Access Alliance
Multicultural Health and Community Services

Canadian Cancer Society

BETTER for All Sustainability Project: Creating Sustainable Pathways to Chronic Disease Prevention

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Disclosure and Copyright

 It was prepared by the Access Alliance's Research & Evaluation Team in collaboration with the Canadian Cancer Society team.

This project was led by Ezza Jalil, MPH, with support from Subrana Rahman and Peer Researchers Francheska Beltran and Moharaj Oritro. The project was championed and supported by Akm Alamgir and Karen Kuzmich.

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Citation

The report, or any part of it, may be used for programmatic or academic purposes provided it is properly cited as follows:

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Executive Summary

Background

Chronic diseases remain a leading cause of morbidity and mortality in Canada and disproportionately affects racialized and newcomer populations due to persistent barriers to preventive healthcare, cancer screening, and chronic disease prevention and management (CDPM). The BETTER for All (BFA) program was developed as a community-based, culturally responsive intervention to improve preventive health behaviours and access to screening among underserved populations through prevention visits, peer health coaching, and community partnerships. Given concerns regarding the long-term sustainability of the program following the anticipated closure of the BETTER Institute after December 2025, the BFA Sustainability Project was initiated to identify strategies to strengthen the integration and continuation of the program within primary care and community health systems.

Project Objectives

The study aimed to identify the organizational, relational, and operational conditions required to sustain the BFA program and its associated health benefits over time. Specific objectives included exploring strategies to maintain participant engagement, strengthen preventive health behaviours, support equitable and culturally responsive program delivery, and identify resources and partnerships necessary for long-term sustainability within multidisciplinary primary care and community settings.

Methodology

This project employed a qualitative study design. Semi-structured interviews were conducted with stakeholders across seven participating BFA sites, including community members, Prevention Practitioners, Peer Health Coaches and site administrators. Representatives from the Canadian Cancer Society (CCS) were also consulted to support validation and interpretation of the study findings. A total of 30 individuals were recruited using purposive sampling strategies. Interviews were conducted virtually between February and March 2026 and analyzed using inductive and deductive thematic analysis supported by NVivo software. Descriptive demographic analyses were conducted using SPSS.

Key Findings

Respondents viewed the BFA program as valuable, culturally responsive, and highly relevant for newcomer and racialized communities. Prevention visits, peer health coaching, motivational interviewing, and individualized goal setting were identified as key strengths that supported trust, accountability, and participant engagement. Community connection and culturally responsive care emerged as central facilitators of participation.

However, several barriers to sustainability were identified, including limited funding, staff workload and turnover, low program client recruitment and retention, language barriers, transportation challenges, and competing socioeconomic priorities among respondents. Stakeholders also highlighted operational challenges related to

paperwork, intake processes, and limited integration within existing clinical workflows. The need for expanded translated materials, culturally tailored resources, and more accessible communication approaches was also emphasized**.**

Recommendations

Key recommendations to support long-term sustainability included:

- Expanding multilingual, community-based outreach and recruitment through the implementation of community health ambassadors.
- Integrating the Better For All (BFA) model into routine primary care and Family Health Team workflows.
- Updating program documentation to reflect linguistic diversity, varying health literacy levels, and gender-diverse populations.
- Sustaining motivational interviewing training through ongoing refresher sessions and continuous professional development.
- Providing structural supports such as transportation assistance and food-related resources, while embedding social determinants of health into program design.
- Establish cross-site governance with standardized evaluation and sustainable funding to support coordinated implementation and long-term sustainability of the BFA program.

Conclusion

The findings demonstrate that the BFA program has been crafted as a timely initiative to address an important gap in culturally responsive chronic disease prevention and cancer screening support for racialized and newcomer populations. While several organizational and structural challenges to sustainability remain, the program demonstrates potential for long-term integration within primary care and community health systems if supported through sustained funding, strengthened partnerships, and continued investment in equity-oriented and community-based approaches.

Introduction and Background

Chronic Disease Prevention and Health Equity

Chronic diseases account for a substantial proportion of healthcare utilization, healthcare expenditures, disability, and premature mortality in Canada [1,2]. Evidence consistently demonstrates that many chronic diseases are preventable through early intervention, health promotion, lifestyle modification, and routine preventive screening practices [3,4]. Preventive behaviours such as healthy eating, physical activity, smoking cessation, alcohol reduction, and participation in recommended cancer screening programs can significantly reduce chronic disease risks and improve overall population health outcomes [5].

Despite these benefits, inequities in preventive healthcare access persist among racialized and newcomer populations. According to the 2011 National Household Survey, immigrants comprised 20.6% of the Canadian population, with projections estimating that by 2031 approximately one in three Canadians would be an immigrant [6,7]. Within this increasingly diverse context, newcomers and racialized communities continue to experience multiple intersecting barriers to preventive care, including limited awareness of available services, language and cultural barriers, discrimination within healthcare settings, transportation constraints, and competing settlement-related social and economic priorities [8]. Collectively, these structural and social determinants contribute to reduced uptake of preventive services and screening, delayed diagnosis, and inequitable long-term health outcomes.

Consequently, there is growing recognition that effective chronic disease prevention strategies must be community-centred and culturally responsive. Peer support and community health coaching models have emerged as promising approaches, as they enhance trust, improve accessibility, and facilitate sustained behaviour change through socially connected and culturally relevant engagement [9].

The BETTER for All Program

The BETTER for All (BFA) program is a community-based, evidence-informed chronic disease prevention and health promotion intervention designed to reduce cancer and chronic disease risk among priority populations, particularly newcomers to Canada and racialized communities. The program aims to support participants in adopting and sustaining healthy lifestyle behaviours, increasing participation in recommended cancer screening, and strengthening overall chronic disease prevention practices through integrated clinical and community-based supports.

A central component of the program is the prevention visit, during which trained Prevention Practitioners (physicians and nurse practitioners) work collaboratively with program participants to review prevention priorities and screening eligibility, assess individual risk factors, and co-develop personalized, SMART health goals. Following the

prevention visit, program participants are matched with Peer Health Coaches who may share similar lived or identity experiences. Over a period of up to six months, Peer Health Coaches provide culturally responsive, peer-based support to help participants achieve and sustain their health goals, with a focus on behaviours such as smoking cessation, physical activity, healthy eating, alcohol reduction, and cancer screening uptake (Figure 1)

The integration of Peer Health Coaches, Prevention Practitioners, and community partners has enabled culturally responsive engagement and extended preventive care beyond conventional clinical settings, particularly for populations experiencing structural barriers related to language, access, and trust. Given the program's dependence on the coordinated functioning of both clinical and community-based components, its long-term effectiveness is intrinsically linked to its capacity for sustained implementation within real-world health and community systems. Accordingly, sustainability emerges as a central consideration for ensuring the continuity of program benefits, the durability of cross-sector partnerships, and the integration of delivery structures into routine practice over time.

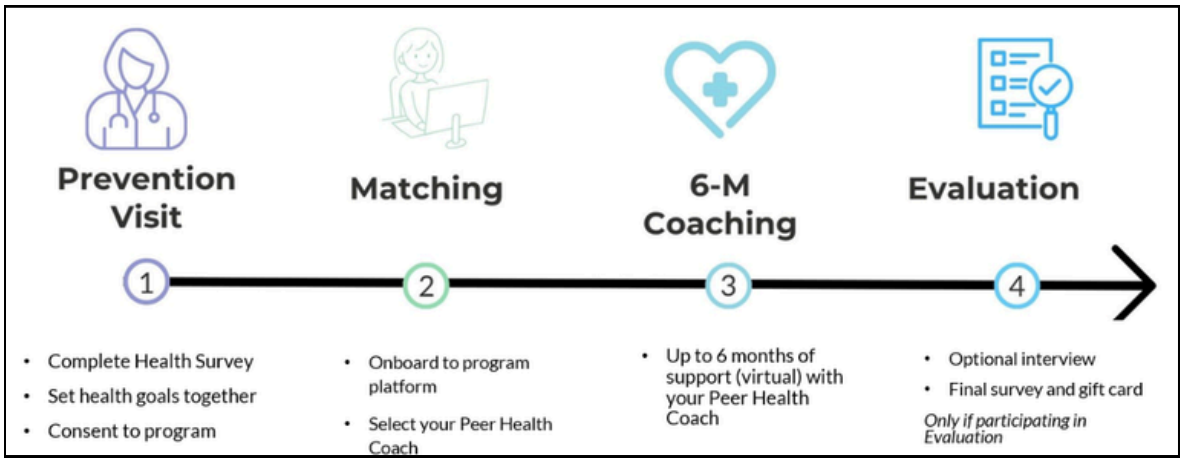

Figure 1: BETTER for All Program Process Overview.

Sustainability in Public Health Interventions

Sustainability has become an increasingly critical focus within public health and implementation science as healthcare systems seek to maintain the long-term impact of prevention initiatives. In public health, sustainability generally refers to the ability to continue program activities, maintain health benefits, and build organizational and community capacity beyond initial funding periods [10]. Sustained impact is more likely when interventions are embedded within existing system structures, supported by robust multi-sectoral partnerships, and responsive to evolving community contexts. Without intentional sustainability planning, community-based prevention programs risk

reduced reach, weakened relationships, and diminished long-term impact.

Despite the strengths of the BFA model, several sustainability challenges were identified during implementation. A key concern was the anticipated loss of infrastructure following the closure of the BETTER Institute after December 2025, creating uncertainty regarding access to training, implementation supports, coordination mechanisms, and prevention resources. In addition, participant engagement remained suboptimal in several communities, as existing outreach approaches, including multilingual materials and provider referrals, were not always sufficient to build trust and sustained engagement among racialized and newcomer populations. These findings reinforced the importance of understanding how community relationships, culturally responsive approaches, and peer-supported engagement strategies could be strengthened and sustained over time.

These challenges highlighted the need for a focused sustainability discovery process capable of identifying both barriers and opportunities associated with long-term implementation and scale up.

BETTER for All (BFA) Sustainability Project

In response to emerging implementation and sustainability challenges, the BFA Sustainability Project was initiated with funding from the Public Health Agency of Canada (PHAC) to examine strategies for strengthening the long-term integration and institutionalization of the BFA program within primary care and community health systems. The project was designed to generate actionable, practice-informed insights into the organizational, relational, and system-level conditions required to sustain program delivery, maintain program participant engagement, and preserve the preventive and equity-oriented health gains associated with the intervention.

Grounded in a participatory qualitative and systems-oriented approach, the Sustainability Project engaged family health teams, community health centres, community partners, Peer Health Coaches, Prevention Practitioners, and other implementation stakeholders through structured interviews and collaborative reflective processes. This approach sought to elicit nuanced perspectives on both enabling conditions and structural constraints shaping sustainability, including workforce capacity, training infrastructure, inter-organizational coordination, and the maintenance of community trust.

Within this framework, the project aimed to identify the resources, partnerships, and operational processes required to sustain the intended outcomes of the BFA model, including continuity of service delivery and preservation of associated health and social benefits. It also explored mechanisms to support sustained participant engagement and the long-term adoption of preventive health behaviours within diverse and underserved communities.

BFA Sustainability Project Objectives

This project aimed to explore factors influencing the long-term sustainability and integration of the BFA initiative within primary care and community settings. The work focused on identifying practical, equitable, and context-sensitive approaches to maintaining preventive health programming and supporting ongoing participant engagement. Particular attention was given to strengthening implementation within multidisciplinary care environments and addressing the needs of structurally marginalized populations.

Key objectives included:

1. Identifying the resources, relationships, and processes required to sustain BFA program outcomes.
2. Examining strategies to maintain program delivery and associated health and social benefits over time.
3. Exploring approaches to support sustained engagement in preventive health behaviours among participants.
4. Ensuring program delivery remains equitable, contextually relevant, and accessible to structurally marginalized populations.

The discovery process further focused on:

- Deepening understanding of the knowledge, attitudes, and beliefs held by priority populations regarding:
  - The role of Peer Health Coaches in supporting personal health goals.
  - The importance of cancer screening in preventive care and wellness.
  - Chronic disease prevention and management (CDPM) health practices.

- Identifying assets, gaps, and challenges related to sustaining prevention visits within multidisciplinary primary care sites beyond the current funding period, including:
  - Resources required for more user-friendly health assessment tools for patients and providers.
  - Opportunities to integrate health goal planning tools and prevention prescriptions into routine or emerging clinical workflows.
  - Alternative curricula and training approaches to support ongoing delivery of prevention visits.

Methodology

Study Design

This study used a qualitative research design to examine the sustainability of the BFA program and identify factors that support its long-term integration within primary care and community health settings. The study incorporated a 360-degree stakeholder perspective by gathering insights through one-on-one interviews from BFA program beneficiaries, community members, Peer Health Coaches, Prevention Practitioners, site admin/support across the six BFA participating sites. To validate the findings representatives from the CCS team were consulted to ensure a holistic understanding of sustainability-related factors (Figure 2).

Site	Participating in BFA Program
Access Alliance (College Site)	Yes
AccessPoint on Danforth (APOD)	Yes
Village Family Health Team	Yes
Davenport Perth Neighbourhood Community Health Centre	Yes
Centre Francophone du Grand Toronto	Yes
Taddle Creek Family Health Team	Yes
Parkdale Queen West Community Health Centre	No

Table 1: Respondents were recruited across seven Better for All (BFA) sites in Ontario.
Note: Parkdale Queen West Community Health Centre withdrew from participation in the BFA program but was included in the study to gather feedback.

Sample Recruitment

A heterogeneous purposive sampling strategy using maximum variation sampling was used to recruit individuals with direct experience in program delivery, participation, or organizational decision-making. This approach ensured representation across diverse stakeholder groups and experiences with the BFA program [11].

A total of 30 individuals participated in the study, including 13 community members, 8 Prevention Practitioners, 4 Peer Health Coaches, 3 site administrators, 2 individuals serving dual roles as both site administrators and Prevention Practitioners, and 3 representatives from the CCS team were consulted as part of the project. Among the 13 community members, 3 were enrolled in the BFA program at AccessPoint on Danforth (APOD), while the remaining respondents were community members engaged through outreach initiatives across the six participating organizations (See Appendix A, Table A1). Program beneficiaries were eligible to participate if they were 18 years of age or older, received care or services at one of the seven BFA sites, were able to provide informed consent, and had any level of experience with the BETTER for ALL program; completion of the program was not required.

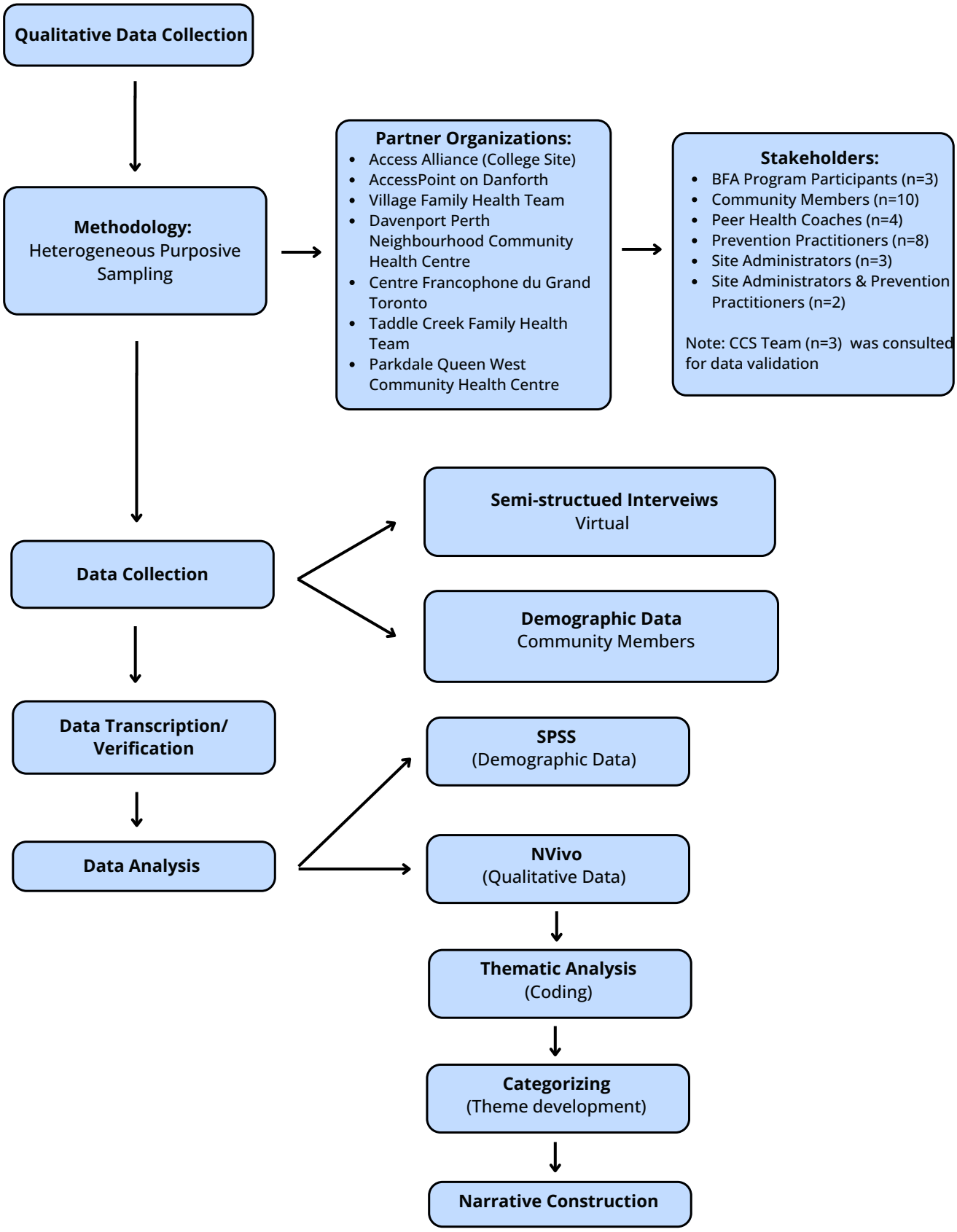

Figure 2: Flow chart outlining the the study design.

Respondents were recruited through several strategies, including:

- BFA staff contact lists, including contact information for site administrators and support staff, Prevention Practitioners, and Peer Health Coaches, shared by the CCS team.
- Email communications sent to participating site administrators to distribute recruitment flyers across participating organizations and primary care waiting areas. Recruitment flyers were distributed across the seven participating sites in multiple languages, including English, Bengali, Chinese, French, Portuguese, and Spanish (See Appendix A, Figure A1)
- Additional recruitment through community outreach events at participating sites, where peer researchers engaged community members and collected contact information from interested participants.

Data Collection

Data collection took place between February and March 2026. Semi-structured individual interviews, lasting approximately 30–60 minutes, were conducted virtually via Zoom. All interviews were conducted individually to facilitate in-depth discussion, maintain confidentiality, and minimize barriers to participation.

Interviews were conducted by members of the Access Alliance's research team and trained peer researchers using semi-structured interview guides and questionnaires with standardized topic prompts tailored to each stakeholder group. Separate guides, consisting of approximately 8–10 questions, were developed for each stakeholder category (see Appendix A for interview questions). Interview topics explored experiences with the BFA program, perceived benefits and challenges, organizational partnerships and capacity, barriers and facilitators to sustainability, and recommendations for long-term program integration. BFA program staff, including site administrators, Prevention Practitioners, and Peer Health Coaches, were also given the option to provide written responses if they were unavailable to participate in a Zoom interview. Community members were also asked to complete a demographic questionnaire to collect respondent background information prior to the start of the interview.

All data were collected by Access Alliance staff, including research assistants and peer workers, who received training in qualitative interviewing techniques and strategies for engaging respondents from diverse backgrounds. With respondent consent, interviews were audio- and video-recorded using Zoom recording functions. Recordings were transcribed verbatim, and all identifying information was removed during transcription to protect respondent confidentiality.

Community members and Peer Health Coaches received an honorarium of CAD $50 per hour in recognition of their time and contributions to the study.

Data Analysis

Data analysis was conducted concurrently with data collection using an inductive and iterative approach [12]. Members of the Access Alliance research team, including the project lead and project support staff, reviewed interview transcripts to develop preliminary interpretations and identify emerging patterns within the data. The research team then conducted detailed line-by-line coding of the transcripts to identify recurring experiences, perspectives, and issues related to program sustainability, organizational integration, partnerships, equity considerations, and implementation challenges [13,14]. Initial descriptive codes were generated and subsequently grouped into broader thematic categories through an iterative process of comparison, discussion, and refinement across stakeholder groups and participating sites [15].

Demographic data was analyzed using SPSS (Statistical Package for the Social Sciences) to generate descriptive statistics and summarize respondent characteristics [16]. NVivo qualitative data analysis software was used to systematically organize, manage, and code the data. The software facilitated the identification of cross-cutting themes and supported comparisons across respondentgroups and participating organizations. Data analysis was conducted between April and May 2026. Throughout the analytical process, the research team engaged in regular discussions and iterative reviews of emerging themes to enhance analytical rigor and ensure that the findings accurately reflected respondents' experiences and perspectives.

Ethical Considerations

Participation in the study was entirely voluntary, and written informed consent was obtained from all respondents prior to data collection. Respondents were informed of the purpose of the study, the nature of their involvement, and their right to decline participation or withdraw from the study at any time without consequence. Measures were implemented throughout the study to ensure respondent confidentiality, privacy, and secure data management. All interview recordings and transcripts were de-identified prior to analysis, and electronic data were stored on password-protected systems maintained by the Access Alliance Research Department and were accessible only to authorized members of the research team.

The study also incorporated accessibility and inclusivity considerations to support participation from equity-deserving populations. These measures included the use of multilingual recruitment materials, flexible interview formats (virtual, in-person, and written responses), and community-based outreach strategies. Efforts were made to create a culturally responsive and accessible research environment that minimized barriers to participation for individuals from diverse linguistic, cultural, and socioeconomic backgrounds.

Quantitative Findings

Sample Characteristics

A total of 30 individuals participated in the study. Demographic information was collected prior to the interview from BFA program participants and community members who consented to complete the demographic questionnaire (N = 12). Table 1 presents the demographic characteristics of the respondents.

Most community respondents identified as female (75%, n = 9), while 25% (n = 3) identified as male (Figure 3). Respondents ranged in age from 25 to 54 years, with the largest proportion between 35–44 years (41.7%, n = 5), followed by those aged 45–54 years (33.3%, n = 4) and 25–34 years (25%, n = 3) (Figure 4). The majority of respondent identified as South Asian (75%, n = 9), while smaller proportions identified as Middle Eastern (8.3%, n = 1) or Mixed Heritage (8.3%, n = 1).

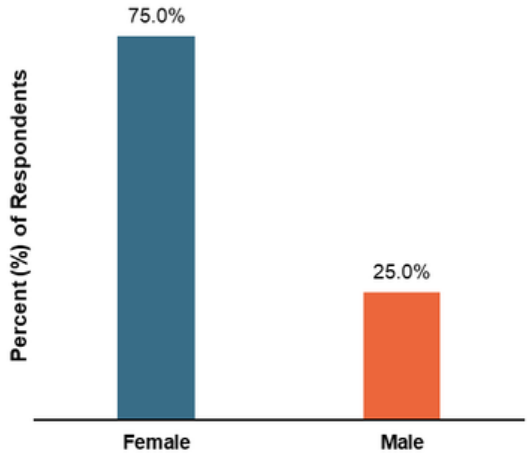

Figure 3. Percentage of respondents by gender. (N=12)

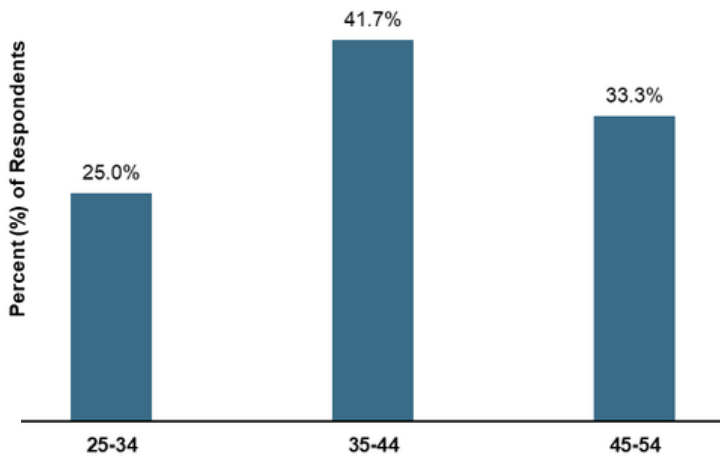

Figure 4. Percentage of respondents by age in years. (N=12)

Respondentrepresented varying lengths of residence in Canada. Approximately one-third had lived in Canada for 1–3 years (36.4%, n = 4), another one-third for 4–10 years (36.4%, n = 4), and 27.3% (n = 3) had resided in Canada for more than 10 years (M = 6.8 years, SD = 4.6) (Figure 5). When asked *"What language would you feel most comfortable speaking in when accessing services?"* English was the spoken language for most respondents (75%, n = 9), while others identified Bengali (16.7%, n = 2) or Dari (8.3%, n = 1) as their preferred language.

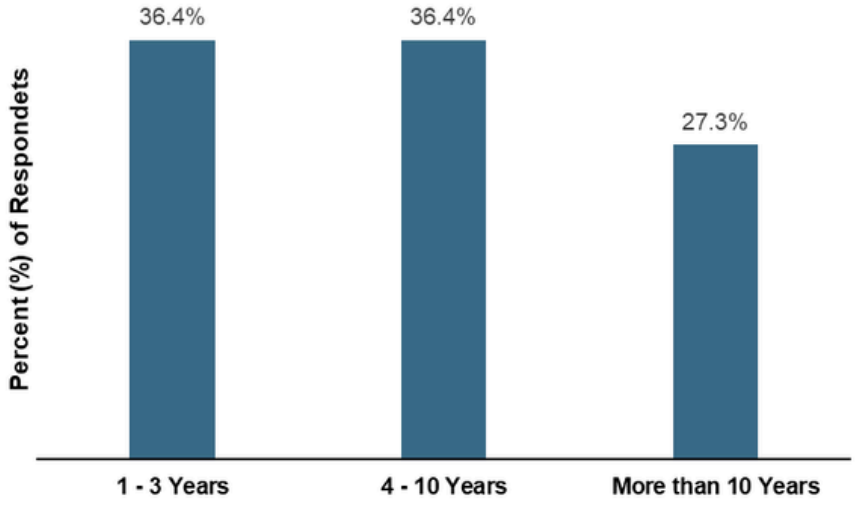

Figure 5. Percentage of respondents by length of stay in Canada. (N=12)

In terms of annual household income, 25% (n = 3) reported earning less than $30,000, 25% (n = 3) reported incomes between $30,000 and $60,000, and 16.7% (n = 2) reported earning more than $60,000 annually; however, 33.3% (n = 4) preferred not to disclose their income (Figure 6). Most respondents reported having between two and four dependents (58.3%, n = 7), while smaller proportions reported one dependent (8.3%, n = 1), between five and ten dependents (8.3%, n = 1), or preferred not to answer (25%, n = 3). Finally, the majority of respondents s identified as heterosexual (75%, n = 9), while 25% (n = 3) preferred not to disclose their sexual orientation.

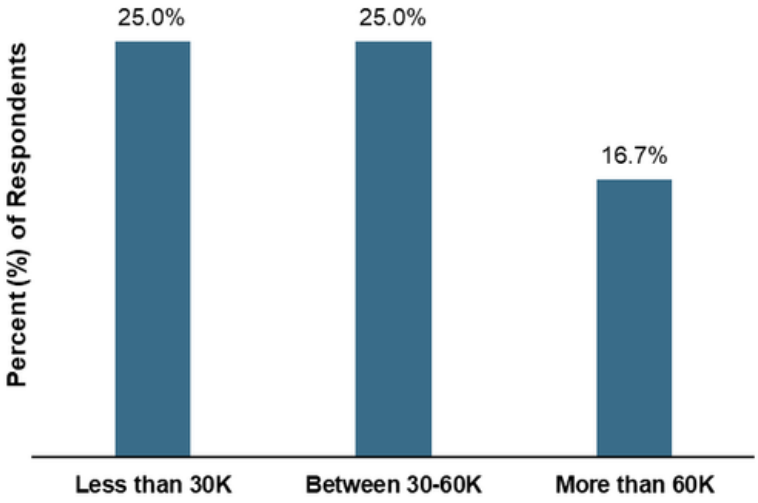

Figure 6. Percentage distribution of respondents by annual household income (N = 12).

Note. Responses categorized as "Prefer not to answer" were excluded from the figure for visualization purposes.

Qualitative Findings

A. BETTER for All Program Participants (n=3)

1. Structural and Social Barriers to Participation

Respondents identified multiple structural and socioeconomic barriers that constrained engagement in the BFA program. Competing demands related to employment, income insecurity, and family responsibilities were frequently cited as limiting sustained participation, with one respondent noting:

"this [BFA program] is challenging, because I need to survive in my family, too... I need job... this program is not, like, stable, huh? So, yeah, so I think this is challenging for me."

Language barriers, particularly for newcomers and older adults, were consistently noted as challenges that would affect both comprehension of program materials and confidence in communication. Respondents (n=2) emphasized the need for multilingual outreach strategies, including translated materials and community-based dissemination:

"If [there] are programs or flyers or something, many, many languages. And we can post it, our common boards, our community, common boards, or our handbook and mouth-to-mouth. It's good, and they can learn, they can read."

Additional barriers included transportation challenges, reliance on external transit supports, and seasonal or weather-related constraints such as winter travel and illness, all of which further disrupted consistent participation.

2. Community-Driven Motivation and Engagement Pathways

Despite these barriers, all respondents consistently described strong community-oriented motivations for participation. Many viewed the program as an opportunity to support others through health knowledge sharing and to strengthen awareness of chronic disease prevention and cancer screening within their communities. One respondent explained:

"if I join this program, if someone, and if I, like, insist to community to join this program, I think it will very benefit it for them as well. So that's why I decided to join this program."

Motivation was further reinforced through personal or observed experiences of illness within social networks. Respondents also emphasized the importance of accessible clinical support and trusted information, particularly in contexts where navigating the healthcare system can be complex, noting that, *"we have a doctor, we have a practitioner, but sometimes when it's not easy to access and easy to gather all information".*

3. Sustainability Requirements and System-Level Gaps
Respondents emphasized that sustainability requires continued access to education, resources, and structured follow-up beyond initial program engagement. Ongoing learning related to chronic disease prevention and management was identified as a central need:

"Also, more knowledge. More, like, the knowledge… knowledge means, like, yeah, I'm controlling this, sugar level and this level, then, then next, what next? We need to provide this, this information too."

Practical supports for chronic disease management were also identified as critical, particularly for diabetes care, where affordability constraints limited adherence:

"Diabetic strip, which strip, and they have the machine, but strip, they are not… they are not getting easily. And it is a little bit… Expensive, too. So, if this program provides, strip to the patient, it would… it would be helpful for them."

Broader socioeconomic constraints, including food insecurity and financial pressure, were repeatedly identified as key determinants of sustained participation, reinforcing the importance of integrating social needs within preventive programming. In terms of outreach, multilingual flyers were consistently identified as the most effective and trusted method of program awareness (n=2). Respondents (n=3) also recommended extending follow-up beyond six months, with some suggesting up to one year to strengthen continuity of care and engagement.

4. Program Experience and Perceived Value
Overall, BFA beneficiaries (n=3) described the BFA program as culturally responsive, respectful, and supportive. Many reported ongoing learning and improved understanding of chronic disease prevention and management, with repeated engagement reinforcing knowledge acquisition over time. One Respondent explained: *"When we attend more and more, we get more information, right?"* and *"found, new information all the time."*

The one-on-one model was particularly valued for enabling individualized discussion, tailored health guidance, and collaborative goal setting. BFA participants reported meaningful lifestyle changes, particularly related to diet and chronic disease self-management, supported by interaction with Prevention Practitioners. One respondent reflected:

"After joining this program, then I got a practitioner, because I recently diagnosed with diabetes so that, nurses also guide me, like, yes, this kind of thing, you can reduce…for that reason, so now I am just very conscious about my food habit. This is the first step."

Flexibility in scheduling and geographic accessibility were also key facilitators of participation. One respondent further noted that the proximity of the BFA program location facilitated engagement, describing it as "*easy to participate*" and "v*ery comfortable*," given its placement at Access Point on Danforth (see Appendix C, Table C1 for a summary of findings).

B. **<u>Community Members</u> (n=10)**

1. Structural and Social Barriers to Participation

Community members from BFA participating sites identified several structural barriers to participation, including employment demands, financial pressures, caregiving responsibilities, transportation challenges, and scheduling constraints. Respondents emphasized the need for flexible program delivery to accommodate competing work, school, and family priorities. Digital accessibility and preferences for virtual versus in-person participation also emerged as important considerations. One community member explained:

"My health coordination and accessibility will be the key part. I mean, traveling is a crucial barrier for me...transportation and, yeah, going to and from sessions. And then accessibility in terms of whether things are online versus kind of in person."

Stigma surrounding cancer screening and chronic disease prevention was identified as a significant barrier, particularly within newcomer and immigrant communities. Respondents described discomfort and hesitancy in discussing topics related to cancer screening, alongside concerns regarding privacy and confidentiality:

"...and they [the community] are really confused about the confidentiality part. This is our body. So, breast is part of the body, okay? Many things happen, because we're getting older, we are 40+, so, you have to be screened. So, they are a little bit kind of shy."

Confusion regarding key components of the BFA program also persisted within communities, particularly surrounding the purpose of prevention visits, and one-on-one sessions. Community members emphasized the importance of clearly communicating the confidential and individualized nature of the program to build trust and improve engagement within communities.

2. Health Needs and Perceived Gaps in Support

Respondents discussed a range of health concerns, with particular emphasis on nutrition, chronic disease prevention, and access to ongoing health guidance. Some community members described receiving recommendations from primary care providers or physical assessments, but emphasized that managing chronic conditions required sustained lifestyle changes beyond medication alone. One respondent explained:

"Only eating medicine is not a solution, so you have to get a proper meal, so where you can... someone, you know, as a mom, as a working woman"

Most community members reported relying primarily on self-directed approaches, including mobile applications, trackers, and personal motivation, to manage their health goals, while others described challenges navigating primary care and specialist services. Several respondents (n=3) viewed the BFA program as a valuable source of consistent and accessible support:

"*So when I heard about this program, I think that is a very important aspect of our life, because I can feel how it is impacting my day-to-day activity. Right? From eating, to going to sleep, to cooking...we really, really need to work on.*"

One respondent referenced previous involvement in a similar chronic disease prevention program offered through a community health centre, while others emphasized the difficulty of obtaining ongoing preventive care and continuity within conventional healthcare systems. Overall, the BFA program was perceived as addressing important gaps in care through individualized guidance, education, and ongoing support.

3. Facilitators of Engagement and Program Relevance

Community connection and collective responsibility emerged as important motivators for participation. Respondents recognized the growing burden of chronic disease and cancer within their communities and viewed the BFA program as an opportunity to improve community health awareness and prevention practices. Many expressed a strong sense of responsibility to share information about the program and encourage participation among others in their communities, particularly women and older adults perceived to be more vulnerable. One respondent reflected:

"I also know that the lung cancer is also has a high risk, as well as my back home, and also in my community. So, I think it will really, you know, satisfy our community's goal set up in a sense that if people, my community people come through this program."

Respondents (n=6) further emphasized the value of Peer Health Coaches and Prevention Practitioners, particularly the individualized and relationship-based nature of one-on-one sessions. These interactions were perceived as increasing comfort, accountability, and motivation to pursue health goals. As one respondent explained: *"That's actually the main crucial piece, that education one, and this I mean, session, that personal interaction, that opportunity to get that session, to get the program customized"*

Community members considered the program relevant to both personal and community health needs, particularly in relation to chronic disease prevention. Family history and previous experiences with illness further reinforced the importance of participation.

4. Outreach and Community Engagement Strategies

Respondents identified several approaches to strengthen awareness and community engagement within the BFA program. Flyers, community events, and community health ambassadors were most frequently identified as effective outreach strategies (n=7). Many emphasized the importance of placing promotional materials within trusted and frequently accessed community spaces:

"If there is any flyer on the community center, on the notice board, so they will reach out, and they will know, while doing all the workshop, okay, these programs provide."

Others suggested expanding outreach to schools, grocery stores, libraries and community gatherings: *"So, what we can do, we can target, community meetings, schools, grocery stores, put flyers there where they're [community members] mostly going.*"

Community health ambassadors were viewed as particularly valuable due to their linguistic abilities, cultural familiarity, and existing trust within communities:

"Another is, like for the community health ambassadors that are working at Access Alliance, they're speaking different languages, right? So we can assign a worker with specific language, with a specific community you know."

respondents also highlighted workshops, videos, social media platforms such as WhatsApp, word-of-mouth promotion, and outreach through religious and community gatherings as additional mechanisms to improve visibility and engagement. The findings highlighted the importance of culturally responsive, community-based outreach approaches in sustaining participation among underserved populations.

5. Language Accessibility and Communication

Language emerged as a central factor influencing access to and understanding of the BFA program. Respondents (n=6) emphasized the need for translated materials, interpreters, and multilingual community ambassadors to support effective communication with newcomer and immigrant populations. One respondent stated:

"In the flyer, in all the language, you know, in all different languages, if it's available, so it might be useful for the community member."

Respondents observed that many community members, particularly newcomers, experienced difficulties understanding English-language health information. They emphasized the linguistic diversity of the communities being served. Community members frequently described acting as informal translators within their communities to help others understand program information and avoid misinformation. One respondent recalled translating information during a BFA information session where Arabic materials were unavailable: *"I distribute it to them, and also I give information they were talking in Arabic, and I find one English speaker, I translate it, like, I give information in English, then they translated in Arabic to all the participants."*

Beyond translation needs, respondents emphasized that medical terminology and technical language created additional barriers to comprehension (see Appendix C, Table C2 for a summary of the findings). Simpler, more accessible language was preferred when discussing chronic disease prevention and cancer screening, with respondents recommending "*...instead of using the medical terminology, if they give a general sense about the... about the preventive disease or the cancer screening, as well...*" and "*Use the general term instead of using the medical jargon.*"

C. Prevention Practitioners (n=8)

1. Structural and Client-Level Barriers to Engagement

Respondents (n=7) described multiple structural and social barriers affecting client engagement in the BFA program. While clients were often advised to adopt healthier dietary practices, practitioners noted that this was frequently unfeasible in the context of food insecurity and limited financial resources. One client, for example, expressed willingness to modify their diet but was unable to afford adequate food. Competing priorities, including employment, volunteering, and caregiving responsibilities, further limited clients' ability to attend scheduled appointments. Transportation barriers also compounded access challenges.

"Clients still face other barriers including social determinants such as high food costs and transportation."

Prevention Practitioners also highlighted limited digital access, with some clients lacking internet or computer access, which restricted program participation. In addition, practitioners reported low client uptake and retention (n=5), alongside incomplete survey follow-up, which further affected program completion rates. As one respondent noted, *"we have... I think we have enough clients here, it's just the... the availability of the client to actually come".*

Another respondent reflected on declining engagement after initial interest, explaining that although clients often expressed enthusiasm at first, follow-up participation was more difficult to sustain: *"when we're explaining the study... initially they're like, yes, yes, that's great... but then we will follow up with them, and then they'll say, actually, no, I'm not down for the peer-to-peer kind of interaction in the community... they've got lots of focus on other things."*

2. Operational and Administrative Barriers

Although some respondents felt appointment time allocation was sufficient, most (n=8) reported time constraints that limited the depth of client interaction. Appointments were often described as extending beyond scheduled time, particularly when language interpretation or complex explanations were required.

"The thing is, if they're coming by appointment, it is a long process...So, having to jump from one to the other, and there's not enough time, you have to think about a patient's, their language"

Prevention practitioners also noted that sessions required significant pre-visit preparation and in-visit support, contributing to workload strain. Administrative burden, particularly related to paperwork and intake processes, was frequently cited as inefficient and overly complex. One respondent summarized the cumulative impact of competing demands:

"Better For All is just one thing that we're trying to juggle right now, and still trying to maintain patient care."

Other barriers included short staffing, high staff turnover, and challenges related to management capacity. Program managers, including middle management and supervisors, were described as providing limited support to respondents and insufficient oversight in the delivery of the BFA program. In addition, inadequate administrative assistance for tasks such as consent distribution and survey management resulted in additional workload being absorbed by Prevention Practitioners.

3. Equity and Cultural Responsiveness

Prevention Practitioners (n=2) described adapting their practice to reflect cultural responsiveness, emphasizing individualized approaches over standardized frameworks. One respondent noted limitations in applying dietary assessment tools that were not culturally inclusive:

"Part of the assessment is based on the Medi diet score, the Mediterranean diet score, and I find that that, although can be helpful for some, isn't always culturally accessible or appropriate for each patient"

Respondents also described referring clients to culturally appropriate food resources when available. While some materials were translated, others (n = 5) reported ongoing language gaps and recommended expanding translation coverage to include consent forms and handouts. One respondent highlighted the need for additional translations, including Portuguese, Amharic, and other languages not currently available within the BFA program.

"At least the consent form, because I think they need to understand it from their own language, what they really are signing, instead of me explaining it to them."

Beyond translation, respondents emphasized that medical terminology itself created comprehension barriers and recommended the use of simplified, plain-language communication in program delivery.

4. Program Effectiveness and Value

Despite implementation challenges, Prevention Practitioners consistently described the BFA program as valuable and aligned with their professional roles. The program was seen as enhancing preventive care capacity and supporting client empowerment.

"*I'm helping out clients…letting them see a bigger picture about their care, and letting them, you know, take charge of their own health*"

In-person, one-on-one sessions were identified as particularly effective for building trust and supporting collaborative goal setting through tools such as the bubble diagram. Respondents also highlighted strong alignment between the program and organizational mandates focused on equitable, preventive care.

Motivational interviewing was highlighted as a key strength of the training model and a skill transferable beyond the program context. Role-play components, in particular, supported practitioners in adopting a client-centered approach that positioned individuals as "the expert of their care."

"*It was pretty unique in that, and that, like, because there's the motivational interviewing… it's a time where I can actually practice it. And I also… it makes me wonder how, like, I could do it better in my other work.*"

5. Sustainability Considerations

Respondents identified several priorities for sustaining the program long term. These included expanding eligibility criteria to include younger populations, extending follow-up beyond six months in efforts to sustain outreach and engagement. Furthermore, improving onboarding processes for clients through simplified and more accessible digital forms. Additional resources were also recommended to broaden behavioural support beyond nutrition alone:

"If we can have more resources, like, for example, physical activity, that would be nice.., because there's people that want to do more… So, it wasn't enough."

While Peer Health Coaches were viewed as valuable for ongoing support and motivation, concerns were raised regarding the sustainability of a volunteer-based model. Integration of BFA into Family Health Teams was repeatedly suggested as a pathway to strengthen continuity, reduce workload pressures, and embed preventive care into routine practice.

"I do think that it would be helpful to integrate Better For All, into family health teams in the long term… taking off some of the workload from nurse practitioners and doctors in terms of reminders with cancer screening, and also, if you're getting dietitians on board, you have that piece where, you know, you can discuss nutrition in a little bit more depth."

Respondents generally described the training and resource materials as comprehensive and practical; however, they emphasized the need for ongoing refresher training, continuous access to updated materials, and more structured implementation support. Internal communication regarding program updates varied across sites, with some organizations relying on weekly team meetings, while others depended on a designated BFA representative to provide regular check-ins. Key learnings, including challenges related to patient access, were also disseminated informally through peer discussions and one-on-one collaboration. In addition, drop-in sessions led by BFA staff were identified as an effective and valued mechanism for sustained support and knowledge exchange (see Appendix C, Table C3 for a summary of the findings).

D. Site Administration Perspectives (n=3)

1. Implementation Barriers and Operational Strain

Site administrators consistently described the BFA program as resource intensive, with significant operational demands. Key challenges included administrative burden, repetitive documentation, limited staffing, and high staff turnover. These constraints were compounded by competing priorities within community health centres, where core clinical services often take precedence over program delivery. As one respondent noted:

"Having to do our programming stuff and then adding this on made it really hard when we didn't have the admin support. Right? And so, the admin support should have come in, in the beginning, I think in the training as well."

Administrators also reported implementation difficulties related to client engagement. Low uptake, limited follow up, and barriers to retention were particularly pronounced among newcomer and immigrant populations, who also face intersecting challenges related to language, digital access, and system navigation.

2. Equity, Inclusion, and Cultural Responsiveness

Site administrators identified important gaps in equity and inclusion within program materials and training. Several noted that current documentation does not adequately reflect gender diversity, limiting inclusivity for transgender and gender-diverse populations. One respondent noted: *"I did raise this before, but the documentation, the material isn't really designed for people who may be gender diverse."*

Cultural responsiveness was also highlighted as an ongoing area for improvement. Respondents emphasized that dietary guidance and health recommendations must be adaptable to diverse cultural contexts rather than assuming a standardized model.

"...what constitutes a certain kind of diet is going to be very different... depending on particular communities or celebrations... what might make sense for those communities might be different than what's there."

3. Program Alignment and Added Value

Despite operational challenges, site administrators described strong alignment between BFA and organizational mandates within community health centres. The program was viewed as complementary to existing chronic disease prevention initiatives, such as the Open Door program at Access Alliance, and was described by one respondent as going “hand in hand”. Site administrators also reported increased provider capacity for prevention planning and a strengthened commitment to the program..

“*The idea itself is… aligns with our goals and what we are trying to accomplish here. So that was the thing that we liked about the idea of Better For All here.*”

Some respondents highlighted issues of isolation experienced within the community, particularly among senior and older adult populations. This emerged as an unintended but important outcome, as respondents observed that the program facilitated ongoing communication through calls and check-ins, helping to foster connection. This was reflected in the following quote:

“…people who are quite isolated or experiencing loneliness… that is another benefit that we saw as a team to the program. Just another person to check in, to provide some motivation, to provide some support.”

Overall, the program was perceived as strengthening prevention capacity while also supporting relational continuity of care.

4. Sustainability, Integration, and System Embedding

Sustainability emerged as a central concern, with funding instability identified as a primary limitation. Respondents suggested that long-term viability could be strengthened through partnerships with funders and academic institutions, alongside integration into existing primary care structures.

“*So, I think those partnerships with funders and academic institutions would support the ongoing life of the program, but also making sure that it's up to date.”*

Administrators also recommended embedding BFA within family health teams to improve referral pathways, streamline delivery, and enhance continuity. Expanding eligibility criteria, particularly for older adults and additional chronic conditions, was also proposed to improve reach and recruitment. In addition, outreach beyond primary care settings was viewed as equally important, particularly for engaging individuals not currently attached to providers. Community-based promotion through events and outreach activities was identified as a key strategy for improving visibility.

Respondents also suggested extending engagement beyond the initial six-month period to support continuity for clients requiring ongoing support:

"Having the variation, having the flexibility, and then if there was sustainability, maybe some kind of future touchpoint for some folks that had a little bit more going on or needed a bit more support".

Finally, respondents noted that formal program evaluation is currently limited, and emphasized the importance of systematic assessment to determine effectiveness and inform future scale-up. A participated noted: "*...but I would really like to see the evaluation of this program to know whether it is effective, and makes a difference."* (see Appendix C, Table C4 for a summary of the findings)

<u>E. Peer Health Coaches</u> (n=4)

1. Implementation Barriers and Digital Platform Limitations

Peer Health Coaches described several operational barriers, particularly related to low client uptake, limited follow-up, and challenges establishing initial contact. Most respondents had engaged with only one client, and maintaining ongoing communication was frequently difficult.

"And also sometimes another challenge is would be there are some patients, as are clients, I would say, which are very hard to reach out... sometimes it's very hard to reach out to them."

The NexJ platform was identified as a key tool for client communication; however, respondents reported usability challenges. It was described as "*not as user-friendly*" as expected, with frequent logins and limited ease of navigation creating additional workload and reducing efficiency.

2. Training Support, Motivation, and Role Engagement

Peer Health Coaches described strong institutional support from CCS staff, particularly during training and early implementation. Regular check-ins and responsive communication were viewed as important enablers of confidence and role clarity. There was also positive feedback on leadership and organizational layout within the team.

"I really appreciated... [CCS Staff] did, like, a check-in with me, which I thought was helpful. Like, it's nice to feel support, from the team."

Peer Health Coaches were primarily students, with flexible roles that aligned well with their academic backgrounds. Motivation to participate was shaped by personal interests in research, prior exposure to health coaching, and family experiences with cancer. Many also emphasized community connection as a key driver of engagement.

"*I think, like, the main reason why I sought out being a PHC was honestly just, like, getting more connected with community*."

3. Equity, Cultural Responsiveness, and Client-Centered Practice
Cultural humility emerged as an important aspect of peer health coaching practice, particularly in adapting to client needs and language preferences. Some respondents described direct involvement in supporting translation or interpretation of materials.

"*I have access to all his notes, and… I could even… translate his health documents, which I thought was really cool."*

These experiences highlighted the importance of flexible, culturally responsive approaches to communication and care delivery.

4. Sustainability, Flexibility, and Program Adaptation
Respondents emphasized that sustainability depends on maintaining relational, flexible, and person-centered approaches. Community connection was identified as an important component to sustain, with in-person sessions offered in both one-on-one and group formats viewed as valuable for client engagement and support. Motivational interviewing was consistently identified as a core training component that supported structured, goal-oriented conversations and enhanced coaching confidence.

"I think, you know, it's the motivational interviewing… it just is so good… helping to focus all of the sessions… how to communicate with the participant is… so helpful."

Client experiences further reinforced the importance of flexibility in goal setting. One respondent described adapting a prescribed activity plan to better align with client preferences:

"I don't want to lift weights. I kind of want to switch it to yoga. Is there anything you can do about that? I was like, okay, for sure."

This adaptability was viewed as essential to supporting engagement, autonomy, and long-term participation in health-promoting behaviours. Peer Health Coaches also suggested that the program may be particularly well suited to supporting older male populations, offering a flexible and non-intimidating entry point into structured health behaviour change. The program's relational and adaptable design was seen as a key strength for expanding reach and sustaining engagement over time (see Appendix C, Table C5 for a summary of the findings).

Discussion

Findings across all stakeholder groups including community members, Prevention Practitioners, Peer Health Coaches and site administrators demonstrate that the BFA program represents a promising model for equity oriented chronic disease prevention and cancer screening support. Across qualitative findings, the program was consistently described as responsive to community needs through its culturally responsive, relational, and person centered approach. However, results also highlight that sustainability is contingent not only on program acceptability but on the alignment of structural conditions, system integration, and organizational capacity required to support long term implementation.

A key cross cutting finding was the centrality of culturally responsive and person centered care as a driver of engagement and perceived program value. Across stakeholder groups, respondents emphasized that the BFA model is particularly relevant for newcomer and immigrant populations because it provides individualized support within a trusting and non judgemental environment. Prevention Practitioners and Peer Health Coaches reinforced the importance of adapting recommendations to cultural context, health beliefs, and lived realities rather than applying standardized behavioural prescriptions. CCS staff further supported this through intentional diversification of staffing and language capacity, reinforcing the program's embedded equity orientation. These findings align across data sources and suggest that cultural responsiveness is not an adjunct feature but a core mechanism through which engagement and trust are generated, consistent with evidence on equity focused preventive interventions [17].

Language accessibility emerged as a structural determinant of program effectiveness and sustainability. All stakeholder groups identified language barriers, limited translation capacity, and reliance on informal interpretation as persistent challenges. Findings together indicate that newcomer populations face compounded barriers related to health literacy, particularly in relation to cancer screening and chronic disease prevention. respondents further highlighted that the use of simplified language and reduced medical jargon would improve comprehension and trust. The consistency of these findings across stakeholder groups strengthens the conclusion that sustainability cannot be achieved through translation alone. Rather, it requires systematic integration of health literacy principles, simplified communication strategies, and multilingual infrastructure embedded across all stages of program delivery, including outreach, intake, and follow up.

Community trust and outreach infrastructure emerged as essential components of sustainable implementation. Community members consistently described informal networks as primary channels of program awareness, a finding corroborated by Prevention Practitioners and CCS staff, who noted that trusted community messengers are often the main conduit through which individuals learn about available programs and services. Community health ambassadors were repeatedly identified as a key

mechanism for improving reach, credibility, and engagement among underserved populations. This convergence across stakeholder groups underscores trust as a central implementation mechanism linking cultural concordance with uptake and sustained participation. These findings align with prior evidence demonstrating the effectiveness of community ambassador models in improving engagement and preventive health uptake in marginalized populations [18] and reinforce relational trust as a determinant of intervention success [19]. Importantly, this positions outreach strategies as core program infrastructure rather than supplementary activities. CCS BETTER for All (BFA) team emphasized that programs serving racialized, newcomer, and immigrant populations must ensure representation that reflects the communities they aim to engage. In this context, community health ambassadors and community champions strengthen culturally grounded communication and relational ties between the program and respondents. Through shared language, cultural understanding, and lived experience, ambassadors can foster trust and enhance engagement beyond conventional outreach approaches. Accordingly, integrating community health ambassadors into outreach infrastructure may strengthen the accessibility, credibility, and sustainability of the BFA program.

Despite these strengths, findings consistently demonstrate that BFA operates within broader structural constraints that limit its sustainability without adaptation. Across stakeholder groups, socioeconomic barriers including food insecurity, transportation costs, caregiving responsibilities, and precarious employment were identified as primary determinants of participation and adherence. These findings were reinforced by quantitative demographic data indicating that a substantial proportion of respondents reported low income (see Appendix B), including both the number of dependents reported by respondents and income levels, with 50% of BFA clients and community members who completed the questionnaire reporting an annual income below $60,000, with over 60% supporting 2 or more dependents, suggesting that many respondents may be experiencing low-income circumstances or be in a low-income household [20]. Together, these indicators highlight the need for embedded social supports within the program to address the intersecting financial and caregiving demands faced by respondents. Collectively, the findings indicate that CDPM behaviours cannot be separated from material and structural conditions. Without integrated social supports such as transportation assistance, food security interventions, and stronger referral pathways to community resources, the program risks placing behavioural responsibility on populations facing structural disadvantage.

Operational and system-level constraints further challenge the long-term sustainability of the BETTER model. The absence of the BETTER Institute limits opportunities for ongoing training, certification renewal, and professional development for Prevention Practitioners. Current Prevention Practitioner certifications are expected to expire in 2027 due to the lack of updated and reviewed resources, which may significantly affect the long-term sustainability and fidelity of the BETTER model as currently designed. These findings highlight the need to identify alternative training and certification pathways to support the continued development and sustainability of the prevention

practitioner workforce. In addition sustaining the program requires substantial volunteer management capacity, including the recruitment, screening, training, supervision, and ongoing monitoring of volunteer Peer Health Coaches. Limited PHC capacity may therefore present a significant barrier to the long-term sustainability and scalability of the BFA program. Given that volunteer management for such programs no longer aligns with CCS organizational priorities, findings further suggest the need to identify alternative organizational partners or community-based agencies with the capacity to support volunteer coordination, training, engagement, and oversight.

Prevention Practitioners and site administrators consistently described the program as administratively burdensome, resource intensive, and difficult to sustain within existing workloads. The CCS team members similarly highlighted the complexity of the implementation pathway, including multiple sequential steps from intake to peer health coaching, which contributed to workflow inefficiencies. Across stakeholder groups, challenges related to low uptake, participant retention, and incomplete follow-up were frequently attributed to administrative burden, staffing shortages, limited support capacity, and high staff turnover. These findings suggest that sustainability is not solely dependent on program effectiveness, but also on the capacity of host organizations to absorb and maintain implementation demands over time. As such, streamlining workflows, reducing duplication in documentation, and strengthening administrative infrastructure may be essential to improving long-term sustainability and scalability.

Within this context, integration into primary care and Family Health Teams emerged as a key systems level strategy for sustainability. Stakeholders consistently viewed BFA as aligned with chronic disease prevention mandates and complementary to existing clinical services. Embedding the program within primary care structures may reduce fragmentation in care pathways while improving continuity, referral efficiency, and follow up consistency [21]. Importantly, integration also offers a pathway to sustainability through alignment with established funding models, staffing structures, and health system accountability mechanisms, thereby shifting the program from an externally supported initiative to an embedded component of routine preventive care.

Finally, across stakeholder groups, the relational and flexible design of the BFA program was consistently identified as one of its strongest assets. The Peer Health Coach model, motivational interviewing approach, and individualized goal setting were widely perceived as enhancing engagement, empowerment, and accountability. However, sustaining these relational benefits requires continued investment in training, ongoing implementation support, and structured knowledge translation mechanisms within and across sites. While respondents described the program as highly promising, the absence of robust, standardized evaluation mechanisms was noted as a limitation. Strengthening evaluation capacity is therefore critical not only for demonstrating effectiveness but also for enabling iterative refinement, accountability, and informed scale up decisions.

Overall, the convergent findings indicate that BFA addresses an important gap in equitable chronic disease prevention and cancer screening support for newcomer and immigrant populations. Its effectiveness is grounded in culturally responsive, relational, and flexible care delivery. However, sustainability depends on addressing structural barriers, strengthening organizational and administrative capacity, embedding health literacy and multilingual infrastructure, and integrating the program within primary care systems. In addition, sustained cross-site collaboration and shared commitment across participating organizations will be critical to ensuring ongoing implementation and effectiveness. This requires continued coordination between organizational leadership, clinical teams, and administrative staff to fully integrate the BFA program into routine practice and support long-term sustainability.

Recommendations

The following recommendations are proposed to strengthen the long-term sustainability, scalability, and equity impact of the BFA program.

1. Outreach, Engagement, and Community Partnerships

A community health ambassador model should be implemented to strengthen outreach through trusted, trained community members embedded in existing networks such as settlement agencies, faith groups, and cultural organizations. This should include training, supervision, and compensation to ensure sustainability. Outreach strategies should also expand beyond flyers to include multilingual, co-designed approaches such as community events, storytelling, and digital platforms.

2. Program Design and Workflow Integration

To enhance sustainability, BFA processes should be more fully integrated into primary care and Family Health Team workflows. Administrative tasks such as intake, consent, and documentation should be streamlined to reduce duplication and staff burden. Structured follow-up beyond the initial six-month period should be introduced through low-intensity check-ins delivered by Peer Health Coaches or digital supports. A tiered engagement model may also improve scalability by matching level of support to participant needs while maintaining continuity of care.

3. Language Access and Health Literacy

All core materials, including consent forms and intake tools, should be translated into priority languages, supported by interpreter services and bilingual staff where possible. Materials should follow plain-language principles to reduce medical jargon. Digital tools such as NexJ should be improved for usability and multilingual access, supported by a basic health literacy review process to ensure clarity.

4. Equity, Inclusion, and Cultural Responsiveness

All program documentation, intake processes, and clinical and health promotion tools should be revised to ensure gender diversity, 2SLGBTQIA+ inclusion, and cultural relevance across diverse populations. This includes adapting frameworks such as dietary assessments to better reflect a range of cultural food practices beyond Western-centric models. Staff and volunteers should receive training in cultural humility, gender inclusivity, and anti-oppressive practice through applied, case-based learning. Ongoing co-design with community members and targeted engagement with underrepresented populations are essential to ensure materials and delivery are inclusive and reflective of diverse lived experiences.

5. Training and Implementation Support

Motivational interviewing should remain a core training component, supported by regular refresher sessions to maintain skills and program fidelity. Prevention Practitioners emphasized the need for accessible, up-to-date resources when unable to attend live training sessions. A centralized resource hub should be developed to provide up-to-date tools, templates, and guidance for staff. Ongoing implementation support, including structured check-ins and troubleshooting, is also necessary. Further, alternate training models for Prevention Practitioner certification must be in place to support sustainability.

6. Addressing Social Determinants of Health

To reduce structural barriers to participation, the program should incorporate practical supports such as transportation assistance and grocery or community resource supports. Flexible service delivery options, including hybrid in-person and virtual models, should be expanded to accommodate competing life demands. Stronger linkage with social services is also recommended, with socioeconomic factors integrated into program design rather than treated as external barriers.

7. System-Level Governance, Evaluation and Funding

Establishing a cross-site governance structure will support coordinated implementation, shared accountability, and standardization of the BFA program. An alternate organization to provide volunteer recruitment, training, supervision, and engagement must also be identified. This should be supplemented by a standardized evaluation framework to monitor reach, uptake, retention, and equity outcomes for continuous improvement. Long-term funding strategies should be developed, including integration into primary care funding models and multi-sectoral partnerships, to ensure sustainability.

Limitations and Strengths

Several limitations should be considered when interpreting the findings of this study. The recruitment and data collection period, conducted between February and March 2026, was relatively brief and contributed to a modest sample size. Recruitment of active BFA clients across participating sites was also challenging due to the limited number of actively engaged and returning participants, potentially reflecting broader issues related to program retention and sustained participant engagement. In addition, approximately 25% of community respondents were below 40 years of age, which may have influenced the perspectives captured regarding aging, chronic disease prevention, and long-term program engagement.

The sample also lacked broader demographic diversity, as most community members were recruited through Access Alliance outreach initiatives, resulting in a predominantly South Asian respondents. Although this reflects the organization's service demographic, it may limit the transferability of findings to other racialized and newcomer communities. To address this limitation, supplementary outreach was conducted across participating sites. Participation from Prevention Practitioners, Peer Health Coaches, and site administrators was also occasionally constrained by competing professional responsibilities; therefore, flexible participation options, including written responses, were offered.

Despite these limitations, the study demonstrates several notable strengths. The use of a multi-stakeholder, 360-degree qualitative approach enabled the inclusion of perspectives from multiple stakeholders, facilitating a nuanced understanding of factors influencing program sustainability. Additionally, the study employed a community-based and culturally responsive research design, incorporating multilingual recruitment materials, flexible interview formats, and community-engaged outreach strategies to support participation from structurally marginalized populations.

Conclusion

This BETTER for All (BFA) Sustainability Project offers an examination of the structural, organizational, and relational conditions required to support the long-term sustainability of the BFA program within primary care and community health systems. The findings indicate that the BFA program is widely regarded as a valuable and contextually relevant model for advancing equity-oriented chronic disease prevention, particularly among newcomer and racialized populations. Its integrated design linking Prevention Practitioners, Peer Health Coaches, and community-based engagement strategies was consistently identified as a key strength in promoting preventive health

behaviours, enhancing cancer screening awareness, and fostering trust in care delivery through culturally responsive approaches.

At the same time, the study identifies significant structural and operational challenges that may limit long-term sustainability if left unaddressed. These include funding uncertainty, workforce capacity constraints, administrative burden, limited integration within existing clinical workflows, and barriers related to language access, digital nclusion, and socioeconomic inequities. Together, these findings underscore that the effectiveness of the BFA model is closely tied not only to its design, but also to the broader health system and community infrastructure in which it is embedded.

Importantly, the study highlights that sustainability requires more than continuation of program activities; it depends on institutional integration, stable resourcing, and sustained partnerships across clinical, community, and policy sectors. Strengthening these elements is essential to preserving the relational and equity-oriented components that underpin the program's success. In the absence of such systemic investments, there is a risk that demonstrated gains in preventive engagement, trust-building, and cancer screening uptake among underserved populations may not be maintained over time. Conversely, coordinated action across public health authorities, funders, and delivery partners can enable the BFA model to transition from a time-limited intervention into a durable component of equity-focused preventive care infrastructure. With these conditions in place, the BFA program has strong potential to be sustained and meaningfully scaled across diverse primary care and community settings, contributing to more equitable access to chronic disease prevention, improved uptake of preventive services, and strengthened population health outcomes at a systems level.

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Appendix A

Site	Stakeholder	Number of Participants
Access Alliance (College Site) & AccessPoint on Danforth (APOD)	BETTER for All Participants Community Member Prevention Practitioner Site Admin/Support	3 11 5 1
Village Family Health Team	Prevention Practitioner Site Admin/Support	1 1
Davenport Perth Neighbourhood Community Health Centre	Community Member Prevention Practitioner Site Admin/Support	2 1 1
Centre Centre Francophone du Grand Toronto	Site Admin & Prevention Practitioners	1
Taddle Creek Family Health Team	Prevention Practitioner	1
Parkdale Queen West Community Health	Site Admin & Prevention Practitioners	1

Table A1: Distribution of study respondents by BFA sites and stakeholder group.

Note: Parkdale Queen West Community Health Centre withdrew from participation in the BFA program but was included in the study to gather feedback.

Appendix A

BFA Program Participant Interview Questions

1. Can you tell me why you decided to join BETTER for All program?
    a. How did you first hear about the program?
    b. Who or what motivated you to take part?
    c. What made it possible for you to participate? (e.g: location, language, cost, childcare, transportation, schedule)
2. Did you face any challenges when joining or participating in the BETTER for All program?
    a. What were the challenges?
    b. Did you feel comfortable in the program space? Why or why not?
    c. What helped you overcome these challenges?
3. How has being part of the BETTER for All program affected your health or health habits?
    a. Have you changed anything about your eating habits?
    b. Have you gone for more check-ups or screenings?
    c. Did the program increase your knowledge about cancer or chronic disease prevention?
    d. Did the program impact your health goals? If so, can you please elaborate?
4. Which parts of the BETTER for All program have been most helpful or meaningful for you, and what made them so?
    a. Was there a specific activity that stood out?
    b. Did you feel culturally understood and respected?
    c. What parts were less helpful?
5. How has the BETTER for All program affected your family or community, if at all
    a. Do you think this program addresses important health needs in your community? Why?
    b. Have you or members of your community benefited from this program? If so, how?
6. What would enable you to continue participating or to re-engage with the BETTER for All program in the future?
7. What challenges would make it difficult for you or others in your community to continue benefiting from the BETTER for All program in the future?
8. If you could change or improve one thing about the BETTER for All program, what would it be?
9. How could the program better support you or your community even after the current program ends?
10. Is there anything else you think is important for us to understand about how this program could better support you now or in the future?

Appendix A

Community Member Interview Questions

1. What have you heard, if anything, about the BETTER for All (BFA) program?
    a. What are your first through or impressions of the program?
    b. What stood out to you?
2. Based on what you know, how relevant does the BETTER for All program seem to you in reaching your health goals?
    a. And/or our community's needs?
    b. Which parts feel most or least relevant?
3. How are you currently maintaining your health or working toward your health goals (e.g., screening, physical activity, nutrition, preventive care)?
    a. What supports or resources do you rely on, if any?
    b. Have you used any programs, applications or services to help with your health?
4. What challenges do you experience in trying to stay healthy?
    a. Are there any areas where you feel you need more support or guidance?
    b. How do you stay motivated to maintain your health goals
5. If you were to consider participating, what components or features of the BFA program do you think would be most meaningful to you, and why?
6. What challenges currently exist for you that make it difficult for you to participate in the program (e.g. timing, access)?
7. How do people in your community usually learn about health programs or services?
    a. What outreach strategies do you think would work best for raising awareness about the BETTER for ALL program?
    b. Would you consider enrolling in the BETTER for ALL program? Why or why not?
8. Is there anything else you think is important for us to understand about how this program could better support you and your community now or in the future?

Appendix A

Prevention Practitioner/Peer Health Coach Interview Questions

1. What factors currently help or limit your ability to deliver BETTER for ALL consistently over time? (Consider workload, staffing, time, competing priorities, and practical realities.)
2. How well does BETTER for ALL fit into your daily workflow and systems?
    a. Do prevention care practitioners have enough time to complete the visit? (for PP)
    b. Are there adequate referral options (e.g., Cancer Society, Access Alliance, health coaches)? Should these referrals be formal or informal? (for PP)
3. From your perspective, what is the long-term value of BETTER for ALL for your role, your organization, and the communities you serve?
4. What resources, training, or supports would need to be strengthened for you to continue delivering BETTER for ALL effectively in the future?
5. What adaptations are needed to ensure BETTER for ALL remains relevant, accessible, and sustainable for newcomer and racialized communities over time?
6. Which components of BETTER for ALL have been most effective in supporting participants, and why?
    a. Are there elements that could be improved for better engagement, especially for newcomer and racialized communities?
    b. What do you see as the most important factors that will determine whether BETTER for ALL continues successfully in the future?
7. How is program knowledge or lessons learned/updates shared within your team or organization to support continuity if staff change?
8. Is there anything else you would like to share about your experience with BETTER for ALL, or any ideas for how the program could be sustained and improved over time?

Appendix A

Site Administrator Interview Questions

1. Can you describe how the BETTER for ALL program aligns with your organization's priorities and long-term strategy?
2. From your perspective, what value does BETTER for ALL bring to your organization and the communities you serve over the long term?
3. How is sustainability of BETTER for ALL currently being considered in organizational planning, budgeting, or decision-making processes?
    a. What organizational supports are most critical to sustaining BETTER for ALL over time (e.g., funding, staffing, leadership commitment)?
4. What barriers or risks in planning, budgeting, or decision-making could affect the sustainability of BETTER for ALL beyond the current funding period?
5. What changes at the organizational level would be needed to embed BETTER for ALL into routine practice? (Consider processes, policies, staffing, or resources)
6. Are there gaps or unmet needs for newcomer and racialized populations that the program could address more effectively?
7. What strategies would help ensure BETTER for ALL remains accessible and sustainable for equity-deserving populations?
8. How do your partnerships with other organizations, funders, or health authorities influence the program's sustainability?
9. How is the impact and effectiveness of BETTER for ALL currently measured within the organization?
10. Is there anything else you would like to share about your experience with BETTER for ALL, or any ideas for how the program could be sustained and improved over time?

Appendix A

Figure A1. Participant recruitment flyer.

Note: The flyer was distributed in seven languages; only the English version is included here for visualization purposes.

Appendix B

Demographic Indicator	Category	Percent	n-Value
Gender	Female Male	75.0 25.0	9 3
Age	25-34 35-44 45-54	25.0 41.7 33.3	3 5 4
Racial/Ethnic Group	Asian – South Middle Eastern Mixed Hertiage Prefer Not to Answer	75.0 8.3 8.3 8.3	9 1 1 1
Length of Stay in Canada	1 – 3 Years 4 – 10 Years More than 10 Years	36.4 36.4 27.3	4 4 3
Preferred Spoken Language	English Bengali Dari	75.0 16.7 8.3	9 2 1
Level of Income	Less than 30K Between 30-60K More than 60K Prefer Not to Answer	25.0 25.0 16.7 33.3	3 3 2 4
Number of Dependents	1 2-4 5-10 Prefer Not to Answer	8.3 58.3 8.3 25.0	1 7 1 3
Sexual Orientation	Heterosexual Prefer Not to Answer	75.0 25.0	9 3

Table B1: The demographic profile of the resps.

Appendix C

	Themes	Key Takeaways
BFA Program Participants	Barriers to Access and Participation	• Socioeconomic needs, transportation, weather
	Facilitators to Access and Participation	• Opportunity to share and inform the community and themselves
	Program Experience	• Respected, understood, comfortable, and easy to participate
	Sustainability	• Education of chronic disease management, socioeconomic supports (ie. groceries, transportation), • Extension of the BFA program beyond 6 months

Table C1. Summary of key findings from BFA Program Participants (n=3).

	Theme	Key Takeaways
Community Members	Barriers to Participate	• Socioeconomic needs and priorities, timing, transportation, weather, digital, stigma surrounding cancer
	Current Health Needs and Support	• Desire to focus on food and nutrition goals • Experiencing challenges with the primary care system • Support with specialist care and medication
	Facilitators to Participate	• Opportunity to share and inform the community and themselves • Value of Peer Health Coaches through one on one sessions • Previous family history of chronic disease/cancer
	Outreach & Engagement	• Flyers, community events, community health ambassadors • Door to door knocking and word of mouth • Social/religious/local gatherings, social media
	Language	• Availability and accessibility of translations, interpreters, and material in diverse languages • Use of laymen language instead of medical terminology and jargon

Table C2. Summary of key findings from community members across seven sites participating in the Better for All program (n=10).

Appendix C

	Theme	Key Takeaways
Prevention Practitioners	Client Barriers	• Recognition of social determinants of health and socioeconomic needs • Low uptake and retention of clients
	Operational & Administrative Barriers	• Not enough time for sessions • Overburden of paperwork and workload • Lack of oversight and support by management staff
	Equity & Diversity	• Cultural competency and appropriateness incorporated in recommendations • Increase availability of translated materials • Use of laymen language instead of medical terminology and jargon
	Program Effectiveness & Value	• High value and benefit from the program for clients and community • Motivational Interviewing described as supportive and a transferable skill
	Sustainability	• Expansion of age criteria • Extension of the BFA program beyond 6 months • Feasibility of Peer Health Coaches • Integration of BFA program into family health teams • Refresher of training and knowledge

Table C3. Summary of key findings from Prevention Practitioners (n=8).

Appendix C

	Theme	Key Takeaways
Site Administrators	Barriers	• High resource and commitment • Overburden of paperwork and workload • Client: Low uptake and retention of clients
	Equity & Diversity	• Lack of gender diverse training and material (current forms do not include transgender groups)
	Program Alignment	• Increased capacity for prevention planning for providers • Reducing isolation as a positive unintended outcome of the program
	Sustainability	• Concerns surrounding funding • Expansion of age criteria and other chronic conditions • Integration of BFA program into family health teams ◦ Clients can be referred to the program by their provider • Extension of the BFA program beyond 6 months

Table C4. Summary of key findings from site administrators (n=3).

	Theme	Key Takeaways
Peer Health Coaches	Barriers	• Low uptake and retention of clients • Challenges using NextJ platform
	Facilitators	• Previous family history of chronic disease/cancer • Connection to community
	Equity & Diversity	• Cultural humility and consideration • Meeting language needs
	Sustainability	• Diverse format of sessions: group and one on one • In person sessions • Continuation of motivational interviewing • Refresher of training and knowledge • Flexibility of health goals and person centered care • Support for older male populations with chronic disease/cancer

Table C5. Summary of key findings from Peer Health Coaches (n=4).