

Exploring the health research priorities of the South Asian community in British Columbia

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ABSTRACT:

Background

South Asian Canadians are not proportionally represented as participants in health research studies and can be attributed to participant-related and researcher-related factors.

Objectives

The South Asian Health Research Collaborative (SAHRC) aimed to determine the top 10 health research priorities for the South Asian community by building engagement in health research.

Methods

SAHRC convened researchers, health-care providers, decision makers, and members of the South Asian community to build engagement in health research and identify the health research priorities of the South Asian community.

Results

The top three research questions related to reducing barriers to mental health services, improving access to diabetes-related dietary information, and exploring the use of complementary and alternative medicine alongside Western medicine.

Conclusion

The identified priorities serve as a foundation for a collaborative research agenda between researchers and the South Asian community, emphasizing the importance of meaningful partnerships to address barriers to participation in health research studies.

KEYWORDS: Community health research, Community-Based Participatory Research, Health Priorities, Community health partnerships, Public Health, South Asian community

Introduction

As the population of Canada becomes increasingly diverse, it is vital that this diversity is reflected in research studies to ensure that clinical evidence addresses the needs and is inclusive to all members of the society. People of South Asian ethnicity make up the largest visible minority in Canada (7.1%) and second largest in British Columbia (BC) (9.6%)¹; however, they are not proportionally represented as participants in health research studies²⁻⁵. South Asian ethnicity” includes individuals with ethnic ties to India, Pakistan, Sri Lanka, Nepal, Bangladesh, Bhutan, and Maldives^{6,7}.

Underrepresentation can limit the generalizability of research findings and can be attributed to participant-related and researcher-related factors. Participant-related factors include: **1) disinterest in research topic or lack of feeling included** (i.e., feelings of not belonging to society or lack of interest in research topic); **2) cultural conflicts with decisional hierarchy**; **3) literacy or education-related** (i.e., unfamiliarity with research or consent processes); and **4) fear of being labelled with health conditions or related adverse effects (stigma)**. Researcher-related factors include: **1) cultural or language-related** (i.e., lack of study material in specific languages); **2) logistical** (i.e., costs associated with greater recruitment requirements, limited time to recruit), **3) study design-related** (i.e., lack of ethnic specific/validated assessment tools, narrow entry criteria); **4) lack of understanding about successful engagement strategies within different cultural and ethnic populations**^{8,9}.

Overcoming such barriers is a challenge in multi-ethnic societies and exacerbated when considering the South Asian population is heterogenous (different cultures, languages, etc.)⁸. In the UK, South Asians comprise greater than 4% of the population, but only 0.6% of research participants self-identified as South Asian¹⁰. Effective research participation strategies include establishing community partnerships, using incentives, and cultural sensitivity towards South Asian norms, among others^{9,11-15}. This study aimed to explore how to overcome barriers to research participation by using these evidence-informed strategies and health research prioritization.

The South Asian Health Research Collaborative (SAHRC) was formed in 2017 by researchers in British Columbia (BC), Canada. SAHRC brought together nine health-care

providers, two decision makers from the largest provincial health authorities, four academic researchers from two of the largest universities in BC (University of the British Columbia and Simon Fraser University), two members of the South Asian community and seven members from local community organizations. SAHRC set three objectives that aligned with their overarching vision statement, “To partner with the South Asian community to build engagement in health research”: 1) to build a community presence and partnership to educate South Asians on research; 2) to support South Asians to participate in research through a health research priority setting process; and 3) to build on community partnerships to address identified research priorities in future research agendas.

Health research priority setting is regarded as an important component in creating and strengthening relevant research agendas¹⁶. The James Lind Alliance Priority Setting Partnership (JLA-PSP), framework for our project, has facilitated health research prioritization for over a decade. It has been used to establish the collaborative research agendas in more than 50 Priority Setting Partnerships (PSP) covering health topics such as acne, miscarriage, asthma, and autism¹⁷. To our knowledge, JLA-PSP has not been used with specific ethnic populations. This project innovatively applied this framework to identify the health research priorities of the South Asian community and engagement strategies that promote participation in health research.

Methods

Our priority setting initiative took place from July 2018 to October 2019 in the Fraser Health Authority (FHA) region of BC. FHA is the largest health authority by population in BC, providing health care services to over 1.8 million people in 20 diverse communities, and is home to the largest South Asian population in BC^{1,18}. The Fraser Health Research Ethics Board reviewed and exempted this initial exploratory study as per Tri-Council Policy Statement 2.

Priority setting framework used to guide our project

The JLA-PSP model’s methodologies are well-established and have been used to identify and prioritize unanswered health research questions in specific diseases^{17,19}. Attention was given to different engagement strategies to recruit South Asian community organizations and participants. Please see Table 1 for a step-by-step guide on SAHRC’s project activities.

Step One: Steering Committee Formation

16 members of the collaborative formed a steering committee (SC) that guided the project from inception to completion. The SC consisted of five clinicians, two researchers, two patient partners, two decision-makers, and five members from the local health authority (some had overlapping roles); all members had academic and/or South Asian engagement expertise. For example, SC members had lived experience, engaged in previous South Asian-specific research, and were affiliated with organizations like Canada-India Network Society and South Asian Health Institution (SAHI).

Step Two: Awareness Building

To build a community presence, 20 community-based organizations (CBOs) that had a history of outreach in the South Asian community were invited to become partners. CBOs included: nine religious institutions (i.e. Gurdwaras, Mosques, Mandirs, etc.), eight community-service organizations, and three local universities.

Step Three: Data Gathering and Engagement

The Questionnaire

A four-page questionnaire created by the SC was used to collect participant responses and took approximately 5-10 minutes to complete. A *sample question* was “*What are your top 3 health-related questions that you believe are important for the South Asian community?*”. To complete the questionnaire, participants had to 1) self-identify as a member of the South Asian community, 2) be age 18 years or older and 3) live within the province of BC. Please see Appendix 1 for questionnaire.

A physical version of the questionnaire was available during in-person community events where participants completed the questionnaire themselves or with on-site assistance or took questionnaires home and returned them later. The questionnaire was available in English, Punjabi, and Hindi as the main languages spoken by South Asian people within BC; 74%, 4.9% and 0.7% respectively¹.

The online version of the questionnaire was available only in English and was distributed using REDCap (secure web application for managing online questionnaires and databases) through email listservs, online newsletters of CBOs, and partner-organization websites. The choice of English was due to the limitation that REDCap was only available in English at the time of the project.

Participants were asked quantitative questions and for their top three health research questions. Participants were also offered to complete a “consent to contact” form for future research project participation. The “consent to contact” was only available in English due to resource and logistical limitations.

Engagement and Recruitment

Convenience and time-space sampling were used for engagement and recruitment into the project. Engagement activities included information booths, presentations, workshops, and a radio interview. During events organized by CBOs, information booths informed attendees about what health research was, the benefits of participating in health research for them and their community, how they could be involved, and the rationale for our questionnaire. Information booths were held during busy times at the CBO (i.e., shortly before or immediately following prayer times) and were in easily accessible areas (i.e., eating areas or near entrances). Presentations were organized by SAHRC, SAHI, or were already scheduled as part of community education by FHA; topics included diabetes, diet, yoga, and general health/wellness. Presentations were done in English, Punjabi, or Hindi depending on the preferred language of the audience. Questionnaires were made available before and after the presentation with dedicated time for completion. Workshops were larger events with multiple organizations and typically included information booths and/or presentations.

A radio interview, on a South Asian radio network, with members of SAHRC was also conducted; topics discussed included defining health research, why it is important, and a link to our questionnaire was shared.

Step Four: Questionnaire Analysis

Gathered research questions were reviewed and thematically organized by a SC member. Research questions were first grouped by topic (i.e., related to diabetes, cardiology, etc.) and then iteratively merged with similar questions (i.e., questions about diabetes management were grouped together). Questions that were already widely answered in the literature or too difficult to interpret (i.e., if handwriting was not legible) were removed. A second team member reviewed the remaining list of questions to ensure validity. A finalized list of questions was agreed on by both team members.

Quantitative responses were tabulated by frequencies and reported in percentages of total respondents.

Step Five: Final Workshop

A final workshop took place in October 2019 where partner organizations from the PSP were invited to participate in the final prioritization of health research questions. The workshop was facilitated by the PSP Coordinator and another member of SAHRC.

Nominal group technique was used for prioritization ranking^{19,20}. 12 participants were deliberately divided into three cohorts to cultivate a conducive environment for meaningful discourse about the appropriate prioritization of the research questions. Facilitators rotated between groups to ensure participation from all members of each group. Full group discussion took place regarding the priority of research questions and a second iteration was completed using the same format. The final ranking of the top health research questions was finalized by group consensus decision making.

Results

Building community engagement

SAHRC took part in 17 community events (9 information-booths; 7 Workshops; 7 Presentations; 1 radio interview). 252 questionnaires were collected, of which 14 were removed because they were incomplete or did not fulfil the inclusion criteria. Of the 238 completed questionnaires, 185 occurred during in-person events and 53 via online methods.

The characteristics of the respondents are presented in Table 2. In brief, 57% identified as female. 51% were between 21-50 years old. Most participants self-identified as Indian (94%), had some level of post-secondary education (67.1%) and lived in Surrey (38.3%) or Abbotsford (27.8%).

Of 252 participants, 44 (18.8%) respondents signed up for the consent to contact for future research participation registry.

Health Research Priorities

Nearly 80% of participants indicated that they had never participated in any form of health research before (Table 2). The most common reasons for lack of participation were “no one asked me” (42%) and “I never knew where to go” (29.3%).

A total of 539 health research questions were provided in the 238 collected questionnaires. The health research questions were thematically categorized (see Table 3) with the most common themes that emerged related to diet, complementary and alternative medicine, diabetes, and mental health.

At the final workshop, the top three identified health research questions were: **1) How can we reduce the barriers that prevent members of the South Asian community from accessing mental health services? 2) What are the best ways to facilitate the uptake or use of diet-related information pertaining to diabetes within the South Asian community? 3) Are complementary and alternative medicine therapies effective in managing illnesses compared to western medicine; can they work together?** Table 4 lists the top 10 health research priorities that emerged from our final workshop.

Discussion

This project highlights how frameworks like the JLA-PSP can bring stakeholders to engage with minority populations, fostering research understanding and overcoming barriers to research participation. For many respondents this was their first formal engagement with health research, with over 75% indicating they had never participated in any form of health research before.

Engagement tactics that successfully recruit White/European participants may not be successful to engage minority populations^{21,22}. Effective recruitment of minority groups into health research studies involves a multi-prong approach that includes authentic collaboration with CBOs, active recruitment methods, and understanding cultural logistical issues of participation^{15,23}.

In South Asian communities CBOs serve as more than a place of social gathering; they also function as a place of refuge, social influence, and as a resource for trusted information²⁴. Early and active engagement with CBOs in a culturally sensitive manner was important in initiating and maintaining momentum throughout this project. CBOs that had a pre-existing relationship with FHA were more inclined to participate. Similarly, those with a history of health-related outreach or affiliations with a member of SAHRC were more likely to work with our team. Individuals are more likely to participate in the project if the CBO they frequently visit trusts the purpose of the research study²⁴.

Being respectful of the CBO's day-to-day activities was critical to enhance research participation; we had to be flexible and adapt our recruitment strategies to the inner workings of the CBO. For example, information-booths had to be rescheduled due to funerals taking place on the same day. Similarly, time-space-sampling was essential to reach different age and socioeconomic groups; in-person events were scheduled around different prayer times, religious holidays, vaccination clinics, etc.²⁵. While in-person events can be resource-demanding, collaborating with partners was effective in reducing costs. For example, we disseminated our questionnaire during presentations organized by FHA's public health department. To mitigate logistical concerns, materials were available in different South Asian languages, on-site team members had linguistic capabilities to explain the project in different languages, and team members with similar ethnic backgrounds^{9,11}.

Most in-person events also included multiple modes of engagement: information booths, presentations, and large workshops²⁶. This created more opportunities to engage with individuals flowing in and out of the venue. While passive engagement methods (posters, newsletter, email listservs, etc.) were useful to raise awareness, active engagement helped build meaningful relationship with members of the community^{27,28}. This led to three times more completed

questionnaires through in-person events than online methods. Conversely, some studies have found that using online methods (i.e., using social media) to recruit participants can be effective depending on the type of study and target demographic²⁹. This method of recruitment was beyond SAHRC's capacity at the time of this study.

We found that diet, complementary and alternative medicine, diabetes, mental health, and heart health were amongst the most common topics suggested that should be addressed in health research. Given that the South Asian population is at an increased risk for diseases like diabetes and cardiovascular disease, it is understandable why these issues may have been named as priorities^{30,31}. Among the top ten health research priorities, three related to mental health. While mental health is highly stigmatized in many cultures, the frequently proposed research priority of mental health in our project aligns with the growing literature about mental health issues in the South Asian community. Existing literature suggests that the prevalence of common mental health disorders among South Asians in Canada is underreported, and the uptake of mental health services continues to be low^{32,33}. In addition, South Asians in Canada reported the highest proportion of unmet mental health needs and the highest perception of barriers to mental health services when compared with other ethnic groups^{34,35}.

The top 10 health research priorities identified by this project can help facilitate the building of a collaborative research agenda between the South Asian community and researchers in different fields. More important, however, was the creation of linkages with the South Asian community to mitigate barriers that prevented this community from participating in health research studies.

Lessons Learned & Next Steps

While 18% of participants agreed to opt-in to our "consent to contact" database, these databases can be resource-demanding to maintain without adequate human resources and have found to have mixed results when recruiting participants^{36,37}. SAHRC's ongoing work includes partnering with existing infrastructures to streamline the recruitment process to enhance inclusion and improve engagement in health research. Similarly, as research funds dissipate at the completion of a study, we acknowledge the need for a dedicated coordinator to sustain

efforts. Leveraging partnerships with universities was valuable to overcome these challenges, fostering educational opportunities and cultivating the next generation of researchers.

Moreover, it is imperative to recognize the necessity for fortifying networks among researchers engaged in South Asian research. In response to this need, SAHRC has established a dedicated website and social media platforms, aimed at fostering connections among researchers and knowledge users. Furthermore, we have strengthened partnerships with CBOs through community of practice calls, facilitating exchange of best practices in the recruitment of South Asian community members. Future work includes a mentor/mentee program, designed to cultivate expertise, and promote capacity building within the realm of South Asian research. Expanding upon these efforts, SAHRC envisages further avenues for collaboration and knowledge dissemination to augment the impact of South Asian-focused research initiatives.

Limitations

It is difficult to assess the level of recruitment bias introduced during our data collection. CBOs with a history of working with FHA or organizing health-related events may have community members with higher education and may inherently reach participants with higher levels of social capital and/or community connection. Projects that rely on self-reporting are also subject to response/recall bias; participants attending a specific health-related presentation may be more inclined to ask questions about that health topic.

While we tried to get participation from all South Asian subgroups, there was a high proportion of participants with ethnic ties to India (94%). This may be because some CBOs engaged with refused to participate in this project which limited representation from various ethnic subgroups. Therefore, project materials were translated to cover the main linguistic diversity in partner CBOs. However, our sample resonates with South Asian ethnic/cultural origin in BC¹.

When determining the health research priorities of a particular community instead of a particular health disease, it can be difficult to determine which questions should be removed. We took reasonable efforts to remove questions that were already answered in the literature, but it was difficult to determine if a question had been answered in the South Asian context^{37,38}.

Conclusion

We found that by creating a collaborative environment for relevant stakeholders (clinicians, researchers, decision-makers, and patients/community members), we were able to partner with the South Asian community and build engagement in health research. We achieved good participation through authentic collaboration, an understanding of the culture and linguistic dimensions, and using active recruitment. The novel use of the JLA-PSP framework and engagement strategies used in this project can also be applied in other communities that are underrepresented in research studies.

The top three proposed health research priorities for South Asian people in BC are related to reducing barriers to mental health services, promoting uptake of diet-related information on diabetes, and integrating complementary and alternative medicine with western medicine for illness management. Ultimately, the priorities identified in this project can help build a collaborative research agenda between researchers and members of the South Asian community.

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Table 1: SAHRC project activities

Step 1:	<i>2017 – June 2018</i>
Steering committee formation	<ul style="list-style-type: none"> • Bring together key stakeholders for a common goal to create a collaborative; included researchers, health care providers, decision-makers, patient partners • Steering Committee: proportionate sample of collaborative. Appointed dedicated team member as PSP Coordinator.
Step 2:	<i>July 2018 – February 2019</i>
Awareness building	<ul style="list-style-type: none"> • Establish community connections. Use existing networks of SAHRC members and researching CBOs/societies that work with the South Asian community • Identify principle point of contact and establish in-person events to create awareness about SAHRC PSP and health research importance through pamphlets, in-person meetings, and table booths • Announcements about survey launch were sent to leaders of CBOs to avoid loss of any momentum gained
Step 3:	<i>March – July 2019</i>
Data gathering	<ul style="list-style-type: none"> • Written surveys were available in English, Punjabi, and Hindi. • Online survey was only available in English • Engagement (community events = one or more <u>workshops</u> (organized event including other organization), <u>presentations</u> (announcements various topics), and <u>table-booths</u> based on needs identified by CBOs) <ul style="list-style-type: none"> ○ 17 community events, 1 radio interview, sharing online survey through email lists
Step 4:	<i>August – September 2019</i>
Analysis of questions*	<ul style="list-style-type: none"> • Questions that were already answered in the literature, too vague, and those that were difficult to interpret were removed • Questions that were similar were joined together • 29 questions remained

<p>Step 5:</p> <p>Health research priority workshop</p>	<p><i>October 2019</i></p> <ul style="list-style-type: none"> • Workshop included representatives from SAHRC, members from partner organizations, and the community. • Nominal group technique was used to establish top 10 health research priorities.
<p>Step 6:</p> <p>Knowledge translation and dissemination</p>	<ul style="list-style-type: none"> • Executive summary to funding agency, local health authority presentations • Peer reviewed conference poster presentation • Academic journal publication • Work with local health authority to close any gaps in knowledge/education uncovered by health research priority findings
<p>CBO: Community-based organization; PSP: Priority Setting Partnership</p>	

Table 2: SAHRC Sample Characteristics (N=238)

	n (%)
Gender (n=223)	
Male	96 (43)
Female	127 (57)
Age (in years) (n=231)	
18-20	4 (1.7)
21-30	36 (16.9)
31-40	44 (19.1)
41-50	35 (15.2)
51-60	25 (10.8)
61-70	31 (13.4)
>70	53 (22.9)
Ethnicity (n=233)	
Indian	219 (94)
Fijian	7 (3)
Pakistani	3 (1.3)

Other	4 (1.7)
City Distribution (n=230)	
Abbotsford	64 (27.8)
Burnaby	32 (13.9)
Surrey	88 (38.3)
Vancouver	26 (11.3)
Surrounding areas ^a	20 (8.7)
Education Level (n=219)	
Elementary/Middle School	20 (9.1)
High School	52 (23.7)
Post-secondary (i.e. University/College)	147 (67.1)
Previous history of research participation (n=220)	
Male	Yes 22 (10)
	No 73 (33.2)
Female	Yes 25 (11.4)

	No	100 (45.5)
Reasons for lack of research participation (n=181) ^b		
	Never interested	26 (14.4)
	Never knew where to go	53 (29.3)
	I was never asked	76 (42)
	Other (scared of results, language related, did not trust researchers, unaware of health research, time constraints)	26 (14.4)
^a Langley, Mission, Delta, Richmond, New Westminster, Hope;		
^b participants were asked to check all that were applicable		

Table 3: Thematical representation of questions submitted	
Topics/Theme	Number of related submissions
Diet	64
Complementary and Alternative Medicine	54
Diabetes	48
Mental health	42
Heart health	36
HCS (including stigma, barriers to access) ^a	28
General Health	28
Bone Health (Arthritis, osteoporosis)	21
South Asian community-related epidemiology	20
Medication Use	18
^a HCS: Health Care System	

1	How can we reduce the barriers that prevent members of the South Asian community from accessing mental health services?
2	What are the best ways to facilitate the uptake or use of diet-related information pertaining to diabetes within the South Asian community?
3	Are complementary and alternative medicine therapies effective in managing illnesses compared to western medicine; can they work together?
4	How can we educate children on healthy habits (including sexual education, diet, vaccines)?
5	What are the impacts on health when moving to a new country (i.e. is one more prone to different illnesses)?
6	How can we reduce the stigma involved with taking prescription medication in the South Asian community?
7	How does South Asian diet/cooking compare to North American diet/cooking?
8	How to manage stress (in culturally appropriate ways) and what effect does it have on other health concerns?
9	How can one educate children about mental health?

10	Why is the South Asian community at an increased risk to develop heart related illnesses?
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Health Research Priorities of the South Asian Community

Who are we?

The South Asian Health Research Collaborative (SAHRC) is a group of patients, researchers, and health care providers (i.e. doctors, nurses, and health promotion workers). We want to understand health care issues that are important to the South Asian community. We have created this 5-10 minute survey to help us identify health issues that are important to your community.

Who should participate?

This survey is meant for members of the South Asian community who are 18 years or older and live in Canada. Patients, caretakers, and health care providers are all welcome to participate.

Participation in this survey is 100% voluntary. You do not need to answer every question. There are no right or wrong answers.

Why should I participate?

Health research (or “medical research”) is done to learn more about human health and is very important in the understanding of diseases and medicines. This survey will help create the foundation for future projects that involve topics that the South Asian community is interested in.

Is my information kept private?

We do not ask for your name, date of birth, or any other identifying questions. If you would like to participate in our 2nd phase workshop, please complete the ‘Consent to Contact’ form. All of this information is kept **100% confidential**.

Who is supporting this project?

SAHRC is funded by the Surrey Hospital Foundation. Members of our team are affiliated with the organisations below.

What happens with the results?

All the answers to this survey are kept 100% confidential and no information is sent to a third party. The results will be used to inform future research funding programs.

Who can I contact for more information?

If you have any questions about the survey, or if you would like more information about SAHRC, please contact Aven Sidhu, Research Coordinator for SAHRC, by email or telephone (aven.sidhu@fraserhealth.ca; 604-542-3167).

Our Partners:



“To partner with the South Asian community to build engagement in health research”

Date: _____

Our Partners:



Version 3.0 14/03/2019





“To partner with the South Asian community to build engagement in health research”

Date: _____

Section 1: Health Research Priorities

1. Based on your experience with the health care system, what could be improved? (i.e. wait times, referrals, follow ups, etc)

2. What are your top 3 health related questions that you believe are important for the South Asian community? The questions can:

- Be about anything to do with health, medicine, or medical research that you are curious about or want to know
- Be about complementary and alternative medicine (i.e. ayurvedic, acupuncture, traditional Chinese medicine), or western medicine.

Examples of questions are:

- *Why do I get sick with my anti-depressant medication?*
- *How do I avoid getting lung cancer?*
- *Is turmeric good for hip bones after a fracture?*
- *Do genetics play a role in heart disease?*

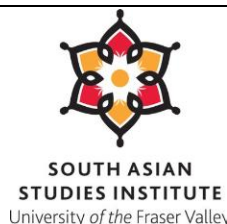
In other words, if you could ask any health question and get the answer right away, what would your question be?

Question 1: _____

Question 2: _____

Question 3: _____

Our Partners:





“To partner with the South Asian community to build engagement in health research”

Date: _____

3. Have you participated in any research studies before?
- a. Yes (please go to 4)
 - b. No (please skip question 4 and go to question 5)
4. If you answered YES to question 3, please describe your experience (i.e. what made the experience good or bad).

5. If you answered NO to question 3, please check all of the reasons that apply.
- a. I was never interested
 - b. I was scared of what the research would find
 - c. There was a language issue (i.e. research material was not in my language)
 - d. I did not trust researchers (or how the information will be used)
 - e. I was never asked to participate
 - f. I was interested but never knew where to go for research
 - g. Other: _____

Our Partners:



Version 3.0 14/03/2019



Section 2: Demographics

6. What is your age?

- | | |
|-----------------------------------|-----------------------------------|
| a. <input type="checkbox"/> 18-20 | e. <input type="checkbox"/> 51-60 |
| b. <input type="checkbox"/> 21-30 | f. <input type="checkbox"/> 61-70 |
| c. <input type="checkbox"/> 31-40 | g. <input type="checkbox"/> 70+ |
| d. <input type="checkbox"/> 41-50 | |

7. What gender/sex do you identify with? _____

8. Which city do you live in?

- | | |
|--|--|
| a. <input type="checkbox"/> Abbotsford | f. <input type="checkbox"/> Richmond |
| b. <input type="checkbox"/> Burnaby | g. <input type="checkbox"/> Surrey |
| c. <input type="checkbox"/> Delta | h. <input type="checkbox"/> White Rock |
| d. <input type="checkbox"/> Langley | i. <input type="checkbox"/> Other: _____ |
| e. <input type="checkbox"/> Mission | |

9. Do you identify as South Asian (heritage or ancestry)?

- a. Yes
b. No

10. If yes to question 9, please select which ethnicity best describes you? (select all that apply)

- | | |
|---|--|
| a. <input type="checkbox"/> Afghan | f. <input type="checkbox"/> Maldivian |
| b. <input type="checkbox"/> Bangladeshi | g. <input type="checkbox"/> Nepali |
| c. <input type="checkbox"/> Bhutanese | h. <input type="checkbox"/> Pakistani |
| d. <input type="checkbox"/> Fijian | i. <input type="checkbox"/> Sri Lankan |
| e. <input type="checkbox"/> Indian | j. <input type="checkbox"/> Other: _____ |

11. What language(s) do you speak at home? (select all that apply)

- | | |
|--|--|
| a. <input type="checkbox"/> Bengali | f. <input type="checkbox"/> Punjabi |
| b. <input type="checkbox"/> English | g. <input type="checkbox"/> Tamil |
| c. <input type="checkbox"/> Farsi/Persian/Dari | h. <input type="checkbox"/> Urdu |
| d. <input type="checkbox"/> Hindi | i. <input type="checkbox"/> Other: _____ |
| e. <input type="checkbox"/> Pashto | |

Our Partners:



“To partner with the South Asian community to build engagement in health research”

Date: _____

12. What is the highest level of education you have completed?

- a. Elementary/Middle School
- b. High School
- c. Post-secondary (i.e. University/College)

13. In the health care environment, I have the most experience as a:

- a. Patient (i.e. someone who uses the health care system)
- b. Caretaker (i.e. I care for someone who uses the health care system)
- c. Health care provider (I am a health care provider and I care for those individuals from the South Asian community – doctor nurse, allied health professional, etc)

14. How did you hear about this survey?

Our Partners:



Version 3.0 14/03/2019

