

**Finding a Doctor Shouldn't Be This Hard:
Healthcare Access for Newcomers from India in Delta**

Kelly Tran, Paige Graham, Swana Ng, Ishan Ramawickrama,

Aleena Chohan, Mariana Cardenas Sepulveda

Simon Fraser University

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Dr. Hadia Samim

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INTRODUCTION

Delta is home to the sixth-largest immigrant population in Metro Vancouver; however, its existing infrastructure and services remain inadequately equipped to meet the complex needs of this growing community (Delta Local Immigration Partnership, 2026). The majority of newcomers in Delta are from India, with the second being the UK and closely followed by China. These realities encompass a shortage of bilingual healthcare workers, inadequate transit access to health and educational services, and limited opportunities in employment and education (Delta Local Immigration Partnership, 2026). Compounding these challenges, persistent long wait times impede timely access to urgent care. Collectively, these structural gaps contribute to newcomers feeling marginalized during an already difficult transition to life in a new country, underscoring the need for better-equipped services and expanded healthcare capacity.

Geographical and demographic differences in South and North Delta highlight varying gaps that need addressing in both respective communities. There are limited urgent care centres in the Delta region, with the only two centres being located in South Delta. This would correspond to individuals in North Delta commuting to either South Delta or Surrey in the event they require urgent care, indicating that access to urgent care is a pressing need for communities in North Delta (City of Delta, 2021). North Delta also has a larger immigrant population than South Delta, where only 23% of the populations of Ladner and Tsawwassen were immigrants, compared to 41% in North Delta. 45% of immigrants in North Delta were of Indian origin, compared to 13% in Ladner, and only 3% of Tsawwassen's population is of South Asian origin (City of Delta, 2021).

Furthermore, a persistent issue exists in Delta surrounding the closure of hospitals when there are no doctors available. This closure exemplifies the major healthcare gaps such as

reduced access to emergency care and overcrowding at other facilities (Delta Local Immigration Partnership, 2026). These compounding barriers informed the project's central problem statement: newcomers from India in Delta experience language, cultural, and systemic barriers that limit their ability to access healthcare in a culturally responsive and anti-racist manner.

APPLICATION OF EQUITY-CENTERED DESIGN

NOTICE AND REFLECT

Before engaging with the community, we examined our own identities and privileges. As a group of university students with varying cultural backgrounds but shared privileges of English fluency, digital literacy, and familiarity with the Canadian healthcare system, we recognized that our positionalities as students could create blind spots that required us to consistently center the community partner's knowledge over our own assumptions. We acknowledged our diverse cultural backgrounds as assets, assigned roles according to individual strengths, and approached the partnership with a commitment to listening rather than leading.

EMPATHIZE AND REFLECT

From the beginning, the community partner's voice anchored our process. Through interviews and lived experience data, a clear consensus emerged: the central challenge for the Indian population in Delta is difficulty accessing family doctors. In regards to our own research, we developed an environmental scan, gathering information about the Indian population in Delta and comparing the differences in their lives before and after arriving in Canada. We also created empathy maps. Considering we lacked the perspective of an individual being from India, we reflected on how our group's limited relatability could create blind spots. Leveraging our group's capacity to understand Punjabi, the most common language among our target population, we

were able to access perspectives from a broader audience, which strengthened both the inclusivity of our empathy map and the depth of our environmental scan.

DEFINE & REFLECT

Drawing on the community partner's input, we defined the core challenge as follows: newcomers need to understand that healthcare is a right in Canada, and that obtaining a family doctor through mechanisms such as the Health Connect Registry is both possible and within reach. We analyzed the information channels and social media formats most used by our target audience, considering age, English proficiency, spirituality, and cultural context. We consistently reminded ourselves that the problem definition had to remain community-owned and not redefined through our own privileged lens.

IDEATE & REFLECT

We brainstormed culturally appropriate ways to spread clear, actionable messages about obtaining a family doctor. Ideas were evaluated for generalizability so materials could benefit communities beyond just our primary population. A short, multilingual video emerged as the strongest format as it is easy to translate, dub, and share across platforms. At every step, we questioned whether our ideas centred on community preferences or our own assumptions about effective communication.

PROTOTYPE, TEST & REFLECT

In the prototyping phase, we produced a short, cross-platform instructional video guiding newcomers through the Health Connect Registry registration process, alongside a slide deck designed for peer-led classroom outreach and a suite of social media templates. Prototypes were shared with the community partner, feedback was incorporated, and deliverables were refined

accordingly. Prototypes were presented to the community partner, feedback was received, and deliverables were updated accordingly. By embedding reflection at every phase, we ensured our project remained equity-centred rather than solution-driven and could produce adaptable tools co-created with the community rather than imposed on it.

DELIVERABLES

Our deliverables were shaped by one central question: *what format would actually reach an Indian newcomer in North Delta who has limited English, limited familiarity with the Canadian healthcare system, and limited time?* Every tool we chose was an answer to that question.

The centerpiece of our deliverables is a multilingual instructional video produced in five languages to reflect the linguistic diversity of the newcomer populations in Delta: English, Punjabi, Hindi, Urdu, and Mandarin. This was identified as a priority deliverable by our community partner, who recommended video as the most effective format for reaching newcomers in Delta. The video walks newcomers through the Health Connect Registry registration process using visuals that are easy to follow with a voiceover format, showing exactly what to click, what information to have ready, and what to expect. Video was chosen as the primary format because it removes the literacy barrier that written materials cannot. In this way, a newcomer does not need to read English fluently to follow along. The video was intentionally kept between 30 and 60 seconds to respect the viewer's time and maximize shareability across platforms including WhatsApp, YouTube, Instagram, and Facebook.

Punjabi and Hindi were prioritized from the outset as the primary languages of our target population. For Punjabi and Urdu, we used Aleena's parents as voiceover contributors rather

than relying on AI-generated audio, as AI tools were unable to produce the level of authenticity and accuracy required for languages so central to the communities we aimed to serve. For English, Mandarin, and Hindi, we utilized the AI voiceover feature available through CapCut.

Beyond the video, we developed Instagram carousel posts tailored to two distinct audiences recognizing that expanding HCR awareness requires engaging both the academic and clinical sectors: the SFU Faculty of Health Sciences and the Delta Division of Family Practice. Each carousel was designed with its respective platform and audience in mind. One is more awareness-driven for a student and academic audience, and the other is more action-oriented for a community and clinical audience. Both direct viewers to register for the HCR and provide the 8-1-1 phone number as an accessible alternative for those who prefer phone-based support.

We also developed a short slide deck designed for future student volunteers to present in post-secondary classrooms. This deliverable was informed by the recognition that healthcare navigation is not only a newcomer issue as it is a broadly relevant topic that peers can help normalize and share. Equipping students with a ready-to-use presentation lowers the barrier to spreading this information through trusted, accessible channels.

An environmental scan infographic was developed to visually synthesize key findings about the Indian newcomer population in Delta, encompassing demographic data, healthcare access barriers, and existing community resources, and was designed to function both as a digital asset and a printable resource for distribution in community spaces. This infographic was designed to function both digitally and as a printable resource for physical distribution in community spaces.

Finally, we developed a WhatsApp channel setup guide to support community organizations and settlement workers in creating their own channels to share health information directly with newcomer communities. WhatsApp was identified as a particularly effective platform for reaching older adults and recent arrivals who may not be active on other social media platforms but maintain strong communication networks through the app.

Across all deliverables, we applied health promotion principles, community-based research methodology, and equity-centred design to ensure that every tool produced was practical, culturally appropriate, and capable of living beyond the scope of this course. Our evidence base throughout was the Delta LIP Immigrant Demographic Profile and 2021 Census data, ensuring every decision reflected the real demographics and needs of the community that we were designing for.

KEY FINDINGS/TAKEAWAYS

Through this project, we recognize there are significant access barriers for newcomers in Delta facing language, cultural, and systemic barriers when accessing healthcare. The barriers lead to miscommunication with providers and lower trust in the healthcare system which ultimately lead to delays or avoidance in seeking care. One of the major gaps that our group also chose to focus on, is the lack of bilingual healthcare providers and translated resources. We also found structural gaps within the Delta's healthcare system with further constraints such as long wait times, limited hospitals (e.g. hospital struggles to function when staffing is low or if a doctor is missing), and transportation barriers, particularly in South Delta where there are tunnel congestions, and weak public transit accessibility.

Newcomers are also unaware of the Health Connect Registry (HCR), which lacks promotion due to language barriers and generally there is a sense of unfamiliarity in navigating and understanding the Canadian healthcare system. This stems from having prior knowledge of their previous countries' health care system. There is a vast difference between what a family doctor or nurse practitioner is in Canada compared to South Asian countries such as India. For instance, newcomers in British Columbia have access to a publicly funded healthcare system through the Medical Services Plan (MSP), which covers essential medical services such as doctor visits, diagnostic tests, and treatments. However, MSP does not include services like dental care, vision care, physiotherapy, or counselling. Eligible individuals (e.g., citizens, permanent residents, some work/study permit holders) must apply as soon as they arrive, though coverage may take up to 3 months to begin, requiring temporary private insurance during the wait.

Moreover, the pathway in accessing healthcare differs as well. For those not eligible for MSP, the Interim Federal Health Program (IFHP) provides limited, short-term coverage for specific groups such as refugees and protected persons, but access is restricted to registered providers. This adds another layer of complexity with navigating when to access the emergency room (ER), walk-in clinics, or a family doctor. It is another factor to adjust to for newcomers.

As a result, increasing HCR awareness is the main focal point of this project. Having gathered the vast amount of information and comprehending the amount of factors newcomers have to adjust to, promoting HCR to specific newcomer groups creates a sense of inclusivity, increases relevance and effectiveness. It begins with ensuring newcomers know where and how to register for HCR. Utilizing audiovisual and multilingual formats (e.g. having multiple promotion videos with captions and translated materials) are more effective especially with plain

language that is straightforward and easy to understand. This connects the community rather than simply providing context heavy information exemplified through the deliverables that we have made.

CHALLENGES & LIMITATIONS

Among the challenges encountered in addressing our problem statement, geographical constraints within Delta represent the most pressing structural limitation. Access to care is a key determinant of health outcomes, making transit accessibility a critical enabling factor for newcomer populations (Delta Local Immigration Partnership, 2026). The geographical differences and restrictions that are unique to both North and South Delta present a challenge that emphasizes the need for easy transit access, considering that both urgent care centres in Delta are in South Delta (City of Delta, 2021). This means that individuals in North Delta would have to commute to either South Delta or Surrey in need of urgent care, which makes health resource promotion efforts more difficult as it may not be feasible for Indian newcomers in North Delta to transit to South Delta (City of Delta, 2021). This potential lack of feasibility could stray them away from considering a commute to South Delta as an option for their health promotion, as it may not be possible for them when considering employment restrictions, conflicting timelines and other commitments. As a result, our efforts to promote available health resources may be dismissed as unfeasible.

A second limitation concerns the predominantly digital format of our deliverables, which may constrain reach among older newcomers who are less digitally engaged than younger populations (Delta Local Immigration Partnership, 2026). Although we created a healthcare promotion infographic that could be used as a brochure, integrating it into healthcare facilities and community centres would require approval from the facilities themselves. In addition,

approval would have to be acquired from Healthlink BC to promote government resources, in our case specifically the Health Connect Registry. This also brings upon an ethical issue, as the infographic is tailored specifically for Indian newcomers as opposed to newcomers of other ethnic backgrounds. However, we were able to address this limitation for our health promotion videos, where we recorded them in Mandarin and Urdu, to show that our health promotion resources can help other newcomers that are not of an Indian background.

A third limitation involves the necessarily narrow scope of this project relative to the breadth of healthcare navigation challenges facing newcomers. We decided to focus on ensuring that Indian newcomers knew the process of registering for a family doctor, considering the importance of having primary care resources for health outcomes (Delta Local Immigration Partnership, 2026). However, this limited our scope from including other areas of focus, such as access to mental health resources or resources specifically for newcomer children. Future efforts can promote these resources among others to ensure that a well-rounded approach is being taken for health promotion.

CONCLUSION

This project highlights an important point where improving healthcare access for newcomers goes beyond simply providing an abundance of information. It requires culturally-aware, accessible, and community-informed communication strategies. By focusing on promoting the Health Connect Registry and simplifying the steps to navigate the healthcare system, we aim to reduce some of the main barriers newcomers face when accessing healthcare services. This project also required tailoring the strategy, and understanding how the healthcare system works in other countries, in our case, India.

A key strength of this project is that we grounded it in equity-centered design. We ensured that the perspective and lived experiences of the community shaped how we approached the problem, and the solutions that we developed. The deliverables were created to be practical, adaptable, and capable to be integrated in the community. The multilingual instructional videos are a valuable resource that could be integrated into official platforms such as the Division of Family Practice or the Delta LIP websites. The inclusivity aspect enables newcomers with direct access to guidance utilizing their native language rather than solely relying on the translation services from the 8-1-1 phone line. This resource also further supports newcomer autonomy in navigating the healthcare system. Additionally, the WhatsApp channel assists in expanding community outreach, considering its popularity among the Indian community particularly with the older population.

It is important to note that these deliverables are not meant to replace existing resources, but to supplement and strengthen the existing ones. For example, the Delta LIP currently offers peer-support services and community events; however, integrating the deliverables could enhance their community outreach aspect as well as increase the efficacy through providing clear, accessible, and multilingual support.

An area of opportunity is expanding this work to other regions in British Columbia with a high percentage of newcomer residents. While using social media expands to a more extensive audience, majority of it does pertain to youth, thus, the individuals in need of these services may be missed. For implementation in the community, there should be a portion of outreach done in-person such as workshops, peer support, and increased collaboration with cultural and faith organizations (e.g. gurdwaras, temples, or mosques). Utilizing these outlets allow for trust building, which significantly impacts engagement, and ultimately the success in making

healthcare access more equitable. Newcomers should not bear the burden of independently navigating a complex and unfamiliar healthcare system. This project represents one step toward ensuring that the pathway to seeing a family physician is comprehensible, accessible, and equitable for all who call Delta home.

AI USE AND ACADEMIC INTEGRITY STATEMENT

This project made use of AI tools in the production of select deliverables. Specifically, the AI voiceover feature available through CapCut was used to generate voiceovers for the English, Mandarin, and Hindi versions of the instructional video. For the Punjabi and Urdu versions, community members served as voiceover contributors, as AI tools were unable to produce the level of accuracy and authenticity required for these languages.

Additionally, Claude (Anthropic) was used throughout the project as a tool to assist with drafting scripts for Punjabi, Hindi, Mandarin, and Urdu versions of the instructional video. The final script was looked over by community members who spoke the language. All content was reviewed, edited, and approved by group members to ensure accuracy and alignment with our source documents and community partner guidance.

Prompts that we used:

- "Please translate the following English script into Punjabi/Hindi/Mandarin/Urdu: [script]"
- "Can you translate this into Hindi? Please use standard Hindi, not Urdu-influenced Hindi: [script]"
- "Translate the following into Mandarin: [script]"
- "Translate this into Urdu: [script]"
- "Can you check if this Punjabi translation sounds natural and accurate for a Punjabi-speaking audience in Canada: [script]"

During the translation process, Claude was unable to produce fully accurate translations for several languages. The Hindi translation generated by Claude was flagged by community

members as Urdu-influenced rather than Standard Hindi, as it used vocabulary and phrasing that are more consistent with Urdu than with the Hindi dialect appropriate for our target population. Similarly, the Urdu translation contained dialect inconsistencies that did not reflect the specific Urdu spoken by Pakistani and South Asian newcomer communities in Delta. The Punjabi translation also contained wording that did not feel natural or accurate to native Punjabi speakers familiar with the dialect most common in North Delta.

As a result, all four script translations of Punjabi, Hindi, Mandarin, and Urdu were reviewed, edited, and revised by community members with native speaker fluency before being used in the final video. This process reinforced a core principle of our equity-centred approach: that AI-generated content, particularly in culturally and linguistically specific contexts, requires community validation before it can be considered appropriate for use with the populations it is meant to serve.

All AI tools were used in a supplementary capacity. The ideas, decisions, analysis, and community-grounded approach reflected in this report and its deliverables are the original work of the project team.

This statement is submitted in accordance with Simon Fraser University's academic integrity policies.

REFERENCES (APA)

Delta Local Immigration Partnership. (2026, January 22). Delta Local Immigration Partnership.

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Ladner 2021 Census Data. City of Delta Community Profiles. (n.d.-a).

<https://www.delta.ca/media/3331>

North Delta 2021 Census Data. City of Delta Community Profiles. (n.d.).

<https://www.delta.ca/media/3333>

Tsawwassen 2021 Census Data. City of Delta Community Profiles. (n.d.-b).

<https://www.delta.ca/media/3335>

APPENDIX

DELIVERABLES:

- **Presentation Powerpoint:** <https://canva.link/be53hafkclkmdor>
- **Environmental scan:**
https://www.canva.com/design/DAHC6wcuAZ0/7XtQQjCAXkMD5isl7YGIRA/edit?utm_content=DAHC6wcuAZ0&utm_campaign=designshare&utm_medium=link2&utm_source=sharebutton
- **Videos showing how to navigate HCR:**
https://drive.google.com/drive/folders/1shaIR_--2y0YeDL0aLsfQWEJIIHytBLc?usp=drive_link
- **Workshop Slide Deck:** <https://canva.link/emqjb7p73zw099k>
- **Instagram Carousels:** <https://canva.link/102s6g5i7wtlfud>
- <https://canva.link/jw0d2lg53eslro4>
- **WhatsApp Channel Guide:** [How To Create A WhatsApp Channel - Guide](#)

MEDIA CONSENT FORMS FOR VOICEOVERS:

https://drive.google.com/drive/folders/1wTLevab_eHGvfTJkbwJfxDA8qMXiANeT?usp=sharing

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COMPOSITE PERSONA: HARPREET & SIMRAN'S FAMILY



ORIGIN	Punjab, India
LANGUAGES	Punjabi (primary), Hindi (secondary), limited English
AGE	Primary earner 28-45; Spouse 25-40; Children 0-14
TIME IN CANADA	0-5 years
IMMIGRATION TYPE	Family-sponsored permanent resident
NEIGHBOURHOOD	North Delta (41% of North Delta's population are immigrants; India is the #1 source country)
EMPLOYMENT	Trades, transportation, retail, or care work. Family-sponsored immigrants have a 55.6% employment rate vs. 75.9% for economic immigrants so credential recognition is a common barrier
INCOME	Recent immigrants in Delta earned ~\$23,424. That's less than half the city average of \$49,483
HOUSING	60.3% of newcomers fall below at least one core housing need indicator (affordability, suitability, or adequacy)
RELIGION	Sikh (majority), Hindu (minority)
SOCIAL NETWORK	Tight-knit extended family; Gurdwara as a central community hub
HEALTH LITERACY	Low familiarity with the Canadian health system; preference for home remedies; doctor seen as last resort
HAS A FAMILY DOCTOR?	No, most likely unattached and not registered with the HCR