

Health Needs Assessment Report of Bhutanese Refugees of Summit County

Summit County Health Department

The purpose of this needs assessment is to determine what are the perceived and expressed healthcare needs of Bhutanese refugees. Refugees are an especially vulnerable population due to their limited means and ability to receive adequate and appropriate care. Minimal or lack of healthcare can result in increasing their likelihood of acquiring mental and physical injury and illness. This document contains cultural information about Bhutanese refugees, descriptions describing the barriers to care, methodology of data collection, results of data collection, and recommended next steps for program planning and educational outreach. Results revealed three major themes of healthcare needs are lack of access to care, increased need for mental health services, and improving understanding of American healthcare system. Recommended steps include providing mental health first aid trainings to community members, art therapy, and patient advocates.

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Introduction

Most Bhutanese refugees are originally of Nepalese descent who migrated to Southern Bhutan as far back as the 1600s.¹ The ethnic Nepalese became known as Lhotsampa, meaning “Southerner” in the Bhutanese language of Dzongkha. Though they identify as Bhutanese regarding to their country of origin, they are ethnically Nepalese. However, most ethnic Nepali do not approve of the term “Lhtosampa” as it contributes to the removal and systematic ethnic cleansing of the ethnic Nepalese. It also is a less familiar term on global platforms, resulting in a lack of acknowledgment of the Bhutanese government’s role in the removal and erasure of the ethnic Nepali. The terms Bhutanese or ethnic Nepalese will be used in this document. This literature review will examine a brief history, the religion and language, family structure, a health profile with health concerns, an overview of the immigration process, and barriers to health for this population. The needs assessment report will also examine the principle research question, the methodology of data collection, results and analysis of responses, discussion of the results, and lastly, recommendations based on existing literature and on participant input.

Literature Review

Brief History

Bhutan is located near Nepal, India, and China, sitting among the Himalayan Mountains. Nepalese migrant workers first came to Bhutan in the 17th century when were invited by a Tibetan lama (a spiritual teacher) to construct a monument.² In the early 19th century, an influx of immigrants from Nepal began settling in Southern Bhutan for employment opportunities. For many decades, the ethnic Nepalese resided peacefully with other Bhutanese citizens. Despite living in Bhutan for decades, this group did not entirely assimilate to Bhutanese culture, choosing to speak Nepali and follow Nepalese culture.² This Bhutanese population began to grow significantly in size and even began successfully campaigning for political offices.

However, the king of Bhutan began to fear Nepalese influence when The Greater Nepal Movement (a Communist political movement) began to expand from Nepal to countries where Nepalese transplants resided.³ Citing this as “Nepalese jingoism” and gravely concerned over

¹ (Aris, 1979)

² (Maxym, Upadhyay, & Dhital , 2010)

Communist influences, the king and other political leaders created the “One Country, One People” initiative, also known as “Bhutanization”.² This resulted in cultural bans on the Bhutanese from teaching Nepalese in schools, wearing traditional clothing in public places, and practicing Hindu beliefs. The Bhutanese government also began administering difficult citizenship verification tests to discern who was an actual Bhutanese citizen. Political groups made mostly of ethnic Nepalese politicians, such as the Bhutan People’s Party, tried to counter these measures by leading protests and anti-government attacks.²

The in-fighting between the government and protests groups resulted in more than 100,000 ethnic Nepalese being forced out of Bhutan. Many returned to Nepal, already knowing the language and customs. However, the Nepalese government also faced its own political instability and had an influx of refugees from other countries.² As a result, nearly all Bhutanese refugees were relegated into refugee camps. For over a decade, negotiations between the Nepalese and Bhutanese governments deliberated over whether the Bhutanese refugees should be naturalized into Nepalese citizens or repatriated to Bhutan. In 2006, both governments reached an agreement for third country resettlement.² Over 80,000 Bhutanese refugees have been resettled since 2008, with the United States taking the majority. Other countries which accept Bhutanese refugees are Canada, Australia, China, New Zealand, and Norway.³

Religion and Language

The Bhutanese refugees are predominantly Hindu, but many identify as Buddhist or Kiranti. Many of the Bhutanese refugees have been exposed to Christianity when living in resettlement camps and about 7% identify as Christians.⁴

Many religious Bhutanese Hindus adhere to the caste system which can decree social order. Conservative Hindus may follow the system closely while liberal Hindus only use it as a way of identifying others. Most will recognize people from different castes by name alone. Conservative Hindus will generally not intermingle with other castes. Additionally, they do not typically disclose information about which caste they are in.² It is advisable for non-Bhutanese not to inquire about castes or discuss it unless the individual brings it up voluntarily and is

³ (Reuters, 2009)

⁴ (Cultural Orientation Resource Center, 2007)

willing to discuss it further. Additionally, there are dietary restrictions which Bhutanese Hindus adhere to. Many Bhutanese Hindus will not consume beef or pork (as many are vegetarian) so it is important to inform patients if medications or vaccinations contain animal product or byproducts in them.²

The Bhutanese are very likely to speak multiple languages. All the ethnic Nepalese will speak Nepali in their homes. In Bhutan, many spoke Dzongkha in public spaces.² For the Bhutanese who had formal schooling, there is a strong chance they are familiar with English and can speak it. However, older Bhutanese may not have had opportunities for learning English in school (if they were able to attend at all). Working with a translator will be a necessity when working with the elderly. However, many have expressed that English in America is sometimes hard to understand.² Care providers and resettlement agency staff members should be mindful to avoid using jargon or talking too fast.

When interacting with the Bhutanese, it is important to start conversations asking about family and how they are doing. Bhutanese do not usually like to directly engage in conversations about work or business without establishing a friendly rapport first.⁶ It is always wise to ask permission to touch or before shaking hands with individuals of the opposite sex. Nodding one's head in acknowledgement and smiling, along with putting one's own hands together is a good way to start but allow the Bhutanese individual to make the first move in greeting. When Bhutanese feel comfortable with others, they tend to be tactile and may stand or talk closely to another. However, personal contact between men and women is not common and direct eye contact also appears bold and aggressive, especially towards older people.⁵ When addressing older adults, using the suffix –ji after their first name (i.e. Subba-ji) is greatly appreciated and can put them at ease.

It is important for healthcare providers and other staff members to understand nonverbal signs of showing agreement or disagreement (shaking or nodding heads) is different for the ethnic Nepalese. Shaking a head means “yes” and nodding a head means “no”. Since this appears reversed for Americans, it can be confusing or difficult to understand.⁶ Many Bhutanese refugees will say “yes” to appear socially pleasing and accommodating. However, non-

⁵ (Government of Canada, 2014)

Bhutanese individuals can put them by ease by smiling and expressing it is alright for them to say what they are thinking.

Family Structure

The Bhutanese generally marry young and are usually under the age of 18 or younger. Marriage preparations begin very early and parents seek suitable matches for their children when they are between ages 7-14.² Arranged marriages are the most common methods of finding spouses. A bride will live with the groom's family for a few days after the wedding and then return to her parents' home until she is between ages 15-16. After she reaches this age, she will live with her husband and his family permanently.² Not all Bhutanese still carry out these cultural practices. For example, Bhutanese with higher education, increased socio-economic status, or reside in cosmopolitan areas may marry later in life or date as a means to find a spouse. Cultural and socio-economic context is important to keep in mind when interacting with Bhutanese.

Bhutanese families are usually large and multigenerational.² Sons are supposed to care for parents financially and will remain in their homes even after marriage. The elder members of the family are the main decision makers about how the household is run, division of chores, and on financial spending. It is also common for extended family members to either live or frequently come to the house where an elderly family lives.

The relationship between a mother and daughter-in-law is an important one. Daughter-in-laws are expected to care for mother-in-laws as if she was caring for her own mother.² There is a familial obligation which requires her to provide food and comfort for her mother-in-law over all else. This may become difficult to achieve when Bhutanese refugee women leave the home to work and an elderly mothers-in-law is unattended at home.²

Raising children is a multiple-person effort in and mainly the responsibility of younger women in the house. Unlike many cultures, corporal punishment is not common among the Bhutanese. Adults will usually use guidance to rectify bad behavior or provide explanation.² Children begin transitioning into adulthood roles around the ages of seven for girls and eight to nine for boys. They are expected to help with the household work or looking after younger siblings.²

Healthcare Profile

Prior to residence in Nepalese camps, most Bhutanese received their healthcare from the Bhutanese Ministry of Health (MOH). Since the 1970s, the MOH has provided universal health care. Five Year Health Plans are utilized to determine health infrastructure and services. There are multiple health care facilities and workers in Bhutan and in 2011, the MOH launched an emergency hotline number and in two months, the number proved to be a successful initiative.⁶

The average life expectancy for the Bhutanese population is about 70 years.⁷ Men have a life expectancy of 69 years while women have 71 years. Maternal mortality rates, as of 2015, was 148 per 100,000 live births and the number of cases for child mortality under 5 was between 300 to 565 in 2015.^{7,8}

Drinking water access and basic sanitation for urban and rural areas of Bhutan increased significantly, based on 2017 data.⁷ However, diarrhea, pneumonia, skin infections, conjunctivitis, and intestinal worms were widespread concerns. The MOH also reported that in 2011, 90% of the Bhutanese population was covered by governmental immunization programs.⁹ HIV rates in Bhutan are low and persons with HIV made up about 0.3% of the population in 2011. However, the MOH claims the percentage is rising and neighboring countries are contributing to an increase of HIV/AIDS.

Tobacco is heavily regulated by the Bhutanese government. The government has passed the Tobacco Control Act “bans the sale of tobacco, tax imports, and places restrictions on quantities individuals may possess.”¹⁰ To discourage alcohol consumption, the Alcohol Control Regulation increased taxes on alcohol up to three times more than previous tax rates. This has led to lower sales in alcohol as prices have gone up. The Bhutanese government remains resolute in its goal to “discourage excessive alcohol intake, abuse, and illness through taxation and regulation.”^{11,12}

⁶ (Meena, 2011)

⁷ (Central Intelligence Agency, 2016)

⁸ (UNICEF, 2016)

⁹ (Bhutan Health Management Information System , 2010)

¹⁰ (Government of Bhutan, 2010)

¹¹ (Namgyal, 2011)

¹² (Wangdi, 2011)

In most of the Nepalese camps, pregnancy health needs are often met. Approximately 91-97% of prenatal care needs are covered along with antenatal care.¹⁴ However, sexual health and a great deal of women's health needs are not readily addressed. Most women in Nepalese camps will not seek out or ask for preventative screenings such as mammograms or pap smears due to cultural stigma of discussing sexual activity or being physically examined.¹⁴

Tuberculosis is a common ailment screened for in refugee populations. Fewer than .08% were a sputum smear or positive culture for *Mycobacterium tuberculosis*.¹⁴ Malaria is generally not screened routinely overseas for refugee and due to low incidence in the United States, the conditions is only screened if symptoms appear present.¹⁴ Confirmed malaria infection rates for the refugee populations were .16 cases per 1,000 per month while suspected cases are approximately 1.6 per 1,000 each month.¹⁴

Some healthcare professionals are concerned that Bhutanese refugees do not eat enough but the meal structure includes only one to two meals daily.¹³ Breakfast, in particular, is usually not a part of the meal structure. Healthcare professionals and resettlement agency staff can propose children eating breakfast before school but should understand it is not negligence when the children do not eat at that time.

Anemia is frequently diagnosed in Bhutanese refugees especially before their arrival to the United States.¹³ There is a higher prevalence (about 28%) in pregnant women compared to other men and women. There is a 20% rate of anemia in children and adults over the age of 65. Conditions such as malaria, intestinal parasites, and overall nutritional deficiencies were main contributors to anemia in children and women but as the children got older, rates of anemia had decreased.¹⁴ Aside from anemia, there is a stark vitamin B12 deficiency in approximately 30-60% of the Bhutanese refugees, which could be a factor in refugees having megaloblastic anemia.¹⁸ It is highly advisable that healthcare staff screen for vitamin B12 deficiencies amongst this population.

Though malnutrition and mortality rates were below emergency thresholds in the Nepalese refugee camps, there are still some causes of concern. Some of the causes of

¹³ (World Health Organization and Centers for Disease Control and Prevention, 2008)

¹⁴ (Centers for Disease Control and Prevention, 2008)

malnutrition arise from a “lack of food diversity, frequent illness, and feeding practices”.¹⁴ Acute malnutrition, otherwise known as wasting, was found in approximately 4.2% of Bhutanese children from 6-59 months but stunting was higher for the same age group at 26.9%.¹⁴

Intestinal parasites are a cause for concern in Bhutanese refugees. More than 50% were positive for *Giardia*, 36% for *Dientamoeba*, and 20% for *Entamoeba*.¹⁴ Parasitic illnesses were also a health concern in Bhutan so it is likely that many refugees were infected prior to their arrival in Nepal and subsequently the United States.

Of chronic illnesses, hypertension is higher among older refugees at 15% but surprisingly lower compared to the same age group of US citizens.¹⁴ Asthma and emphysema are also commonly reported as chronic conditions faced among the Bhutanese refugees. Tobacco consumption both a previous history and or current use were also highly reported (6.5% and 4.8% respectively) among US-bound refugees between 2008 and 2011.¹⁴

The biggest health concerns currently studied among Bhutanese refugees surrounds mental health and suicidality. Reports of suicide among the Bhutanese refugees are high and since 2009, at least 16 reported suicides have occurred out of the 49,010 refugees resettled in the United States.² Statistics may be underreported due to cultural stigma surrounding mental health. Risk factors for suicide could arise from depression from being expelled from their home country, inability unable to assimilate in Nepal (despite shared culture and language), and relocation to a third country. Additional stresses which can arise come from having trouble finding employment, culture shock of living in America, change in housing and family structure, and learning sufficient English before they are released from the resettlement agency. Men and women have recounted being tortured physically upon their removal from Bhutan but men are less likely to disclose any trauma compared to women.¹⁴ In a 2015 study, depressive symptoms were highly associated with being a family provider, self-reported poor health, lack of literacy in Nepali were common for men while women only cited self-reported poor health and lack of literacy.¹⁵

The state of Ohio compiled an epidemiological report in 2015 to monitor mental health conditions, including, but not limited to, post-traumatic stress disorder and suicide. From the

¹⁵ (Vohname , Lankau, Shetty, & Cardozo, 2015)

report, 13% were told by a doctor they were in need of mental health services. Seventy percent of recipients said they had depression when asked which mental health condition they had, along with 13% reporting anxiety. At least 21.4% reported they had a family member who had a mental health condition.¹⁶ For prevalence of conditions such as depression, anxiety, and psychological distress, 30% of participants reported having symptoms of anxiety and 26% with symptoms of depression.²⁵ At least four percent had serious feelings of ending their lives on a frequent basis. Lastly, 21% of participants reported a family member had committed suicide. However, a strong protective factor from suicide attempts and completion were strong family relationships and being in close proximities to friends.²⁵ It is critical that elderly Bhutanese refugees are observed for feelings of isolation due to the lack of family members spending time with them at home. The sudden shift in which both men and women are seeking employment and children going to school can lead to many older adults feeling anxious from being alone and or depressed about the many life changes.

Health Beliefs and Customs

Among the Bhutanese, use of traditional healing and medicine vary from age group and education level. Overall, the Bhutanese will use multiple methods including Western and traditional medicine. Unlike other refugee groups who try one method of healing before resorting to using Western medicine, there is no observed pattern of which healing method is used first among the Bhutanese.²

The Bhutanese believe in multiple causes of illnesses, many which are non-bacterial or non-viral agents. Things such as bad karma, deceased ancestors who are struggling in their after lives, planetary positions, and the overall daily environment in which a person lives can all be causes of illness.² Additionally, since most Bhutanese are Hindu, many follow the Ayurveda lifestyle, a traditional healing system which embraces holistic health behaviors.^{2,17} In accordance to Ayurvedic principles, food and drink consumed along with general lifestyle habits are indicative of various ailments. The Bhutanese have distinct healing methods. Common methods of traditionally healing a sick person include consuming basil, turmeric, garlic, ginger, and cardamom.² If these methods do not work, a traditional healer is called. There are three

¹⁶ (Adhikari, Yotebieng, Acharya, & Kirsch, 2015)

¹⁷ (WebMD, 2016)

types of healers and each one follows a different school of thought when it comes to treatment and care.

A shaman, also called a *dhami jhakri*, can go into trances, read rice or leaves for a cure, read spiritual chants, and or blow into the mouth of the infirmed. A *dhami jhakri* usually associates illness with a humoral imbalance or illness was caused by ghosts or evil spirits.² Sometimes the *dhami jhakri* will recommend a different eating regimen, touch an object that is important and special to the sick individual, or sprinkling hot water on the person. *Vaidhyas* are traditional Ayurvedic healers and their approach to illness encompasses mind-body holism. Lastly, *drungtso* are Tibetan healers, who administer traditional that rely on natural remedies for healing and disease states and bodily health are tied to the five natural elements.¹⁸

Immigration Process

In hopes of finding residence and citizenship in Nepal, the Bhutanese came in large numbers around the mid-nineties. Unfortunately, the Bhutanese were sent to live in refugee camps and resided there for years. These refugee camps where Bhutanese reside: Beldangi (camps 1 and 2), Sanischare, Goldhap, Khudunabari, and Timai.¹⁹ Most of the refugees residing in these camps are under the age of 18 (35.5%). One note of interest in the report was the infant and child population (0-2 years) population was the same as the elderly population (over 60) which is an uncommon occurrence in a refugee camp. It is likely that high usage of family planning tools can explain the low numbers of infants and toddlers.¹² Overall, the Bhutanese have generally good health compared to their Nepalese counterparts. The CDC reports that malnutrition and mortality rates are below emergency level thresholds.²⁰

Data collected from the years 2008 to 2011 indicate that the crude birth rate in Nepalese camps was (per 1,000 population) 17.5 and the crude mortality rate was (per 1000) 416.²¹

¹⁸ (Drungtso Tibetan Healing and Astrological Centre, 2011)

¹⁹ (International Organization of Migration, 2008)

²⁰ (Centers for Disease Control and Prevention, 2014)

²¹ (United Nations High Commission on Refugees, 2011)

Routine immunizations are generally provided by Association of Medical Doctors of Asia (AMDA), and vaccinations for Hepatitis B, DPT, Measles, and Oral Polio Vaccine among others are provided. Vaccine coverage rates in the Nepalese refugee camps are high, averaging above 90%. However, these statistics are not exact since the number of refugees at a given time in the camps fluctuates on a continual basis.¹⁴ Supplemental vaccinations are also distributed by AMDA-Nepal along with other non-profit groups.¹⁴

The camps in Nepal illustrate a very different reality for other refugees who reside in refugee camps elsewhere. For example, women play active leadership roles, sometimes becoming Camp Secretaries or leaving the camps to attend universities.¹³ Though women have some opportunities which are not often afforded in other refugee camps, women are still highly vulnerable to gender based violence, domestic abuse, and exploitation by other refugees as well as by aid workers.¹³ Most women adhere to traditional gender roles and are still expected to cook and care for the family unit.²²

In Nepalese refugee camps, food and water are somewhat better accessible compared to other camps. The World Food Program provides rice, lentils, oil, sugar, salt, and seasonable vegetables but in small quantities per family.¹³ Fish and meat are rare commodities in Nepalese camps as most Bhutanese are Hindu and abstain from eating meats. However, protein deficiencies are something to watch for in this population.¹⁴

Bhutanese will construct their own small homes within the refugee camps and try to hold as many family members in one house as possible.¹³ Communicable disease can be spread quickly with large numbers of people in a home and in a small space. It has also been observed that trash accumulation and littering is a common problem in camps and proper waste disposal is deeply needed.

Access to healthcare is often a significant barrier to good health in most refugee camps. However, in the Nepalese camps, access to services and healthcare are considered “quite good” in comparison to other camps within Asia or other continents which hold refugee camps.¹³ Women are much more likely to utilize family planning services and can access medical facilities, healthcare staff from AMDA and United Nations High Commissioner of Refugees

²² (Human Rights Watch , 2003)

(UNHCR). In the International Organization of Migration (IOM) report, medical staff noted that most healthcare issues other refugees face in different camps are not common problems in the Nepalese camps. Bhutanese patients are very forthcoming about health concerns, including mental health.¹³ Though this is excellent news, mental health is still a large cause of concern for Bhutanese refugees. There are higher indicators of suicide among Bhutanese refugees in camps, approximately four times more at risk compared to the local population. Depression is also extremely common in the refugee population and psychosocial support is critically needed.^{13,14}

In 2012, approximately 49,000 Bhutanese refugees have been resettled into the United States.⁶ Bhutanese tend to be resettled into states like Texas, Pennsylvania, New York, and Georgia but at least 41 states take in Bhutanese refugees. Ohio took 4.7% of incoming Bhutanese refugees in 2012 but it is very likely that more are being accepted in 2016.¹³

Health Screening Process

The International Office of Migration offers the largest amount of Migration Health Assessments. In 2014, the Office reported completing close to one third of million assessments for seventy seven countries²³ The overall process includes a panel of physicians who conduct a medical screening, review of patient medical history, preventive or curative treatment, counselling and health education, and preparing of medical reports from the screenings. The initial screening looks for cases of tuberculosis, sexually transmitted diseases/illnesses, Hansen's disease, HIV/AIDS, and mental health disorders with harmful behaviors. These cases are considered as "Class A" and prohibit refugees from travel until they no longer pose harm to others.¹⁸

Class B conditions are "physical or mental abnormalities, diseases, or disabilities serious enough or permanent enough to be considered as substantial departure from normalcy" and are highly recommended to receive follow up treatment soon after arrival to the United States²⁴ Examples of Class B conditions include, but are not limited to, inactive or latent tuberculosis, treated syphilis, other sexually transmitted diseases, treated Hansen's disease, sustained and/or full remission of substance abuse, and sustained history of non-harmful behaviors of mental

²³ (International Office of Migrant Health, 2013)

²⁴ (Centers for Disease Control and Prevention, 2015)

health disorders.²⁵ In regards to vaccinations, refugees are not required to meet vaccination requirements with the exception of children attending school (those schools may require vaccinations in order to attend). When refugees apply for Legal Permanent Resident, then they must comply with U.S. vaccination requirements.¹⁹

Barriers to Care

During the period in which Bhutanese refugees are utilizing health care services, there may be several barriers to attaining appropriate and adequate care.

In the Ohio-based study, nearly 70% Bhutanese refugees felt they received little or inadequate care from agencies or charities as their biggest problem post-settlement. At least 69.5% of individuals felt they did not receive adequate or insufficient assistance from the government. Language was considered the third biggest concern post-settlement.²¹ However, the study did not specify what concerns Bhutanese refugees felt were not being addressed well by charity groups or the government. Under the umbrella of healthcare expectations, use of mental health services is low among Bhutanese refugees due to differing cultural contexts of mental health or stigma.²¹ The Ohio Mental Health and Addiction Services survey recommended further research examine unmet needs of mental health problems. Additional research is needed to investigate the low-levels of help seeking behaviors.²¹

Though it was the third concern Bhutanese refugees had, language continues to be a substantial barrier to healthcare. This can be particularly difficult if a refugee has been advised to schedule an appointment and the scheduling department may not speak the same language or access an interpreter. For the appointment itself (if a resettlement agency makes one for them), a translator will be required to translate health questions and assist the Lhotsampa refugee with understanding and answering questions. Some Bhutanese women may feel discomfort in answering reproductive and or sexual health questions to male interpreters. Male interpreters may also be reticent in asking personally intimate questions to women and girls. However, same-sex interpreters may not be available to assist.

Another immediate barrier to healthcare is transportation. There may not be a reliable transportation service for a resettlement agency to use for the refugees or the services may be too

²⁵ (Centers for Disease Control and Prevention, 2016)

costly, such as a taxi cab. Public transportation such as buses or trains may be intimidating for new refugees, especially if the refugee is unfamiliar with using public transportation or reading scheduling and route maps. Ultimately, refugees may not want to wait for long periods of time while awaiting a transportation service to take them to and from appointments or if it is going to cost them a lot of money.

Lastly, payment and the concept of health insurance may not be familiar to Bhutanese refugees. Health care prices for medications or other services can be very high, which discourages refugees from utilizing services. While most refugees are given Medicaid or other government assistance to pay for treatment, transportation, and other necessary healthcare costs, it may not be available after a certain period of time. Or, refugees may fall into the “doughnut hole” and lose benefits but still cannot afford healthcare.

Research Question

The question this study raises is what are the perceived and expressed healthcare needs of Bhutanese refugees who have resided in Summit County for three months or longer? The purpose of this question is to gather information from Bhutanese refugees on their healthcare experiences in Summit County and to create or maintain health programming and services that are sensitive and beneficial to the needs of this refugee group.

Methodology

In order to best examine the complex attitudes and beliefs of the Bhutanese experiences getting health care in Summit County, a focus group was held with seven Bhutanese men and women. Though a previous report had been written about Bhutanese refugees for the Ohio Health Department, it focused specifically on mental health, suicide, and PTSD as opposed to overall healthcare needs and recruited from Franklin County.¹⁶ Rather than interviewing individual participants, focus groups are a useful qualitative data collection method which looks closely at the “why” of a participant response. Focus group can augment conversation in a group setting where multiple perspectives are offered and responses are built upon by other participant

opinions and experiences.²⁶

IRB approval was not needed on the grounds of “standard public health practice” and liabilities were removed by providing translators and speaking only to adults. To further minimize risks, assent forms were translated into Nepali and read aloud by the translator assisting with the focus group. Participants signed the document or showed their understanding and consent with an “X” if they were not literate.

Participants were selected based on two major criteria. All participants had to be over the age of eighteen and had been residing in the United States of three months or longer. The time period was selected because after the initial three months of residence, many refugees are no longer receiving assistance from refugee resettlement agencies. The recruitment process involved the creation of fliers written in English and in Nepali and were initially distributed to refugee resettlement agencies. Flier distribution took place in mainly English and citizenship classes hosted by local refugee resettlement agencies or faith-based group. Participants interested in participating in the study utilized sign-up sheets and were contacted before the focus group to confirm attendance.

The discussion was limited to one hour in order to accommodate work and school schedule of the participants. A local refugee resettlement agency offered to host the focus group since it was a familiar location and not far from where many Nepali refugees resided. This helped with reducing transportation and distance barriers.

As an incentive and token of appreciation, the participants and translator were given a gift and refreshments were provided. The focus group responses were electronically recorded and files were saved in a secured computer. The audio files were transcribed and all files of the focus group were destroyed after the completion of the report.

Themes

Prior to the focus group, seven themes were discussed of which best illustrate perceived and expressed needs. To clarify, a perceived need was described with language that did not expressly use the words “I need” or “I want” but still appeared important to the speaker in the

²⁶ (Evidence Base, 2006)

group either by repetition, tone of voice, or facial expression. Other indicators of perceived needs were through anecdotes in which the participant described an incident or situation which they found difficult or troubling. An expressed need specifically used language which indicated need or want (i.e. “I need”, “I want”, or “it would help”) when responding to a question.

The themes were selected and modified based on best practice recommendations from Harvard Public Health Review Healthcare Recommendations for Recently Arrived Refugees: Observations from EthnoMed.²⁷

- 1) Need for healthcare services and education
- 2) Need for cultural competency
- 3) Understanding the American healthcare system
- 4) Timeliness
- 5) Lack of knowledge
- 6) Access to care (includes barriers such as language, transportation, distance, and or payment)
- 7) Other

Need for healthcare services and education includes but is not limited to need for health education (i.e healthy pregnancy, mental health, nutrition, etc.), instructional classes on the American healthcare system, or specific healthcare needs such as screenings or home-visits. Need for services and classes can also include need for modified resources such as videos or visual guides.

Cultural competency is defined as “the ability of providers and organizations to effectively deliver health care services that meet social, cultural, and linguistic needs of patients.”²⁸ Cultural competence can include but is not limited to interactions with care providers and front desk staff, interactions with physicians, provided with linguistically appropriate resources, and demonstrating cultural knowledge and context when speaking to refugees (i.e. allowing men or women to decide whether they wish to shake hands with the opposite sex). Cultural competency

²⁷ (Jackson, et al., 2016)

²⁷ (Betancourt, Green, & Carillo, 2002)

also includes accommodation for individuals with disabilities and appropriate usage of gender pronouns.

Understanding the American healthcare system focuses on refugees understanding concepts of appointment etiquette, preventative service use, knowing where to find in-network providers, and details of insurance coverage.

Time can be an unmet need for refugees due to competing demands of finding employment, enrolling children into schools, going to other government offices for benefits, English classes, case management appointments, healthcare needs may not be met simply because the time to go to appointments is not available.

Lack of knowledge is a selected theme due to refugees not knowing what resources are available to them and how to use them. While lack of knowledge could fall under other themes such as need for healthcare education or access issues, lack of knowledge focuses on specific concepts. These concepts are, but not limited to, knowing when and where to utilize community resources, patient rights, and knowing how and when to use emergency services.

Access to care has been discussed in previous sections of this assessment focuses mainly on transportation issues, payment, and language barriers. Lastly, the theme of “other” includes issues such as mental health needs and assistance with meeting non-healthcare related needs such as childcare assistance, educational needs, employment, or citizenship.

Analysis Methods

This needs assessment utilized thematic analysis when examining focus group data. Data was manually examined due to lack of availability of coding software. Themes were differentiated by color and then counted to look for the most frequently mentioned needs. Multiple colors could be used for the same statement if more than one theme was discussed. All transcripts were coded more than once to check for accuracy and consistency. After the needs assessment was completed, all copies of the transcript were destroyed and or deleted.

Results

Participants spoke for approximately 47 minutes which had been piloted and approved by Nepali translators for ease of understanding and appropriateness. Each theme will be discussed in order of prevalence or importance in the transcript.

Access to Care

Access to care was featured in the Bhutanese transcripts twelve times. Transportation and English barriers were both cited as the main issues impeding their access to healthcare. However, Bhutanese refugees did express their gratitude and relief for having interpreters available to speak to doctors and staff. One participant felt interpreting services made things easier when seeking his healthcare but the majority of participants wanted to continue learning English. The interpreter also reaffirmed that the most primary need for Lhtosampa refugees was English proficiency. In general, the Bhutanese praised organizations and hospitals for making it easier for them to access care. In regards to payment, Bhutanese refugees felt costs were high, but having medical insurance was very helpful. Unlike in their home country, they could still have access to care even with high costs.

Cultural Competency

Cultural competency was discussed seven times in the transcript. Overall, participants did not express issues regarding cultural competency of physicians and doctors. One participant stated they felt doctors in America were “kind and generous” whereas doctors from Bhutan and Nepal were “rough”. Most participants agreed they were well looked after and treated with respect. The female participants did say they felt shy with male physicians and felt it would be better if they had female doctors attending to them. However, they did not ask for having same-sex care providers.

Other

Though the theme of “other” was not discussed too often in the transcript, it was one of the few themes cited as most important. The interpreter stated mental health counseling was much needed for Bhutanese across age groups. The interpreter described that the refugee experience contributed to great deal of mental health concerns. He specifically mentioned among older refugees, many had dementia and struggled with daily living. Overall, he felt that

counseling was the only solution to address many Bhutanese refugees inability to cope appropriately with difficult situations, calling it “making mountains out of molehills”. Lastly, he felt recreation spaces for Bhutanese refugees would improve the community’s overall physical and mental health.

Understanding the American Healthcare System

This theme was mentioned seven times but the overall consensus of the Bhutanese participants was they felt comfortable utilizing the American healthcare system. They understood when emergency services were to be used, as one participant described, “we go when it is serious or no one is at home to help”. Participants also agreed they knew where to go for medical help if it was after hours or their doctor was not available to help. However, a few participants believed that if their doctor wrote a note, it would help citizenship application process. However, medical offices and NIH cite they are not responsible for helping with any issues which are not medically related, such as getting a green card and or U.S. citizenship.²⁹ In general, Bhutanese refugees understood how the American healthcare system worked and did feel it was hard to understand or had remaining questions regarding the care system.

Lack of Knowledge

Bhutanese refugees appeared to be comfortable with getting assistance for their healthcare or being understood by staff and physicians. However, when asked about whether they knew about requesting same-sex providers or translators, they did not respond. The interpreter stated participants may be aware but choose not to do this, despite discomfort with opposite sex providers and interpreters. It was not clear if participants were aware of patients’ rights, which ensures seeking other doctors if they do not want the current physician they had without penalty. Two participants claimed they had little education and were not very literate, or as one described, they “did not have a big mind” so it did not occur to be concerned with things such as patients’ rights. As previously mentioned, they felt well cared for and so long as they were able to be seen or be communicated with by a care provider, they were content.

Education and Classes

²⁹ (NIH Clinical Center, 2017)

Bhutanese refugees described their process of learning about health from their children. Most of the participants were not literate in either English or Nepali, leading to increased reliance on others to provide and explain medical information or health education. When asked if they would like to attend a health class or receive education on a health topic of their choosing, all participants expressed interest. However, two participants stated they didn't know what they would want to learn about and repeated they did not have "big minds" or know how to read. They were, however, more receptive when told the class would accommodate their needs.

Timeliness

When asked if participants felt they had enough time to be seen by their physician or keep their appointments, all participants said yes. Overall, participants in the focus group did not feel as though appointments took up too much time or feel it was a problem to wait for transportation. The ultimate concern was getting treatment and so long as they were seen by a healthcare provider, they were satisfied. Time did not serve as a concern for Bhutanese refugees.

Discussion

Bhutanese refugees have resided in Summit County for approximately eight to ten years. During this time, civic organizations and businesses have contributed to a growing and active community. With established roots in Akron, it appears that many Bhutanese refugees have been able to make strong social connections with others share knowledge and resources amongst themselves. Newer Bhutanese refugees coming to Summit County will still face challenges in adjusting to a new country and culture but have social supports which can ease their transition and adjustment.

It is very likely that many of the participants in the focus group did not have many healthcare needs or wants since they had access to community resources and were given useful advice on navigating the healthcare system. However, this is not to say all Bhutanese healthcare needs have been met adequately or appropriately. Even with community supports, it is still critical to provide information of local resources within and outside of the Bhutanese community.

The focus group was also comprised of mainly older adults. The interpreter had expressed many older Bhutanese refugees were “tired” and were content to receive whatever benefits and services they could. He also stated at this point in their lives, their main desire was to attain citizenship and not much else. From a cultural perspective, older adult Bhutanese refugees may also have many of their needs met by younger family members or children. They also did not have to be concerned with finding employment or enrolling into school. Though many adult children are too working, elderly Bhutanese refugees are not entirely isolated since there are plenty of other Bhutanese refugees of the same age residing near them.

Especially with this demographic, many may feel reticent to disclose personal feelings or air grievances before strangers. Though the participants were reassured their responses were confidential, they kept their answers brief and amenable. It is entirely possible that the members of this focus group did not feel they had unmet healthcare needs or had other priorities to focus upon. However, the interpreter told the facilitator at the end many older Bhutanese refugees would not be very forthcoming with their responses in order to not be perceived negatively or have their chances of citizenship harmed.

Recommendations

Based on the input of the focus group, local refugee resettlement agencies, and existing literature, these recommendations may address some of the unmet needs of the Bhutanese refugee population. All suggestions are subject to review and revision, based on economic feasibility and resources availability.

Art therapy initiatives have proven to be widely successful for helping refugees cope with mental illness and stress. The UNHCR recently published a list of art therapy initiatives that benefited various refugee camps.³⁰ With appropriate tailoring for target populations within the Bhutanese community, Bhutanese refugees can cultivate healthy coping skills by engaging in a hobby and increase their community involvement if they were inclined to sell their work.

Lastly, in order to assist Bhutanese refugees with access to care, namely in transportation and language barriers, social worker interns or volunteer social workers can assist refugees by

³⁰ (Parater, 2015)

taking refugees to their appointments (if they are unable to get transportation from family or neighbors) and act as moral support when going to the appointments. Additionally, CHWs can serve as a conversation partner for Bhutanese refugees to practice their English skills. Forming a partnership with local hospital groups which already employ CHWs can spare costs for the health department and increase appointment adherence for medical offices. Weekly office hours in a local library or community location central to the refugees where a CHW or hospital case worker can volunteer to assist refugees with making and or cancelling appointments, arranging for rides, and answering questions about what to expect at a doctor's visit.

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