**May 2002**

# TIBETAN HEALTH INITIATIVE

## *EXECUTIVE SUMMARY*


The *Tibetan Health Initiative* is dedicated to restoring and maintaining the health and well-being of Tibetan refugees living in India. Starting with senior teachers and destitute monks and nuns in the pilot area, the project is committed to developing a health plan and health system that provides Tibetan and Western medicine so that the health care services delivered are culturally and medically appropriate and accessible.

The Tibetan culture is ancient; rich with wisdom and beauty. In these deeply troubling times, it is a precious gift to have as an example for the world a leader and a people who despite a background of enormous hardship and extreme brutality have maintained a life practice of compassion and peace.

A critical link to this culture's survival is the health and well being of the Tibetan teachers, monks and nuns. These individuals embody the Tibetan spiritual traditions. They dedicate their lives to carrying forward and passing on Tibetan knowledge, wisdom, and spiritual practices to future generations of Tibetans and all of us who appreciate this culture's gifts to the world.

Thousands of Tibetans fled Tibet seeking a safe haven in neighboring countries. Many of these refugees are senior teachers, monks and nuns who followed His Holiness the Dalai Lama to India. The majority settled in South India. Of this group, many escaped with only their lives. They are living in monasteries and nunneries with nothing – no family, no resources, and in very poor health.

Working primarily with the Central Tibetan Administration in exile and Manipal Health Systems, the *Tibetan Health Initiative* started a pilot project in South India providing solely emergency inpatient medical services for several hundred senior teachers and destitute monks and nuns at one monastery. The pilot has expanded in scope and membership. Through a key Manipal Health System teaching hospital in Southern India, the project now provides a full range of health care services for nearly 1,000 individuals residing at several monastery centers.

With sufficient funding, the next steps are to expand membership to include destitute individuals in the communities and refugee camps adjacent to these monasteries/nunneries, and over time includes all senior teachers and destitute monks and nuns in South India.

Parallel to expanding the number of beneficiaries, it is our intention to design a health plan, in collaboration with our Indian and Tibetan medical care colleagues, which seeks to integrate Tibetan and Western medicine and includes other medical approaches as appropriate. Designing an increasingly "integrated" system of health services marks an exciting new phase in the delivery of health care, especially for refugee populations who typically must cope with the stress of living in duress and poverty in foreign country and with foreign medical care.

The goal of this project is to establish a sustainable system of health care that eventually is available to <u>all</u> Tibetan refugees in India. As we do this work, we will be documenting our process. In whatever way our experience is transferable, we wish to share it and be of service to others dedicated to improving the health and well-being of refugees in other areas of the world.

**May 2002**

# TIBETAN HEALTH INITIATIVE

## *PROJECT DESCRIPTION*

### Purpose

The *Tibetan Health Initiative* is dedicated to restoring and maintaining the health and well-being of Tibetan refugees living in India. Starting with senior teachers and destitute monks and nuns in the pilot area, the project is committed to developing a health plan and health system that *integrate* Tibetan and Western medicine so that the health care services delivered are culturally appropriate and accessible. *[integrate issue again]*

The ultimate outcome of this endeavor is the design, development and implementation of an increasingly "integrated health system" for Tibetan refugees in India. Designed at a community level, such a system would offer a choice of health services from Eastern and Western traditions, weave together resources from a variety of health institutions in the area, include targeted health education and health promotion services, provide training programs leading to a variety of medically-oriented employment opportunities, and strive for a set of public health improvements, all locally focused.

### Background

With the flight of the Dalai Lama from Tibet to India came, over time, approximately 130,000 of his followers, including a significant number of monks and nuns. Most of these refugees came to India with very little or nothing and continue to live in poverty. A number of them are in ill health.

Many organizations have worked diligently to organize services for this exiled community, dispersed throughout India and other countries. Health care services for destitute Tibetan refugees is one of the most critical needs.

<u>History: The Gere Foundation's Involvement</u>

Mr. Gere has a strong commitment to the Tibetan people and the importance of preserving the Tibetan culture and religion despite the tragedy and hardships of their country's history. Mr. Gere's personal teacher, Ribur Rinpoche, emphasized the importance of addressing the health needs of the monks and nuns, as they carry the past and hold the future of the Tibetan spiritual tradition.

Starting in 1997, the Gere Foundation worked with the Central Tibetan Administration (CTA), Manipal Health Systems, the Private Office of His Holiness the Dalai Lama (HHDL), and other organizations to explore methods of providing health services, starting with the destitute clergy: those that escaped from Tibet with no personal possessions or resources and have no family members in India with them.

In October 1999, the Gere organization initiated a pilot project in South India, at the country's largest Tibetan monastery, Mundgod, located in Karnataka State. Contracting with Manipal

Health Systems, the health plan made available much-needed inpatient emergency medical services to several hundred senior teachers and destitute monks and nuns.

Emergency inpatient medical services addressed only the most extreme medical needs. In the second year, the Gere organization expanded its contract with Manipal to provide a full range of health services and more than double the number of beneficiaries receiving care by including senior teachers and destitute monks and nuns from the five key monastery centers in Karnataka State. (Please see the maps in the Appendix.)

Year Three is now underway. Successful negotiations with Manipal resulted in a long list of enhancements that have strengthened the pilot plan's infrastructure, including transportation services from the monasteries to the hospital, translation services so that Tibetan patients are better represented in a Hindi-speaking facility, and educational materials in Tibetan for the beneficiaries and monastery administrators.

Over the course of this project, the Gere organization created a new 501(c)(3) called the Initiatives Foundation, a public charity which can support the expansion of this program by receiving and distributing charitable funds internationally.

This systematic expansion is laying solid ground work for the future phases of the pilot, which are to broaden the plan's operation and extend eligibility to include destitute members of the lay communities surrounding the monastery centers and later to expand eligibility geographically. The proposed expansions will be explored as financing, priorities, and organizational capacity permit.

**Health System Overview**

*The intention of the Tibetan Health Initiative is to collaboratively design an integrated health plan and system which facilitates access to Tibetan and Western medical services, plus other medical approaches, as appropriate.*

The project concept and the project itself evolved from the collaborative efforts of a core team studying multi-tradition health system design, reading reports generated from colleagues in India, and learning from those most involved in caring for Tibetan refugees. For example, the CTA Department of Health has disseminated policy documents describing their wish for access to and the provision of both Tibetan and Western medical care (separately and as an integrated service).

Incorporating Tibetan medicine into the health plan facilitates protecting, preserving, and revitalizing one of Asia's most ancient and learned medical traditions, which like the rest of the Tibetan cultural heritage is in danger of being displaced and/or lost.

Advantages of an Integrated Approach

The optimal advantage of an integrated system is that it brings together essential elements of both medical approaches, i.e. the Tibetan approach to develop/maintain balance (physical/mental/spiritual) throughout the lifecycle and the power of Western medicine to

address accidents and illness of an urgent or emergency nature for which the Western techniques and medicines may be particularly effective and efficient.

Even taking initial steps to integrate Tibetan and Western medicine could be particularly advantageous to a refugee population, especially one that has experienced a significant range of serious health issues, from deprivation, brutal trauma, lack of prior care, and a pattern of several illnesses very commonly present in exiles arriving from Tibet.

Necessity of a Health System

In order to adequately address the health needs of communities of Tibetan refugees living in India, it is necessary to manifest more than a health plan standing alone. The health plan can best be effective serving as the core component of an overall health system which would incorporate an array of integrated components as listed below: The system includes three categories of service: a public health infrastructure, provision of health services with a strong emphasis on prevention through health education and health promotion, and a spiritual element delivered through a healing/meditative component of care. As explained further below, the system is generated locally and takes advantage of local resources. (See the Summary Description of Services on page 10.)

1. A **health plan design** based on the needs and resources of a given community. A pre-paid health plan would provide beneficiaries with a certain set of guaranteed inpatient and outpatient health services.

   The current health plan, available through Manipal, is designed to meet the special needs of the current beneficiaries – senior teachers and destitute monks and nuns. As the pilot is expanded to include laity from surrounding communities, the health plan design would need to expand accordingly to incorporate the needs of families and children.

2a . An **integration (weaving together) of existing health services** to take full advantages of the present resources and create a more comprehensive system. As a first step, health plan members would be given knowledge of existing health services available in the community, ranging across medical traditions.

   A next step would be to have the health plan develop contracted services with health care institutions in the geographical area, thus providing a broader range of services and potential easier geographic access to care. For instance, the current Pilot health plan provided by Manipal has contracted with the two CTA-sponsored hospitals in the area, thus expanding the network of available health facilities that can provide initial treatment of the ill and injured.

   There is a array of existing Tibetan and Western medicine-oriented organizations providing health services to the exile population. These include hospitals and clinics sponsored by CTA, the Indian Public Health Service, community clinics, and other non-governmental organizations. In addition, there are programs that provide free care to first year refugees. There are also non-profit organizations that provide an array of both direct health services and auxiliary care. Lastly, a few foundations are providing limited specialized services, such as cataract surgery. Any, or all, of these resources have the potential to be coordinated into a network of integrated services on behalf of the beneficiary population. These arrangements

could be informal or could be explicitly part of the health plan design through contractual arrangements.

2b. The **advantages of integrating Tibetan medicine** into this system are: (a) it is culturally appropriate and therefore has a stronger "healing" quality, (b) it helps preserve the cultural/spiritual medical heritage which is especially important to refugee communities, (c) using traditional local providers is potentially much less expensive than Western trained providers and more likely to be a stable/culturally acceptable resource over the long-term, and (d) it strengthens local knowledge and local resources as long as there is a mechanism built into the system that recognizes at what point a patient needs Western medicine and then makes those resources available.

3. A plan for developing **public health infrastructures and improvements** targeted to specific communities. The basic living conditions of many of the refugees are significantly detrimental to their health status. The concept is to develop a zone around a given community and seek to upgrade clean water and sewage facilities, test for agricultural and other chemical contamination, increase the safety and quality of housing and provide more and healthier food supplies. Targeted public health efforts could produce significant overall positive change in health status, eventually even more than a health plan could accomplish.

4. A **training component** for those interested in health-related careers. This component would provide employment and skills training, in addition to serving the community. Examples include primary care training for community-based outreach workers, drivers for patients' transportation needs, interpreters for patients requiring services in non-Tibetan facilities (staff in Indian Hospitals typically speak Hindi), and necessary personal aides for hospital inpatients.

   The training component creates an opportunity for the next generation to learn and serve as providers of traditional Tibetan medicine and Western medicine – from community outreach workers to nurses and physicians. Manipal Health Systems has offered to join forces with the Gere organization and create training opportunities for a full range of providers including internship training programs for Tibetan doctors, scholarships for Tibetan nurses, and seminars/workshops in the field of traditional medicines of Tibet and India.

5. A **health education/health promotion component** including training of on-site workers at the monastery centers and interested participants (members) in both approaches: standard first aid, the fundamentals of self-care, hygiene, nutrition which from a Tibetan perspective is a key component to maintaining health, and approaches to increasing a healthy internal balance within one's life – mentally, physically and spiritually.

6. A **spiritual component** which incorporates tenets of Tibetan healing spiritual practice, both to be culturally specific to the Tibetan monks, nuns, and laity and to provide a particularly powerful element of care from Tibetan medicine which promotes health and healing. This component is relevant for both religious and lay refugees, as the health plan has at its core the uniquely advantageous presence and example of His Holiness the Dalai Lama along with the great meditative heritage and other spiritually based healing practices of the tradition.

7. A **learning organization (learning community) approach** which encourages all those actively involved in the plan's development to work together to generate a shared vision, develop communication systems for the exchange of ideas and information, create shared models of design and implementation, utilize the benefits of systems thinking, and document/publish the endeavor so that others involved in refugee health initiatives might benefit from the project working group's efforts.

   One of the most exciting aspects of this project is the wide array of resources and possible collaborations that can be established locally, nationally, and internationally.

## Next Steps

Even at this early stage in the project's development, it is clear that to bring to fruition a goal of this scale, the project must generate more resources. Thus, the Tibetan Health Initiative is researching possible funding partners who would support the development, design and implementation phases of this important endeavor. The Gere organization is looking to foundations to provide this support, and it is in the process of developing "Letters of Inquiry" to a select set of U.S. foundations.

In addition, the project needs to consider methods for developing the long-term sustainability of the integrated health system. Traditionally, foundations only fund the initial phases of a major undertaking such as this. Thus, the Gere organization is exploring others mechanisms for generating plan funds including enrolling financial partners who would establish dedicated endowments to generate funds to cover premium costs in perpetuity.

To assist in managing various aspects of the project, the Gere organization retained health consultants, Skip Robinson, Ph.D. and Jennae Wallach, M.H.S.A. Dr. Robinson and Ms. Wallach facilitated the contracting process with Manipal to strengthen the existing plan, expanded the health plan design for Year Three and future years, and lay the groundwork for the future steps of the pilot. They also have prepared the initial fundraising materials for use with foundations and other funders.

A key next step is to expand the current core team to more regularly involve representatives from the organizations that are primary participants and stakeholders -- the office of HHDL, the CTA, the Manipal Health Plan, and at this point in the Pilot project representative(s) from the monasteries and nunneries. Assuming successful fundraising, the Gere organization hopes to bring in more India-based expertise to round out the core team. The team will also regularly seek counsel from the primary participants on the spectrum of project issues.

## Closing

On behalf of the Tibetan Health Initiative, the Gere organization wishes to work systematically, involving all the primary participants in the planning and decision-making process. The responses from the foundations will help to clarify our next steps and our timetable.

The initial project team has had a number of conversations with primary stakeholders in India. Study and comments have led to the preparation of this paper.

Thank you for allowing the Gere organization to share its preliminary project documents with you. We look forward to an opportunity to work with you which will lead to positive improvements in the lives of the Tibetan population living in India.

## Appendix

The next section contains the Appendix which includes:

- A one-page summary of our proposed Three-Year Calendar
- A one-page summary of the Tibetan Health Initiative's Health Care System Elements
- Maps to orient our readers: The first map displays India relative to its neighbors and highlights Karnataka, the state in which our pilot project is located. The second map provides more detail of Karnataka State and places the key monastery centers and the primary plan hospital in geographic perspective.

# The Tibetan Health Initiative – Health Plan & System: Proposed Three-Year Calendar

## August 2001 to October 2004

| ☐ **CURRENT CONTRACT**<br>☐ **CREATION OF FUNDRAISING MATERIALS** | ☐ **FUNDRAISING ACTIVITIES**<br>☐ **CONSULTANT ACTIVITIES**<br>☐ **MANIPAL CONTRACT NEGOTIATIONS** | ☐ **FUNDED STUDIES – ASPECTS OF THE HEALTH PLAN AND SYSTEM**<br>☐ **MANIPAL CONTRACT NEGOTIATIONS** | ☐ **DIALOGUE & DECISION-MAKING BY PRIMARY STAKEHOLDERS** | ☐ **INTEGRATION OF DECISIONS INTO THE PLAN AND SYSTEM**<br>☐ **MANIPAL CONTRACT NEGOTIATIONS** |
|---|---|---|---|---|
| *Aug. – Dec. 2001* | *May – Oct 2002* | *Nov. 2002 – Oct. 2003* | *Nov. 2003 – Apr. 2004* | *May – Oct. 2004* |
| 5 months | 6 months | 12 months | 6 months | 6 months |
| Negotiation of Year 3 contract<br><br>October 9, 2001: Year 3 contract begins<br>-------------------------<br>Project Materials:<br>• Completion of vision statement and draft design of overall project<br>• Solid draft of foundation/ fundraising materials complete<br>• Distribution of materials to key reviewers<br>• Feedback from reviewers received | Fundraising Activities:<br>• Foundations<br>• Donors<br>• Premium payers<br>• Other existing foundation plan entitlements<br>-----------------------------------<br>Exploration by Bangalore consultants:<br>• Tibetan exile entitlements with Indian state and regional governments<br>• Indian health plan marketplace<br>---------------------------------<br>Manipal Contract Negotiations – 2002<br>• June: Negotiation of the Year 4 Contract begins<br>• Possible market sources for health plan for Year 4 Contract<br>• September 8th: Deadline for Year 4 agreement<br>• October 9th: Year 4 Contract begins | Studies made possible by grants. Examples of topics to explore:<br>• Designing a public health micro-zone system around the pilot monasteries<br>• Inventorying health care services in Karnataka State for networking purpose<br>• Developing sustainable health plan funding<br>--------------------------<br>At end of year, conclusions and recommendations are issued<br>---------------------------<br>Manipal Contract Negotiations – 2003<br>• June: Year 5 Contract negotiation begins<br>• September 8th: Deadline for Year 5 agreement<br>• October 9th: Year 5 Contract begins | Conclusions & recommendations considered by the primary parties. Decisions and a course of action are set in place. Primary parties include:<br>• CTA – Department of Health and Department of Home (including monastery administrators)<br>• Manipal Health System<br>• US and Indian Consultants, Researchers, and Foundation Representatives<br>• Gere Organization<br>--------------------------<br>Recommendations which can be implemented immediately are negotiated and integrated into the current or following year contract with Manipal Health Systems. | The comprehensive set of decisions concluded by the parties are integrated into the health plan and health system according to an agreed-upon work plan. As appropriate, components are quality-tested.<br>--------------------------<br>Manipal Contract Negotiations – 2004<br>• June: Year 6 Contract negotiation begins<br>• September 8th: Deadline for Year 6 agreement<br>• October 9th: Year 6 Contract Begins |
| | Management consulting to guide and oversee plan operations, quality assurance, foundation studies, recommendations for implementation, and the implementation process. | | | |

**Tibetan Health Initiative: Health Plan and System**

# SUMMARY DESCRIPTION OF THE HEALTH CARE CATEGORIES & SERVICES

## Spirituality and Healing

**MEDITATION** – The center of the healing system. All plan participants have this practice in common.

## Health Care Plan and Other Contracted Medical Services

**HEALTH PROMOTION ACTIVITIES** – It is the intention of the health plan to increase this category of services over time, as resources and the networking of existing and developed services expand. Examples include focused attention to nutrition, hygiene and physical activities. Physical activities most likely would include traditional Tibetan practices such as prostrations, circumambulation, and walking meditation. Exercise programs offered by the local communities around the monasteries might include Chi Gong, Yoga, and other healing movements which combine exercise and quiet reflection. This category of care is particularly well suited for integrating Tibetan and Western approaches to health and well being.

**HEALTH EDUCATION** – Health education services would include motivation and incentives to take advantage of the health promotion activities listed above. A second segment under health education would be other services which incorporate Tibetan medical practices designed to address personal balance and inner harmony at various stages of the lifecycle. (This segment would benefit from a systematic review of the literature and current practices.) Lastly, and most beneficial in the immediate term, are health education activities which increasingly focus on high-incidence health problems appearing in the plan's health claims reports and which respond well to health education intervention.

**EDUCATION ABOUT SPECIFIC HEALTH PLAN BENEFITS** – Manipal Health System is contracted to create materials for distribution which describe the health plan benefits in Tibetan, Hindi and English. These materials include brochures for the participants and posters to be displayed in the monasteries and health facilities. These materials can also be available at "nearby" Indian public health and other community health service providers. All plan participants are to receive photo identification cards which will aid in directing participants to services as covered by the plan.

**INDIVIDUAL AND GROUP HEALTH ASSESSMENT** – Manipal Health Systems currently conducts periodic physical health screenings through scheduled visits to "health" camps. Other systematic options are needed to ensure a complete assessment and to ensure the health plan services are sufficient and relevant. One option is the distribution of written health risk assessment questionnaires to the plan members. This option would necessitate arranging for the help and support of monastery administrators and other in the monastic community to assist and support plan participants who cannot read. Initial assessments of plan members (through physical or written screening) can lead directly to further testing at the Kasturba Hospital in Manipal, the pre-paid hospital plan, and, as necessary, to further treatment there.

**ON-SITE PRIMARY CARE** – Currently, primary care is available through the health plan at Kasturba Hospital in Manipal, which is a distance away from the remote system of monasteries covered by the Manipal health plan. The intention of the health plan and system is to develop an adequate cadre of primary care workers to serve on-site at the monasteries or to be available in the surrounding communities. Medical education training is a critical element of this arrangement. Manipal Health Systems has offered support in establishing medical education programs. Taking advantage of current technology, some of the training could take place on-line. Further, an on-site system would substantially benefit from primary care workers taking advantage of tele-medicine arrangements (medicine-by-telephone/computer) in conjunction with the development of a well-coordinated physician visit system.

**OUTPATIENT CARE –** Currently, outpatient care, whether primary or specialty care, is provided only at the Kasturba Hospital Clinic in Manipal, which is a distance away. This benefit includes certain transportation services to/from the facility and certain interpreting services. A potential next step is to create a networking agreement with Manipal Health Systems so that referrals to community health institutions and providers can be designed into the plan. This would broaden a patient's options and reduce the necessity for long-distance travel for outpatient care.

**WESTERN MEDICINE PHARMACY PRESCRIPTIONS & TIBETAN MEDICINE HERBS** – The possibility of offering both Tibetan and Western pharmaceuticals is an exciting potential element of this plan. The pharmacy benefits in the current plan need to be studied, as does the use and interactivity of treatments from the two traditions.

**INPATIENT & EMERGENCY CARE –** Currently, inpatient and emergency care is provided only at the Kasturba Hospital in Manipal, which is a distance away. This benefit includes certain transportation services to/from the facility and certain interpreting services. As described above, the identification of Central Tibetan Administration (CTA) hospitals, Indian public health hospitals, and other community health institutions would broaden treatment possibilities.

## Public Health Infrastructure

**PUBLIC HEALTH INFRASTRUCTURE MICRO-ZONES** – The delivery of all of the above services (health education, outpatient care, inpatient and emergency services, etc.) addresses only a fraction of the factors that significantly impact the health of the community. Basic public health services including clean water, sanitation systems, adequate and healthy food, and adequate and safe housing are crucial to establish and maintain the population's well being. As part of the study, an inventory/status check of these public health systems would establish what is known about the pilot area. From there, the intention of the health plan/system would be to share findings with the primary stakeholders; set priorities regarding the order of systems to be upgraded; develop action plans for funding and implementation, and, finally, determine methods of maintaining the new systems.

**The Tibetan Health Initiative**

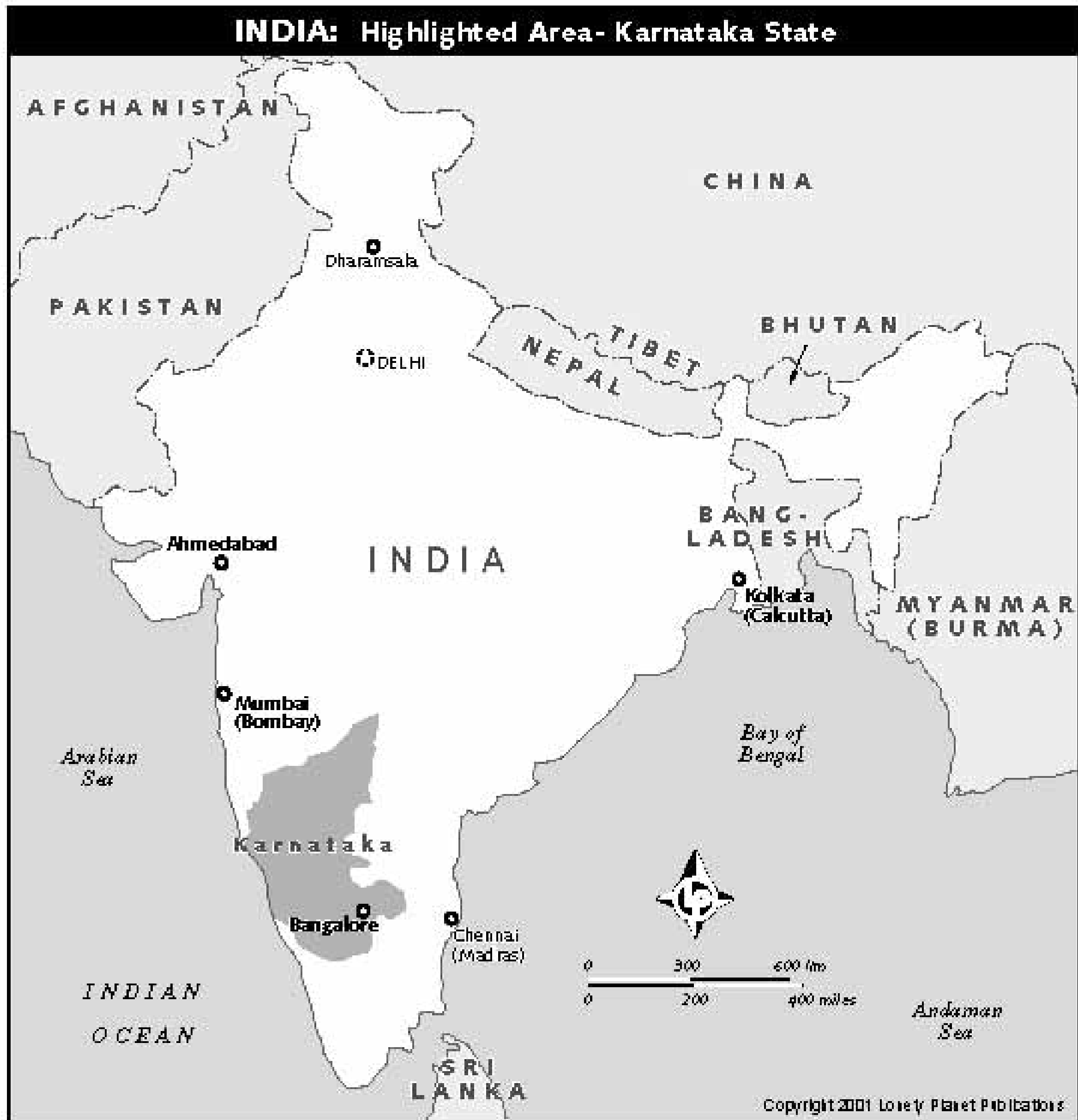
**Graphic Overview**

# Categories of Care for the Health Plan and Health System

| Categories of care | Level |
| --- | --- |
| • **Meditation** | **Spirituality & Healing** [1] |
| • **Health Education**<br>• **First Aid & Hygiene**<br>• **Outpatient Services**<br>• **Inpatient Services**<br>• **Emergency Services** | **Health Care Plan** [2] |
| • **Clean Water & Sanitation Services**<br>• **Safe & Healthy Food** | **Micro-Zone**<br>**Public Health Infrastructure** [3] |

1. Spirituality practice in place
2. Health plan in place and in progress
3. Micro-Zone system to be created.

The Tibetan Health Initiative has implemented a pilot project offering a pre-paid health plan through Manipal Health Systems to exiled Tibetan senior teachers and destitute monks and nuns exiled in the Karnataka region of South India. The pilot started with the Mundgod Monastery. Now, in its third contract year with Manipal, the service area includes the Bylakuppe, Hunsur, and Kollegal Monastery centers which encompasses 24 monasteries and nunneries, all in Karnataka State. As it becomes feasible, the next step is to extend plan benefits to destitute laity living in settlement camps in the surrounding geographical area. The full vision of the Tibetan Health Initiative is to expand health services to all Tibetan clergy and laity living in exile throughout India.


TIBETAN HEALTH INITIATIVE
INDIA: Highlighted Area- Karnataka State
AFGHANISTAN
CHINA
PAKISTAN
Dharamsala
DELHI
TIBET
NEPAL
BHUTAN
BANG-
LADESH
INDIA
Ahmedabad
Kolkata
(Calcutta)
MYANMAR
(BURMA)
Mumbai
(Bombay)
Arabian
Sea
Bay of
Bengal
Karnataka
Bangalore
Chennai
(Madras)
INDIAN
OCEAN
Andaman
Sea
SRI
LANKA
0 300 600 km
0 200 400 miles
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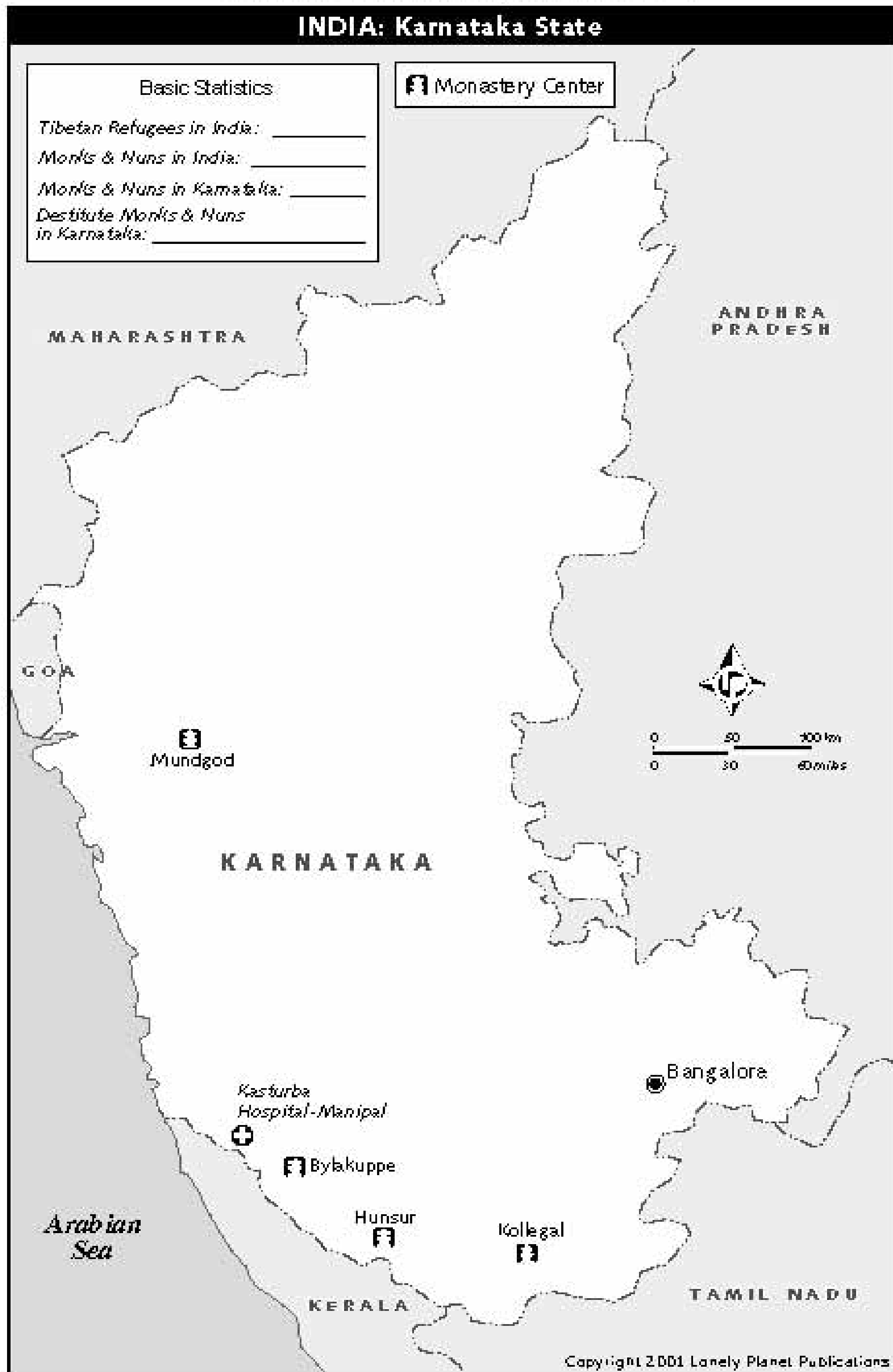
TIBETAN HEALTH INITIATIVE
INDIA: Karnataka State
Basic Statistics
Tibetan Refugees in India:
Monks & Nuns in India:
Monks & Nuns in Karnataka:
Destitute Monks & Nuns in Karnataka:
Monastery Center
MAHARASHTRA
ANDHRA PRADESH
GOA
Mundgod
KARNATAKA
0 50 100 km
0 30 60 miles
Bangalore
Kasturba Hospital-Manipal
Bylakuppe
Hunsur
Kollegal
Arabian Sea
KERALA
TAMIL NADU
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## FINAL NOTES

The following is descriptive information from CTA about the region in which the pilot project is located. Karnataka State in South India is what the Central Tibetan Administration calls the Southern Region. It contains four monastery centers (Mundgod, Bylakuppe, Hunsur, and Kollegal) which together hold 24 monasteries and nunneries, including the largest monasteries in India. This area has great significance as a center for Tibetan Buddhism teaching.

The CTA's demographic guide, The Demographic and Health Surveillance of the Tibetan Refugee Population in India, says of the pilot project area: "Eight of (the monasteries) are located in Mundgod, seven in Bylakuppe (old and new), three in Hunsur and five in Kollegal….The settlement near Mundgod is the seat of the monasteries of Gaden and Drepung, two of the great institutions of Tibetan Buddhism. The Sera Monastery, one of the major institutions of Buddhism in Tibet, has been reformed in Bylakuppe. Between 70-75 % of the total Tibetan monk/nun population in India reside in the monasteries/nunneries in South India."

The guide also says: "…Scholars of Tibetan Buddhism from all over the world attend (monastery) seats of higher learning (in India). It is clear that monasteries in Mundgod and Bylakuppe, which are among the larger monasteries, attract more monks from Tibet and also from countries like Nepal, Bhutan, and Mongolia….

"The Gyudmey Monastery in Hunsur, being the seat of higher education in Tantrik learning, also, had nearly all its monks coming from Tibet….The presence of a higher percentage of monks at the Geshi (equivalent to a Ph.D.) and above level in Hunsur was due to the fact that monks who had completed their Geshe level training in other monasteries spent a year or two at the Gyudmey monastery in Hunsur to specialize in Tantrik Buddhism."