION
The percentage of patients on second line anti-tubercular treatment showed 35.0% in 1985; 32.1% in 1986; 36.2% in 1987 and 28.68% in 1988 (upto Nov.) The cause for this is the starting of second line treatment at private clinics and other centres which do not follow the National Tuberculosis Programme recommended regime. A standard treatment policy in all the settlements in accordance with the National Tuberculosis programme is being implemented.	1. Ensuring that all Tibetan Settlers approach their own health centres or the nearest District Tuberculosis Centre to enable the standard treatment policy to be followed.
	2. Consider mobile health worker with first line drugs; even if the diagnosis is made by the private practitioners, treatment to be followed should be as per the National Tuberculosis Programme.
	3. Links with local practitioners/ organizations could be established for following the National Tuberculosis Programme (NTP) regime.
From the statistics provided, it is noticed that more than 31% of the proposed budget for TB and Primary Health Care programme is earmarked for anti-tuberculosis drugs in view of the high proportion of cases being on costlier second line treatment, and the inability of the District Tuberculosis Centre to supply these drugs. This cost is despite the fact that all other health care activities are being met by the community itself.	4. Consider training of mobile sweater sellers for tuberculosis programme.
	5. Employer of thesweater sellers may be requested to take action as in 1-3 above on detection of tuberculosis cases.
	6. Check if second line drugs with Comprehensive Medical Services-India (CMS-I), Madras, are cheaper, details of which are being sent to Doeguling Hospital.
	7. A goal for eradicating/controlling (to national level) the TB problem should be set.

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OBSERVATIONS	RECOMMENDATIONS/POSSIBLE ALTERNATIVES FOR ACTION
There is no definite staff development and continuing education programme as a policy in the South Indian settlements.	Taking this up as a policy matter will enhance the skills of the team in performing their work more effectively. In addition, regular monthly meetings of the staff, discussion of health and related problems, training of staff not individually but as a team, will further strengthen their team work towards providing primary health care.
Detailed studies of diseases incidence/prevalence are not being done due to lack of funds for this activity.	
II. COMMUNITY HEALTH	
a. <u>Water Supply and Sanitation</u>	
Adequate potable water is available from borewells within walking distance.	Overflow and sullage water can be utilised for kitchen gardens.
Collection and storage of water is unhygienic.	Proper health education of the community in this area is needed.
Sanitary facilities for excreta and waste disposal are grossly inadequate.	Propagation of the concept of atleast community latrines to be considered.

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OBSERVATIONS	RECOMMENDATIONS/POSSIBLE ALTERNATIVES FOR ACTION
b. General hygiene	
Concepts of general hygiene, especially oral and personal is poor.	Health education to alter the habits which were notharmful in their homeland of Tibet but are conducive to spread of diseases in the present circumstances is required.
c. Maternal and Child Health (MCH)	
Immunization coverage is good.	
Breast feeding is promoted as part of the culture. Birth weight of newborns is above average.	
Pregnancy is usually diagnosed after 5-6 months. Hence the critical period of MCH care in the first and early second trimester are not availed of to a full extent.	The services of a Community Health Nurse will help improve the situation.
Abortions are not reported and home deliveries are conducted by elders in the family who are untrained.	Awareness building programme (through community participation) to elders who conduct deliveries could be organized. Concepts of hygiene etc., could be included in the programme. Since prevalent cultural practices

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OBSERVATIONS	RECOMMENDATIONS/POSSIBLE ALTERNATIVES FOR ACTION
	appear to be adequate in producing healthy children, maternal and child health needs deeper study especially antenatal practices in order to foster good traditional practices.
d. Health Workers	
The health workers are well trained, motivated, sincere and capable of handling responsibility, especially in TB control programme. They were given adequate on the spot training by the medical officer for TB control, MCH care and Health Education. They are occasionally utilized in hospital care in place of nurses in addition to above.	Health workers can be trained to handle minor ailments and given some drugs for it thus reducing the hospital out-patient load.
	Additional work with more incentives to be considered for health workers to ensure committed primary health care.
There are 3 drop outs out of the original 8 health workers trained and the replacement workers are yet to be fully trained.	In order to ensure replacement of staff easily regular training programme for health workers could be organised.
The younger unmarried health workers are not well accepted by the community yet.	The services of part time health workers could be considered; they could be selected from amongst school teachers/staff of co-operatives/ staff of handloom weaving centres etc., who are likely to be permanent residents of the settlements.

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OBSERVATIONS | RECOMMENDATIONS/POSSIBLE ALTERNATIVES FOR ACTION

e. Villages 1,2,3,5 and Lama Camps 1, 2

Majority of TB cases are found in the mobile population of sweater sellers especially those coming from major cities. Many people affected by TB belong to the age group 15-35 years, while in Lama Camp 1 under 20 years and above 55 years are affected. It is believed that the higher incidence rates in monastries is due to newcomers from Tibet.

Cases on second line treatment have been initiated elsewhere.

Females show a lower incidence compared to males.

(observations pertaining to other aspects of health are as recorded in previous paragraphs.)

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OBSERVATIONS	RECOMMENDATIONS/POSSIBLE ALTERNATIVES FOR ACTION
f. Nunnery	
It has 25 residents and is clean and well maintained. Adequate water and sanitation facilities are provided to it. Since it is next to the hospital, the inmates utilise health services well.	
g. Homes for the old, infirm and destitute	
They have been provided with adequate water and sanitation facilities. However, general and personal hygiene in the general section is poor. It is better in the lama section.	More community health worker's activity especially in the field of hygiene is required. Participation of community to be sought to take care of those who are unable to help themselves.
h. Tibetan Medicine and Astro Institute	
It aims at revival and popularisation of traditional system of medicine. According to the Medical Officer, its theoretical principles are similar to Ayurveda.	Integration of activity with the allopathic system and more so in the direction of providing primary health care to be considered.
Source of medicine is centralised at its head quarters in Dharmsala.	Imparting some skills to health workers and utilising them would strengthen their efforts.
	It could play an important role

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OBSERVATIONS	RECOMMENDATIONS/POSSIBLE ALTERNATIVES FOR ACTION
No local/herbal/home remedies propagated which can be easily made at home.	in taking over of hospital over-load of out-patients wherever possible.
The institute is staffed by a senior doctor and two trainee doctors. They conduct home visits and treatment on request.	Comparative clinical trials of treatment for chronic diseases using both allopathic and Tibetan systems can be initiated at the settlement level.
i. Representative of the Settlement	
Mr G Choeden was very concerned about the mobile population of sweater sellers since a. they constitute the younger population; b. they are unable to learn any skills; and c. they are the major source of the tuberculosis problem.	Screening of settlers returning from their prolonged stay outside to spot TB cases could be considered. (other suggestions regarding TB as in I.c. above).
Mr Choeden invited us to speak at a Seminar-cum-Workshop on INTEGRATED DEVELOPMENT PLAN FOR TIBETAN SETTLEMENT AT MUNDGOD.	

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OBSERVATIONS	RECOMMENDATIONS/POSSIBLE ALTERNATIVES FOR ACTION
During the discussions here, it was noticed that "health" did not form a part at all of their "Human Resource Development". This was pointed out and stressed by a member of our team.	It will be good to involve the health team to introduce health aspects in all the social/economic activities of the settlement.
j. Cultural and Social factors	
Community eating and drinking habits from common plates and glasses is prevalent.	Health education to create awareness of the adverse health effects in the present conditions to be organized.
A traditional barley brew is consumed by many though alcoholism does not seem to be a problem. Smoking and chewing of tobacco are not common while using of snuff is widely prevalent.	
There are no organised health promotive activities like youth clubs, community reading rooms/libraries, play grounds, games etc.	Community participatory activities to be considered.

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OBSERVATIONS	RECOMMENDATIONS/POSSIBLE ALTERNATIVES FOR ACTION
k. Schools and School Health	
There are 3 central schools: one upto higher secondary (XI Std) and two are primary schools.	
There is a high drop out rate at middle school level.	The causes for high rate of school drop outs to be analysed and some action initiated to control it.
There is no regular system of school check ups and health record maintenance.	Regular school health check ups and recording could be undertaken.
The medical officer has noticed a very high incidence of dental caries.	Health and hygiene/sanitation to be made a part of school curriculum.
There are 9 creches with under 5 children. Some of the personnel are trained in the Montessori system. Mid-day meals, supplementary nutrition and growth monitoring are done here.	These places can be used for education of mothers in health, hygiene and nutrition aspects of children.
There are no regular formal/ non-formal adult education classes.	Regular adult education classes to be considered.

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OBSERVATIONS	RECOMMENDATIONS/POSSIBLE ALTERNATIVES FOR ACTION
comments not covered above	
From the available statistics, the following is noticed:	
a. The Crude Birth Rate shows a decreasing trend in the settlement population.	A detailed study of these statistics from hospital and community records will help in formulating a more meaningful health programme for the future, especially since this settlement has a large monastic population and also an old age/destitute home which may account for the present interpretation of statistics.
b. The crude death rate is mainly due to old age and destitute home accounting for it.	
c. The infant mortality, neonatal mortality, maternal mortality, and mortality by cause could not be calculated.	
d. The high rate of BCG immunization is due to the fact that all settlers under 19 years of age were immunized in 1985 and more newcomers into the settlement.	
e. The in-patient and out-patient attendance has decreased while the referrals have increased during October 1988 due to the absence of the medical officer.	

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AREAS OF STUDY

1. A thorough study of the trends and pattern of tuberculosis in Tibetan settlements in Karnataka.

2. Comparative study of the relation and impact of agriculture, dairy farming and other socio-economic activities on health in the different settlements in Karnataka.

3. A study of the child bearing and child rearing practices of the Tibetan community.

4. A study of the training needs and training in areas of MCH/under fives and school health.

5. Study of utilisation pattern and scope for integration in community health practices of the Tibetan system of medicine.

The above studies could be initiated by the health team themselves as part of an ongoing Health Research strategy. It would enable the evolution of a more appropriate and effective strategy for the future of the settlers. The studies can be of an action-research orientation.

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SUMMARY

1. The Hospital and dispensary are well equipped and organised. Most aspects of hospital management are being looked into by the medical officers themselves and alternatives being explored. Staff development and continuing education programmes, however, need much more attention.

2. The tuberculosis programme is well organised and conducted. However, since the prevalence is very high in spite of the commendable efforts, further intensification is required to bring down the prevalence to atleast the Indian National average.

3. Though a 'primary health care orientation' is evident in the overall planning and training efforts, the focus at the field level is still very much oriented to tuberculosis. The infrastructure, health team functions, routines and activities geared to TB control can be, without much difficulty and a certain creative re-orientation, focussed on a larger range of primary health care problems. Community based activity need to be further strengthened.

4. The community participates in decision making and pays for much of the health needs apart from the tuberculosis programmes. This dimension needs to be further strengthened and decentralised. Health co-operatives/health insurance schemes can be further explored.

5. Considering the high cost of the TB control programme, various avenues of better management have been explored in the report. The suggested study will also help in pointing out an appropriate course of action.

6. Health education and appropriate Public Health Engineering will help further to prevent many of the minor illnesses and promote primary health care.

7. Good cultural traditional practices in maternal and child health need to to be studied and fostered in the MCH programmes.

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8. The health workers need to be supported in carrying out at the field level a wider range of health action other than tuberculosis control activities.

9. The phenomena of a large mobile population predominantly of 'sweater sellers' seem to be a major problem at health practice level. A detailed study of the phenomena and its epidemiological implications is an urgent first step. From this, appropriate medical/administrative actions to tackle the problems could emerge.

10. Integration of Tibetan Medicine at all levels of the health service will prevent duplication of efforts and promote a more holistic planning. Compartmentalization needs to be avoided.

11. 'Education for Health' is an area not adequately explored in the existing health planning. The school as a focus of health activity and health education needs to be explored more dynamically. Pre-school and non-formal education efforts which include the health dimension need to be organised.

12. Community involvement in health can be further strengthened by exploring the involvement of youth/youth clubs, women/women's clubs and the lamas in primary health care activities particularly preventive and promotive activities.

Shirdi Prasad Tekur

K Gopinathan

6. Appendices

(1) Demographic Data of Mundgod Settlement
(2) Community Statistics
(3) Immunization Statistics
(4) Hospital
(5) Tuberculosis
(6) Mother and Child Health

Demographic Data of Mundgod Settlement

1.	Total Population	:	9658
	Males	:	5788 (including Lamas - 2400)
	Females	:	3870 (including Nuns - 25)
2.	Total Area of Settlement	:	3000 Acres
3.	Number of Villages	:	9
4.	Number of Lama Camps	:	2
5.	Nunnery	:	1
6.	Home for the Aged	:	1
7.	Number of Creches	:	9
8.	Number of Schools	:	3 (1 High School, 2 Primary Schools run by the Central Government)
9.	Cooperatives	:	1
10.	Banks	:	2
11.	Post office	:	1
12.	Transport facility	:	2 Government Buses to Mundgod daily
13.	Main Occupation	:	Agriculture
14.	Seasonal Occupation (3 to 7 Months)	:	Sweater selling (more than 60% according to the Representative)
15.	Other Occupations	:	Carpet Weaving/Handicrafts/Dairy

Community Statistics

	1985	1986	1987	1988 (till Nov)
Crude Birth Rate (1981 - Indian - 33.2)	16.21	12.0	11.33	6.41
Crude Death Rate (1981 - Indian - 12.5)	8.62	9.78	8.14	4.34
Under-5 Population	741	764	696	717
- as % of total population (Indian - 15%)	(8.52)	(8.59)	(7.66)	(7.42)
0-1 Population	141	107	103	62

Immunization Statistics

		1985	1986	1987	1988 (till Nov)
B.C.G (Good Coverage, see comments)					
DPT & OPV	1st	20	108	93	81
	2nd	10	102	83	74
	3rd	4	106	69	55
Measles		46	82	113	115
Boosters	I	Nil	119	79	45
	II	Nil	91	21	43

Hospital

	1985	1986	1987	1988 (till Nov)
Total Outpatients	25,960	21,862	21,536	14,418
Total Inpatients	612	696	625	484
Referrals	11	8	4	19
Average Stay in Hospital (Days)	9	9	9	9

Tuberculosis

	1985	1986	1987	1988 (till Nov)
Total New Cases Diagnosed	108	86	144	83
Incidence of TB - new case (India - 0.13%)	1.24%	0.96%	1.58%	0.85%
Average Number on Treatment	116	94.25	89.41	93.0
% on 1st line	65.0	67.9	63.8	71.32
% on 2nd line	35.0	32.1	36.2	28.68
Total completed Treatment	84	111	80	76
Total Relapse	7	14	8	3
Total Expired	8	-	-	-
Total Gland TB	3	-	-	2
Meningitis	1	-	-	1
Joint	-	-	1	-

Mother and Child Health

	1985	1986	1987	1988 (till Nov)
Ante-natal Clinic attendance	1059	895	864	308
Hospital Delivery	36	39	24	30
Home Delivery	63	39	33	31
Outside Delivery	45	25	28	6