Exploring Beliefs about Contraception in Bhutanese Women

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This project is submitted in partial fulfillment of the Doctorate of Nursing Practice

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Executive Summary

Bhutanese immigrants are the first poor Hindus to arrive in the United States as refugees in large numbers. They lived in seven refugee camps in Nepal for about twenty years. They also identify themselves as Nepalese or Nepali Bhutanese. More than 49,000 Bhutanese refugees have been resettled in the United States as of early 2012. Health care providers are not familiar with family planning beliefs and practices of Bhutanese women. In addition, there is a gap in literature about contraception in Bhutanese Women. As a result, health care providers may not be able to facilitate family planning services congruent to Bhutanese beliefs. A qualitative study is important to increase understanding among health care providers about their contraceptive practices.

The objectives were to explore and identify Bhutanese contraceptive beliefs and practices and disseminate findings to health care providers to facilitate provision of contraception to Bhutanese women. Another objective was to make recommendations for future research focusing on contraceptive needs in this immigrant population.

According to the literature review, all contraceptive methods are acceptable in Hindu culture (Srikanthan & Reid, 2008). Sexual relationships are to be experienced within the norms of marriage in Hindu religion (Srikanthan & Reid, 2008). Therefore, sex before marriage is forbidden. Sexual health is often forbidden topic in traditional Hindu culture (Fisher, Bowman & Thomas, 2003; Aggarwal, Sharma & Chhabra, 2000) and in Bhutanese society (Maxym, 2010). Young women may have no education regarding contraception or normal sexual intercourse. They may not understand the concepts of ovulation and timing of pregnancies (Fisher et al., 2003). Hindu women are generally not educated about contraception until after the birth of the first child (Srikanthan & Reid, 2008). However, contraception was widely used and accepted in the Bhutanese refugee camps in Nepal (Human Rights Watch, 2003; Maxym, 2010).

IRB approval was obtained from University Utah and individual interviews were conducted in 14 Bhutanese women in Nepali language. The interviews were audio recorded, later translated and transcribed verbatim. The interviews were evaluated for common themes and quotes. Findings from these interviews revealed that birth control is a private matter for Bhutanese women. They are comfortable talking about pregnancy and other health issues instead of birth control. Family planning is known and accepted in Bhutanese culture. There are no religious prohibitions regarding contraception. Depo Provera injection was the most common method of contraception. None of the Bhutanese women used long term contraception such as IUDs. Women are hesitant to use contraception because of the concerns about menstrual side effects and fears about infertility. Birth Control appears to be used by married women only and after the ideal family size is met. Single women did not use any contraception. Most of the women agreed that they discussed among married women for contraceptive information. Most women were exposed to birth control methods at the hospital after the birth of the first child. These findings will be presented nationally at the American College of Nurse Midwives convention. The findings will inform health care providers about Bhutanese women's beliefs so that they design culturally sensitive contraceptive counseling.

Content experts on this project are Jane Dyer CNM, FNP, MBA, PhD, FACNM and Patricia Murphy CNM, DrPH, FACNM. The scholarly project committee includes the program director Susanna Cohen MSN, CNM; project chair Ana Sanchez-Birkhead, PhD, WHNP-BC, RN, and executive director Katie Ward DNP, WHNP, ANP. Jane Dyer was also my mentor without whom the study would not be complete

Exploring Beliefs about Contraception in Bhutanese Women

Introduction and Background

Many cities in the United States, including Salt Lake City, Utah, have recently experienced an influx of Bhutanese refugees of Nepali origin (United Nations High Commissioner for Refugees, 2010). According to statistics by Utah Refugee Services, about 466 Bhutanese refugees were resettled in 2008-2009 (Department of Workforce Services, 2009), making them the second largest refugee population, after Burmese, to resettle in Salt Lake City in 2009. As of early 2012, more than 49,000 Bhutanese refugees have been resettled in the United States (United States Department of State, Bureau of Population, Refugees, and Migration, 2012). The Bhutanese immigrants are the first poor Hindus to arrive in the United States as refugees in large numbers. They lived in seven refugee camps in Nepal for about two decades on United Nations food assistance before being resettled in the United States.

Contraceptive decisions are influenced by cultural, religious and other social factors (Dunn et al., 2011). In addition, women arriving from developing countries often have insufficient knowledge about reproduction and contraception to make an informed decision about family planning (Sedgh, Husain, Bankole & Singh, 2010). There is no process that screens or supports women who need contraception during migration (Dunn et al., 2011). As a result, when compared with the general population, refugee women are less likely to seek counseling for family planning. Therefore, primary care practitioners have an important role in assisting women and couples to achieve their reproductive health intentions (Dunn et al., 2011).

Bhutanese immigrants have been newly resettled in the United States since 2008, and there is a gap in literature on Bhutanese cultural beliefs. Qualitative study and findings on

contraceptive beliefs can be informative to health care providers and can also used to advocate for better culturally competent health care for refugee population.

Problem Statement

Cultural, social and religious influences on contraceptive decisions often vary in refugee immigrant women when compared with women of the dominant culture (Dunn et al., 2011). However, health care providers have insufficient knowledge about Bhutanese culture and attitudes toward health experiences, in particular family planning health, as these refugees have only been resettled in the United States since 2008. When these women approach their reproductive years, health care providers may be unable to offer culturally competent family planning services to Bhutanese women. This lack of understanding will add to the already existing unmet contraception needs and increased unintended pregnancies in the United States. Refugees are vulnerable populations that need help learning their options, opportunities, and limitations in a new country (McGinnis, 2012).

Clinical Implications

The dissemination of the findings of the study will increase understanding among health care providers about contraceptive beliefs and practices of Bhutanese women. This will support the provision of culturally sensitive contraceptive counseling. The health care providers can develop family planning educational materials and education sessions congruent to the beliefs of Bhutanese women. Refugees are vulnerable populations that need help learning their options, opportunities, and constraints in a new country (McGinnis, 2012).

Purpose and Objectives

The project will explore cultural beliefs and attitudes about contraception in Bhutanese refugee women residing in Salt Lake City using individual interviews. The researcher will

interview the women on their cultural beliefs and attitudes toward contraception. The findings of the study will be disseminated to health care providers at University of Utah through a poster presentation and nationally through a power point presentation. The proposal has already been submitted and accepted at the American College of Nurse Midwives convention that will be held in Nashville in June, 2013. As a result, health care providers all over the United States will be informed about the Bhutanese contraceptive beliefs. They will be able to provide culturally sensitive family planning health care when encountered with Bhutanese women in their practices.

Literature Search Strategy

An extensive review of literature was undertaken using the database of CINAHL, PUBMED and their linked databases; website search engines including Google, Google Scholar, and relevant newspapers and magazines. Additional resources were found via citation lists from articles already obtained. Search terms included: *Bhutan, Bhutanese-Nepalese, Lhotshampas, Bhutanese refugees* and *refugees.* These terms were combined with other terms: *reproductive, contraception, family planning, beliefs, cultural,* and *religious.* Hundreds of articles were returned and about 54 retrieved based on review of abstracts and titles that were appropriate for the subjects. United Nations High Commissioner for Refugees (UNHCR) and International Rescue Committee (IRC) were other websites used.

Literature Review

Bhutanese Refugees Defined

The Bhutanese refugees in United States also identify themselves as Nepali Bhutanese or Lhotshampas. According to Evans (2010), Lhotshampas, sometimes referred to as Nepali Bhutanese, include "peoples from a range of different ethnic and linguistic backgrounds" whose

ancestors migrated from Nepal or from the Nepali-speaking part of Darjeeling in West Bengal a few generations ago. Approximately 60% of the refugees are Hindu, 27 % are Buddhists, 10% are Kirat (indigenous animistic faith), and the remaining are Christian (United States Department of State, Bureau of Population, Refugees, and Migration, 2012; CDC, 2012). The Lhotshampas are predominantly Hindu and belong to caste groups, such as Brahmins, Chhetris or Dalits. Other ethnic groups such as Rais, Limbus, Gurungs, and Tamangs practice Buddhism (Evans, 2010). Although the Bhutanese refugee population in the United States is rapidly growing, there is a gap in literature about the family planning beliefs and practices of Bhutanese women. Therefore, the literature review focuses mainly on religious and cultural beliefs in South East Asian on contraception making relevant to the refugee population from Bhutan.

Bhutanese Refugee Women and Family Planning

Numerous studies focusing on forced migration, discrimination, resettlement and mental health consequences have been conducted on the Bhutanese population living in refugee camps in eastern Nepal (Thapa, Van Ommeren, Sharma & de Jong, 2003). The majority of the studies were carried out by the United Nations High Commissioner for Refugees (UNHCR) and report Bhutanese refugee women suffer high rates of depression and anxiety (Human Rights, 2003). As Bhutanese refugee women suffered from many health and mental health issues, they will likely experience significant challenges resettling and acculturating to the American health care system (Benson, Sun, Hodge & Androff, 2012), including family planning health. However, relatively few studies have examined the cultural practices of Bhutanese refugees after they were resettled in the United States.

Hindu Beliefs about Contraception

The majority of Bhutanese refugees are Hindu (United States Department of State, Bureau of Population, Refugees, and Migration, 2012; CDC, 2012). Family sexual relationships are to be experienced within the confinement of marriage in Hindu religion. Such relations are for both reproduction and pleasure (Srikanthan & Reid, 2008). Therefore, sex before marriage is not common in this culture. Traditionally in Bhutanese society, arranged marriages take place between members of the same caste and the parents of the bride and groom usually meet and assure a good match (Maxym, 2010).

Sexual health is often considered a forbidden topic in traditional Hindu culture (Fisher, Bowman & Thomas, 2003; Aggarwal, Sharma & Chhabra, 2000; Srikanthan & Reid, 2012) and in Bhutanese society (Maxym, 2010). Therefore, women may not know about normal sexual intercourse, concepts of ovulation and contraception. Women are generally not educated about contraceptive options until after the birth of the first child (Srikanthan & Reid, 2008). The birth of the first child is used to assure the families involved that the marriage was a good match. Thus, among some couples, birth control may not be used until the first child is born (Srikanthan & Reid, 2008).

Although Hindu beliefs discourage premarital sex, all contraceptive methods are considered acceptable (Srikanthan & Reid, 2008). The contraceptive intent should be morally right with no ethical or spiritual harm. The decision to use contraception is therefore considered a personal choice (Srikanthan & Reid, 2008).

According to Hindu beliefs, life enters the embryo at conception. Thus, abortion and emergency contraception are condemned (Jain, 2003). Although abortion is discouraged, in certain situations, women may decide that it is a necessary and moral course of action depending on their circumstances (Jain, 2003).

As sexuality is a forbidden topic, sexual practices, sexuality and gynecological conditions are awkward topics for Bhutanese women to discuss (Maxym, 2010). Sex education does not traditionally have a place in Bhutanese culture or education, but is a standard part of education in the refugee camps (Maxym, 2010). Women, particularly younger and/or more educated ones, do discuss sensitive topics amongst themselves, but almost never with elders, male friends or family members (Maxym, 2010). As there is limited understanding of the concept and value of preventive health care among Bhutanese women (Mayxm, 2010), women may have lack of knowledge about contraception.

Proper education regarding accurate contraceptive use is lacking among women of Hindu faith (Srikanthan & Reid, 2008). According to Jain (2003) and Srikanthan & Reid (2008), cultural resistance, sexism, and lack of female empowerment could be some of the factors why family planning is not utilized. Other Factors include lower education levels and lack of accessibility of services (Iyer, 2002; Srikanthan & Reid, 2008). Although, the religion allows contraception, not all Hindu women utilize contraceptive methods (Srikanthan & Reid, 2008).

Hindu society is patriarchal in nature and attempts made by the woman to influence contraceptive decisions could potentially result in physical abuse, allegations of infidelity, or divorce (Fisher, Bowman & Thomas, 2003; Srikanthan & Reid, 2008). When discussing contraception, a study suggest that it may be wise to ask the husband for permission to discuss contraception with the wife (Fisher et al., 2003). According to Human Rights Watch (2003), contraception and family planning services were widely used and accepted in the Bhutanese refugee camps. Methods were provided free of cost. Maxym (2010) also conducted interviews with Bhutanese Nepalese women in Seattle and reported that contraception was widely accepted

and was used at the refugee camps except by a very few highly traditional individuals (Maxym, 2010).

Buddhist Beliefs about Sexuality and Contraception

Approximately 27 % of Bhutanese refugees are Buddhists (United States Department of State, Bureau of Population, Refugees, and Migration, 2012). In Buddhist culture, marriage and sexuality are still viewed as positive life events (Sponberg, 2005). However, there are no specific prohibitions or obligations regarding contraception in Buddhism. Family planning is permissible and encouraged when the intention to use contraception is not harmful (Sponberg, 2005; Srikanthan & Reid, 2008).

Abstinence is considered the method of choice in Buddhist culture; however, other methods such as permanent sterilization is not opposed (Srikanthan & Reid, 2008). Intrauterine devices (IUDs) are not considered appropriate contraceptive options for those who believe that they prevent implantation. Health care providers may want to discuss the likely mechanisms of action for those considering IUD to influence acceptability (Srikanthan & Reid, 2008). Contraception may not be used to engage in self-indulgent activities such as promiscuity. Such behavior is considered to result from ineffective control of one's passions (Srikanthan & Reid, 2008, Sponberg, 2005). Although abortion and emergency contraception are considered murder, both are permissible in certain situations such as serious maternal health problems, rape, or economic hardship, provided that the intentions of the mother are ethically sound (Srikanthan & Reid, 2008). Early terminations are preferred to later terminations (Spongberg, 2005). Despite increased usage, there is a belief in Buddhist culture that contraception use promotes widespread premarital sexual intercourse (Srikanthan & Reid, 2008).

Cultural and Social Attitudes of Bhutanese Women

Bhutanese refugees seek out care if they have serious health problems rather than seeking preventive care (Ranard, 2007). This approach may affect contraceptive utilization among Bhutanese women. The reluctance of community members to seek care unless severely ill may be amplified by the fact that refugees may not continue to have adequate health coverage after an eight-month period of federal resettlement benefits (International Rescue Committee, 2009; CDC, 2012). Women may not seek health care, including family planning health, if their resettlement benefits end as they may be unable to meet the financial costs of medical care (Maxym, 2010; CDC, 2012).

Gender Roles and Contraception

Gender roles are distinct and clearly defined in a family unit. Girls experience heavier household workloads than boys, a distinction that continues into adulthood. Women generally do not have equal access to information and resources and do not enjoy equal decision-making authority in the family and the community (Ranard, 2007).

Traditional gender roles significantly impact contraception. For instance, Hindu society is patriarchal in nature. Men are usually the decision makers (Srikanthan & Reid, 2008). As a result, a woman might not perceive herself to be the decision-maker for contraception, but could be strongly influenced by her spouse, mother-in-law, sex role, and religious beliefs (Srikanthan & Reid, 2008). Recognition of the partner's influence and his involvement in contraception where appropriate, are important in counseling and in supporting women's choices. Additionally, traditional gender roles that influence women's independence and empowerment are often challenging in the United States (Maxym, 2010), as many women may be required to be responsible for their own contraception care and well-being for the first time in their lives.

Sexual assault, rape, trafficking, polygamy, domestic violence, and child marriage have all been reported in the Bhutanese camps. Domestic violence is probably the most pervasive form of gender-based violence suffered by Bhutanese refugees (Human Rights Watch, 2003; CDC, 2012). According to the report on Bhutanese Refugee Health Profiles conducted by CDC (2012), female victims of sexual violence and their families can face alienation from their community. Such gender-based violence also affects contraceptive attitudes and usage in Bhutanese women.

Culture-Specific Fear of Adverse Effects

Use of some contraception can be influenced by culture-specific fear of adverse effects. Bhutanese women are considered unclean during their menstrual cycle and may not touch, prepare or serve any food or drink (Maxym, 2010). The women may not touch the male members during this time and sexual intercourse is prohibited during four days of the cycle each month (Maxym, 2010; Ranard, 2007). Spotting and bleeding associated with some methods are problems for women who have religious and cultural restrictions on intercourse or other activities while bleeding. Such beliefs may deter them from using contraceptives that may result in spotting and bleeding between cycles. Similarly, condoms may have connotations of infidelity, promiscuity or sexually transmitted infection or are used only with non-marital partners (Dunn et al., 2011). As a result, condom use may not be as prevalent between married partners.

Acceptability of contraception and method preferences varies among women of different cultures. Health care providers should provide contraception counseling that is sensitive to the many socio-cultural and religious beliefs influencing decisions about contraception in refugee women (Dunn et al., 2011), including Bhutanese women. Cultural attitudes towards pregnancy

and family planning vary among different refugee populations. Cultures that believe that "children are God's will," such as Somali refugees, also discourage pregnancy prevention or use of contraception (Degni, Koivusilta & Ojanlatva, 2006). In some cultures, women who bear many children are highly esteemed. Religious beliefs about the acceptability of contraceptive practices are also influences for some women (Degni et al., 2006; Srikanthan & Reid, 2008). However, health providers should avoid assumptions and assess each woman or couple individually (Sedgh et al., 2010; Srikanthan & Reid, 2008).

Culturally appropriate health services play an important role in helping immigrant women achieve successful resettlement (Benson et al., 2012; Dunn et al., 2011). Effective family planning and contraceptive counseling can only be provided if health care providers are culturally aware of refugees' cultural practices and how those practices affect their contraceptive usage. Given the growing Bhutanese community in the United States and the gap in literature, research on the above topic is particularly important (Benson et al., 2012).

Theoretical Model

Cultural beliefs and attitudes about contraception use can be explored in Bhutanese women using the theory of reasoned action/planned behavior. According to the theory of reasoned action a person's behavior (use of contraception) is determined by his/her intention to perform the behavior. The best predictor of behavior is intention. This intention is, in turn, a function of his/her attitude towards the behavior (contraception use) and his/her subjective norms. Intention is a person's readiness to perform a given behavior and is influenced by three things: his or her attitude toward the specific behavior, subjective norms, and perceived behavioral control (Azhen, 2002). Therefore, the intention of using contraceptives is affected indirectly by one or more of the theory of reasoned action components such as behavioral beliefs, normative beliefs,

subjective norms, and attitude towards contraceptives. It is important that health care providers measure not only attitudes toward contraception but people's subjective norms to provide contraceptive counseling.

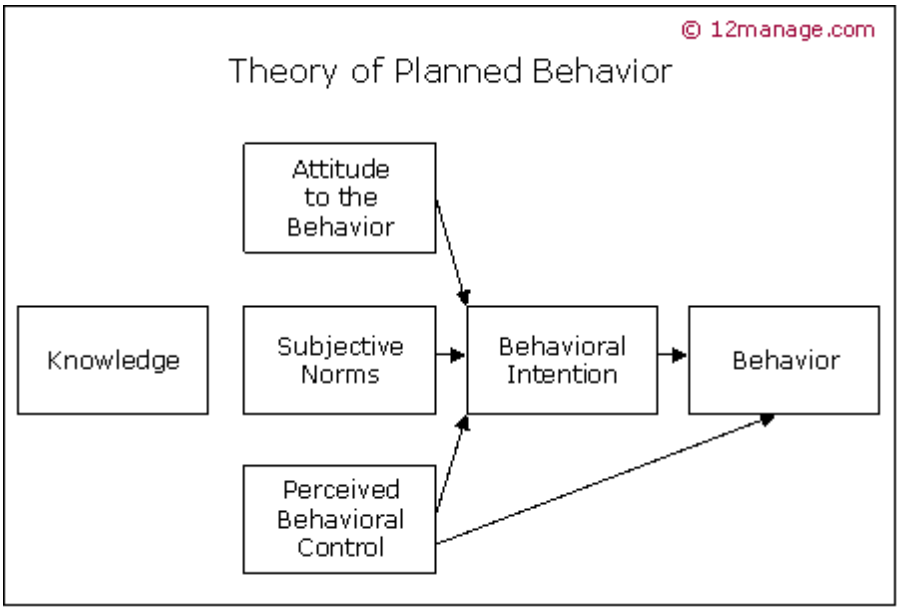

Figure 1. Theory of reasoned action or planned behavior

Project Implementation

Methods

Ethics and human subject protection. IRB approval was obtained from University of Utah Institutional Review Board prior to the implementation of project. The participants were provided signed waiver consent per IRB suggestion prior to the interview and educated on risks/benefits of the study. The participants were also educated that they have the right to end their participation in the study at any time if they choose not to participate.

Confidentiality. Bhutanese community is small and cohesive. Most of the Bhutanese women know each other. Therefore, this study asked women generalized open ended questions on birth control and beliefs about what was common in their community, as opposed to their own

direct experiences to minimize identifying information. Additionally, this study does not report names or any identifying information in the study findings.

Study design. This was a small pilot qualitative study that explored the cultural beliefs and practices that influence the contraceptive decisions in Bhutanese women. Interviews were conducted among Bhutanese women residing in south Salt Lake City. The interviews were carried out in the Nepali language. Audio recordings of the interviews were also made. The findings from the pilot study as themes and direct quotes will be disseminated to health care providers to inform them about Bhutanese culture and how it affects their reproductive health decisions.

Time frame. Each interview was conducted for an average of half hour to an hour using the subjective questionnaire as the guide which is listed under appendix. The length of the entire study for recruitment and interview was about three weeks, from February 15 through March 2, 2013. The interviews were conducted within 3-4 days.

Setting and resources. The project took place at south Salt Lake City. Bhutanese women who are interested in the study were provided signed waiver consent forms in the Nepali language before the interview. Questionnaires for the interviews included questions on demographic, knowledge, and beliefs on contraception in Nepali language. An audio recorder was used to record the interview discussions.

Study population. The study participants consisted of 14 Bhutanese refugee women residing near 900 East and 3300 South, Salt Lake City.

Inclusion criteria. Bhutanese immigrant women aged 18 and up who have lived in the United States for 5 years or less were recruited in the study. They were single or married. All participants spoke Nepali language primarily.

Exclusion criteria. All Bhutanese men were excluded. Bhutanese women with age less than 18 were excluded due to requirement of parental permission. Those women who have lived in the United States for 5 years or more were excluded in the study as majority of Bhutanese refugees were resettled after 2008.

Data Analysis

The interview guide and demographic questionnaire was created after extensive literature review. The interview guide was created using questionnaires used by McGinnis (2012) on the study conducted in Burmese refugee population due to almost no data about the Bhutanese in the literature. The interview guides were open ended to encourage women to make more contribution to the birth control discussion. The interview guide was approved by the content experts Jane Dyer and Patricia Murphy. The interview questions were also sent to an OB/GYN physician who works with majority of Bhutanese women in Red Wood Health Center for feedbacks. Then, the questionnaires were also approved by IRB at University of Utah.

Individual interviews were conducted in Nepali language and audio recorded. The audio recordings of the interviews were later translated and transcribed back to the English language verbatim by the investigator. The feedbacks were received from content expert and project chair. No identifying information was transcribed. Common reemerging themes and quotes were identified from the interview. The observation was made about home environment and behaviors of Bhutanese women during the study. The demographic results, direct quotes, and common identified themes are presented in the results section. All recordings will be deleted at the end of the study.

Results

First, the demographics of the sample are described. Second, the results of the interviews are organized and presented by the themes that emerged during the analysis of transcribed interviews. Direct quotes and narratives that support the identified themes were grouped together. Direct quotes are written in italics. If common quotes were found they were collapsed together to form narratives.

Demographics of Bhutanese Women

Fourteen women over the age of 18 from South Salt Lake community were interviewed after reading a signed waiver consent form (see Table 1).

Table 1: Demographics of Bhutanese Women

Age	
18-22	3
23-27	3
28-32	2
33-37	1
38-42	1
43-47	1
48 +	3

Birth place	
Bhutan	12
Nepal	2
Other country	0

Marital status	
Single	3
Married	10
Other	1

Number of children	
0	4
1-2	4
3-4	3
5 or more	2

Years of education	
0 -6	6

7-9	
10-12	6
Some college	2

Religion	
Hindu	14
Buddhist	0
Christian	0
Other	0

Years in America		Years in Utah	
Less than a year	2	Less than a year	6
1-5 years	12	1-5 years	8
6 or more	0	6 or more	0

Job	
Yes	10
No	4

Health insurance	
Yes	11
No	3

Type of Health insurance	
Self	0
Government/Medicare/Medicaid	9
Insurance from Job	3
None	2

Where do you seek care	
Intermountain healthcare clinics	2
University of Utah health care clinics	11
Community health clinics	0

The majority (n=11) Bhutanese women ranged in age from 18 to 47 and three woman were 49 and older. All of the women had spent 20 or more years in Nepalese refugee camps prior to being resettled in United States. Twelve women were born in Bhutan and two women were born in Nepal. Three women in the sample were single, one was a widow, and ten women were married. All three single women did not have any child. All married women had children

except for one recently married woman. Five women had one to two children, three women had three to four children and two women had five or more children. Four women had no formal education, two women had between one and six years of education, and six women between 10 and 12 years of education. Two women in the sample had some college education. All the women self-identified as Hindu. Most women had jobs (n=10), and four women did not have any jobs. Only three women had husbands that did not work because of ill health. Two women had been in the United States for less than a year; however the majority (n=12) had been living in the United States for one to five years. Only three women had lived in another state and recently moved to Utah for less than a year whereas one woman had come to Utah directly from Nepal about 4 months ago from the Nepalese camps. The majority (n=11) had some sort of health insurance whereas two women did not have any health insurance. The majority of women had government assisted Medicare and Medicaid for the health insurance whereas three women had health insurance at their work place. The majority (n=11) seek care at University health care clinics whereas two women seek care at Intermountain health care clinics and only one woman seeks care at St. Marks.

Investigator observations

The apartment complexes were two storied which opened to a common balcony. All of the apartments were very clean. A large plastic carpet could be seen on the living room carpet floor which was used for sitting purposes in most homes. I was offered tea in two homes and two families insisted that I join them for dinner. The majority of women were wearing their traditional dresses- Sari or Kurta, whereas a few women in 20s were in their trousers. Most of the women were always engaged in the kitchen in between conversations.

All the Bhutanese women were very polite and welcoming. They asked me to take a seat in the living room immediately. I explained the study and asked the women if they would like to participate in the study. As I am from Nepal, I was asked about my home town and other personal questions each time I visited a new family. This exchange of information again helped to build some trust. I asked the husbands if it was okay to talk to their wives about the study if they were present. The interview was conducted in the living room if woman was alone or in a separate room if there were other family members in the living room.

Common Themes

Knowledge about contraception and preferred contraception. "*From what we have seen with Bhutanese women, majority use Depo injection. I have heard a little about Copper T and Norplant on the arm."* Majority women knew about Depo Provera injection and referred to it as "Depo injection". Three women knew of the pill and referred to it as "tablet" and four knew of the implant referred as "Norplant". None of them talked about condoms. Some older women and one single woman said they did not know about contraception methods because they have never used it. During the conversation some women mentioned that they had received Depo Provera injection at the hospital after the delivery. Thus, it may have been used to space pregnancy. One woman who was recently married expressed that she and her husband are both focusing on studies, and did not want to have child for another two years. However, she said, "*I am not using any contraception now but my husband and I have an understanding. I know that it is not entirely reliable or sure. If I happen to be pregnant that does not really change anything, I am okay with it.*" She did not further clarify if understanding meant following natural family planning or safe periods. The breastfeeding women denied using any birth control currently. One woman who was using bottle feeding was using Depo Provera injection. Majority women

reported that they had breastfed for at least a year in the past. It was also evident from discussion that some women breastfed for at least a year and half and did not use any contraception methods. It seems they associate breastfeeding with contraception but some women sought for Depo Provera injection after the first menstrual cycle after they gave birth to a child. One woman said, I *have used Depo injection and I like it. I have not missed a dose. I have not had any problems of bleeding with it.* Another woman replied, "*I have used Depo injection in the past, and did not have any problems with it."* Currently, she was not using any contraception methods because her husband had a vasectomy after she had three girls. She further shared, *"Back in camps, most of my friends told me they used 3 or 5 year medication on the arm"* She had also heard about Copper T in the uterus but the implant on the arm was very popular. According to one woman, surgeries were very common in Nepalese camps for permanent family planning about five years ago. Most women, who received Depo Provera injection missed subsequent doses and became pregnant. Therefore, it was common to ask these women once they had two children at the hospital if okay to do surgery for permanent family planning. These surgeries caused many Bhutanese women to be weak, as they could not get healthy food in camps. Thus surgeries for permanent birth control were getting less common. Women referred to surgery as "operation" during the interviews; however they were unable to tell me more about the kind of surgeries.

Most women who were married and had children obtained information about contraception from the doctors and nurses whereas most single women obtained information from other married friends and women. "*In our culture, we talk among married women about contraception. Nobody uses any contraception prior to marriage.* One woman had received information on contraception and how to keep baby healthy in workshops in Maryland. "*In our*

culture, you don't talk as freely about contraceptives like here, especially when you are younger." Similarly another woman said, "*In camps, we had women's group where we discussed about contraception and spacing in pregnancy. In the hospitals, they would ask about if we wanted pills or injections or if we wanted to do operations* (surgeries)*."*

Family Size and composition. Family is one of the highest priorities among the Bhutanese women (Maxym, 2010). It is very common to see elderly parents live with their sons and daughter in law because younger generation are expected to take care of their older relatives (Maxym, 2010; Ranard, 2007). It is very important for the Bhutanese to have children, because children are expected to take care of their parents as they age. In Bhutanese culture, it is important to have a child after getting married. One woman said "*We came from remote part in Nepal; there is belief that you should have a child right after marriage. Everybody desires for a child after marriage."* The concept of being able to control family size is apparent in Bhutanese women. Majority reported that both husband and wife make decisions together about family size and contraception. Most women went with their husband for medical appointments as their spouse help with interpretation. Ideal family size varied from 2-3 for most Bhutanese women with a pregnancy spacing of 2-4 years in between. "*I have seen that in the past Bhutanese woman had children every year. Now they are much more aware. Some women like to have twins so they can raise them together or they have second child when first one goes to school."* Some women expressed they did not desire multiple children as both spouses have to work to support family and could not afford.

Menstruation rituals. Most women reported they follow the menstrual cycle ritual strictly. The women reported that they are considered unclean during their menstrual cycle and not allowed to do some daily chores such as cooking or praying. However, the degree of

strictness varied with each family. Some families were not as strict because of being in the US and other inconvenient circumstances, such as work schedules or nobody to help with daily chores. Absence of menstruation is considered unhealthy. *"It's not good if they don't get menstruation because their stomach gets big,"* Absence of menstruation caused by some contraception was considered unhealthy and problematic for some women. One woman said, "*My mother used Depo injection and she did not get menstruation for 8-9 months. She had excessive bleeding with her next menstrual cycle requiring blood transfusion.*" Similarly, another woman said, "*Depo injection causes you to acquire fat because the blood cannot come out."*

Beliefs and expectations on contraception. Contraception seems best understood by the Bhutanese women as preventing children after the ideal family size is met. No particular religious beliefs were expressed by women. Contraception is well accepted in the family and society. "Our *family, society and culture allow us to use contraception*." Another woman responded, *"My family was okay with us waiting two years to have our first child."* Most women expressed that husband and wife usually decide family size and contraception. *"We usually decide between husband and wife about how many children to have and what to do use for contraception."* However, a 49 year old woman said, "I *don't know how society views contraception now. However during my time, everybody believed that they should have children right away and men should do vasectomy."* The older Bhutanese women did not seem to have much knowledge about contraception methods as compared to younger women in 20s and 30s. Three women reported that they have never used any contraception methods but upon further probing they reported they have used Depo Provera injection in the past. Therefore, it seemed like some women did not recognize Depo Provera injection as a method of contraception.

It was evident from the interviews that Bhutanese women did not think it was proper or necessary to talk to single women about birth control methods. *"At hospitals, they ask unmarried women, "Do you have a baby? We are surprised to hear that."* Another woman said*, "It is good not to ask women that are unmarried if they use any birth control method."* The mother of one of the participant who was single said, "*Her daughter has never used any birth control methods, and it is not necessary to ask single women about birth control."*

Problems and side effects with contraception. A recently married woman expressed that she did not wish to become pregnant for another two years. However, she did not use any contraception methods because of the fear of infertility. "*I have heard about many side effects about those contraceptives. It causes you to become infertile. I have seen many Bhutanese women around us using them after they were married and they did not have child and are in stress because of no child."* Similarly, another woman quoted "*Younger women prefer Depo injection but older women disapprove of it because of the fear of infertility*." She added, "*We have seen some women not have any children after they started using Depo injection. My sister in law used Depo injection after first child, and she never got pregnant. Now she has an 18 year old daughter only."* She further added that she would like health care providers talk to them if this is true or not. *Other side effects caused by contraceptives are health problems. With the Depo injection, it stops the period, and sometimes there is no period for about 8-9 months.* She further reported, *"There are fat deposits possibly caused by trapped unclean blood inside.*

It was evident from discussion that women commonly used Depo Provera injection but did not receive subsequent injections. *"Some women use one form of contraception, and if they see side effect or find it problematic, they change into another method and this continues until they get tired with all the contraception methods. At the end, they have problems with all methods of*

contraception and do not use anything." Other comments about side effects included, "*Pills and Depo injection cause too many problems with bleeding."*

"*Usually Bhutanese women do not use any birth control until they have the first baby. They do not prevent the pregnancy. When they have the first baby they breastfeed for a year or half and do not use any birth control until they get the first menstrual cycle."* Three other women gave similar answers.

Most women reported that the doctors talked to them about birth control during prenatal and postpartum visits. However, one woman reported, " there were several barriers such as lack of language interpreters when needed, transportation barriers and lack of health insurance or paying out of pocket. Another woman expressed, "*I think the doctors should talk to Bhutanese women about prevention, and contraception, because some of the women do not know about the options, after having one or two children. We have to adapt according to the culture in United States, and when I look at the Bhutanese women here, I feel they would benefit if doctors would tell them about what contraception methods are available."*

Child birth experience. Most Bhutanese women refer to vaginal birth as "normal delivery" and cesarean delivery or any surgery as "operation". They prefer vaginal birth and do not prefer cesarean deliveries or operative deliveries. Most Bhutanese women agreed that birth was easier in the United States as compared to the camps, and easier in camp when compared to Bhutan. *"In Bhutan, the labor and birth was very hard because neighbors lived very far to come and help push baby out. In camp it was easy, because there were lot of neighbors that would come and help when labor started. They referred to local midwives as TBAs who were trained to help with labor at the camps. If labor was very hard, difficult, and if some women did not tolerate labor, they would go to the hospital.* Some common comments included "In *camps birth*

happened at home and TBAs were there. But later it was more common tradition to go to hospital for child birth once the labor started." Some of the comments included: "The child birth and delivery is much easier and better at the hospitals here." "In camps women were weak, did not have enough food or good living conditions." "In America, you just go to hospital when labor starts, and doctors and nurse do everything. I hear it is easy for labor because they give you injection on your back to help with labor pain". The three women who had given birth in the United States were pleased with their experience. *"Here you go to doctor every month when you are pregnant and go to hospital when labor starts."* Some women said that child birth in Bhutan was hard but prenatal care in camps was similar to care in the United States except for the pain medication during labor. They had to tolerate labor pain in camps. Only few women mentioned that the language barrier and lack of interpreter were few challenges during birth in the United States.

Summary of Findings

Birth control is a private matter for Bhutanese women. They are comfortable talking about pregnancy and other health issues instead of birth control. Contraception is known and accepted in Bhutanese culture. There are no religious prohibitions regarding contraception, however there is a lack of knowledge about contraception methods. Birth Control appears to be used only after Bhutanese women meet ideal family size. It was evident in the interviews that there is a cultural expectation that contraception is used by married women only and single women do not need any contraception. Depo Provera injection was the most common method of contraception but women did not consistently use it in timely manner. Women were hesitant to use contraception because of the concerns about menstrual side effects and fears about infertility. Most of the women agreed that they discussed among married women for contraceptive information. Most

women were exposed to birth control methods at the hospital after the birth of the first child. Long term contraception methods such as IUDs is not commonly used by Bhutanese women. Majority of women did not know about IUDs. Vasectomy was commonly preferred long term family planning method used in the Nepalese camps in the past. Some women responded with similar beliefs and experiences, strengthening the accuracy of the data.

Most women spoke of the difficulties of having children in Bhutan due to lack of access to medical care, and lack of nutritious food during pregnancy in the camps. Women were comfortable giving birth in the United States, happy with their prenatal and delivery care. They were pleased with the option of having no pain in labor. Barriers to birth control and other health care mainly included language and availability of interpreters.

Dissemination of Findings

The study findings were disseminated through a poster presentation at University of Utah among fellow Nurse Practitioner students and college of Nursing faculty. The study proposal has also been accepted for a presentation at the annual national convention of the American College of Nurse Midwives in Nashville, Tennessee. The study findings will also be disseminated nationally to the midwives in the convention on June, 2013. These findings will help health care providers recognize the contraceptive needs of this population and advocate for culturally competent health care at national level. Bhutanese Refugees are vulnerable populations and they need help learning about contraceptive options to ensure that couples can create healthy families with adequate spacing to fit their dreams.

Evaluation

Table 2: Evaluation Table

Project Objective	Evaluation of Objective

Comprehensive Literature Review	Completion and submission of literature review successful when approved by Capstone chair.
Meet with experts in the field and obtain their support.	A documented contract with content experts is considered a success.
Obtain IRB from University of Utah and partner with a faculty to conduct interview to identify the beliefs on contraception in Bhutanese refugee women.	Acceptance and approval of IRB will be considered a success. The summary of study findings after identifying common themes in interview transcripts will be considered a success.
Write a scholarly paper for publication	Acceptance and approval of scholarly paper by capstone chair and content experts will be considered a success.
Submit the proposal at Annual American College of Nurse Midwives (ACNM) convention in Nashville and present the findings. Submit the scholarly paper to Advance Practice Nursing Journal.	Acceptance and approval of study for presentation at ACNM convention will be considered a success. Documentation of scholarly paper submission to selected advanced practice nursing journal(s) will be considered a success. Publication and acceptance of article is not part of the project evaluation.

Limitations

The major limitations to this study included small sample size. It was difficult to recruit Bhutanese women for the study even when the investigator was from similar culture and spoke their language. Majority of the women did not have their own cell phone or home phone and depended on their spouses cell phones. Therefore, it was challenging to coordinate time with the Bhutanese women between their works schedules and other commitments. The lack of involvement of the community leader in the study and the sensitive nature of interview on birth control may have discouraged some women to participate in the study. Some women may have been hesitant to participate in the study because of the fear of confidentiality breach as Bhutanese community in Salt Lake City, Utah is fairly small.

The interview guide was very open-ended to encourage women to talk about their beliefs and experiences however, some Bhutanese women usually gave vague and short answers even for very broad questions. In addition, the women were more interested to talk about health concerns of their family and the health insurance issues and less about birth control questions. If the questions were very sensitive, they responded with "I don't know". It would be very beneficial to learn how to ask more specific questions or word questions differently without intimidating them.

Future Recommendations

Many gaps exist in the literature on contraceptive use in immigrant and refugee populations, in particular, Bhutanese refugee women. More qualitative studies on attitudes towards contraception in immigrant and refugee women should be carried out to enable development of culturally appropriate and accessible family planning services.
Bhutanese women minimally understand about different short term and long term birth control options. They are hesitant to use contraception because of concerns of side effects and

associated fears. It is evident from the study that women would benefit from education on long term contraception methods such as intrauterine devices. Women also need to be encouraged to discuss about side effects and fears with health care providers. Further research is needed about why Depo Provera injection is the most commonly used method despite the fear of infertility among Bhutanese women.

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Appendices

Appendix A: Demographic Questionnaire

Identification Code

Age

Country you were born: a. Bhutan b. Nepal c. other _____

Marital status: a. single b. married c. other

Number of children

Education Level:

a. grade school – 0 – 6 years b. 7 – 9 years high school 10- 12 years

c. some college more than 12 years

Religion: a. Hindu b. Buddhist c. Christian d. other_____

How many years have you lived in the United States?

Time in Salt Lake City

How many years have you lived in Salt Lake City?

Do you work outside the home? a. Yes b. No

Do you have health insurance of some sort? a. Yes b. No

If yes, what kind of health Insurance?

a. Private b. Public (Medicaid, Medicare) c. Insurance at Job d. others

Where do you seek healthcare?

a. Intermountain Health Care clinics b. University of Utah Healthcare clinics c. Community Health Center clinics d. others

Appendix B: Interview Guide

What are your major health concerns for yourself?

What are your major health concerns for your family?

What do you know about family planning methods?

What kinds of birth control methods do Bhutanese women like best?

What kinds of birth control methods are problematic for Bhutanese women?

What method of family planning are you using currently?

Why did you choose this method?

Does your religion and culture allow contraception?

How do family and friends view contraception?

Where do you get your information about birth control?

What are the barriers to getting birth control methods? (In the United States)

What do you like health care providers to ask you before providing birth control methods?

How can we help provide better care for you during pregnancy, childbirth, and postpartum period?