Historical, Political, and Medical Context of Bhutan's Refugee Crisis

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Abstract
Bhutan is a multiethnic and multireligious state composed of a majority of people with Buddhist faith and Ngalung ethnic ancestry. The nation has been engaged in ethnoreligious conflict since the second half of the 20th century, when ethnic Nepalis living in the south of Bhutan, also referred to as the Lhotshampa, began increasing in numbers and politically organizing, threatening the dominant cultural and political groups. In 1989, the nation's dominant religious group, the Drukpa, gained political dominance through the monarchy and enacted the "One Nation, One People" policies. These policies forced all people in Bhutan to adhere to Drukpa customs, culture, and language, leading to the discrimination and abuse of ethnic Nepalis who practiced a different religion, language, and culture. While once citizens peacefully cohabitating with other ethnic and religious groups, the Lhotshampa were denationalized, imprisoned, and tortured, leading to their mass exodus from Bhutan. Between 1990 and 1993, approximately one-seventh to one-fifth of the population of Bhutan (over 100,000 people) fled to refugee camps in Nepal. A large portion of these refugees were resettled to the United States between 2008 and 2012, and as of 2017, over 86,000 refugees from Bhutan had been resettled. Healthcare providers should be aware of the medical and mental health conditions that disproportionately impact refugees from Bhutan so they can provide proper screening and treatment. Refugees from Bhutan are particularly impacted by anemia, which may be related to nutritional deficiencies and diet, vitamin B12 deficiency, and suicidality. Culturally appropriate screenings and interventions should be applied to all refugees from Bhutan, including screening for mental health disease. Interventions to improve coping strategies and those related to diet to combat iron and/or vitamin B12 deficiency should be considered.

History of Ethnoreligious Conflict in Bhutan

History and Evolution of Bhutan's Governmental Structure

Bhutan was an absolute monarchy until the second half of the 20th century, when the nation transitioned to a constitutional monarchy.[1] The third monarch, King Jigme Dorji Wangchuk (1952–1972), restructured Bhutan's government by establishing a National Assembly in 1953.[2] In 1965, the Royal Advisory Council was established to advise the king, and, in 1968, the Council of Ministers was established to represent heads of governmental departments appointed by the king. These two groups made up Bhutan's cabinet.[2] However, it wasn't until 1969 that the king surrendered the monarch's veto power over to the National Assembly, gaining the organization more political power.[1] The National Assembly had approximately 150 members at one time, with 105-110 of these members elected, 35-39 appointed by the king, and 10-12 appointed by the Buddhist monastic establishment.[3] In 1972, Jigme Dorji Wangchuk was succeeded by his son, King Jigme Singye Wangchuk (1972–2006), who dissolved the cabinet in 1998 to have it reconstituted by elected officials. In 2006, Jigme Singye Wangchuk abdicated his throne to his son, Jigme Khesar Namgyal Wangchuk. It was the rule of King Jigme Khesar Namgyal Wangchuk that prompted the transition to a parliamentary democracy, with a new constitution established in 2008.[4]

The Parliament currently consists of the National Council, the National Assembly, and the king. The nonpartisan National Council has 25 members, 20 of which are elected by the 20 districts and 5 of which are appointed by the king. The partisan National Assembly comprises 47 members elected from 47 constituencies. Until 2007, political parties were illegal in Bhutan; however, unregistered political parties did exist, mostly made up of ethnic Nepalis.[2] As of 2023, the ruling political party is the Druk Nyamrup Tshogpa, and the opposition is the Druk Phuensum Tshogpa.

Bhutan's Ethnic and Religious Groups

Bhutan is a multiethnic, multireligious, and multilingual state. The nation is composed of four main ethnic groups. The Ngalung are people of Tibetan origin who migrated to Bhutan starting in the ninth century. They speak Dzongkha, which is now recognized as the national language, and they are concentrated in northern and western Bhutan. The Sharchop are the nation's earliest inhabitants and are concentrated in the east. They have mostly adopted Tibetan-Buddhist culture but speak Tsangla. The Lhotshampa are ethnically Nepali, and this group was concentrated in the south. The fourth group is not actually one single ethnic group but comprises multiple scattered indigenous tribes. Kargupa Buddhism is mostly practiced by the Ngalung, Nyingmapa Buddhism is mostly practiced by the Sharchop, and Sanatan Hinduism is mostly practiced by the Lhotshampa.[1,3] Drukpa is a sub-sect of Buddhism viewed as the dominant religious group in Bhutan due to its political influence in the nation and consists of members of both the Ngalung and Scharchop.[3]

Nepali Immigration and Political Organization in Bhutan

Nepalis began migrating to Bhutan in the 19th century. They settled in the south and were referred to as the Lhotshampa. Maintaining their culture, language, and Hindu religion, these people were viewed as outcasts compared with the majority Drukpa people. In 1952, the Lhotshampa established the country's first political party, the Bhutan State Congress. Through this political organization they were able to acquire Bhutanese citizenship under the 1958 Nationality Law.[1,3] In the 1950s and 1960s, the Nepalis were represented in the National Assembly and held positions in the national army, police, and judiciary. Overall they had peaceful existence with the other ethnic and religious groups.[3]

"One Nation, One People" Policies

While once a peaceful nation, Bhutan has been faced with ethnoreligious conflict since the 1980s, when the Drukpa, a sub-sect of Kargupa Buddhism, gained tremendous political influence through the nation's monarchy. The formation of a political party by the Nepali immigrants as well as their increasing numbers of migration were viewed as a threat to the identity, culture, and political dominance of the Drukpa, and ethnoreligious conflict in the nation was amplified. In 1989, the Drukpa began enacting "One Nation, One People" policies. In January 1989, the king decreed that all people of Bhutan must adhere to *driglam namzha*, traditional Bhutanese values, dress, and etiquette.[3,5] These policies unjustly impacted the minority Lhotshampa people, forcing them to assimilate to the customs and cultures of the Drukpa.[1] The Lhotshampa also had to take classes in traditional etiquette, wear traditional clothing, and speak in the language of the Drukpa. Adherence to *driglam namzha* was enforced through fines and imprisonment.[3] In February 1989, teaching the Nepali language in schools was also banned.

Ethnic Nepali Citizenship and Denationalization

The 1958 Nationality Act allowed for immigrants to obtain citizenship if they have been in Bhutan for more than 10 years (or more than 5 years if they work for the government) and own land in Bhutan.[3] In 1977 and 1985, however, two laws were passed that made it more difficult for ethnic Nepalis to acquire or maintain citizenship. The 1977 Citizenship Act increased the residency requirement for citizenship from 5 years to 15 years for those who have done government service and from 10 years to 20 years for anyone who has not performed government service. The act also tightened the criteria for spouses and children of Bhutanese nationals to gain citizenship. The spouse of a Bhutanese citizen, as well as the children of a Bhutanese mother and a non-national father were no longer automatically granted citizenship but had to apply. The children of a Bhutanese father and a non-national Bhutanese mother, however, were granted automatic citizenship. The new application process required some knowledge of Bhutanese history, culture, and customs, and written and spoken Dzongkha, the native language of the Drukpa people that is not spoken in South Bhutan. Finally, the act allowed that citizenship may be revoked for disloyalty against the king or the government.[3] The 1985 Citizenship Act further tightened requirements. This act only allowed citizenship by birth if both parents were Bhutanese nationals and increased the knowledge requirement from "some knowledge" to "proficiency" of Dzongkha and "good knowledge" of history and culture. Those who had ever been imprisoned in Bhutan or elsewhere were not eligible to apply for citizenship.[3] These acts resulted in the mass denationalization of ethnic Nepalis, as any attempt to speak out against "One Nation, One People" policies was viewed as a betrayal to Bhutan.

Anti-Nationalism and Violence

Ethnic Nepalis were dissatisfied with these "Bhutanization" policies and the forced erasure of their culture in Bhutan. Beginning around 1990, many criminal acts occurred in South Bhutan and were attributed to a group of Lhotshampa who were labeled as *ngolops,* or anti-nationals. Some of these anti-nationals were linked with the Bhutan People's Party.[3] Crimes occurring in the area included murder, kidnapping of government officials, harassment, rape, assault, and stripping people of the traditional Bhutanese dress that was being enforced.[3] In response to these crimes, the government began to target anyone suspected of involvement in anti-nationalism or protest of any kind, even peaceful protest. Raids of the homes of the Lhotshampa and ethnic Nepalis were common. Suspects were arrested and held in poor conditions for up to 12 months without fair trial. Prisoners were tortured, raped, and left without proper medical care. Some Lhotshampa fled the country during this time while others were forced out. Some Nepalis report that they were threatened with rearrest should they not leave the country.[3] Additionally, the Bhutanese government forced many to sign "voluntary migration certificates," thus surrendering their rights to Bhutanese citizenship under the nationality laws.[3] Some Lhotshampa received compensation for the land they were forced to sell, but others did not. Thus, the refugee crisis in Bhutan began as ethnic Nepalis were fleeing the country in great numbers.

Refugees from Bhutan and Resettlement

Refugee Camps

Refugees of ethnic Nepali origin began fleeing Bhutan in the 1990s. During this time, an estimated one-seventh to one-fifth

of Bhutan's total population was living in exile from the country.[1] Initially, refugees migrated to northeast India and West Bengal. However, these nations were not equipped to handle the influx of refugees, and Nepal began accepting these people as well.[5] In 1991, the United Nations High Commissioner for Refugees developed its relief program to help relocate these ethnic Nepali refugees into East Nepal, where the majority of refugee camps were established.[5] Over 100,000 Lhotshampa refugees came through Nepal and were later resettled into other places of the world, including the United States.[6] While in refugee camps, these people received basic medical care. Routine vaccinations were provided in the camps, including bacille Calmette Guerin; diphtheria, pertussis, and tetanus; measles; oral polio vaccine; hepatitis B; haemophilus influenzae type b; and tetanus toxoid.[7] Refugees also received food rations consisting of rice, lentils, chickpeas, vitamins A- and D-fortified vegetable oil, sugar, salt, fresh vegetables, and a fortified wheat and soy supplement called Unilito. Malnourished children and pregnant women could receive additional supplementation.[7,8]

Resettlement in the United States

As of 2017, over 86,000 of these refugees have resettled in the United States, and the majority of these people arrived to the U.S. between 2008 and 2012.[9] During this time frame, 5,000 to 15,000 refugees from Bhutan arrived annually.[7] The majority of these refugees settled in Pennsylvania (10.0%), Texas (9.9%), New York (8.1%), Georgia (7.0%), and Ohio (4.7%) and were aged 15-44 years (60%).[7] All refugees from Bhutan who resettle in the U.S. need to complete a visa medical examination before departure performed by physicians selected by the Department of State.[7] Unlike immigrants, vaccination requirements do not apply for refugees at the time of initial admission to the U.S., although vaccinations are offered.[7] A pre-departure medical screening also takes place in Nepal three weeks prior to resettlement for refugees diagnosed with class B1 tuberculosis (TB), which is TB that has been fully treated using directly observed therapy, or TB with abnormal chest x-ray with negative sputum smears and cultures, or extrapulmonary TB.[7] Two pre-embarkation checks also occur within 48 hours of departure from the refugee camps to assess for fitness to travel and to treat parasites.[7] All refugees 2 years old and older receive one dose of 400 mg of albendazole, and children 12-23 months old receive one dose of 200 mg of albendazole to treat intestinal parasites. All individuals are also screened and treated for head lice. Within 30 days after arrival, refugees also have a post-arrival medical screening.[7]

Medical Considerations for Ethnic Nepali Refugees

Refugees from Bhutan need medical care for chronic and acute issues upon resettlement as well as routine health maintenance. Some of the most common chronic medical issues faced by these refugees include hypertension, dizziness, and arthritis, which are conditions commonly faced by the general U.S. population.[10] However, these refugees may also be disproportionately impacted by certain conditions, including vitamin B12 deficiency, anemia, and mental health disease and suicidality.[7,8,11–17]

Anemia

Anemia commonly affects refugees from Bhutan, which may be linked to malnutrition or micronutrient deficiencies such as iron or vitamin B12 deficiency.[8,15,18] A U.S. Centers for Disease Control and Prevention (CDC) cross-sectional study on anemia in refugees in camps in Nepal found that 43.3% of the children had anemia (hemoglobin $\leq$11.0 g/dL), and this prevalence decreased with

age.[18] Anemia was present in 78.8% of infants aged 6-11 months and in 20.1% of children aged 48-59 months. Anemia also was found in 13.6% of adult women, which was more prevalent in vegetarians (26.2%) than in non-vegetarians (12.1%). Another study on refugees from Bhutan found a prevalence of anemia in children of 40%, which also decreased with age.[8] This study assessed hemoglobin in refugee children from Bhutan before and after providing a micronutrient supplement including 16 vitamins and minerals based on the recommended nutrient intake for children 1-3 years of age. There was not a significant increase in hemoglobin following the supplementation; however, the supplementation may have been ineffective at improving hemoglobin because most of the participants were over 12 months of age, and iron requirements are highest for children aged 6-12 months, which is the age group with higher rates of anemia at baseline.[8] Additionally, the older children may have had more access to iron-rich foods than infants under 12 months of age. Most of the children in the study were only mildly anemic or nonanemic (hemoglobin > 100 g/L), and the supplementation may have had more effect on those with severe anemia. Potential causes for anemia related to nutritional deficiency could be lack of iron-rich foods, poor feeding practices, or chronic diarrhea.[18] However, anemia is likely multifactorial and may have been due to causes unrelated to nutritional deficiencies.

Vitamin B12 Deficiency

Refugees from Bhutan, like refugees from other countries, have been found to have low levels of Vitamin B12. One study of 916 refugee patients who resettled in Australia found that one third of their refugees from Bhutan (n=196) had vitamin B12 deficiency (<150 pmol/L).[16] For these patients, there was an association between vitamin B12 deficiency and advancing age but no association with sex. In this study, many of the refugee patients were also found to have anemia; however, no association between anemia or macrocytosis was found for them. Another study involving refugees from Bhutan in the U.S. also found that a significant portion of them were deficient in vitamin B12 (<203 pg/mL).[15] Vitamin B12 deficiency was detected in 64% (63 of 99) of specimens taken from refugees while still abroad, 27% (17 of 64) of specimens collected at post-arrival medical screenings, and 32% (19 of 60) of specimens taken at clinic follow-up visits.[15] In both of these studies, vitamin B12 deficiency was rarely seen in patients younger than 15 years of age, possibly due to the additional nutrient supplementation that children and pregnant women were eligible to receive in the refugee camps.[15] Vitamin B12 is involved in DNA synthesis, and its deficiency can result in megaloblastic anemia, peripheral neuropathy, and other neurologic symptoms.[15] Causes of vitamin B12 deficiency include low dietary intake, malabsorption, atrophic gastritis, and *Helicobacter pylori* infection.[15,19] For refugees from Bhutan, deficiency may be multifactorial; however, diet may play a significant role as people of Nepali culture often do not eat meat, eggs, or dairy, which are all significant sources of vitamin B12.[15] Vitamin B12 may also be provided in the Western diet through fortified products such as cereal. Poverty and food insecurity may exacerbate or contribute to this issue, and refugees are disproportionately affected by food insecurity.[20] *H. pylori* is also a cause of Vitamin B12 deficiency, and refugees in the U.S. have a higher prevalence of *H. pylori* than the U.S. as a whole.[21] Infection with *H. pylori* causes achlorhydria and gastric atrophy, eventually leading to vitamin B12 malabsorption.[19] Refugee patients from Bhutan should be screened for signs and

symptoms of vitamin B12 deficiency, including megaloblastic anemia, peripheral neuropathy, and other unexplained neurologic symptoms. Given that diet is a significant cause of vitamin deficiency, one clinic tested the efficacy of a dietary screening and nutrition counseling for refugee patients.[17] All refugees at this clinic received a diet survey and nutrition counseling regarding foods containing vitamin B12. Of the 49 refugees from Bhutan included, 2 refugees were deficient at baseline and only 4 had knowledge of vitamin B12. For refugees from all countries, vitamin B12 serum concentration was measured pre-intervention and 3 months following the nutrition counseling. At the 3-month assessment, 58% of the refugees had an increase in serum vitamin B12 levels, 28% demonstrated improved knowledge of vitamin B12, and 85% reported consuming more foods with vitamin B12.[17] This indicates that nutritional education is beneficial for refugees, and this could even be started in the refugee camps as people are waiting for resettlement. When vitamin B12 deficiency is detected, patients should receive oral or parenteral supplementation and be assessed for underlying causes of deficiency such as gastritis or *H. pylori* infection.

Mental Health and Suicidality

Refugees from Bhutan have often experienced mental and physical torture, ethnic and religious discrimination, and difficult conditions in Bhutanese prisons or in refugee camps, and these difficult life experiences can lead to psychologic distress (PD) including depression and anxiety, post-traumatic stress (PTS), and suicidal ideation (SI).[1,3,11,12,22,23] For refugees from Bhutan, rates of depression have been cited between 15% and 71%, rates of anxiety between 13% and 79%, and rates of PTS between 4.5% and 6.2%.[11,12,22] In studies involving refugees from Bhutan, significant predictors of PD included history of mental health treatment and less education.[22] Significant predictors of PTS were history of mental health treatment, being female, less education, and being single.[22] For this population, anxiety has also been associated with surviving torture, and depression has been associated with both surviving torture and experiencing threats to well-being while in Nepali refugee camps.[24] Suicidality is also prevalent for these refugees. Refugees from Bhutan are dying from suicide at a rate of 2 times higher than the general U.S. population, and the suicide rate for refugees in Nepali refugee camps (approximately 20.8 per 100,000) has been higher than the national rate in Bhutan (approximately 13.9 per 100,000).[11,13] Common risk factors identified for suicide attempts by people in Nepali refugee camps include untreated mental illness, alcohol abuse, and family history of suicide attempt(s).[13] A CDC study found that for refugees from Bhutan resettled in the U.S., those who attempted suicide were more likely to be male, married, and to be in a role where they are expected to be the family's primary financial provider but are not functioning as such.[11,14] Prompt detection of suicidality and intervention can reduce suicide-related fatalities, and, therefore, screening is essential for refugees who are at an increased risk. However, refugees from Bhutan may have unusually low rates of SI (approximately 3%) compared with that of the general U.S. population (approximately 14%), so it may be difficult to identify refugees at risk for committing suicide.[11–13,25] One survey-based study found that PTS was a predictor of SI for refugees from Bhutan, which may or may not be useful in screening for those at risk for suicide because PTS is so prevalent in refugees.[22] Additionally, there is social stigma around mental health conditions and suicidality in

Nepali culture, which adds to the challenges in detecting and treating these conditions.[26,27] Therefore, culturally competent mental health screenings and interventions should be done for all refugees from Bhutan. The *Hopkins Symptom Checklist 24 (HSCL-24)* Nepali version is one such screening that has shown good validity and reliability for detecting PD in refugees from Bhutan.[22,28] One intervention that has been tested for refugees from Bhutan is called Mental Health First Aid (MHFA) and was developed to be culturally appropriate for immigrant and refugee communities.[29] Following MHFA intervention, refugees from Bhutan had improved ability to recognize and seek help for schizophrenia, ability to seek help for depression, and overall mental health literacy compared with pre-intervention.[29] Another study looked at a Social and Emotional Well-being (SEW) intervention aimed at teaching coping and conflict resolution skills to improve mental health outcomes for refugees from Bhutan.[30] The participants had a significant reduction in stress, anxiety, and depression, and improved coping, self-efficacy, and family and community networking at the post-intervention follow-up. A peer-led intervention focused on community building through discussions and health promotion and education was also studied in refugees from Bhutan.[31] The refugees in this study reported meaningful improvement in knowledge, awareness, and skills related to diet, mental health, and emotional coping. Involving family members or peers who share the same culture or belief system in discussions related to physical and mental health may be beneficial for this population to promote healthy behaviors.[27,31]

Conclusions

Ethnic Nepalis from Bhutan faced physical and mental torture as well as ethnic and religious discrimination leading to their mass exodus from Bhutan in the 1990s. A significant portion of these refugees have resettled in the United States, and while resettlement from refugee camps has slowed down since 2008, it is important for U.S. healthcare providers to be aware of the history of the crisis to better understand the physical and mental health needs of these resettled refugees who remain in the U.S. Refugees from Bhutan experience many of the same health conditions as the general U.S. population, but they may be particularly affected by anemia, vitamin B12 deficiency, and suicide. Providers should consider screening for anemia and vitamin B12 deficiency for all refugees from Bhutan and assess for underlying causes of malnutrition or malabsorption. Refugees from Bhutan are also at an increased risk for committing suicide, but may have less suicidal ideation identified, emphasizing the critical need for mental health screening in this population. All screenings as well as educational and behavioral interventions regarding mental health and diet should be culturally appropriate. Involvement of family and peers in the community may be of benefit when considering behavioral intervention or health literacy.

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