

Sadhee Sehayth (Our Health): Experiences of Punjabi Ancestry Canadians Living with Cardiovascular Disease

Cardiovascular disease (CVD) continues to be a concern for the public healthcare system as it is the leading cause of death among Canadian women and men, costing the healthcare system in excess of \$22 billion per year. For Canada's largest 'visible minority' community, CVD related deaths are decreasing at a significantly slower pace than their European ancestry counterparts (Yeolekar, 1998). South Asian (SA) ancestry Canadians experience CVD at a younger age; a 3-5 fold greater risk of premature death; and a higher risk of further coronary events (Joshi et al, 2007; Singh & Gupta, 2005). The lack of conventional risk factors (i.e. absence of high fat diets, smoking and high rates of obesity (Chiu, Austin, Manuel and Tu, 2010)) to explain the higher prevalence of CVD in SA communities, consequently has been identified as the SA 'paradox'. Findings that SA individuals were 70% less likely than other Canadians to report to emergency departments 3 hours after the onset of classic myocardial infarction symptoms, and typically waited more than 12 hours to seek help (King, Khan & Quan, 2009) suggests significant barriers to accessing emergency care. This proposed study uniquely aims to unpack the structural and institutionalized mechanisms operating within the Canadian healthcare system that may impede healthcare access by 'ethnic' communities, and limit healthcare equity. **Research Questions:** (1) What institutionalized mechanisms act as structural barriers and facilitators to accessing CVD healthcare? (2) What perceptions and experiences do healthcare providers negotiate while providing CVD healthcare? (3) How do various social determinants of health impact CVD healthcare access, and (4) How do Punjabi ancestry CVD patients consider, seek, access, value, utilize and experience cardiac health services? **Theoretical Approach:** Given the paucity of research regarding how SA ancestry communities experience CVD healthcare access - particularly how institutional mechanisms support or limit healthcare access - a qualitative approach will be used. The application of a critical perspective will inform the role of gender, culture and ethnicity, as well as "identifying structural forces that sustain uneven relations of power" (Anderson, Khan & Reimer-Kirkham, 2011). **Methods and Procedures:** Sample: SA ancestry Canadians comprise the largest 'visible minority' community in Canada, and India continues to be a leading source country for current and future projected migration. Census data from 2001 identifies almost a million Canadians as having SA ancestry, and locates major populations to reside in BC and Ontario. Given the population of Punjabi ancestry Canadians in BC, understanding the CVD healthcare access experiences of this community is essential in delivering universal and equitable healthcare. Data Collection: Utilizing purposeful sampling, semi-structured interviews with 5-8 cardiac healthcare providers will be conducted to explore barriers and facilitators to providing care. Observational field notes will be compiled from 3 cardiac oriented settings to observe facilitators/barriers to accessing information and healthcare. In-depth semi-structured interviews with 20-30 patients living with cardiac illness will be conducted in Punjabi/English to understand how Punjabi ancestry CVD patients experience CVD healthcare. Analysis: Critical Ethnography will anchor the qualitative analysis as it will go beyond conventional ethnographic methods that generally describe "what is", to reveal "why this is" and "what can be done about it" (Cook, 2005). Each digitally recorded interview will be translated, transcribed and accuracy checked. Data analyses will proceed with reading and rereading the interviews and field notes to identify patterns of theoretical relevance and thematic saturation using substantive coding, theoretical memoing and constant comparison approaches. Critical Ethnography will guide the coding of the data, using the qualitative software program: NVIVO 8™. **Contribution:** The data generated from this research project will (a) help bridge the existing gap in understanding how Punjabi ancestry British Columbians experience CVD and access services; (b) identify what institutionalized/structural barriers impede and support CVD healthcare access; and (c) contribute to understanding the wider South Asian CVD 'paradox'. Policy makers, clinicians, health educators and community members will benefit from a better understanding of structural barriers that impede health equity; and significantly impact healthcare policy and practice. With the mentorship and guidance of my supervisors, Dr [REDACTED] and Dr [REDACTED]; and committee member: Dr [REDACTED], I will design the research protocol; conduct data collection; theoretically informed analysis; write my dissertation; and complete knowledge translation activities (i.e. peer-reviewed articles, community based reports, and presentations).