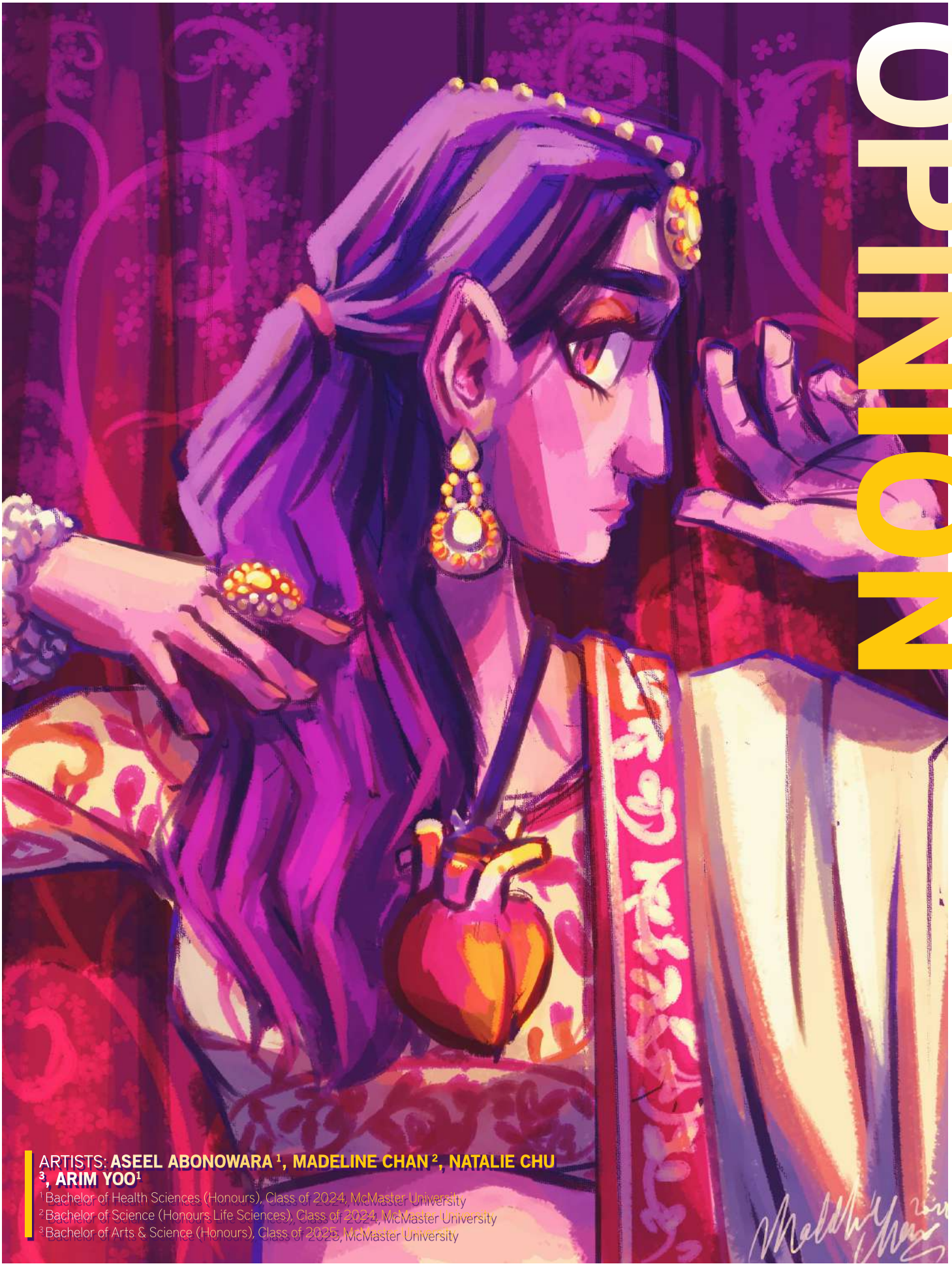
OPINION



ARTISTS: **ASEEL ABONOWARA [1], MADELINE CHAN [2], NATALIE CHU [3], ARIM YOO [1]**

[1] Bachelor of Health Sciences (Honours), Class of 2024, McMaster University
[2] Bachelor of Science (Honours Life Sciences), Class of 2024, McMaster University
[3] Bachelor of Arts & Science (Honours), Class of 2025, McMaster University

SARAB ROG KA AUKHAD NAAM: OUTLINING A SIKH-SPECIFIC CARDIAC REHABILITATION PROGRAM IN PEEL REGION

doi: 10.35493/medu.42.16
AUTHOR: **JASMINE UPPAL**
Bachelor of Health Sciences (Honours), Class of 2025, McMaster University

INTRODUCTION AND NECESSITY

"Sarab rog ka aukhad naam" ("The recitation of God's name cures all diseases") is a quotation from the Guru Granth Sahib —the Sikh Holy Book— highlighting Sikhism's perspective on illness, referring to the Guru Granth Sahib as the primary source of guidance regarding issues of health.[1] However, in the decades since this quotation was first written, the burden of chronic illness in the Sikh community has become more severe.[1] Notably, cardiovascular disease (CVD) has become increasingly prevalent within the Sikh and broader South Asian (SA) populations.[2] Several studies have outlined how the SA community has the highest prevalence of CVD in Canada, along with a higher CVD mortality rate compared to other ethnic groups.[2,3]

Although some biological factors may explain the SA community's increased risk for CVD, there is no denying the social and psychological factors at play.[4] It has been established that sedentary behaviour, depression, and psychological stress increase CVD risk.[5-7] As such, the fact that SA individuals in Canada are more likely to be sedentary and diagnosed with depression than their non-SA counterparts only intensifies their likelihood of developing CVD.[5,6] Moreover, much of the SA population in the West exists as visible racial and religious minorities, subjecting them to additional social and psychological harms, including stress stemming from migration and discrimination, all of which contribute to CVD.[2,7] SA individuals in Canada are also more likely to experience lower quality-of-life one year post-surgical interventions for CVD-related events, as well as increased recurrent CVD events.[8] That is, not only are SAs more likely to develop CVD, but their disease prognosis appears to be worse than non-SAs.[8] As such, improving CVD management procedures for the SA population would prove valuable, given the significant prevalence of the disease in this community.[2,3,8]

More specifically, areas with a prominent SA population, like the Peel Region of Ontario, should consider providing CVD interventions specific to SAs, such as culturally sensitive rehabilitation programs.[9] As SA is a broad term encompassing many distinct ethnic and cultural backgrounds, this paper recommends focusing on interventions tailored to a specific population within the SA community, to avoid cultural generalizations.[1]

For the purposes of this paper, the focus population is the Sikh community, defined specifically as individuals with an ethnic background from the Punjab region in India who practice Sikhism. The Sikh community as a target population is optimal as it falls under the broader SA community and it is one of the largest religious minorities in the Peel Region; thus, this plan would ensure that a sizeable community in the Peel Region receives access to treatment that acknowledges their religious and cultural diversity.[10] Peel Regional Health should design a rehabilitation plan specific to the Sikh community for patients diagnosed with CVD, or recovering from a CVD-related incident. However, it is critical to note that there are certain challenges associated with implementing such a program, specifically relating to funding issues and the program's perceived practicality.

PROGRAM FRAMEWORK

Several studies have examined the Sikh community's perspective on cardiac rehabilitation.[1,11-14] These studies can serve as a guide in developing the Peel Region's version of a rehabilitation plan specific to the Sikh community by developing a culturally competent and safe rehabilitation program including the following elements:

1. HEALTHCARE PROFESSIONALS THAT ARE FLUENT IN PUNJABI OR IDENTIFY AS BEING SIKH AND/OR PUNJABI.

Numerous studies identified that Sikh patients enrolled in rehabilitation programs preferred interacting with healthcare professionals that spoke their first language, Punjabi, and identified as being part of the Sikh religion and/or Punjabi culture.[11-13] As such, these professionals were able to provide culturally relevant advice, particularly regarding dietary changes in cultural cuisine to promote healthier lifestyles, and overall, increasing patients' willingness to practice the interventions.[12-14] Galdas et al. found when reflecting on their post-myocardial infarction recovery, Sikh patients stressed the value of having Punjabi-speaking healthcare professionals to sufficiently comprehend and implement their cardiac rehabilitation plan, indicating the benefits of hiring professionals fluent in the patients' primary language.[1]

2. IMPLEMENTATION OF SIKHISM.

When Sikh patients were asked about their recovery, researchers noted that they would highlight the importance of Sikhism in coping with diagnosis and attempts at leading healthier lifestyles.[1,11-13] As an example, Galdas et al. noted that some patients engaged in Seva —a key Sikh principle which is a form of volunteering— at their local Gurdwaras in place of traditional methods, such as exercise.[1] As such, these patients felt that they were able to improve their health in a comfortable, familiar, and spiritually fulfilling method, thus serving as motivation to continue the rehabilitation process.[1]

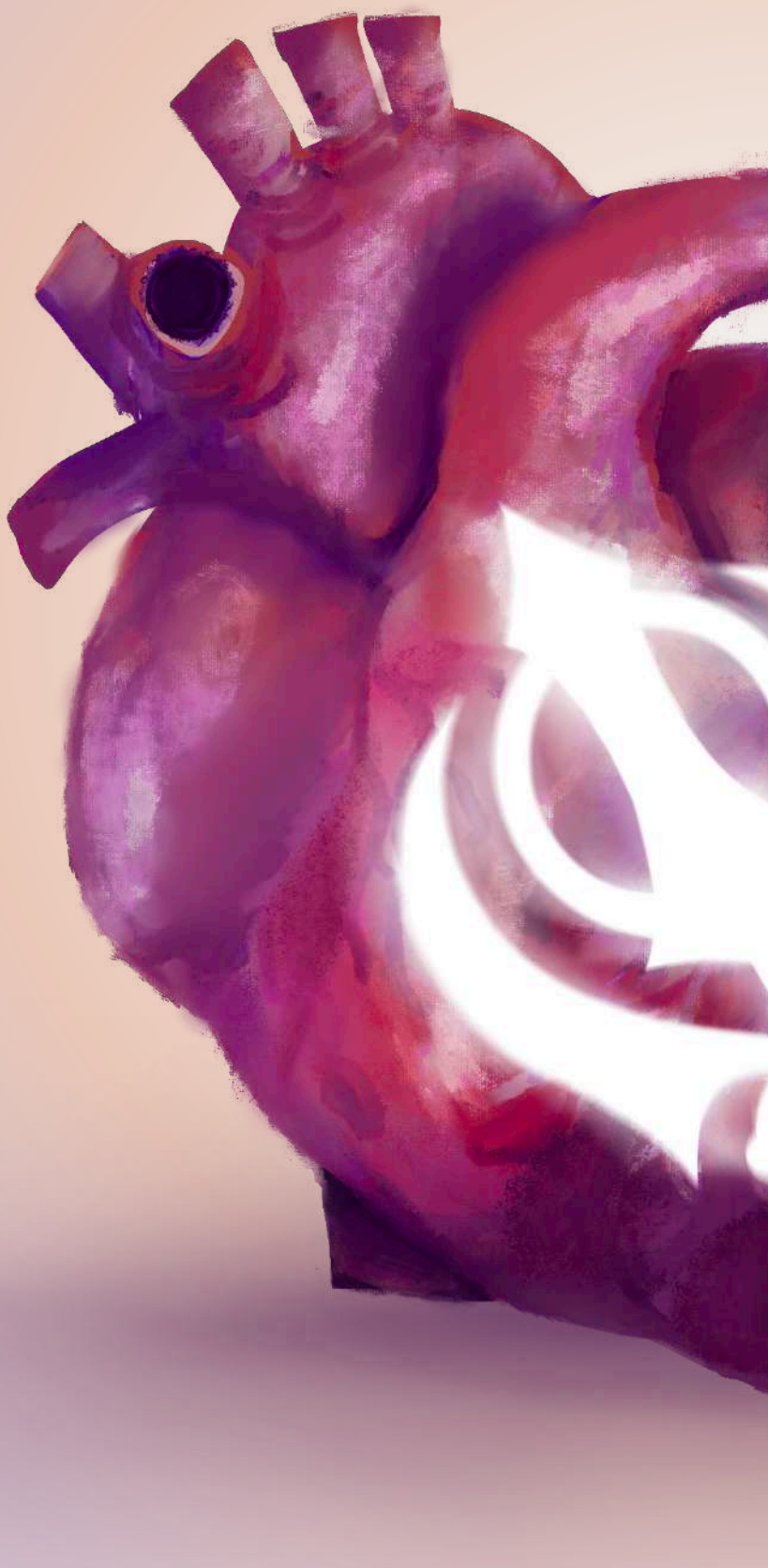
3. AN OPTION TO RECEIVE COMPREHENSIVE HOME-BASED CARE.

Despite the benefit of cardiac rehabilitation programs, there is a historically low participation rate, mainly due to patients' lack of transportation to program centers.[13,15] Similarly, senior Sikh patients cited their discomfort when asking their adult children for transportation to rehabilitation programs, since their children were the breadwinners of the family and were often preoccupied with work during the day.[13] However, certain studies have demonstrated that home-based cardiac rehabilitation programs are equally effective at improving cardiac health outcomes as centre-based care, while further enhancing patient quality of life and psychological well-being.[15,16] For example, in a study by Akeroyd et al. on Indian CVD patients, when health professionals completed telephone-based health check-ins, the medication non-adherence rate of those patients dropped from 51.2% to 4.6%, underscoring the value of personalized home-based care in the Sikh population.[17]

CRITICISMS

Despite the justifications for creating a cardiac rehabilitation program specific to the Peel Region's Sikh community, there are valid criticisms that may offset its benefits. Notably, the SA community has displayed historically lower adherence rates to traditional cardiac rehabilitation programs relative to their non-SA counterparts.[8,18] Thus, it appears that efforts should be focused on increasing CVD awareness and prevention, as opposed to treatment.[19] It is crucial to note, however, that the studies that examined adherence in rehabilitation programs were not tailored to SA lifestyles and needs, thus highlighting the necessity for the type of program outlined in this article.[18,19] As for awareness regarding CVD, several studies have demonstrated that although the Sikh community lacks some knowledge of CVD, many individuals understand the unhealthy aspects of their lifestyles that may increase their CVD risk.[20-22] In spite of this knowledge, the Sikh community still has a concerningly high prevalence of CVD.[5] As such, focusing on CVD awareness may not prove as impactful as alternative solutions, such as addressing the shortcomings of rehabilitation programs to improve health outcomes.

Furthermore, the logistical implications of a unique, culturally-centric cardiac rehabilitation program to the healthcare system must be considered; this program may be costly and difficult to implement, especially when fulfilling cultural background requirements.[23] However, similar programs established in the United Kingdom reported no significant difference in cost between a traditional and more accessible rehabilitation plan for SA individuals.[16] Moreover, a Canadian study completed by Agarwal et al. addresses the issue of language and cultural barriers through volunteers who spoke and identified as Punjabi.[23] This program was widely used by the community, thereby rendering it successful enough to be implemented in similar prominently Sikh communities.[23] Therefore, well-trained volunteers serve as a reliable solution if there is a shortage of healthcare professionals meeting the aforementioned program criteria.[23]



CONCLUSION

The Sikh community, as part of the larger SA community, is disproportionately at risk for CVD.[1,2,11,12] It is thus imperative that the Peel Region, which consists of the largest Sikh population in the GTA, develops a targeted cardiac rehabilitation program.[2,10] Several research studies have demonstrated that a program including (1) Punjabi or Sikh-identifying healthcare professionals, (2) some aspects of Sikhism, and (3) an accessible home-based care option, is bound for success.[1,12,13,16] Despite the need for a culturally specific approach to cardiac rehabilitation, there are legitimate concerns regarding the feasibility of this plan. Therefore, it is recommended the Peel Region implements a pilot cardiac rehabilitation program that utilizes volunteers in the community.

More specifically, launching a pilot program would provide a low-risk method of determining if a comprehensive cardiac rehabilitation plan would have a positive, measurable impact on cardiac health and program adherence within the Sikh community. The use of volunteers who identify as Sikh and/or Punjabi would help mitigate the program's financial concerns and provide better care, while increasing CVD awareness in the community.[23] Ultimately, by appealing to the Sikh community's existing perspectives on illness, this program would encourage healthier lifestyles by utilizing the community and its beliefs to effectively combat CVD.

THIS PIECE WAS PEER REVIEWED BY AN ANONYMOUS ASSOCIATE PROFESSOR AT MCMASTER UNIVERSITY.

EDITED BY: RAYMOND QU & RIDA TAUQIR

1. Galdas P, Oliffe J, Wong S, Ratner P, Johnson J, Kelly M. Canadian Punjabi Sikh men's experiences of lifestyle changes following myocardial infarction: Cultural connections. Ethn Health. 2012;17(3):253–66. Available from: doi:10.1080/13557858.2011.610440.
2. Sekhon S, Jhajj A, Gill HP, Khan N, Tang T. Undiagnosed hypertension in Vancouver's Punjabi Sikh community: A cross-sectional study. J Immigrant Minority Health. 2022;24(5):1371-4. Available from: doi:10.1007/s10903-022-01355-3.
3. Anand S, Yusuf S, Vuksan V, Devanesen S, Teo K, Montague P, et al. Differences in risk factors, atherosclerosis, and cardiovascular disease between ethnic groups in Canada: The Study of Health Assessment and Risk in Ethnic groups (SHARE). Lancet. 2000;356(9226):279-84. Available from: doi:10.1016/S0140-6736(00)02502-2.
4. Williams ED, Kooner I, Steptoe A, Kooner JS. Psychosocial factors related to cardiovascular disease risk in UK South Asian men: A preliminary study. Br J Health Psychol. 2007;12(4):559-70. Available from: doi:10.1348/135910706X144441.
5. Bainey K, Gupta M, Ali I, Bangalore S, Chiu M, Kaila K, et al. The burden of atherosclerotic cardiovascular disease in South Asians residing in Canada: A reflection from the South Asian Heart Alliance. CJC Open. 2019;1(6):271-81. Available from: doi:10.1016/j.cjco.2019.09.004.
6. Dhar A, Barton D. "Depression and the Link with Cardiovascular Disease." Front. Psychol. 2016;7(33). Available from: doi:10.3389/fpsyt.2016.00033.
7. Karasz A, Gany F, Escobar J, Flores C, Prasad L, Inman A, et al. Mental Health and Stress Among South Asians. J Immigrant Minority Health. 2019;21(suppl 1):7-14. Available from: doi:10.1007/s10903-016-0501-4.
8. Rana A, de Souza RJ, Kandasamy S, Lear SA, Anand S. Cardiovascular risk among South Asians living in Canada: A systematic review and meta-analysis. CMAJ Open. 2014;2(3):183-91. Available from: doi:10.9778/cmajo.20130064.
9. Anand S, Arnold C, Bangdiwala SI, Bolotin S, Bowdish D, Chanchlani R, et al. Seropositivity and risk factors for SARS-CoV-2 infection in a South Asian community in Ontario: A cross-sectional analysis of a prospective cohort study. CMAJ Open. 2022;10(3):599-609. Available from: doi:10.9778/cmajo.20220031.
10. Peel Data Centre. 2011 NHS Bulletin: Ethnic Diversity and Religion. Peel Region and Greater Toronto Area (ON): Region of Peel; 2013. 4 p.
11. Sidhu MS, Griffith L, Jolly K, Gill P, Marshall T, Gale NK. Long-term conditions, self-management and systems of support: An exploration of health beliefs and practices within the Sikh community, Birmingham, UK. Ethn Health. 2016;21(5):498–514. Available from: doi:10.1080/13557858.2015.1126560.
12. King-Shier KM, Dhaliwal KK, Puri R, LeBlanc P, Johal J. South Asians' experience of managing hypertension: A grounded theory study. Patient Prefer Adherence. 2019;13:321-9. Available from: doi:https://doi.org/10.2147/PPA.S196224.
13. Galdas PM, Kang HBK. Punjabi Sikh patients' cardiac rehabilitation experiences following myocardial infarction: A qualitative analysis. J Clin Nurs. 2010;19(21-22):3134-42. Available from: doi:10.1111/j.1365-2702.2010.03430.x.
14. Darr A, Astin F, Atkin K. Causal attributions, lifestyle change, and coronary heart disease: Illness beliefs of patients of South Asian and European origin living in the United Kingdom. Heart Lung. 2008;37(2):91-104. Available from: doi:10.1016/j.hrtlng.2007.03.004.
15. Jolly K, Lip GY, Sandercock J, Greenfield SM, Raftery JP, Mant J, et al. Home-based versus hospital-based cardiac rehabilitation after myocardial infarction or revascularisation: Design and rationale of the Birmingham Rehabilitation Uptake Maximisation Study (BRUM): A randomised controlled trial [ISRCTN72884263]. BMC Cardiovasc Disord. 2003;3(10). Available from: doi:10.1186/1471-2261-3-10.
16. Jolly K, Lip GY, Sandercock J, Greenfield SM, Raftery JP, Mant J, et al. The Birmingham Rehabilitation Uptake Maximisation Study (BRUM). Home-based compared with hospital-based cardiac rehabilitation in a multi-ethnic population: Cost-effectiveness and patient adherence. Health Technol Assess. 2007;11(35):1-118. Available from: doi:10.3310/hta11350.
17. Akeroyd JM, Chan WJ, Kamal AK, Palaniappan L, Virani SS. Adherence to cardiovascular medications in the South Asian population: A systematic review of current evidence and future directions. World J Cardiol. 2015;7(12):938-47. Available from: doi:10.4330/wjc.v7.i12.938.
18. Jolly K, Greenfield SM, Hare R. Attendance of ethnic minority patients in cardiac rehabilitation. J Cardiopulm Rehabil. 2004;24(5):308-12. Available from: doi:10.1097/00008483-200409000-00004.
19. Banerjee AT, Grace SL, Thomas SG, Faulkner G. Cultural factors facilitating cardiac rehabilitation participation among Canadian South Asians: A qualitative study. Heart & Lung. 2010;39(6):494-503. Available from: doi:10.1016/j.hrtlng.2009.10.021.
20. Cunningham CT, Sykes LL, Metcalfe A, Cheng A, Riaz M, Lin K, et al. Ethnicity and health literacy: A survey on hypertension knowledge among Canadian ethnic populations. Ethn Dis. 2014;24(3):276-82. Available from: https://pubmed.ncbi.nlm.nih.gov/25065067/ [cited 2022 Aug 2].
21. Gany FM, Gill PP, Ahmed A, Acharya S, Leng J. "Every disease...man can get can start in this cab": Focus groups to identify South Asian taxi drivers' knowledge, attitudes and beliefs about cardiovascular disease and its risks. J Immigrant Minority Health. 2013;15(5):986–92. Available from: doi:10.1007/s10903-012-9682-7.
22. Ratner P, Tzianetas R, Tu AW, Johnson JL, Mackay M, Buller CE, et al. Myocardial infarction symptom recognition by the lay public: The role of gender and ethnicity. J Epidemiol Community Health. 2006;60(7):606-15. Available from: doi:10.1136/jech.2005.037952.
23. Agarwal G, Pirrie M, Bhandari M, Angeles R, Marzanek F. Feasibility of implementing a community cardiovascular health promotion program with paramedics and volunteers in a South Asian population. BMC Public Health. 2020;20(1). Available from: doi:10.1186/s12889-020-09728-9.