Why are there refugees from Bhutan?

- Bhutanese refugees are of Nepalese origin. This population first began to leave Bhutan in the 1980s, primarily for economic reasons. The majority speak Nepali and practice Buddhism, whereas Bhutan's official language is Dzongkha and the state religion is Buddhism. The Bhutanese government, ruled by a monarchy, accepted an immigrant group. In 1985, starting in the 1980s, the Nepali Bhutanese were increasingly recognized and integrated into traditional Bhutanese society.1,2

- The 1980s brought a dramatic change, with increasing government concerns over the extent of Immigration and the cultural distinction in the southern region. The new government policy “One Nation, One People” endeavored cultural uniformity, resulting in fear among the Nepali-Bhutanese. By 1993 as many as 80,000 had fled to Nepal for protection.2

- Permitted to remain in Nepal as refugees but not welcomed in Nepali society, the Nepali Bhutanese set up self-managed camps in southeastern Nepal in 1993, with the United Nations High Commissioner for Refugees (UNHCR) soon offering assistance.2

- Over the next 18 years, many factors such as the long duration in the camps, political instability in surrounding Nepal, and the uncertainty of returning home or safety going elsewhere created an enormity that resulted in mental health and other social challenges that are well documented in the literature.3

How have Bhutanese refugees come to the United States?

- Refugee resettlement in Arizona includes limited financial assistance for up to 8 months; moderate case management support from the resettlement agency for 3 to 6 months; and health insurance coverage by the Refugee Medical Assistance Program (REAP), for 8 months.2

- Settlement experience for many refugee groups is often characterized by a lack of information and understanding about health care services in the new country, as well as significant logistical and cultural challenges.2

- For the Bhutanese, the first refugee arrivals in 2002 and 2003 were more likely to speak English than those who have arrived more recently. The Bhutanese are frequently characterized as a cohesive group, willingly providing social support for their entire community.2

- Upon learning of the high numbers of Bhutanese refugees in Thailand and receiving funding to work with the research mentor, the research assistant implemented a large scale background search about Bhutanese refugees and health, searched previous students’ work with refugees for an understanding of how the US had worked with this community before, and attended the 2013 Arizona Refugee Resettlement Conference to better understand the resettlement process.4

- The research mentor contacted La Salle, an organization that has well-established ties with the refugee community in Tucson, and met an introduction to the president of the Bhutanese Mutual Assistance Association of Tucson (BMAAT); BMAAT is a recently registered 501(c)3 community organization in Tucson.5

- In response, the BMAAT president invited the UA team to a regular community meeting of this group. The BMAAT president explained the UA research team’s background and introduced the conversation about women’s health. Additionally, the UA team had the honor of being invited to the BMAAT community’s annual celebration of Dzakpa, a traditional festival. After this remarkable event, the BMAAT president brought the UA team on a tour of a large refugee settlement in the city and introduced the UA team to a local spiritual leader.2

- Subsequently, a group of Bhutanese women crossing a 30 years of age, English language proficiency, and employment status; some single, some married, with children and without; met with the UA team to continue the conversation about women’s health. Meanwhile, the UA team attended meetings with the International Rescue Committee and others to further understand the resettlement process and to identify available resources.2

- Throughout this process, the Bhutanese refugee community has identified numerous concerns for women’s health, including:
  - Lack of health insurance
  - Limited access to preferred contraceptive methods
  - Cultural barriers to achieving a level of comfort in expressing personal women’s health needs
  - Lack of women’s health knowledge about cervical cancer screening
  - Challenges to patient-provider communication
  - Limited English language proficiency

    What’s next?

  - Work with the women’s group to build cohesion and commitment to work together
  - Identity community (and others) assets and women’s health priorities
  - Create a plan of action and funding strategy that will enable the Bhutanese community to participate actively in the improvement of women’s health outcomes

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