Panjabi-Centred Design: Embracing Transgressive Liberation and Fostering Accessibility in Healthcare and Social Welfare for the Panjabi Communities

By: Imroze Singh Deol (ਇਮਰੋਜ਼ ਸਿੰਘ ਦਿਓਲ)

Submitted to OCAD University in partial fulfillment of the requirements for the degree of Master of Design in Inclusive Design

Toronto, Ontario, Canada, 2023

Abstract

This Major Research Paper (MRP) critically investigates the inadequate relationships between healthcare and social welfare organizations and Panjabi communities in Canada, exposing the colonial foundations that continue to perpetuate systemic marginalization. Present services fail to adequately address the long-standing presence of intergenerational trauma, community-driven practices, and language and access barriers. The provision of translated materials in Panjabi (Gurmukhi) constitutes a reactive approach that perpetuates the illusion of liberation, rather than offering comprehensive care. Despite strategic plans that profess to provide equitable healthcare for all, the Canadian healthcare and social welfare systems remain entrenched in deeply rooted colonial practices that oppress marginalized voices.

This MRP presents the Panjabi-Centred Design (PCD) Framework, a culturally-responsive approach that confronts the unique needs and experiences of the Panjabi diaspora within the Canadian healthcare and social welfare systems. By fusing traditional Panjabi values and practices with contemporary design methodologies, the PCD Framework strives to cultivate equity, inclusivity, and well-being for Panjabi communities. The research emphasizes the importance of contemplating factors such as intergenerational trauma, generational family structures, and language barriers in devising proactive solutions while advocating for the dismantling of prevailing reactive and half-measured approaches.

The PCD Framework ultimately aspires to achieve transgressive liberation for Panjabi communities and other marginalized populations by contesting colonial practices, holding healthcare authorities accountable, and nurturing community engagement and empowerment.

Land Acknowledgement

This project explores the impact of silenced histories and forced displacement upon marginalized communities. The paper also references Indigenous, Black, and Sikh-Panjabi authors and frameworks of knowledge. As such, it is essential to initially acknowledge the land where the Ontario College of Art and Design resides, and where this work transpired.

As a settler of Sikh-Panjabi heritage and an immigrant, I am a guest on the traditional territory of numerous nations, including the Mississaugas of the Credit, the Anishnabeg, the Chippewa, the Haudenosaunee, the Wendat peoples, and the unceded traditional territories of the xʷməθkʷəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish), səlilwətaɬ (Tsleil-Waututh) Nations, and Stó:lō people. This gathering place remains home to many Indigenous individuals from across Turtle Island. I am grateful for the privileges and opportunities afforded to me by living and working on this land. Beyond land acknowledgments, I recognize that much work remains in dismantling colonial frameworks and challenging white supremacy.

Acknowledgment

ਬਾਬਾਣੀਆ ਕਹਾਣੀਆ ਪੁਤ ਸਪੁਤ ਕਰੇਨਿ ॥

The stories of ancestors nurture virtues in children. – Guru Amardas Ji, Guru Granth Sahib, 951

This paper is a testament to the innate struggle and unyielding resilience embedded by my Vadde Mumma, ਕੁਲਦੀਪ ਕੌਰ (Kuldeep Kaur), and my Bijji, ਗੁਰਬਚਨ ਕੌਰ (Gurbachan Kaur), into my mother, ਗੁਰਸ਼ਰਨ ਕੌਰ (Gursharn Kaur), and my father, ਪ੍ਰਿਤਪਾਲ ਸਿੰਘ (Pritpal Singh). I cherish the unwavering support from my sister, Anish Kaur.

Manvinder Kaur Gill, you guided me in my pursuit of passion and helped me recognize the love within my own people, even when they were blind to it. My gratitude extends to Dr. Sharanjit Kaur Sandhra and Karin Jager for inspiring me to chase my dreams, despite moments of self-doubt. Sarah Ciurysek's photography class will forever be dear to my heart, as it taught me to love my community through my work.

I am deeply grateful to Dr. Michelle Wyndham-West for her guidance, immense support, and thorough edits, even when the time was scarce. In moments of nervousness, when I would check Google Docs, your comments and words gave me the courage to persevere. I thank my dear friends, and cohort & the faculty of inclusive design for lending their ears as I attempted to clarify my unhinged and scattered thoughts.

Finally, I acknowledge and honour my ancestors and the sacrifices they made. Without them, I could not stand tall and walk with ਅਣਖ (sense of honour).

ਇਨਕਲਾਬ ਜ਼ਿੰਦਾਬਾਦ (Long live the revolution)

Table of Content

Introduction

In the words of my father, "Nobody intentionally seeks to abandon their home." This phrase has been a wellspring of inspiration for my research journey. I immersed myself in dialogues with specialists caring for Panjabi communities throughout Canada, examining the obstacles they confront when seeking healthcare and social welfare information. To build a comprehensive care framework, my work interlaces multiple themes, aiming to dismantle piecemeal solutions and establish a blueprint for healthcare and social welfare systems. Recognizing that frameworks become obsolete without ongoing assessment of power dynamics and feedback, my research attempts to remain adaptive.

The pioneering Panjabi-Centred Design (PCD) framework aspires to offer holistic guidance for healthcare and social welfare institutions, attending to the distinct requirements of the Panjabi diaspora in Canada. This MRP[1] embarks on an exploration of the multifarious challenges faced by Panjabi communities, such as intergenerational trauma, generational family structures, and language barriers, while concurrently illuminating the inadequacy of Canadian healthcare and social welfare systems in recognizing and addressing these matters. By scrutinizing the reactive, superficial approach frequently employed by healthcare services, this research exposes existing strategy limitations, emphasizing the need for a more all-encompassing and culturally-sensitive method.

In the opening chapter, we present an in-depth narrative of the background and historical context of the Panjabi diaspora in the West, with a particular focus on factors contributing to the immigration and displacement of Panjabi communities. This chapter aims to provide an

[1] MRP- Major Research Paper

understanding of the enduring presence of the Panjabi diaspora in Canada and the contemporary state of the Panjabi language within the diaspora.

Chapter Two investigates present gaps and practices in healthcare and social welfare organizations that serve Panjabi communities. We delve into themes such as colonization and its impact on the Panjabi diaspora, colonial practices in Canadian healthcare, knowledge dissemination and language translation, gender dynamics, Google Translate usage, and insights gathered from consultations with Subject Matter Experts (SMEs) intimately engaged with Panjabi communities, including family doctors, nurses, counsellors, project managers, and executive directors.

Chapter Three scrutinizes various inclusive design approaches that possess the potential to address the concerns raised in Chapter Two. These approaches encompass decolonization, emerging inclusive practices, extant Panjabi community practices, co-design practices, trauma-informed and cultural safety initiatives, and the utilization of plain language for public health communication.

The concluding chapter unveils the Panjabi-Centred Design Framework, synthesizing the concerns articulated in Chapter Two with the inclusive methodologies discussed in Chapter Three. Inspired by the works of Professor Puran Singh, bell hooks and Paulo Freire, we delineate the overarching aim of the PCD framework, which is transgressive liberation, and offer specific implementation guidelines, including translation principles. Ultimately, this MRP aspires to enrich the development of a more just and inclusive healthcare and social welfare system that genuinely caters to the needs of the Panjabi diaspora and other marginalized communities in Canada.

Franz Fanon's poignant words in *The Wretched of the Earth*, "The colonized, often silenced and voiceless, find refuge in dreams..."[2] reveal the vital necessity for the Panjabi diaspora not only to assert their voice but also to demand a meaningful impact. My research cultivates a framework that transcends mere recognition and, instead, situates the Panjabi narrative at its core.

Furthermore, I wish to acknowledge my positionality as a researcher and the inherent power disparity that inevitably arises during the consultation sessions. My professional background as a community interpreter, bridging the Panjabi language in hospitals and various social settings, combined with my ongoing lived experience as a privileged immigrant, contributes modestly to an ever-expanding conversation surrounding knowledge dissemination and language translation challenges. It is my hope that this work fuels further inquiry and critical examination.

Chapter One: Context

In the words of Paulo Freire, education is not a neutral act; it is a political act[3]. The act of educating oneself and others is always situated within a particular social, cultural, and political context, and it is inextricably linked to power relations. In the context of healthcare and social welfare, access to information and knowledge is often unequally distributed, and those who are marginalized or oppressed often have limited access to the resources they need to make informed decisions about their health and well-being.

[2] (Fanon, 2004)
[3] (Freire, 2000, 19)

This is especially true for the Panjabi[4] diaspora in Canada, who face a range of social, cultural, and linguistic barriers that prevent them from accessing the healthcare information they need. In order to address these barriers, it is necessary to develop a framework that centers on the needs of the Panjabi community and takes into account the complex intersectionalities that shape their experiences.

Panjabi-Centred Design (PCD) is one such framework, which seeks to provide accessible healthcare and social welfare information to the Panjabi diaspora in Canada. This framework is grounded in the understanding of the existing gaps in Canada's healthcare knowledge dissemination and linguistic translation models, as well as the ways in which language barriers, cultural practices, intergenerational trauma, gender roles, and faith practices shape the experiences of Panjabi Canadians.

The purpose of this research is also to explore the challenges facing the Panjabi community in accessing healthcare information, and the ways in which second and third generations can play a role in facilitating accessibility. By developing a framework that is rooted in the experiences and needs of the Panjabi community, this research aims to create a more equitable and just healthcare system in Canada, one that truly centers the needs of all Canadians, regardless of their social, cultural, or linguistic background.

In a world witnessing the rapid proliferation of diversity, it becomes imperative to identify and confront the obstacles that hinder non-English speakers from accessing critical healthcare and social welfare information. Among these marginalized groups are the Panjabi diaspora in Canada, who grapple with immense challenges when navigating the labyrinthine

[4] ‘Panjab’ is a colonized rendition of the word. The British spelt 'Panjab' as such to pronounce the 'u' as a long vowel, such as the 'u' in the word 'lure.' This distastefully and indolently delineates from the native pronunciation. (Kaur, 2023)

systems of healthcare and social welfare due to linguistic and cultural constraints. Despite recent diversity initiatives aiming to promote inclusion and bridge the gap in healthcare access, the systemic transformation essential for improving care for marginalized and immigrant communities, such as the Panjabi population, remains elusive.[5]

A burgeoning body of research underscores the enduring disparities within the Canadian healthcare system for immigrant and minority populations.[6] One study reveals that these communities persist in confronting inadequate access to healthcare services owing to language barriers, cultural differences, and a scarcity of culturally competent providers.[7] Another investigation emphasizes the significance of language proficiency in accessing healthcare, as non-English speakers report heightened difficulties in comprehending and articulating their health needs.[8]

Although diversity initiatives have broadened in scope, including the implementation of translation services and cultural competency training for healthcare providers.[9] These endeavors have yet to manifest in tangible systemic changes that improve care for marginalized and immigrant communities. According to a report by the Canadian Institute for Health Information (CIHI), health equity demands further scrutiny and targeted interventions.[10] This holds particularly true for immigrant populations like the Panjabi diaspora, who continue to face challenges in accessing culturally appropriate and linguistically accessible healthcare services.

[5] (Bauer, 2014)
[6] (Hankivsky et al., 2014)
[7] (Bauer, 2014)
[8] (Koehn, 2009)
[9] (Karliner et al., 2012)
[10] (Canadian Institute for Health Information, 2016)

While progress has been made in fostering diversity and inclusion within the Canadian healthcare system, a considerable amount of work remains to dismantle the systemic barriers faced by marginalized and immigrant communities, such as the Panjabi population. Researchers and policymakers must persist in addressing these disparities and collaborate to devise interventions that effectively cater to the unique needs of these populations.[11]

It is imperative that we center the needs of communities when developing resources, particularly in relation to healthcare and welfare. This is especially true for the Panjabi diaspora, a community that has been present in Canada since 1897[12] and whose population is rapidly growing according to the 2021 census[13]. It is crucial that we acknowledge and honour the significant contributions that Panjabi diaspora members have made to Canadian society in various domains such as the economy, politics, and history.

But even with the long presence of the Panjabi diaspora in Canada, the community members continue to be exposed to challenges in healthcare and social welfare. "In reviewing the research of immigrants' health care experiences, the most common access barriers were found to be language barriers, barriers to information, and cultural differences. These findings, in addition to low cultural competency reported by interviewed health care workers in the reviewed articles, indicate inequities in access to Canadian health care services for immigrant populations."[14]

The language of equity, diversity, inclusion (EDI), and diversity, equity, and inclusion (DEI) is frequently evoked by those in positions of power and authority when addressing the needs of marginalized communities such as the Panjabi diaspora. However, it is essential to

---

[11] (Setia et al., 2011)

[12] Kesur Singh, a Risaldar Major in the British India Army, being the first Sikh settler in Canada, who arrived in Vancouver as early as 1897. (Agnihotri, 2015)

[13] According to 2021 Canadian Census, More than half a million people speak predominantly Mandarin or Panjabi at home in Canada (Statistics Canada, 2022)

[14] (NewsRX LLC, 2016, 3161)

recognize that mere lip service to these concepts is insufficient[15]. The lived experiences of the Panjabi diaspora and their unique cultural and linguistic needs must be at the forefront of all efforts to support and care for them.

It is heartening to note that in Panjabi-dense areas such as Surrey, B.C., Edmonton AB, Winnipeg MB, and Brampton ON, there has been a proliferation of Panjabi healthcare practitioners, workers, and community organizations. Organizations like PCHS[16] in Brampton, Ontario and PICS[17] in Surrey, B.C. that serve the Panjabi diaspora are great examples of that. These developments have undoubtedly provided vital assistance to the Panjabi diaspora, but it is vital to acknowledge that these care providers cannot be with individuals at all times.

In the spaces, where the need is most acute, they are often forsaken. Toronto hailed as the emblem of diversity in the Canadian tapestry, revealed disheartening truths in 2021. A CBC exposé illuminated the dark reality of a city with over 700,000 inhabitants in the Greater Toronto Area, grappling with a COVID-19 test positivity rate of 22.7 percent between April 18th and 24th (2021), according to Peel Region Public Health, including Brampton. This eclipses Ontario's highest daily test positivity rate during that same interval, peaking at 10.5 percent on April 19th.[18] The COVID-19 pandemic laid bare the fissures in Canada's healthcare system, disproportionately impacting areas with dense immigrant populations. Brampton, a haven for a sizable South Asian immigrant community and essential workers who fuel Canada's economic engine— from manufacturing to warehousing to meatpacking and grocery clerks—felt the brunt

[15] (Dreachslin et al., 2013)
[16] PCHS - Panjabi Community Health Service is a Brampton based not-for profit, charitable, accredited and a health service provider organization.
[17] PICS - Progressive Intercultural Community Services Society, provides a variety of comprehensive programs and services to assist new and recent immigrants in British Columbia.
[18] (CBC Radio, 2021)

of the crisis.[19] In cities like Brampton, where essential labor and low-income residents abound,[20] the impact was devastating. Gurinder Singh Khehra, a Brampton resident infected with COVID-19 following an outbreak at his wife's workplace, lamented, "I'm very sorry to say that our government treated us like a third world."[21]

Nevertheless, there are resources available, such as pamphlets, brochures, web links, web docs, and app suggestions, that can assist individuals in managing their own health and increasing their self-efficacy[22]. It is our collective responsibility to ensure that these resources are culturally and linguistically appropriate, easily accessible and designed with the well-being and empowerment of the Panjabi diaspora in mind.

In the pursuit of self-management, it is essential, to begin with, lived experiences[23] and the recognition of emerging gaps in the dissemination of healthcare and welfare information. As a community interpreter and design researcher, I have witnessed firsthand how the cultural and religious practices of the Panjabi diaspora impact access to healthcare. The existing knowledge dissemination and translation & interpretation services fail to factor in the nuanced effects of the language barrier, and cultural practices, leading to misunderstandings, low self-efficacy rates, and the spread of misinformation. This situation results in a lack of trust from the Panjabi communities in the Canadian healthcare system.

Despite the awareness of healthcare providers, practitioners, and community service organizations about the negative impacts of poorly translated materials, there is still a view that the Panjabi diaspora exists in a static, stereotypical state of pleasantness. The solutions provided

[19] (CBC Radio, 2021)
[20] (Pelley, 2021)
[21] (CBC Radio, 2021)
[22] (Doi-Kanno et al., 2021)
[23] Dr. Kathryn Birnie suggests that lack of inclusion of lived experience, and the broader social context is isolated in knowledge generation and its implementation. (Brine, 2021)

are often one-size-fits-all, which proves harmful to the Panjabi diaspora's unique needs and ever-changing nature. As Stuart Hall[24] reminds us, identity is a never-completed process of becoming, and as such, the healthcare authorities and community service organizations must acknowledge and come to terms with the changing needs of the Panjabi diaspora.

Inclusive methodologies involve centring the experiences and voices of marginalized communities, challenging dominant power structures, and creating spaces of possibility for transformative learning. In the context of healthcare, this means understanding the cultural and linguistic nuances that impact access to care and creating solutions that meet the unique needs of the Panjabi diaspora. Only then can we move towards a more equitable and just healthcare system that honours and respects the full humanity of all communities.

In considering the struggles faced by the Panjabi diaspora in accessing healthcare information, it is important to acknowledge the profound impact that trauma and displacement have had on this community. For many Panjabi people, the experience of being uprooted from their homeland and forced to migrate to Canada has left deep emotional scars that continue to reverberate through their lives. In addition to the challenges posed by language and cultural differences, the Panjabi diaspora must contend with the stigma and taboos that often surround mental health issues, making it even more difficult for them to access the care they need.

When attempting to translate healthcare materials for this community, it is crucial to take into account the nuances of language and culture that can so easily be overlooked. The usage of Google Translate with healthcare and social welfare authorities is a reactive approach that fails to consider the importance of proper usage of correct terms, gender, and tone. The utilization of technology to address the complex issue of language barriers is a superficial solution that is

[24] ("Cultural Identity and Diaspora," 2018)

counterproductive to the goal of providing comprehensive and equitable services. The language used in healthcare and social welfare settings often requires a nuanced and precise understanding of terms, which can vary based on cultural, social, and regional contexts. The limitations of Google Translate are further amplified by the machine's inability to consider gender and tone, both of which are integral aspects of effective communication. The absence of these key elements can lead to confusion, misunderstanding, and even mistrust, creating an environment that is not conducive to establishing positive and meaningful relationships between providers and patients. It is crucial that healthcare and social welfare authorities prioritize the development of programs that prioritize the hiring of professional interpreters, who possess the cultural knowledge, linguistic competency, and emotional intelligence necessary to facilitate effective communication. Such an approach is necessary to ensure that individuals receive comprehensive and equitable services that respect their cultural and linguistic differences.

The older adults of the Panjabi diaspora in Canada have been known to maintain a strong attachment to traditional media outlets such as radio, television, and news. These media outlets hold a great deal of significance in their lives as they provide a sense of familiarity and comfort in a foreign land. It is through these outlets that they are able to stay connected to their culture and community. Older adults find these traditional media sources to be a reliable means of consuming content, as they are often not as proficient in using technology and prefer the simplicity of these traditional media outlets. However, the younger generation of the Panjabi diaspora in Canada has embraced technology and web-based platforms, using them to access healthcare and social welfare information. This often puts leaves the younger generation in the role of facilitating access to information for older adults.

Despite the clear generational differences in the modes of consuming information within the Panjabi diaspora, the Canadian healthcare system's knowledge dissemination strategies do not factor in these unique attributes. There is a lack of recognition of the value that traditional media holds in the lives of older adults. The healthcare system's reliance on web-based platforms may lead to a significant gap in the provision of healthcare services to this group. The failure to recognize and value the cultural differences that exist within our communities is a failure to truly serve those communities. Therefore, it is essential for the Canadian healthcare system to recognize and value the importance of traditional media outlets for older adults and the role of younger adults in the Panjabi diaspora and to incorporate them into their knowledge dissemination strategies. This would ensure that healthcare services are accessible to all, regardless of their generational differences in accessing information.

If we are to truly serve the needs of the Panjabi diaspora, we must move beyond a one-size-fits-all approach to healthcare translation and embrace a more nuanced and culturally sensitive perspective. This requires a deep understanding of the historical and cultural context in which this community exists, as well as a commitment to listening and responding to the unique needs and challenges faced by Panjabi patients. By doing so, we can begin to build a healthcare system that truly serves the needs of all Canadians, regardless of their background or identity.

Panjabi diaspora communities often face significant barriers to accessing healthcare in their new countries.[25] This is particularly true for those who struggle with language barriers, which can make it difficult to communicate with healthcare providers and understand medical information. Moreover, Panjabi individuals and communities may experience discrimination or prejudice in healthcare settings, which can further complicate their ability to access adequate

[25] (Turin et al., 202)

care. Therefore, it is crucial to understand the complex histories and experiences of the Panjabi diaspora and to work to address the barriers that prevent them from accessing the healthcare they need.

1.1 Panjabi Diaspora:

In examining the Panjabi diaspora, it is important to acknowledge the historical and linguistic contexts that have shaped its emergence and evolution. British colonialism and more recent global economic and political forces have contributed to the displacement and fragmentation experienced by diaspora communities. As William Mude notes, this displacement often leads to a complex negotiation of identity and cultural practices[26] as individuals seek to maintain connections to their heritage while navigating new cultural contexts.

It is also important to recognize the diversity of experiences and identities within the Panjabi diaspora, as individuals negotiate their sense of self and belonging within the intersection of multiple factors such as race, class, gender, and national identity. By understanding the complexity and nuance of the Panjabi diaspora, we can better appreciate the challenges and opportunities faced by individuals and communities within this diverse and dynamic phenomenon.

The Panjabi diaspora has a long and complex history, shaped by political, economic, and social factors. As a result of colonialism, globalization, and migration, Panjabi individuals and communities have dispersed throughout the world, from North America to Europe to Southeast Asia. However, the experiences of Panjabi diaspora communities in different parts of the world

[26](Amoah & Mwanri, 2014, 127-133)

are not uniform and are shaped by a variety of factors such as race, class, gender, and national identity.

Rooted in a rich and multifaceted history, the Panjabi diaspora embodies diversity and complexity. Spanning the globe, Panjabi people have migrated to places like North America, Europe, and Southeast Asia due to forces such as colonialism, globalization, and migration[27] [28]. Yet, their experiences are not uniform, as they are influenced by race, class, gender, and national identity.

Grasping the intricacies of the Panjabi diaspora allows us to better understand the challenges and opportunities individuals and communities face within this dynamic phenomenon. For example, the intersectionality of race and ethnicity significantly impacts the Panjabi diaspora's experiences with discrimination, racism, and identity formation[29]. Furthermore, class distinctions shape migration patterns, access to resources, and social mobility within the Panjabi diaspora.[30]

Gender also plays a critical role in shaping the experiences and identities of Panjabi diaspora communities. The interplay between gender and cultural norms profoundly affects women's roles, expectations, and experiences within the diaspora.[31] Likewise, national identity contributes to a sense of belonging and integration into host societies, as individuals navigate multiple identities and negotiate their place in the broader cultural landscape.[32]

[27] (Tatla, 1999)
[28] (Dusenbery & Tatla, 2009)
[29] (Purewal & Kalra, 2010)
[30] (Dhanda, 2014)
[31] (Brah, 1996)
[32] (Ebaugh, 2000)

By delving into the diverse factors that influence the experiences and identities of the Panjabi diaspora, we can gain a deeper appreciation for the challenges and opportunities faced by individuals and communities within this complex phenomenon. This understanding can, in turn, guide the development of culturally responsive and inclusive policies, practices, and interventions that cater to the unique needs and aspirations of the Panjabi diaspora.

1.2 Historical Context - Immigration and Displacement:

During the period spanning from 1903 to 1908, the Sikh population in British Columbia, Canada experienced a noteworthy upsurge from a meagre 300 individuals to an impressive 5,000.[33] Simultaneously, Sikh immigrants began settling in California around 1899.[34]

In 1914, the infamous Komagata Maru incident transpired, wherein a vessel travelling from India to Vancouver remained moored for 62 days.[35] Eventually, the vessel was compelled to depart. The 376 passengers[36] aboard the ship, many of whom were of Sikh origin, were denied entry into Canada due to the perceived threat of contagious illnesses. Upon their return to India, a considerable number of surviving passengers were arrested and detained under the directives of British colonial authorities.[37]

One important distinction within the Panjabi diaspora is between the East Panjabi diaspora, which is primarily located in Pakistan, and the West Panjabi diaspora, which is primarily located in India. The Panjabi diaspora is a cultural and social phenomenon that has been shaped by a history of displacement, civil unrest, genocide, and constant oppression from

[33] (Johnston, 2006, 141)
[34] (Miller, 2020)
[35] (Johnston, 2006)
[36] Ibid
[37] Ibid

the State. The East Panjabi diaspora is characterized by the legacy of the Partition of India in 1947, which resulted in the creation of Pakistan as a separate country for Muslims.[38] This traumatic event led to the displacement of millions of people, including Panjabis, who were forced to migrate across the newly created border. The legacy of this violence and displacement continues to shape the experiences of East & West Panjabi diaspora communities, who often maintain a connection to their ancestral land and culture.

Also, the West Panjabi diaspora is characterized by the ongoing conflict between India, as well as the legacy of Sikh-Panjabi in the 1980s [39] and 1990s [40]. This has led to a complex set of relationships between Panjabi communities in India and those in other parts of the world, as well as a diverse range of political and social identities.

The diaspora was formed following the partition of India in 1947, which resulted in the displacement of millions of people along religious lines. This traumatic event had a lasting impact on the East Panjabi community, as families were torn apart and forced to leave their homes and belongings behind.

The year 1984 was a turning point for the East Panjabi community, as it marked the beginning of a period of civil unrest and violence that would last for several years. In June of that year, the Indian government launched Operation Blue Star, a military operation aimed at flushing out Sikh militants who had taken refuge in the Golden Temple in Amritsar. The operation resulted in the deaths of thousands of people, including innocent civilians, and sparked a wave of violence and retaliation across the region.

[38] (Talbot, 2019, 7-25)
[39] (Jodhka, 1996, 273)
[40] (Chima, 2014, 258–290)

Following the events of 1984, the East Panjabi community continued to face discrimination and oppression from the Indian state. The government's response to the civil unrest included the use of extrajudicial killings, torture, and disappearances. In addition, the state-sponsored drug epidemic that began in the 1980s had a devastating impact on the community, contributing to high rates of addiction and HIV/AIDS.

The harmful effects of the green revolution in East Panjab have also had a lasting impact on the community. The introduction of high-yielding crop varieties and chemical fertilizers led to increased agricultural production but also had negative consequences for the environment and public health. The intensive use of fertilizers and pesticides led to soil degradation and water pollution, while the high levels of pesticide use were linked to a range of health problems among farmers and their families.

It is also important to understand the intersectionality of Panjabi as a language that exists in East & West Panjab. Language plays a pivotal role in shaping culture and identity, and the Panjabi language is no exception. However, the differences and use of Panjabi in East and West Panjab are often overlooked, with many people unaware of the linguistic nuances that exist between the two regions. This lack of recognition can lead to a lack of appreciation for the rich diversity of the Panjabi language and the cultures it represents.

Diasporic identities are comprised of a panoply of diverse cultures... (which) are inherently imbricating and cannot be disengaged from each other'.[41] Language is a crucial component of cultural identity and heritage, and the Panjabi language is no exception. Despite differences in dialect, script, and vocabulary, there are striking similarities between the Panjabi spoken in East and West Panjab, reflecting the enduring legacy of a shared cultural history.

[41](Taylor et al., 2007)

One of the most remarkable features of Panjabi is its tonality, which imbues the language with a lyrical and melodic quality. This tonality is shared between East and West Panjabi, with both dialects utilizing changes in pitch to convey meaning. Additionally, the use of shared vocabulary and idiomatic expressions is evident, further underscoring the linguistic similarities between the two regions.

Although there are differences in the pronunciation and grammar of the two dialects, these differences do not fundamentally alter the essence of the language. Instead, they serve to enrich and diversify the ways in which Panjabi can be expressed, offering a glimpse into the cultural diversity and richness of the language. It is important to note, however, that despite these linguistic similarities, there are also significant differences between the two regions. These differences arise from a complex interplay of historical, political, and cultural factors, which have shaped the linguistic and cultural landscape of East and West Panjab. This diasporic group can be seen as part of a wider 'transnational community' - 'groups based in two or more countries that engage in recurrent, enduring and significant cross border activities, which may be economic, political, social or cultural in character'.[42]

However, it is important to recognize that the Panjabi diaspora is not a monolithic entity, and the experiences and identities of Panjabi individuals and communities in different parts of the world may vary greatly. As Hall writes, diaspora identities are constantly being negotiated and re-negotiated,[43] shaped by the intersection of multiple factors such as race, class, gender, and national identity. Therefore, it is crucial to understand the Panjabi diaspora as a diverse and dynamic phenomenon that is constantly evolving.

[42] (Castles, 2003, 13-34)
[43] ("Cultural Identity and Diaspora," 2020)

Nevertheless, by recognizing the similarities and differences between the two dialects, we can better understand the complex and multifaceted nature of the Panjabi language and culture. Moreover, by celebrating the rich and diverse heritage of Panjabi-speaking communities, we can foster a greater understanding and appreciation of the enduring legacy of Panjabi culture, both in East and West Panjab and across the Panjabi diaspora. We need to acknowledge and celebrate the linguistic diversity of Panjabi and recognize the differences that exist between the dialects of East and West Panjab. By doing so, we can promote a greater appreciation of the unique cultures and identities of Panjabi-speaking communities. Moreover, we can work to address the ignorance and lack of recognition that often hinders cross-cultural communication and understanding, both within and beyond the Panjabi diaspora.

Regardless of these distinctions, however, the Panjabi diaspora as a whole is characterized by a sense of displacement and fragmentation, as individuals and communities navigate the challenges of living in new cultural contexts while also maintaining a connection to their homeland and heritage. This can manifest in a variety of ways, such as maintaining traditional customs and practices, participating in community organizations, or engaging in transnational political and economic networks.

1.3 Present Day - Diaspora:

The growth of the Panjabi diaspora in Canada is a phenomenon that has captured the attention of scholars and policymakers alike. According to the 2021 Canadian Census, Panjabi speakers constitute the third largest linguistic group in the country, after English and French.[44] The census

[44] (Singer, 2019)

data also reveals that Panjabi is the most widely spoken language in the province of British Columbia, and is the third most common language in Ontario.[45]

The Panjabi diaspora in Canada has been growing steadily since the 1970s,[46] when the Canadian government began to actively encourage immigration from South Asia. Today, Panjabi Canadians are one of the largest and most successful ethnic groups in the country. They have made significant contributions to Canada's economy, culture, and society.

The 2016 census data shows that the Panjabi population in Canada has grown by over 40% in the past decade. This growth can be attributed to a number of factors, including increased immigration, higher birth rates, and improved integration into Canadian society. The vast majority of Panjabi Canadians are concentrated in the provinces of British Columbia and Ontario, with smaller communities in other parts of the country. In Halifax, Panjabi immigration is a relatively recent phenomenon, with many Panjabi families settling in the city in the 1990s and 2000s.[47] Today, the Panjabi community in Halifax is small but growing, with a vibrant cultural scene that includes food festivals, music concerts, and other events celebrating Panjabi culture.

The Panjabi community in Canada is known for its strong sense of cultural identity and its commitment to preserving the Panjabi language and culture. Many Panjabi Canadians are bilingual or multilingual and are able to navigate between different cultural and linguistic contexts with ease. This ability to adapt to new environments has made them an integral part of Canadian society. The settling of Panjabi immigrants and diaspora around Sikh and Hindu temples and places of worship is a phenomenon that speaks to the importance of community and

[45] (Statistics Canada, 2022)
[46] ("The Panjabi Diaspora in Canada: Listening to the Voices of the Diasporic Panjabi Seniors in Canada," 2008, 13–53)
[47] (Bierman et al., 2012, 111-117)

culture in the immigrant experience. It is through community that immigrants are able to find support, resources, and a sense of belonging in a new and often unfamiliar environment.

In the East Panjabi region of Pakistan and the West Panjabi region of India, a diverse array of religions and faiths are practiced, reflecting the region's rich cultural history and pluralistic society. Among the most prominent faiths in the region are Sikhi[48] [49], Hinduism, and Islam.

As Panjabi immigrants have settled in Canada, they have brought their religious traditions and practices with them. In cities such as Toronto and Vancouver, Sikh temples, Hindu temples, and mosques have become increasingly common, reflecting the growing diversity of Canada's urban landscape. These institutions serve not only as places of worship but also as centers of community life, providing social, cultural, and educational opportunities for Panjabi Canadians and other members of the community.

The rise of these religious institutions in Canada reflects the ongoing importance of faith and spirituality in Panjabi culture, and the enduring importance of community ties in shaping individual and collective identities. As Professor Puran Singh has noted in his work on the intersection of spirituality and social justice, faith[50] can serve as a powerful force for personal and social transformation, enabling individuals and communities to connect with deeper truths and values and to build more just and equitable societies. In the Panjabi context, these values are

[48] The word 'Sikh' comes from the Panjabi verb 'Sikhana', meaning 'to learn'. Thus a 'Sikh' is one who learns. The term 'Sikhi' as opposed to 'Sikhism' implies a continuous state of learning and engagement, rather than a box into which people can be placed. Sikhi is not an 'ism', it is a way of life. (Mandair, 2013, 5)

[49] The term 'Sikhism' is a Western term coined by Europeans during the nineteenth century. The term Sikhism like Hinduism is not indigenous to the Indian lexicon. (Oberoi, 1994, 342)

[50] Professor Puran Singh in the Spirit Born People says that (one) disciple dies when this spark of life is extinguished. The disciple is in aching struggle to keep this flame burning. His lungs breathe the moral spirit of the spiritual universe, and his eyes see what those around him do not see. His attitude undergoes a revolutionary transformation. (Singh, 2017, 77)

reflected in the rich tapestry of faith, traditions and practices that continue to shape the lives of Panjabi Canadians and others around the world.

For Panjabi immigrants and diaspora, the establishment of neighbourhoods around Gurduaras, Hindu temples and places of worship has been an important means of building community and preserving cultural traditions. These neighbourhoods are often characterized by a strong sense of communal identity, with residents sharing a common language, religion, and cultural heritage. Surrey, Vancouver, Abbotsford in British Columbia, Edmonton & Calgary in Alberta, and Brampton, Ontario are great examples of the Panjabi diasporic neighbourhoods.

The significance of these neighbourhoods can be seen in the way they function as social and cultural hubs for the Panjabi community. They provide a space for community gatherings, religious ceremonies, and cultural celebrations. They also offer a range of services, from language classes and cultural events to social and welfare programs.

But the Panjabi psyche is deeply impacted by the experiences of pre-immigration trauma, the process of immigration itself, and post-immigration trauma, all of which are transmitted through generations. Pre-immigration trauma refers to events that occur prior to migration force an individual to leave their homeland. For example, the events of 1984 forced many Sikh-Panjabis to flee India due to the fear of persecution. The experience of immigration itself can also be traumatic, as immigrants and refugees occupy an in-between space as they await permanent citizenship within their new host country. Post-immigration trauma, on the other hand, is related to events that occur in the host country, such as loss of social status, social support, and separation from family. Difficulty integrating into a new culture, and lack of employment are also factors that contribute to post-immigration trauma.

The members of the Panjabi diaspora have not been able to traumatic experiences and incidents even after they have their homeland in order avoid such events. The aftermath of the 9/11 attacks has led to a re-traumatization of Sikh-Panjabis, who have been targeted as victims of hate crimes, similar to Muslims. Balbir Singh Sodhi[51], a Sikh Panjabi-American gas station owner, was the first to fall victim to such hate crimes. The vandalization, looting, and burning of gurudwaras that followed only served to rearticulate the violent and traumatic memories of the events of 1984, and further exacerbated the fear of persecution.

These incidences illustrate the ongoing trauma to which immigrants are subject, and how such trauma can be perpetuated across generations.[52] It is imperative that society recognizes and addresses the impact of immigration trauma, and provides support and resources to mitigate its effects.

The growing number of Panjabi international students[53] in Canada is a phenomenon that reflects both the opportunities and challenges of global migration. The presence of Panjabi international students in Canada has contributed significantly to the country's economy. According to recent data, international students contribute over $21 billion annually to the Canadian economy, making them a significant source of revenue for the country. Furthermore, international students bring diversity and new perspectives to Canadian universities and society, enriching the cultural fabric of the country.

However, the growing number of Panjabi international students in Canada is not without its challenges. Many international students are vulnerable to exploitation, including wage theft, workplace abuse, and unsafe living conditions. This vulnerability is exacerbated by the fact that

[51] (Kaur & O'Hara, 2021)

[52] The U.S.-based Sikh Family Centre's research found that one in four Sikh women and one in 10 Sikh men experienced family violence at some point in their lives, including as children. (Kaur, 2022)

[53] (Kahlon, 2022)

international students often face language barriers and a lack of knowledge about Canadian laws and regulations. In recent news, the Panjabi community learned that BC's government is not collecting any data relating to overdose deaths among international students despite growing concerns from local community members and faith leaders. [54]

[54] (Johal, 2023)

Chapter Two: Current gaps & practices

In this chapter, we embark on a journey to unveil the prevailing gaps and practices influencing the Panjabi diaspora in the realm of healthcare and social welfare services in Canada. Our exploration commences with a reflection on the residual effects of colonization on the Panjabi diaspora and the ways in which colonial practices continue to shape the Canadian healthcare system. We proceed to scrutinize the current dissemination and translation practices of healthcare and welfare information, drawing attention to the myriad challenges encountered by Panjabi communities in accessing culturally and linguistically appropriate resources. To deepen our understanding of these challenges, we engage in dialogue with a language service expert, illuminating the intricacies and constraints of translation services in health and social welfare authorities. Furthermore, we delve into the role of gender within Panjabi communities and the diaspora, dissecting the dynamics of patriarchy and female narratives, and their implications on healthcare experiences. Ultimately, we present findings from subject-matter experts (SMEs) on the existing gaps in the Canadian healthcare and social welfare system, underscoring the pressing need for more effective strategies and interventions to foster health equity and well-being for the Panjabi diaspora and other marginalized communities.

2.1 Colonization effects on the Panjabi diaspora

The effects of colonization on Panjabis and the Panjabi diaspora living in Canada are profound and far-reaching. From the displacement of Panjabis from their homeland to the persistent discrimination and marginalization they have faced in their adopted country, colonization has left an indelible mark on the Panjabi community.

To create a more just and loving society, it is imperative to examine critically the ways in which intergenerational trauma affects marginalized communities. The Panjabi diaspora, encompassing those of Panjabi descent living outside of India, has encountered numerous obstacles stemming from this form of trauma. Among the most prominent consequences of intergenerational trauma within the Panjabi community are the elevated rates of mental health disorders and substance abuse. Through an exploration of the intergenerational trauma prevalent among Panjabis, this chapter aims to elucidate how it has led to these health issues within Panjabi communities in Canada.

One of the most devastating impacts of colonization is the intergenerational trauma that Panjabis have experienced. This trauma is a direct result of the violence, oppression, and cultural erasure that Panjabis faced under colonial rule. For many Panjabis, the trauma of colonization has been passed down from generation to generation, manifesting in a range of physical and mental health issues.

The Panjabi community comprises numerous individuals and families who have migrated to Canada from India and Pakistan, either directly or as part of a larger diaspora. While such migration presents various benefits, including enhanced access to economic opportunities and better living conditions, it also poses significant challenges relating to intergenerational trauma.

Intergenerational trauma within the Panjabi community predominantly stems from the continuous exposure to trauma and violence. Embedded within the very fabric of its geography, Panjab has served as a vital gateway to India since antiquity. Endowed with a rich cultural heritage, the resilient denizens of Panjab have endured countless invasions and emerged as formidable fighters and unwavering survivors. Indeed, the British Raj successfully conquered Panjab in 1849, marking the final province to fall under the imperialist clutches of British

colonialism within Panjab. This rule resulted in form of the partition of India and Pakistan in 1947. As discussed in the previous chapter, events like 1984 and the systemic oppression followed by the Indian state have also compounded the effects of intergenerational trauma. As a result, a range of mental health and substance abuse issues persist among Panjabis living in Canada.

The impact of colonization on Panjabi's mental health is particularly concerning. Panjabi culture traditionally emphasizes community and family, with little attention paid to individual mental health concerns. This has resulted in a lack of understanding and awareness about mental health issues within the community. Additionally, the cultural stigma surrounding mental health has made it difficult for Panjabi Canadians to seek help and support for mental health concerns.

The impact of colonization on mental health is compounded by the discrimination and exclusion that Panjabi Canadians face in Canadian society. Panjabi Canadians who may not speak English fluently or who may be perceived as different due to their cultural practices or appearance may be at a higher risk of experiencing discrimination or exclusion. This can further exacerbate mental health issues and create additional barriers to accessing mental health services.

A 2018 study, aimed to determine the prevalence of mental morbidity in Panjab, India.[55] The results indicated that 17.94% of the population had experienced mental illness at some point in their lifetime, while 13.42% were currently affected. Based on a projected population of over 9.5 million adults, it was estimated that around 1.28 million individuals were living with mental illness in Panjab as of 2016. Mood disorders were the most prevalent, with 7.58% experiencing it at some point in their lifetime, and 1.95% currently affected.

[55] (Chavan et al., 2018)

Another consequence of intergenerational trauma among Panjabis in Canada is the high rates of substance abuse. Studies have shown that Panjabi Canadians are more likely to use drugs and alcohol than the general population, and this increased risk is linked to intergenerational trauma. Substance abuse can be a coping mechanism for individuals who are struggling with the effects of trauma, including depression, anxiety, and PTSD.

Higher prevalence of alcohol (7.9%) and substance abuse (2.4%) is the major factor for higher prevalence of mental morbidity in Panjab.[56] The high rates of substance abuse among Panjabis in Canada are also linked to cultural factors, including the stigma associated with mental health issues and substance abuse within the Panjabi community. Many individuals may be reluctant to seek help for these issues due to cultural barriers and the fear of being ostracized from their community.

According to Tschureney in "A History of Alcohol and Drugs in Modern South Asia,"[57] the consumption of alcohol has been a regular, albeit problematic, aspect of social life in India for centuries, despite efforts by India's governing bodies to portray the country as a land of teetotalers and a positive antiMRP to the supposed debauchery of the West. Tschureney argues that the issue of alcohol consumption has been viewed simplistically as a problem caused by Western influence. The image of India as a spiritually superior, abstinent culture was constructed by using religious rhetoric to link alcohol consumption, especially excessive drinking, with the shallow materialism of rapidly modernizing and secularizing Western countries.

However, it is important to recognize that alcohol played a dual role in colonial India. On the one hand, it served as a status symbol for the upper class, a means of displaying wealth and

[56] Ibid
[57] (Fischer-Tiné & Tschurenev, 2014)

sophistication. On the other hand, it also served as a coping mechanism for the working class, providing relief from the stress and hardship of daily life. In this way, alcohol consumption became both a marker of social status and a form of self-medication for those struggling to cope with the harsh realities of colonial life.

The prevalence of alcohol consumption in colonial India, therefore, reveals not only the economic and political interests of the colonial powers but also the complex social and cultural dynamics of the time. The legacy of colonialism continues to impact contemporary attitudes towards alcohol consumption in India and highlights the ongoing need to critically examine the intersections of power, culture, and identity in shaping individual and collective behavior.

In recent years, there has been a disturbing trend of overdoses among international students from Panjabi India studying in Canada.[58] While the root cause of this trend is complex, it is clear that intergenerational trauma plays a significant role in the lives of these young people.

Intergenerational trauma, or the transfer of trauma from one generation to the next, is a widely recognized phenomenon in post-colonial societies like India. The trauma of displacement, loss, and violence experienced by their ancestors has had a lasting impact on Panjabi communities, leading to high rates of mental illness, substance abuse, and suicide.

When Panjabi students come to Canada to study, they are faced with a new set of challenges that compound their existing traumas. Many of these students come from low-income families who have taken on significant debt to send them abroad. Once in Canada, they must navigate a complex and often an unwelcoming system that provides limited support for international students. Financial strain, combined with the pressure to succeed academically and

[58] (Johal, 2023)

the isolation that comes with living in a foreign country, can be overwhelming for many students.

Furthermore, the Canadian government does not record data on the number of overdoses among international students. This lack of data reflects a broader systemic issue of neglect and erasure of the experiences of marginalized communities. Without accurate data, it is difficult to understand the scope of the problem and to develop effective interventions to address it.

Drawing inspiration from Frantz Fanon's groundbreaking work, *The Wretched of the Earth*, we contemplate the psychological and societal challenges encountered by colonized individuals in a racially divided world. [59] Delving into Fanon's insights, we examine the experiences of Panjabi immigrants in healthcare settings, even when they possess fluency in English. Their struggles are not merely linguistic but deeply entrenched in the historical and continuing impact of colonization and systemic discrimination.

Similar to colonized people described by Fanon, Panjabi immigrants may also feel the necessity to remain aware of their image and safeguard their position in healthcare settings. The racialized environment can provoke heightened vigilance and a visceral intelligence dedicated to preserving body and spirit. [60] This sense of heightened awareness stems from the experiences of marginalization, discrimination, and assimilation pressures that many immigrants face in their host countries. [61]

The historical context of colonization plays a vital role in shaping Panjabi immigrants' experiences in healthcare settings. The power dynamics inherent in colonizer-colonized

---

[59] "A colonized person must constantly be aware of his image, jealously protect his position. The defences of the colonized are tuned like anxious antennae waiting to pick up hostile signals of a racially divided world. In the process, the colonized acquire a peculiar visceral intelligence dedicated to the survival of body and spirit." (Fanon, 2004)

[60] Ibid

[61] (Bhugra, 2004)

relationships may manifest subtly, such as healthcare providers' paternalistic attitudes or the marginalization of traditional health practices.[62] These dynamics may create a sense of vulnerability and mistrust, resulting in Panjabi immigrants being less likely to seek care or adhere to treatment recommendations.[63]

Moreover, the pressure to assimilate into the dominant culture may lead Panjabi immigrants to suppress their cultural identity and conform to the healthcare system's expectations.[64] This process of acculturation can result in the loss of social support networks and the erosion of cultural practices that promote health and well-being.[65]

It is crucial that we recognize and address the intersecting systems of oppression that contribute to the struggles of Panjabi students in Canada. This requires a holistic approach that centers on the experiences and needs of these young people, including culturally responsive mental health care, financial support, and community-based interventions. By acknowledging the impact of intergenerational trauma and addressing the structural barriers faced by Panjabi students, we can work towards creating a more equitable and just society for all.

The effects of colonization on the faith and religious practices of Panjabis in India, including Sikhs, Hindus, and Muslims, have been profound and enduring. For these communities, faith and spirituality have always been deeply intertwined with cultural traditions and social practices, creating a holistic worldview that has been disrupted and distorted by colonialism.

[62] (Kirmayer, 2012)
[63] (Bhugra, 2004)
[64] (Berry, 2005)
[65] (Kirmayer, 2012)

At the heart of this disruption lies the imposition of binary doctrines that have forced Panjabis to choose between competing religious and cultural identities. Rather than embracing the rich diversity of their heritage, many have been forced to adopt a narrow and exclusionary perspective that denies the validity of other traditions and perpetuates the divisive legacy of colonization.

For Sikhs, Hindus, and Muslims alike, spirituality has always been a source of strength and resilience in the face of adversity. Whether through prayer, meditation, or communal worship, these communities have drawn sustenance and meaning from their faith, using it as a bulwark against the challenges of daily life.

However, the impact of colonization has been to erode this spiritual foundation, creating a sense of disconnection and alienation from the cultural practices and traditions that once nourished their souls.[66] Instead of embracing the holistic and integrative nature of their spiritual traditions, many Panjabi-Sikhs have been forced to compartmentalize their faith, reducing it to a set of rigid binary doctrines that offer little room for self sovereignty, self-governance, or personal growth.

This has had a profound impact on the social and cultural fabric of Panjabi communities, creating divisions and conflicts that have undermined the unity and cohesion that were once hallmarks of their cultural identity. By denying the spiritual and cultural richness of their heritage, colonizers have effectively stripped Panjabis of their agency and autonomy, leaving them to grapple with the legacy of their own cultural erasure.

In the face of these challenges, it is crucial that we work to reclaim the spiritual and cultural traditions that have been lost to colonization. By embracing the holistic and integrative

[66] (Battiste, 1998)

nature of these practices, we can begin to rebuild the foundations of a vibrant and resilient cultural identity, one that honours the diversity and richness of our collective heritage. Only then can we begin to heal the wounds of the past and create a more just and equitable future for all Panjabis, regardless of their faith or cultural background.

2.2 Colonial practices and their effect on the Canadian healthcare system

The healthcare system in Canada has a long history of colonial practices that continue to have detrimental effects on the health and well-being of marginalized communities, including the Panjabi diaspora. The legacy of colonialism has left deep scars on Indigenous communities and non-Indigenous people of colour, and these scars manifest in the policies, practices, and attitudes of the healthcare system. In Canada, the healthcare system has long been marred by colonial practices that have disproportionately impacted BIPOC communities. These practices are deeply rooted in the country's colonial history and continue to exert their pernicious influence in the present day. In this essay, we will reflect on these practices, their impacts, and what can be done to address them.

One of the key colonial practices that persist in the Canadian healthcare system is the imposition of Western medical models on non-Western communities. This approach assumes that Western medicine is superior and fails to take into account the unique health needs and perspectives of BIPOC communities.[67] This can lead to a lack of trust in healthcare providers and a reluctance to seek medical care, especially for those who have experienced trauma or discrimination within the healthcare system.[68]

[67] (Loppie, 2007)
[68] (Allan & Smylie, 2015)

Another colonial practice that persists in the healthcare system is the underfunding of healthcare services in Indigenous communities. This has resulted in a lack of resources and infrastructure for Indigenous healthcare providers and has contributed to poor health outcomes for Indigenous peoples.[69] Additionally, Indigenous peoples have historically been subject to medical experimentation, sterilization, and forced removal from their families for medical reasons.[70] [71] These actions have led to a deep mistrust of healthcare providers and institutions among Indigenous peoples, which further exacerbates health disparities.[72]

The impacts of these colonial practices are significant and far-reaching. BIPOC communities experience higher rates of chronic illnesses, mental health issues, and mortality rates than their non-BIPOC counterparts.[73] These health disparities are a direct result of the marginalization and discrimination that BIPOC communities have experienced within the healthcare system. The lack of culturally responsive care, language barriers, and limited access to healthcare services contribute to these disparities, leading to further systemic racism.[74]

To address these issues, there needs to be a fundamental shift in how healthcare is delivered in Canada. One of the first steps is to acknowledge the colonial history of the healthcare system and commit to anti-colonial practices.[75] This includes working towards culturally responsive care and investing in IBPOC-led healthcare services.[76] Healthcare

[69] (Reading & Wien, 2015)
[70] (Kelm, 1998)
[71] (Stote, 2015)
[72] (Browne et al., 2016)
[73] (Veenstra, 2009)
[74] (Betancourt et al., 2003)
[75] (Tang & Browne, 2008)
[76] (Browne & Varcoe, 2006)

providers must also receive cultural competence training to provide equitable care that meets the needs of IBPOC communities.[77]

Another way in which colonial practices are perpetuated in Canadian healthcare is through the failure to acknowledge and support traditional medicine practices that are deeply rooted in Panjabi culture. Traditional medicine has been used by Panjabi communities for centuries, and it plays an essential role in promoting physical, emotional, and spiritual health. However, the healthcare system has failed to recognize the value of these practices, and in doing so, has perpetuated the marginalization of Panjabi communities.

The Canadian healthcare system, like many others, has a long history of colonial practices that have resulted in the invalidation of traditional medicine practices. This is particularly felt by members of the Panjabi diaspora in Canada, who rely on these practices to maintain a connection with their culture. The lack of recognition of traditional medicine by Canadian healthcare not only makes these individuals feel invalidated but also results in the efficacy rate of healthcare for this community.

Franz Fanon, in The *Wretched of the Earth*[78] notes that the colonizer's aim is to strip the colonized of their culture and identity, rendering them powerless and dependent on the colonizer. This can be seen in the case of the Panjabi diaspora in Canada, where the lack of recognition of traditional medicine practices by Canadian healthcare undermines the cultural identity of this community.

Moreover, the healthcare system's neglect of traditional medicine practices also perpetuates a broader colonial attitude that dismisses and devalues Indigenous knowledge and

[77] (Sue & Sue, 2013)
[78] (Fanon, 2004)

practices. This attitude stems from a long history of colonialism that sought to erase the culture and traditions of Indigenous communities, including those of the Panjabi diaspora. As such, the healthcare system's neglect of traditional medicine practices is a continuation of this colonial legacy.

Traditional medicine practices are not simply a solution to healthcare problems, but they are also a way for the Panjabi community to maintain a connection with their cultural heritage. By disregarding these practices, the Canadian healthcare system effectively erases the cultural significance of traditional medicine, leaving the Panjabi diaspora feeling powerless and disconnected from their heritage. Traditional medicine practices have been used for centuries and have been shown to be effective in treating a wide range of ailments. However, by refusing to recognize these practices, the Canadian healthcare system is depriving the Panjabi community of access to effective healthcare solutions.

In a nation such as Canada, where two official languages, English and French, coexist, the abundance of linguistic diversity due to the influx of immigrants from various corners of the world is undeniable. Yet, the attention given to the French language in numerous sectors, including healthcare, is disproportionately greater than that afforded to other languages spoken by immigrants. One must recognize the historical colonial practices as the root of this disparity, continuing to cast a shadow on modern-day Canada.[79] Drawing inspiration from Frantz Fanon's work, we shall examine the pervasiveness of these colonial practices in today's world and how the liberation of oppressed immigrant voices can only be realized when these practices are dismantled.

[79] (Kymlicka, 1996)

The French language, a symbol of the historical presence of French settlers, receives significant attention in Canada, particularly in the healthcare sector. Here, French-speaking individuals find themselves accommodated through bilingual or French-speaking staff and resources.[80] However, this same level of attention and accommodation is rarely extended to speakers of other immigrant languages.

The disregard for immigrant languages in Canadian healthcare can severely undermine the quality of care for those who do not speak English or French. Such language barriers often lead to misunderstandings, misdiagnoses, and inadequate treatment.[81] Furthermore, this neglect of immigrant languages perpetuates the marginalization of these communities, reinforcing their status as "the Other".[82]

Frantz Fanon, an esteemed anti-colonial writer and philosopher, contended that colonial practices and mentalities persistently shape the world even after the formal cessation of colonial rule.[83] The unequal attention given to the French language and other immigrant languages in Canadian healthcare can be viewed as a manifestation of these colonial practices. The privileging of French and the marginalization of immigrant voices uphold a hierarchy in which the historically colonized language takes precedence over languages spoken by immigrants, who often originate from formerly colonized territories.

Fanon insisted that the only route to the liberation of oppressed voices is through the dismantling of colonial practices, not merely by acknowledging their existence.[84] In the realm of Canadian healthcare, this entails actively striving for an inclusive and equitable system that

[80] (de Moissac & Bowen, 2018)
[81] (Shamsi et al., 2020)
[82] (Said, 1994)
[83] (Fanon, 2004)
[84] Ibid

embraces and values the linguistic diversity of its population. This can be achieved through the provision of language-specific resources, the employment of multilingual staff, and the offering of cultural competency training for healthcare providers.[85]

The unrelenting dominance of the French language in Canadian healthcare and the marginalization of immigrant languages embody the colonial practices that continue to permeate today's world. Guided by Frantz Fanon's work, we assert that the liberation of oppressed immigrant voices will remain a distant goal unless these colonial practices are dismantled, rather than simply acknowledged.

To combat these colonial practices, there is a need for a more culturally responsive and inclusive healthcare system. This includes acknowledging and supporting traditional medicine practices and recognizing their value in promoting health and well-being. It also requires healthcare professionals to engage in ongoing education and self-reflection to address their biases and better understand the unique needs of Panjabi patients.

In the words of Paulo Freire[86], "The oppressors do not perceive their monopoly on having more as a privilege which dehumanizes others and themselves. They cannot see that, in the egoistic pursuit of having as a possessing class, they suffocate in their own possessions and no longer are; they merely have." The neglect of traditional medicine practices in Canadian healthcare perpetuates a colonial mindset that prioritizes Western knowledge and practices over those of Indigenous communities. To break free from this oppression, we must acknowledge and value the diverse ways of knowing and healing that exists within our communities. Only then can we truly work towards creating a healthcare system that promotes health and well-being for all?

[85] (Anderson et al., 2003)
[86] (Freire, 2000)

2.3 Existing dissemination of healthcare & welfare information

In our quest to illuminate and engage with the diverse knowledge dissemination practices in the Canadian healthcare system, we must first acknowledge the intricate network of power dynamics and the need for equitable access to information.[87] It is through this critical lens that we can truly begin to understand how knowledge and information are communicated, shared, and made accessible within the healthcare landscape.[88]

The Canadian healthcare system,[89] a vast and intricate entity, operates under the guidance of various governmental and non-governmental organizations. These institutions, responsible for crafting policy, directing research, and setting guidelines, have a profound influence on the flow of knowledge within the system.[90] Yet, as with all structures of power, these organizations must strive to ensure that the dissemination of knowledge is not only efficient but also equitable and inclusive, fostering a spirit of collective engagement.

The Canadian healthcare system is well-regarded for its quality and accessibility. One of the key factors behind its success is the effective dissemination of knowledge, which ensures that healthcare professionals stay up-to-date with the latest research, best practices, and innovations. The following are some of the existing knowledge dissemination practices in the Canadian healthcare system:

1. Government agencies and organizations: Various federal, provincial, and territorial government bodies oversee the Canadian healthcare system, such as Health Canada, the

[87] (Driedger et al., 2014)
[88] (Graham et al., 2006)
[89] (Canadian Institutes of Health Research, 2023)
[90] (Lavis et al., 2003)

Canadian Institutes of Health Research (CIHR)[91], and provincial ministries of health. These organizations play a vital role in distributing new research findings, policy updates, and practice guidelines to healthcare providers and the public. They disseminate information through various channels, including websites, reports, webinars, and social media.

2. Professional associations and regulatory bodies: Healthcare professionals in Canada are represented and regulated by several associations and colleges, such as the Canadian Medical Association (CMA)[92], the Canadian Nurses Association (CNA)[93], and the Royal College of Physicians and Surgeons of Canada (RCPSC)[94]. These organizations share updated clinical guidelines, professional standards, and new research with their members through newsletters, online platforms, and continuing education programs.
3. Healthcare conferences and workshops: Conferences, workshops, and seminars are essential avenues for knowledge dissemination in the Canadian healthcare system. They bring together professionals from various disciplines to present research findings, discuss challenges, and exchange ideas. These events help foster collaboration and knowledge sharing among professionals, leading to improved patient care and outcomes.
4. Peer-reviewed journals: Medical and healthcare research in Canada is published in various peer-reviewed journals, such as the Canadian Medical Association Journal (CMAJ)[95], the Canadian Journal of Public Health[96], and the Journal of Interprofessional

[91] (Canadian Institutes of Health Research, 2023)
[92] (Canadian Medical Association, 2023)
[93] (Canadian Nurses Association, 2023)
[94] (The Royal College of Physicians and Surgeons of Canada, 2023)
[95] (Canadian Medical Association Journal, 2021)
[96] (Canadian Journal of Public Health, 2023)

Care. These journals act as platforms for sharing new research findings, promoting evidence-based practice, and ensuring the quality of the knowledge shared.

5. Electronic health record (EHR)[97] systems: The Canadian healthcare system has increasingly adopted EHR systems to improve patient care and coordination. These systems not only provide access to patients' medical histories but also facilitate the sharing of evidence-based guidelines, decision support tools, and best practices among healthcare providers. This real-time sharing of information helps enhance the quality of care and enables the effective dissemination of knowledge.
6. Online platforms and social media: The rise of digital technology has made it easier for healthcare professionals to access and share knowledge. Online platforms, such as UpToDate, DynaMed, and the Cochrane Library, offer evidence-based clinical decision support tools and resources. Social media platforms, such as Twitter and LinkedIn, enable professionals to engage in discussions, share research, and collaborate with peers.
7. Community-based initiatives: Community-based initiatives are essential for knowledge dissemination in the Canadian healthcare system, particularly in the context of public health and health promotion. These initiatives often involve partnerships between healthcare providers, non-profit organizations, and local communities to share information, resources, and best practices to address specific health issues and improve overall community health.

The Canadian healthcare system is complex and decentralized, with a variety of stakeholders involved in the provision and management of healthcare services.[98] While this

[97] (Centers for Medicare & Medicaid Services, 2023)
[98] (Marchildon, 2013)

diversity can be an asset in terms of promoting innovation and diversity of perspectives, it can also create barriers to knowledge dissemination. For example, researchers may have difficulty reaching practitioners working in remote or under-resourced areas[99], while clinicians may have limited time and resources to keep up with the latest research and best practices.[100] And from the Panjabi diaspora's needs perspective, often the healthcare providers can't source an appropriate piece of translated information.[101] This often leads to patients leaving with incomplete and half-informed translated information.

As we strive for a healthcare system that embodies equity and inclusivity, we must confront the obstacles and difficulties encountered by non-English speakers and immigrants within the Canadian healthcare context.[102] Through a critical evaluation of prevailing knowledge dissemination practices, we need to explore the interplay of language, culture, and digital literacy, recognizing how these elements contribute to the marginalization and exclusion of various communities.[103]

The Canadian healthcare system, with roots in a colonial past, frequently reinforces prevailing cultural and linguistic standards, favouring the English language and Western medical practices.[104] This hegemonic inclination can have significant repercussions for non-English speakers and immigrants, who might face difficulties accessing information and navigating the healthcare system due to language barriers and cultural distinctions.[105] It is essential for

[99] (Pottie et al., 2013)
[100] (Grimshaw et al., 2012)
[101] (Bhawra et al., 2016)
[102] (Nestel, 2012)
[103] (Hankivsky & Cormier, 2010)
[104] (Fiske & Browne, 2006)
[105] (Browne et al., 2016)

healthcare professionals and institutions to address these challenges, fostering cultural competence and embracing linguistic diversity.[106]

The current knowledge dissemination process in the Canadian healthcare system relies heavily on digital technologies such as electronic health records, telemedicine, and online resources.[107] These technologies facilitate the dissemination of knowledge and enable healthcare professionals to access and share information in a timely and efficient manner. However, digital literacy challenges exist, which could limit the effectiveness of the knowledge dissemination process.[108]

The Canadian healthcare authorities have made numerous public commitments to promote practices that foster inclusivity, equity, and accessibility within the healthcare system.[109] However, it is essential to critically examine the ways in which power dynamics and structural inequalities can undermine these promises, perpetuating disparities and exclusion.[110]

Despite commitments to enhance cultural safety among healthcare providers, many non-English speakers and immigrants continue to encounter linguistic and cultural barriers when accessing healthcare services.[111] The lack of meaningful implementation of cultural competency training reinforces existing power imbalances, privileging dominant cultural norms while marginalizing diverse perspectives and needs.

Cultural safety is an important aspect of healthcare delivery, and many healthcare authorities and organizations in British Columbia have implemented policies and programs to

[106] (Pottie et al., 2020)
[107] (Romanow, 2002)
[108] (Paprica et al., 2015)
[109] (Government of Canada, 2018)
[110] (Reading & Wien, 2009)
[111] (Betancourt et al., 2003)

improve cultural competency. For example, the British Columbia Ministry of Health has developed Cultural Safety and Humility Action Plan[112] which aims to improve the cultural safety and humility of health care services for Indigenous peoples. This plan includes strategies for improving Indigenous cultural competency within the healthcare system, such as providing cultural safety and humility training for healthcare providers, developing cultural humility protocols and guidelines, and partnering with Indigenous communities to co-design healthcare services.

Similarly, while healthcare authorities have recognized the importance of trauma-informed care, there remains a significant gap between this recognition and the actual provision of such care for non-English speakers and immigrants.[113] The failure to comprehensively integrate trauma-informed practices within the healthcare system can result in retraumatization and further marginalization of already vulnerable populations.[114]

For example, HealthLink BC[115] and the BC Seniors' Guide[116] are notable endeavours in British Columbia, striving to deliver crucial health information and guidance to the public, centring on the needs of seniors. HealthLink BC is a health information and advice service provided by the government of British Columbia, Canada. It offers free, reliable, and easy-to-understand health information to the residents of British Columbia through a variety of channels, including a website, a telephone line (8-1-1), and printed materials. The BC Seniors' Guide is a comprehensive resource developed by the government of British Columbia, Canada, to help seniors and their families navigate the various programs, services, and resources available to

[112] (BC Patient Safety & Quality Council, 2015)
[113] (Harris & Fallot, 2001)
[114] (Grossman et al., 2021)
[115] (HealthLink BC, 2023)
[116] (Government of British Columbia, 2020)

them within the province. The guide is designed to provide information on key topics related to seniors' health, financial wellbeing, and overall quality of life.

Although these initiatives work to broaden accessibility by providing resources in a range of languages such as Panjabi, Hindi, Chinese, and more, they still face significant challenges. These include issues of cultural safety, language nuances, and limited adaptability across the web and various transmedia platforms. In this reflection, we will explore these limitations and contemplate potential solutions to address them.

Despite the efforts of Healthlink BC and the BC Seniors' Guide to present resources in multiple languages, they struggle to ensure cultural safety and address language nuances. Cultural safety is a vital component of healthcare, recognizing the influence culture has on an individual's health and well-being experiences. Health services that respect and respond to the diverse cultural needs, beliefs, and values of various populations are considered culturally safe.[117]

Yet, Healthlink BC and the BC Seniors' Guide frequently overlook the cultural context within which health information and advice are shared. This oversight can lead to misunderstandings and misinterpretations, undermining the effectiveness of these resources. Furthermore, language nuances, such as idiomatic expressions, regional dialects, and culturally specific terminology, can impede the precise and unambiguous communication of health information. Consequently, these initiatives might not wholly address the needs of diverse communities.

[117] (Williams, 1999)

An additional critical constraint of Healthlink BC and the BC Seniors' Guide is their limited adaptability across multiple transmedia platforms. In our ever-evolving digital world, it is essential for health information and advice to be accessible through various channels like websites, mobile applications, social media, and other digital platforms.[118] This approach ensures that the information reaches a wider audience, catering to the diverse needs and preferences of users.

Nonetheless, Healthlink BC and the BC Seniors' Guide have yet to effectively adapt to these changes, with resources often restricted to specific platforms like websites. This lack of adaptability can hinder the reach and impact of these initiatives, especially for those who may depend on alternative platforms to access health information.

2.4 Existing translation practices and processes

In the Canadian landscape, an array of translation frameworks and initiatives have been woven together by healthcare authorities, healthcare providers, and community organizations, seeking to bridge language gaps and cultivate authentic connections between providers and patients from a myriad of linguistic backgrounds. By nurturing this sense of belonging, these frameworks have the potential to enhance the overall quality and accessibility of healthcare services for individuals with limited proficiency in English or French.

One such initiative, the Provincial Language Services (PLS)[119], emerges from the Provincial Health Services Authority (PHSA) in British Columbia. The PLS offers interpretation and translation services to patients with limited English proficiency, as well as healthcare

[118] (Eggeling et al., 2017)
[119] (Provincial Health Services Authority, 2023)

providers across the province.[120] Supporting over 200 languages, including indigenous languages, PLS provides in-person and remote services that foster effective communication in healthcare settings.[121]

Another example is the Language Services Toronto (LST),[122] an initiative offered by the Toronto Central Local Health Integration Network (LHIN). A collaborative effort between multiple healthcare organizations, LST provides language interpretation and translation services across the Greater Toronto Area (GTA), seeking to promote health equity and improve access to healthcare services for diverse linguistic communities in the region.[123]

Complementing these provincial and regional initiatives, national programs such as the Canada Interpreter Services (CIS)[124] strive to dismantle language barriers in healthcare settings. CIS, a free, confidential, and 24/7 service provided by the Government of Canada, offers interpretation services in over 200 languages for healthcare providers and patients with limited English or French proficiency.[125]

A collection of translation frameworks and initiatives has been crafted by healthcare authorities, healthcare providers, and community organizations in Canada, seeking to bridge language barriers and create a space of access for diverse linguistic communities. Ranging from provincial and regional programs to national services and institutional guidelines, these initiatives illuminate the importance of effective communication in healthcare settings and affirm a commitment to health equity and inclusivity.

---

[120] Ibid
[121] Ibid
[122] (Toronto Central Healthline, 2023)
[123] Ibid
[124] (Government of Canada, 2023)
[125] Ibid

2.5 Unearthing the Challenges of Translation Services in Health and Social Welfare Authorities

In an illuminating conversation with a subject matter expert, who chose to remain anonymous and will be referred to as Bikram, we delved into the current state of translation services provided by health and social welfare authorities. Bikram, an executive in a provincial health authority's language service department, has held a managing position in the program for over a decade, while the overarching program has been in existence for more than twenty years.

The program's mission, as stated on its website, is to support organizations in providing services to linguistically and culturally diverse clients, including immigrants, refugees, official minority language speakers, and members of the Deaf, Deaf-Blind, and Hard of Hearing community. They aim to address language and communication access issues and barriers, offering high-quality language access services to health authorities, family practice practitioners, specialist offices, and other allied health professionals.

Bikram shared valuable insights into the hiring process for interpreters[126], which involves a written language test. However, the program does not require interpreters to possess any official training or certification. They highlighted that Vancouver Community College (VCC) once offered interpreter training programs but ceased operations in 2012[127]. The college attempted to return with a minimalist community interpreting program, but it closed after a few years, possibly due to increased competition.

[126] Translators typically operate in a written medium, translating text from one language into another, and can do this work conveniently from their desks. Interpreters provide their language services orally as they translate the speech of one or more parties, typically in a real-time environment. (BIG Language Solutions, 2022)
[127] (Vancouver School of Interpreting and Translation, 2018)

Bikram mentioned another organization, The Interpreter's Lab (TIL), which provides training programs specializing in health, mental health, legal, and social service settings[128]. Their program often collaborates with TIL for professional development opportunities for interpreters. Although certification is not required for interpreters, it may help applicants stand out. All selected candidates must pass a written language test and attend a professional development session hosted by the program.

When discussing the process for written translation, Bikram revealed that the program uses an internal database to contact its roster of interpreters, who then translate the text into the target language. However, no guidelines or directions are provided concerning the target audience or platform for the translated text. Additionally, there are no feedback rounds or translation frameworks in place to ensure trauma-informed, culturally safe translations that account for language nuances.

While healthcare providers can provide feedback on their experiences with interpreters during patient appointments, there is no established process for patients to offer feedback on their interpreter experiences. Bikram acknowledged the existing gaps in the translation process, emphasizing that healthcare authorities often treat translations as an afterthought. They recalled an incident during the early stages of the COVID-19 pandemic when their program received numerous text files for translation on short notice, which they described as overwhelming and unfair.

Despite these gaps in translation processes, which are perpetuated by the administrating health authority and the B.C. Ministry of Health, Bikram recognized the positive impact of translation services on patients and clients. Published studies report positive benefits of

[128] (The Interpreter's Lab, 2022)

professional interpreters on communication (errors and comprehension), utilization, clinical outcomes and satisfaction with care[129]. However, they could not overlook the system's shortcomings and the healthcare and social welfare authorities' tendency to treat translation as an afterthought.

Venturing into the realm of translation services offered by health and social welfare authorities, a dialogue with Bikram, an anonymous executive from a provincial health authority's language service department, unveils disconcerting practices. These practices bear significant ramifications for a linguistically and culturally diverse clientele, including immigrants, refugees, official minority language speakers, and members of the Deaf, Deaf-Blind, and Hard of Hearing communities[130]. Providers need to collect reliable language data at the patient's point of entry and document the language services provided during the patient-provider encounter[131].

Bikram sheds light on the interpreter hiring process, revealing that despite administering a written language test, there is no mandate for official training or certification. This absence of formal training potentially gives rise to subpar interpreter performance and jeopardized patient-provider communication, culminating in diminished patient satisfaction and exacerbated health disparities[132].

Moreover, Bikram draws attention to the written translation process, highlighting the lack of an established framework or guidelines addressing vital aspects such as trauma-informed care, cultural safety, and language nuances, all of which are integral to effective communication

[129] (Karliner et al., 2007)
[130] (Divi et al., 2007)
[131] Ibid
[132] (Flores, 2005)

within healthcare settings.[133] The lack of feedback loops and patient input compounds these issues further.[134]

Additionally, Bikram's insights underscore the proclivity of healthcare authorities to view translations as secondary considerations, resulting in the inadequate allocation of time and resources to these vital services. Such practices may engender inaccuracies, delays, and detrimental consequences for patients and clients dependent on these services for crucial information and care.[135]

In closing, Bikram's revelations emphasize the imperative for healthcare and social welfare authorities to reconsider their approach to translation. The adoption of more stringent training requisites for interpreters, the development of all-encompassing translation frameworks, and the prioritization of prompt and accurate translations are pivotal steps in enhancing the quality of care for linguistically and culturally diverse patients[136].

2.6 Role of gender

Rooted in the heart of the multicultural tapestry of the UK, Canada, and the United States, the South-Asian diaspora has woven its vibrant threads, leaving an indelible mark on the landscape. Panjabi families, in particular, have carved out their own niche within these diverse immigrant populations.[137] Often, cultural values and practices shape the roles and expectations of men and women in these families, standing in stark contrast to the norms of their Western counterparts.[138]

[133] (Sue et al., 2009)
[134] (Hashim, 2017)
[135] (Bauer & Alegria, 2010)
[136] (Pottie et al., 2008)
[137] (Bhachu, 1985)
[138] (Pessar & Mahler, 2003)

Within South-Asian and Panjabi families, traditional structures uphold a patriarchal order in which men assert their dominance, while women submit to these roles.[139] This hierarchy assigns specific responsibilities, such as breadwinning for men and domestic work for women.[140] Furthermore, women often bear the burden of preserving the family's honour, which may impose limitations on their social interactions, education, and career aspirations.[141] The U.S.-based Sikh Family Centre's research found that one in four Sikh women and one in 10 Sikh men experienced family violence at some point in their lives, including as children.[142]

As they migrate, South Asian and Panjabi's families encounter cultural and social environments that provoke a reevaluation of traditional gender roles. Studies suggest that both persistence and change in gender roles manifest among these immigrant families[143] [144], influenced by factors such as education, employment opportunities, and social support networks in their adopted countries.[145]

In the UK, South Asian and Panjabi women have encountered increased opportunities for education and employment, engendering a shift in traditional gender roles.[146] Similarly, in Canada, higher education and labour force participation have allowed South Asian and Panjabi women to claim greater autonomy and independence.[147] Yet, in the United States, research

[139] (Kandiyoti, 1988)
[140] (Dasgupta, 1998)
[141] (Filmer & King, 2013)
[142] (Kaur, 2022)
[143] (Ghuman, 2001)
[144] (Moghadam, 2019)
[145] (Veenstra & Patterson, 2016)
[146] (Dale et al., 2010)
[147] (Veenstra & Patterson, 2016)

reveals that traditional gender roles may persist among South-Asian and Panjabi families due to conservative social networks and limited exposure to mainstream American society.[148]

The evolution of gender roles carries significant implications for the family dynamics and relationships within South-Asian and Panjabi immigrant families. Studies indicate that renegotiating traditional gender roles can result in heightened marital conflict and domestic violence.[149] However, this process can also foster greater equality in decision-making and improve the well-being of women.[150]

Patriarchy continues to be a deeply rooted system shaping social organization within South Asian societies, including Panjabi families.[151] This structure, which privileges men and subordinates women, has profound effects on gender roles, power relations, and family configurations. In this chapter, we delve into the role of patriarchy in South Asian and, more specifically, Panjabi immigrant families in the UK, Canada, and the United States, utilizing academic sources to investigate its expressions and consequences in these settings.

Within patriarchal South Asian and Panjabi families, men take on dominant roles in decision-making, resource distribution, and family leadership.[152] This system frequently assigns gender-specific responsibilities, such as financial provision for men and caregiving and household duties for women.[153] Moreover, patriarchal standards can lead to the regulation of women's social interactions, movement, education, and career options to safeguard the family's honor.[154] Studies indicate that patriarchal structures may endure, adapt, or evolve among these

[148] (Dasgupta, 1998)
[149] (Raj & Silverman, 2002)
[150] (Dale et al., 2010)
[151] (Kandiyoti, 1988)
[152] Ibid
[153] (Dasgupta, 1998)
[154] (Chanana, 1993)

immigrant families depending on factors like education, job opportunities, and social networks in their new societies.[155] [156]

In the UK, South Asian and Panjabi families' patriarchal systems have reportedly experienced significant changes as women access education and employment.[157] Likewise, in Canada, patriarchal norms have been contested by South Asian and Panjabi women's growing participation in higher education and the labor force.[158] However, in the United States, traditional patriarchal systems may be more firmly embedded among South Asian and Panjabi families due to conservative social networks and limited engagement with mainstream American culture.[159]

Patriarchal norms carry considerable implications for family dynamics and relationships among South Asian and Panjabi immigrant families. The perpetuation of patriarchal structures can result in reinforcing traditional gender roles, maintaining gender inequality, and obstructing women's empowerment.[160] Moreover, research suggests that patriarchal systems can contribute to increased marital strife, domestic abuse, and mental health issues for women.[161]

In contrast, the disruption or transformation of patriarchal structures can encourage greater gender equality, improving women's well-being and autonomy.[162] This reevaluation of patriarchal norms can also impact the overall integration of South Asian and Panjabi immigrant families into their host societies, as women's involvement in education, work, and social networks can promote economic and social assimilation.[163]

---

[155] (Veenstra & Patterson, 2016)
[156] (Ghuman, 2001)
[157] (Dale et al., 2010)
[158] (Veenstra & Patterson, 2016)
[159] (Dasgupta, 1998)
[160] (Kandiyoti, 1988)
[161] (Raj & Silverman, 2002)
[162] (Dale et al., 2010)
[163] (Veenstra & Patterson, 2016)

Patriarchy plays a nuanced and multifaceted role in South Asian and Panjabi immigrant families in the UK, Canada, and the United States. While traditional patriarchal systems may endure in some cases, there is evidence of change and adaptation in others. The rethinking of patriarchal norms can have both positive and negative effects on family dynamics, gender equality, and the overall integration of immigrant families into their host communities. Further research is required to examine the factors contributing to the persistence or transformation of patriarchy among South Asian and Panjabi immigrant families in these contexts.

2.6.1 Men and Patriarchy

In the realms of mental and physical well-being, South Asian and Panjabi men residing in Canada and the United States face a distinct set of challenges. As these populations encounter health issues rooted in various cultural, social, and environmental factors, this exploration seeks to delve into the mental and physical health complications that arise or are at risk for South Asian and Panjabi men in these locations. Moreover, this analysis will investigate the potential influence of trauma on the mental health difficulties faced by these communities.

Depression stands out as a primary mental health issue among South Asian and Panjabi men in Canada and the United States.[164] The reluctance to discuss mental health matters and cultural stigmas may contribute to underdiagnosis and insufficient treatment within these communities.[165] Furthermore, challenges associated with immigration, such as the difficulties of acculturation, social isolation, and discrimination, can amplify depressive symptoms.[166]

The connection between trauma and mental health struggles for South Asian and Panjabi men has also been probed. Research has unveiled a relationship between traumatic experiences

[164] (Tewari & Alvarez, 2009)
[165] (George et al., 2015)
[166] (Noh & Kaspar, 2003)

before and after migration and the onset of mental health disorders, including PTSD, anxiety, and depression.[167] This link implies that trauma plays a significant role in shaping the mental health of South Asian and Panjabi men in Canada and the United States.

Regarding physical health, this population faces heightened risks for cardiovascular diseases, such as coronary artery disease and hypertension.[168] A combination of genetic predispositions and lifestyle factors, including sedentary living, unhealthy diets, and elevated stress levels, may contribute to these increased risks.[169] Additionally, diabetes is a prevalent health concern among these communities, as South Asians have higher rates of type 2 diabetes compared to other ethnicities.[170]

Cancer, particularly oral and pharyngeal cancers, is another significant health issue among South Asian and Panjabi men, who have higher incidences of these cancers compared to other ethnic groups.[171] The use of tobacco, especially smokeless varieties, and cultural practices like chewing betel quid may contribute to these increased risks.[172] Suicide rates among Panjabi men in India and South Asian and Panjabi men in the UK, Canada, and the United States have become a pressing focus in academic circles. Various factors, including cultural, social, and environmental influences, contribute to these rates. In India, Panjabi men have been reported to experience higher suicide rates compared to the national average.[173] Patel et al. (2012)[174] found that the suicide rate among Panjabi men was significantly higher than women, which may stem

[167] (Bhui et al., 2003)
[168] (Enas & Mehta, 1995)
[169] (Misra et al., 2009)
[170] (Ramachandran et al., 1997)
[171] (Chaudhary et al., 2019)
[172] (Niaz et al., 2017)
[173] (Patel et al., 2012)
[174] Ibid

from cultural expectations placed on men as providers and protectors, leading to increased stress and vulnerability to mental health challenges.

Additionally, the agrarian crisis in the Panjabi region has been associated with higher suicide rates among farmers, predominantly men, who face economic struggles and debt.[175] In the UK, studies have shown that South Asian and Panjabi men are at a heightened risk of suicide compared to the general population.[176] Factors contributing to this elevated risk include acculturation stress, social isolation, and experiences of discrimination.[177] Moreover, cultural stigma surrounding mental health and reluctance to seek help may exacerbate the risk of suicide among South Asian and Panjabi men in the UK.[178]

In Canada, limited research has specifically addressed suicide rates among South Asian and Panjabi men. However, studies focusing on the broader South Asian population have found that they may be at a higher risk for suicide compared to other immigrant groups (Khan et al., 2015). Similar to the UK, factors such as acculturation stress, social isolation, and cultural stigma surrounding mental health may contribute to this increased risk.[179]

In the United States, research on suicide rates among South Asian and Panjabi men is also scarce. A study by Wong et al. (2011)[180] found that South Asian men in the United States have a higher risk of suicide compared to other Asian American subgroups. The study suggests that factors such as cultural expectations, discrimination, and barriers to accessing mental health services may contribute to this elevated risk.[181]

---

[175] (Singh et al., 2022)
[176] (Ineichen, 2008)
[177] (Bhugra, 2004)
[178] (Bhui et al., 2003)
[179] (Forte et al., 2018)
[180] (Wong et al., 2012)
[181] (Wong et al., 2012)

The issue of suicide rates among Panjabi men in India and South Asian and Panjabi men in the UK, Canada, and the United States is a significant public health concern. Factors such as cultural expectations, acculturation stress, social isolation, discrimination, and stigma surrounding mental health contribute to these increased rates. Further research is necessary to explore additional factors and create targeted interventions for addressing suicide risk among these populations. Culturally sensitive mental health services and community-based initiatives promoting mental health awareness and help-seeking behaviors may be crucial in addressing this issue.

South Asian and Panjabi men in Canada and the United States encounter unique mental and physical health challenges, including depression, cardiovascular diseases, diabetes, and specific types of cancer. The presence of trauma in mental health difficulties among this demographic underscores the need to address pre-migration and post-migration experiences when crafting targeted interventions. To improve the health outcomes of South Asian and Panjabi men in these countries, it is crucial to tackle cultural barriers, promote mental health awareness, and offer culturally sensitive healthcare services. Further exploration is necessary to better understand the additional factors that contribute to the health disparities experienced by this population.

2.6.2 Female Narrative

In diverse intersectional spaces, including those encompassing Indigenous, Black, and People of Color (IBPOC) cultures, the female narrative often experiences marginalization or exclusion. Such exclusion arises from both Western societal influences and ingrained cultural practices, perpetuating the systemic silencing of female voices. Drawing from the works of bell hooks and

other racial academic writings, this paper will explore the exclusion of female narratives in IBPOC cultures and discuss potential approaches to addressing this marginalization.

In her groundbreaking book "*Ain't I a Woman: Black Women and Feminism*" (1981), bell hooks examines the exclusion of Black women's experiences and narratives from mainstream feminist discourse. hooks asserts that this exclusion arises from the dual oppression faced by Black women, who confront not only patriarchy but also racism. This intersectional viewpoint emphasizes the complexities of the female narrative within IBPOC communities, which are often overlooked or dismissed in both feminist and racial dialogues.[182]

Similarly, Chandra Talpade Mohanty, in her impactful essay "Under Western Eyes: Feminist Scholarship and Colonial Discourses" (1988), critiques the ethnocentric and monolithic depiction of "Third World women" within Western feminist writings. Mohanty contends that this portrayal reinforces power dynamics and contributes to the erasure of diverse female voices and experiences in non-Western cultures. By perpetuating essentialist narratives, Western feminist scholarship inadvertently silences women's voices within IBPOC communities.[183]

Patriarchy and male dominance often contribute to the exclusion of female narratives within traditional cultural practices of IBPOC communities. For instance, confining women to domestic spaces and policing their social interactions and mobility may limit their access to education, professional opportunities, and public life.[184] Such restrictions can hinder women's ability to express their voices and share their experiences, further marginalizing them within their communities.[185]

---

[182] (hooks, 2015)
[183] (Mohanty, 1988)
[184] (Chanana, 1993)
[185] Ibid

Additionally, cultural gatekeeping by both men and women may perpetuate the exclusion of female narratives in IBPOC cultures. This gatekeeping can manifest as enforcing women's adherence to traditional gender roles and perpetuating patriarchal norms that uphold male dominance while restricting women's autonomy.[186]

To address the exclusion of female narratives in IBPOC cultures, it is essential to cultivate spaces for dialogue and amplify the voices of women from these communities. Intersectional feminism offers a valuable framework for understanding and addressing the complexities of oppression and marginalization that women in IBPOC communities encounter.[187] By adopting an intersectional perspective, feminist movements and scholarship can become more inclusive and considerate of the diverse experiences and narratives of women from various cultural backgrounds.[188]

The exclusion of female narratives in IBPOC cultures is a complex issue perpetuated by both Western society and traditional cultural practices. Works by bell hooks, Chandra Talpade Mohanty, and other racial academic writings emphasize the need for a more inclusive and intersectional approach to understanding and addressing the marginalization of female voices within IBPOC communities. By fostering dialogue and amplifying the voices of women from these communities, we can work towards dismantling the systemic silencing of female narratives and promoting a more inclusive and equitable society.

South Asian and Panjabi females hold an indispensable position in the provision of healthcare and social welfare services across Canada, the United States, and the UK. In Sikh communities, culture plays a large role in practice rather than the Sikh paradigm given to us by

[186] (Lorde, 2007)
[187] (Crenshaw, 1989)
[188] Ibid

the Guru. Some Sikhs tend to imbibe the Indic majority's cultural and doctrinal stance on women.[189] These women are active in a myriad of capacities, from direct care providers to advocates and community supporters. This paper delves into the multifaceted roles of South Asian and Panjabi women in these realms, whilst acknowledging the often-overlooked emotional labor they exert beyond their household responsibilities.

In the sphere of healthcare, South Asian and Panjabi women contribute significantly as frontline caregivers, taking on roles such as nurses, doctors, and other healthcare professionals. Their unique expertise and cultural insights enable them to deliver culturally sensitive care to diverse patients.[190] Moreover, South Asian and Panjabi women have been pivotal in spearheading community-based healthcare initiatives, aimed at reducing health disparities and enhancing access to healthcare services for marginalized groups.[191]

In the context of social welfare services, South Asian and Panjabi women actively advocate for and support vulnerable populations, including immigrants, refugees, and economically disadvantaged families.[192] Their work often concentrates on overcoming barriers to accessing social services and endorsing culturally relevant interventions.[193] Additionally, South Asian and Panjabi women hold influential roles in the establishment and management of non-profit organizations, contributing to the overall welfare and well-being of their communities.

Yet, in addition to their professional commitments within healthcare and social welfare services, South Asian and Panjabi women frequently undertake emotional labor that remains

[189] (Kaur & Singh, 2023)
[190] (Fernandez et al., 2004)
[191] (Mumtaz et al., 2003)
[192] (Ahmad et al., 2013)
[193] Ibid

unrecognized.[194] This emotional labor may encompass offering care and support to extended family, neighbors, and friends, often without financial compensation. This added weight can place considerable stress on these women, who concurrently navigate their professional and domestic duties.

The expectation for South Asian and Panjabi women to engage in emotional labor beyond their household chores is deeply entrenched in traditional gender roles and cultural expectations.[195] These expectations can result in an unequal distribution of caregiving duties, with women shouldering the majority of both physical and emotional work.[196] This imbalance can negatively impact women's mental and physical health, as they might grapple with heightened stress, burnout, and limited opportunities for self-care.

In summation, South Asian and Panjabi females perform essential functions in facilitating healthcare and social welfare services within Canada, the United States, and the UK. Their involvement spans a wide range of sectors, including direct care provision, advocacy, and community-based support. However, it is imperative to recognize and address the emotional labor these women perform beyond their professional and household duties. By acknowledging and confronting this issue, policymakers and community leaders can work towards forging more equitable and supportive environments for South Asian and Panjabi women, ultimately promoting their well-being and success in both their personal and professional lives.

[194] (Karasz et al., 2013)
[195] (Dasgupta, 1998)
[196] Ibid

2.7 Current state of translated materials

In the struggle for health and well-being, the dissemination of health-related information stands as a crucial instrument for empowering the masses. Canadian organizations, such as the Fraser Health Authority, Canadian Mental Health Association, and Centre for Mental Health and Addiction, are producing booklets, brochures, and pamphlets to illuminate the people about various dimensions of mental and physical health. Yet, recent explorations have unmasked inconsistencies in the translated terms, spelling mistakes, formatting, and cultural safety of these materials, exposing a hidden weakness in the educational armament. This analysis seeks to confront these inconsistencies head-on and proposes remedies for enhancing the caliber of health-related materials produced by Canadian organizations.

In the vast linguistic landscape of Canada, the necessity of providing health-related materials in multiple languages is self-evident.[197] Nonetheless, inconsistencies in the translated terms sow seeds of confusion and misinterpretation, potentially sabotaging the effectiveness of these materials.[198] Erroneous translations may give rise to misunderstandings and perpetuate false beliefs about health-related matters.[199] To conquer this dilemma, organizations must marshal resources for professional translation services or forge alliances with community-based organizations to guarantee the precision and lucidity of translated materials.[200]

Spelling mistakes and formatting inconsistencies, seemingly trivial, may erode the credibility of the source and impede the understanding of the intended message.[201] To safeguard

[197] (Statistics Canada, 2017)
[198] (Moissac & Bowen, 2018)
[199] (Berman & Tyyskä, 2011)
[200] (Moissac & Bowen, 2018)
[201] (O'Mahony & Donnelly, 2007)

the integrity of the information and ensure effective knowledge dissemination, organizations must commit to rigorous proofreading and editing processes.[202] Collaboration with multidisciplinary teams, including health communication experts, can help identify and rectify these errors before they reach the unsuspecting public.[203]

Cultural safety must not be overlooked in the development of health-related materials, for it guarantees the relevance and sensitivity of the information to diverse populations.[204] Cultural insensitivity can give birth to feelings of alienation and marginalization, diminishing the likelihood that individuals will embrace the materials.[205] To champion cultural safety, Canadian organizations must engage with representatives from different cultural backgrounds during the development process, ensuring that the materials resonate with the target audience. Moreover, culturally-appropriate imagery, examples, and case studies can foster a deeper understanding and acceptance of health-related messages.[206]

The Canadian Mental Health Association (CMHA) launched an initiative in 2016 called Bounce Back[207]. This evidence-based program, grounded in Cognitive Behavioural Therapy [CBT], endeavours to alleviate early symptoms of depression and anxiety among individuals aged 15 and above, and bolster their mental health. As stated on Bounce Back's website, this free skill-building program is designed to assist adults and youth aged 13 and over in managing low mood, mild to moderate depression, anxiety, stress, or worry. Delivered through an online platform or over the phone with a coach, participants gain access to tools that support their

[202] (Dutta-Bergman, 2004)
[203] (O'Mahony & Donnelly, 2007)
[204] (Papps & Ramsden, 1996)
[205] (Kirmayer, 2012)
[206] (Kirmayer, 2012)
[207] (Canadian Mental Health Association, 2016)

journey towards mental wellness. The program also offers booklets translated into Panjabi, Hindi, and Mandarin.

In our exploration, we shall scrutinize one of the Panjabi booklets that are available to the public for a fee of $5.00. This booklet is part of another initiative by CMHA called Living Life To The Full (LLTTF). Bearing the Panjabi title "ਯਾਦਾਸ਼ਤ ਲਈ ਪਰਚੀਆਂ ਬਣਾਉਣੀਆਂ - ਅਤੇ ਇਨ੍ਹਾਂ ਨਿੱਕਆਂ ਕਿਤਾਬਚੀਆਂ ਦਾ ਵੱਧ ਤੋਂ ਵੱਧ ਲਾਭ ਲੈਣ ਦੇ 14 ਹੋਰ ਤਰੀਕੇ" (Yādāśata la'ī paracī'āṁ baṇā'uṇī'āṁ - atē inhāṁ nika'āṁ kitābacī'āṁ dā vadha tōṁ vadha lābha laiṇa dē 14 hōra tarīkē), the title is translated to "making notes for memory." This Panjabi booklet (image 1) is derived from an English booklet titled "Write all over your bathroom mirror- and 14 more ways to get the most out of these booklets."[208] On CMHA's website, this booklet is categorized under youth booklets. Despite the modified title for the Panjabi booklet, a Gurmukhi (Panjabi) reader would not need to leaf through multiple pages to discover a spelling mistake, as there is one in the title itself. The accurate Panjabi translation for memory is ਯਾਦਦਾਸ਼ਤ (Yādadāśata), while the booklet uses ਯਾਦਾਸ਼ਤ (Yādāśata).

[208] (Canadian Mental Health Association, 2008)

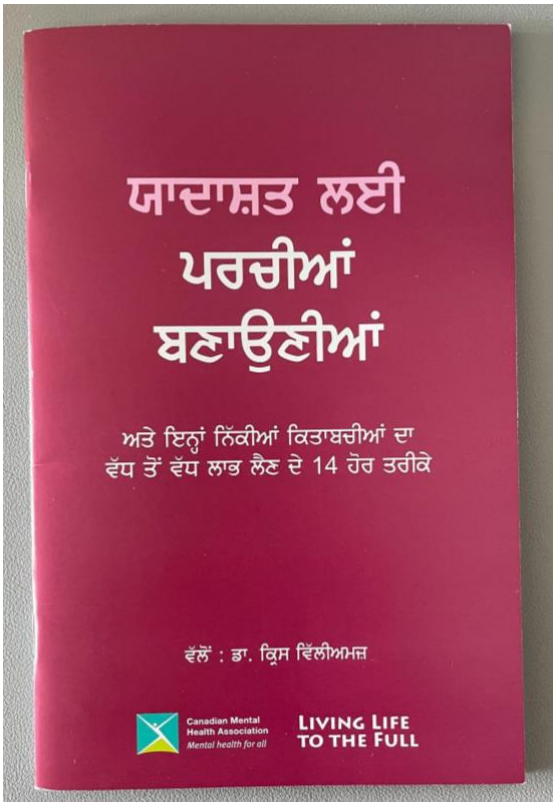

Image 1- ਯਾਦਾਸ਼ਤ ਲਈ ਪਰਚੀਆਂ ਬਣਾਉਣੀਆਂ - ਅਤੇ ਇਨ੍ਹਾਂ ਨਿੱਕਆਂ ਕਿਤਾਬਚੀਆਂ ਦਾ ਵੱਧ ਤੋਂ ਵੱਧ ਲਾਭ ਲੈਣ ਦੇ 14 ਹੋਰ ਤਰੀਕੇ" (Yādāśata la'ī paracī'āṁ baṇā'uṇī'āṁ - atē inhāṁ nika'āṁ kitābacī'āṁ dā vadha tōṁ vadha lābha laiṇa dē 14 hōra tarīkē) booklet by Living Life To The Full

Throughout the booklet, there are two different Gurmukhi spellings of the word "booklet". In image 2, the word ਕਿਤਾਬਚੀਆਂ (Kitābacī'āṁ) [209] is used. In image 3, the word ਕਿਤਾਬੜੀ (Kitābaṛī) [210] is used.

[209] ਕਿਤਾਬਚੀਆਂ (Kitābacī'āṁ) means booklets. The singular word would be ਕਿਤਾਬਚੀ. This word is also used for a bookkeeper.
[210] ਕਿਤਾਬੜੀ (Kitābaṛī) means a booklet.

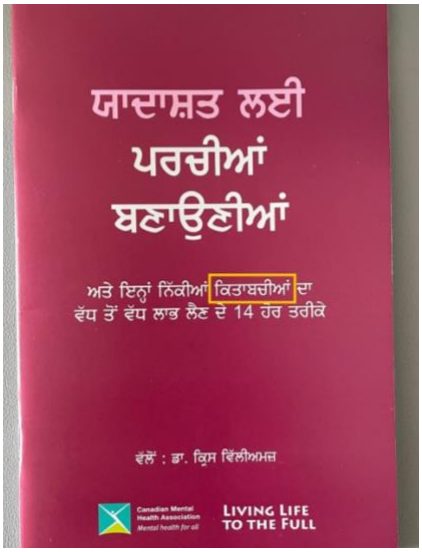

Image 2 Close up Panjabi booklet by Living Life to The Full - Canadian Mental Health Association)

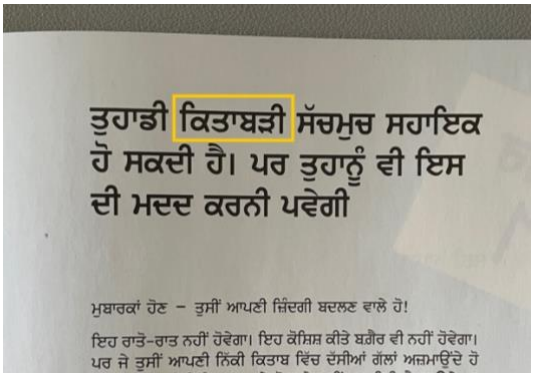

Image 3 -Close up of the Panjabi booklet by Living Life to The Full - Canadian Mental Health Association)

Beyond the veil of spelling errors, we must examine the context in which this booklet is disseminated. The original target audience is the youth, yet it reaches the hands of adults. A single resource can indeed serve multiple purposes, but the question of cultural safety demands a profound understanding of the intended users, their behaviors, and values. The content of the booklet not only suffers from spelling mistakes but also lacks any semblance of cultural safety.

The Bounce Back program distributes these booklets to the Panjabi communities in British Columbia, fueled by funding from the Provincial Health Services Authority (PHSA)[211].

[211] (Canadian Mental Health Association, 2016)

As we shall see in the upcoming chapter, the PHSA also operates the Provincial Language Services (PLS)[212], a program that provides language access services to health authorities, family practice practitioners, specialist offices, and other allied health professionals. Despite having access to professional language services, these errors persist, exacerbating the ongoing challenges faced by patients or readers attempting to navigate their health journeys.

Inconsistencies in health-related materials, whether in translation errors, spelling mistakes, inappropriate formatting, or lack of cultural safety, threaten users' capacity to understand and confront their health challenges. It is imperative to address these issues to fortify the effectiveness and accessibility of health-related materials. By ensuring accurate translations, correcting spelling mistakes, adopting appropriate formatting, and prioritizing cultural safety, health organizations can invigorate users' understanding and fortify them in making informed decisions about their health.

2.8 Role of Google translate

In a world where the need for comprehensive and culturally sensitive information is vital for those seeking healthcare and social welfare services, linguistic barriers can stand as formidable obstacles. These barriers not only perpetuate health disparities but also further marginalize already vulnerable communities.[213] Enter Google Translate, a machine translation service created by Google, which has been embraced as a means to bridge language gaps and facilitate quick translations for healthcare and social welfare information. Here, we delve into the role Google

[212] (Provincial Health Services Authority, 2008)
[213] (Karliner et al., 2007)

Translate plays in making these resources available, scrutinizing its strengths, limitations, and the potential impact on achieving equitable and efficient services.

Google Translate provides free and swift translations in more than 100 languages.[214] This allows healthcare providers and social welfare organizations to share multilingual resources without the burden of significant costs or time constraints. For settings where resources are scarce, and professional translation services seem like an unattainable luxury, Google Translate emerges as a beacon of hope.

Translation accuracy and context sensitivity loom as crucial concerns when depending on Google Translate. Despite the impressive strides in machine learning, this translation tool struggles with crafting translations that are both consistently accurate and attuned to the context surrounding the information.[215] Such limitations can spawn misunderstandings, misdirected diagnoses, and ill-suited care, all of which harbor the potential to endanger patient safety and overall well-being.

The intricate nature of healthcare and social welfare terminology, interwoven with the complexities of human language, underscores the necessity for precise translations that encompass cultural, regional, and colloquial subtleties. For example, certain medical terms might hold multiple meanings, making the context in which they are employed vital for discerning the intended message. Likewise, social welfare information could entail delicate situations or cultural customs demanding a profound grasp of local context.

Within the sphere of patient-provider interactions, the repercussions of miscommunication can be disastrous. An erroneous translation could precipitate improper

[214] (TechCrunch, 2016)
[215] (Freitag et al., 2021)

treatment, delayed care, or even irreparable harm. In social welfare contexts, imprecise translations might lead to resource misallocation, stigmatization, or the disempowerment of individuals and communities.

Given the current state of Google Translate's limitations in terms of accuracy and context sensitivity, a prudent approach is necessary when employing the tool for healthcare and social welfare purposes. The fusion of machine translation and human expertise is crucial for conveying essential information with the highest degree of accuracy, cultural consciousness, and contextual sensitivity. This collaborative strategy can pave the way for enhanced communication, nurture trust, and ultimately foster more equitable and efficacious healthcare and social welfare outcomes.

Cultural competence stands as a vital element in communication across healthcare and social welfare settings. Yet, Google Translate might falter in fully embracing cultural subtleties, resulting in translations perceived as unsuitable or offensive to specific populations.[216] Failing to recognize these nuances can obstruct the growth of trust and thwart the nurturing of healthy patient-provider relationships, both of which are crucial to successful care and support.

Culturally competent communication transcends simple linguistic translations, demanding a profound grasp of the target audience's beliefs, values, customs, and practices. In healthcare, this understanding is paramount to ensure that patients feel valued and listened to, which in turn encourages adherence to treatment plans and enhances overall health outcomes. Similarly, in social welfare settings, adopting a culturally competent approach enables service providers to better understand the unique challenges faced by diverse communities, paving the way for tailored and effective support.

[216] (Garcia & Peña, 2011)

When relying on Google Translate, the absence of cultural competence can reveal itself in various forms, such as misinterpreting idiomatic expressions, neglecting culturally specific metaphors, or overlooking non-verbal communication cues. These shortcomings can generate misunderstandings, misconceptions, and even strained relationships between patients and providers, as well as between service users and social welfare organizations.

To confront these issues and ensure culturally competent communication, it is imperative to augment machine translation with human expertise, specifically from individuals who embody cultural knowledge and insights relevant to the target population. By uniting the strengths of both technology and human understanding, healthcare providers and social welfare organizations can cultivate a more inclusive and respectful environment that fosters trust, collaboration, and ultimately, more equitable and effective care and support for all individuals.

2.9 Findings from subject-matter experts (SMEs)

Over the span of a month, I engaged in consultation sessions with SMEs from healthcare and social welfare who serve the diverse needs of Panjabi communities in Canada, where they are present in significant numbers. The SMEs included a family physician, nurse practitioner, registered counselor, project manager, and director of a language service at a provincial health authority from the Greater Vancouver and Fraser Valley area in British Columbia and Brampton, Ontario. Each consultation session unfolded over an hour, with consistent questions across sessions, adapted as necessary to resonate with each SME's area of work and to foster meaningful dialogue.

In the subsequent chapter, we delve into the interactions between SMEs and various members of the Panjabi communities within the diaspora. Through these sessions, SMEs

illuminated the barriers and challenges faced by Panjabi community members during their appointments, offering a glimpse into their lived experiences. These conversations also shed light on the reactive solutions implemented by healthcare authorities and social welfare organizations, highlighting the need for systemic and holistic approaches to provide inclusive and effective care.

2.9.1 Mental health

In session with Gary Thind, the founder of Moving Forward Family Service[217], Gary discussed his background in social work, his experiences working in various roles, and the systemic issues he observed throughout his career. He noticed a lack of resources, long waitlists, and difficulty in addressing the needs of culturally diverse communities. Despite recognizing the need for collaboration, many organizations struggled to work together due to the limitations of the system.

Frustrated with turning people away and the inefficiencies within the system, Gary was inspired to create Moving Forward Family Service. He noticed that students on practical placements, with proper support, could address the gaps in service provision. This led to the creation of the organization, which now serves thousands of clients across the country without direct government funding.

Gary also mentioned that Moving Forward Family Service has become a special interest group, partnering with like-minded organizations to address the needs of the community. He wears multiple hats at the organization, including founder, executive director, and clinical

[217] (Moving Forward Family Services, 2021)

supervisor. Despite his many responsibilities, he remains focused on the clients and their diverse needs.

It was discussed that Moving Forward Family Service provides support to clients from diverse backgrounds, offering services in 33 languages. These include Tamil, Cantonese, Mandarin, Korean, Farsi, Panjabi, Hindi, Urdu, and Arabic, among others. But the main clientele speaks Panjabi, Hindi and Urdu. The organization is open to helping anyone in need, regardless of their background.

An observation from this session is the impressive linguistic diversity within the organization, which highlights its commitment to inclusivity and addressing the unique needs of various communities. This dedication to serving a wide range of clients, including white Canadians and newer immigrants, illustrates how Moving Forward Family Service is striving to bridge gaps in the social work system for all individuals, regardless of their background or language.

In session with Gary, he mentioned that clients generally come alone for sessions, although the initial contact might come from a family member. If clients want to attend together, they would do a family session. He also highlighted the importance of interdependence that is present in the Panjabi culture. Gary mentioned that very often he notices a person coming along with the client even though the initial role of that was to provide language services but ends up transitioning to moral support. He also discussed the importance of confidentiality and setting boundaries in counselling, particularly within diverse communities. Gary acknowledged that in some cases, self-disclosure may be beneficial for establishing rapport and helping clients feel more comfortable. He shared his own experience of being open to discussing his background to

break the ice and connect with clients. Gary emphasized that clients aren't trying to manipulate the session but are simply seeking connection and understanding.

This session highlights the importance of flexibility and cultural sensitivity when working with clients from diverse backgrounds. Gary's approach to counselling demonstrates his willingness to adapt traditional practices to better serve the unique needs of his clients. This open-mindedness and understanding of cultural nuances are key factors contributing to the success of Moving Forward Family Service.

In the session with Gary, he discussed the limitations of traditional interventions in addressing intergenerational traumas, particularly for diverse communities. He expressed concerns that the current system focuses too much on a medical model, often neglecting the broader context of clients' lives, including the traumas they've experienced and the challenges of migration and cultural adjustment. Gary criticized the concept of individualism in Western societies, arguing that it has negatively affected people, including white Canadians. He believes that the current system needs adjustments for all communities, not just specific populations. He also mentioned that traditional intervention methods, like cognitive-behavioural therapy, may not fully address the traumatic experiences that have shaped families' lives.

He highlighted the lack of timely resources for diverse communities, and how the current system contributes to stigma and barriers to access. He mentioned that even mainstream efforts like "Bell Let's Talk"[218] have limitations, as they encourage session without always providing adequate resources to support those in need.

Gary discussed the importance of cultural awareness and sensitivity in mental health services. He mentioned that skilled therapists should be able to incorporate cultural practices and

[218] Bell Let's Talk is a campaign created by the Canadian telecommunications company, Bell Canada, in an effort to raise awareness and combat stigma surrounding mental illness in Canada. (Bell Canada, 2010)

faith-based elements into their sessions, even if they don't share the same background as their clients. Gary shared examples of misunderstandings that can occur when therapists don't take the time to understand the cultural context of their clients' lives. For instance, he mentioned cases where South Asian Panjabi clients were advised to leave relationships or kick out adult children without considering the cultural implications of such decisions. He also discussed the assumptions and misconceptions surrounding extended family households, which can sometimes be stigmatized in Western societies. However, he pointed out that these living arrangements have become more normalized as the cost of housing has increased and as other communities have adopted similar practices.

Gary emphasized the need for mental health professionals to be culturally sensitive and open to exploring their clients' cultural backgrounds. This will help them better understand the clients' experiences and provide more effective support. It also highlights the importance of challenging assumptions and stereotypes in order to foster a more inclusive approach to mental health care.

Gary discussed the gender disparity in seeking mental health services, particularly within the Panjabi community. Gary mentioned that a significant number of men who do seek help often do so due to ministry involvement or criminal justice-related issues, such as intimate partner violence or substance use. He noted that there is still work to be done to encourage men to openly discuss their feelings and seek help.

Gary provided examples of the challenges in engaging men in mental health support. He mentioned the success of a Panjabi women's group that consistently attracts participants, while a men's group struggled to gain traction and primarily drew mandated clients. This highlights the need for more proactive and culturally sensitive outreach to help address the stigma around

mental health services for men, particularly within communities where traditional gender roles may still be prevalent.

Gary also discussed your approach to helping Panjabi clients by combining dialogue, person-centred, and narrative methods. You mentioned that you used to gather resources to provide clients with practical tools to address specific issues, such as sleep hygiene or stress management. Gary created a WordPress site, where he stored and shared these resources, including videos and psychoeducational materials in Panjabi.

Additionally, we discussed the availability of translated materials from various sources, such as health authorities and government organizations. While acknowledging some shortcomings in translation and complexity, these resources can be useful for Panjabi-speaking clients. Overall, the session highlights the importance of using culturally relevant and linguistically accessible resources to better serve diverse communities in mental health care.

Gary discussed the coping mechanisms of Panjabi men and women, noting that men often turn to alcohol or opioids to cope with suffering, while women tend to internalize and somatically manifest their struggles. You observed that the medical profession might not always recognize these cultural patterns, which could lead to inadequate treatment and support.

We touched on the importance of communication and asking open questions to better understand the underlying issues in mental health care. The session highlights a potential disconnect between the way Panjabi individuals may express their struggles and the approach of healthcare providers. This emphasizes the need for healthcare professionals to be empathetic and culturally sensitive, ensuring they take the time to ask probing questions to uncover the root causes of the issues being faced by their patients.

Gary discussed his early experiences adapting resources for Panjabi clients by having his mother help with translations and modifying materials. He noted that he still sometimes uses this approach when certain resources are missing. He emphasized the importance of not merely providing literal translations of English materials, but also considering cultural nuances and metaphors that are more appropriate for the target audience. Gary shared an example of a parenting program while providing valuable content, that lacked cultural relevance for Panjabi parents, with examples that were not relatable and not a practice in the Panjabi culture to even begin with. This underscores the importance of adapting resources and programs to be culturally sensitive and using examples that resonate with the specific communities being served. The session highlights the need for culturally appropriate resources and communication in order to bridge gaps and improve understanding of mental health care and other support services.

In our session, Gary discussed the role of technology in the Panjabi diaspora and the difference in attitudes between newly arrived immigrants and those who have been in the country longer. He mentioned an observation from a journal that highlighted how couples from India were seen as "backwards" by some Canadians for holding hands, despite the fact that these newcomers were often more tech-savvy and liberal in their outlook. This session highlights the complexities and misconceptions that can arise within a diaspora and emphasizes the importance of understanding and respecting the diverse perspectives within a community.

Gary provided an overview of the translation practices at Moving Forward Family Services. The organization focuses on community-university engagement and actively welcomes individuals who speak different languages to address the diverse language needs of clients. Due to the lack of funding, external translation services are not utilized; instead, students are often asked to help with smaller translation tasks. When it comes to translating materials, the

organization tries to adapt existing resources from different sources, such as merging English and Panjabi versions of a manual from Vancouver Island Health[219]. This approach highlights the resourcefulness and commitment of Moving Forward Family Services to meet the diverse linguistic needs of its clients despite funding limitations.

In our session, Gary discussed the importance of developing a holistic approach to understanding clients' assessments or diagnoses. Gary mentioned that the community relies heavily on television, radio, and visual information, which can be both beneficial and concerning. It allows medical professionals and counsellors to disseminate information, but it also opens the door to unethical practices and self-promotion.

Gary also pointed out the increasing use of social media and messaging apps like WhatsApp among the older generation, making it a useful tool for spreading information. However, he expressed concerns about the limitations of traditional methods like distributing pamphlets in medical clinics. Gary emphasized the need for a more comprehensive approach to truly address issues and facilitate behaviour change in the community. He also shared his experiences of having to compromise in the nonprofit sector, accepting subpar support in hopes of obtaining funding for future goals.

In the session with Gary, we discussed the impact of Western society's individualistic approach on various communities, including the Panjabi diaspora. Gary pointed out that the individualistic approach is not only harmful to non-white communities but also to white people, as the system was designed for able-bodied white men, leaving others without proper support.

[219] Island Health, also known as the Vancouver Island Health Authority, is the publicly funded health care provider in the southwestern portion of the Canadian province of British Columbia. (Island Health, 2023)

Gary also mentioned the work of Gabor Maté[220], who emphasizes the importance of interconnections and how the loss of these connections contributes to trauma and issues like the opioid crisis. The session highlighted the need for a balance between individualism and collectivism, as extreme approaches on either side can be problematic. Gary stressed the importance of collaborating with like-minded people to make a difference and emphasized that the evidence supports the value of a more collectivist approach, making it difficult to disregard.

In the heart of our conversation with Gary, we delved into the intricate tapestry of language, cultural sensitivity, and the interplay between individualism and collectivism within the Panjabi diaspora and other communities. Gary underscored the crucial nature of accessible translations and resources in the Panjabi language, while also cautioning against the limitations of literal translations. Rather, he passionately advocated for attending to cultural nuances and tailoring resources to resonate with the unique experiences of specific communities.

Gary confronted systemic issues and the shortcomings of reactive solutions in social work, sharing his imaginative approach to harnessing student placements as a means to address community needs, and displaying unwavering dedication to forging collaborative bonds with other organizations. It is abundantly clear that Gary's heartfelt commitment to uplifting those in need acts as a powerful catalyst for the success of Moving Forward Family Service. His critique of the prevailing system illuminates the necessity of reevaluating the efficacy of conventional intervention methods and crafting accessible, timely resources that embrace all communities.

Within our dialogue, Gary explored the influence of technology on the Panjabi diaspora, observing that newly arrived immigrants frequently possess a more open-minded outlook and greater tech-savviness compared to their counterparts with a longer tenure in Western countries.

[220] Gabor Maté is a Canadian physician and author. He has a background in family practice and a special interest in childhood development, trauma and potential lifelong impacts on physical and mental health. (Maté, 2023)

He further highlighted the importance of holistic approaches in comprehending assessments or diagnoses and addressing the gaps in services and resources for the Panjabi and other communities.

Moreover, Gary shed light on the challenges imposed by Western society's predilection for individualism and the untapped potential of embracing a more collectivist orientation. He contended that both perspectives hold merits and flaws, and discovering equilibrium between the two could engender benefits for all communities.

In essence, Gary's perceptive insights accentuate the imperative for culturally-sensitive resources, a harmonious balance between individualism and collectivism, and the significance of collaboration in addressing the distinct needs of our diverse communities.

2.9.2 Social Welfare

In this consultation, I spoke with Preet, whose name has been changed for anonymity. Preet is the project manager for a seniors initiative based in Surrey, working for a local nonprofit community service society. She has been in the nonprofit sector for five years. Preet's organization primarily serves South Asian clients and is involved in various roles within the community.

The project Preet manages is funded by the federal government under the New Horizons for Seniors program grant[221]. It is a five-year initiative in partnership with five different organizations and the municipality, each offering various strengths and catering to diverse demographics. The main aim of the project is to address social isolation among seniors.

[221] The New Horizons for Seniors Program (NHSP) is a federal grants and contributions program. It provides funding for projects that make a difference in the lives of seniors and in their communities. (Government of Canada, 2023)

As the project manager, Preet oversees seven different initiatives, each run by one of the partner organizations. These initiatives include teaching seniors technology skills, storytelling programs, supporting indigenous elders, providing a resource hub, and organizing walking, gardening, and group telephone call programs. The project also involves informative services, workshops, and connections with healthcare providers to support seniors' healthcare needs.

Preet's role involves ensuring that the initiatives run smoothly, reporting back to the funder, monitoring the projects' objectives, and maintaining continuous communication within the network. The backbone team, including Preet, meets on a monthly basis to discuss the progress of the projects, address any challenges, and share upcoming events or ideas to introduce to the community. They also provide administrative support to partner organizations.

Preet discussed the demographics and language preferences of the clients her organization serves. Preet mentioned that around 80-90% of their clients are South Asian, and while many of them speak English, they often prefer to communicate in their native language, such as Panjabi, to ensure clarity. Staff members at the organization are able to speak the clients' native languages and provide translation services as needed.

Preet also described how clients usually attend the programs or services offered. She observed that couples tend to come together, men often come with male friends, and younger groups attend with their families. Seniors are generally accompanied by someone, but some do come in by themselves. She also mentioned that there are often internal referrals within the organization, where clients seek additional services after being introduced to other programs or services.

Preet's observations indicate that the clients her organization serves come from diverse backgrounds and have varying preferences when it comes to language and attending programs.

The organization takes these factors into account to provide effective and accessible services to its clients. She shared her insights on staff-client dynamics and the nonprofit sector. She observed that the majority of staff in the sector are women, and clients tend to feel comfortable discussing their issues with them, regardless of gender. This suggests that both male and female clients feel at ease with female facilitators, though this doesn't negate the importance of male facilitators.

Preet also highlighted the importance of building rapport with clients, which enables them to share their concerns more openly. The network of organizations collaborates to provide resources and services to address clients' issues, including mental health support and various workshops. These services are accessible in different formats, such as online, in-person, or over the phone, depending on the service provider and client preference.

Additionally, Preet discussed the translation of promotional materials into multiple languages to reach a wider audience. The organization sometimes relies on internal departments that would source external contacts for translation support, showcasing the importance of community engagement in their work. These observations emphasize the crucial role of relationship-building, collaboration, and cultural sensitivity in the nonprofit sector to effectively meet the diverse needs of clients and foster a supportive environment.

In the session with Preet, she discussed the process of distributing promotional materials and the follow-up from community members. She noted that there isn't a specific protocol for translations, and she is not aware of the details related to the reviewing process for translations. At community events, questions are usually addressed on the spot, and brochures serve as additional resources for clients to contact the organization if interested. Preet also mentioned that she noticed more women participating in their programs than men.

When it comes to registration and inquiries, Preet observed that both men and women call, and sometimes their children would reach out on behalf of their parents. She also noted that couples often join the programs together, but women might show more interest in certain cases. In-person sessions have higher engagement levels compared to online sessions, as it is more difficult to maintain clients' attention online. Regarding children's involvement, Preet shared that they usually ask about the details of the program and support their parents during the registration process. She noticed that children would help their parents or grandparents log in to online sessions, but seniors might face difficulties when children aren't available to provide support.

These observations highlight the importance of understanding clients' preferences and the role of family members in facilitating access to programs and services. Additionally, the session emphasizes the need for easy-to-understand promotional materials, accessible support, and the right balance between in-person and online sessions to accommodate diverse clients.

In the session with Preet, she shared feedback received from South Asian seniors regarding presentations and promotional materials. The seniors mentioned that they faced difficulty hearing during a presentation and would have preferred a copy of the presentation in front of them to follow along. Preet also observed that the older demographic still prefers hard copies of materials, while younger generations are more inclined to use digital platforms.

She emphasized the importance of using visuals, diagrams, and pictures to make healthcare information easily understandable. In terms of translations, Preet noted that using simplified, sessional language is more effective than formal or elaborate language, as it aligns with how people actually speak and helps them better understand the material. These observations indicate the need for accessible and user-friendly materials that cater to various age

groups and preferences. Additionally, designing materials that incorporate visuals and sessional language can enhance understanding and engagement among diverse audiences.

Preet discussed the challenges faced during verbal communication and translation, particularly in the healthcare sector. Using her personal experience, Preet highlighted that while the younger generation might understand what the doctor says in English, they may struggle to accurately translate certain words or phrases into their native language for the older generation. Conversely, the older generation may understand their native language well but may not grasp what the doctor says in English. Preet emphasized that the language barrier can be a significant challenge when trying to convey crucial medical information. In many cases, the older generation relies on their children or grandchildren for translation, but they may not always be equipped to handle medical jargon or accurately convey the intended message. These observations underscore the importance of addressing language barriers in healthcare and other sectors. Providing clear, accessible, and accurate translations can help improve communication and understanding, ensuring that critical information does not get lost in translation.

In an exchange with Preet, she delved into the profound significance of utilizing a rich tapestry of media channels and platforms to connect with the Panjabi community and impart crucial healthcare information. Preet observed that her community maintains a strong affinity for traditional platforms such as television and radio, rendering them as powerful conduits for disseminating healthcare messages. She accentuated the need for lucid communication in the native tongue, employing accessible language in videos, brochures, and other materials to ensure comprehension across generations.

Additionally, Preet unveiled the value of enlisting esteemed and respected figures within the community to impart vital healthcare knowledge, recognizing that their credibility holds the

power to sway the reception of the message. She illuminated the resilience and unity of the Panjabi community in moments of crisis and the untapped potential of harnessing that unity to bolster healthcare endeavours.

Preet also ventured into the realm of collaboration, advocating for synergy among healthcare service providers and organizations. She proposed that embracing a collective impact approach, where distinct groups unite their efforts and resources, could give rise to more fruitful outcomes and robust support for the community.

Throughout our exchange, Preet emphasized the potency of effective communication, collaboration, and the artful use of diverse media platforms to reach deep into the heart of the Panjabi community with essential healthcare information. She underscored the need for unambiguous communication in the native language, crafting materials that resonate with individuals of all ages. Preet acknowledged the importance of revered community figures in sharing healthcare information, as their credibility and positive reputation can amplify the impact of crucial messages. She also extolled the strength and unity of the Panjabi community, which, when channelled effectively, can bring about transformative change in healthcare initiatives.

By weaving together existing media platforms and fostering a spirit of collaboration, Preet envisions a world where healthcare providers can make a substantial difference in the Panjabi community's access to and comprehension of healthcare information, ultimately nourishing the well-being of the community as a whole.

2.9.3 Family care - doctor

Dr. Gurmeet Singh (name changed for anonymity) is a family doctor who practiced in Coquitlam, BC for a year before moving to Brampton. They primarily see patients of all ages for

outpatient care, focusing on preventative care, well-child visits, annual exams, and medication checks. They handle blood pressure and diabetes-related issues and refer patients to specialists when needed.

Dr. Singh serves a diverse patient population, with 25-30% of patients being of Panjabi speakers. They interact with younger patients in English and offer to converse in Panjabi if the patient prefers. Many of their younger Panjabi patients are international students or on work visas. Dr. Singh occasionally struggles with medical terminology in Panjabi, which can lead to misunderstandings and require clarification.

In their practice, Dr. Singh encounters patients with depression and anxiety, although they haven't seen many substance abuse cases. They observe that many patients are hesitant to take medication for mental health issues, preferring to rely on family support or religious practices. Dr. Singh hasn't encountered patients who rely solely on religious practices for treatment, but they encourage incorporating meditation and positive social interaction for mental well-being if the patient is religious.

Dr. Singh primarily educates patients on depression, anxiety, and other diagnoses through word of mouth and personal interactions. They sometimes use diagrams and discuss treatment plans during follow-up visits. They also engage with younger family members who may be involved in the elderly patient's healthcare management.

Dr. Singh provides educational literature on specific topics, such as the DASH diet for high blood pressure and safe sleep practices. They may explain these materials to the patient and their family in Panjabi to ensure understanding.

Most of the time, patients who come with someone else are either elderly or have mobility issues. Younger patients typically attend appointments alone or with a partner. In some

cases, elderly patients initially come with a translator but choose to attend future appointments alone after discovering Dr. Singh speaks Panjabi.

There is a noticeable power dynamic between male and female patients. Female patients are more likely to be accompanied by a male family member, but they tend to be more concerned about their health and their partner's health than male patients. Male patients often rely on their wives to encourage them to seek medical attention and address health issues.

Elderly Panjabi patients frequently attend appointments with an adult family member, such as a child, niece, or nephew, to help with translation and understanding their medical history. Dr. Singh has not observed many instances of much younger family members accompanying elderly patients in their practice.

Dr. Gurmeet Singh discusses the preferences of Panjabi and Indian patients, who often seek natural remedies for chronic health issues and prefer to avoid medication. However, for acute problems, they want a quick-fix pill. This dichotomy is more pronounced in the Panjabi community.

When patients mention traditional remedies or naturopathic treatments, Dr. Gurmeet approaches the situation cautiously, as he is only familiar with conventional medicine. He asks patients to bring in any naturopathic treatments they are using to check for interactions with prescribed medications. Dr. Gurmeet emphasizes that his recommendations are based on his knowledge and training, and he cannot endorse treatments he is not familiar with.

In an exchange with Dr. Gurmeet Singh, he tenderly offers suggestions for enriching healthcare literature and resources, emphasizing the need to make information accessible and digestible by avoiding complex medical jargon. Enlisting the aid of flow diagrams or imagery, he believes, can convey messages with more potency. Dr. Gurmeet also envisions creating distinct

levels of detail in pamphlets (beginner, intermediate, and advanced) to cater to the diverse array of knowledge and comprehension within the community.

Dr. Gurmeet acknowledges that even in his own practice, he may inadvertently employ medical terminology that obfuscates rather than enlightens his patients. He underscores the urgency of simplifying language and ensuring that patients grasp the terms and concepts discussed during their visits.

Throughout our intimate conversation with Dr. Gurmeet Singh, numerous intriguing points and observations emerged about healthcare in the Panjabi community. One notable aspect entailed the challenge of connecting with different generations and subgroups within the community, offering health information that resonates deeply with their experiences. Dr. Gurmeet accentuated the importance of tailoring communication methods and materials to embrace the preferences of varying age groups, education levels, and cultural backgrounds.

Another compelling topic explored was the design and accessibility of healthcare resources, such as pamphlets. Dr. Gurmeet stressed the need for more straightforward language, vivid visuals, and tiered information to accommodate diverse levels of understanding. Ensuring that patients can engage and comprehend the material is vital for nurturing their healthcare outcomes.

Moreover, the session delved into the unique attitudes of the Panjabi community toward medical treatment. Dr. Gurmeet observed that many patients lean towards natural remedies for chronic conditions while seeking swift solutions for acute problems. This duality can create challenges for healthcare providers in addressing patients' expectations and guiding them toward the most effective treatments.

Lastly, our discussion ventured into the challenges faced by healthcare providers in integrating traditional and naturopathic remedies within their practice. Dr. Gurmeet elucidated that his medical training limits his understanding of alternative treatments, which may sometimes result in difficulty advising patients on their efficacy or potential interactions with other medications. This illuminates the need for a deeper understanding and collaboration between diverse healthcare disciplines to ensure the most compassionate and holistic care for patients.

2.9.4 Family care - nurse

In the consultation session with Mandeep (name has been changed for anonymity), a nurse practitioner with an extensive background in healthcare. Mandeep has been working in the field since 2014, initially at a children's hospital where she dealt with various patient diagnoses, including diabetes in Panjabi families. In 2020, she transitioned to a family practice role and currently works with patients aged 0 to 100. Mandeep is also an adjunct professor at UBC, where she lectures and works with nursing students during their clinical rotations. She has experience working with Panjabi patients who have been in Canada for varying lengths of time, from recent immigrants to second and third-generation Canadian-born Panjabis.

Mandeep speaks Panjabi and is often called upon to provide translation services, though she also relies on phone translation services at least once weekly. She finds these translation tasks to be exhausting as she has to disseminate information, translate it, and chart it in English. Mandeep's patient age group used to be limited to 0 to 19 years old, but now it spans the entire lifespan, with her oldest patient being 90 years old and the youngest a newborn.

During the session, Mandeep discussed the presence of relatives accompanying patients during their visits, particularly in the Panjabi community. Mandeep observes that family

members are often present and it's more common for females, such as granddaughters or daughters-in-law, to accompany the patient. She notes that this trend is consistent across Asian cultures.

Mandeep acknowledges a level of discomfort when discussing sensitive topics with preteens in front of their parents. To mitigate this, she asks the accompanying adult to step out during part of the visit to facilitate open communication with the preteen. Mandeep also discusses the frequency of repeating information due to patients not understanding the diagnosis or treatment details. She attributes this to factors such as language barriers, shock, and the need to present information in multiple ways for better comprehension.

In the session, Mandeep shared the challenges of providing diagnoses to Panjabi patients, particularly when it comes to translating medical terms and addressing mental health issues. Mandeep notes that some diagnoses are harder to translate and might not be well-known among the Panjabi community. Additionally, mental health issues are sometimes not taken seriously due to cultural taboos.

Mandeep explains that she often provides referrals to resources such as handouts, websites, or booklets post-diagnosis. However, she mentions that Panjabi translations for these resources are limited, and she sometimes struggles to find them. In cases where resources are unavailable, Mandeep tries to educate her patients herself, translating the information in-person or providing the English version while discussing the content in Panjabi.

The session highlighted the importance of addressing cultural differences and language barriers in healthcare settings to ensure patients receive appropriate information and support. Mandeep's observations indicate a need for more Panjabi-language resources and increased awareness of mental health issues within the Panjabi community.

In this session, Mandeep discussed the challenges faced by the Panjabi community in understanding medical information, particularly due to language barriers and varying levels of education. Mandeep mentioned her experience with a video call-based translation service on wheels during her clinical rotation at BC Cancer Agency[222], which she found helpful in providing a more personal connection with patients.

Mandeep also shared her experiences in finding translated medical information online and the importance of understanding patients' level of education to provide appropriate care. She acknowledged that some patients may feel judged when asked about their level of education and may not fully disclose their understanding or lack thereof.

Patients' acceptance of their diagnosis, the use of home remedies, and their reluctance to disclose such practices were also discussed. Mandeep highlighted the importance of providing educational resources in multiple formats, such as videos and workshops, to cater to different learning preferences. She also mentioned the potential for knowledge dissemination in community gathering spaces like Gurdwaras, though she observed hesitancy and distrust in those settings.

Throughout the session, it is evident that language barriers, cultural factors, and the patient's level of education are significant challenges in providing effective medical care to the Panjabi community. Ensuring the availability of resources in multiple formats and fostering trust between healthcare providers and patients can help address these challenges.

In this session with Mandeep, we explored the distinctive challenges encountered by the Panjabi community in their quest to comprehend and access medical information. Mandeep, a compassionate healthcare professional working alongside Panjabi patients, underscored the

[222] BC Cancer (part of Provincial Health Service Authority) provides a comprehensive cancer control program for the people of BC in partnership with regional health authorities. (BC Cancer, 2023)

significance of transcending language barriers and recognizing patients' educational backgrounds to render effective care. Sharing her experiences and wisdom, she illuminated potential avenues for enhancing the existing system.

Mandeep elucidated the merit of video call-based translation services, which foster a more intimate bond with patients. By grasping their expressions and emotions, healthcare professionals can refine communication and cultivate trust. She also emphasized the necessity of ensuring medical information is accessible in various languages and formats, including online resources, allowing patients to tap into pertinent information irrespective of their linguistic or geographic constraints.

Discerning a patient's educational background is pivotal in customizing communication and care effectively. Mandeep revealed that she now inquires about patients' education levels to assess their comprehension and convey suitable information. She observed that patients might be reluctant to divulge their lack of understanding, potentially resulting in miscommunication or inadequate care.

Mandeep highlighted the importance of acknowledging and conversing about patients' use of home remedies or alternative treatments, as these practices may influence their health and treatment outcomes. In conclusion, she proposed that offering video education, online resources, and community-based workshops could aid in constructing a holistic approach to understanding patients' diagnoses and assessments. Such measures would also contribute to nurturing trust between healthcare providers and the Panjabi community.

Chapter Three: Inclusive design framework

In this chapter, we take a deep dive into the Inclusive Design Framework[223] woven into the fabric of the Panjabi-Centred Design (PCD) Framework, examining its revolutionary potential to engage with the intricate intersections of culture, language, and systemic barriers affecting diverse communities. The Inclusive Design Framework aspires to bring together various strategies to empower IBPOC[224] and immigrant communities, focusing on decolonizing knowledge dissemination, uplifting IBPOC voices, embracing Community-Based Participatory Research (CBPR)[225] approaches, and integrating existing Panjabi community practices.

To this end, the chapter will explore co-design practices, such as the Gurmat Framework, nurtured by the Sikh Research Institute (SikhRI)[226] and the Panchayati Raj system, a time-honored form of local governance in India.[227] These practices embody the principles of community engagement, shared decision-making, and collective action, which are integral to the PCD Framework. Additionally, the chapter will delve into the integration of Trauma-Informed and Cultural Safety principles[228] to further amplify the efficacy of the Inclusive Design Framework in nourishing the well-being and resilience of the Panjabi diaspora and other marginalized communities.

By examining the intersectionality of these diverse strategies, this chapter seeks to offer insights into the development of a comprehensive, culturally-responsive, and contextually-

[223] Inclusive design is design that considers the full range of human diversity with respect to ability, language, culture, gender, age and other forms of human difference. (Inclusive Design Research Centre, 2023)
[224] Indigenous, Black, and People of Color
[225] (Minkler et al., 2003, 1210-1213)
[226] Sikh Research Institute (SikhRI) is a non-profit organization connect people with the teachings of Sikhi, making them accessible and easy to digest, for people of all ages, genders and backgrounds. (Sikh Research Institute, 2022)
[227] (Hussain & Ahmed, 2022)
[228] (Elliott et al., 2005)

relevant approach to inclusive design within the PCD Framework. Through a profound understanding of the unique needs and experiences of the Panjabi diaspora, and by extension other immigrant and IBPOC communities, the Inclusive Design Framework aspires to ignite meaningful change, advocate for health equity, and cultivate a more inclusive, just, and compassionate society.

3.1 Decolonization

Decolonization unveils the manifold layers of disconnection pervading healthcare and IBPOC well-being, unearthing the very core of perpetual inequity. This transformative journey embraces the reclamation of political, cultural, economic, and social self-determination, nurturing the blossoming of affirmative identities within individuals, families, communities, and nations.

Decolonization is the encounter between two congenitally antagonistic forces that in fact owe their singularity to the kind of reification secreted and nurtured by the colonial situation.[229] The Canadian healthcare and social welfare landscape has, for too long, been dominated by Eurocentric models of knowledge production and dissemination.[230] This hegemony of Eurocentric knowledge has led to the marginalization and erasure of Indigenous and other non-dominant epistemologies, thus perpetuating colonial power dynamics and engendering disparities in access to and quality of care.[231] This chapter contends that a radical decolonization of knowledge dissemination and translation is necessary to address these issues, dismantle colonial structures, and foster a more equitable, inclusive, and culturally responsive healthcare and social welfare system in Canada. While Canada has provided leadership in the conceptual development

[229] (Fanon, 2004)
[230] (Phillips-Beck et al., 2020)
[231] (Kerr, 2014)

of health promotion and population health, it has failed to implement public policies and programmes that effectively address social determinants of health, leading to the persistence of a variety of health challenges, not least of which are Aboriginal health inequities.[232]

Colonization, a sinister force, thrives on the art of dividing and conquering, ruthlessly severing the connections between IBPOC and their cherished narratives. In the Canadian context, the insidious creation of reserves, often a mere fraction of a nation's ancestral territory, encapsulates this tactic.[233] By imposing such confines, colonization perpetuates a state of estrangement, distancing communities from the essence of their collective identity and the richness of their cultural heritage.

Yet, the colonizer's machinations do not end there; they further infiltrate the very core of human communication by silencing the voices that dare to speak the languages of the oppressed.[234] The notorious residential schools stand as a testament to this brutal endeavour, where innocent children were denied the right to express themselves in their mother tongue and subjected to unspeakable abuse. Stripping away the power of language not only effaces the histories and wisdom of generations but also weakens the bonds that bind communities together. The decimation of language is an attack on love, for it is through language that we forge connections and share the stories that define our humanity.

In the pursuit of centring the oppressed voices, decolonization emerges as a beacon of hope, weaving together the threads of 'colonized time' and 'pre-colonized time'[235] or in other words as Frantz Fanon puts it “Imperialism leaves behind germs of rot which we must clinically

[232] (Raphael et al., 2008, #)
[233] (Kelm, 1998)
[234] (Kirmayer et al., 2003)
[235] (Smith, 2021)

detect and remove from our land but from our minds as well."[236] This process, steeped in the wisdom of ancestral ways, endeavours to counteract the detrimental legacy of colonialism by reclaiming and revitalizing pre-colonial knowledge and practices. It is through this act of reclamation that we can begin to bridge the chasms wrought by colonial forces, fostering a renewed sense of interconnectedness and shared humanity.

As we embark on this transformative journey, it is vital for both IBPOC to participate wholeheartedly, fostering a mutual understanding rooted in respect and honour for all relationships[237]. The colonizers must shed their armour of dominance and seek to learn from the oppressed, while the colonized must strive to recognize and resist the lingering influence of the colonizer's coat[238]. In so doing, we can collectively re-envision a world where love transcends the boundaries imposed by colonialism, nurturing a sense of belonging that encompasses all of humanity.

The production is inherently political and deeply intertwined with power dynamics. Colonialism, as a system of domination and exploitation, has led to the privileging of Eurocentric knowledge systems while subjugating, erasing, and appropriating Indigenous and other non-dominant forms of knowledge. This has created an epistemic hierarchy that has been perpetuated and reinforced through various institutions, including healthcare and social welfare systems.

Decolonizing knowledge dissemination and translation entails challenging and dismantling the epistemic hierarchies and colonial power dynamics that underlie the Canadian healthcare and social welfare systems. It involves the recognition and validation of Indigenous and non-dominant epistemologies, the re-centring of marginalized voices and perspectives, and

[236] (Fanon, 2004)
[237] (McCaslin & Breton, 2008)
[238] Ibid.

the fostering of a pluralistic, inclusive, and equitable knowledge landscape. To achieve this, we must interrogate and disrupt the ways in which knowledge is produced, disseminated, and translated, as well as the processes and structures that uphold colonial power relations.

Strategies for Decolonizing Knowledge Dissemination and Translation:

1. Deconstructing dominant narratives: This involves critiquing and challenging the Eurocentric assumptions and biases that underpin mainstream healthcare and social welfare discourses, policies, and practices, and promoting alternative narratives that reflect diverse, non-dominant perspectives.
2. Centring IBPOC voices: Amplifying the voices and perspectives of marginalized communities and individuals, and ensuring their active participation and leadership in knowledge production, dissemination, and translation processes.
3. Indigenizing and diversifying curricula: Implementing culturally responsive and inclusive educational and training programs that reflect the diversity of epistemologies, worldviews, and experiences of Indigenous and non-dominant communities.
4. Building reciprocal relationships: Establishing respectful, collaborative, and equitable partnerships between Indigenous and non-Indigenous stakeholders, researchers, and practitioners in the co-production and sharing of knowledge.
5. Implementing culturally safe and trauma-informed care: Ensuring that healthcare and social welfare services are culturally safe, trauma-informed, and responsive to the unique needs and contexts of Indigenous and non-dominant communities.

3.2 Emerging inclusive practices and lack of cultural sensitivity

In the quest for inclusivity and cultural safety, we must be mindful of the valuable insights that can shape the development of a Panjabi-Centred Design. This process necessitates an appreciation for the distinctive cultural, linguistic, and social contexts of diverse populations, such as the Panjabi-speaking community. We must engage with and learn from a range of research and practice areas that can contribute to the cultivation of a Panjabi-Centred Design.

Embracing cultural competency training as a means to foster communication, build trust, and alleviate health disparities among diverse populations is essential.[239] By incorporating such training, we can enhance our understanding of the Panjabi culture, paving the way for more effective communication and service delivery.

Community-Based Participatory Research (CBPR) provides an opportunity for collaboration between researchers and community members, addressing health and social issues together.[240] Adopting this approach in Panjabi-Centred Design can meaningfully engage the Panjabi-speaking community in the development and implementation of programs and services attuned to their unique needs and preferences.[241]

In our pursuit of Panjabi-Centred Design, we must also acknowledge the profound impact of trauma on individuals and integrate trauma-informed care principles. This approach minimizes re-traumatization and promotes healing,[242] addressing the unique experiences and needs of the

[239] (Betancourt et al., 2003)
[240] (Israel et al., 1998)
[241] (Horowitz et al., 2009)
[242] (Substance Abuse and Mental Health Services Administration, 2014)

Panjabi-speaking community who may have faced trauma related to migration, violence, or discrimination.

An intersectional lens encourages us to examine the interconnectedness of social identities, such as race, ethnicity, gender, and socio-economic status, and their contribution to health disparities.[243] Employing intersectionality in Panjabi-Centred Design can help identify and address the multifaceted factors that influence the health and well-being of the Panjabi-speaking community.[244]

Lastly, we must recognize the importance of health literacy, which pertains to an individual's ability to obtain, process, and understand basic health information and services for informed decision-making.[245] Culturally and linguistically appropriate health education materials and interventions can improve health literacy for the Panjabi-speaking community, promoting better health outcomes.[246]

In essence, the wisdom of emerging inclusive practices and cultural safety studies guides our journey toward the creation of Panjabi-Centred Design. By weaving together the principles of cultural competency training, community-based participatory research, trauma-informed care, intersectionality, and health literacy, we can envision programs and services that truly serve the unique needs and preferences of the Panjabi-speaking community.

[243] (Crenshaw, 1989)
[244] (Hankivsky & Cormier, 2010)
[245] (Nielsen-Bohlman, 2004)
[246] (Berkman et al., 2011)

3.3 Existing Panjabi community practices and co-design practices

Acknowledging that the communities invited to participate in research and co-design may possess their own established frameworks and perspectives on the representation and dissemination of their histories, this project must be anchored in the tenets of design justice. This approach compels us to examine the intricate connections between design and the dynamics of domination and resistance across personal, community, and institutional dimensions.[247]

In examining the intricate tapestry of human identity, we find that faith and culture, while distinct, are deeply interconnected dimensions. Faith encompasses beliefs, rituals, and practices connected to the sacred, while culture represents the broader fabric of social customs, traditions, values, and norms that bind a group together.[248] This interplay is beautifully illustrated by the relationship between Sikhi and Panjabi culture.

Sikhi, a monotheistic faith originating from Guru Nanak in the 15th century, has left an indelible mark on the Panjabi region of India and Pakistan. Rooted in spiritual devotion, selfless service, and social justice[249], Sikhi has woven itself into the fabric of Panjabi culture, shaping daily life, social norms, and traditions.

Equality and social justice, central tenets of Sikhi, have profoundly influenced Panjabi culture. The practice of Langar, communal kitchens in Gurduaras[250] offering free meals to all visitors, embodies the Sikh values of inclusivity and service.[251] This practice cultivates a sense of communal responsibility and support that transcends religious boundaries.

---

[247] (Costanza-Chock, 2020)
[248] (Geertz, 1973)
[249] (McLeod, 1997)
[250] Sikh Temples in Gurmukhi (Panjabi) are called Gurduaras.
[251] (Nesbitt, 2016)

Moreover, the Sikh emphasis on family and community has reinforced kinship and social bonds in Panjabi culture. The joint family system, intergenerational support, and the role of elders in decision-making reflect the Sikh teachings on the importance of family and community.[252]

Yet, it is crucial to recognize the distinction between Sikhi and Panjabi culture. Panjabi culture is a mosaic of diverse religious, linguistic, and ethnic groups, not all of which are Sikhs. As Panjabi people have migrated globally, their culture has evolved and adapted, embracing elements from other cultures and religious traditions.[253]

Ultimately, the relationship between Sikhi and Panjabi culture highlights the complex dance between faith and culture. While distinct, these facets of human identity intertwine in powerful ways, shaping our individual and collective experiences. By exploring Sikhi and Panjabi culture, we deepen our understanding of the dynamic nature of human societies and the rich layers of human identity.

Embracing the Sikh Research Institute's Gurmat Framework[254], which highlights the profound connections between bani (wisdom), tavarikh (history), and rahit (lifestyle) in understanding and living out Sikhi, we uncover a pathway to an inclusive and empowering approach to Panjabi-Centred Design. By weaving the principles and values embedded within the Gurmat Framework into the design process, we can create solutions that honor and celebrate the unique cultural, historical, and spiritual facets of the Panjabi community, fostering a sense of belonging and agency.

[252] (Ballard, 1996)
[253] (Dusenbery, 1997)
[254] (Singh, 2017)

Bani, the bedrock of wisdom in the Sikh faith[255], illuminates our path towards Panjabi-Centred Design. Engaging with the teachings and wisdom of the Guru Granth Sahib, along with other revered texts, designers can delve into the core values and principles that define Panjabi culture and identity. This understanding paves the way for design solutions that embody the principles of equality, social justice, and spiritual devotion, which lie at the heart of Sikhi and Panjabi culture.[256]

Tavarikh, encompassing the transformative history of the Sikh Gurus and the Guru Khalsa Panth[257], unveils the resilience, adaptability, and activism that breathe life into Panjabi communities.[258] By examining the social, political, economic, and spiritual dimensions of Sikh history, designers can comprehend the diverse contexts and challenges encountered by Panjabi people across time and space. This awareness can guide the creation of design solutions that acknowledge and address the unique historical experiences and aspirations of Panjabi communities.[259]

Rahit, manifesting the Sikh lifestyle, provides a practical and context-specific approach to integrating the Gurmat Framework into Panjabi-Centred Design. By studying Rahitname, legal definitions, and personal accounts of Sikhs living their faith, designers can gain insights into the daily practices, ethical codes, and social norms shaping Panjabi life. This knowledge can inform the development of design solutions that are not only culturally appropriate but also responsive to the unique socio-economic and environmental contexts of Panjabi communities.

---

[255] Ibid
[256] (Nesbitt, 2016)
[257] Guru Khalsa Panth- The Khalsa Panth refers to both a community that practises Sikhi and a specific group of initiated Sikhs. Guru Gobind Singh, the Tenth Guru of Sikhi, established the Khalsa tradition in 1699.
[258] (Singh, 2017)
[259] (Singh, 2004)

In our journey towards understanding, the Gurmat Framework, emphasizing the interconnectedness of bani, tavarikh, and rahit, invites us to an inclusive and holistic approach to Panjabi-Centred Design. By engaging with and incorporating the wisdom, history, and lifestyle dimensions of the Sikh faith and Panjabi culture, designers can create contextually relevant, culturally sensitive, and empowering design solutions that nourish and uplift Panjabi communities.

As we contemplate the essence of local governance in India, we must recognize the significance of the Panchayati Raj system, which deeply shapes the community dynamics in the villages of Panjab and other Indian states. By engaging with the structure, functions, and impact of Panchayati Raj institutions (PRIs) in Panjabi villages, we can conceive Panjabi-Centred Design solutions that effectively resonate with the unique needs and contexts of these communities.

The Panchayati Raj system, born out of the 73rd Constitutional Amendment Act in 1992, gave rise to a three-tier structure of local governance, encompassing Gram Panchayats at the village level, Panchayat Samitis at the block level, and Zila Parishads at the district level.[260] This model of decentralized governance empowers communities to shape decisions on various aspects of local administration, including resource allocation, infrastructure development, and social welfare programs.[261]

Panjabi-Centred Design can draw upon the influence and functions of PRIs to create culturally sensitive and contextually relevant solutions for Panjabi villages. By connecting with PRIs and embracing their insights, designers can cultivate a more profound understanding of

[260] (Sahu, 2021)
[261] (Raghunandan, 2012)

local needs, challenges, and aspirations. PRIs, for instance, can offer invaluable input on resource management, infrastructure planning, and service delivery in domains such as education, healthcare, and sanitation, ensuring that design interventions harmonize with community priorities and values.

Collaboration with PRIs also allows designers to encourage community participation and ownership in the design process, ultimately yielding more sustainable and effective outcomes.[262] By involving PRIs and local stakeholders in decision-making, designers can guarantee that their solutions are not only culturally appropriate but also responsive to the unique socio-economic and environmental contexts of Panjabi villages.[263]

The Gurmat Framework and the Panchayati Raj system offer insightful perspectives into the faith-based and cultural foundations of community-based reliance within the Panjabi diaspora. Delving into these systems enables us to better comprehend how to effectively collaborate with and support Panjabi communities in the diaspora, fostering a sense of belonging, empowerment, and self-reliance.

The Gurmat Framework, an approach to Sikhi that emphasizes the interconnection of bani (wisdom), tavarikh (history), and rahit (lifestyle), serves as a potent resource for understanding the essential values, principles, and practices that underlie Panjabi culture and identity.[264] By engaging with the teachings and wisdom of the Guru Granth Sahib and other revered texts, we can deepen our understanding of the spiritual, social, and ethical dimensions of Panjabi communities, thus informing the development of culturally responsive and inclusive

[262] (Chambers, 1994)
[263] (Smith, 1953)
[264] (Singh, 2004)

policies, practices, and interventions that address the unique needs and aspirations of the Panjabi diaspora.[265]

The Panchayati Raj system, a model of decentralized governance in India, offers a valuable example of community-based resilience and self-reliance among Panjabi communities. This system, which involves local self-government at the village level, encourages democratic decision-making, community participation, and collective action, ensuring that the needs and concerns of Panjabi communities are represented and addressed.[266] By examining the Panchayati Raj system, we can glean valuable insights into the principles and practices of community-based reliance, which can inform the development of support structures for the Panjabi diaspora that emphasizes collective action, local autonomy, and community empowerment (Mathur, 2009).

By understanding the Gurmat Framework and Panchayati Raj system, we can better appreciate the faith-based and cultural context of community-based reliance among the Panjabi diaspora. These systems provide important lessons for working with and supporting Panjabi communities in the diaspora, emphasizing the importance of culturally responsive and inclusive approaches that foster belonging, empowerment, and self-reliance. By drawing on the wisdom, history, and practices of the Gurmat Framework and Panchayati Raj system, we can create contextually relevant, culturally sensitive, and empowering support structures that enrich and uplift Panjabi communities in the diaspora.

[265] (Nesbitt, 2016)
[266] (Gurumurthy, 1986)

3.4 Trauma-Informed and Cultural Safety

Trauma-informed and cultural safety practices hold great significance in shaping Panjabi-Centred Design that is both effective and mindful. By acknowledging the historical and cultural contexts of the Panjabi community, we can envision design solutions that are sensitive to the experiences and needs of those who have faced trauma or encountered unique cultural challenges. Embracing trauma-informed and culturally safe practices can elevate the overall quality of design solutions, augmenting their accessibility, relevance, and impact on diverse Panjabi communities.[267]

The trauma-informed design acknowledges the ubiquity of trauma and its potential influence on an individual's cognitive, emotional, and social well-being. By integrating a trauma-informed perspective, we can create environments, products, and services that minimize the risk of re-traumatization, while promoting healing and resilience.[268] Key principles of trauma-informed design—safety, trustworthiness, choice, collaboration, and empowerment—can be adapted and woven into Panjabi-Centred Design solutions.

Cultural safety, conversely, highlights the importance of recognizing and respecting the cultural identities, values, and practices of diverse communities. It involves crafting spaces and environments where individuals feel secure, respected, and valued for their cultural backgrounds and experiences.[269] Within the realm of Panjabi-Centred Design, cultural safety practices can be integrated by incorporating the unique traditions, languages, and perspectives of the Panjabi

[267] (Harris & Fallot, 2001)
[268] (Substance Abuse and Mental Health Services Administration, 2014,)
[269] (Kurtz et al., 2008)

community in design solutions, ensuring that they are accessible, relevant, and respectful of cultural differences.[270]

To effectively merge trauma-informed and cultural safety practices into Panjabi-Centred Design, we must embark on a continuous journey of learning, reflection, and adaptation. This process can involve collaborating with Panjabi community members and stakeholders, soliciting input and feedback on design solutions, and embracing the knowledge and experiences of individuals who have encountered trauma or face unique cultural challenges.[271] Furthermore, we must confront our own cultural biases and assumptions and actively strive to challenge and address these biases in our design process.[272]

In essence, trauma-informed and cultural safety practices form the bedrock of Panjabi-Centred Design, contributing to the development of inclusive, accessible, and culturally relevant design solutions. By weaving these practices into our approach, we can better address the needs and experiences of diverse Panjabi communities, fostering healing, resilience, and cultural understanding. By nurturing collaboration and continuous learning, we can create more impactful and empowering design solutions that honour the rich cultural heritage and experiences of the Panjabi community.

3.4 Plain language for Public Health

The Plain Language for Public Health guide, crafted and shared by the Public Health Communications Collaborative,[273] offers a crucial resource for transforming complex healthcare

[270] (Browne et al., 2016)
[271] (Chandler & Lalonde, 1998)
[272] (Sue et al., 2009)
[273] (Public Health Communications Collaborative, 2023)

and social welfare information into accessible and comprehensible content for diverse communities. The Panjabi-Centred Design (PCD) Framework can learn from this guide, applying its principles to create effective communication materials for the Panjabi communities. Additionally, this guide serves as a valuable tool for healthcare and social welfare organizations working with other marginalized communities, offering insights on creating and translating materials into a variety of languages to foster inclusivity.

The Plain Language for Public Health guide[274] presents a four-step process for generating clear, accessible, and useful communication materials, centring on the intended audience's needs. For the PCD Framework, these principles can be employed to develop culturally-sensitive and easily understandable materials for the Panjabi diaspora, tackling language barriers and cultural subtleties that may hinder comprehension.[275]

In Step 1, "Prepare Your Communications," the guide emphasizes understanding the audience's unique needs and interests to produce messaging that is straightforward, relevant, engaging, and lucid.[276] By customizing the message for the Panjabi community, the PCD Framework can ensure effective communication of vital healthcare and social welfare information.

Step 2, "Develop and Organize Your Communications," stresses using everyday words, avoiding jargon, and adopting a conversational tone by writing in the second person.[277] The PCD Framework can integrate these principles to craft accessible and relatable materials for the Panjabi communities.

---

[274] Ibid
[275] (Napoles et al., 2013)
[276] (Public Health Communications Collaborative, 2023)
[277] (Public Health Communications Collaborative, 2023)

During Step 3, "Review and Testing," the guide advises carrying out internal reviews and user testing to fine-tune materials based on feedback from both internal reviewers and the target audience.[278] By incorporating these feedback loops, the PCD Framework can ensure that the materials are culturally relevant, resonate with the Panjabi diaspora, and achieve the desired outcomes.

Furthermore, healthcare and social welfare organizations can leverage the Plain Language for Public Health guide[279] to create and translate materials into multiple languages, ensuring diverse marginalized communities can access and comprehend essential information. This approach aligns with the recommendations of Betancourt et al.[280] (2003), who advocate for the development of linguistically and culturally appropriate resources to address health disparities and improve health outcomes for diverse populations. By incorporating plain language principles and translating materials into various languages, organizations can contribute to the reduction of health disparities and the promotion of health equity among marginalized communities.[281]

In conclusion, the Plain Language for Public Health guide, developed by the Public Health Communications Collaborative[282], serves as a vital resource for the Panjabi-Centred Design Framework and other healthcare and social welfare organizations working with marginalized communities. By employing plain language principles and translating materials into multiple languages, these organizations can ensure that complex healthcare and social

[278] Ibid
[279] Ibid
[280] (Betancourt et al., 2003)
[281] (Institute of Medicine, 2003)
[282] (Public Health Communications Collaborative, 2023)

welfare information is accessible and understandable for diverse populations, ultimately promoting health equity and well-being across communities.

Chapter Four: Methodology

This research began with the need to contextualize my previous professional experience as a community interpreter and a member of the Panjabi communities in the Greater Vancouver and Fraser Valley area in British Columba. I facilitated as a language conduit and witnessed the Panjabi diaspora's interaction with healthcare providers and social welfare services. This methodology section also outlines the research methods employed in the study that aimed to understand the perspective and experience of healthcare providers and service organizations while serving the Panjabi diaspora in Canada. The study employed qualitative research design[283], specifically utilizing semi-structured consultation sessions with a total of five participants. The five participants are subject-matter experts (SMEs) in healthcare, mental health and social welfare. The five SMEs include a family physician, nurse practitioner, registered councillor, project manager, and director of a language service at a provincial health authority. These SMEs provide care and service in Greater Vancouver and Fraser Valley area in British Columba and Brampton, Ontario where the Panjabi diaspora is present in high population.

4.1 Recruitment

The diversity of understanding lived experience, and expertise of my participants gave insight into the complexities of the community also. The inclusion criteria for this study were that the participants must be subject matter experts who provide healthcare and social welfare services to the Panjabi diaspora in Canada. The participants had to be fluent in English, Panjabi or both. I approached five SMEs with first-hand knowledge of the challenges faced by the Panjabi diaspora in Greater Vancouver and the Fraser Valley area in British Columba and Brampton, Ontario. The

[283] (Busetto et al., 2020)

participants included a family physician, a nurse practitioner, an executive of a language service department in a healthcare authority, a registered counsellor, and a project manager at a community service organization that dominantly serves areas with a high density of Panjabis in Greater Vancouver and Fraser Valley area in British Columba and Brampton, Ontario.

4.2 Data Collection

The data were collected through semi-structured consultation sessions conducted over MS Teams. The consultations were audio-recorded, transcribed verbatim, and then analyzed. The subject matter experts (SMEs) were provided with informed consent forms that outlined the objectives of the consultation sessions and the intended utilization of the data derived from these consultations. To preserve anonymity, the SMEs were granted the option to either employ their actual names or adopt a pseudonym. The majority of the questions were the same for each participant, but some were modified to consider the participant's area of practice. The consultations focused on exploring the participants' experiences in providing healthcare and social welfare services to the Panjabi diaspora in Canada, as well as their perspectives on the challenges and opportunities in the context of patient-client interactions, methods of knowledge dissemination, and translation needs.

4.3 Data Analysis

The data analysis followed a thematic analysis approach, as described by Braun and Clarke.[284] The thematic analysis involves identifying and analyzing patterns and themes in the data.[285] The

[284] (Braun & Clarke, 2006)
[285] (Braun & Clarke, 2006)

data were analyzed iteratively, with each round of analysis informing the subsequent round.[286] The analysis was conducted manually by the researcher and a research assistant.[287] I coded the transcripts and identified recurring themes and patterns, which were organized into categories.[288] The analysis involved multiple readings of the transcripts to ensure that the themes and categories identified were consistent with the data collected.[289]

4.4 Ethical Considerations

The study received approval from the supervisor to consult subject matter experts in the field of healthcare and social welfare, following ethical guidelines.[290] [291] The participants were provided with an informed consent form before the consultations.[292] [293] The informed consent form outlined the purpose of the study, the nature of the consultation, the risks and benefits of participation, and the right to withdraw at any time. The participants were also informed that their identities would be kept confidential, and their data would be de-identified to ensure anonymity.

[286] (Fereday & Muir-Cochrane, 2006)
[287] (Creswell, 2014)
[288] (Saldana, 2016)
[289] (Lincoln & Guba, 1985)
[290] (Kvale, 1994)
[291] (Marshall & Rossman, 2016)
[292] (Childress & Beauchamp, 2013)
[293] (Mertens & Ginsberg, 2009)

Chapter Five: Outcome

In the contemporary Canadian healthcare and social welfare landscape, the necessity of addressing the distinct needs and preferences of the Panjabi diaspora is paramount. As one of the most populous[294] and heterogeneous ethnic collectives[295] in the nation, the Panjabi communities confront a multitude of linguistic, cultural, and societal impediments when seeking access to healthcare and social welfare services. The implementation of a framework offers a means to surmount these obstacles, ultimately engendering enhanced health outcomes, augmented social support, and an enriched quality of life for the Panjabi communities. These guidelines equip healthcare and social welfare professionals with the tools and understanding necessary to engage effectively with the Panjabi communities and respond to their unique needs.[296]

Embracing a guided framework can profoundly transform the landscape of healthcare and social welfare services within the Panjabi communities, leading to a more just and equitable system, by standardizing methods, uplifting the quality of care, and advocating for fair and inclusive access.[297] This framework confronts essential objectives, such as empowering efficacy through purposeful interventions, amplifying efficiency by minimizing the time and energy spent deciphering cultural and linguistic complexities, and eradicating unsuitable variations in practice.[298] Offering comprehensive guidelines, this framework nurtures a holistic approach that encompasses language accessibility, cultural awareness, and the power of community, which in turn allows professionals to better meet the distinct needs of the Panjabi communities. By standardizing practices and addressing language and cultural barriers, this framework paves the

[294] (Statistics Canada, 2017)
[295] (Chima, 2015)
[296] (Medves et al., 2010)
[297] (Betancourt et al., 2003)
[298] (Nair & Adetayo, 2019)

way for a more equitable and accessible system, ensuring all members of the community have the opportunity to receive high-quality, culturally respectful services.[299]

Addressing language barriers and cultivating cultural safety are essential components in ensuring that the Panjabi diaspora in Canada can access and understand vital healthcare and social welfare services. A framework focusing on language proficiency and translation guarantees that information is accessible and accurately communicated to the Panjabi communities.[300] Furthermore, emphasizing the importance of cultural sensitivity and awareness among healthcare and social welfare practitioners can lead to a better understanding of the Panjabi communities' values, beliefs, and practices, resulting in more effective care and improved health outcomes.[301] [302]

The Panjabi diaspora, akin to numerous immigrant communities, grapples with profound emotional labour resulting from factors such as intergenerational trauma, the lingering effects of colonization, and the navigation of dual identities. Integrating this emotional labour into a framework is essential to comprehend the distinct needs and challenges faced by the Panjabi communities.[303]

Recognizing the emotional labour endured by the Panjabi diaspora enables the framework to decipher their complex needs, aiding healthcare and social welfare professionals in tailoring their services accordingly. This customized approach fosters comprehensive and empathetic care for the Panjabi communities.[304] Additionally, embedding emotional labour

[299] (Sue & Sue, 2013)
[300] (Napoles et al., 2013)
[301] (Kirmayer, 2012)
[302] (Capell et al., 2007)
[303] (Viruell-Fuentes et al., 2012)
[304] (Kirmayer, 2012)

within the framework helps pinpoint areas necessitating targeted support, empowering professionals to devise specialized interventions and resources that address the root causes of emotional labour, culminating in more effective and enduring outcomes.[305]

Emphasizing cultural sensitivity and awareness proves crucial when tackling the emotional labour experienced by the Panjabi diaspora. Grasping the cultural context and subtleties within the community equips healthcare and social welfare professionals to offer support that acknowledges and validates the Panjabi communities' experiences, nurturing trust and rapport.[306]

Confronting the emotional labour of the Panjabi diaspora can alleviate the burden tied to navigating intricate emotions and experiences, enabling individuals to cope more effectively with their challenges and fostering healing and holistic well-being.[307] By considering the emotional labour of the Panjabi communities, the framework can facilitate healing and resilience. Through the provision of appropriate resources, support, and services, healthcare and social welfare professionals can assist individuals and families in surmounting challenges and nurturing resilience, ultimately improving their quality of life.[308]

In Panjabi culture, the sense of sangat[309] (ਸੰਗਤ) is foundational. A framework supporting community engagement and self-determination by involving the Panjabi diaspora in decision-making processes and policy development can empower the community in various ways.[310] Active participation in decision-making ensures that Panjabi voices are heard and fosters a sense

[305] (Ungar, 2011)
[306] (Capell et al., 2007)
[307] (Kirmayer, 2012)
[308] (Ungar, 2011)
[309] Sangat in Panjabi refers to a congregation of devotees regardless of caste, class, creed, sex or religion.
[310] (Minkler et al., 2008)

of ownership and responsibility, enabling the community to take charge of their healthcare and social welfare needs.[311] Additionally, engaging the Panjabi diaspora in policy development allows healthcare and social welfare authorities to leverage the community's unique cultural expertise, leading to more effective and culturally sensitive solutions.[312] [313]

Empowering the Panjabi communities through involvement in decision-making processes fosters a sense of agency and enables them to challenge systemic barriers and work collaboratively to create a more equitable and accessible healthcare and social welfare system.[314] [315] Participating in policy development and decision-making processes also builds capacity and strengthens the community's ability to navigate complex systems, advocate for their needs, and collaborate with other stakeholders for positive change.[316] The emphasis on community engagement and self-determination fosters stronger connections within the Panjabi diaspora and with healthcare and social welfare providers, promoting transparency and accountability within healthcare and social welfare systems.[317] [318]

In the spirit of interconnectedness, the Panjabi-Centred Design framework blossoms as a culturally-responsive and inclusive approach, tailored for those healthcare authorities, social welfare organizations, and community service organizations that hold space for the Panjabi diaspora. With the intention to honour the unique cultural, historical, and spiritual dimensions of the Panjabi community, this framework nurtures belonging and empowerment.

---

[311] (Zimmerman, 2000)
[312] (Trickett, 2011)
[313] (Betancourt et al., 2003)
[314] (Minkler et al., 2008)
[315] (Laverack, 2006)
[316] (Laverack & Labonte, 2000)
[317] (Wallerstein & Duran, 2010)
[318] (Brinkerhoff, 2004)

Guided by the wisdom of the Gurmat Framework[319], with its emphasis on the harmonious relationship between Bani (wisdom), Tavarikh (history), and Rahit (lifestyle), the Panjabi-Centred Design framework allows healthcare authorities, social welfare organizations, and community service organizations to weave culturally-sensitive and contextually-relevant solutions that embrace and celebrate the distinct facets of the Panjabi community.

Furthermore, the Panjabi-Centred Design framework finds inspiration in the Panchayati Raj system, a model of decentralized governance in India that cultivates community-based resilience and self-reliance among Panjabi communities.[320] This system imparts valuable lessons on fostering democratic decision-making, community participation, and collective action within the Panjabi diaspora, informing the development of support structures that honour local autonomy and community empowerment.

Recognizing the diverse and complex needs of the Panjabi diaspora[321], the application of the Panjabi-Centred Design framework in healthcare and social welfare contexts becomes ever more significant. By addressing language barriers, cultural differences, and unique health and social concerns, this framework enables healthcare authorities, social welfare organizations, and community service organizations to provide more equitable and accessible services to the Panjabi community.

The Panjabi-Centred Design framework radiates as a culturally-responsive and inclusive approach for healthcare authorities, social welfare organizations, and community service organizations serving the Panjabi diaspora. Infused with insights from the Gurmat Framework and the Panchayati Raj system, this framework empowers these organizations to create

[319] (Singh, 2017)
[320] (Gurumurthy, 1986)
[321](Dusenbery & Tatla, 2009)

culturally-sensitive, contextually-relevant, and uplifting solutions that meet the unique needs and aspirations of the Panjabi community.

5.1 Transgressive Liberation: Centering Panjabi Voices in the Western Narrative

Reflecting on the potential of Panjabi-Centred Design (PCD) demands a deep connection with the critical pedagogical insights of bell hooks[322], Paulo Freire[323], and Professor Puran Singh[324]. Their combined knowledge highlights the transformative possibilities within the PCD framework. I suggest a groundbreaking method to comprehend and address the distinct experiences of the Panjabi diaspora in Canada, which I term Transgressive Liberation.

For over a century, the Panjabi communities have been an essential component of Canadian society, substantially contributing to the country's economy and cultural diversity.[325] Nevertheless, their voices are often marginalized in the wider Canadian narrative. Transgressive Liberation aims to focus on the experiences of the Panjabi diaspora by exploring how multiple dimensions of oppression, including race, ethnicity, language, and religion, intersect and influence their lives.

Transgressive Liberation is based on the understanding that the marginalization of the Panjabi diaspora in Canada does not result from a single type of oppression but is rather a complex interplay of multiple, intersecting power systems. Using an intersectional perspective, this approach allows for a more refined understanding of the diverse aspects of marginalization experienced by the Panjabi communities, cultivating opportunities for significant change . [326] [327]

[322] (hooks, 1994)
[323] (Freire, 2000)
[324] (Singh, 2017)
[325] (Rai, 2010)
[326] (Crenshaw, 1989)
[327] (Nayar, 2004)

At the core of Transgressive Liberation is the idea that genuine liberation necessitates dismantling oppressive structures and amplifying marginalized voices.[328] [329] In the context of the Panjabi diaspora, this involves contesting dominant narratives that obscure or downplay their contributions and experiences, as well as advocating for policies and practices that encourage greater equality and representation.[330]

Transgressive Liberation advocates for a thorough analysis of how the unique challenges faced by the Panjabi communities have been overshadowed by broader discussions of immigrant experiences. It also aims to confront the superficial inclusion of Panjabi voices without genuinely engaging with their concerns.[331] [332](Bannerji, 2000; Nagra, 2011).

By focusing on the experiences of the Panjabi diaspora and amplifying their voices, Transgressive Liberation seeks to cultivate a more inclusive and equitable Canadian society where the Panjabi communities are not only recognized for their contributions but also actively involved in shaping the country's future. Transgressive Liberation aims to move beyond the mere acknowledgment of the Panjabi diaspora's marginalization, fostering a transformative dialogue that addresses the underlying reasons for their exclusion and empowering the community to assert their rightful position within the Canadian narrative.

In "*Teaching to Transgress*," bell hooks[333] praises education as an act of liberation, a way to overcome oppressive systems. She astutely identifies the lack of feminist voices in Paulo Freire's "*Pedagogy of the Oppressed*"[334] and fervently advocates for their inclusion. By

[328] (hooks, 1994)
[329] (Freire, 2000)
[330] (Bannerji, 2000)
[331] Ibid
[332] (Heer, 2018)
[333] (hooks, 1994)
[334] (Freire, 2000)

incorporating feminist perspectives, hooks reveal the intersectional nature of oppression and emphasize the need for education that empowers and liberates all marginalized individuals, including women.[335] PCD, enhanced by this inclusive outlook, aims to address the varied needs and experiences of the entire Panjabi diaspora.

In "*Pedagogy of the Oppressed*," Paulo Freire posits that education should foster critical consciousness, empowering marginalized communities to challenge and transform their situations. This idea shapes PCD's goal to facilitate critical dialogue, consciousness, and collective transformation within the Panjabi communities in Canada.

Through "*The Spirit Born People*," Professor Puran Singh[336] conveys an insightful understanding of true freedom and knowledge as existential states rather than the simple accumulation of information. PCD can embrace this wisdom by prioritizing the holistic well-being of the Panjabi diaspora. This strategy surpasses language barriers and cultural sensitivities, addressing the spiritual and emotional aspects of the community. By cultivating a deeper understanding of these elements, PCD encourages the Panjabi communities to liberate themselves from marginalization and enter their "real world," as eloquently expressed by Singh.

By delving into the pedagogical insights of bell hooks, Paulo Freire, and Professor Puran Singh, we establish PCD as a powerful instrument for the empowerment and liberation of the Panjabi diaspora in Canada. This methodology, rooted in the essence of true freedom, knowledge, and well-being, carries the potential for a fairer and more equitable society for all.

Within the framework of Panjabi-Centred Design (PCD), Transgressive Liberation seeks to cultivate critical thinking, raise consciousness, and foster self-determination among the

[335] (Crenshaw, 1989)
[336] (Singh, 2017)

Panjabi communities, ultimately contributing to a more equitable and accessible healthcare and social welfare system.

Key Principles of Transgressive Liberation:

1. Critical consciousness:

   In "*Black Skin, White Masks*," Fanon[337] investigates how colonialism and racism affect the psychological well-being and self-concept of the colonized, frequently resulting in internalized feelings of inadequacy and self-estrangement.

   a. Applying Prof. Puran Singh work from The Spirit of Born People "True knowledge is not knowing, but being"[338], encourage the Panjabi communities and service providers to engage in critical reflection and dialogue about the existing power structures and inequalities within the healthcare and social welfare system.
   b. Foster an environment that promotes questioning, challenging, and reimagining the status quo to create a more inclusive and equitable system.

2. Dialogic learning and collaboration:

   bell hooks' pioneering work, *"Teaching to Transgress: Education as the Practice of Freedom*"[339] (1994), offers valuable perspectives on the transformative potential of dialogic learning and collaboration for advancing social justice and empowerment. Drawing from her experiences as an educator and feminist scholar, hooks stresses the significance of engaging in critical dialogues and nurturing an atmosphere of mutual respect, understanding, and learning within educational contexts. Applying hooks' principles to the Panjabi communities and service providers in the healthcare and social

[337] (Fanon, 2007)
[338] (Singh, 2017)
[339] (hooks, 1994)

welfare system, dialogic learning and collaboration can be emphasized through the following approaches:

a. Facilitate open and honest dialogues between the Panjabi communities and service providers, embracing the exchange of ideas, experiences, and perspectives. Encouraging transparent and sincere conversations between the Panjabi communities and service providers, fostering the sharing of ideas, experiences, and viewpoints. Informed by hooks' concept of "engaged pedagogy,"[340] these discussions should prioritize exploring diverse perspectives, experiences, and cultural contexts, promoting a more inclusive and empathetic understanding of the unique challenges and opportunities encountered by the Panjabi communities in healthcare and social welfare settings. Attempting to liberate the oppressed without their reflective participation in the act of liberation is to treat them as object and transforms into manipulation.[341]
b. Emphasize the importance of mutual learning, active listening, and collaboration in creating a healthcare and social welfare system that genuinely addresses the needs and concerns of the Panjabi communities. Highlighting the significance of reciprocal learning, attentive listening, and cooperation in devising a healthcare and social welfare system that authentically caters to the needs and issues of the Panjabi communities. This involves acknowledging and valuing the knowledge and expertise contributed by both the Panjabi communities and service providers

[340] Ibid
[341] (Freire, 2000)

and cultivating a sense of shared responsibility and dedication to collaboratively develop culturally responsive and equitable policies, practices, and interventions.

c. Incorporate and amplify the female narrative within the Panjabi communities and service providers' dialogues, recognizing the unique experiences and insights of Panjabi women. Drawing upon bell hooks' feminist thought, which emphasizes the importance of centring on the experiences and voices of women from diverse backgrounds, it is crucial to ensure that the perspectives of Panjabi women are represented and heard in these conversations (hooks, 2000). This inclusion of female narratives contributes to a more comprehensive understanding of the Panjabi communities' experiences in healthcare and social welfare systems, thereby fostering a more inclusive and gender-sensitive approach to addressing their needs and concerns.

   The act of embracing and magnifying women's stories within the Panjabi community and service providers' conversations is a powerful force for honouring their unique lived experiences and wisdom. Understand where there may be gaps in current codes of conduct and reflect on a more egalitarian framing.[342] As bell hooks have passionately argued, it is essential that we center the voices and experiences of women from diverse backgrounds to ensure that Panjabi women's perspectives are truly heard and acknowledged in these dialogues.[343] By weaving women's narratives into our collective understanding, we deepen our knowledge of the Panjabi communities' experiences within healthcare and social welfare

[342] (Kaur & Singh, 2023)
[343] (hooks, 1994)

systems, paving the way for more inclusive and gender-sensitive approaches to meet their needs and aspirations.

To transform these ideas into tangible actions, we must be courageous and intentional in our efforts. We must first create and implement gender-specific training and awareness programs for service providers, illuminating the unique experiences and challenges that Panjabi women encounter within healthcare and social welfare contexts.[344] We must also cultivate safe spaces within these facilities, where Panjabi women can freely share their stories, concerns, and aspirations without fear of judgment or discrimination.[345] And lastly, we must join forces with Panjabi women's organizations and groups to craft targeted outreach initiatives, support services, and educational resources that address the distinct obstacles Panjabi women face when accessing healthcare and social welfare services.[346] By undertaking these deliberate actions, we not only amplify the female narrative within the Panjabi communities and service providers' conversations but also contribute to a more inclusive, gender-sensitive, and equitable healthcare and social welfare system that uplifts the entire Panjabi community.

3. Cultural and linguistic empowerment:

   Noam Chomsky's[347] linguistic research emphasizes the significance of language as a crucial element of human experience and culture.

[344] (Crenshaw, 1989)
[345] (Kaur & Singh, 2023)
[346] (Moss-Racusin et al., 2012)
[347] (Chomsky, 1965)

a. Prioritize language training, translation services, and bilingual resources to empower the Panjabi communities to overcome language barriers. Recognizing the essential role of language in forming thought, identity, and social relationships, as illuminated by Chomsky's work, it is critical to ensure the Panjabi communities have access to linguistic resources and support that facilitate effective communication, access to services, and self-advocacy within healthcare and social welfare settings.

b. Design and implement culturally responsive training programs for service providers, concentrating on enhancing their understanding of the Panjabi language, culture, and community-specific needs. Building on Chomsky's insights into the interconnectedness of language and culture[348], such training can enable service providers to better appreciate and respect the unique linguistic and cultural heritage of the Panjabi communities, ultimately fostering more inclusive and responsive services.

c. Celebrate and affirm the unique cultural heritage of the Panjabi communities, fostering an environment that encourages cultural exchange, creativity, and self-expression.

4. Emancipatory education:

a. Develop educational materials and programs that focus on raising awareness of the social, political, and cultural factors that impact the health and well-being of the Panjabi communities.

[348] (Chomsky, 2000)

    b. Utilize Freire's concept of problem-posing education[349] to create a participatory learning environment that enables the Panjabi communities to critically analyze their circumstances and develop solutions to address their needs.

5. Community engagement and self-determination:
    a. Ensure that the Panjabi diaspora is actively involved in decision-making processes related to healthcare and social welfare services, promoting a sense of agency and self-determination.
    b. Encourage community-led initiatives and grassroots activism that empower the Panjabi communities to advocate for their rights and work towards creating a more equitable and accessible system. Fund and empower these initiatives rather than controlling their narrative.
6. Transgressing boundaries and stereotypes:
    a. Challenge and confront the stereotypes, prejudices, and biases that may affect the quality of care and support received by the Panjabi communities.
    b. Emphasize the importance of self-reflection, empathy, and open-mindedness in breaking down barriers and fostering an environment of understanding and acceptance.

Transgressive Liberation is an approach rooted in the pedagogical insights of Professor Puran Singh, bell hooks, and Paulo Freire. It seeks to address the unique challenges and experiences of the Panjabi diaspora in Canada by cultivating critical consciousness, fostering dialogic learning and collaboration, promoting cultural and linguistic empowerment, and implementing emancipatory education. By prioritizing community engagement and self-

[349] (Freire, 2000)

determination, this framework aims to empower the Panjabi communities to actively participate in decision-making processes and advocate for their rights, ultimately contributing to a more equitable and accessible healthcare and social welfare system.

Transgressive Liberation transcends boundaries and stereotypes by challenging and confronting the prejudices, biases, and misconceptions that may affect the quality of care and support received by the Panjabi communities. By emphasizing the importance of self-reflection, empathy, and open-mindedness, this approach fosters an environment of understanding, acceptance, and transformative dialogue, paving the way for a fairer and more inclusive society for all.

Transgressive Liberation serves as a catalyst "that calls everyone to become more and more engaged, to become active participants in learning."[350] Through the combined wisdom of Professor Puran Singh, bell hooks, and Paulo Freire, Transgressive Liberation leverages the power of education, critical thinking, and holistic well-being to create a profound and lasting impact on the lives of the Panjabi diaspora in Canada. With its focus on true freedom, knowledge, and well-being, this methodology carries the potential to shift the focus of healthcare and social welfare systems, ensuring a more equitable and empowering future for the Panjabi communities and beyond.

5.2 Panjabi-Centred Design (PCD) framework: Praxis of transgressive liberation

In this chapter, we will embark on an exploration of the Panjabi-Centred Design (PCD) Framework, a culturally-responsive approach to addressing the unique needs and experiences of the Panjabi diaspora. The PCD Framework seeks to integrate traditional Panjabi values and

[350] (hooks, 1994)

practices with contemporary design methodologies to promote equity, inclusivity, and well-being for Panjabi communities. By delving into the foundational principles, methodologies, and applications of the PCD Framework, this chapter aims to provide insights into the development and implementation of culturally-sensitive strategies that empower and engage Panjabi communities, while offering a valuable lens through which to examine the broader context of culturally-responsive design in diverse settings.

Similar to many other immigrant communities in Canada, the Panjabi diaspora confronts distinct challenges as they navigate healthcare and social welfare systems. These challenges, including cultural, linguistic, and emotional barriers, reveal the necessity for a framework tailored to the specific needs of the Panjabi communities. Panjabi-Centred Design (PCD) emerges as a visionary and practical approach that intertwines knowledge dissemination and language translation, offering guidelines for healthcare authorities and social welfare organizations. Drawing on the wisdom of Professor Puran Singh, bell hooks, and Paulo Freire, PCD nurtures transgressive liberation, empowering the Panjabi diaspora to break free from the constraints of marginalization and embrace true freedom, knowledge, and well-being.

Transgressive liberation, a concept deeply woven into the self-consciousness learnings from Professor Puran Singh and the critical pedagogical perspectives of bell hooks and Paulo Freire, fosters education and dialogue as transformative practices that liberate individuals and communities from oppressive systems.[351] By embracing the principles of transgressive liberation, PCD aspires to create opportunities for the Panjabi community in Canada to engage in critical dialogue, cultivate consciousness, and pursue collective transformation. This approach aligns

[351] (Freire, 2000)

with the pursuit of a more equitable and just society for the Panjabi community, addressing their unique challenges.

Informed by the holistic perspective of Professor Puran Singh,[352] the PCD framework underscores the importance of attending to the emotional, mental, spiritual, and physical well-being of the Panjabi diaspora. By considering these aspects, PCD seeks to foster a deeper understanding of the community's needs and facilitate a more comprehensive and empathetic approach to delivering healthcare and social welfare services.

PCD Framework (diagram 1) signifies an approach to addressing the unique needs of the Panjabi diaspora within Canada's healthcare and social welfare systems. The diagram shows how each principle is correlated to eachother and the ultimately results in fostering holistic engagement and vice-versa. By learning from critical pedagogues and embodying the principles of transgressive liberation, PCD holds the potential to catalyze enduring change and cultivate a more equitable society for the Panjabi community and other marginalized groups.

[352] (Singh, 2017)

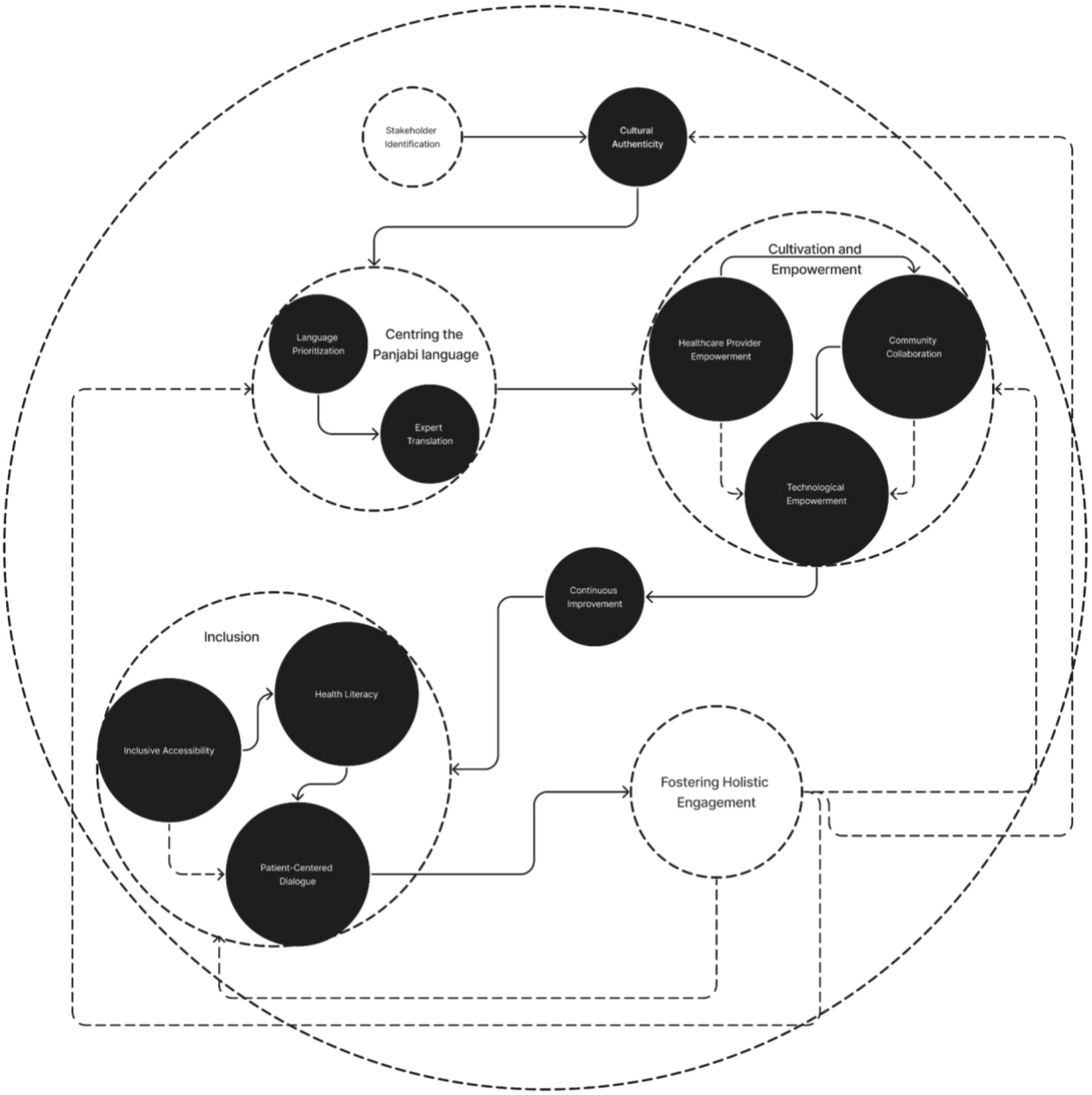

Diagram 1. Panjabi-Centred Design Framework.

Here's a more detailed explanation of how to implement the principles of Panjabi-Centred Design (PCD) framework:

1. Identify the target audience (Stakeholder Identification): Stakeholder analysis is essential for understanding the different groups that have a vested interest in the Panjabi-Centred

Design (PCD) framework. By identifying these stakeholders and considering their unique perspectives, the PCD framework can be tailored to meet the needs of the Panjabi diaspora in Canada effectively.

a. Individuals and families:
    i. Identify diverse age groups, castes, and socioeconomic backgrounds within the community. In previous chapters, we discussed the main stakeholders in the Panjabi diaspora. For example the helpers, young adults, older adults, and international students.
    ii. Understand the distinct healthcare and social welfare needs of different demographics.
b. Community organizations:
    i. Collaborate with Panjabi community centers, religious institutions, and cultural associations.
    ii. Leverage their networks and resources to disseminate information and gather feedback.
    iii. Foster partnerships to create targeted programs and initiatives addressing the unique needs of the Panjabi community.

2. Embracing cultural authenticity in Panjabi-Centred Design (Cultural Authenticity):

The development of a Panjabi-Centred Design necessitates the creation of materials that not only acknowledge and honour the needs of Panjabi-speaking individuals, but also actively embrace their cultural values, customs, and beliefs. To truly embody this spirit, it is vital that we engage with the Panjabi community, inviting their input and feedback to ensure that the materials we create genuinely resonate with their lived experiences and

echo their voices.

Adopting a trauma-informed and culturally safe framework requires us to craft materials that are mindful of the cultural norms and values of Panjabi-speaking individuals, while also remaining sensitive to potential triggers for those who have experienced trauma. This empathetic approach calls for a profound understanding of the community's history and experiences, both in their homeland and as part of the diaspora in Canada.

The successful creation of culturally appropriate materials hinges upon our collaboration with Panjabi community leaders, organizations, and individuals with relevant expertise. This shared process ensures that the materials are authentic, meaningful, and relevant to the Panjabi-speaking community, while also demonstrating our commitment to working in partnership with the community, cultivating trust and solidarity.

As we design these materials, we must recognize the diverse nature of the Panjabi community, taking into account factors such as age, gender, socio-economic background, and faith beliefs. This approach will help us create inclusive and accessible resources that address the unique needs and preferences of the Panjabi-speaking populations.

Additionally, as we develop these materials, we must be mindful of the significance of visual elements, such as images, colours, and symbols, that hold cultural meaning and resonate with the Panjabi community. By incorporating these elements, we can enhance the effectiveness of the materials, making them more engaging and accessible to our intended audience.

In essence, the cultivation of culturally appropriate materials hinges on our engagement with the Panjabi community, our understanding of their values, customs, and beliefs, and our adoption of a trauma-informed and culturally safe approach. Through prioritizing

collaboration and inclusivity, healthcare authorities and social welfare organizations can create materials that truly serve and uplift the Panjabi diaspora in Canada.

3. Centring the Panjabi language in material creation and translation (Language Prioritization):

    To genuinely serve the Panjabi-speaking community and provide them with accessible healthcare and social welfare information, we must not merely translate existing English documents, such as health and social welfare brochures, pamphlets, videos, webpages, and social media posts. Instead, we need to prioritize creating materials in Panjabi from the beginning. In doing so, we challenge the marginalization of the Panjabi language and assert its significance as a central aspect of Panjabi-Centred Design.

    A trauma-informed and culturally safe approach calls for attentiveness to potential trauma triggers while developing and translating materials. This implies that both original Panjabi materials and English translations must undergo a thorough examination to ensure sensitivity to Panjabi-speaking patients' experiences and avoid unintentional harm.

    By crafting materials in Panjabi first, we underscore the importance of the Panjabi language and its unique cultural context, which can greatly influence the effectiveness of healthcare and social welfare communication. This approach fosters a profound understanding of the Panjabi community's experiences, ensuring materials are not just linguistically precise but also culturally relevant and resonant.

    To further augment the cultural safety and pertinence of these materials, it is crucial to engage Panjabi-speaking community members, healthcare professionals, and translators in the development and review processes. Their expertise and lived

experiences will contribute to creating materials that genuinely address the needs and preferences of the Panjabi-speaking community.

By centering the Panjabi language in material creation and translation, we reaffirm its importance and cultural context within healthcare and social welfare systems. Embracing a trauma-informed and culturally safe approach throughout the material creation and translation processes guarantees that the Panjabi diaspora in Canada obtains the information that is not only accessible but also attuned to their distinct experiences and perspectives.

4. Embracing professional translators and services in a feedback-rooted translation framework for Panjabi-Centred Design (Expert Translation):

   In the spirit of Panjabi-Centred Design, crafting a translation framework that embraces professional translators and services becomes a necessity for ensuring accurate and culturally relevant translations. By engaging translators skilled in both English and Panjabi, we make healthcare and social welfare materials more accessible and significant for the Panjabi diaspora in Canada.

   Outlined below are the fundamental aspects of a rooted translation framework in Panjabi-Centred Design:

   a. Mindful selection: Formulate criteria for choosing professional translators and services, taking into account language proficiency, cultural understanding, experience with healthcare and social welfare materials, and dedication to a trauma-informed and culturally safe approach.
   b. Collective effort: Cultivate collaboration among professional translators, Panjabi-speaking community members, and healthcare professionals throughout the

translation process. This unified approach ensures that translations are culturally resonant, precise, and attuned to the community's desires and needs.

c. Ensuring quality: Establish a comprehensive quality assurance and review process that involves diverse stakeholders, including Panjabi-speaking community members, healthcare professionals, and fellow translators. This step guarantees that translated materials meet the highest standards of accuracy and cultural relevance.

d. Continuous growth: Offer opportunities for professional translators to engage in training and ongoing development, such as workshops, conferences, and knowledge-sharing events. This dedication to growth helps maintain exceptional translation quality while deepening the understanding of Panjabi-Centred Design and its goals.

e. Reflective evaluation: Create a mechanism for evaluating the effectiveness of translated materials and collecting feedback from Panjabi-speaking patients, healthcare providers, and community members. This reflective loop enables ongoing improvement and ensures that the translation framework remains responsive to the Panjabi community's needs.

f. Inclusive accessibility: Guarantee that the translation framework addresses the diverse needs of the Panjabi community, considering individuals with disabilities by providing translations in various formats such as braille, audio, and large print.

g. Community empowerment: Strive to build the capacity of Panjabi-speaking community members and organizations to participate in the translation process, nurturing a sense of ownership and empowerment within the community.

In the article "Self report in clinical and epidemiological studies with non-English speakers: the challenge of language and culture," Lisa Hanna, Sonja Hunt and Raj Bhopal[353] explore the difficulties of translating questionnaires and interview schedules for non-English speaking populations in clinical and epidemiological research. Traditional translation procedures, which involve professional translators translating English questions into target languages, have faced criticism for producing translations that are overly formal and not representative of the broader population.

To address these issues, the translation process (in box 1)[354] has evolved to encompass item selection, testing, retesting, and consultations with monolingual speakers of the target languages. This iterative process, seen as cutting-edge, strives to generate more accurate translations that maintain the original meaning and suit the target population. However, even this method has faced criticism for its inability to fully address the disparities in meaning and appropriateness between languages, particularly when involving languages with roots different from English.

Within the context of the Panjabi-Centred Design Framework, the translation process detailed in Hunt and Bhopal's article lays the foundation for creating a robust translation framework. By integrating an iterative process that involves bilingual teams, consultations with monolingual speakers, field testing, and validation in each language,

[353] (Hanna et al., 2006)
[354] Ibid

the Panjabi-Centred Design Framework can better ensure the cultural and linguistic suitability of translated materials. This approach addresses the unique challenges associated with languages like Panjabi, which have distinct roots from English, and ultimately fosters more effective healthcare and welfare services for the Panjabi diaspora.

Box 1: State of the art translation/adaptation procedures
● Translation of items by a team of bilinguals ● Comparison of translations ● Negotiation of "best" items ● Consultations with people who are monolingual in the target languages. ● Item refinement ● Field testing with monolinguals ● Refinements as needed ● Testing for face, content and construct validity in each language

Drawing inspiration from the work of Lisa Hanna, Sonja Hunt and Raj Bhopal,[355] as well as the Panjabi-Centred Design Framework's communal, feedback-centered structure, these translation guidelines seek to foreground cultural understanding, inclusive collaboration, and a keen awareness of language's complexities. Hanna, Hunt and Bhopal's iterative translation approach informs the process, emphasizing the need to engage in continual dialogue, reflection, and refinement.

The Panjabi-Centred Design Framework's spirit of engagement shines through these guidelines, highlighting the importance of connecting with the target population, healthcare professionals, and social welfare experts at each stage of the translation process. By embracing community partnerships and weaving translated materials into

[355] (Hanna et al., 2006)

healthcare and social welfare services, these guidelines embody the Panjabi-Centred Design Framework's dedication to collective involvement and persistent growth.

These translation guidelines marry the wisdom of Hunt and Bhopal's translation process with the Panjabi-Centred Design Framework's principles (in box 2), yielding a holistic, culturally-aware methodology for crafting healthcare and social welfare materials that resonate with diverse linguistic communities.

Panjabi-Centred translation guidelines:

- Setting base and assessing cultural context: Begin by understanding the cultural, historical, and spiritual dimensions of the target population, as well as their unique healthcare and welfare needs. This understanding will inform the development of culturally-sensitive materials and services.
- Assemble a diverse translation team: Engage bilingual individuals who are knowledgeable about both English and the target language(s) and cultures. Ideally, the team should include representatives from the target population, healthcare professionals, and social welfare experts.
- Develop a glossary of key terms: Collaboratively create a glossary of essential terms and phrases related to healthcare and social welfare in the target language(s), ensuring that they are culturally appropriate and relevant.
- Translate materials by a team of bilinguals: Utilize the bilingual translation team to translate healthcare and social welfare materials, including questionnaires, informational brochures, and guidelines.

- Review and compare translations: Compare translations produced by the bilingual team members, identifying similarities and differences, and ensuring that translations are accurate and culturally appropriate.
- Negotiation of "best" items and collaborative refinement: Work together to select the most suitable translations that retain the original meaning and are appropriate for the target population. Modify and refine translations as needed to achieve the best fit for the specific cultural context.
- Consultation with resident healthcare practitioners, providers, facilitators, and monolingual speakers in the target languages: Seek input from local healthcare professionals, service providers, facilitators, and monolingual speakers of the target languages to review translations and provide feedback on their understandability and cultural appropriateness.
- Field testing with community/community partners: Conduct field tests of the translated materials with members of the target population and partnering organizations to assess their effectiveness and appropriateness in real-world settings.
- Refinements as needed: Based on the feedback and observations gathered from the field tests, consultations, and negotiations, make necessary refinements to the translations to enhance their cultural and linguistic appropriateness.
- Implement and evaluate translated materials and services: Integrate the translated materials into healthcare and social welfare services, monitor their effectiveness, and gather feedback from the target population to continuously improve and adapt the materials and services to their evolving needs.

Box 2: Panjabi-Centred translation guidelines
● Setting base and assessing cultural context ● Assemble a diverse translation team ● Develop a glossary of key terms ● Translation of items by a team of bilinguals ● Review and compare translations ● Negotiation of "best" items and collaborative refinement ● Consultation with resident healthcare practitioners, providers, facilitators, and monolingual speakers in the target languages ● Field testing with community/community partners ● Refinements as needed ● Implement and evaluate translated materials and services

Embracing professional translators and services within a feedback-rooted translation framework is vital for guaranteeing accurate and culturally appropriate translations in the context of Panjabi-Centred Design. By valuing collaboration, quality assurance, and continuous professional development, this framework plays a pivotal role in making healthcare and social welfare information more accessible and attuned to the unique experiences and perspectives of the Panjabi diaspora in Canada.

5. Cultivating skills in healthcare providers to empower Panjabi-speaking patients (Healthcare Provider Empowerment):

   To effectively serve Panjabi-speaking patients, it is vital that we nurture the necessary skills and knowledge in healthcare providers. This process encompasses mastering basic Panjabi phrases, gaining insights into cultural nuances, and fostering sensitivity to the distinctive needs of Panjabi-speaking patients. By committing to the professional growth of healthcare providers, we pave the way for a more inclusive and culturally aware healthcare setting.

Outlined below are crucial aspects of educating healthcare providers to work proficiently with Panjabi-speaking patients:

a. Language mastery: Offer language courses that impart essential Panjabi phrases and terminology, empowering healthcare providers to communicate more effectively with patients. This may include familiar greetings, empathetic expressions, and crucial medical terms concerning symptoms, treatments, and diagnoses.
b. Cultural awareness: Offer transformative cultural competency training to help healthcare providers delve into the depths of Panjabi culture, values, and beliefs. This journey may encompass the exploration of family dynamics, religious practices, dietary restrictions, and various other cultural norms that could shape a patient's experiences and choices within the realm of healthcare. Cultural awareness ought to embrace the intricate nuances, textures, and differences present within and across communities, as shaped by factors such as geographic region, migration history, socioeconomic status, educational background, language proficiency, and degrees of acculturation. In recognizing and deeply understanding these diverse elements, healthcare providers can more effectively tailor their services to meet the singular needs and preferences of Panjabi patients.
c. Sensitivity development: Design sensitivity training modules that heighten healthcare providers' awareness of potential cultural variances in communication styles, body language, and privacy expectations. This training could also tackle potential biases, stereotypes, and misconceptions that may unintentionally affect patient-provider interactions.

d. Trauma-informed care: Integrate trauma-informed care principles into training programs, ensuring healthcare providers are mindful of potential triggers and stressors that might surface when working with Panjabi-speaking patients, especially those who have endured trauma.
e. Case Studies and scenarios: Utilize case studies and role-playing situations to equip healthcare providers with hands-on practice in addressing culturally specific circumstances and challenges that could arise when engaging with Panjabi-speaking patients.
f. Mentorship and networking: Promote mentorship and networking opportunities that connect healthcare providers with Panjabi-speaking peers or community leaders, fostering collaboration, knowledge exchange, and cultural understanding.
g. Continuous learning: Establish ongoing learning opportunities for healthcare providers, such as workshops, conferences, and online resources, to maintain and update their skills and knowledge in alignment with the evolving needs of the Panjabi-speaking community.

Preparing healthcare providers to work effectively with Panjabi-speaking patients demands a comprehensive approach addressing language mastery, cultural awareness, sensitivity, and trauma-informed care principles. By investing in healthcare providers' professional development, we can create a healthcare environment that is more inclusive, culturally adept, and attuned to the unique needs of Panjabi-speaking patients.

6. Solidarity and empowerment through collaboration with Panjabi community organizations (Community Collaboration):

Solidarity with Panjabi community organizations is fundamental in our endeavour to disseminate healthcare and social welfare information within the Panjabi-speaking population. Through collective efforts, such as the distribution of materials and the organization of community events, we strive to provide education and resources that resonate with the community's distinct needs and cultural context.

Outlined below are the key aspects of forging partnerships with Panjabi community organizations:

a. Building bridges: Connect with prominent Panjabi community organizations, including religious institutions, cultural associations, and social service groups. These organizations have direct access to the Panjabi-speaking community and provide valuable insights into their needs, preferences, and challenges.
b. Co-constructing knowledge: Engage in dialogue with community organizations to co-create culturally relevant materials that address the specific concerns and interests of the Panjabi-speaking population. This collaborative approach ensures that the materials are authentic, engaging, and resonate with the target audience.
c. Sharing resources: Work in partnership with community organizations to disseminate healthcare and social welfare materials through their networks and channels, such as community centers, places of worship, and social media platforms. This collaborative approach amplifies the reach and impact of the materials, ensuring they effectively reach the intended audience.
d. Creating spaces for dialogue: Co-organize and host community events with Panjabi community organizations, such as workshops, seminars, and health fairs, providing opportunities for Panjabi-speaking individuals to engage in dialogue,

access services, and connect with healthcare professionals in a culturally familiar and safe environment.

e. Supporting capacity building: Strengthen community organizations' ability to provide healthcare and social welfare information and services to the Panjabi-speaking population. This may include offering training and resources, funding support, or sharing best practices and expertise.
f. Cultivating ongoing dialogue: Sustain regular communication and collaboration with Panjabi community organizations to continually assess the community's needs, gather feedback on existing materials and initiatives, and identify areas for improvement or new opportunities for partnership.
g. Assessing collective impact: Join forces with community organizations to evaluate the impact of collaborative initiatives on the Panjabi-speaking population. This could involve tracking the distribution of materials, monitoring attendance at community events, and gathering feedback from participants. Evaluating impact helps ensure that resources and efforts effectively address the community's needs.

Solidarity with Panjabi community organizations is essential in sharing healthcare and social welfare information with the Panjabi-speaking population. By engaging in dialogue and working collectively to create, distribute, and evaluate culturally appropriate materials and initiatives, healthcare providers and community organizations can ensure that the Panjabi diaspora in Canada has access to the education and resources they need for their well-being.

7. Technology as a tool for empowerment and connection in the Panjabi-speaking community (Technological Empowerment):

The pursuit of accessible healthcare and social welfare information for Panjabi-speaking patients demands that we recognize the transformative power of technology. By embracing the development of mobile applications and online resources in Panjabi, we can create platforms that empower individuals, cultivate community, and forge connections between healthcare providers and the Panjabi-speaking population.

Highlighted below are the essential aspects of harnessing technology in service of Panjabi-speaking patients:

a. Creating culturally relevant mobile applications: Develop mobile applications that address the healthcare and social welfare needs of the Panjabi-speaking community, offering features such as appointment scheduling, prescription management, symptom tracking, and access to healthcare resources, all available in the Panjabi language.
b. Designing online health portals: Establish online health portals that provide Panjabi-speaking patients with access to their medical records, test results, and healthcare resources in their native language. This approach empowers patients with a greater understanding of their health and fosters informed decision-making.
c. Offering telehealth services: Provide telehealth services in Panjabi, connecting patients with healthcare professionals who speak the language and understand the cultural context. This connection helps bridge language barriers and makes healthcare more accessible for Panjabi-speaking individuals, especially in remote or underserved areas.

d. Developing educational resources: Craft online resources in Panjabi, such as articles, videos, and e-learning modules, to educate the community on various healthcare and social welfare topics. These resources, tailored to the unique needs and cultural context of the Panjabi-speaking community, can cover disease prevention, healthy living, mental health, and social welfare programs.
e. Engaging with social media: Utilize social media platforms to share healthcare and social welfare information in Panjabi, reaching a wider audience, encouraging community engagement, and creating a space for dialogue and support.
f. Prioritizing accessibility: Ensure that technology-based healthcare resources are accessible to all members of the Panjabi-speaking community, including individuals with disabilities. This may involve incorporating features such as screen readers, text-to-speech, and adjustable text size in mobile applications and online resources.
g. Embracing feedback and continuous improvement: Establish a mechanism for gathering feedback from Panjabi-speaking patients on technology-based healthcare resources. This feedback loop enables continuous improvement and ensures that technology remains responsive to the evolving needs of the Panjabi community.

Leveraging technology can significantly enhance the accessibility of healthcare and social welfare information for Panjabi-speaking patients. By developing mobile applications, online resources, and telehealth services in Panjabi, we can create platforms that empower individuals, nurture community connections, and bridge the gap between healthcare providers and the Panjabi-speaking population.

8. Continual reflection and growth: monitoring and evaluating the framework's effectiveness in engaging the Panjabi-speaking community (Continuous Improvement):

    To ensure the long-term success of the translation framework and the dissemination of healthcare and social welfare knowledge among Panjabi-speaking patients, ongoing monitoring and evaluation are essential. By gathering feedback from both Panjabi-speaking patients and healthcare providers, we can identify areas for improvement, address emerging needs, and maintain a responsive and evolving framework that aligns with the community's expectations.

    Outlined below are key aspects of monitoring and evaluating the framework's effectiveness:

    a. Establish clear evaluation metrics: Develop a set of measurable indicators that reflect the goals and objectives of the translation framework, such as the number of translated materials, patient satisfaction levels, and changes in healthcare access or outcomes among Panjabi-speaking patients.
    b. Create a feedback mechanism: Implement a structured feedback mechanism that allows Panjabi-speaking patients, healthcare providers, and community members to share their insights and experiences with the translated materials and initiatives. This could involve surveys, focus groups, or one-on-one interviews.
    c. Regularly assess impact: Conduct regular assessments of the translation framework's impact on the Panjabi-speaking community, examining factors such as the accessibility of healthcare information, the quality of patient-provider interactions, and overall satisfaction with the healthcare experience.

d. Engage multiple stakeholders: Involve diverse stakeholders, including Panjabi-speaking patients, healthcare providers, community organizations, and translators, in the monitoring and evaluation process. Their perspectives can provide invaluable insights into the framework's effectiveness and areas for growth.
e. Identify and address emerging needs: Continuously monitor the needs and preferences of the Panjabi-speaking community, staying attuned to changing demographics, cultural shifts, and new healthcare challenges. Adjust the translation framework and initiatives accordingly to ensure their relevance and responsiveness.
f. Document and share findings: Compile and disseminate the findings from monitoring and evaluation activities, sharing insights and best practices with other healthcare providers, community organizations, and stakeholders. This fosters a culture of learning and collaboration that can lead to collective improvement and growth.
g. Iterate and improve: Use the insights gained from monitoring and evaluation to refine and enhance the translation framework, making necessary adjustments and improvements to better serve the Panjabi-speaking community. This iterative process ensures that the framework remains effective, inclusive, and culturally appropriate.

The ongoing monitoring and evaluation of the translation framework's efficacy in knowledge dissemination and language translation are crucial in ensuring that the needs of the Panjabi-speaking community are met. By engaging diverse stakeholders, establishing clear evaluation metrics, and embracing a culture of continuous

improvement, we can create a responsive and evolving framework that supports the well-being of the Panjabi-speaking population.

9. Creating spaces of radical openness - prioritizing accessibility for Panjabi-speaking patients in all their diversity (Inclusive Accessibility):

    Acknowledging the diverse needs of Panjabi-speaking patients with disabilities, it is crucial to ensure that healthcare materials and resources are not only accessible but also presented in formats that resonate with various individuals and communities. By offering translations in braille, audio, and video formats, and harnessing the power of popular social media platforms, we can cultivate an inclusive and adaptive framework that addresses the distinct requirements of the Panjabi-speaking community.

    Key aspects of fostering accessibility for Panjabi-speaking patients include:

    a. Embracing diverse formats: Commit to developing materials and resources in a range of formats, such as braille, audio, and large print, to cater to the unique needs of Panjabi-speaking patients with disabilities. This dedication to inclusivity ensures equitable access to essential healthcare and social welfare information.
    b. Harnessing video resources: Craft video materials in Panjabi designed for effortless sharing and engagement on social media platforms like Facebook, YouTube, and WhatsApp, which are widely utilized within the Panjabi diaspora. These platforms serve as effective channels for disseminating information and fostering community connections.
    c. Incorporating captioning: Ensure that video materials are accessible to Panjabi-speaking patients who are deaf or hard of hearing by providing captions. This

inclusive approach allows all community members to benefit from the resources provided.

d. Adopting responsive design: Guarantee that online resources, including websites and mobile applications, employ responsive design to accommodate a variety of devices and screen sizes. This enables users with visual impairments or other disabilities to access and navigate content with ease.
e. Seeking community input: Engage with Panjabi-speaking patients with disabilities and the community organizations that represent them to gain insights into their specific accessibility needs and preferences. This collabourative approach guarantees that materials and resources are genuinely responsive and adaptive to the needs of all community members.
f. Promoting training and education: Offer training and education to healthcare providers on the significance of accessibility and the various ways they can render their services more accessible to Panjabi-speaking patients with disabilities. This commitment to inclusivity can foster a more supportive and welcoming healthcare environment.
g. Embracing continuous assessment and improvement: Regularly evaluate the accessibility of materials and resources, gather feedback from Panjabi-speaking patients with disabilities, and implement improvements as needed. This ongoing process ensures that the framework remains adaptable and responsive to the evolving needs of the community.

Prioritizing accessibility is critical in addressing the diverse needs of Panjabi-speaking patients. By providing materials and resources in various formats, engaging

with the community, and continually assessing and improving accessibility, we can nurture a more inclusive and adaptive framework that caters to the unique requirements of the Panjabi-speaking population.

10. Embracing clarity and empowerment – nurturing health literacy in the Panjabi-speaking community (Health Literacy):

    Addressing health literacy is a vital aspect of offering comprehensive healthcare and social welfare information to Panjabi-speaking patients. Incorporating health literacy considerations into the materials and resources we provide ensures that information is accessible and comprehensible for individuals with varying literacy skills. Through the use of simple language, visuals, and other strategies, we can assist patients in better understanding their health, making informed decisions, and navigating the healthcare system with confidence.

    Outlined below are key aspects of nurturing health literacy for Panjabi-speaking patients:

    a. Emphasizing clarity: Prioritize simple and clear language in Panjabi when conveying healthcare and social welfare information, steering clear of complex terminology and jargon. This approach empowers patients with limited literacy skills to better comprehend the information provided, enabling them to make informed decisions about their health and well-being.
    b. Visual connections: Employ visual aids such as diagrams, illustrations, and infographics to support written information and clarify complex concepts. Visual aids can be especially beneficial for patients with limited literacy skills or those who are more visually-oriented learners.

c. Guidance and support: Provide step-by-step instructions and explanations for medical procedures, treatments, and self-care practices. This approach can help patients feel more confident and knowledgeable when managing their health.
d. Cultural resonance: Utilize culturally relevant examples and metaphors when explaining healthcare concepts to Panjabi-speaking patients, as this can make the information more relatable and easier to understand within their cultural context.
e. Engaging learning tools: Create interactive learning tools, such as quizzes, games, or simulations, that allow Panjabi-speaking patients to engage with and apply healthcare information in a practical manner. These tools can reinforce learning and enhance health literacy.
f. Compassionate communication: Educate healthcare providers on patient-centered communication techniques, including using plain language, confirming patient understanding, and actively listening. These skills contribute to a supportive environment where patients feel comfortable asking questions and discussing their concerns.
g. Inclusive formats: Guarantee that health literacy materials are available in various formats, such as print, audio, and video, to accommodate the diverse learning preferences and needs of the Panjabi-speaking community.
h. Continual growth and adaptation: Consistently assess the effectiveness of health literacy materials and resources, gathering feedback from Panjabi-speaking patients and healthcare providers. This process allows for continuous improvement, ensuring that the materials remain relevant, accessible, and effective in addressing the community's health literacy needs.

Nurturing health literacy is an essential component of serving the Panjabi-speaking community. By embracing clarity, cultural resonance, and inclusivity in the materials and resources provided, we can empower patients with the knowledge and skills they need to understand their health, make informed decisions, and navigate the healthcare system with confidence.

11. Fostering dialogue and learning (Patient-Centered Dialogue): Engaging with Panjabi-Speaking Patients' Experiences

The creation of a feedback mechanism holds immense importance in grasping the experiences of Panjabi-speaking patients within the healthcare system and with the resources provided. Collecting their insights allows healthcare providers to pinpoint areas that need improvement and confirm that patients' needs are effectively addressed.

The following are essential elements in cultivating a comprehensive feedback mechanism for Panjabi-speaking patients:

a. Empowering anonymity and confidentiality: Establish anonymous and confidential feedback channels, such as online surveys, feedback forms, and suggestion boxes, empowering patients to share their experiences and concerns without fear of consequences.
b. Deepening conversations: Engage in focus groups and one-on-one interviews with Panjabi-speaking patients to delve deeper into their experiences with the healthcare system and the resources provided. These conversations can uncover valuable insights into patients' needs, preferences, and obstacles.
c. Language inclusivity: Make certain that feedback channels are accessible in Panjabi, allowing patients to convey their thoughts and concerns in their native

language. This strategy can help eliminate language barriers and promote more honest and accurate feedback.

d. Embracing accessibility: Provide feedback channels in a variety of accessible formats, such as large print, braille, and audio recordings, ensuring that patients with disabilities can also share their experiences and contribute feedback.
e. Consistent opportunities for feedback: Offer regular opportunities for Panjabi-speaking patients to share feedback, like during annual check-ups or follow-up appointments. This practice can keep healthcare providers informed about patients' ongoing experiences and reveal trends or emerging issues.
f. Centring patient voices in decision-making: Utilize patient feedback as a valuable source of information to guide decision-making processes, including the development of new resources, modifications to existing services, or the implementation of new policies. This patient-centered approach guarantees that the healthcare system remains responsive to the needs of the Panjabi-speaking community.
g. Responsive action: Create a system to prioritize and address feedback received from Panjabi-speaking patients. This may involve assigning responsibility for specific issues, establishing deadlines for resolution, and monitoring progress towards improvement.
h. Transparent communication: Share outcomes and improvements with Panjabi-speaking patients, letting them know about any changes made in response to their concerns. This transparency can foster trust and encourage patients to continue sharing their experiences.

i. Continuous evaluation and adaptation: Routinely assess the effectiveness of the feedback mechanism, gathering insights from patients and healthcare providers. This continuous evaluation process ensures that the feedback mechanism remains responsive and adaptive to the evolving needs of the Panjabi-speaking community.

Crafting a comprehensive feedback mechanism is crucial for understanding the experiences of Panjabi-speaking patients and enhancing the healthcare system. By gathering information through diverse channels and incorporating patient feedback into decision-making processes, healthcare providers can identify areas for improvement and ensure that the needs of the Panjabi-speaking community are effectively met.

12. Fostering connection and empowerment - a holistic, collaborative strategy for engaging Panjabi-speaking patients (Holistic Engagement):

To effectively engage Panjabi-speaking patients and ensure their access to crucial healthcare information and resources, we must adopt a multi-pronged strategy that embraces collaboration, holistic thinking, and empathy. By working with local media, organizing community health fairs, and utilizing social media platforms, healthcare providers can cultivate a supportive network that fosters awareness, education, and solidarity within the Panjabi-speaking community.

Key components of implementing a multi-faceted strategy for engaging Panjabi-speaking patients include:

a. Local media alliances: Forge alliances with newspapers, radio stations, and television networks that cater to the Panjabi-speaking community. By disseminating healthcare information and resources through these channels, we

can broaden our reach and raise consciousness about accessible services and programs.

b. Community health gatherings: Establish community health events centred on the Panjabi-speaking population, providing free health screenings, educational workshops, and informational materials. Such gatherings can promote preventative care, encourage early detection of health concerns, and create enduring connections between healthcare providers and the community.
c. Social media connections: Engage Panjabi-speaking patients through social media platforms by sharing relevant healthcare information, updates, and resources in their native language. Platforms like Facebook, WhatsApp, and YouTube can encourage community engagement, foster dialogue, and provide a supportive online environment for patients.
d. Collaboration with community organizations: Partner with community organizations, cultural centers, and religious institutions that serve the Panjabi-speaking community to circulate healthcare information and resources. These partnerships can amplify the impact of healthcare initiatives and address the unique needs and cultural context of the Panjabi-speaking population.
e. Targeted outreach efforts: Design outreach programs that address specific health concerns or demographics within the Panjabi-speaking community, such as chronic disease management, maternal and child health, or mental health support. These targeted initiatives can promote early intervention, reduce health disparities, and enhance overall community health.

f. Culturally competent healthcare provider training: Educate healthcare providers on cultural competency and linguistic sensitivity to better serve the Panjabi-speaking community. This training can help providers better comprehend the unique needs and cultural context of their patients, fostering more effective communication and a welcoming healthcare environment.
g. Continuous evaluation and adaptation: Regularly assess the efficacy of the multi-pronged approach, gathering feedback from Panjabi-speaking patients, healthcare providers, and community partners. This ongoing evaluation process allows for continuous improvement and ensures that the approach remains responsive and adaptive to the evolving needs of the Panjabi-speaking community.

A multi-pronged approach is vital for effectively engaging Panjabi-speaking patients and ensuring their access to essential healthcare information and resources. By adopting a holistic, collaborative strategy that includes local media alliances, community health gatherings, and social media engagement, healthcare providers can cultivate awareness, education, and support for the Panjabi-speaking community.

5.3 Cultivating empowerment and cultural understanding: The transformative potential of the Panjabi-Centred Design Framework

In this chapter, we immerse ourselves in the rich and varied benefits of the Panjabi-Centred Design Framework, embracing its transformative capacity to cultivate cultural understanding, empower the Panjabi diaspora, and serve as an exemplar for engaging with diverse immigrant communities. We initiate our exploration by investigating the framework's capacity to bridge cultures, with a focus on its influence on healthcare and welfare services, and

the ways in which it attends to the distinctive needs and experiences of Panjabi communities. Subsequently, we engage in conversation about the empowerment of the Panjabi diaspora through culturally-responsive self-management and self-awareness strategies, made possible by the Panjabi-Centred Design framework. Lastly, we broaden our perspective to consider the wider implications of this framework, underscoring its potential as a model for attending to diverse immigrant communities beyond the Panjabi milieu, ultimately fostering health equity and social welfare for all marginalized populations.

5.3.1 Bridging Cultures: The Panjabi-Centred Design framework and its impact on healthcare and welfare services

In a landscape where the connection is vital, the Panjabi-Centred Design framework weaves a bridge between the Panjabi community and those who provide healthcare and welfare services. By embracing a culturally-responsive and inclusive approach, this framework nurtures understanding, trust, and dialogue between providers and the Panjabi diaspora, ultimately cultivating accessibility and enriching the quality of healthcare and welfare services.

Rooted in the Gurmat Framework and the Panchayati Raj system, the Panjabi-Centred Design framework intertwines the cultural, historical, and spiritual threads of the Panjabi community to create contextually-relevant and culturally-sensitive solutions.[356] [357] This approach enables healthcare and welfare providers to attune to the unique needs, values, and aspirations of the Panjabi community, resulting in more effective interventions and enhanced well-being.[358]

[356] (Singh, 2004)
[357] (Gurumurthy, 1986)
[358] (Dusenbery & Tatla, 2009)

Language barriers and cultural distinctions can often obstruct access to healthcare and welfare services for immigrant communities, including the Panjabi diaspora. The Panjabi-Centred Design framework endeavors to dismantle these barriers by weaving linguistic and cultural competency training into the fabric of healthcare and welfare providers, fostering effective communication and a mutual respect.

Furthermore, the Panjabi-Centred Design framework invites community participation and empowerment, drawing inspiration from the principles of the Panchayati Raj system. By including the Panjabi community in the decision-making process and the development of healthcare and welfare services, this approach nurtures a sense of ownership and shared responsibility, fostering trust and collaboration between the community and providers.

The framework encourages active community engagement and collaboration between healthcare and welfare providers and the Panjabi diaspora, fostering a sense of shared responsibility and ownership in the decision-making process.[359] [360] This approach not only builds trust between the community and providers but also empowers community members to actively participate in shaping the healthcare and welfare services tailored to their needs.

The PCD framework helps providers identify and address health disparities and social determinants of health specific to the Panjabi community, such as occupational hazards, dietary habits, and mental health stigma.[361] [362] This targeted approach ensures that healthcare and welfare services are better aligned with the unique needs of the Panjabi diaspora, ultimately promoting health equity and reducing health disparities.

[359] (Gurumurthy, 1986)
[360] (Dusenbery & Tatla, 2009)
[361] Ibid
[362] (Purewal & Kalra, 2010)

Moreover, the framework's emphasis on incorporating traditional knowledge and practices from the Panjabi community enriches the understanding of healthcare and welfare providers, allowing them to integrate these practices with conventional care.[363] [364] This holistic approach not only enhances cultural competency but also contributes to more comprehensive and effective healthcare and welfare services for the Panjabi community.

The Panjabi-Centred Design framework plays a crucial role in building a bridge between the Panjabi community and healthcare and welfare providers. By adopting a culturally-responsive and inclusive approach that incorporates the unique cultural, historical, and spiritual dimensions of the Panjabi community, this framework facilitates improved communication, understanding, and trust, ultimately enhancing the accessibility and quality of healthcare and welfare services for the Panjabi diaspora.

The Panjabi-Centred Design framework serves as a bridge, connecting the Panjabi community with healthcare and welfare providers. By adopting a culturally-responsive and inclusive approach that intertwines the unique cultural, historical, and spiritual dimensions of the Panjabi community, this framework nurtures understanding, trust, and dialogue, ultimately cultivating accessibility and enriching the quality of healthcare and welfare services for the Panjabi diaspora.

[363] (Dusenbery & Tatla, 2009)
[364] (Singh, 2004)

5.3.2 Empowering the Panjabi diaspora: Culturally-responsive self-management and self-awareness through the Panjabi-Centred Design framework

Embracing self-management and self-awareness is crucial for the efficacy of healthcare and mental health care, empowering individuals to actively engage in their healing journey and fostering self-determination. A rich body of research highlights the significance of self-management and self-awareness in relation to diverse health conditions and mental health challenges.

Self-management encompasses an individual's capacity to navigate the symptoms, treatments, physical and emotional consequences, and lifestyle shifts that come with chronic conditions or mental health challenges.[365] Interventions focusing on self-management have been shown to boost health outcomes, such as improved self-efficacy, increased adherence to treatment plans, and enhanced quality of life.[366] Moreover, these interventions can lead to reduced healthcare utilization and associated costs.[367]

Self-awareness, conversely, involves an individual's comprehension of their diagnosis, recognizing symptoms, and identifying triggers or factors that intensify their condition.[368] Heightened self-awareness has been linked to improved coping strategies, more significant engagement in healthcare decisions, and higher satisfaction with care.[369]

[365] (Lorig & Holman, 2003)
[366] (Bodenheimer et al., 2002)
[367] (Lorig et al., 1999)
[368] (Ryan & Deci, 2000)
[369] Ibid

Additionally, self-determination theory suggests that autonomy, competence, and relatedness are crucial elements for nurturing self-motivation and psychological well-being.[370] By enhancing self-management and self-awareness, individuals develop a deeper sense of autonomy and competence in caring for their health, thus nurturing self-determination and improved well-being.[371]

Self-management and self-awareness hold a vital place in augmenting the efficacy of healthcare and mental health interventions, empowering individuals with the knowledge and skills necessary to actively participate in their care. This active participation leads to better health outcomes, self-determination, and overall well-being. Therefore, integrating self-management and self-awareness strategies into healthcare and mental health interventions is essential for optimizing patient care and elevating health outcomes.

The Panjabi-Centred Design (PCD) Framework offers a valuable approach for healthcare authorities, social welfare organizations, and health researchers to provide holistic self-management and self-awareness skills to the Panjabi diaspora. By incorporating the unique cultural, historical, and spiritual dimensions of the Panjabi community, the PCD Framework fosters a culturally-responsive and inclusive approach that addresses the specific needs, values, and aspirations of the Panjabi population.

One of the key components of the PCD Framework is the emphasis on incorporating traditional knowledge and practices from the Panjabi community. By integrating these practices with conventional healthcare and welfare services, the PCD Framework allows healthcare providers and organizations to develop culturally-sensitive and contextually-relevant self-

[370] Ibid
[371] Ibid

management and self-awareness strategies. This holistic approach not only enhances cultural competency but also contributes to more comprehensive and effective healthcare and welfare services for the Panjabi community.

Furthermore, the PCD Framework encourages active community engagement and collaboration between healthcare and welfare providers and the Panjabi diaspora, fostering a sense of shared responsibility and ownership in the decision-making process.[372] [373] This approach not only builds trust between the community and providers but also empowers community members to actively participate in shaping the healthcare and welfare services tailored to their needs. As a result, self-management and self-awareness skills are strengthened, leading to increased self-determination among the members of the Panjabi diaspora.

The Panjabi community faces unique health challenges, including higher risks of diabetes, cardiac issues, and unaddressed mental health concerns, which further underscores the need for self-management and self-awareness skills that are culturally-sensitive and contextually relevant. The Panjabi-Centred Design (PCD) Framework provides a valuable approach to addressing these specific health challenges by fostering culturally-responsive and inclusive strategies that promote self-determination within the community.

Diabetes and cardiovascular diseases are major health concerns among the Panjabi community, attributed to a combination of genetic predisposition, dietary habits, and lifestyle factors.[374] The PCD Framework can help healthcare providers and organizations develop tailored self-management and self-awareness interventions that incorporate traditional Panjabi dietary practices, physical activity, and cultural perspectives on health and well-being. By integrating

[372] (Dusenbery & Tatla, 2009)
[373] (Gurumurthy, 1986)
[374] (Sekhon et al., 2022)

these cultural aspects into healthcare strategies, the PCD Framework can enhance the effectiveness of interventions and improve health outcomes for the Panjabi community.

Mental health challenges, including stigma and underutilization of mental health services, are also prevalent in the Panjabi community.[375] The PCD Framework addresses these issues by fostering culturally-sensitive self-management and self-awareness strategies that encompass the unique cultural, historical, and spiritual dimensions of the Panjabi community. By promoting an understanding of mental health from a Panjabi perspective, the PCD Framework can help dismantle stigma, encourage help-seeking behaviors, and empower individuals to actively engage in their mental health care.

Moreover, the PCD Framework encourages active community engagement and collaboration between healthcare providers and the Panjabi diaspora.This approach not only builds trust between the community and providers but also empowers community members to actively participate in shaping healthcare services tailored to their needs. As a result, self-management and self-awareness skills are strengthened, leading to increased self-determination and improved health outcomes for the Panjabi community.

By providing culturally-sensitive self-management and self-awareness skills, the PCD Framework addresses health disparities and social determinants of health specific to the Panjabi community, such as occupational hazards, dietary habits, and mental health stigma. This targeted approach ensures that healthcare and welfare services are better aligned with the unique needs of the Panjabi diaspora, ultimately promoting health equity, reducing health disparities, and increasing self-determination.

[375] (Purewal & Kalra, 2010)

The Panjabi-Centred Design Framework offers a vital approach for healthcare authorities, social welfare organizations, and health researchers to provide holistic self-management and self-awareness skills to the Panjabi diaspora. By fostering a culturally-responsive and inclusive approach, the PCD Framework enables the development of culturally-sensitive and contextually-relevant self-management and self-awareness strategies that lead to increased self-determination among the members of the Panjabi community.

5.3.3 Centralizing access: A radical act of love for IBPOC and immigrant populations

Healthcare and social welfare information access emerges as a vital concern, especially for Indigenous, Black, and People of Color (IBPOC) and immigrant communities, as they often confront systemic barriers to resources and services.[376] [377] Emphasizing access as central moves us toward achieving health equity, granting these communities the support they need to flourish. As Leah Lakshmi Piepzna-Samarasinha expresses in *Care Work: Dreaming Disability Justice*, "When access is centralized at the beginning dream of every action or event, that is radical love. I mean that access is far more to me than a checklist of accessibility needs – though checklists are needed and necessary."[378] Placing access at the forefront signifies an act of radical love transcending a mere checklist of accessibility needs.

Placing access centrally demands an all-encompassing approach, addressing the interlocking social determinants of health and systemic obstacles faced by IBPOC and immigrant populations.[379] [380] This involves grappling with language barriers, enhancing cultural

[376] (Ahmed, 2012)
[377] (Viruell-Fuentes et al., 2012)
[378] (Piepzna-Samarasinha, 2018)
[379] (Marmot, 2005)
[380] (Williams et al., 2019)

competence among healthcare professionals, and ensuring the availability of culturally-specific resources and services.[381] [382] By prioritizing access, decision-makers, healthcare providers, and social welfare organizations can embody a commitment to radical love and transformative change.

Studies reveal that centralizing access to healthcare and social welfare information significantly impacts health outcomes for marginalized communities.[383] [384] For instance, implementing culturally-appropriate health promotion programs and community-based services can heighten access to preventative care, reducing health disparities among IBPOC and immigrant populations.[385] [386]

Moreover, centralizing access requires collaboration across various sectors—public health, social services, education, and community organizations—to devise and execute strategies addressing the unique needs of IBPOC and immigrant populations.[387] [388] In doing so, the emphasis shifts from tackling individual health concerns to fostering the overall well-being and resilience of these communities.

Prioritizing access to healthcare and social welfare information emerges as a critical stride towards achieving health equity and uplifting the well-being of IBPOC and immigrant populations. This approach embodies the radical love articulated by Piepzna-Samarasinha[389] and transcends attending to individual needs by nurturing systemic change. By centring access and

[381] (Betancourt et al., 2003)
[382] (Viruell-Fuentes et al., 2012)
[383] (Institute of Medicine, 2003)
[384] (World Health Organization, 2010)
[385] (LaVeist et al., 2011)
[386] (Napoles et al., 2013)
[387] (Marmot, 2005)
[388] (World Health Organization, 2010)
[389] (Piepzna-Samarasinha, 2018)

working collaboratively across sectors, we can create a more inclusive, equitable, and compassionate society.

5.3.4 Panjabi-Centred Design Framework: A model for serving diverse immigrant communities beyond the Panjabi communities

In the Panjabi-Centred Design (PCD) Framework, we find a model with the potential to transcend its original context, offering vital guidance for those who serve various immigrant communities and their unique diasporas. The framework's focus on cultural sensitivity, engaging with the community, and ensuring accessibility makes it particularly relevant to healthcare and social welfare organizations that serve diverse populations, including those speaking growing languages like Chinese, Vietnamese, Arabic, and Farsi.

At the heart of the PCD Framework lies an emphasis on acknowledging and respecting cultural nuances and the broader context. Healthcare and social welfare organizations can embrace this approach by tailoring their services and resources to suit the distinct needs and contexts of different communities.[390] In doing so, they can develop culturally appropriate materials, enhance cultural competence among professionals, and address language barriers with translation and interpretation services.[391]

The PCD Framework also champions a community-driven methodology, actively involving the target population throughout the design and implementation of programs and services.[392] Applying this approach to healthcare and social welfare organizations working with Chinese, Vietnamese, Arabic, Farsi, and other immigrant communities means fostering genuine

[390] (Betancourt et al., 2003)
[391] (Viruell-Fuentes et al., 2012)
[392] (Napoles et al., 2013)

connections with community members. This engagement not only ensures cultural relevance and acceptance but also cultivates trust and collaboration between organizations and the communities they serve.[393]

Accessibility constitutes a crucial aspect of the PCD Framework, recognizing that centralizing access is key to addressing disparities in healthcare and social welfare services. To meet the needs of immigrant communities with growing languages, this might involve providing translated materials, interpretation services, and resources that are both linguistically and culturally appropriate.[394] By prioritizing accessibility, organizations can more effectively serve the diverse needs of immigrant populations, ultimately reducing health disparities and promoting health equity,[395]

The Panjabi-Centred Design Framework, although initially developed to address the needs of the Panjabi diaspora, presents a valuable blueprint for healthcare and social welfare organizations working with diverse immigrant communities across their respective diasporas. By centring cultural sensitivity, community engagement, and accessibility, the PCD Framework can guide organizations that serve various populations, including those speaking growing languages such as Chinese, Vietnamese, Arabic, and Farsi.

[393] (Minkler et al., 2008)
[394] (Chen et al., 2016)
[395] (National Academies of Sciences, 2017)

Chapter Six: Conclusion

In the spirit of the decolonization struggle, the Panjabi-Centred Design (PCD) framework seeks to offer a liberating and empowering approach to addressing the unique needs and experiences of marginalized communities. Inspired by the teachings of Professor Puran Singh, bell hooks, and Paulo Freire, PCD envisions a transgressive liberation for these communities, achieved through active engagement, critical reflection, and the dismantling of oppressive structures within healthcare and social welfare authorities.

PCD strives towards a genuine understanding of the cultural, historical, and social contexts of the Panjabi communities while recognizing the impacts of trauma, intersectionality, and systemic disparities on health and well-being. Heeding the insights of Professor Puran Singh,[396] PCD recognizes that true knowledge is not merely about knowing, but about being. This demands a deep commitment to community engagement and the genuine participation of authorities, rather than tokenistic gestures or performative acts.

Informed by the works of bell hooks[397] and Paulo Freire[398], PCD emphasizes the importance of questioning and critically examining the actions of healthcare authorities. It calls for dismantling colonial practices that perpetuate oppression and marginalization, holding authorities accountable for their commitments to equity, diversity, and inclusion. PCD envisions a healthcare system that is inclusive, responsive, and attentive to the diverse needs of communities.

PCD goes beyond the provision of guidelines to healthcare and social welfare authorities. It serves as a mirror, reflecting the power dynamics and structural inequalities that shape the

[396] (Singh, 2017)
[397] (hooks, 1994)
[398] (Freire, 2000)

experiences of the Panjabi community and other marginalized populations. By engaging with community members, stakeholders, and authorities, PCD strives to create a healthcare system that is more equitable, just, and compassionate, one that respects and values cultural diversity and promotes healing and resilience.

The presence of the Panjabi diaspora in Canada dates back to 1897[399], and yet the communities continue to face barriers to accessing competent healthcare. Despite being a part of the fabric of Canadian society for over a century, Panjabi Canadians are often required to provide evidence of their experiences and need to healthcare authorities. This requirement stems from a system that is rooted in colonialism and perpetuates systemic biases and discrimination. As James Baldwin famously said, "You've always told me it takes time. It's taken my father's time, my mother's time, my uncle's time, my brother's and my sister's time, my niece's and my nephew's time. How much time do you want for your 'progress'?"[400] The time for progress toward equitable healthcare access for all communities, including the Panjabi community, is long overdue.

Panjabi communities dispersed across the globe must perpetually bear in mind the indispensable wisdom: "In the pursuit of emancipation, neither the realm of passivity shall be neglected, nor shall the instant of awakening be disregarded."[401] This sacred call to consciousness is to be rooted in the ancestral praxis of ਚੜ੍ਹਦੀ ਕਲਾ (caṛhadī kalā)[402], the embodiment of radical-unconditional resilience.

[399] (Agnihotri, 2015)
[400] (Evans, 2020)
[401] (Freire, 2000)
[402] (Kaur, 2020)

As eloquently articulated by Shubhdeep Singh Sidhu, known to the world as Sidhu Moosewala, this unwavering resilience is the bedrock upon which the Panjabi spirit thrives. It is through the collective and individual embracement of this unyielding vigour that Panjabi communities will transcend the shackles of oppression, forging a new path toward liberation and self-determination.

“ਜਿਹਦੀ ਰਗਾਂ ਵਿੱਚ ਫ਼ਿਤਹ ਉਹ ਕਦੇ ਹਾਰ ਦੇ ਨਹੀਂ ਹੁੰਦੇ”[403]

(who has victory in their veins never loses)

In the future, this research might extend its reach to encompass other marginalized and immigrant communities, such as Chinese, Vietnamese, and Arabic populations, with the goal of examining the transferability and adaptiveness of the Panjabi-Centred Design Framework. Continually evolving this framework for the liberation of others remains an essential objective. The research could benefit from incorporating pilot programs within select healthcare and social welfare organizations to assess and refine the PCD framework. These pilot initiatives would offer invaluable feedback, enabling the identification of areas for improvement, potential challenges, and best practices for real-world implementation.

As I embark on my doctoral studies, I aspire to translate this research into action and actualize this framework through the Kosh Health Foundation, a transmedia web platform designed for Panjabi communities to comprehend mental and physical health terminologies through video, audio, and text. By placing the Panjabi narrative at the center, we strive to fortify the Panjabi community's sense of unity and self-determination, elements that seem to have vanished from the essence of Panjabi identity.

[403] (Sidhu, 2022)

Works Cited

Agnihotri, P. (2015, April 12). *Colourful Indian story in black and white*. Tribune India. Retrieved March 14, 2023, from https://www.tribuneindia.com/news/archive/features/colourful-indian-story-in-black-and-white-66126

Ahmad, F., Rai, N., Petrovic, B., Erickson, P. E., & Stewart, D. E. (2013). Resilience and Resources Among South Asian Immigrant Women as Survivors of Partner Violence. *Journal of Immigrant and Minority Health*, *15*(1), 1057–1064. 10.1007/s10903-013-9836-2

Ahmed, S. (2012). *On Being Included: Racism and Diversity in Institutional Life*. Duke University Press.

Allan, B., & Smylie, J. (2015). *First Peoples, Second Class Treatment: The Role of Racism in the Health and Well-being of Indigenous Peoples in Canada*. Wellesley Institute.

Amoah, J. K., & Mwanri, L. (2014). The Identity Question for African Youth: Developing the New While Maintaining the Old. *The Family Journal*, *22*(1), 127-133. https://doi.org/10.1177/1066480713505068

Anderson, J., Perry, J., Blue, C., Browne, A., & Henderson, A. (2003). "Rewriting" Cultural Safety Within the Postcolonial and Postnational Feminist Project. *Advances in Nursing Science, 26*(3), 196-214.

Ballard, R. (1996). *Desh Pardesh: The South Asian Presence in Britain* (R. Ballard, Ed.). B.R. Publishing Corporation.

Bannerji, H. (2000). *The dark side of the nation: essays on multiculturalism, nationalism, and gender*. Canadian Scholars' Press.

Battiste, M. (1998). Enabling the Autumn Seed: Toward a Decolonized Approach to Aboriginal Knowledge, Language, and Education. *OJS*, *22*(1). 10.14288/cjne.v22i1.195792

Bauer, A. M., & Alegria, M. (2010). Impact of Patient Language Proficiency and Interpreter Service Use on the Quality of Psychiatric Care: A Systematic Review. *Psychiatric Services*, *61*(8), 765-73. 10.1176/ps.2010.61.8.765

Bauer, G. R. (2014). Incorporating intersectionality theory into population health research methodology: challenges and the potential to advance health equity. *Social Science & Medicine*, *110*, 10-17. 10.1016/j.socscimed.2014.03.022

BC Cancer. (2023). *About*. BC Cancer. Retrieved April 27, 2023, from http://www.bccancer.bc.ca/about

BC Patient Safety & Quality Council. (2015). *Improve Culture - Cultural Safety & Humility*. BC Patient Safety & Quality Council. Retrieved April 26, 2023, from https://bcpsqc.ca/improve-culture/cultural-safety-and-humility/

Bell Canada. (2010). *Find out our 4 strategic key pillars to help people | Bell Let's Talk*. Bell Let's Talk. Retrieved April 27, 2023, from https://letstalk.bell.ca/our-initiative/

Berkman, N. D., Sheridan, S. L., Donahue, K. E., Halpern, D. J., & Crotty, K. (2011). Low health literacy and health outcomes: an updated systematic review. *Annals Intern Med, 155*(2), 97-107. 10.7326/0003-4819-155-2-201107190-00005

Berman, R., & Tyyskä, V. (2011). A Critical Reflection on the Use of Translators/Interpreters in a Qualitative Cross-Language Research Project. *The International Journal of Qualitative Methods*, *10*(2), 176-190. 10.1177/160940691101000206

Berry, J. W. (2005). Acculturation: Living successfully in two cultures. *International Journal of Intercultural Relations*, *29*(6), 697-712.

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Ananeh-Firempong, O. (2003). Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports*, *118*(4), 293-302. 10.1016/S0033-3549(04)50253-4

Bhachu, P. (1985). Twice Migrants. *East African Sikh Settlers in Britain*, *11*(3), 175-176. 10.7202/006445ar

Bhawra, J., Toulany, A., Cohen, E., Hepburn, C. M., & Guttmann, A. (2016). Primary care interventions to improve transition of youth with chronic health conditions from paediatric to adult healthcare: a systematic review. *BMJ Open*, *6*(5). 10.1136/bmjopen-2016-011871

Bhugra, D. (2004). Migration and mental health. *Acta Psychiatrica Scandinavica*, *109*(4), 243-258. 10.1046/j.0001-690X.2003.00246.x

Bhugra, D. (2004). Migration and mental health. *Acta Psychiatrica Scandinavica*, *109*(4), 243-58. 10.1046/j.0001-690x.2003.00246.x

Bhui, K., Abdi, A., Abdi, M., Pereira, S., Dualeh, M., Roberston, D., Sathyamoorthy, G., & Ismail, H. (2003). Traumatic events, migration characteristics and psychiatric symptoms among Somali refugees--preliminary communication. *Social Psychiatry and Psychiatric Epidemiology*, *38*(1), 35-43. 10.1007/s00127-003-0596-5

Bierman, A. S., Johns, A., Hyndman, B., Mitchell, C., Degani, N., Shack, A. R., Creatore, M. I., Lofters, A. K., Urquia, M. L., Ahmad, F., Khanlou, N., & Parlette, V. (2012). Social Determinants of Health & Populations at Risk. In *Ontario Women's Health Equity Report.* (pp. 111-117). POWER (Project for an Ontario Women's Health Evidence-Based Report.

BIG Language Solutions. (2022, December 28). *Interpreter vs. Translator: What's the Difference? - BIG Language Website*. BIG Language Solutions. Retrieved April 26, 2023, from https://biglanguage.com/blog/interpreter-vs-translator-whats-the-difference/

Bodenheimer, T., Lorig, K., Holman, H., & Grumbach, K. (2002). Patient self-management of chronic disease in primary care. *JAMA*, *288*(19), 2469-75. 10.1001/jama.288.19.2469

Brah, A. (1996). *Cartographies of Diaspora: Contesting Identities*. Routledge.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101.

Brine, K. (2021). Engaging people with lived experience through integrated knowledge translation: From basic pain research design to knowledge synthesis to clinical policy impact. *CANADIAN JOURNAL OF PAIN*, *5*(2), A3-A33. 24740527.2021.1914213

Brinkerhoff, D. W. (2004). Accountability and health systems: toward conceptual clarity and policy relevance. *Health Policy Plan*, *19*(6), 371-9. 10.1093/heapol/czh052

Browne, A. J., & Varcoe, C. (2006, September). Critical cultural perspectives and health care involving Aboriginal peoples. *Contemporary Nurse*, *122*(2), 155-167. 10.5172/conu.2006.22.2.155

Browne, A. J., Varcoe, C., Lavoie, J., Smye, V., & Wong, S. T. (2016). Enhancing health care equity with Indigenous populations: evidence-based strategies from an ethnographic study. *BMC Health Services Research*, *16*(544). 10.1186/s12913-016-1707-9

Busetto, L., Wick, W., & Gumbinger, C. (2020). How to use and assess qualitative research methods. *Neurological Research and Practice*, *2*(14).

Canadian Institute for Health Information. (2016). Trends in Income-Related Health Inequalities in Canada. *Trend Report.*

Canadian Institutes of Health Research. (2023, January 17). Funding overview - CIHR. Retrieved April 26, 2023, from https://cihr-irsc.gc.ca/e/37788.html

Canadian Journal of Public Health. (2023). *Canadian Journal of Public Health | Aims and scope*. Springer. Retrieved April 26, 2023, from https://www.springer.com/journal/41997/aims-and-scope

Canadian Medical Association. (2023). *Our focus*. Canadian Medical Association | CMA. Retrieved April 26, 2023, from https://www.cma.ca/

Canadian Medical Association Journal. (2021). *About CMAJ*. CMAJ. Retrieved April 26, 2023, from https://www.cmaj.ca/content/about-cmaj

Canadian Mental Health Association. (2008). *Write All Over Your Bathroom Mirror (Youth)*. Canadian Mental Health Association. Retrieved April 27, 2023, from https://cmha.app.neoncrm.com/np/clients/cmha/product.jsp?product=406&catalogId=2&

Canadian Mental Health Association. (2016, May 31). *Bounce Back®: reclaim your health*. CMHA Vancouver-Fraser. Retrieved April 27, 2023, from https://vancouver-fraser.cmha.bc.ca/programs-services/bounce-back/

Canadian Mental Health Association. (2016, May 31). *Bounce Back®: reclaim your health*. CMHA Vancouver-Fraser. Retrieved April 27, 2023, from https://vancouver-fraser.cmha.bc.ca/programs-services/bounce-back/

Canadian Nurses Association. (2023). *Who We Are - Canadian Nurses Association*. CNA | AIIC. Retrieved April 26, 2023, from https://www.cna-aiic.ca/en/about-us/who-we-are

Capell, J., Veenstra, G., & Dean, E. (2007). Cultural competence in healthcare: Critical analysis of the construct, its assessment and implications. *Journal of Theory*, *11*(1), 30-37.

Castles, S. (2003). Towards a Sociology of Forced Migration and Social Transformation. *British Sociology Association*, *37*(1), 13-34. 10.1177/0038038503037001384

CBC Radio. (2021, May 5). *'The system failed the people of Brampton': How COVID-19 is taking a toll in hard-hit city*. CBC. Retrieved April 3, 2023, from https://www.cbc.ca/radio/thecurrent/the-current-for-may-4-2021-1.6012904/the-system-failed-the-people-of-brampton-how-covid-19-is-taking-a-toll-in-hard-hit-city-1.6012995

Centers for Medicare & Medicaid Services. (2023, February 13). *Electronic Health Records*. CMS. Retrieved April 26, 2023, from https://www.cms.gov/medicare/e-health/ehealthrecords

Chambers, R. (1994). The origins and practice of participatory rural appraisal. *World Development*, *22*(7), 953-969. 10.1016/0305-750X(94)90141-4

Chanana, K. (1993). Partition and Family Strategies-Gender-Education Linkages among Punjabi Women in Delhi. *Women's Studies*, *28*(17).

Chandler, M. J., & Lalonde, C. (1998). Cultural Continuity as a Hedge against Suicide in Canada's First Nations. *Transcultural Psychiatry*, *35*(2), 191-219. 10.1177/136346159803500

Chaudhary, V., Rayatt, R., & Kwestany, L. (2019, July 1). *The Indian state where farmers sow the seeds of death*. The Guardian. Retrieved April 27, 2023, from https://www.theguardian.com/global-development/2019/jul/01/the-indian-state-where-farmers-sow-the-seeds-of-death

Chavan, B., Das, S., Garg, R., Puri, S., & Banavaram, A. A. (2018). Prevalence of mental disorders in Punjab: Findings from National Mental Health Survey. *Indian Journal of Psychiatry*, *60*(1), 121-126.

Chen, J., Vargas-Bustamante, A., Mortensen, K., & Ortega, A. N. (2016). Racial and Ethnic Disparities in Health Care Access and Utilization Under the Affordable Care Act. *Med Care*, *54*(2), 140-6. 10.1097/MLR.0000000000000467

Childress, J. F., & Beauchamp, T. L. (2013). *Principles of Biomedical Ethics*. OUP USA.

Chima, J. S. (2014). The Punjab Police and Counterinsurgency against Sikh Militants in India: The Successful Convergence of Interests, Identities, and Institutions. In C. C. Fair & S. Ganguly (Eds.), *Policing Insurgencies: Cops as Counterinsurgents* (pp. 258–290). Oxford University Press.

Chima, J. S. (2015). The 'Political Economy' of Sikh Separatism: Ethnic Identity, Federalism and the Distortions of Post-Independence Agrarian Development in Punjab-India. In M. Webb & A. Wijeweera (Eds.), *The Political Economy of Conflict in South Asia*. Palgrave Macmillan.

Chomsky, N. (1965). *Aspects of the Theory of Syntax*. M.I.T. Press.

Chomsky, N. (2000). *New Horizons in the Study of Language and Mind*. Cambridge University Press.

Costanza-Chock, S. (2020). *Design Justice: Community-Led Practices to Build the Worlds We Need*. MIT Press.

Crenshaw, K. W. (1989). Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics. *University of Chicago Legal Forum*, *1989*(8).

Creswell, J. W. (2014). Research Design: Qualitative, Quantitative and Mixed Methods Approaches (4th ed.). *Thousand Oaks*.

Cultural Identity and Diaspora. (2018). In S. Hall (Ed.), *Essential Essays, Volume 2: Identity and Diaspora*. Duke University Press.

Cultural Identity and Diaspora. (2020). In L. McDowell (Ed.), *Undoing Place? A Geographical Reader*. Taylor & Francis Group.

Dale, A., Shaheen, N., Kalra, V., & FIledhouse, E. (2010). Routes into education and employment for young Pakistani and Bangladeshi women in the UK. *Ethnic and Racial Studies*, *25*(6), 942-968. 10.1080/0141987022000009386

Dasgupta, S. D. (1998). Gender Roles and Cultural Continuity in the Asian Indian Immigrant Community in the U.S. *Sex ROles*, *38*(1), 953-974.

de Moissac, D., & Bowen, S. (2018). Impact of Language Barriers on Quality of Care and Patient Safety for Official Language Minority Francophones in Canada. *Journal of Patient Experience*, *6*(1). 10.1177/2374373518769008

Dhanda, M. (2014). Caste in Britain: Socio-legal Review. *quality and Human Rights Commission*, *91*.

Divi, C., Koss, R. G., Schmaltz, S. P., & Loeb, J. M. (2007). Language proficiency and adverse events in US hospitals: a pilot study. *International Journal for Quality in Health Care*, *19*(2), 60-67. 10.1093/intqhc/mzl069.

Doi-Kanno, M., Kanoya, Y., & Moriguchi, E. H. (2021). The effects of a leaflet-based health guide on health literacy, self-efficacy, and satisfaction among older Japanese-Brazilian adults living in Brazil: A quasi-experimental study. *BMC Public Health*, *21*(10). 10.1186/s12889-020-10129-1

Dreachslin, J. L., Gilbert, M. J., & Malone, B. (2013). *Diversity and Cultural Competence in Health Care: A Systems Approach*. Wiley.

Driedger, S.M., Cooper, E. J., & Moghadas, S. M. (2014). Developing model-based public health policy through knowledge translation: the need for a 'Communities of Practice'. *Public Health, 128*(6), 30-34. 10.1016/j.puhe.2013.10.009

Dusenbery, V. A. (1997). The poetics and politics of recognition: diasporan Sikhs in pluralist polities. *American Ethnologist, 24*(4), 738-762. 10.1525/ae.1997.24.4.738

Dusenbery, V. A., & Tatla, D. S. (Eds.). (2009). *Sikh Diaspora Philanthropy in Punjab: Global Giving for Local Good*. Oxford University Press.

Dutta-Bergman, M. (2004). The unheard voices of Santalis: Communicating about health from the margins of India. *Communication Theory*, *14*(3), 237–263. 10.1111/j.1468-2885.2004.tb00313.x

Ebaugh, H. R. F. (2000). *Religion and the New Immigrants: Continuities and Adaptations in Immigrant Congregations* (J. S. Chafetz & H. R. F. Ebaugh, Eds.). AltaMira Press.

Eggeling, R., Grosse, I., & Grau, J. (2017). InMoDe: tools for learning and visualizing intra-motif dependencies of DNA binding sites. *Inernational Society for Computational Biology, 33*(4), 580-582. 10.1093/bioinformatics/btw689

Elliott, D. E., Bjelajac, P., Fallot, R. D., & Markoff, L. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology, 33*(4), 461-477. 10.1002/jcop.20063

Enas, E. A., & Mehta, J. (1995). Malignant coronary artery disease in young Asian Indians: thoughts on pathogenesis, prevention, and therapy. Coronary Artery Disease in Asian Indians (CADI) Study. *Clinical Cardiology, 18*(3), 131-135. 10.1002/clc.4960180305

Evans, G. (2020, May 28). *George Floyd: This James Baldwin quote remains as vital as ever | indy100 | indy100*. Indy100. Retrieved April 27, 2023, from

https://www.indy100.com/viral/james-baldwin-racism-quote-george-floyd-death-minneapolis-9537066

Fanon, F. (2004). *The Wretched of the Earth* (R. Philcox, Trans.). Grove Press.

Fanon, F. (2007). *Black Skin, White Masks* (R. Philcox, Trans.). Grove Press.

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating Rigor Using Thematic Analysis: A Hybrid Approach of Inductive and Deductive Coding and Theme Development. *nternational Journal of Qualitative Methods*, *5*, 1-11. 10.1177/160940690600500107

Fernandez, A., Schillinger, D., Grumbach, K., Rosenthal, A., Stewart, A. L., Wang, F., & Pérez-Stable, E. J. (2004). Physician language ability and cultural competence. An exploratory study of communication with Spanish-speaking patients. *J Gen Intern Med*, *19*(2), 167-74. 10.1111/j.1525-1497.2004.30266.x

Filmer, D., & King, E. (2013). Gender Disparity in South Asia: Comparisons between and within Countries. *Policy Research Working Papers*, *1*(1). 10.1596/1813-9450-1867

Fischer-Tiné, H., & Tschurenev, J. (Eds.). (2014). *A History of Alcohol and Drugs in Modern South Asia: Intoxicating Affairs*. Routledge, Taylor & Francis Group.

Fiske, J.-A., & Browne, A. J. (2006). Aboriginal citizen, discredited medical subject: Paradoxical constructions of Aboriginal women's subjectivity in Canadian health care policies. *Policy Sciences*, *39*(1), 91-111.

Flores, G. (2005). The impact of medical interpreter services on the quality of health care: A systematic review. *Medical Care Research and Review*, *62*(3), 255-99. 10.1177/1077558705275416

Forte, A., Trobia, F., Gualtieri, F., Lamis, D. A., Cardamone, G., Giallonardo, V., Fiorillo, A., Girardi, P., & Pompili, M. (2018). Suicide Risk among Immigrants and Ethnic Minorities: A Literature Overview. *Int J Environ Res Public Health*, *15*(7).

Freire, P. (2000). *Pedagogy of the oppressed*. Bloomsbury Academic.

Freitag, M., Foster, G., Grangier, D., Ratnakar, V., Tan, Q., & Macherey, W. (2021). Experts, Errors, and Context: A Large-Scale Study of Human Evaluation for Machine Translation. *Transactions of the Association for Computational Linguistics*, *9*(1), 1460–1474. 10.48550/arXiv.2104.14478

Garcia, I., & Peña, M. I. (2011). Machine translation-assisted language learning: Writing for beginners. *Computer Assisted Language Learning*, *24*(5), 1-17. 10.1080/09588221.2011.582687

Geertz, C. (1973). Thick Description: Toward an Interpretive Theory of Culture. In *The interpretation of cultures* (pp. 310-323). Basic Books.

George, U., Thomson, M. S., Chaze, F., & Guruge, S. (2015). Immigrant Mental Health, A Public Health Issue: Looking Back and Moving Forward. *Int J Environ Res Public Health*, *12*(10), 13624-48. 10.3390/ijerph121013624

Ghuman, P. (2001). *Double Loyalties: Asian Adolescents in the West*. University of Wales Press.

Government of British Columbia. (2020). *BC Seniors' Guide - Province of British Columbia*. Gov.bc.ca. Retrieved April 26, 2023, from https://www2.gov.bc.ca/gov/content/family-social-supports/seniors/about-seniorsbc/seniors-related-initiatives/bc-seniors-guide

Government of Canada. (2018). *Health Equity and Diversity Strategy*. Government of Canada. Retrieved April 26, 2023, from https://www.canada.ca/en/public-health/services/health-equity-diversity-strategy.html

Government of Canada. (2023, February 8). *Using the services of an accredited interpreter*. Canada.ca. Retrieved April 26, 2023, from https://www.canada.ca/en/immigration-refugees-citizenship/corporate/publications-manuals/operational-bulletins-manuals/interview/interpreter/using-services.html

Government of Canada. (2023, February 27). *About the New Horizons for Seniors Program*. Canada.ca. Retrieved April 27, 2023, from https://www.canada.ca/en/employment-social-development/programs/new-horizons-seniors.html

Graham, I. D., Logan, J., Harrison, M. B., Straus, S. E., Tetroe, J., Caswell, W., & Robinson, N. (2006). Lost in knowledge translation: time for a map? *Journal of Continuing Education in the Health Professions*, *26*(1), 13-24. 10.1002/chp.47

Grimshaw, J. M., Eccles, M. P., Lavis, J. N., Hill, S. J., & Squires, J. E. (2012). Knowledge translation of research findings. *Implementation Science*, *7*(1), 1-17.

Grossman, S., Cooper, Z., Buxton, H., Hendrickson, S., Lewis-O'Connor, A., Stevens, J., Wong, L.-Y., & Bonne, S. (2021). Trauma-informed care: recognizing and resisting re-traumatization in health care. *Trauma Surg Acute Care Open*, *6*(1). 10.1136/tsaco-2021-000815

Gurumurthy, U. (1986). *Panchayati Raj and the Weaker Sections*. Ashish Publishing House.

Hankivsky, O., & Cormier, R. (2010). Intersectionality and Public Policy: Some Lessons from Existing Models. *Political Research Quarterly*, *64*(1), 217-229. 10.1177/1065912910376385

Hankivsky, O., Grace, D., Hunting, G., Giesbrecht, M., Fridkin, A., Rudrum, S., Ferlatte, O., & Clark, N. (2014). An intersectionality-based policy analysis framework: critical

reflections on a methodology for advancing equity. *International Journal for Equity in Health, 13*(119).

Hanna, L., Hunt, S., & Bhopal, R. (2006). Cross-cultural adaptation of a tobacco questionnaire for Punjabi, Cantonese, Urdu and Sylheti speakers: qualitative research for better clinical practice, cessation services and research. *J Epidemiol Community Health, 60*(12), 1034-9. 10.1136/jech.2005.043877

Harris, M., & Fallot, R. D. (Eds.). (2001). *Using Trauma Theory to Design Service Systems: New Directions for Mental Health Services, Number 89*. Wiley.

Hashim, M. J. (2017). Patient-Centered Communication: Basic Skills. *American Academy of Family Physicians, 95*(1), 29-34.

HealthLink BC. (2023). *HealthLink BC*. HealthLink BC - 24/7 Health Advice You Can Trust. Retrieved April 26, 2023, from https://www.healthlinkbc.ca/

Heer, K. (2018). Becoming Sikh : Sikh youth identities and the multicultural imaginary. 10.14288/1.0364584

hooks, b. (1994). *Teaching to transgress : education as the practice of freedom*. Routledge.

hooks, b. (2015). *Ain't I a Woman: Black Women and Feminism*. Routledge.

Horowitz, C. R., Robinson, M., & Seifer, S. (2009). Community-based participatory research from the margin to the mainstream: are researchers prepared? *Circulation, 119*(19), 2633-42. 10.1161/CIRCULATIONAHA.107.729863

Hussain, F., & Ahmed, I. (2022). The Panchayati Raj System in India: An Overview. *International Journal of Political Science and Public Administration, 2*(2), 73-85.

Inclusive Design Research Centre. (2023). *Philosophy*. Inclusive Design Research Centre. Retrieved April 27, 2023, from https://idrc.ocadu.ca/about/philosophy/

Ineichen, B. (2008). Suicide and attempted suicide among South Asians in England: who is at risk? *Ment Health Fam Med, 5*(3), 135-8.

Institute of Medicine. (2003). Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. https://pubmed.ncbi.nlm.nih.gov/25032386/

The Interpreter's Lab. (2022, 11 25). *Training Programs*. The Interpreter's Lab. Retrieved April 26, 2023, from https://www.interpreterslab.org/programs/

Island Health. (2023). *Learn About Health*. Island Health. Retrieved April 27, 2023, from https://www.islandhealth.ca/learn-about-health

Israel, B. A., Schulz, A. J., Parker, E. A., & Becker, A. B. (1998). Review of community-based research: assessing partnership approaches to improve public health. *Annual Reviews Public Health, 19*(1), 173-202. 10.1146/annurev.publhealth.19.1.173

Jodhka, S. S. (1996). 'Crisis' of the 1980s and Changing Agenda of 'Punjab Studies': A Survey of Some Recent Research. *Economic and Political Weekly, 32*(6), 273-279.

Johal, R. (2023, January 16). *International Students Are Dying From Overdoses at an Alarming Rate. But BC's Government Isn't Tracking the Problem.* Press Progress. Retrieved April 3, 2023, from https://pressprogress.ca/international-students-overdoses-british-columbia-20230116/

Johnston, H. (2006). Group Identity in an Emigrant Worker Community: The Example of Sikhs in early Twentieth-Century British Columbia. *BC Studies, 148*, 141.

Johnston, H. (2006, February 26). *Komagata Maru*. The Canadian Encyclopedia. Retrieved April 3, 2023, from https://www.thecanadianencyclopedia.ca/en/article/komagata-maru

Kahlon, B. S. (2022, June 1). *Canada's exploitation of Punjabi international students is history repeating itself.* Toronto Star. Retrieved April 3, 2023, from

https://www.thestar.com/opinion/contributors/2022/06/01/canadas-exploitation-of-punjabi-international-students-is-history-repeating-itself.html?rf

Kandiyoti, D. (1988). Bargaining with Patriarchy. *Gender and Society*, *2*(3), 274-290.

Karasz, A., Patel, V., Kabita, M., & Shimu, P. (2013). “Tension” in South Asian Women: Developing a Measure of Common Mental Disorder Using Participatory Methods. *Prog Community Health Partnersh*, *7*(4), 429-441. 10.1353/cpr.2013.0046

Karliner, L., Ma, L., Hofman, M., & Kerlikowske, K. (2012). Language Barriers, Location of Care and Delays in Follow-up of Abnormal Mammograms. *Medical Care*, *50*(2), 171-178. 10.1097/MLR.0b013e31822dcf2d

Karliner, L. S., Jacobs, E. A., Chen, A. H., & Mutha, S. (2007). Do Professional Interpreters Improve Clinical Care for Patients with Limited English Proficiency? A Systematic Review of the Literature. *Health Service Research*, *42*(2), 727-754. 10.1111/j.1475-6773.2006.00629.x

Kaur, H., & O'Hara, C. (2021, September 11). *A Sikh man's murder at a gas station revealed another tragedy of 9/11*. CNN. Retrieved April 3, 2023, from https://www.cnn.com/interactive/2021/09/us/balbir-singh-sodhi-9-11-cec/

Kaur, I. (2020, December 4). *"Never Treat Your Citizens as Slaves" | Inni Kaur | SikhRI Articles*. Sikh Research Institute. Retrieved April 27, 2023, from https://sikhri.org/articles/never-treat-your-citizens-as-slaves

Kaur, J., & Singh, H. (2023, April 25). *Women & Gender in Sikhi | Harinder Singh & Jasleen Kaur | SikhRI Articles*. Sikh Research Institute. Retrieved April 27, 2023, from https://sikhri.org/articles/women-gender-in-sikhi

Kaur, K. (2023, January 31). *WHY DID I TITLE MY BOOK 'PANJABI GARDEN' AND NOT 'PUNJABI GARDEN.'* [Instagram Post] [Instagram Post]. Instagram - Keerat Kaur. https://www.instagram.com/p/CoGqvRpLdNW/?hl=en

Kaur, S. (2022, May 19). *Coming To Terms With Childhood Trauma*. SikhNet. Retrieved April 3, 2023, from https://www.sikhnet.com/news/coming-terms-childhood-trauma

Kelm, M.-E. (1998). *Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900-50*. UBC Press.

Kerr, J. (2014). Western epistemic dominance and colonial structures: Considerations for thought and practice in programs of teacher education. *Decolonization: Indigeneity, Education & Society*, *3*(2), 83-104.

Kirmayer, L., Simpson, C., & Cargo, M. (2003). Healing Traditions: Culture, Community and Mental Health Promotion with Canadian Aboriginal Peoples. *Australasian Psychiatry*, *11*(1). 10.1046/j.1038-5282.2003.02010.

Kirmayer, L. J. (2012). Cultural competence and evidence-based practice in mental health: Epistemic communities and the politics of pluralism. *Social Science & Medicine*, *75*(2), 249-256. 10.1016/j.socscimed.2012.03.018

Koehn, S. (2009). Negotiating candidacy: ethnic minority seniors' access to care. *Ageing & Society*, *29*(4), 585-608. 10.1017/S0144686X08007952

Kurtz, D. L., Nyberg, J. C., Tillaart, S. V. D., & Mills, B. (2008). Silencing of Voice: An Act of Structural Violence Urban Aboriginal Women Speak Out About Their Experiences with Health Care. *International Journal of Indigenous Health*, *4*(1), 53-63. 10.18357/ijih41200812315

Kvale, S. (1994). *InterViews: An introduction to qualitative research interviewing.* Sage Publications.

Kymlicka, W. (1996). *Multicultural Citizenship: A Liberal Theory of Minority Rights*. Clarendon Press.

LaVeist, T. A., Gaskin, D. J., & Richard, P. (2011). The Economic Burden of Health Inequalities in the United States. *HEALTH POLICY AND MANAGEMENT FACULTY PUBLICATIONS*.

Laverack, G. (2006). Improving health outcomes through community empowerment: a review of the literature. *J Health Population Nutr.*, *24*(1), 113-20.

Laverack, G., & Labonte, R. (2000). A planning framework for community empowerment goals within health promotion. *Health Policy and Planning*, *15*(3), 255-262. 10.1093/heapol/15.3.255

Lavis, J. N., Robertson, D., Woodside, J. M., McLeod, C. B., Abelson, J., & Knowledge Transfer Study Group. (2003). How can research organizations more effectively transfer research knowledge to decision makers? *The Milbank Quarterly*, *81*(2), 171-172. 10.1111/1468-0009.t01-1-00052

Lincoln, Y., & Guba, E. (1985). *RWJF*. Qualitative Research Guidelines Project. Retrieved April 28, 2023, from http://www.qualres.org/HomeLinc-3684.html

Loppie, C. (2007). Learning From the Grandmothers: Incorporating Indigenous Principles Into Qualitative Research. *Qualitative Health Research*, *17*(2), 276-284. 10.1177/1049732306297905

Lorde, A. (2007). *Sister Outsider: Essays and Speeches (Crossing Press Feminist Series)*. Clarkson Potter/Ten Speed.

Lorig, K. R., & Holman, H. (2003). Self-management education: history, definition, outcomes, and mechanisms. *Ann Behav Med*, *26*(1), 1-7. 10.1207/S15324796ABM2601_01

Lorig, K. R., Sobel, D. S., Stewart, A. L., Brown Jr., B. W., Bandura, A., Ritter, P., Gonzalex, V. M., Laurent, D. D., & Holman, H. R. (1999). Evidence suggesting that a chronic disease self-management program can improve health status while reducing hospitalization. *APA PsycInfo*, *37*(1), 5-14. 10.1097/00005650-199901000-00003

Mandair, A.-P. S. (2013). *Sikhism: A Guide for the Perplexed*. Bloomsbury Academic.

Marchildon, G. (2013). Canada: Health system review. *Health Systems in Transition*, *15*(1), 1-179.

Marmot, M. (2005). Social determinants of health inequalities. *The Lancet*, *365*(9464), 1099-104. 10.1016/S0140-6736(05)71146-6.

Marshall, C., & Rossman, G. B. (2016). *Designing Qualitative Research*. SAGE Publications.

Maté, G. (2023). *Addiction Recovery Resources*. Dr. Gabor Maté. Retrieved April 27, 2023, from https://drgabormate.com/about/

McCaslin, W. D., & Breton, D. C. (2008). Justice as Healing: Going Outside the Colonizers' Cage. *In Handbook of Critical and Indigenous Methodologies*. 10.4135/9781483385686

McLeod, W. H. (1997). *Sikhism*. Penguin Books.

Medves, J., Godfrey, C., Turner, C., Paterson, M., Harrison, M., MacKenzie, L., & Durando, P. (2010). Systematic review of practice guideline dissemination and implementation strategies for healthcare teams and team-based practice. *Int J Evid Based Healthc*, *8*(2), 79-89. 10.1111/j.1744-1609.2010.00166.x.

Mertens, D. M., & Ginsberg, P. E. (2009). *The Handbook of Social Research Ethics* (D. M. Mertens & P. E. Ginsberg, Eds.). SAGE Publications.

Miller, A. (2020, July 6). *Library Guides: Echoes of Freedom: South Asian Pioneers in California, 1899-1965: 9. Home Life*. UC Berkeley - Library Guides. Retrieved April 3, 2023, from https://guides.lib.berkeley.edu/echoes-of-freedom/home-life

Minkler, M., Blackwell, A. G., Thompson, M., & Tamir, H. (2003, August). Community-Based Participatory Research: Implications for Public Health Funding. *American Public Health Association, 93*(8), 1210-1213. 10.2105/ajph.93.8.1210

Minkler, M., Wallerstein, N., & Wilson, N. (2008). Improving health through community organization and community building. *Health behavior and health education: Theory, research, and practice*, 287-312.

Misra, A., Khurana, L., Isharwal, S., & Bhardwaj, S. (2009). South Asian diets and insulin resistance. *British Journal of Nutrition, 101*(4). 10.1017/S0007114508073649

Moghadam, V. M. (Ed.). (2019). *Identity Politics and Women: Cultural Reassertions and Feminisms in International Perspective*. Taylor & Francis Group.

Mohanty, C. T. (1988). Under Western Eyes: Feminist Scholarship and Colonial Discourses. *boundary 2, 12*(3), 333-358. 10.2307/302821

Moissac, D. d., & Bowen, S. (2018). Impact of Language Barriers on Quality of Care and Patient Safety for Official Language Minority Francophones in Canada. *Journal of Patient Experience, 6*(1), 24-32. 10.1177/23743735187690

Moss-Racusin, C. A., Dovidio, J. F., Brescoll, V. L., & Handelsman, J. (2012). Science faculty's subtle gender biases favor male students. *PSYCHOLOGICAL AND COGNITIVE SCIENCES, 109*(41), 16474-16479. 10.1073/pnas.1211286109

Moving Forward Family Services. (2021). *About.* Moving Forward Family Services. Retrieved April 27, 2023, from https://movingforward.help/about

Mumtaz, Z., Salway, S., Waseem, M., & Umer, N. (2003). Gender-based barriers to primary health care provision in Pakistan: the experience of female providers. *Health Policy Plan, 18*(3), 261-9. 10.1093/heapol/czg032.

Nair, L., & Adetayo, O. A. (2019). Cultural Competence and Ethnic Diversity in Healthcare. *Plast Reconstr Surg Glob Open, 7*(5). 10.1097/GOX.0000000000002219 PMCID: PMC6571328

Napoles, A., Santoyo-Olsson, J., & Stewart, A. L. (2013). Methods for translating evidence-based behavioral interventions for health-disparity communities. *Prev Chronic Dis, 10*. 10.5888/pcd10.130133

National Academies of Sciences. (2017). *The Root Causes of Health Inequity - Communities in Action*. NCBI. Retrieved April 28, 2023, from https://www.ncbi.nlm.nih.gov/books/NBK425845/

Nayar, K. E. (2004). *The Sikh Diaspora in Vancouver: Three Generations Amid Tradition, Modernity, and Multiculturalism*. University of Toronto Press.

Nesbitt, E. M. (2016). *Sikhism: A Very Short Introduction*. Oxford University Press.

Nestel, S. (2012, February 1). *Colour Coded Health Care: The Impact of Race and Racism on Canadians' Health*. Wellesley Institute. Retrieved April 26, 2023, from https://www.wellesleyinstitute.com/health/colour-coded-health-care-the-impact-of-race-and-racism-on-canadians-health/

NewsRX LLC. (2016, July 22). Queen's University Details Findings in Immigrant and Minority Health (A Scoping Review of Immigrant Experience of Health Care Access Barriers in Canada). *Health & Medicine Week,* 3161. https://link-gale-

com.ocadu.idm.oclc.org/apps/doc/A458478840/AONE?u=toro37158&sid=bookmark-AONE&xid=87087db3

Niaz, K., Maqbool, F., Khan, F., Bahadar, H., Hassan, F. I., & Abdollahi, M. (2017). Smokeless tobacco (paan and gutkha) consumption, prevalence, and contribution to oral cancer. *Epidemiol Health, 39*. 10.4178/epih.e2017009

Nielsen-Bohlman, L. (Ed.). (2004). *Health Literacy: A Prescription to End Confusion*. National Academies Press.

Noh, S., & Kaspar, V. (2003). Perceived Discrimination and Depression: Moderating Effects of Coping, Acculturation, and Ethnic Support. *American Journal of Public Health, 93*(2), 232-38.

Oberoi, H. (1994). *The Construction of Religious Boundaries: Culture, Identity, and Diversity in the Sikh Tradition*. University of Chicago Press.

O'Mahony, J. M., & Donnelly, T. T. (2007). The influence of culture on immigrant women's mental health care experiences from the perspectives of health care providers. *Issues Ment Health Nurs ., 31*(5), 453-471. 10.1080/01612840701344464

Papps, E., & Ramsden, I. (1996). Cultural safety in nursing: the New Zealand experience. *Int J Qual Health Care., 8*(5), 491-7.

Paprica, P. A., Culyer, A. J., Elshaug, A. G., Peffer, J., & Sandoval, G. A. (2015). FROM TALK TO ACTION: POLICY STAKEHOLDERS, APPROPRIATENESS, AND SELECTIVE DISINVESTMENT. *nternational Journal of Technology Assessment in Health Care*, *31*(4), 1-8.

Patel, V., Ramasundarahettige, C., Vijayakumar, L., Thakur, J., Gajalalshmi, V., Gururaj, G., Suraweera, W., Jha, P., & Million Death Study Collaborators. (2012). Suicide mortality

in India: a nationally representative survey. *The Lancet*, *379*(9834), 2343-51. 10.1016/S0140-6736(12)60606-0

Pelley, L. (2021, March 27). *COVID-19 variants spreading faster in GTA areas with more low-income residents, essential workers: study*. CBC. Retrieved April 3, 2023, from https://www.cbc.ca/news/canada/toronto/covid-19-variants-spreading-faster-in-gta-areas-with-more-low-income-residents-essential-workers-study-1.5966501

Pessar, P. R., & Mahler, S. J. (2003). Transnational Migration: Bringing Gender in. *The International Migration Review*, *37*(3), 812-846.

Phillips-Beck, W., Eni, R., Lavoie, J. G., Kinew, k. A., Achan, G. K., & Katz, A. (2020). Confronting Racism within the Canadian Healthcare System: Systemic Exclusion of First Nations from Quality and Consistent Care. *Int J Environ Res Public Health*, *17*(22). 10.3390/ijerph17228343

Piepzna-Samarasinha, L. L. (2018). *Care Work: Dreaming Disability Justice*. Arsenal Pulp Press.

Pottie, K., Hadi, A., Chen, J., Welch, V., & Hawthrone, K. (2013). Realist review to understand the efficacy of culturally appropriate diabetes education programmes. *The Diabetes Educator*, *37*(6), 1017-25. 10.1111/dme.12188

Pottie, K., Kendall, C. E., Aubry, T., Magwood, O., Andermann, A., & Salvalaggio, G. (2020). Clinical guideline for homeless and vulnerably housed people, and people with lived homelessness experience. *Canadian Medical Association Journal*, *192*(10), 240-254. 10.1503/cmaj.190777

Pottie, K., Ng, E., Spitzer, D., Mohammed, A., & Glazier, R. (2008). Language proficiency, gender and self-reported health: an analysis of the first two waves of the longitudinal

survey of immigrants to Canada. *Canadian Journal of Public Health*, *99*(6), 505-510. 10.1007/BF03403786

Provincial Health Services Authority. (2008). *Provincial Language Services*. Provincial Health Services Authority. Retrieved April 27, 2023, from http://www.phsa.ca/our-services/programs-services/provincial-language-services

Provincial Health Services Authority. (2023). *Language Services*. Provincial Health Services Authority. Retrieved April 26, 2023, from http://www.phsa.ca/health-professionals/professional-resources/language-services

Public Health Communications Collaborative. (2023, February 9). *Communications Tool: Plain Language for Public Health*. Public Health Communication Collaborative. Retrieved April 28, 2023, from https://publichealthcollaborative.org/resources/plain-language-for-public-health/

The Punjabi Diaspora in Canada: Listening to the Voices of the Diasporic Punjabi Seniors in Canada. (2008). In K. Mehta & A. Singh (Eds.), *Indian Diaspora: Voices of the Diasporic Elders in Five Countries*. Brill.

Purewal, N., & Kalra, V. S. (2010). Women's ‘popular’ practices as critique: Vernacular religion in Indian and Pakistani Punjab. *Women s Studies International Forum*, *33*(4), 383-389. 10.1016/j.wsif.2010.02.012

Purewal, N. K., & Kalra, V. S. (2010). Women's ‘popular’ practices as critique: Vernacular religion in Indian and Pakistani Punjab. *Women's Studies International Forum*, *33*(4), 383-389. 10.1016/j.wsif.2010.02.012

Raghunandan, T. R. (Ed.). (2012). *Decentralisation and Local Governments: The Indian Experience*. Orient Blackswan.

Rai, R. (Ed.). (2010). *The South Asian Diaspora: Transnational Networks and Changing Identities*. Routledge.

Raj, A., & Silverman, J. G. (2002). Intimate partner violence against South Asian women in greater Boston. *Journal of the American Medical Women's Association, 57*(2), 111-4.

Ramachandran, A., Snehalatha, C., Latha, E., Vijay, V., & Viswanathan, M. (1997). Rising prevalence of NIDDM in an urban population in India. *Diabetologia, 40*(2), 232-7. 10.1007/s001250050668

Raphael, D., Curry-Stevens, A., & Bryant, T. (2008). Barriers to addressing the social determinants of health: insights from the Canadian experience. *Health Policy, 88*(2-3), 222-35. 10.1016/j.healthpol.2008.03.015

Reading, C., & Wien, F. (2015). *Health Inequalities and Social Determinants of Aboriginal*. National Collaborating Centre For Aboriginal Health.

Reading, C. L., & Wien, F. (2009). *Health inequalities and social determinants of Aboriginal peoples' health*. National Collaborating Centre for Aboriginal Health.

Romanow, R. J. (2002). *Building on Values: The Future of Health Care in Canada*. Commission on the Future of Health Care in Canada.

The Royal College of Physicians and Surgeons of Canada. (2023). *About the Royal College*. The Royal College of Physicians and Surgeons of Canada. Retrieved April 26, 2023, from https://www.royalcollege.ca/rcsite/about/about-royal-college-e

Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist, 55*(1), 68-78. 10.1037/0003-066X.55.1.68

Sahu, S. (2021). *Panchayati Raj System: Prior And After The 73rd Amendment*. Legal Service India. Retrieved April 27, 2023, from https://www.legalserviceindia.com/legal/article-8234-panchayati-raj-system-prior-and-after-the-73rd-amendment.html

Said, E. W. (1994). *Orientalism*. Knopf Doubleday Publishing Group.

Saldana, J. (2016). *The Coding Manual for Qualitative Researchers*. SAGE Publications.

Sekhon, S. S., Jhajj, A. S., Gill, H. P. S., Khan, N., & Tang, T. S. (2022). Undiagnosed Hypertension in Vancouver's Punjabi Sikh Community: A Cross-Sectional Study. *J Immigr Minor Health, 24*(5), 1371-1374. 10.1007/s10903-022-01355-3

Setia, M. S., Quesnel-Vallee, A., Abrahamowicz, M., Tousignant, P., & Lynch, J. (2011). Access to health-care in Canadian immigrants: a longitudinal study of the National Population Health Survey. *Health and Social Care, 19*(1), 70-79. 10.1111/j.1365-2524.2010.00950.x

Shamsi, H. A., Almutairi, A. G., Mashrafi, S. A., & Kalbani, T. A. (2020). Implications of Language Barriers for Healthcare: A Systematic Review. *Oman Med J, 35*(2). 10.5001/omj.2020.40

Sidhu, S. S. (2022, April 11). *SCAPEGOAT : Sidhu Moose Wala | Official Audio | Mxrci | New Song 2022*. YouTube. Retrieved April 27, 2023, from https://www.youtube.com/watch?v=1mzP0yIdHuY

Sikh Research Institute. (2022). *About*. Sikh Research Institute. Retrieved April 27, 2023, from https://sikhri.org/about

Singer, C. R. (2019, January 24). *Punjabi Now Third Language in Parliament of Canada*. Immigration.ca. Retrieved April 3, 2023, from https://www.immigration.ca/punjabi-now-third-language-in-parliament-of-canada/

Singh, H. (2017). *How to Develop a Sikh Response | Harinder Singh | SikhRI Articles*. Sikh Research Institute. Retrieved April 27, 2023, from https://sikhri.org/articles/how-to-develop-a-sikh-response

Singh, K. (2004). *A History of the Sikhs: 1469-1838*. Oxford University Press.

Singh, P. (2017). *The Spirit Born People*. CreateSpace Independent Publishing Platform.

Singh, S., Kaur, M., & Kingra, H. S. (2022, June 18). *Farmer Suicides in Punjab : Incidence, Causes, and Policy Suggestions*. Economic and Political Weekly |. Retrieved April 27, 2023, from https://www.epw.in/journal/2022/25/commentary/farmer-suicides-punjab.html

Smith, L. T. (2021). *Decolonizing Methodologies: Research and Indigenous Peoples*. Bloomsbury Academic.

Smith, M. W. (1953). Social Structure in the Punjab. *THE ECONOMIC WEEKLY*.

Statistics Canada. (2017, August 2). *Census in Brief: Linguistic diversity and multilingualism in Canadian homes*. Statistics Canada. Retrieved April 27, 2023, from https://www12.statcan.gc.ca/census-recensement/2016/as-sa/98-200-x/2016010/98-200-x2016010-eng.cfm

Statistics Canada. (2022, August 17). *Chart 1 More than half a million people speak predominantly Mandarin or Punjabi at home in Canada*. Statistics Canada. Retrieved March 29, 2023, from https://www150.statcan.gc.ca/n1/daily-quotidien/220817/cg-a001-eng.htm

Statistics Canada. (2022, August 17). *The Daily — While English and French are still the main languages spoken in Canada, the country's linguistic diversity continues to grow*.

Statistics Canada. Retrieved April 3, 2023, from https://www150.statcan.gc.ca/n1/daily-quotidien/220817/dq220817a-eng.htm

Stote, K. (2015). *An Act of Genocide: Colonialism and the Sterilization of Aboriginal Women*. Fernwood Publishing.

Substance Abuse and Mental Health Services Administration. (2014). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. *SAMHSA's Trauma and Justice Strategic Initiative*.

Sue, D., & Sue, D. W. (2013). *Counseling the Culturally Diverse: Theory and Practice*. Wiley.

Sue, S., Zane, N., Nagayama Hall, G. C., & Berger, L. K. (2009). The Case for Cultural Competency in Psychotherapeutic Interventions. *Annual Review of Psychology*, *60*(1), 525-548. 10.1146/annurev.psych.60.110707.163651

Talbot, I. (2019). LEGACIES OF THE PARTITION FOR INDIA AND PAKISTAN. *Politeja*, *59*, 7-25. 10.12797/Politeja.16.2019.59.01

Tang, S. Y., & Browne, A. J. (2008, April). 'Race' matters: racialization and egalitarian discourses involving Aboriginal people in the Canadian health care context. *Ethnicity & Health*, *13*(2), 109-127. 10.1080/13557850701830307

Tatla, D. S. (1999). *The Sikh Diaspora: The Search for Statehood*. University of Washington Press.

Taylor, S., Singh, M., & Booth, D. (2007). A Diasporic Indian Community: Re-Imagining Punjab. *Sociological Bulletin*, *56*(2). 10.1177/003802292007

TechCrunch. (2016, February 18). *Google Translate Now Has More Than 100 Languages And Covers 99 Percent Of The Online Population*. TechCrunch. Retrieved April 27, 2023, from https://techcrunch.com/2016/02/17/google-translate-hits-100-languages/

Tenzek, K. E. (2022, July 29). *Snowball Subject Recruitment*. Sage Research Methods. Retrieved April 28, 2023, from https://methods.sagepub.com/reference/the-sage-encyclopedia-of-communication-research-methods/i13493.xml

Tewari, N., & Alvarez, A. N. (2009). *Asian American psychology: Current perspectives*. Routledge/Taylor & Francis Group.

Toronto Central Healthline. (2023). *Translation and Interpretation Services - Toronto Central - torontocentralhealthline.ca*. Toronto Central Healthline. Retrieved April 26, 2023, from https://www.torontocentralhealthline.ca/listServices.aspx?id=10569

Trickett, E. J. (2011). Community-Based Participatory Research as Worldview or Instrumental Strategy: Is It Lost in Translation(al) Research? *Am J Public Health*, *101*(8), 1353-1355. 10.2105/AJPH.2011.300124

Turin, T. C., Haque, S., Chowdhury, N., Ferdous, M., Rumana, N., Rahman, A., Lasker, M., & Rashid, R. (2021, January). Overcoming the Challenges Faced by Immigrant Populations While Accessing Primary Care: Potential Solution-oriented Actions Advocated by the Bangladeshi-Canadian Community. *Journal of Primary Care & Community Health*, *12*. 10.1177/21501327211010165

Ungar, M. (2011). The social ecology of resilience: addressing contextual and cultural ambiguity of a nascent construct. *Am J Orthopsychiatry*, *81*(1), 1-17. 10.1111/j.1939-0025.2010.01067.x.

Vancouver School of Interpreting and Translation. (2018, 8 8). *About VANSIT*. Vancouver School of Interpreting and Translation. Retrieved April 26, 2023, from https://www.vansit.com/about/

Veenstra, G. (2009). Racialized identity and health in Canada: results from a nationally representative survey. *Social Science & Medicine*, *69*(4), 538-42. 10.1016/j.socscimed.2009.06.009

Veenstra, G., & Patterson, A. C. (2016). South Asian-White health inequalities in Canada: intersections with gender and immigrant status. *Ethn Health*, *21*(6), 639-48. 10.1080/13557858.2016.1179725

Viruell-Fuentes, E. A., Miranda, P. Y., & Abdulrahim, S. (2012). More than culture: structural racism, intersectionality theory, and immigrant health. *Soc Sci Med*, *75*(12), 2099-106. 10.1016/j.socscimed.2011.12.037

Wallerstein, N., & Duran, B. (2010). Community-based participatory research contributions to intervention research: the intersection of science and practice to improve health equity. *American Journal of Public Health*, *100*(1). 10.2105/AJPH.2009.184036

Williams, D. R., Lawrence, J. A., & Davis, B. A. (2019). Racism and Health: Evidence and Needed Research. *Annual Reviews Public Health*, *40*, 105-125. 10.1146/annurev-publhealth-040218-043750

Williams, R. (1999). Cultural safety — what does it mean for our work practice? *Australian and New Zealand Journal of Public Health*, *23*(2), 213-214. 10.1111/j.1467-842X.1999.tb01240.x

Wong, Y. J., Brownson, C., & Schwing, A. E. (2012). Risk and protective factors associated with Asian American students' suicidal ideation: A multicampus, national study. *Journal of College Student Development*, *52*(4), 396-408. 10.1353/csd.2011.0057

World Health Organization. (2010). *A conceptual framework for action on the social determinants of health*. World Health Organization (WHO). Retrieved April 28, 2023, from https://apps.who.int/iris/handle/10665/44489

World Health Organization (WHO). (2008, August 27). *Closing the gap in a generation: health equity through action on the social determinants of health - Final report of the commission on social determinants of health*. World Health Organization (WHO). Retrieved April 28, 2023, from https://www.who.int/publications/i/item/WHO-IER-CSDH-08.1

Zimmerman, M. A. (2000). Empowerment Theory. In J. Rappaport & E. Seidman (Eds.), *Handbook of Community Psychology* (pp. 43-63). Springer US.