COVID PERIOD 2021 – 2024

DIXIE BLOOR NEIGHBOURHOOD CENTRE

COMMUNITY HEALTH AMBASSADOR PROGRAM

Evaluation Report

Informing Program Quality Improvement to Enhance its Adaptation and Sustainability

Prepared by:
Evaluation Team, Family Child Health Initiative, Institute for Better Health, Trillium Health Partners

Trillium Health Partners | Institute for Better Health | Family and Child Health Initiative | DBNC

Mississauga, Ontario, Canada

Land Acknowledgement

We would like to ground this evaluation report by recognizing that the land on which this program takes place is situated in the Region of Peel, Ontario, Canada, which is located within the traditional territory of many First Nations and other Indigenous Peoples. In particular, this is the land of the Haudenosaunee, Huron-Wendat, Seneca, and the Mississaugas of the Credit First Nation. We recognize that this land is still home and will continue to be home to Indigenous Peoples and Nations from across Turtle Island. We also acknowledge the diverse communities who came here as immigrants, as well as those who were forcibly brought here, particularly due to the Trans-Atlantic Slave Trade and other trade practices.

We must recognize the legacies of colonization, racism, exclusion and injustice, as well as the ongoing negative impact on Indigenous families and many other communities in Peel.

Cheltenham Badlands. Copyright: Tom Samworth, Dreamstime.com

To the First Nations, the Credit River ranged from Long Point on Lake Erie to the Rouge River on Lake Ontario. The inhabitants of this land became known as the Credit River First Nation. Their descendants today are the Mississaugas of the Credit First Nation.

Evaluation Team

Dr. Cilia Mejia-Lancheros, (RN, MPH, PhD, Msc.GHP) Evaluator Lead

Dr. Mejia-Lancheros is the Portfolio Research Lead at the Family and Child Health Initiative, Trillium Health Partners, and a CIHR REDI Award Scholar. A senior public health and epidemiology researcher, she examines how social and structural conditions, as well as policy, impact health and social outcomes throughout the life course. Her work uses multi- and mixed-methods to co-design, implement, and evaluate equitable and impactful health and social solutions for diverse communities.

Ms. Elaine Kwee, Evaluation Assistant

Ms. Kwee is an MA candidate in Adult Education and Community Development at the University of Toronto. She has contributed to research on newcomers, dementia, social entrepreneurship, and community well-being. With a background in public relations and media, she brings strong communication skills and a deep understanding of diverse audiences. She is passionate about using research to drive socially meaningful and positive change.

Dr. Dianne M. Fierheller, PhD, Co-Evaluator

Dr. Fierheller is a Scientist and Co-Lead of the Family and Child Health Initiative at Trillium Health Partners. She works closely with diverse community-based organizations and communities in the Region of Peel to co-design and advocate for equitable, inclusive, and culturally responsive health and social solutions for families and individuals.

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Dixie Bloor Neighbourhood Centre: Collaborative Evaluation Team

Ms. Priyanka Sheth, CEO, Dixie Bloor Neighbourhood Centre

Ms. Sheth is an experienced social and community leader and has been the CEO of Dixie Bloor Neighbourhood Centre since the onset of the COVID-19 pandemic. She has played a pivotal role in driving the implementation, delivery, and adaptation of the Centre's Community Health Ambassador Program. Through close collaboration with a diverse workforce and a wide range of community and cross-sectoral stakeholders in Peel and beyond, Ms. Sheth has led efforts to address the intersecting and multidimensional social, financial, and health needs of the diverse local communities served by Dixie Bloor Neighbourhood Centre.

Hameed Shaheer, Project Manager, Dixie Bloor Neighbourhood Centre

Mr. Shaheer is an internationally educated physician with strong expertise in community health and program management. He has been supporting the Community Health Ambassador Program at Dixie Bloor Neighbourhood Centre in her role as Project Manager. In this capacity, he has led and overseen the planning, implementation, and impact of a diverse portfolio of social and health service programs, including the CHA Program—from its initial implementation during the acute response phase of the pandemic to its current adaptation as part of broader community health programming.

Acknowledgements

Funders

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Community participants who contributed to the evaluation data.

We sincerely thank all participants from diverse Peel communities and clients of the Community Health Ambassador Program at Dixie Bloor Neighbourhood Centre for sharing their invaluable experiences with the program's services and providing insights on how it can be further strengthened and sustained. Likewise, we thank the leadership and frontline workforce of the Community Health Ambassador Program at Dixie Bloor Neighbourhood Centre for sharing their expert insights since the program's onset and throughout its ongoing adaptation as a community health initiative, as well as for facilitating access to the program's extensive and diverse administrative data records. All these shared insights have been instrumental in shaping our evaluation project.

Community Health Ambassador Program's workforce and partners.

We would like to extend our deepest gratitude to our dedicated, compassionate, and professional team members who played a vital role in the implementation, delivery, and adaptation of our programs throughout both the acute response phase and the recovery period of the COVID-19 pandemic. Particularly, our colleagues, Jaspreet Kaur, Alaa Sharaf, Lexiao Zheng, Mahamed Amine El Massalkhi.

We also sincerely thank our community members and cross-sectoral partners for their invaluable collaboration in supporting the diverse communities of Peel during the pandemic, throughout its recovery, and in the continued adaptation of our social and health programs to meet the evolving needs of our local communities. Finally, we are deeply grateful to Ontario Health for their ongoing support of our program.

Suggested Citation

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"It is not the unloved who initiate disaffection, but those who cannot love because they love only themselves. It is not the helpless, subject to terror, who initiate terror, but the violent, who with their power create the concrete situation which begets the 'rejects of life.' It is not the tyrannized who initiate despotism, but the tyrants. It is not those whose humanity is denied them who negate humankind, but those who denied that humanity (thus negating their own as well). Force is used not by those who have become weak under the preponderance of the strong, but by the strong who have emasculated them."

— Paulo Freire

Pedagogy of the Oppressed

Foreword: Evaluation Team's Reflections

The COVID-19 pandemic brought unprecedented public health and social challenges worldwide, **exposing, compounding, and deepening multidimensional and intersecting social and health disparities and inequities within and between countries, communities, and individuals.** These inequities, along with the direct impacts of coronavirus infection and the effects of public health measures implemented to contain the virus, were also evident in high-income settings such as Canada, particularly in the Region of Peel.

Peel is one of the most ethno-culturally, religiously, and socioeconomically diverse regions in the country, where more than half of the population comprises immigrant communities. These communities experienced disproportionate morbidity and mortality rates during the pandemic, as well as intensified social, health, and financial constraints that negatively affected their overall well-being. Despite these challenges, community-based agencies such as the Dixie Bloor Neighbourhood Centre stepped up as critical local pandemic responders. Through the Community Health Ambassador Program, Dixie Bloor Neighbourhood Centre adapted its service delivery to meet urgent needs, ultimately evolving the program into a broader community health initiative that provided comprehensive social and health support to local residents, families and communities.

This evaluation of the Ambassador Program reflects Dixie Bloor Neighbourhood Centre's ongoing commitment to building research-informed evidence on the program's implementation, adaptations, and impacts, identifying both facilitating and challenging factors, and gathering collaborative, community-driven recommendations. This will significantly strengthen and sustain the program's role in improving the social and health well-being of diverse communities in Peel.

Dr. Cilia Mejia-Lancheros
Ms. Elaine Kwee
Dr. Dianne M. Fierheller
Dr. Ian Zenlea

Evaluation Summary

Introduction: Dixie Bloor Neighbourhood Centre (DBNC), a Peel-based community organization, participated in the Ontario government's **High Priority Communities Strategy**—an initiative aimed at providing targeted support to communities disproportionately affected by COVID-19 and other health disparities. Through this initiative, DBNC implemented the **Community Health Ambassador (DBNC-CHA) Program**, launched in January 2021, to support community-based pandemic response efforts. The program aimed to address systemic discrimination, racism, and barriers to accessing essential social and health services during the pandemic. This report presents the **evaluation of the impacts of the DBNC CHA Program** during both the **COVID-19 response phase (January 2021 to September 2022)** and the **COVID-19 recovery phase (October 2022 to March 2024)** in the Region of Peel.

Program Impacts: The **DBNC's CHA Program** made a significant contribution to implementing and enhancing a **community-focused and inclusive pandemic response**. The program employed **multimodal strategies** to promote COVID-19 protection, testing, and vaccination, distributed essential personal protective equipment (PPE), and addressed everyday needs, including **food insecurity and transportation**. It also supported the delivery of **wraparound social and health services** for local communities. Overall, the program served **over 58,000 Peel residents during the acute response phase of the pandemic**.

During the recovery phase of the pandemic, the DBNC-CHA program evolved into a more comprehensive community health initiative. It sought to build on the trusted role it had developed within the communities it served during the acute response pandemic phase. As many local community needs remained unmet—either emerging from the direct social and health impacts of the pandemic or due to the exacerbation of existing health and social inequities—the program expanded its service portfolio beyond COVID-19-specific supports.

It has provided and facilitated access to **primary care, preventive care, and health promotion services**, while maintaining a **community-centred, culturally and linguistically sensitive approach**. With **104,429 community residents served** during the recovery phase, the program's continued commitment and impact are undeniable. It has been adapted to meet **existing and emerging health and social needs**, with a particular focus on **underserved and often excluded communities**, including **seniors, newcomer immigrants and refugees, families, and individuals facing economic and language barriers** to accessing services, employment, and educational opportunities.

Recommendations to Strengthen and Sustain the Program: The evaluation presents **community-informed, collaborative recommendations** to enhance the long-term impact and sustainability of the CHA Program. These include:

- **Addressing Structural Challenges.** Tackling root causes, such as **poverty and food insecurity,** is essential, as these are key drivers of many negative social, financial, and health-related outcomes in Peel's communities.
- **Expanding Infrastructure, Access, and Inclusion Supports.** Continued investment is needed to **expand the program's accessibility across Peel**, especially in underserved areas. This includes improving **digital inclusion and literacy**, as digital platforms are increasingly used to deliver health and social services. Ensuring that all community members can access and navigate these platforms is critical.
- **Improving Access to and Continuity of Health Services.** Ensuring the **ongoing delivery of health promotion, primary care, and preventive services** through the CHA Program is essential. These services should remain community-centred and responsive to evolving needs, contributing to the development of a **stronger local public health and crisis response system**.
- **Enhancing Workforce Capacity, Training, and Well-being Support.** Continued investment in the **training, retention, and support of a diverse workforce** is vital. Staff with lived experience, professional expertise, and **cultural and linguistic competencies** are best positioned to deliver inclusive and impactful services in local communities.
- **Community Engagement, Leadership, and Policy Integration**. Strengthening **cross-sector collaboration and community-led engagement** is critical. This includes actively involving **community peer leaders, system-level actors, and policymakers** in shaping and supporting the program. Importantly, there is a clear call for **committed, ongoing, and sustainable funding** to ensure the program's adaptation, continuity, and lasting contribution to the health and well-being of Peel residents.

Moving Forward: We hope that the findings from this evaluation contribute to increased **recognition and visibility** of the critical role that **CHAs** and community-based organizations—such as **DBNC**—play in delivering responsive and impactful health and social services during and beyond acute public health crises. This demonstrated program impact should support **structural, governmental, and community-level investment commitments**, including sustainable **funding, infrastructure, workforce development, service coordination**, and **material support to sustain the program** and leverage its capacity to provide **holistic, culturally and linguistically responsive community health care alongside social wraparound supports**, grounded in the realities of the **diverse and intersecting needs** of local Peel communities.

Introduction

About Dixie Bloor Neighbourhood Centre

The Dixie Bloor Neighbourhood Centre (DBNC) is a community-based, human-centred services provider founded in 1988 by diverse local community members who recognized the need to improve the quality of life and associated social determinants for individuals, families, and communities residing in the Dixie Bloor area of the Region of Peel, Ontario, Canada. DBNC has been a leader in implementing and delivering timely, responsive, and free social and health-related services to various local communities and groups, including newcomers (immigrants and refugees), families, youth, children, seniors, and other community partners. DBNC is also proud to have been an instrumental community change agent in addressing the diverse social and health challenges during the COVID-19 pandemic response and recovery in Peel, which disproportionately affected local communities across multiple dimensions—from economic and family well-being to health and social welfare.

This report showcases the evaluation of the role and impact that DBNC made during a time of intense public health and social crisis, such as the COVID-19 pandemic. These achievements were only possible due to a strong commitment to supporting local communities and the active engagement of community members as the program-driven workforce — from teachers to international health professionals — who contributed their diverse expertise to pandemic and post-pandemic service work across Peel's diverse communities. The DBNC's work has also been supported through both financial and in-kind contributions from various governmental and non-governmental partners. Their generous support—whether financial, in-kind, or through service collaboration—has played a vital role in our success and the delivery of impactful services.

COVID-19 in the Region of Peel: local context and impact

Peel Region, Ontario, is one of Canada's most diverse areas, with half of its population having an immigration history and 69% identifying as racialized (1). Individuals and communities in Peel face ongoing disparities in employment, housing, education, health, and access to services, stemming from systemic exclusion, racism, and discriminatory policies (2,3), even within healthcare settings (4). Social and health inequities negatively impact economic welfare and well-being across generations (5), a phenomenon further exacerbated by the COVID-19 pandemic (3,6). The first two COVID-19 waves disproportionately affected racialized and other excluded communities in Peel compared to other regions in Ontario and Canada (7). Many struggled to access essential resources like personal protective equipment (PPE), testing, self-isolation facilities, and meal support (8), leading to higher infection and mortality rates (7). In response, cross-sectoral Peel community organizations,

particularly those providing social and health services, helped the Ontario government to launch the High Priority Communities Strategy (HPCS) to address these inequalities (9), focusing on the most impacted neighborhoods in the region, through the establishment of the Community Health Ambassador (CHA) Program (8,9).

The CHA Program

Launched in January 2021 through the HPCS, the CHA Program was implemented across six Peel agencies serving racialized and marginalized communities (8). These organizations included Indus Community Services, Punjabi Community Health Services, Roots Community Services Inc., WellFort Community Health Services, DBNC, and the Canadian Mental Health Association Peel Dufferin (8). The program enlisted community members as trusted Community Health Ambassadors (CHAs) to help address systemic discrimination, racism, and barriers to essential social and health services during COVID-19 (8). CHAs provided direct support, ensuring community needs and priorities were met across healthcare and social systems (8).

DBNC-CHA Program Evaluation

DBNC, as one of the community agencies that implemented the CHA Program (DBNC-CHA) during the COVID-19 pandemic response phase (January 2021 to September 2022**)**, has adapted the CHA Program to address the unmet needs of its users over the subsequent pandemic recovery period (October 2022 to March 2024). They are committed to building evidence on the implementation, impacts, and ongoing adaptations of their DBNC-CHA program to inform further quality improvement, programming service decision-making, and sustainability. Furthermore, the evaluation's findings can be used to inform their emergency and non-emergency response strategies/programs to support the diverse community members they serve in the Peel region.

The leadership of DBNC engaged the Family and Child Health Initiative (FCHI) at the Institute for Better Health (IBH), Trillium Health Partners (THP) (Mississauga, Canada), to evaluate the DBNC-CHA Program and its role in supporting the COVID-19 response and addressing the social and health needs of local communities from January 2021 to March 2024.

Evaluation Project Objectives

The evaluation of DBNC-CHA aimed to characterize successes and challenges in the implementation, delivery, and adaptation of the program, as well as identify opportunities for improvement. **The Specific objectives were to:**

1) Characterize the CHA Program's reach, delivery strategies, and impact, as well as success enablers and challenge factors of its supportive COVID-19 response and community social and health service during the acute response COVID-19 period (January 2021–September 2022) and its adaptation during the recovery pandemic period (October 2022–March 2024).
2) Assess the perceived impact of the DBNC-CHA Program on the social, health and economic well-being of served community clients.
3) Identify collective recommendations for improving the program's quality, sustainability, adaptability and scalability.

Evaluation Methodology

Evaluation approach

This DBNC-CHA program quality improvement evaluation employed a retrospective mixed-methods design, combining quantitative and qualitative data (10,11) to assess the program's implementation and impact at various time points. Informed by the CDC Framework for Program Evaluation (12), the evaluation included both retrospective and summative components. It explored implementation strategies, program adaptations, and their data-informed and perceived impacts in local communities; examined the program's success and associated enabling and challenging factors influencing it, and opportunities for improvement and sustainability.

The evaluation considered two timeline stages to assess the implementation and impact achievements of the DBNC-CHA Program, informed by the program's collected administrative quantitative data, and narrative insights from program leadership, frontline service providers, and clients collected through tailored individual interviews. **The first stage focused on the pandemic response phase (January 2021 to September 2022), while the second addressed the pandemic recovery phase (October 2022 to March 2024).** This approach enabled a deeper understanding of the program's evolving role during the pandemic and into reopening and recovery phases, highlighting how the program adapted to respond to the increasing and intersecting social and health needs of local communities.

Data Sources

In partnership with the DBNC leadership team, the program evaluation team collected both quantitative and qualitative data.

Quantitative data were drawn from DBNC-CHA's administrative and program records, capturing the types of service delivery and key implementation and impact outcomes. Data were de-identified, aggregated, and provided by DBNC. Quantitative impacts were measured as the total of interactions

or occurrences (n = count/frequency) for each evaluation period. The specific type of administrative data is displayed in **Figure 1** below. We also used text-based data (field notes) recorded in the administrative data to further characterize the observed findings.

These are presented as "*Insights from Field Notes"* in some of the finding's sections of this evaluation.

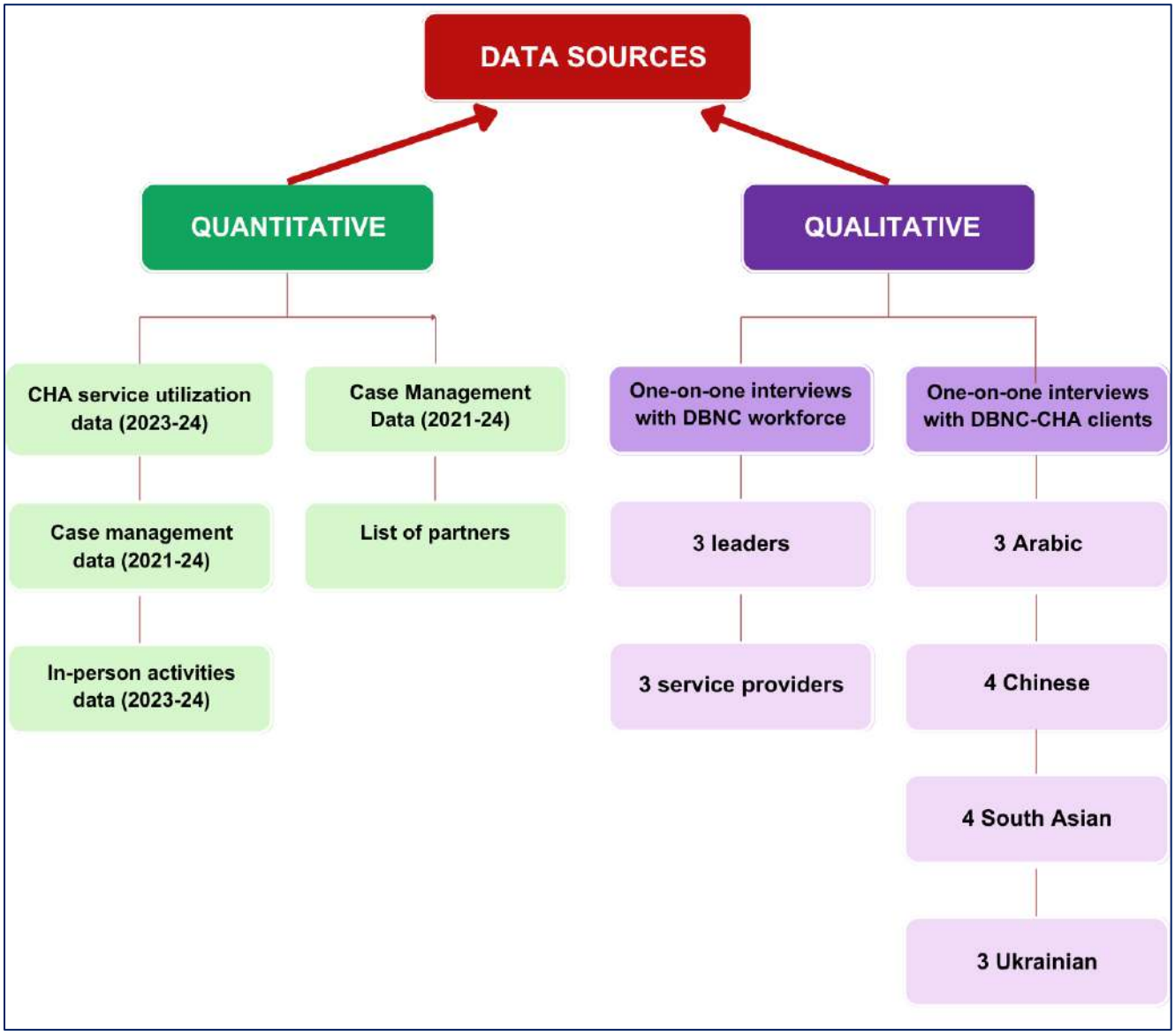


Figure 1. Data sources used in the DBNC-CHA evaluation process during the response (January 2021 to September 2022) and recovery (October 2022 to March 2024) phases of the COVID-19 pandemic.

The qualitative data for the evaluation were collected through semi-structured and individual interviews with DBNC-CHA program leadership, frontline service providers, and service clients. These interviews, conducted either virtually or in person using a flexible interview guide (see Appendix A and B), aimed to gather in-depth insights into the individual, contextual, and structural factors that influenced the program's implementation and impact. Also. They were used to gather collaborative

perspectives to strengthen the program adaptation, quality improvement, sustainability and long-lasting social and health impacts. Interviews lasted 40–60 minutes, were audio-recorded with the participant's consent, and were securely stored in de-identified formats within the encrypted drive system of the evaluation team's organization (IBH, THP).

A total of 20 participants, including DBNC-CHA program's leadership/management staff, frontline providers, and service clients from the primary ethnocultural communities served by the program. The specific number and characterization of interview participants who contributed narrative data are presented in **Figure 1**. Among the participants, 14 self-identified as women and six as men. Sixteen were currently citizens or permanent residents—yet many had an immigration background to Canada—while the remaining four were temporary residents. Participant ages ranged from 23 to 83 years. Our interviewed targeted sample of leadership/management, frontline providers, and program clients provided sufficient data to achieve salient thematic saturation (13).

Participants were recruited using a convenience sampling approach based on interest and eligibility, with recruitment supported by DBNC through flyers and direct outreach. Interpretation services were offered for non-English speakers to ensure inclusivity. All participation was voluntary, with written or oral consent obtained (see further details below in the Ethics Consideration section).

Ethics Considerations in the Evaluation

The protocol guiding this evaluation was reviewed by the THP Ethics Review Board, which deemed it exempt from research ethics review, as it was classified as a program evaluation for quality improvement. Therefore, formal ethics approval was not required for its conduct. This is consistent with the Tri-Council Policy Statement 2 (TCPS2) governing research ethics in Canada(18). TCPS2 considers that program evaluation and qualitative improvement studies do not fall under the auspices of the TCPS2 or institutional Research Ethics Boards (REBs). TCPS2, Article 2.5: "*Quality assurance and quality improvement studies, program evaluation activities, and performance reviews, or testing within normal educational requirements when used exclusively for assessment, management or improvement purposes, do not constitute research for the purposes of this Policy, and do not fall within the scope of REB review"*(16).

However, interview participants received an informed consent process, either in writing or verbally (17). The informed consent process for the interview participant was carried out using tailored consent forms specifically designed for DBNC-CHA program clients (See Appendix C) and frontline providers and leadership members (See Appendix D). Interested participants (program clients, frontline providers, and leadership members) were contacted by a trained evaluation team member and provided with a copy of the consent form several days before their scheduled interview, allowing

time for review and to raise any questions with the evaluation team before deciding to participate. Consent was obtained either verbally for virtual interviews or in writing for in-person interviews. The consent was also documented in the participant's consent form, a copy of which was appropriately shared with the participant and the original copy stored in a securely password-protected IBH, THP IT server (digital copies) or locked cabinet.

Participants invited for the semi-structured interviews were informed, both during scheduling and through the consent form, of their right to decline participation or withdraw their interview data at any time before it was analyzed and incorporated into publicly available findings outputs (17). Participation or withdrawal had no impact on their access to services at DBNC or other social and health organizations. Participants were also informed that if they wished to withdraw their data, they needed to do so before the findings derived from their interview were analyzed, approximately three months from the date of data collection. Once the analysis and reporting phase was completed and participant data had been integrated into publicly available documents, such as this evaluation report, withdrawal of their data was no longer possible.

All interviews were conducted in private settings to ensure confidentiality and maintain the integrity of the research. Personal identifiers were only recorded on consent forms and stored securely in a restricted-access Master Linking Log within THP's organization's server, accessible only via a THP-authorized and encrypted computer or remote server. No identifying information was recorded in the interview transcripts or field notes, and participants were given the option to choose a pseudonym. Audio recordings were destroyed after verification of transcription. Field notes were securely stored digitally, and any paper copies were shredded. Anonymized data from the interviews will be retained for up to five years, with planned destruction by January 2030.

Participants received a $30 e-gift card honorarium of their preference and, if needed, transit tokens for in-person participation.

Analytical Approach

The evaluation employed **an integrated, mixed-methods analytical approach** (14,15), combining quantitative data from the DCBH-CHA administrative records with qualitative data collected through semi-structured interviews to provide a comprehensive understanding of the program's implementation and impact during both the response and recovery periods, which served as the timelines for this evaluation's components. For the mixed-methods analytical approach (14,15), the following three steps were conducted:

1) **Quantitative administrative** data were cleaned and then analyzed using descriptive summary statistics (frequencies and percentages) to capture the interactions/occurrences of the program's main service focus areas during each pandemic period: the response phase (January 2021 to September 2022) and the recovery phase (October 2022 to March 2024).
2) **The qualitative or narrative data** were analyzed through thematic analysis by two members of the evaluation team to ensure rigour and validity(19,20). Thus, the main salient themes, facilitated by the coding process of verbatim transcribed data from the audio-recorded interviews, were identified using both inductive and deductive analytical approaches (19,20), in line with our evaluation objectives.
3) Next, **mixed-method integration** was performed using narrative and quantitative data through a joint display analytical approach (14,15). Key findings from both data types were organized in joint display graphs or tables, linked, and interpreted together to generate deeper insights beyond what each dataset could provide on its own.

For the characterization of the DBNC-CHA workforce, the communities it served, perceived community impacts, program success enablers and challenges, remaining unmet community needs, and recommendations, components of the evaluation, only narrative data from the DBNC-CHA program leadership, frontline service providers, and service clients were used to inform the qualitative, narrative-driven insights.

The same process described in Step 1 for thematic analysis (19,20) was followed to identify salient insights across each narrative data source—from DBNC-CHA leadership and management, frontline staff, and program clients. Triangulation of key findings from these three participant groups was applied during interpretation to enhance the reliability and validity of the results. Graphs were used to visually display the results for these evaluation components, and illustrative narrative or spoken data excerpts were included to enrich the reported findings.

The People Behind the Program: Workforce Contributions to DBNC-CHA's Success and Adaptation

Behind the successful implementation, delivery, adaptation, and sustainability of the DBNC-CHA program—from the onset of the COVID-19 pandemic through the recovery phase—was a passionate, inspiring, resilient, deeply committed, and skilful workforce.
This workforce brought not only professional and lived expertise but also a strong sense of purpose in responding to the needs of their own local communities. Many shared similar migration experiences, cultural and linguistic backgrounds, and faced similar challenges while serving those they assisted. These unique strengths significantly contributed to the program's impact, enabling it to evolve into a critical community-based COVID-19 response initiative and later into an adaptable, responsive health and social support program. As highlighted in the following sections, this workforce played a central role in shaping and delivering services tailored to the complex and intersecting social and health needs of diverse communities in the region of Peel.

Figure 2 highlights the core roles and responsibilities carried out by the dedicated DBNC-CHA team, complemented by powerful narrative insights shared in their own words. These team members were the backbone of the program's success, navigating challenges not only as service providers but also as trusted members of the communities they served. Their work was grounded in empathy, innovation, and sustained commitment to improving community well-being.

The workforce structure, illustrated in Figure 3, included the following key roles:

- **Executive Director**
- **Community Health Program Manager**
- **Community Health Project Coordinator**
- **Community Health Ambassadors**
- **Case Managers**
- **Social Workers**

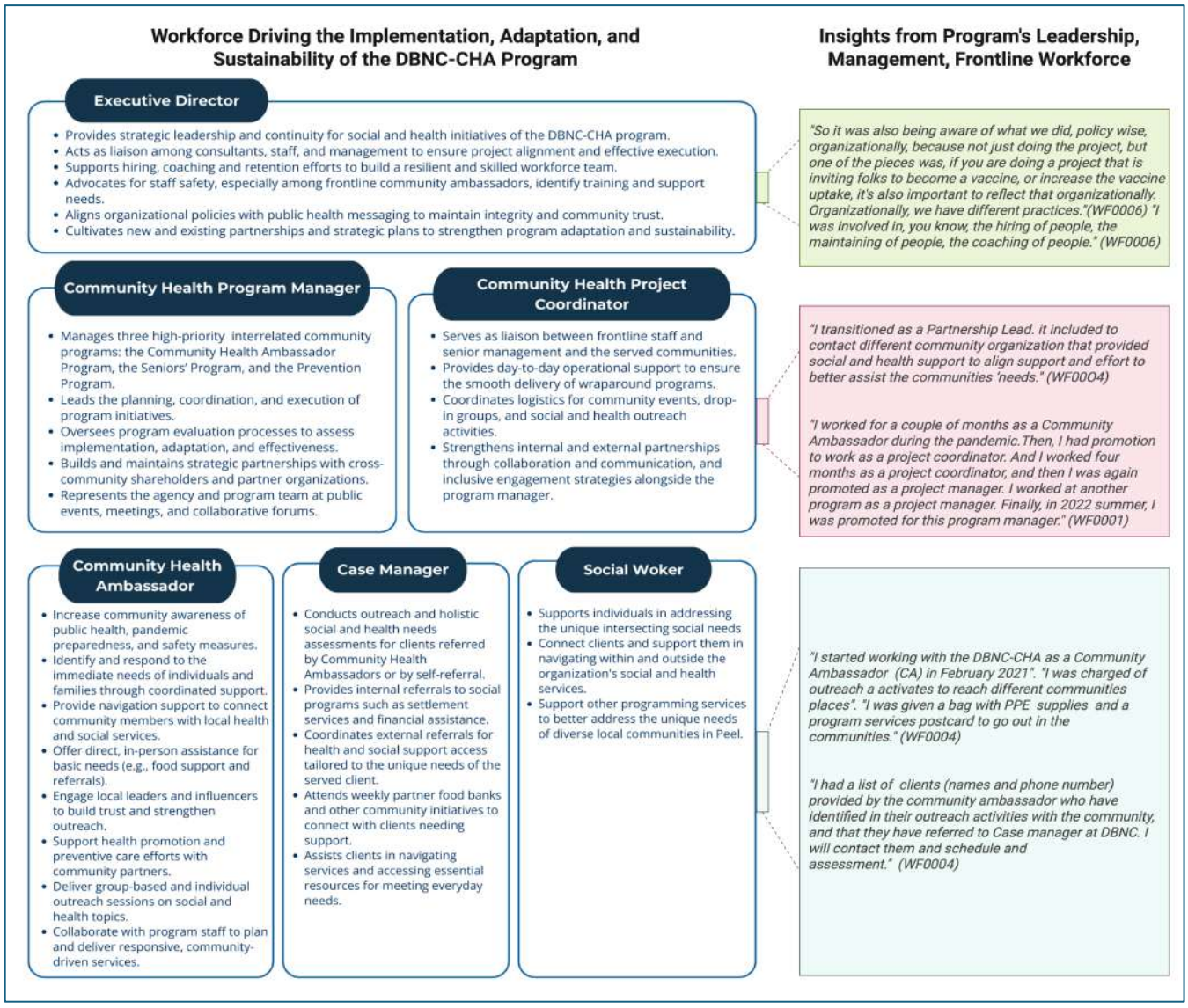


Figure 2. Characterization of the key workforce members driving the DBNC-CHA program during the pandemic response and recovery phases (January 2021 to March 2024).

Communities That Trusted the DBNC-CHA Program During the Pandemic Response and Recovery

Figure 3 presents an example of the narrative data highlighting the wide variety of diverse communities served by the DBNC-CHA program during its COVID-19 response, including both the response and recpovery phases of the pandemic. The narrative data indicate that the program supported local communities across the Peel Region, particularly those in its operational neighbourhoods or areas, while also extending its reach beyond the region.

Specific groups were served, including immigrants and refugees, seniors, and individuals from diverse ethno-cultural backgrounds or geographic origins. As it is reflected in the following sections on program-achieved impacts, which demonstrate how DBNC-CHA developed a range of targeted services for communities with higher needs or unique social and health challenges, including refugees, seniors, and individuals identifying as South Asian, Ukrainian, Chinese, and Arab, Black Caribbean, Polish, Afghans, and Spanish-speaking people, among other identities or origins. In addition to directly supporting these communities, the program also collaborated with other local organizations as part of a broader effort to strengthen the response to and better serve the local communities (**Figure 3**).

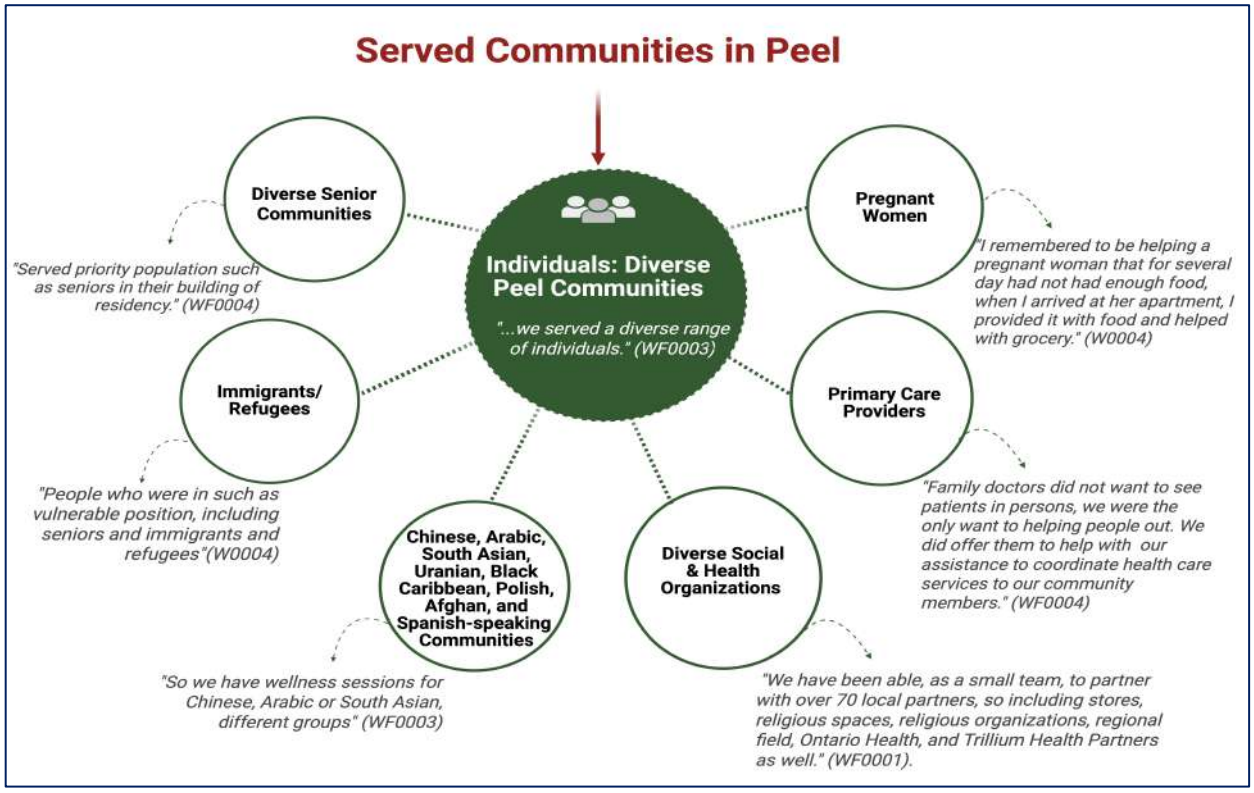


Figure 3. Sample of communities served by the BNC-CHA program during the pandemic response (January 2021 to March 2024).

DBNC-CHA's Impactful Role in the Response Phase of the COVID-19 Crisis

This section highlights the significant role of the DBNC-CHA program in responding to the peak of the acute phase of the COVID-19 pandemic (pandemic response phase). During this time, many unknowns surrounded the COVID-19 virus, and strict public health and social measures (i.e., closure of businesses and non-essential services, mandatory quarantines, social isolation, and stay-at-home orders) were implemented in the Region of Peel and beyond to contain its spread, with an increased focus on public health protection awareness, community-based testing, and vaccination efforts.

The insights presented here are based on data-driven evidence, including DBNC-CHA program administrative records from **January 2021 to September 2022,** as well as semi-structured interviews with DBNC-CHA project leaders and managers, frontline workforce members, and clients from diverse ethno-cultural backgrounds and of different genders, identities and ages who used the program during this critical period. Traditionally focused on delivering social services, the DBNC organization stepped up as one of the lead pandemic response agencies of the Peel-based HPCS initiative, despite not having prior experience or pandemic preparedness plans. Amidst uncertainty, evolving health directives, and limited funding (further explored in subsequent sections), DBNC-CHA provided significant support to public health and pandemic response efforts.

These efforts included the field deployment of a courageous and diverse CHA workforce (**A cumulative total of 76 CHAs were deployed to conduct outreach activities during the pandemic response and recovery (2021 to 2024)**) to build trust and awareness around COVID-19 protection measures, distributing personal protective equipment (PPE), facilitating access to testing and vaccination, providing navigation support, and promoting individual and community well-being through appropriate information, education, outreach, wellness, referrals, and wraparound programming.

Findings across the following six main action pillars —Program Promotion and Marketing Strategies; Outreach Support Through Social/Health Sessions; COVID-19 Protection and Testing Support; Communities Served Through Outreach Services; Partnership Building and Engagements; and Wraparound Health and Social Supports—highlight the essential and critical pandemic response role played by the DBNC-CHA program, specifically during the pandemic response period (January 2021 to September 2022).

Program Promotion and Marketing Strategies

Figure 4 presents the numeric data (occurrence counts) for program promotion and marketing, reflecting the reach of the program's multimodal strategy used to promote its services during the response phase of the COVID-19 pandemic. The program made a significant effort to account for the diversity of the local population, many of whom do not speak English as a first language, by providing information in over 80 languages (cumulative total over the 2021 and 2024 period). This helped expand the program's reach and ensured inclusive access to COVID-19 response measures for many diverse communities living in Peel. Printed materials and social/digital media were the most frequently used promotional methods, with over 23,000 and 2,000 occurrences, respectively. Television and radio advertisements were also used, though to a lesser extent. Overall, these program promotion and marketing activities reached over 24,000 residents of Peel, demonstrating the program's extensive outreach and visibility. Building on this context, narrative insights from both the program workforce and clients further underscore how the strategic investment in multichannel

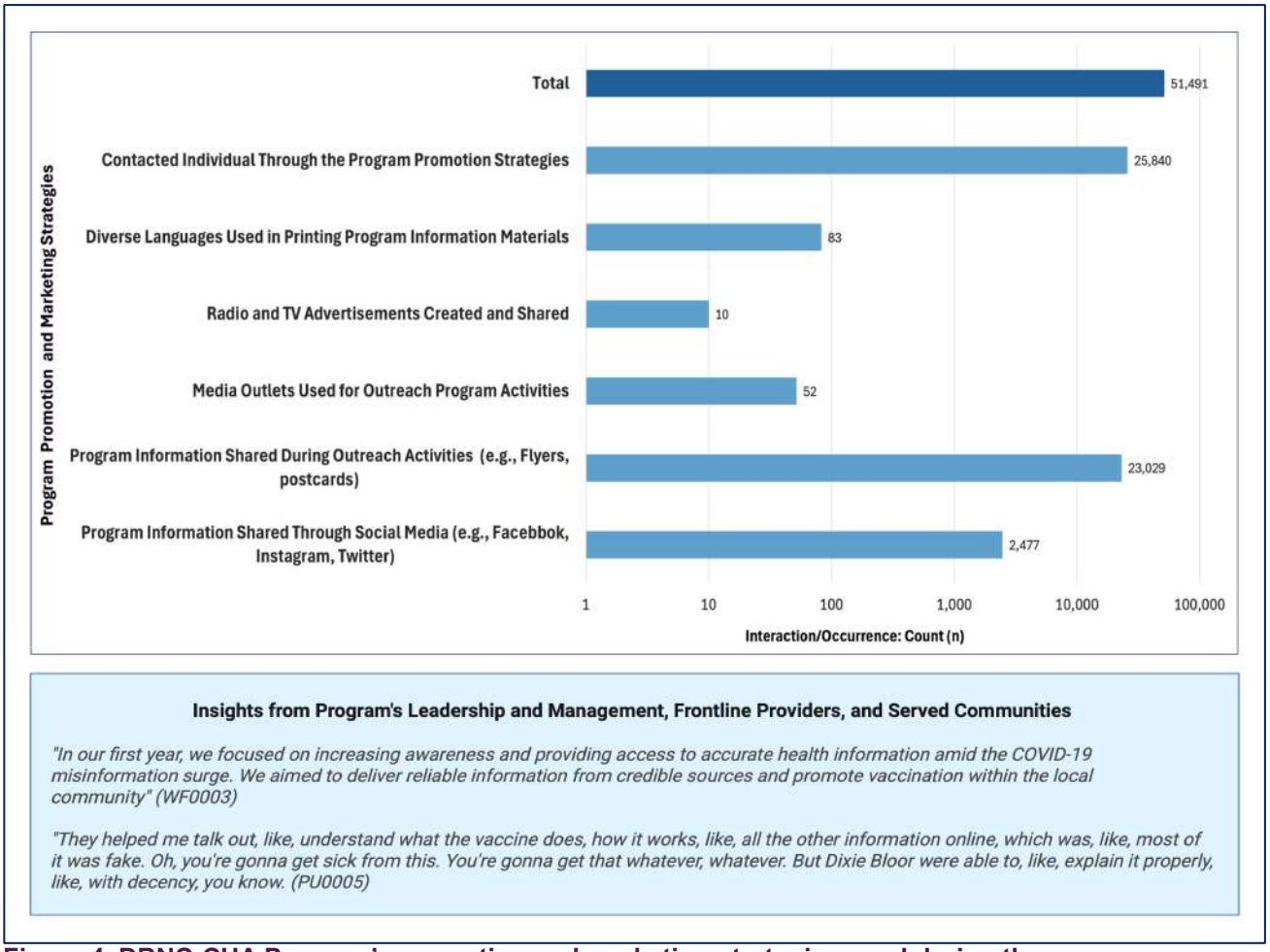
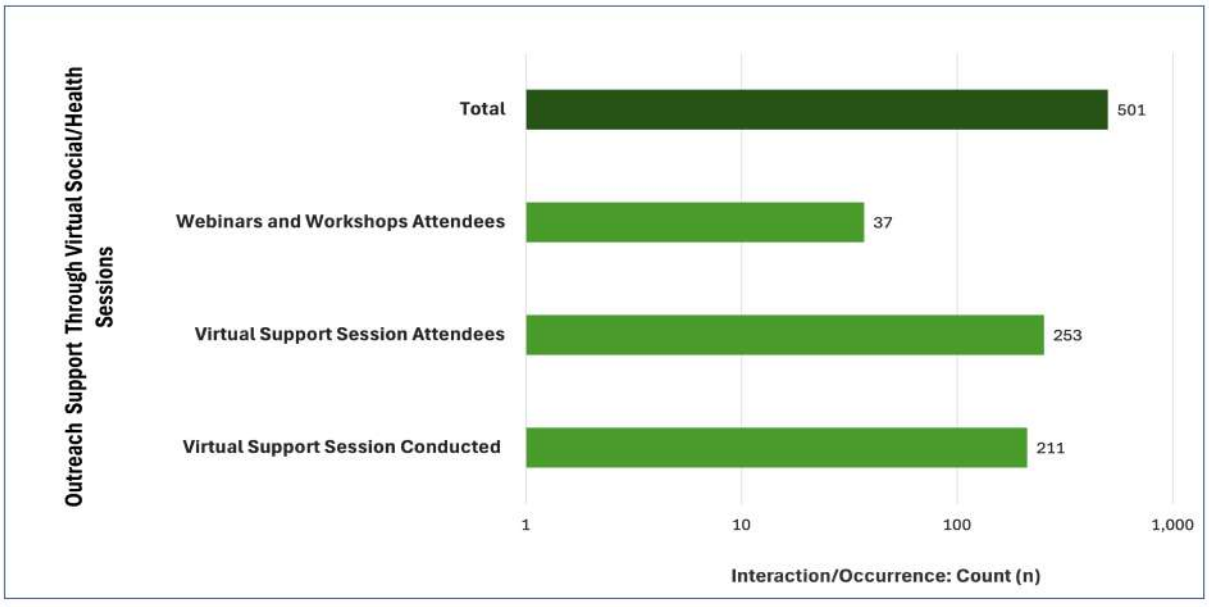


Figure 4. DBNC-CHA Program's promotion and marketing strategies used during the response pandemic period (January 2021 to September 2022).

promotional efforts positively impacted community awareness and understanding of the program's purpose and pandemic-related response activities (**Figure 4).**

Outreach Support Through Social/Health Sessions

Figure 5 presents key insights derived from both DBNC-CHA program administrative data (interaction and occurrence frequencies) and narrative accounts from program leadership, management, the workforce, and community members. These insights relate to the virtual social and health sessions implemented during the recovery period of the COVID-19 pandemic response. The sessions aimed to support the local community by providing information on COVID-19 and non-COVID-19-related topics, addressing social isolation, enhancing well-being (including mental well-being), and offering support for other social challenges experienced during the pandemic. The program specifically targeted individuals at higher risk of isolation and COVID-19 exposure, including seniors and newcomers from diverse ethnocultural backgrounds who primarily spoke languages other than English.



Insights from Program's Leadership and Management, Frontline Providers, and Served Communities

"The first year was more around awareness of COVID, like a lot of people, they were denied the fact that it exists, and they said government is trying to spread this misinformation. There was so much misinformation online about COVID. That was the first goal, that this exists, and you need to be careful, like you need to isolate yourself." (WF0002) Spoken words translated into English.

"I remember attending two of them. So the first one I remember attending was them talking about COVID, how, like, people get infected, what the things they should be doing, shouldn't be doing, like wearing masks, whatever. And then the second one was about the vaccines, them explaining how it works, and there's nothing to be worried about from it. Honestly, it helps a lot, because they explain things a lot better than what was available online." (PU0005).

Figure 5. DBNC-CHA program's virtual social and health sessions conducted, and individuals reached during the pandemic response period (January 2021 to September 2022).

More than 200 virtual sessions were held, with a total of 253 attendees (**Figure 6**). This reflects how the DBNC-CHA program leveraged virtual spaces to continue supporting local communities during the response phase of the pandemic, when many in-person social and health services were shut down. Virtual sessions also helped counter the proliferation of misinformation related to the

pandemic, testing, and vaccination, as confirmed in narrative data from both the program workforce and participating clients (**Figure 5)**

COVID-19 Protection and Testing Support

Figure 6 depicts the diverse and extensive COVID-19 protection and testing-related activities that the DBNC-CHA program significantly and impactfully contributed to during the height of the COVID-19 pandemic. Overall, there were more than **230,000 recorded occurrences** of this pillar's activities. These efforts included the provision of tailored COVID-19 prevention information, such as safety measures to reduce virus transmission and exposure, awareness campaigns on vaccination and facilitating access to testing. These services were designed to ensure that diverse community members, including seniors with reduced mobility and individuals facing transportation or affordability constraints, had equitable opportunities to access protective services during the pandemic.

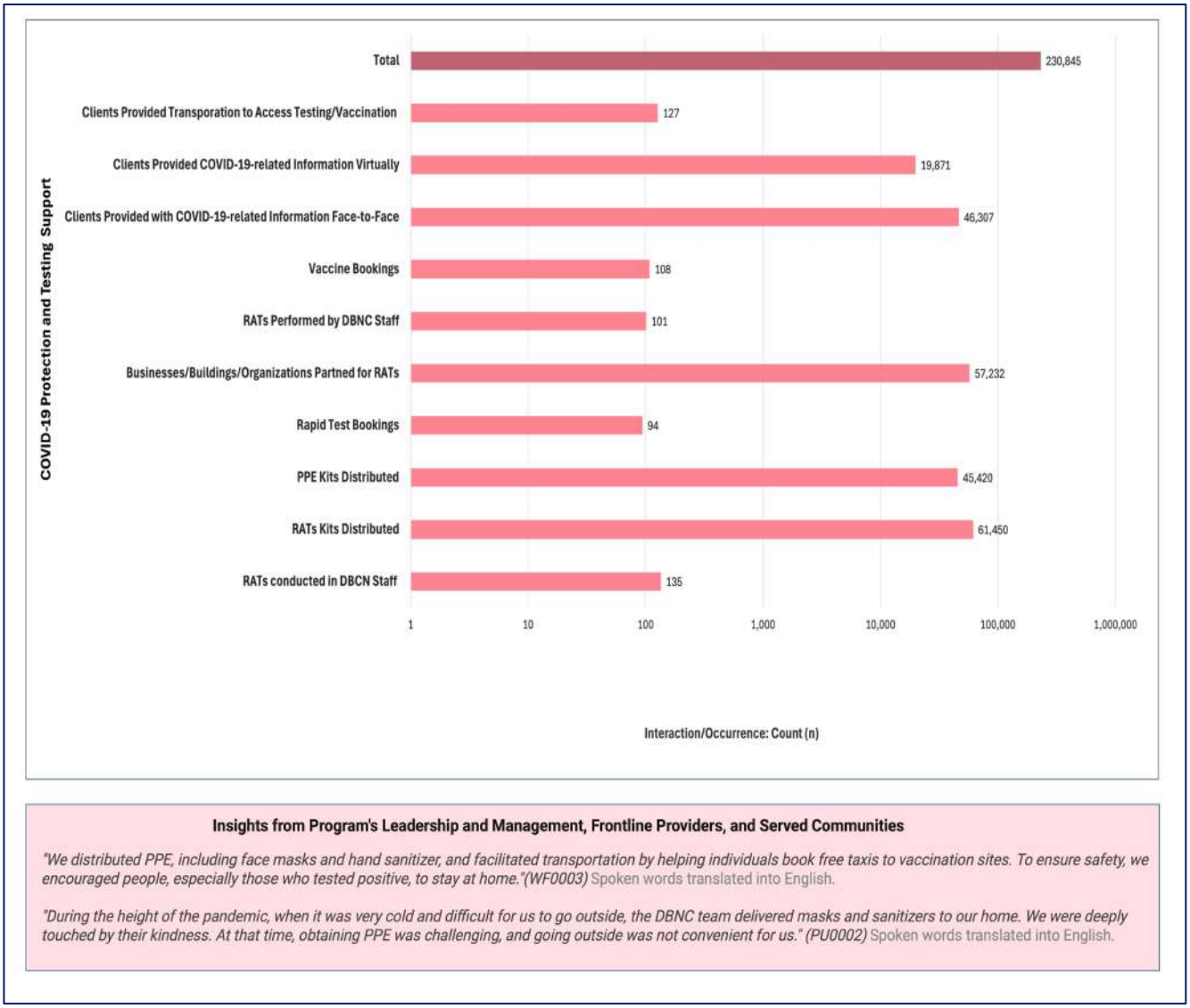


Figure 6. DBNC-CHA program's COVID-19 protection and testing support achievements during the pandemic response period (January 2021 to September 2022).

Among the most impactful services provided were the distribution of over **61,000 rapid antigen tests (RATs)** and more than **45,000 PPE kits** to the local communities. These efforts were complemented by **over 46,000 persons receiving face-to-face COVID-19-related information**, and an additional approximately **19,000 individuals receiving COVID-19 protection information through virtual platforms (Figure 6).** This represents a significant achievement by the frontline workers and CHAs who were deployed across communities—going door-to-door, business-to-business, and engaging online—to share essential guidance on sanitation practices, virus transmission, and support access to vaccination and testing.

Importantly, CHAs were deployed directly into key community spaces, including residential buildings, small and large businesses, and local organizations, resulting in more than **57,000 partnership interactions** to enhance access to RATs. In addition, **staff testing** was implemented as a key priority to ensure that the workforce did not become a source of virus transmission. As COVID-19 vaccines became more widely available, the DBNC-CHA program joined public health efforts to **facilitate vaccine access**, including assisting with **108 vaccine bookings**, as illustrated in **Figure 6.**

Facilitating transportation to access testing and vaccination, with 127 recorded occurrences, underscores the need for transportation access in local communities, a crucial determinant of pandemic response disparities within and between populations. Individuals who often required this support (e.g., seniors) were also at higher risk of severe COVID-related outcomes if exposed to or infected by the virus. Therefore, enhancing their access to vaccination and testing by supporting their transportation needs was a key commitment of the DBNC-CHA program.

These quantitative impact figures presented in **Figure 6**, are covered by narrative insights from frontline providers and program users, who highlighted the crucial role of the DBNC-CHA program in helping communities access reliable COVID-19 protection information, personal protective equipment (PPE), testing, and vaccination during the response phase of the pandemic.

Communities Served Through Outreach Services

Figure 7 presents the quantitative and qualitative insights into the impact of this outreach service's pillar. It highlights three main groups of community clients served during the response phase of the pandemic, based on the two main channels through which the outreach program activities were delivered. **Overall, the DBNC-CHA program served 58,475 clients through the outreach activities.** Of these, the majority **(n = 58,079) were reached through outreach activities conducted in the field by the program's CHAs**. An additional **312 clients** received personalized, **client-centred support through a tailored COVID-19 hotline** operated by frontline providers.

Figure 7. DBNC-CHA program served clients during the pandemic response period (January 2021 to September 2022).

The program also supported community-based health clinics organized by other agencies, joining efforts and resources to better meet the needs of local communities. These impactful outreach figures are further complemented by powerful insights from program clients, who acknowledged how both the in-person outreach activities and digital helpline support made a meaningful difference in the challenging circumstances for which they sought help (**Figure 7**).

Partnership Building and Engagements

Figure 8 presents the data insights for the *Partnership Building and Engagement* pillar. The quantitative data shows that there were **a total of 625 partnership-building and engagement occurrences** through the DBNC-CHA program, involving a wide range of cross-sectoral community organizations.

These included partnerships with organizations involved in COVID-19 testing (n = 94). However, the largest number of partnership interactions occurred **with residential organizations and buildings (n = 321),** where DBNC-CHA program CHAs conducted extensive outreach and support for local communities during the response phase of the pandemic.

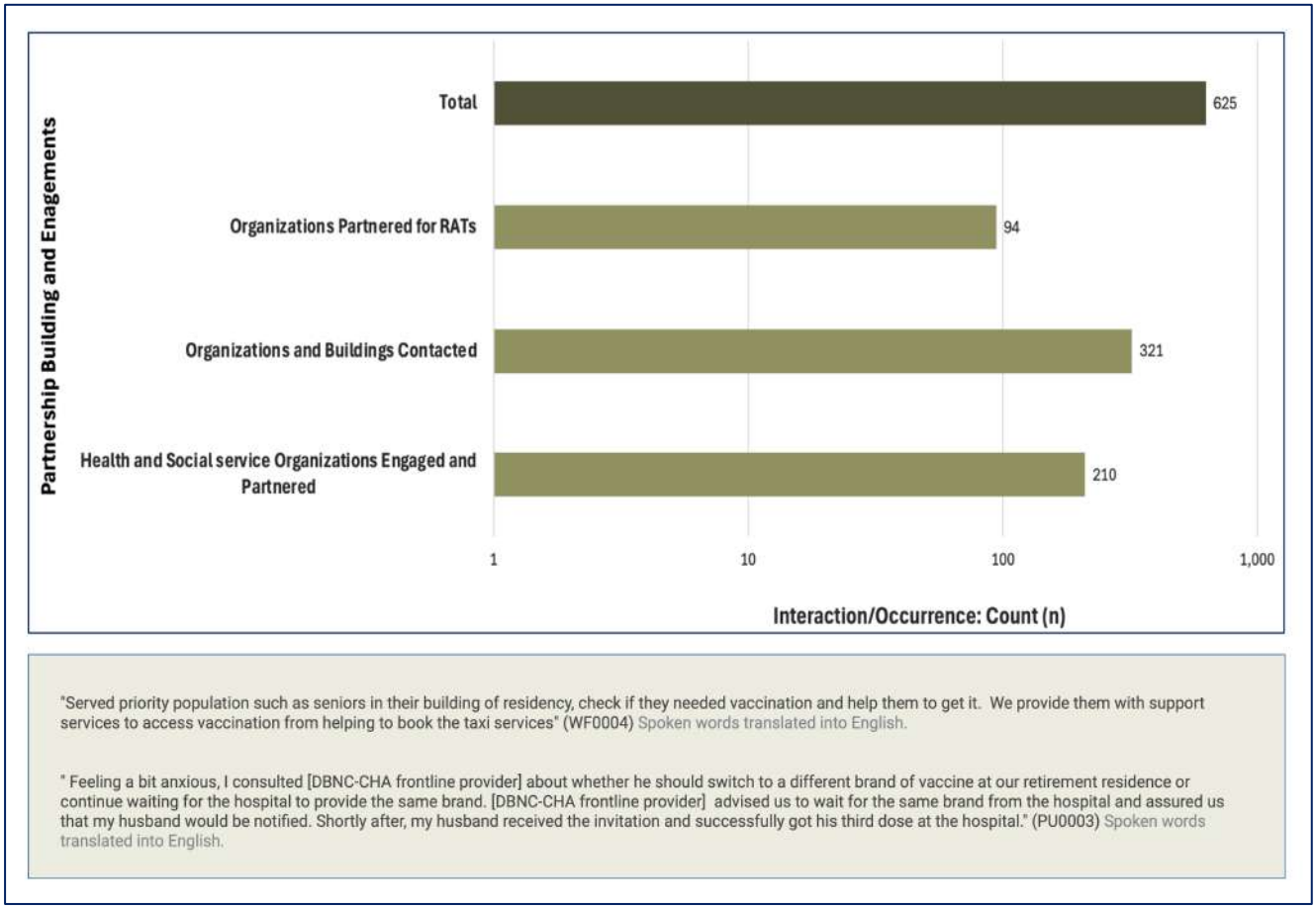


Figure 8. DBNC-CHA program partners engaged during the pandemic response period (January 2021 to September 2022).

Additionally, the numeric and narrative data highlight the **significant efforts made to engage other social and health organizations,** ensuring that local communities were appropriately supported through joint efforts across community agencies and provider systems (**Figure 8**). This is important, as discussed in the previous and following sections, because individuals often faced diverse needs, not only requiring access to COVID-19 protection and testing services, but also health and broader social support during the pandemic response period.

Wraparound Health and Social Supports

Figure 9 presents the numeric and narrative insights related to the DBNC-CHA program's Wraparound Support pillar. It highlights that, beyond its response to the COVID-19 pandemic in terms of protection and control during the response phase, the program also provided holistic, wraparound support to its clients, even during a time of limited social interaction and widespread service closures.

A total of 1,668 wraparound service interactions were recorded, with **case management accounting for the highest proportion of services delivered (1,508 occurrences). Food**

assistance was also a critical component, with 85 meal deliveries provided. This service is strongly emphasized in the narratives from program clients, who appreciated the flexibility of receiving food either through home delivery or by picking it up at DBNC headquarters (**Figure 9**).

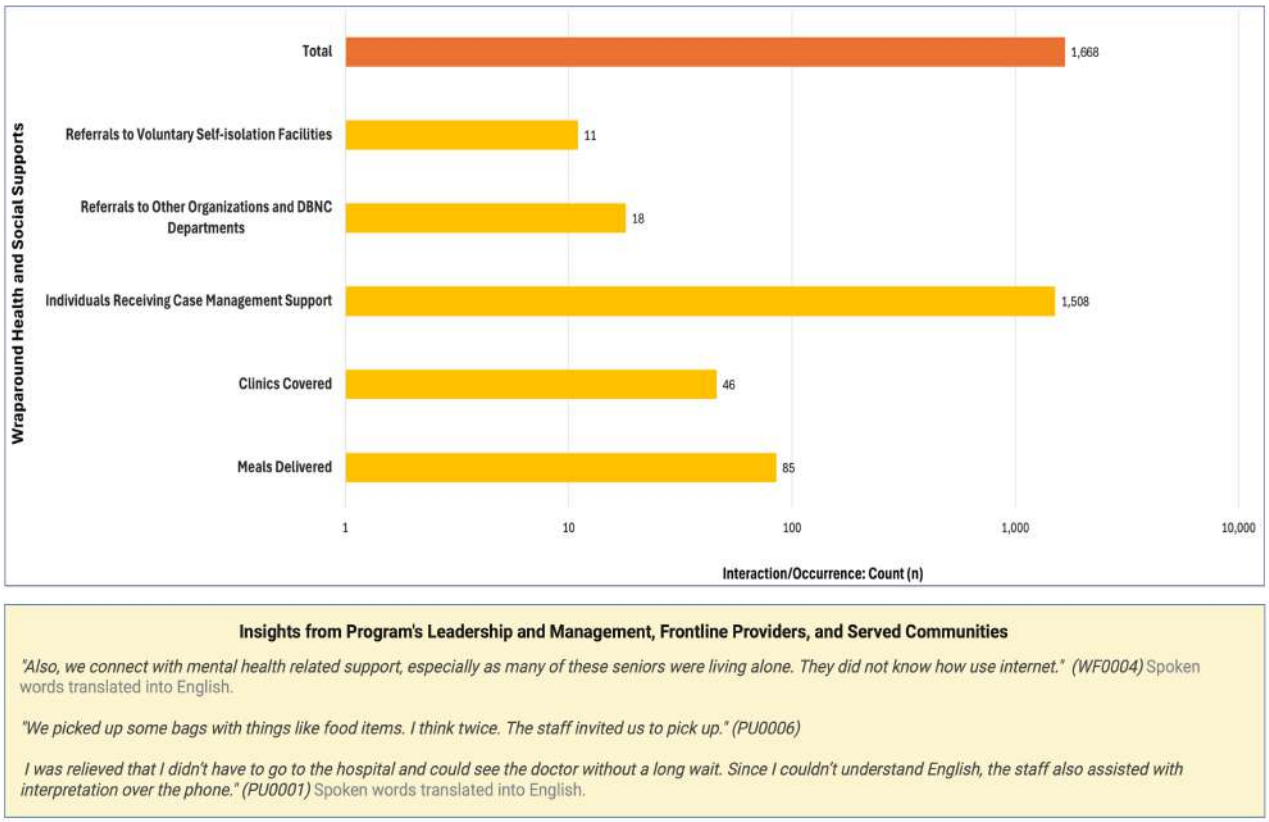


Figure 9. DBNC-CHA program wraparound supports during the pandemic response period (January 2021 to September 2022).

Finally, although to a lesser extent, **the program also supported clients' health and social needs through both internal and external referral pathways**, including facilitating access to safe and supported isolation venues for individuals who needed to quarantine but lacked appropriate space in their homes (**Figure 9**).

From Crisis to Resilience: Program's Adaptation During the COVID-19 Recovery Period

As the acute response to COVID-19 (repose period) and associated public health measures (such as stay-at-home orders, quarantines, and the closure of businesses and social services) began to lift in summer 2022, DBNC started adapting its DBNC-CHA program to align with the evolving needs of the community during the COVID-19 pandemic reopening and recovery. The DBNC focused on maximizing the ongoing funding received by Ontario Health and the government of Canada to continue addressing the unique health needs of diverse communities in the Peel Region. Alongside this and leveraging the building on the workforce, leadership, community partnerships, and service coordination efforts established since the onset of the pandemic response, the DBNC aimed to diversify, expand, and adapt DBNC-CHA program services to increase access and responsiveness. These strengthened foundations were leveraged to support the continuation of and adaptation of the DBNC-CHA program as a trusted, holistic, and responsive initiative, one that continued to address the COVID-19 pandemic needs alongside the complex and intersecting social and health-related needs and priorities of local Peel communities. This program adaptation and portfolio services expansion have also been made possible through strong leadership and management, a committed workforce, meaningful community partnerships, and the trust of the clients they serve, as presented in the sections below, which focus on the recovery period of the COVID-19 pandemic (October 2022 to March 31, 2024).

It is essential to note that through the adaptation of the DBNC-CHA program, DBNC has evolved from being primarily a social service-focused community organization before the pandemic to becoming a more community-based healthcare provider since the COVID-19 pandemic. This is supported by the insights reported in the sections below, which outline the various health-related areas the program supported, either through direct health-related service provision or by facilitating referrals and care pathways in collaboration with other local organizations. This shift is also captured in the narrative insight shared below by one of the program's workforce members.

"DBNC never had a health department before. So we started with a couple of community ambassadors. We didn't have a health department, and now we have a community health program that has seniors." (WF0001)

Program's Adaptation During the Pandemic Recovery: Overview of the Primary Action/ Service Areas

Figure 10 presents an overview of the key achievements according to the DBNC-CHA program's primary areas of operation during the pandemic recovery period (October 2022 to March 31, 2024), alongside testimonial insights from the leadership and managers who guided the program's service strengthening, adaptation, expansion, and diversification efforts.

Panel A of **Figure 10** displays the impacts (count) and percentage of service and interaction occurrences for the overall recovery pandemic period**, totalling 104,429,** and the total for each of the primary areas of focus**,** which are explained below.

- Community Engagement and Interaction Approaches. This accounts for a higher share (49%) of the service interactions (**Figure 10**).
- Community Partnership Building: This area remains important, albeit to a lesser extent, as the program increasingly leverages existing partnership-building efforts (**Figure 10**).
- COVID-19 Risk Prevention, Reduction, and Screening. It remains one of the most significant areas of program services, accounting for approximately 27% of the overall service and interaction occurrences (**Figure 10**).
- Service Navigation and Referral. This accounts for 5% of the services.
- Direct Health- and Social-Related Services Delivered. The 5% reflects the shift to expand beyond COVID-19 and address more social determinants-related needs (**Figure 10**).
- Supporting Mental Health: Service Referral and Delivery. With a 5% share of service occurrences, mental health represents a growing priority in local communities (**Figure 10**).
- Enhancing Access to Primary Care. With 4%, it highlights that primary care service access support has become an additional area that the program is adapting to support.
- Supporting Physical Health: Screening, Service Referral, and Delivery. With a 3% service share, this area highlights the evolving role in supporting the physical health needs of local communities (**Figure 10**).
- Enhancing Access to Preventive Care Services: With only 1% of programs focusing on this area, the emerging role of such initiatives highlights their potential contribution to broader health prevention efforts (**Figure 10**).

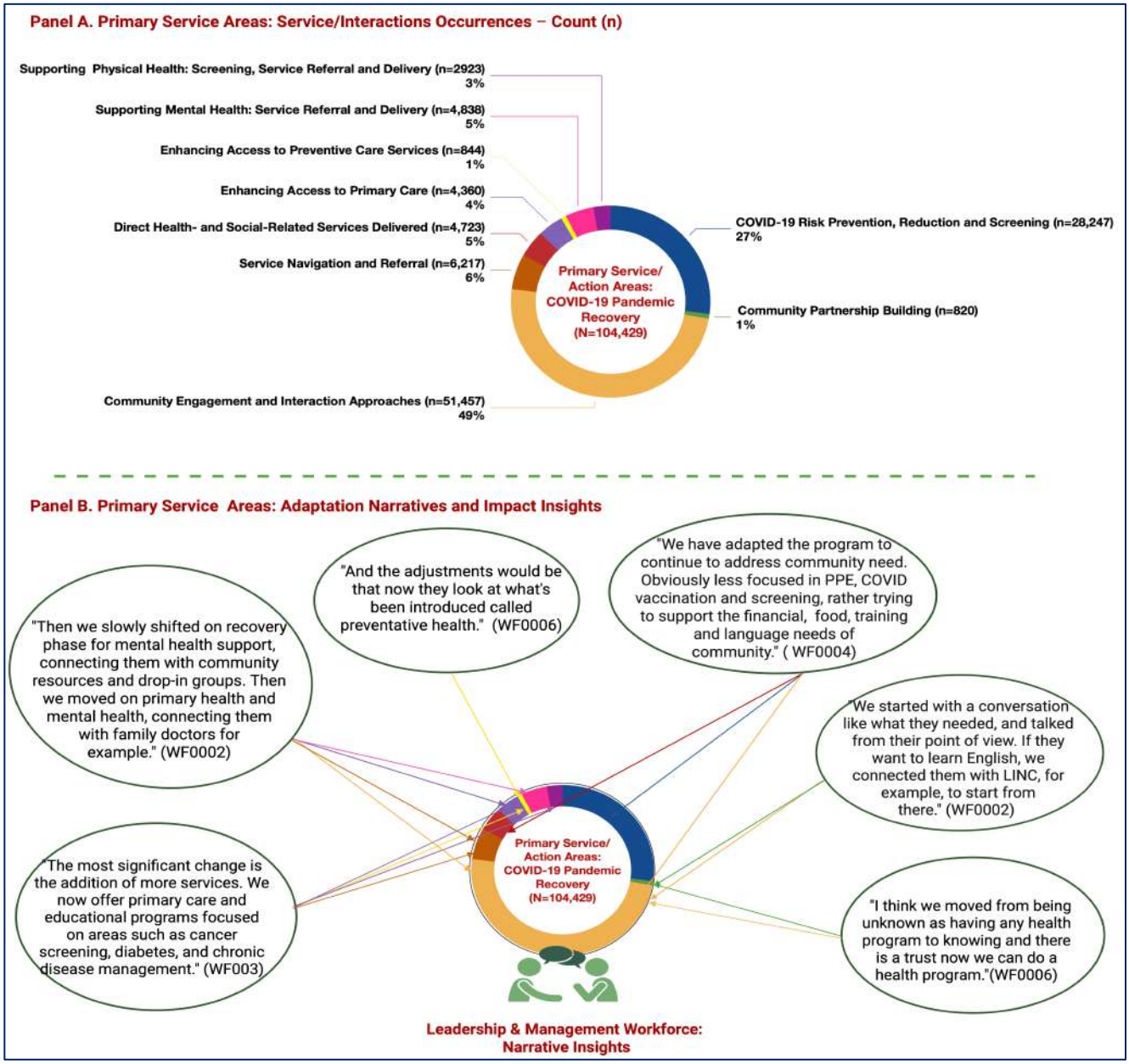


Figure 10. Main DBNC-CHA Program's action and service areas, associated interactions/occurrences, and narrative insights during the COVID-19 recovery period (October 2022 to March 2024).

The above number-based service achievements are further contextualized in Panel B of **Figure 10**, which illustrates testimonial (narrative data from leadership, frontline staff, and program clients) insights on the program's shifting focus areas. It highlights the commitment of collective leadership and program managers to continue building partnerships and strengthening connections with local communities through the expansion of their portfolio of health services and support. These efforts also reflect the ongoing efforts of the DBNC-CHA program to adapt its services and areas of action to meet the diverse and intersecting health and social needs of the community, whether through internal initiatives or externally coordinated service pathways facilitated by referrals and expanded community engagement activities.

Services and Impact in Key Program Focus Areas During Pandemic Recovery: A Closer Look

This section presents the specific services provided under each of the Primary Service Focus Areas of the DBNC-CHA during the pandemic recovery period (previously introduced in Figure 10). It offers a closer look at the types of services delivered. It highlights their quantitative impact, supported by evidence from field program notes recorded in the program's administrative data (labelled in the figure as *"Insights from Program Field Notes")* and narrative insights collected through qualitative interviews with leadership, program frontline staff, and served clients, as explained in the methodological section.

Community Engagement and Interaction Approaches Area

Figure 11 showcases the main approaches and strategy streams that comprise the Community Engagement and Interaction Approaches area. These were used to engage with, interact with, and address community needs, as well as to address social, health, and well-being priorities during the recovery COVID-19 pandemic period.

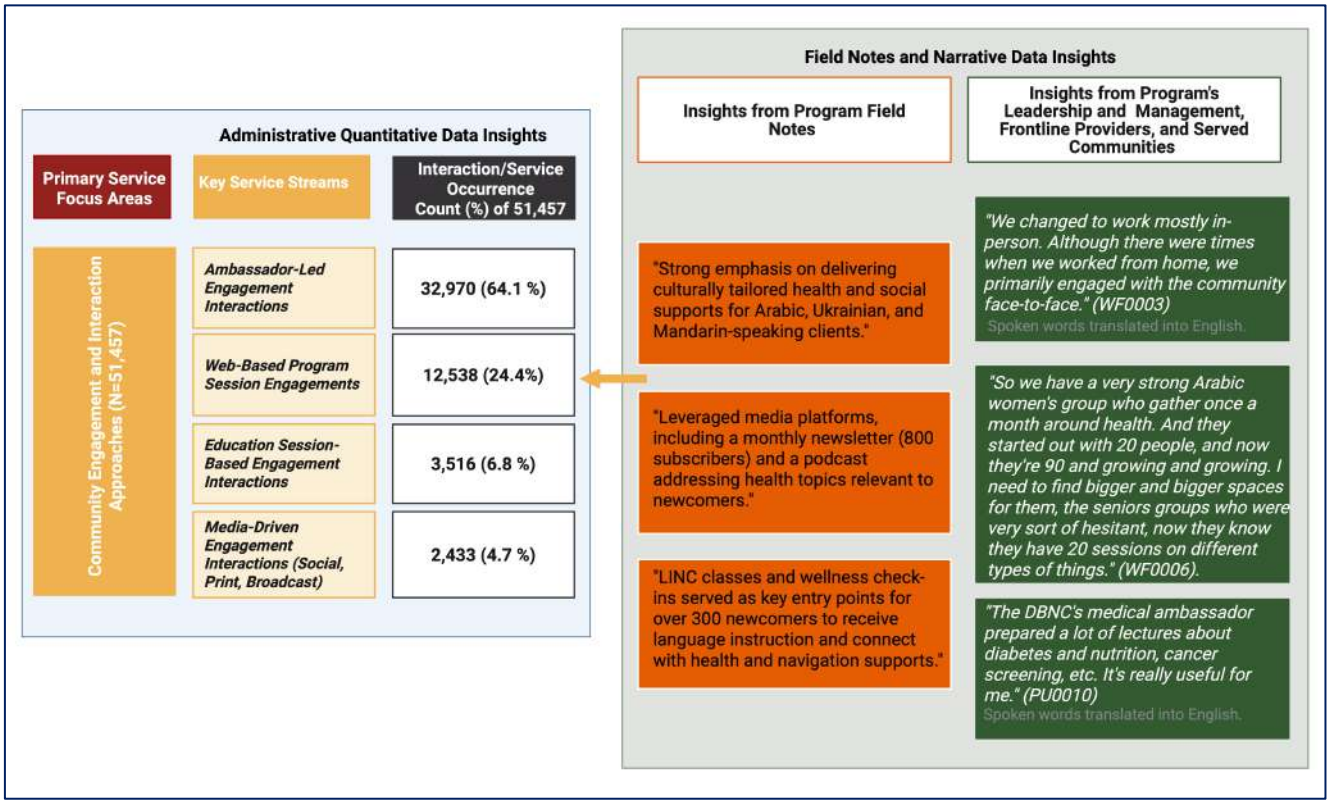


Figure 11. Main DBNC-CHA program's approaches and strategies used for community engagement and associated interactions/occurrences during the pandemic recovery period (October 2022 to March 2024).

These approaches supported efforts to build awareness, foster trust, and enhance community participation and accessibility, while considering language preferences, cultural contexts, and various ways to engage (**Figure 11**). This ultimately enhanced the continuity of effective programs and services as society, communities, and service providers began transitioning out of the response phase of the COVID-19 pandemic.

- CHA-led engagement interactions represented the primary marketing and information services-related component of the program, delivered to local community members. Some of these interactions focused on raising awareness about the various services offered by the program. In contrast, others aimed to provide direct and referral support tailored to the specific social and health needs of individuals and specific local communities. This aligns with the core role of the ambassador workforce (community members with diverse professional, experiential, cultural, and linguistic skills), who continue to serve and connect with the local population over the recovery pandemic period. These interactions accounted for 61.1% of the 51,457 total interactions/occurrences (**Figure 11**).
- Web-based program session engagement, which was used to provide health and social information and support, and programs, emerged as the second most utilized approach to connect with and provide social and health support with local communities, accounting for 24.4% of engagement interaction occurrences. This reflects the broader societal shift from in-person to digital service delivery during the COVID-19 pandemic (**Figure 11**).
- Education session-based engagement represents an interactional approach used to deliver health and social education on topics tailored to diverse communities, including health promotion, disease prevention, social and emotional well-being, settlement support, community belonging and connection, employment, and other available social services. These interactions accounted for 6.8% of the total recorded engagements in this program area. This highlights the project's focus on COVID-19 response as well as broader health and social promotion, with education playing a key role. Field notes and narrative insights suggest that many of these sessions took place in face-to-face formats as public health restrictions eased and pandemic control measures were relaxed (**Figure 11**).
- Media-driven engagement interactions, including social media, print, and broadcast media, were utilized to increase awareness of program services and share health and social support tips, as well as available resources, both within and outside the DBNC. These interactions represented 4.7% of all engagement strategies. This media leverage usage supported not only COVID-19-related priorities but also broader efforts in health promotion, prevention, access to health services, and social supports, helping to diversify outreach strategies and increase program reach and impact across diverse communities (**Figure 11**).

Community Partnership Building Area

Quantitative insights into the number of key partnerships formed with diverse and multisectoral health and social organizations during the recovery phase of the COVID-19 pandemic are presented in **Figure 12.** These findings underscore the importance for DBNC-CHA leadership of establishing trust-based, collaborative partnerships with a diverse range of local and regional organizations across various sectors. These partnerships were a core commitment and a key factor in strengthening the overall success of the DBNC Project during the pandemic recovery period. This also demonstrates how the program adapted and invested in proactive approaches to meet the diverse and intersecting health and social needs of the communities it served in Peel. By working together through coordinated pathways and shared resources, the DBNC-CHA program helped ensure that diverse Peel community members received the attention and services they needed (this is also reflected in the diverse areas of service delivery outlined below).

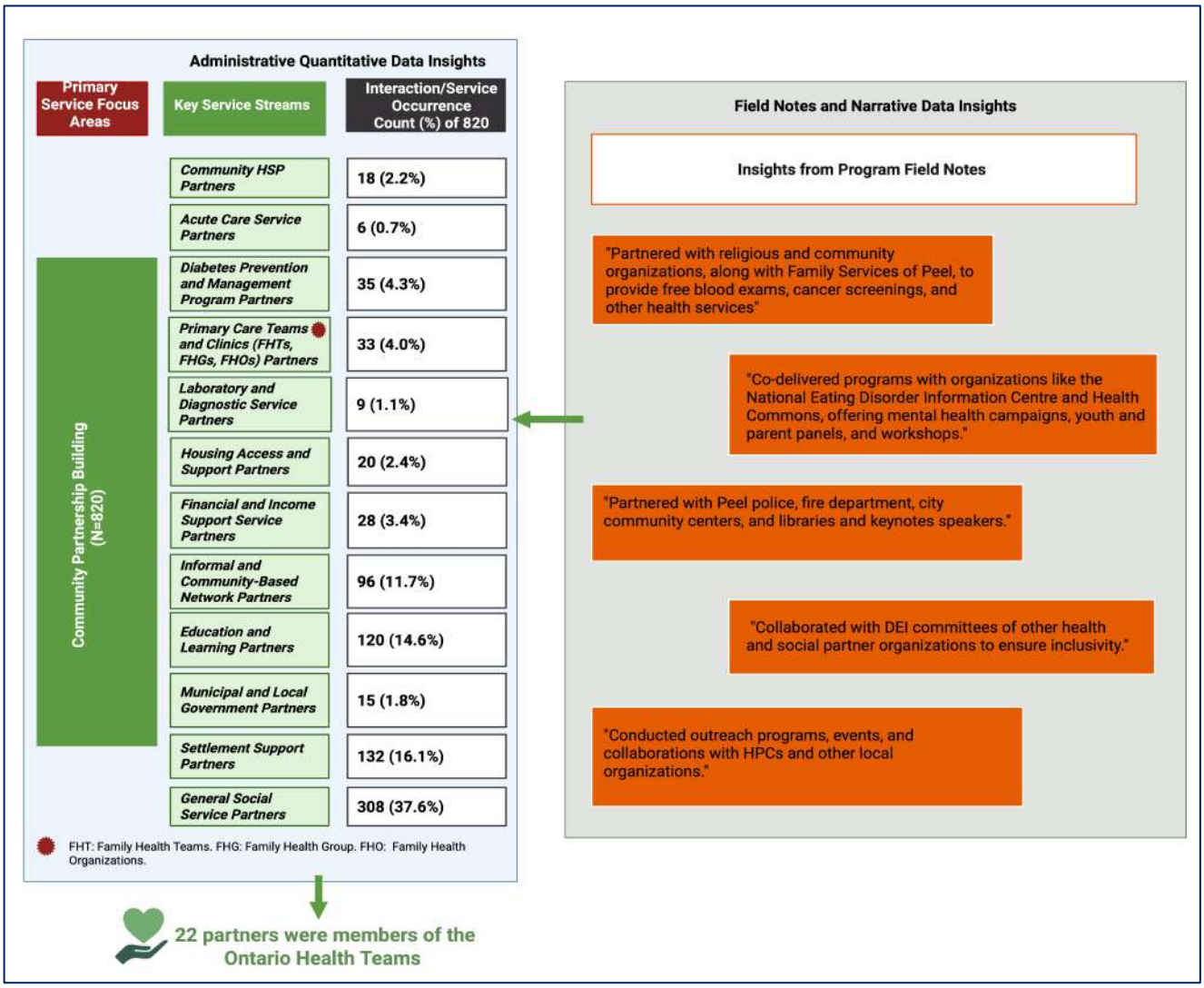


Figure 12. Main type of DBNC-CHA program's cross-sectoral parentship engaged and associated interactions/occurrences and narrative insights during the pandemic recovery period (October 2022 to March 2024).

Out of the **820 total** partnerships established, the following key insights highlight the main types of partners with which the DBNC-CHA program collaborated across the health, social, financial, settlement, and education sectors (**Figure 12**).

- Partnerships with diverse health organizations, including other community-based health services providers (2.2%), acute care (0.7%), primary care (4.0%), specialized or targeted partners that provide chronic disease prevention and management (e.g., diabetes prevention and management) (4.3%), and laboratory and diagnostics service providers (1.1%) were a vital component of the program's partnership-building efforts (**Figure 12**). This demonstrates the program's strong commitment to building trust-based and collaborative relationships in the health sector, supporting the effective health needs of the communities it serves
- Partnerships with housing (2.4%) and financial support providers (3.4%) were central to the program's efforts to ensure that clients had access to critical resources (**Figure 12**). This reflects the program's strong focus on helping community members facing income insecurity and housing instability, ensuring they can connect with services in these essential areas.
- Building partnerships with informal community leaders (e.g., faith and religious, sports, and social leaders) and networks represented 11.7% of all partnerships established (**Figure 12**). Engaging these local leaders and other grassroots community organizations was crucial to continuing to reach and support diverse communities during the recovery COVID-19 pandemic. Many individuals trust their community and religious leaders more than formal service providers, making these relationships vital to increasing program reach, impact, and trust.
- Partnerships with settlement programs and services (16.1%) accounted for the second-largest proportion of partnerships (**Figure 12**). This aligns with DBNC-CHA's primary focus on serving immigrant and refugee communities in Peel, who often face challenges related to finances, language, employment, and overall settlement journey. These partnerships allowed the program to respond quickly and effectively to their evolving needs.
- Partnerships with the education sector (student wellness support groups and networks, undergraduate and postgraduate colleges, and educational institutions, among others) represented 14.6% of all partnerships. Alongside more general social service partnerships, which accounted for 37.6% (**Figure 12**) of these collaborations, highlight the complex and multidisciplinary needs of the community. Many individuals require support not only in their health but also in education, training, and skill development. These partnerships were critical in helping the program achieve its broader goals and impact across multiple areas of community well-being, as further illustrated in the sections below.
- It is essential to note that, among the engaged partners and partnership-building efforts mentioned above, 22 were members or partners of the Ontario Health Team (OHT).

COVID-19 Risk Prevention, Reduction, and Screening Area

Figure 13 illustrates the main types of services provided by the DBNC-CHA within the COVID-19 Risk Prevention, Reduction, and Screening Service Focus Area during the recovery phase of the COVID-19 pandemic. It also presents the quantitative impact of each service based on the frequency of occurrences or interactions, complemented by text-based and narrative data insights that highlight the role of these services in this focus area.

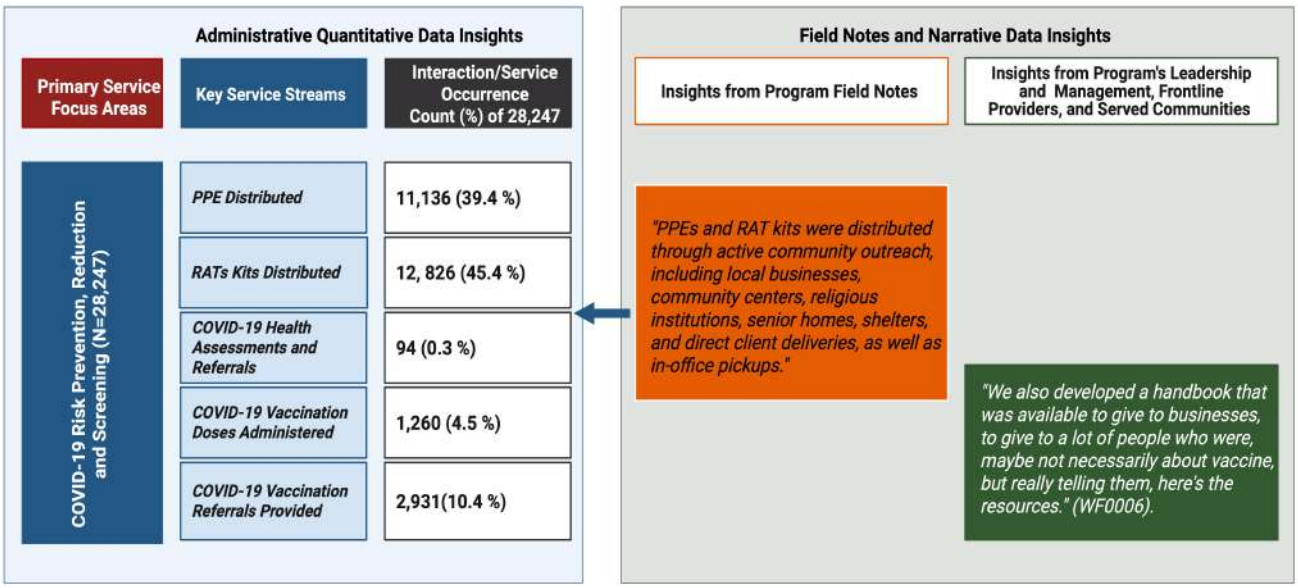


Figure 13. Main DBNC-CHA program's COVID-19 risk prevention, reduction, and screening services provided and associated interactions/occurrences and narrative insights during the pandemic recovery period (October 2022 to March 2024).

- While PPE kit distribution remained a major focus of program activities (39.4%) during the recovery pandemic, there was also a notable increase in the distribution of rapid antigen tests (RATs) (45.4%). This, along with the broader availability of public and community-based screening resources and services, reflects the evolving landscape of responses.
- COVID-19 vaccination and referral services also emerged as important contributions of the project, accounting for a combined 15.9% of the total service interactions (28,247) within this service area (**Figure 13**).

Service Navigation and Referrals

During the recovery phase of the COVID-19 pandemic, one of the key focus areas of the DBNC-CHA program was helping community members find and connect to the social and health services they needed. This was done by strengthening and streamlining referral and navigation pathways, ensuring

that people from diverse backgrounds could access the support available in their local community. This highlights the program's ongoing commitment to addressing the complex social and health needs that were intensified during and after the pandemic. It also highlights the importance of building trust and collaborating across diverse health and social sector providers to enhance the coordination and effectiveness of service access.

Figure 14 illustrates the specific types of social and health service referrals made through this program. It includes the number and percentage of occurrences of each type of referral made, showing the program's adaptation to community needs, reach and impact. These quantitative data are supported by powerful stories and insights shared by program leadership, frontline staff, and community clients who have been served. Together, they demonstrate that the program's impact extends beyond numbers. The program was adapted to support people's broader social and health needs, particularly those related to the social determinants of health. These efforts demonstrated how a community program, such as the BNC-CHA program, can bridge the gap between community members and services beyond traditional health and social institutions.

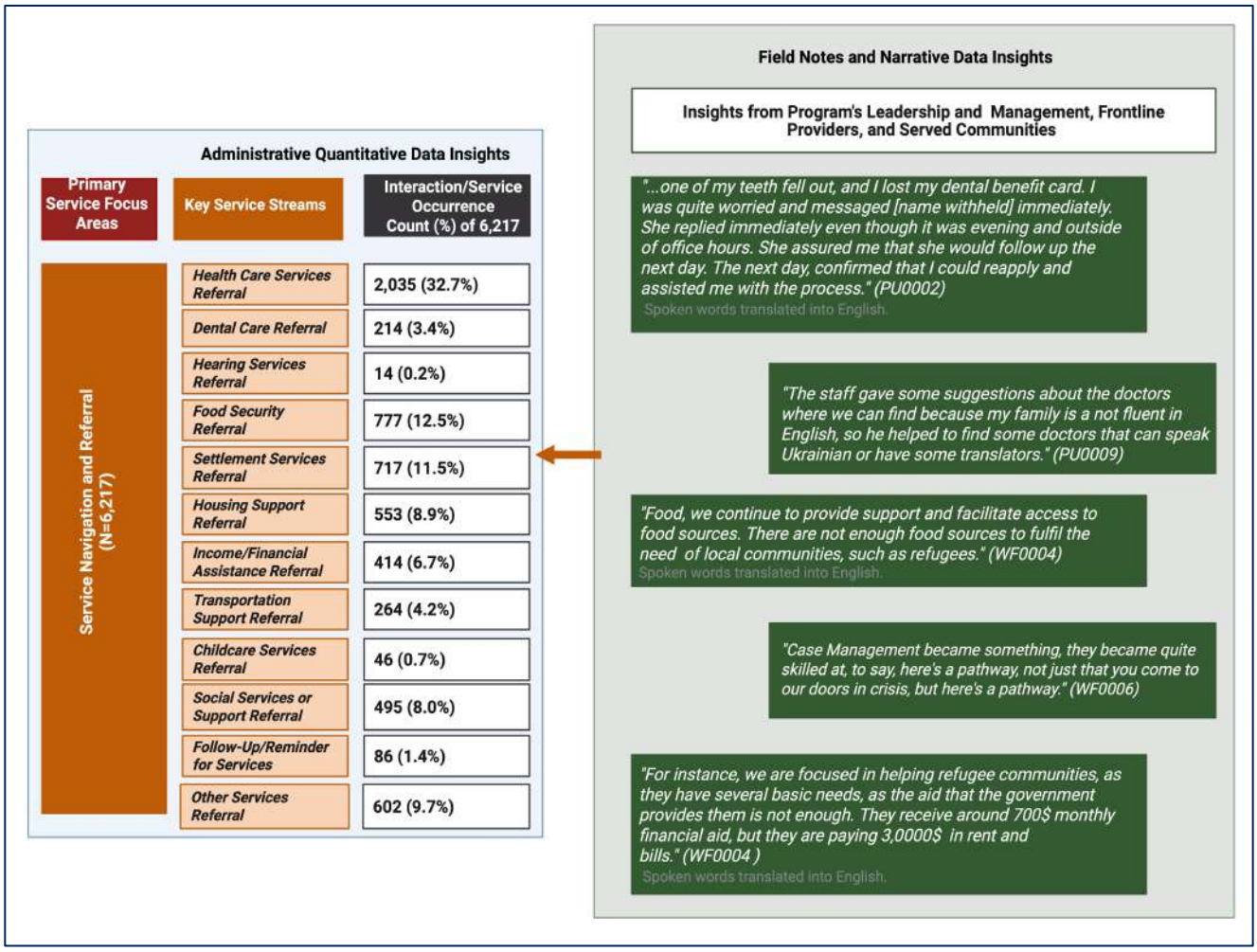


Figure 14. Main DBNC-CHA program's services navigation and referrals provided and associated interactions/occurrences and narrative insights during the pandemic recovery period (October 2022 to March 2024).

Among key areas where additional support and services were most needed, navigation support and referrals are outlined in **Figure 14** and described below.

- Healthcare referrals (e.g., referral to mental and physical clinic services and providers) made up the largest proportion (32.7%) of all referrals (**Figure 14).** This suggests that many community members were in urgent need of healthcare support during the post-pandemic recovery period. This could be due to existing health issues that were left untreated during the pandemic or new health problems that emerged because of it. It is important to note that the recovery period is when general health services, beyond emergency or urgent care, began reopening and becoming accessible again.
- Dental care referrals accounted for 3.4% (**Figure 14**). Although dental care is a vital part of overall health, it is not universally and freely covered under Canada's public health system. Narrative data insights highlight the ongoing need for access to affordable dental care, which remains a significant challenge for many individuals and families served by DBNC-CHA.
- Food insecurity was a pressing concern, with 12.5% of all referrals made for food support (**Figure 14**). Community narrative data indicate that many residents continue to face food shortages during the COVID-19 recovery period. Food insecurity has serious impacts on people's physical and mental health, as well as their overall well-being.
- Referrals to settlement services accounted for 17.5% of all referrals (**Figure 14**). This reflects the DBNC-CHA program's significant role in continuously supporting newcomers, particularly refugees, during the challenging post-pandemic period. Many DBNC-CHA narrative data insights demonstrated that immigrants and refugees face multiple challenges, including unstable housing and insufficient financial resources to meet their basic health and social needs.
- Referrals for housing support accounted for 8.9% of the total (**Figure 14**). These numbers reflect the housing crisis in local communities. Many families continue to face serious challenges finding safe, stable, and affordable housing.
- Referrals for financial support (6.7%), access to general social services (8.9%), and other types of social supports (9.7%) were also significant (**Figure 14**). These numbers reinforce what community members shared: the post-pandemic period has left many people struggling to meet basic needs, and programs like DBNC-CHA play a key role in helping bridge the gap.

Direct Health- and Social-Related Services Delivery Area

Figure 15 illustrates the vital role of the DBNC-CHA program in fulfilling its commitment to continue delivering a wide range of social services while also taking on a newly emerging role as a direct, community-based provider of health-related services, including health promotion, disease prevention and screening and enhanced access to primary care (see further details below). As reflected in both

the quantitative and narrative insights, the program actively delivered these services directly to the local Peel communities during the COVID-19 pandemic recovery. The pandemic and its broader impacts, as observed in **Figure 15,** not only highlight the commitment of local organizations like DBNC-CHA but also their capacity to step into roles traditionally reserved for formal health institutions. It also underscores the importance of addressing social determinants of health as immediate drivers of health challenges that require timely and responsive service, including those health-related services delivered by trusted local organizations.

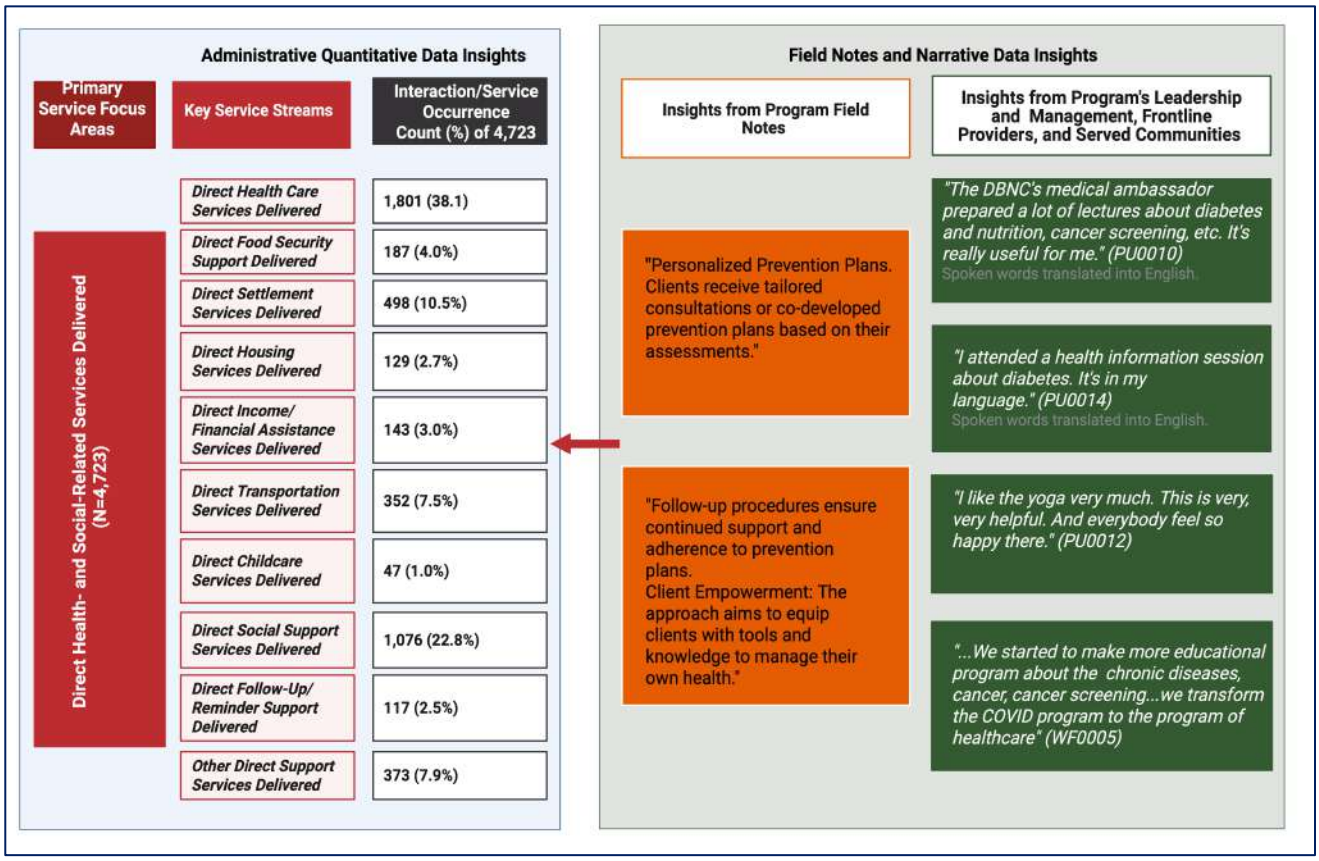


Figure 15. Main DBNC-CHA program's social and health services delivered and associated interactions/occurrences and narrative insights during the pandemic recovery period (October 2022 to March 2024).

The data presented in **Figure 15** demonstrate the promising and emerging role of the DBNC-CHA program to meet the complex and intersecting health and social needs of the community in ways that are more culturally relevant, holistic, and often more timely than traditional service models.

- Direct health care service delivery (health services and supports delivered directly by the DBNC program or in close partnership with health-related provider partners through community clinic events and health promotion sessions) accounted for 38.1% of the **4,723** total service and support interactions provided by the DBNC-CHA program during the recovery pandemic period (**Figure 15**).

- Food support represented 4.0% of the services directly delivered by the program, once again highlighting the ongoing struggle with food insecurity in the community, as noted in previous sections (**Figure 15**).
- General social support made up the second largest proportion of overall direct services, at 22.8%, followed by settlement services at 10.5%, and transportation support (7.5%) as another key area. These types of social supports were especially important, given that the DBNC-CHA program actively served diverse refugee and immigrant communities, as well as senior groups (as described in the community profile section below) (**Figure 15**).

As in-person interactions resumed during the post-pandemic period, the DBNC-CHA program expanded some of the above services for face-to-face delivery (**Figure 15**). This shift improved community reach by offering support in local spaces, while also leveraging partnerships and promoting inclusive engagement. In-person services helped bridge digital access gaps and fostered social connection, belonging, and stronger community ties. This is further contextualized and detailed in the following case evaluation section.

Case evaluation section: Social- and Health-Related In-Person Sessions Delivered

This case evaluation section illustrates how DBNC-CHA delivered both health and social care services in person, advancing group-based support, networking, and well-being initiatives for the diverse communities it serves. This achievement highlights the strong leadership of the DBNC program and its workforce, as well as their ongoing commitment to promoting the overall well-being of the communities they serve.

In-person social sessions:

Figure 16 provides a sample overview of the in-person social sessions delivered by the DBNC-CHA program during the recovery period of the COVID-19 pandemic, including total attendance and the key communities served.

South Asian, Chinese, and Arabic-speaking communities were among the primary groups engaged in targeted topics or activities. The program offered tailored sessions focused on social integration, networking, and fostering a sense of belonging through topics such as financial literacy, cultural influences, equity, diversity and inclusion, parenting, and employment. The data also highlight broad community participation in sessions ranging from everyday skill development to health education and financial management, demonstrating the program's responsiveness to community needs and its adaptability in delivering diverse and meaningful support.

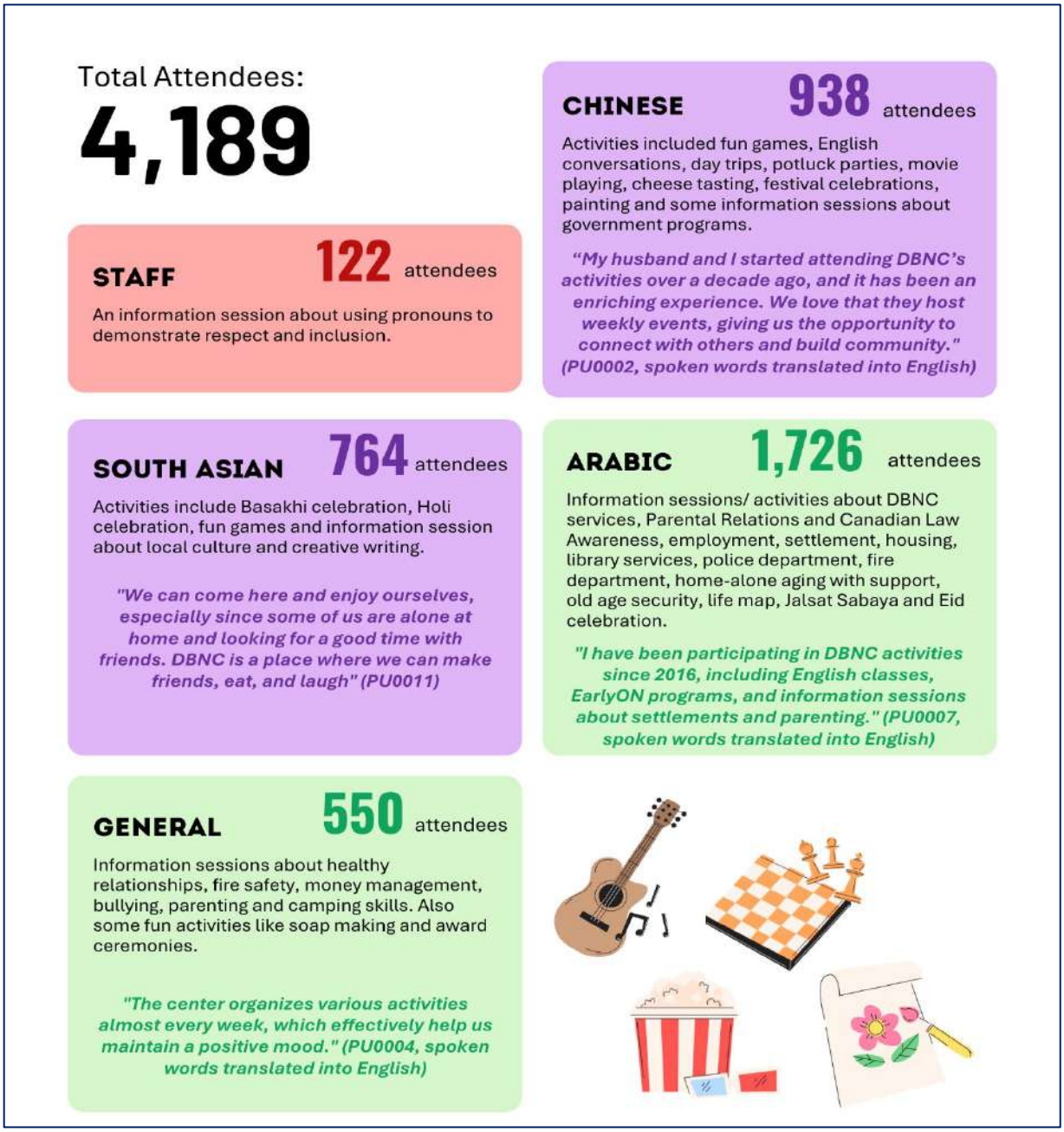


Figure 16. A sample of the main DBNC-CHA program in-person social sessions, associated attendee figures and narrative insights during the pandemic recovery period (October 2022 to March 2024).

In-person health sessions:

Figure 17 provides a sample overview of the in-person health-related sessions delivered by the DBNC-CHA program for diverse local communities during the COVID-19 pandemic recovery period. The figure illustrates how tailored sessions were designed to meet the specific needs of different cultural groups. For example, sessions for the Chinese community focused on accessible health practices, including yoga, mindfulness, and gentle exercise, as well as mental and overall well-being. For South Asian communities, sessions addressed diabetes prevention and management as well as

mental well-being. Sessions with Arabic communities included information on navigating the local healthcare system, available services, and strategies for building wellness and resilience. Additionally, general community sessions provided education on the importance of preventive screening and check-ups, as well as emotional and mental well-being.

Figure 17. A sample of the main DBNC-CHA program in-person health session and associated attendee figures and narrative insights during the pandemic recovery period (October 2022 to March 2024).

Supporting Mental Health: Service Referral and Delivery

Figure 18 illustrates how mental health emerged as a key focus area for the DBNC-CHA program during the recovery phase of the COVID-19 pandemic, highlighting the program's ongoing commitment to adaptation and responsive service delivery to support the holistic health of served communities. Given the traumatic nature of the pandemic and its widespread impact—social, financial, and health-related challenges, the need for mental health and substance use support was clear within the local communities served by DBNC-CHA.

Out of the total 4,838 service interactions or occurrences (including both direct supports and referrals) related to mental health and substance use support, quantitative and qualitative data highlight the significant emphasis of the DBNC-CHA program, providing support through direct services or referrals, as detailed in **Figure 18** and below.

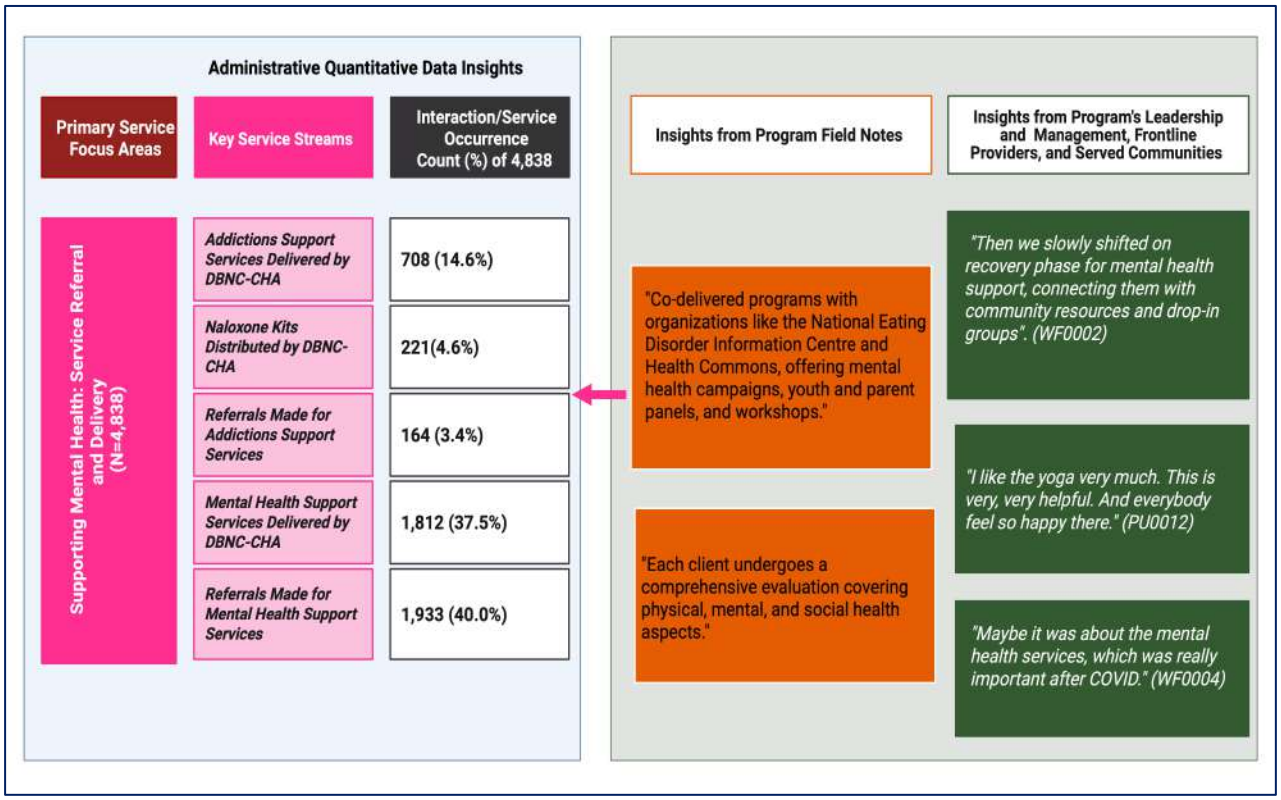


Figure 18. Main DBNC-CHA program's mental health and addiction services delivery and referral, and associated interactions/occurrences and narrative insights during the pandemic recovery period (October 2022 to March 2024).

- Addiction-related support services (e.g., addiction and harm reduction services and support and prevention) accounted for 14.6% of the overall share of mental health and addiction service interactions or occurrences (out of 4,838 total). In addition, the distribution of naloxone kits made up 4.6% of this total, both figures indicating that substance use concerns were a significant issue

within the communities served by the DBNC-CHA program (**Figure 18**). The program responded proactively by adapting its approach and leveraging available resources to meet these emerging and exacerbating needs.

- Mental health support (e.g., emotion awareness and management, mental mindfulness and well-being), both through direct services and referrals to external providers, represented a substantial portion of service delivery in this area. Specifically, direct mental health support accounted for 37.5%, and mental health referrals made up 40% of the total service interactions related to mental health and substance use (**Figure 18**).

The data in **Figure 18** further emphasize the heightened mental health and well-being challenges experienced by local DBNC-CHA served communities during the recovery of the COVID-19 pandemic period, challenges often worsened by broader financial, social, and health-related impacts.

Enhancing Access to Primary Care

Figure 19 presents the two main components—primary care attachment and referrals—through which the DBNC-CHA program supported and enhanced access to primary care for the communities it served during the recovery pandemic period.

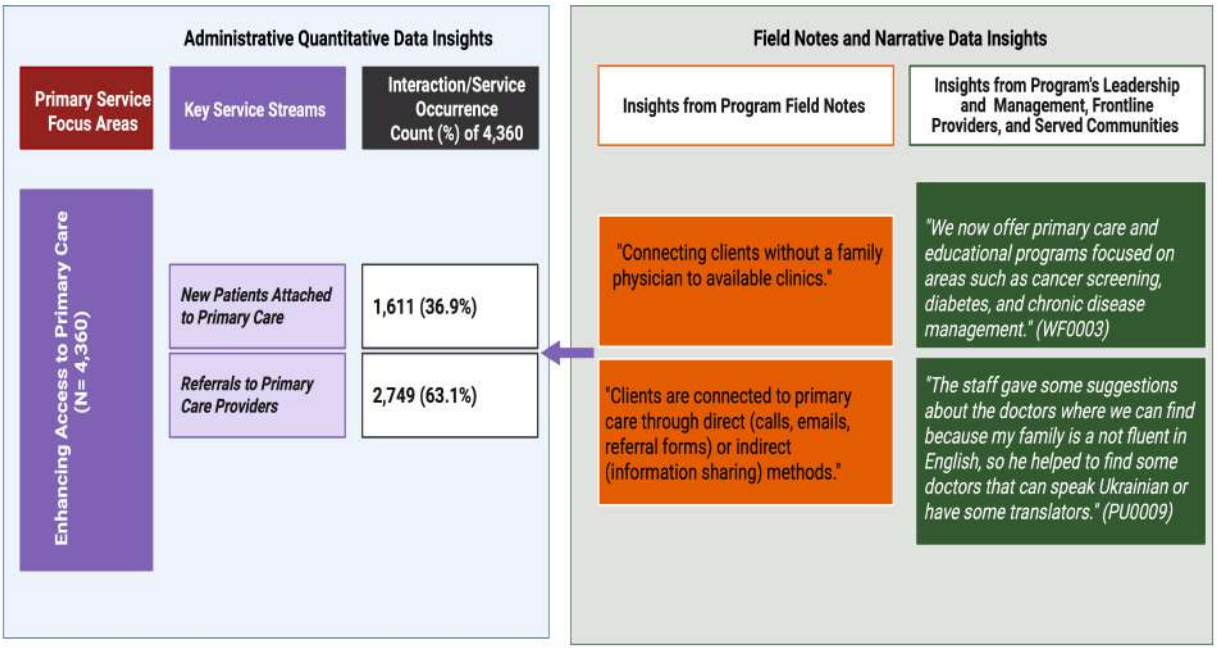


Figure 19. Main DBNC-CHA program's primary care services supported and associated interactions/occurrences and narrative insights during the pandemic response period (October 1, 2022, to March 31, 2024).

- Of the total 4,360 interactions/occurrences, 36.9% involved attaching new patients to a primary care provider. In contrast, 63.1% consisted of referrals or linkages to primary care services. This

indicates that many individuals served by the DBNC-CHA program lacked an existing primary care provider to support their health needs. Given that primary care serves as the main entry point to both physical and mental health services in Canada, this gap is significant. Furthermore, the high proportion of referrals demonstrates that local communities faced substantial unmet health needs that extended beyond what the DBNC-CHA program could directly provide, reinforcing the importance of coordinated care and access to primary health services, which was a service role the DBNC-CHA program actively supported.

Supporting Physical Health: Screening, Referrals and Service Delivery

Figure 20 illustrates the various healthcare screening supports that the DBNC-CHA program provides during the pandemic recovery period. Specific attention was given to screening, monitoring, and referral services tailored to population health conditions such as diabetes, eye health, and cancers, including breast and cervical cancer. This demonstrates how community-based health services can significantly enhance the reach and coverage of critical health condition monitoring, particularly for diverse ethnocultural and socio-economic communities that often face individual, cultural, and systemic barriers to accessing or seeking such screenings.

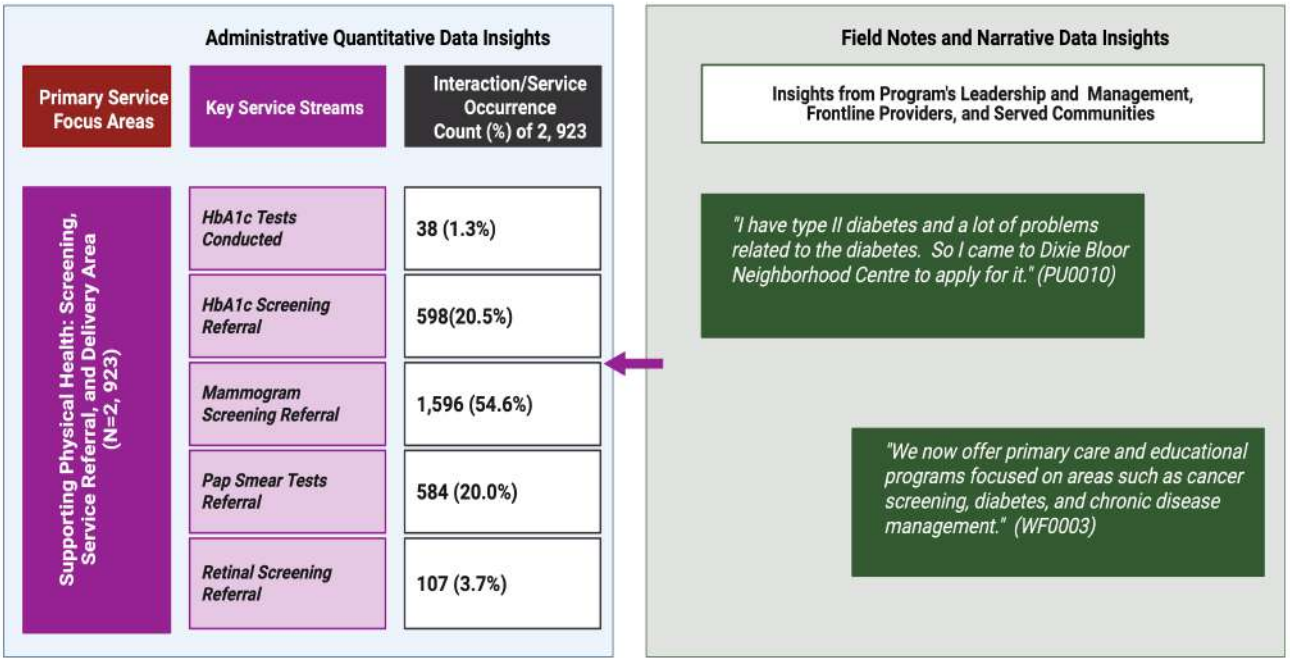


Figure 20. Main DBNC-CHA program's specific health conditions screening and referral services supported and associated interactions/occurrences and narrative insights during the pandemic recovery period (October 2022 to March 2024).

- Screening and monitoring for diabetes were supported through both direct administration of haemoglobin A1c (HbA1c)tests and external referrals for testing, representing 1.3% and 20.5% of the overall (N = 2,923) interactions/occurrences in this area, respectively (**Figure 20**). This

highlights diabetes monitoring as an important health concern among the populations served by the program.

- Referrals for breast cancer screening (mammograms) accounted for 54.55% of the total 2,923 interactions/occurrences(**Figure 20**). The enhancement of this service is important given the ethno-cultural and religious diversity of the women served by the program, many of whom may be underserved or face barriers—whether individual, contextual, or systemic—that limit their access to or use of breast cancer screening services.
- Referrals for cervical cancer screening (Pap smears) represented 20% of the overall interactions in this area. Facilitating access to Pap smear testing for cervical cancer is a significant contribution of the program (**Figure 20**), particularly for the highly diverse female populations it serves.
- Referrals for retinal screening (including diabetic retinopathy) accounted for 3.5% of the overall share of specific screening-related referrals, further underscoring the program's role in addressing key health needs related to screening (**Figure 20**).

Enhancing Access to Preventive Care Services

Figure 21 presents both the quantitative and narrative insights related to the preventive services delivered/supported by the DBNC-CHA program during the pandemic recovery period. Collectively,

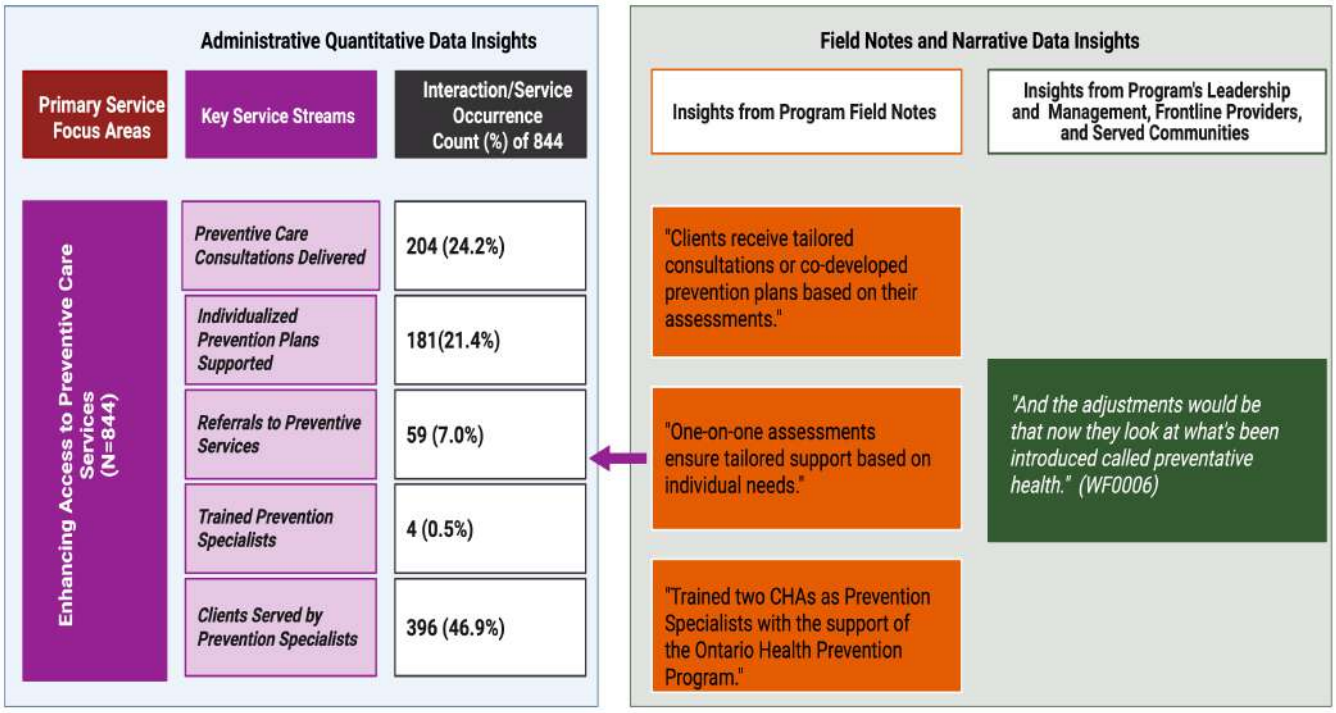


Figure 21. Main DBNC-CHA program's specific preventive care services supported, associated interactions/occurrences and narrative insights during the pandemic recovery period (October 2022 to March 2024).

these data demonstrate the important role of DBNC-CHA in preventive care, further confirming its evolving profile as both a community-based health and social service provider.

- Preventive care consultations accounted for 24% of the 844 total interactions/occurrences in this area of support. Through these consultations, the CHA frontline workforce, in partnership with existing local prevention specialists, supported clients in identifying their individual preventive care needs and subsequently provided direct or referral support to address these needs appropriately (**Figure 21**).
- 21.4% of the interactions involved the development of individualized preventive care plans, highlighting the program's commitment to tailoring prevention strategies to the unique needs of clients (**Figure 21**).
- 7.1% of the interactions involved referrals to external preventive services (e.g., mental, physical, and chronic disease preventive services, as well as services addressing intersecting social determinants of health) in the community.
- 0.5% of the DBNC-CHA workforce were formally trained as Prevention Specialists, contributing to this focused area and enabling the program to provide immediate in-house preventive support as reflected in the above preventive main insights.
- Finally, 46.5% of the total 844 interactions involved services delivered in a close partnership between the program Case Manager, who assessed the unique social and health needs of their served clients, and existing local Prevention Specialists who actively supported meeting such needs (**Figure 21**).

From Crisis to Recovery: Perceived Community Impacted Outcomes from the Perspective of the DBNC-CHA Program's Clients

This evaluation section presents the key and unique community outcomes that were positively influenced by the DBNC-CHA program, as described by the community clients it served. It provides additional evidence of the various outcomes the program positively supported, as shared by the clients themselves. It adds depth to the overall implementation and service impact data (based on mandatory key performance indicators) presented in the previous section. Drawn from semi-structured interviews with a sample of 14 DBNC-CHA service clients, these insights into impact span both the response and recovery phases of the COVID-19 pandemic. We asked participants to share what they felt were the top three most significant impacts the DBNC-CHA program had on them, using the following question: *What are the three main positive impacts you or your family experienced through the services you (have) received through the DBNC-based Community Health Ambassador Program (DBNC health team)?*

The findings underscore the program's central impact on community outcomes by addressing the health and social challenges and needs faced by diverse Peel communities, as observed from the perspective of those directly served during the pandemic. Offering these firsthand accounts complements the program achievements described earlier and reinforces the CHA program's sustained and critical impact on supporting community social and health well-being.

The three main categories of positive community-perceived outcome impacts are as follows and cover the overall DBNC-CHA response period: January 2021 to March 2024:

- Enhanced Health-Related Support & Knowledge
- Improved Capacity to Overcome Barriers and Meet Resource Needs
- Strengthened Social Networks, Basic Needs Support, and Overall Well-Being

Each of these perceived impact categories is further detailed below.

Enhanced Health-Related Support & Knowledge Impact

Figure 22 illustrates the *Enhanced Health-Related Support & Knowledge* impact outcome category, highlighting narrative insights from DBNC-CHA program clients. It highlights the specific aspects of health that community members valued, along with examples of health-related outcomes that positively impacted them. These findings further support the critical role that DBNC played in

promoting, supporting, and addressing the health and well-being of local Peel communities during both the response and recovery phases of the pandemic. The DBNC-CHA program's ongoing adaptation in the recovery period continues to demonstrate this commitment as presented in the previous section of this evaluation report.

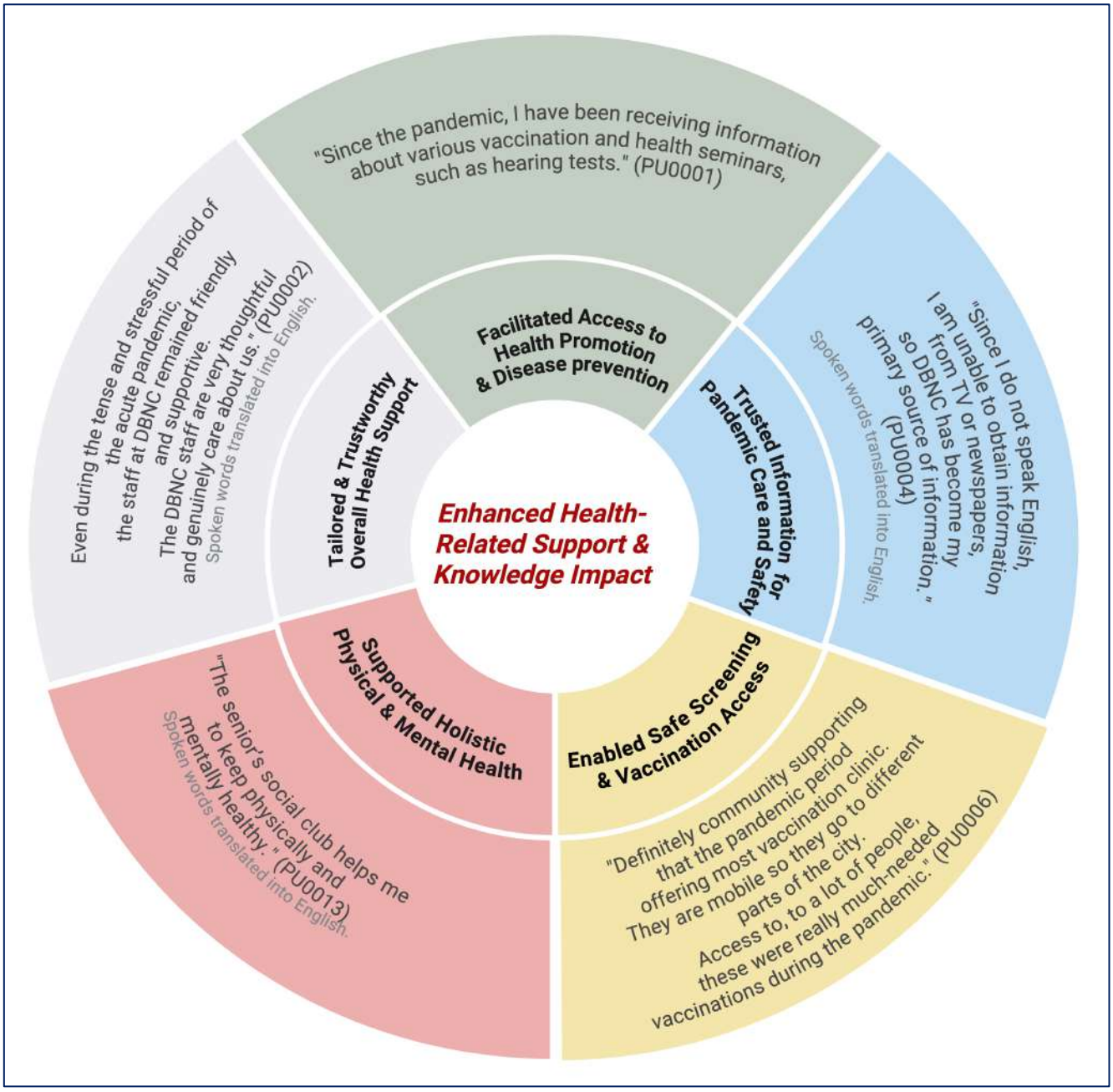


Figure 22. Main community-perceived health-related and knowledge impacts of the DBNC-CHA program from the perspective of clients served during the COVID-19 pandemic response and recovery periods(January 2021 to March 2024).

Among the main perceived positive community outcomes driven by the program were:

- **Facilitated Health Promotion & Disease Prevention.** This impact extended beyond COVID-19, encompassing broader awareness and prevention efforts related to chronic conditions, disease

screening, and general health promotion. Community members valued the multidisciplinary support the program offered in helping them stay informed and take proactive steps to promote their health and prevent and manage illness (**Figure 22**).

- **Trusted Information for Pandemic Care & Safety.** In a time of overwhelming and sometimes conflicting messaging, participants viewed the DBNC-CHA program as a trusted, accurate, and culturally appropriate source of COVID-19-related information. The program offered education on prevention, infection control, and adherence to public health measures. The program's outreach, utilizing diverse and accessible strategies (in-person, community partnerships, and virtual and media communication channels), helped increase awareness and promote safe practices during critical periods of the pandemic (**Figure 22**).
- **Enabled Safe Screening & Vaccination Access.** The DBNC-CHA program played a pivotal role in advocating for, facilitating access to and delivering COVID-19 screening and vaccination services. Through community outreach and frontline engagement, the program effectively reached underserved populations, including seniors, individuals in congregate settings, newcomers, refugees, and those facing language, financial, or transportation barriers, ensuring equitable access to essential health services (**Figure 22**).
- **Supported Holistic Physical & Mental Health.** Community members appreciated the range of activities and support the program offered to promote both physical and mental well-being. These included culturally relevant recreational programs, group-based activities, and linkages to additional health services. Supports were tailored to meet the needs of individuals based on their age, language, culture, and personal preferences, contributing to a more comprehensive approach to wellness (**Figure 22**).
- **Tailored & Trustworthy Overall Health Support.** Participants valued the client-centred and culturally responsive approach of the DBNC-CHA program. The program conducted health and social assessments, provided internal support, and made referrals to external health services, all while maintaining a user-driven, personalized approach to care (**Figure 22**).

Improved Capacity to Overcome Barriers and Meet Resource Needs

Figure 23 presents the *Capacity to Overcome Barriers and Meet Resource Needs* impact outcome category, as perceived by community members served by the DBNC-CHA program. It shows that local communities faced various pandemic-related challenges, including limited access to resources and barriers within the health and social systems. The DBNC-CHA program was perceived to have contributed positively to addressing these barriers and enhancing problem-solving capacity, enabling communities to receive appropriate support and solve their unique needs and challenges across multiple dimensions—from health to effective system navigation and access to related services. The

key community-reported outcomes within this category are illustrated in **Figure 23** and briefly described below:

Figure 23. Main community-perceived improved problem-solving for barriers and resource needs impacts of the DBNC-CHA program from the perspective of clients served during the COVID-19 pandemic response and recovery periods(January 2021 to March 2024).

- **Facilitated Language Bridging Services.** Language barriers were a prevalent challenge for many communities in Peel, where residents often spoke languages other than English. This impacted their ability to access and receive appropriate health and social services. DBNC-CHA provided accessible and supported language bridging interpretation and translation supports, which community members found to have had a positive impact on their lives. (**Figure 23**).

- **Received Culturally & Linguistically Appropriate Support.** DBNC offered culturally and linguistically responsive health and social services. Served communities viewed these efforts as crucial in providing more barrier-free personalized and equitable access for them, many of whom belong to diverse communities with varying linguistic and cultural backgrounds (**Figure 23**).
- **Offered Flexible & Accessible Care & Social Support.** Clients appreciated the program's use of multiple service delivery formats—online, outreach, and in-person—tailored to meet their diverse and intersecting needs. For many, such flexibility was essential due to challenges in mobility, digital access, or caregiving and work responsibilities/barriers, demonstrating the program's strong commitment to ensuring inclusive and flexible service delivery (**Figure 23**).
- **Enabled Access to Material Resources.** The program supported access to tangible resources, including communication technology services (e.g., Internet access) and digital devices. During the height of the pandemic, when many health and social services transitioned to virtual platforms, these supports were critical to ensuring continued access. The program also provided support directly to people's homes, such as in residential buildings or congregate settings, which helped meet community needs effectively by reducing service access barriers **(Figure 23).**
- **Facilitated Effective Pathways to Government & Broader Community Support.** This outcome underscores the DBNC-CHA program's role in helping clients navigate complex and broader systems to access government services, financial aid, healthcare, and other social benefits (e.g., tax filing support). By creating these pathways, the program enabled greater system accessibility and reduced the burden on and unequal access for underserved community members (**Figure 23**).

Strengthened Social Networks, Basic Needs Support, and Overall Well-Being

Figure 24 presents the community-perceived impact of *Strengthened Social Networks, Basic Needs Support, and Overall Well-Being*. Communities served by the DBNC-CHA program felt that the program contributed positively to creating opportunities for increased social connection, friendship, and a sense of belonging through tailored, culturally sensitive, and diverse activities, including leisure and group-based events. These were seen as essential sources of coping and meaningful support, particularly in addressing loneliness, social exclusion, and limited access to community resources. Additionally, the program was perceived to play a significant role in supporting communities with basic material needs and aiding newcomers who often struggle to access health, financial, and social services.

The positively impacted outcomes that community members identified are presented in **Figure 24** and briefly described below:

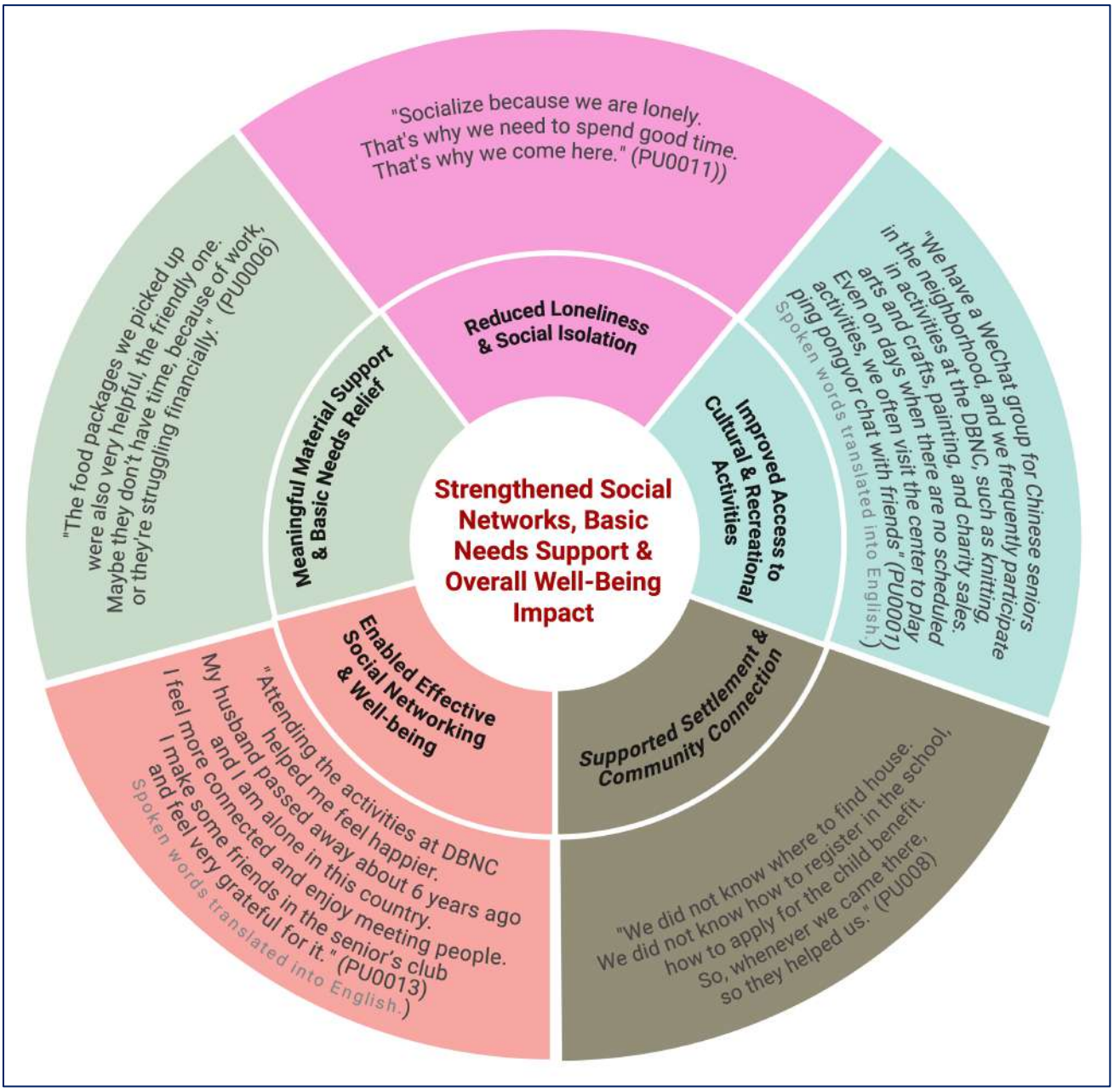


Figure 24. Main community-perceived strengthened social Networks, basic needs support & overall well-being Impact of the DBNC-CHA program from the perspective of clients served during the COVID-19 pandemic response and recovery periods(January 2021 to March 2024).

- **Reduced Loneliness & Social Isolation.** Loneliness and social isolation were significant concerns among local Peel communities served by DBNC-CHA programs during the pandemic. Participants recognized the DBNC-CHA program's meaningful role in alleviating these challenges through its social and leisure activities. These supports were especially critical for older adults

living alone and for diverse ethno-cultural groups, including immigrants and refugees, who often face barriers to community connection and have limited social networks (**Figure 24**).

- **Improved Access to Cultural & Recreational Activities.** Community members valued the opportunity to participate in a variety of cultural and recreational activities organized and delivered by the program, recognizing it as a positive outcome of the DCBC-CHA program. These activities not only supported their cultural expression but also facilitated community connection, skill development, and improvements in overall social and emotional well-being (**Figure 24**).
- **Supported Settlement & Community Integration.** The program supported newcomer communities, particularly refugees, by helping them address settlement challenges related to social and community integration, functioning, and support. These supports were particularly impactful during the pandemic, when access to services was limited and opportunities to socialize and interact with others were also restricted (**Figure 24**).
- **Enabled Effective Social Networking & Well-Being.** The DBNC-CHA program helped community members enhance their social networks, improve integration, and foster a sense of belonging. These experiences contributed to participants feeling more supported and happier. The program had a positive impact on individual and community well-being, underscoring the importance of integrated, wraparound supports that address the social aspects of health and overall well-being (**Figure 24**).
- **Meaningful Material Support & Basic Needs Relief.** The program made a significant and tangible contribution to addressing everyday material needs, particularly in the area of food security. These supports were essential given the financial strain many program clients experienced during the response and recovery phases of the pandemic (**Figure 24**).

Driving Success: Core Enablers of the DBNC-CHA Program During the Pandemic

This section outlines the key enabling factors that contributed to the DBNC-CHA program's impact during both the response and recovery phases of the COVID-19 response in Peel. It emphasizes the role of multi-level and integrating factors in sustaining program success during times of public health and social crisis. Findings are based on interviews with four frontline providers, including former ambassadors and case managers from diverse ethnocultural backgrounds, as well as three members of the leadership and management team. The four main themes or success factors identified are summarized in **Figure 25** and described below.

Leadership/Management-Related Factors

Key leadership and management actions were central to the program's success. These included securing funding despite uncertain government support, fostering internal and external collaboration, and responding to community feedback. Leadership also prioritized capacity-building for ambassadors and staff, many of whom lacked prior experience in crisis response. The DBNC and DBNC-CHA leadership's commitment, adaptability, and community-centred approach were crucial in sustaining the program and maximizing its impact during the COVID-19 pandemic **Figure 25**.

Workforce-Related Factors

This theme highlights that the passion and sense of purpose among the DBNC-CHA program workforce, many of whom had lived experience as immigrants or shared cultural and linguistic backgrounds with the communities served, were key to the DBNC-CHA program's impact. It also underscores the valuable contributions of ambassadors, frontline providers, and managers with formal training in health-related fields, including internationally trained professionals who brought their expertise to support the local community during the pandemic **Figure 25**.

Community Partnership-Related Factors

Establishing cross-sector partnerships, including health, education, social services, law enforcement, food, private, cultural, and government sectors, was a key driver of the DBNC-CHA program's impact. Additionally, as outlined in the previous section, the DBNC-CHA successfully established partnerships with other organizations in Peel that were also delivering the CHA program, thereby further strengthening a shared commitment to serving local communities in the region. These collaborations enabled coordinated pandemic responses, facilitated the sharing of resources, and achieved a greater impact. The program demonstrated that joint efforts are essential not only during

public health and social crises, but also in addressing the complex, intersecting needs of local communities beyond these crises (**Figure 25**).

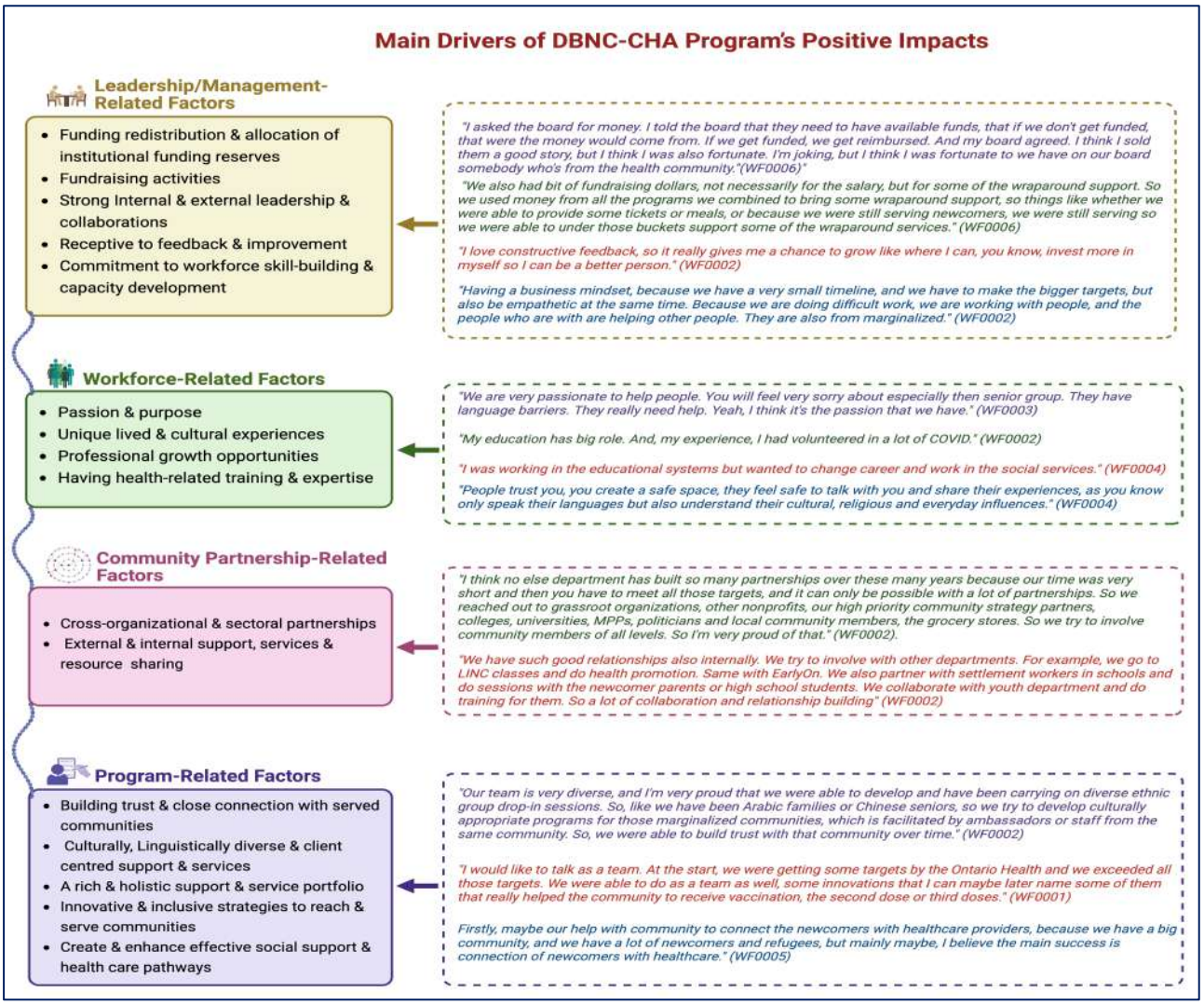


Figure 25. Main factors contributing to the DBNC-CHA program's success, impact, and adaptations during the COVID-19 pandemic (January 2021 to March 2024).

Program-Related Factors

Being able to establish and adapt a diverse and well-rounded portfolio of social and health-related programs responsive to the ongoing needs of local communities, was identified as a key factor in the DBNC-CHA program's impact (**Figure 25**). Despite resource constraints, many of the services the program offered were culturally and linguistically aligned with the communities they served. This approach strengthened existing relationships and reinforced trust between the DBNC agency and the local community, which was essential for ensuring the program's continued impact (**Figure 25**). This demonstrates that local community organizations, which already have strong connections with their communities and a deep understanding of their needs, are often better positioned to maximize the reach and effectiveness of public health interventions in urgent public health situations and beyond than more traditional or outsider-led service providers.

Barriers To Success: Challenges Faced by the DBNC-CHA Program During the Pandemic

This section presents findings based on narrative evaluation data collected from DBNC-CHA leadership, management, and the frontline workforce. They were asked (*What were/are the three main challenges you experienced in such a role? Which factors contributed to such challenges?*) to identify the main challenges they experienced in their roles, as well as broader challenges they observed throughout the project's implementation, delivery and adaptation of the DBNC-CHA.

As previously highlighted in the 'Driving Success' findings section, the DBNC-CHA program addressed the diverse and intersecting social and health needs of local Peel communities during the COVID-19 pandemic, due to various cross-sectoral and cross-level factors and efforts. However, it is equally important to understand which factors hindered program implementation, service delivery, and impact. This is especially relevant given that the community-based ambassador model was a new and unprecedented approach in a public health crisis, launched with limited planning time. Therefore, understanding the challenges faced by the DBNC-CHA program can inform ongoing adaptations during the post-pandemic recovery phase and guide the development of future community-based initiatives. These insights are crucial for enhancing pandemic and social crisis preparedness and response efforts at all levels, particularly through models grounded in community engagement that have demonstrated effectiveness in promoting public health and addressing complex local needs during the pandemic crisis and beyond.

Four overarching challenge categories were identified that directly or indirectly hindered, diminished, or interfered with the implementation, service delivery, and adaptation of the DBNC-CHA program. Each is presented below, along with **Figures 26 to 29.**

Program Structure & Implementation Challenges

This category is presented in **Figure 26** and encompasses key intersecting challenges, including **gaps in monitoring, evaluation, and feedback loops; a lack of clear operational guidelines and implementation/adaptation plans; an evolving program model without adequate system-level support; and limited integration of community-based workforce learnings.**

The different narratives from the leadership and frontline workforce described how implementing this type of community-based program was highly reactive, with minimal guidance or sustained support from funders and health and social systems (**Figure 26**). Despite DBNC's strong foundation as a social service provider, the organization was not adequately prepared or equipped to respond to a

public health crisis of this magnitude. There was no integrated technical or operational support framework to guide implementation, workforce training, or resource allocation in support of the CHA program response model.

The absence of sustainable funding and clear planning timelines made it difficult to determine which services could be implemented, how many staff could be hired and trained, and what the expected meaningful and key community impacts should be. While DBNC staff brought critical lived, cultural, and linguistic experience, as well as health and social skills, to the pandemic response, there was a need for greater recognition, system-level advocacy, and commitment to support their leadership, employment stability, and workload. Without sustainable financial investment and structured capacity-building support, the program's ability to respond effectively and scale its impact was significantly challenged (**Figure 26**).

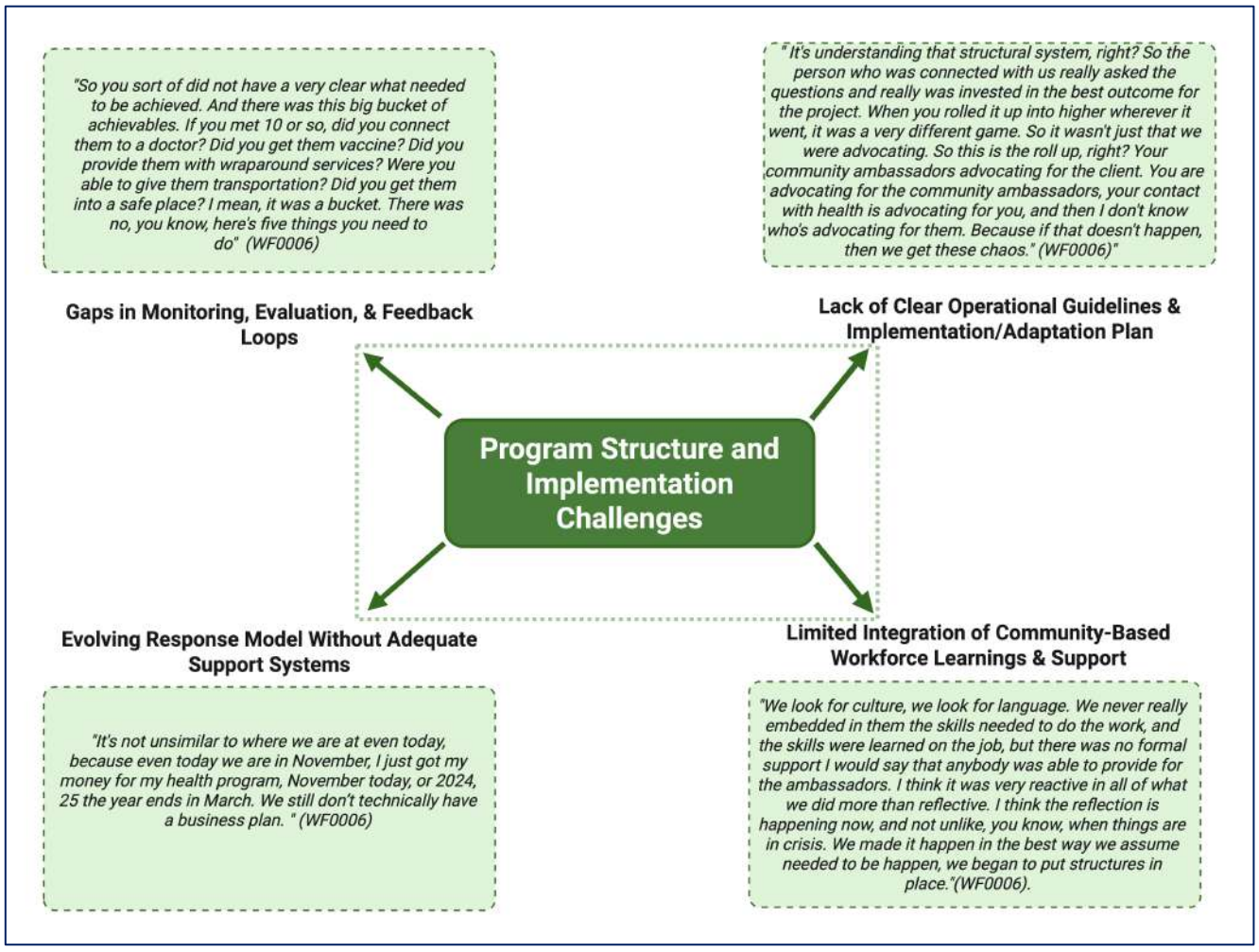


Figure 26. The program structure and implementation challenges impacting the DBNC-CHA program, during the COVID-19 pandemic response and recovery periods (January 2021 to March 2024).

Capacity and Resource Constraints

The main components of this challenge category are presented in **Figure 27**. These challenges relate directly to having sufficient and appropriate capacity and resources to implement an effective and impactful health and social response in local communities during the COVID-19 pandemic. A pandemic community-based model like DBNC-CHA, designed not only to support a single pandemic-related objective (e.g., vaccination) but also to address the intersecting social, health, communication, and structural needs of diverse local communities, requires a strong embedded capacity and sustained resource support. Many of the communities the DBNC-CHA served faced significant barriers, including language, financial constraints, cultural and religious influences, and complex family or individual circumstances. Key challenges in this category included: **Insufficient and unstable funding for program continuity**; **High demand for social and health support outpacing available resources**; **Gaps in digital access and communication tools, including limited digital literacy**; **Limited capacity to recruit, train, and retain workforce across all roles (outreach, coordination, leadership)** (**Figure 28**).

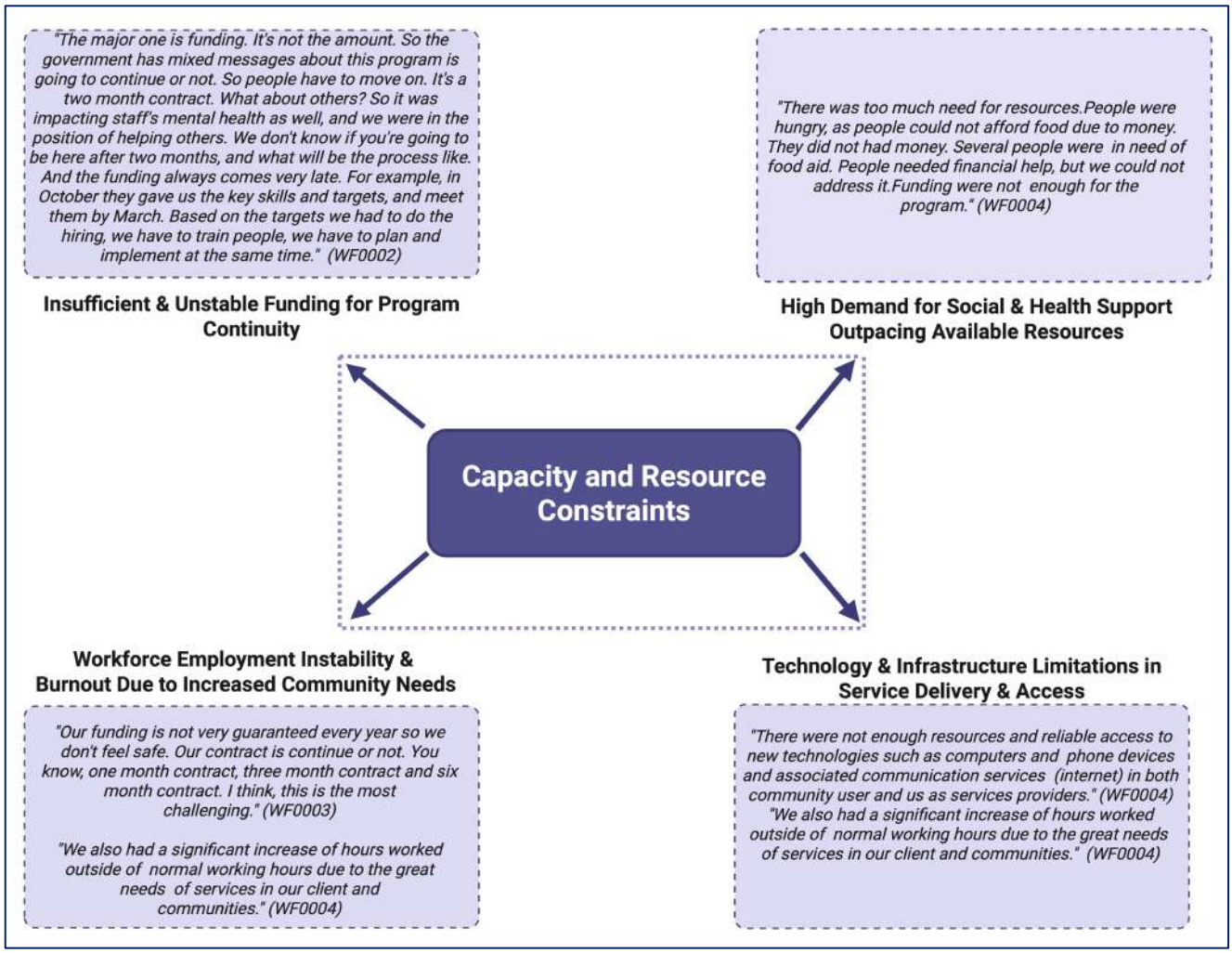


Figure 27. The program capacity and Resource challenges impacting the DBNC-CHA program during the COVID-19 pandemic response and recovery periods (January 2021 to March 2024).

The narrative data (**Figure 27**) revealed that the community's needs were vast and complex, ranging from access to basic resources, such as food, to functional communication infrastructure, including reliable internet and the skills to utilize it, which surpassed the DBNC-CHA's capacity and resources. At the same time, there was a pressing need to ensure community organizations like DBNC had the timely financial and logistical support to sustain program delivery and staff well-being. The workforce, particularly frontline staff, often felt immense pressure as they became the sole source of support and hope for many community members. This was especially evident in cases like isolated seniors, who lacked access to communication tools, social networks, or a clear understanding of the evolving public health situation. Without stable funding and adequate resources, these supports were at risk, jeopardizing the DBNC-CHA program's capacity to meet the complex and overlapping needs of the served Peel communities.

Cultural and Community-Specific Challenges

Figure 28 presents the main components of cultural and community-specific challenges, which include the following: **Influence of cultural norms on health-seeking behaviours**; **Language barriers and lack of culturally appropriate communication**; **Community hesitancy toward external support or collaboration**; and **Stigma and mistrust impacting service uptake.** The findings in this section demonstrate that in highly diverse communities, where people come from different socio-cultural, religious, and linguistic backgrounds, such as in Peel, these factors significantly influence how public health and social issues are understood, perceived, responded to, and addressed. They also shape how services are received, interpreted, and trusted.

These challenges directly impacted both program implementation and its effectiveness. For example, stigma and mistrust, rooted in past experiences in their countries of origin or current local Peel settings and systems, along with misinformation or weak connections to local systems and within and between communities, often led community members to hesitate or reject available supports. Despite DBNC-CHA's strong efforts to deliver culturally and linguistically appropriate services, the vast diversity in the local Peel population made consistent service delivery and adaptation challenging (**Figure 28**).

Similarly, while the program built strong partnerships and demonstrated collaboration across sectors (as discussed in the impacts and enabling factors section), gaps remained in engaging often overlooked yet influential community actors, such as small and large businesses that serve as key hubs for local communities. Additionally, in some communities, seeking health or social support is not culturally typical, unless help comes from familiar or traditional sources. Having outreach workers or unfamiliar individuals promoting health or services at the doorstep may not align with these community expectations or practices, further complicating engagement and uptake (**Figure 28**).

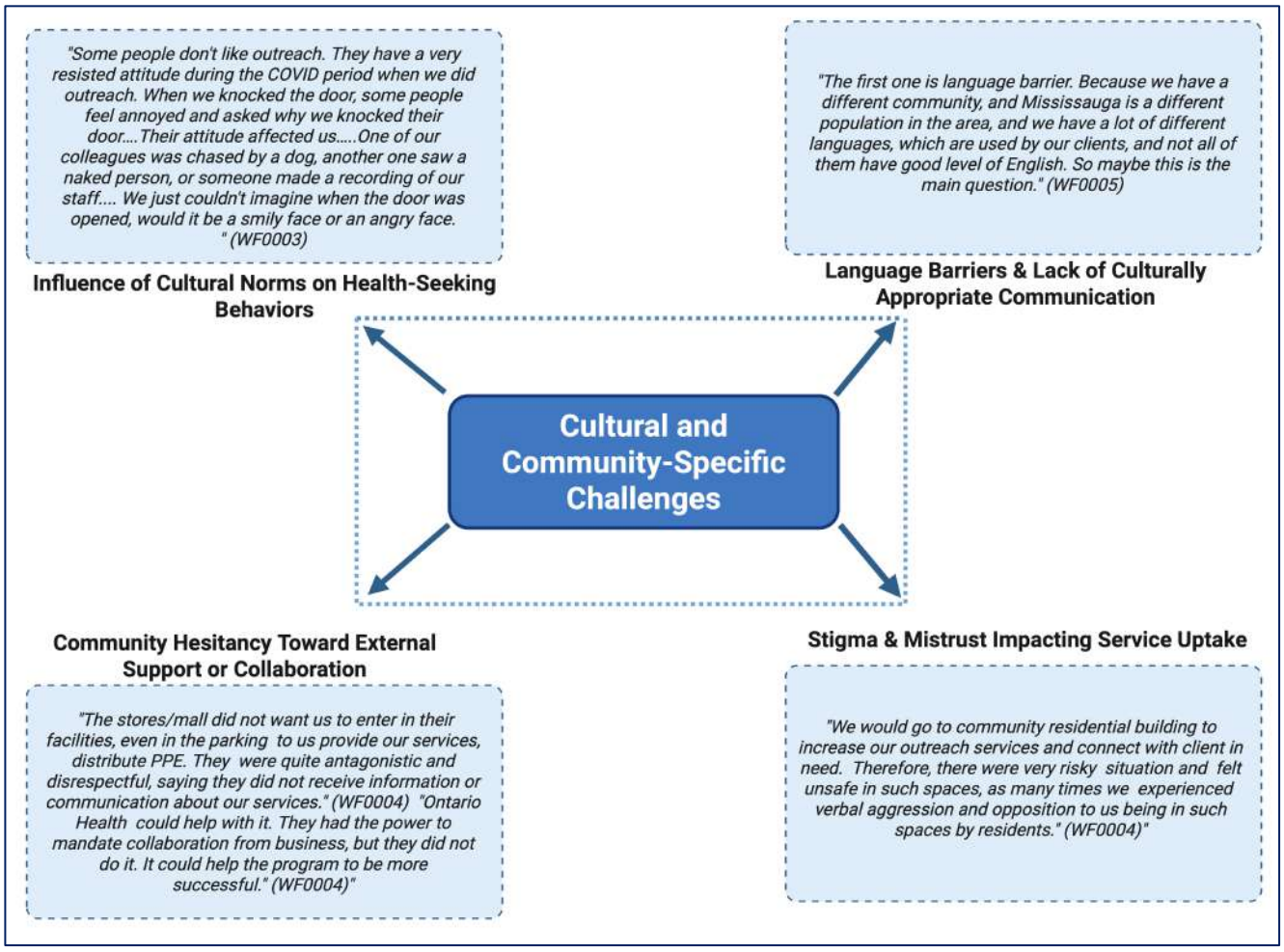


Figure 28. The program's cultural and community-specific challenges impacting the DBNC-CHA program during the COVID-19 pandemic response and recovery periods(January 2021 to March 2024).

Information, Communication, and Misinformation Challenges

Figure 29 outlines the key components of this theme. Narrative data emphasized that timely, accurate information is vital for effective program implementation, delivery, uptake, adaptation, and overall impact. During public health and social crises, such as the COVID-19 pandemic, community-level communication becomes especially critical. In highly diverse regions such as Peel, where residents hold varied cultural, religious, linguistic, and economic backgrounds, perceptions of public health measures can differ significantly. Therefore, communication must be culturally and linguistically tailored to promote inclusive engagement.

The DBNC-CHA program encountered challenges where many community members were either unaware of the program or unclear about its purpose. This was often linked to limited access to trusted information sources, particularly in the languages and formats relevant to community members, and the absence of culturally appropriate communication strategies. The lack of engagement with traditional community leaders, such as faith or cultural leaders, who are often more

trusted than formal healthcare providers, further hindered outreach and trust-building efforts (**Figure 29**).

Additionally, the absence of coordinated and unified public health and social messaging created confusion. Contradictory pandemic response messages between governmental, political, or community figures undermined public trust, reduced adherence to health measures, and negatively impacted the reach and effectiveness of programs like DBNC-CHA. Disparities in access to technology and digital communication tools compounded these challenges. Many essential health and social services, including those beyond the DBNC-CHA program, shifted to online formats during the pandemic **Figure 29**). However, not all served community members had access to smart devices, reliable internet, or the digital literacy required to navigate these systems. As a result, certain groups faced significant barriers in accessing vital services. They needed additional support to bridge the digital divide and mitigate the reach and impact of the DBNC-CHA program **(Figure 29**).

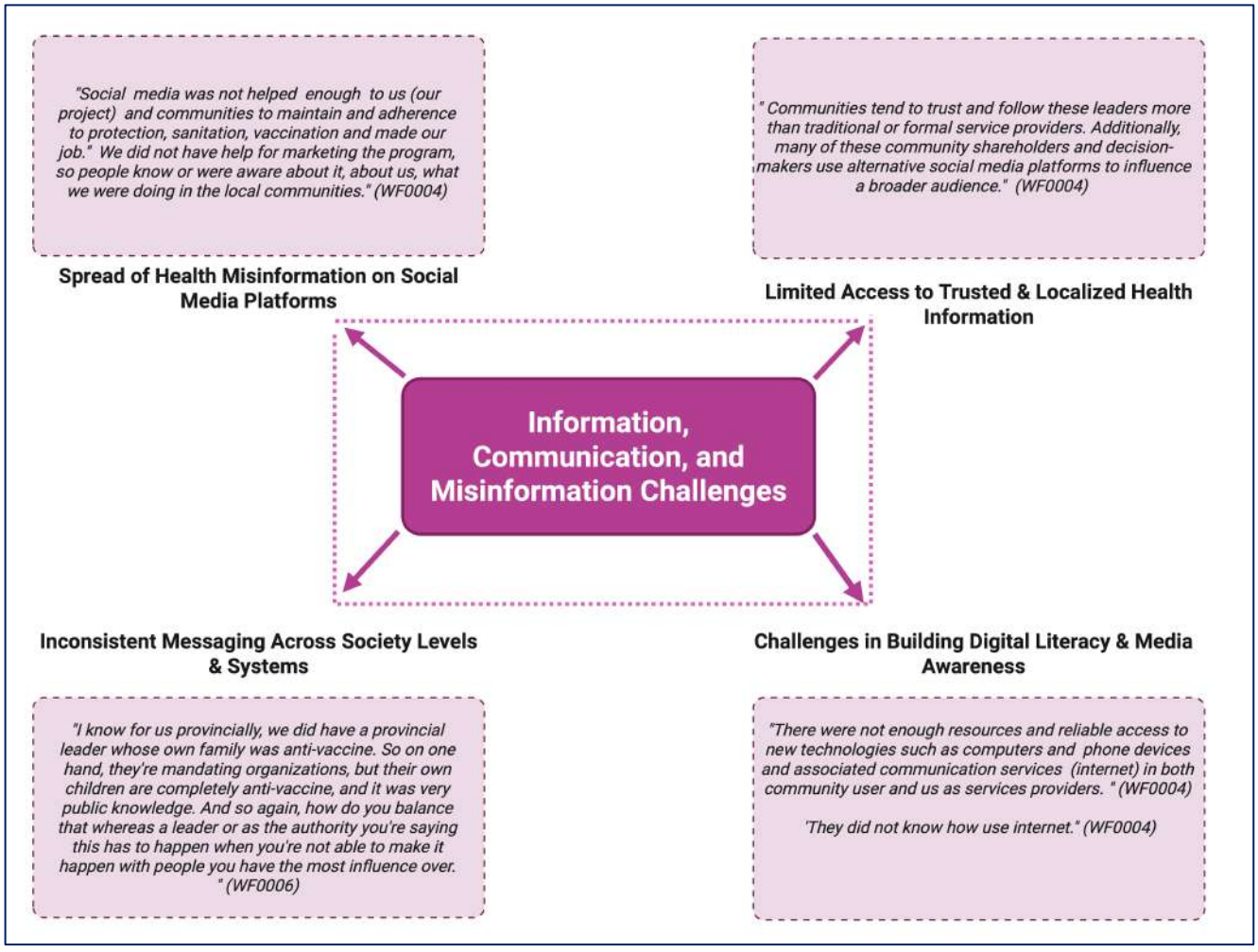


Figure 29. The program's information, communication, and misinformation challenges impacting the DBNC-CHA program during the COVID-19 pandemic response and recovery periods(January 2021 to March 2024).

Unmet Demands: Community Needs Requiring Expanded Support Beyond the DBNC-CHA Program

This section presents the evaluation findings based on narrative data collected from the leadership and managers of DBNC-CHA programs, frontline workers, and community members they serve across diverse local communities in Peel. It highlights the persistent structural and intersecting unmet needs within these communities during the COVID-19 response. Despite the extensive efforts and services delivered by the DBNC-CHA program during both the response and recovery phases, many of these needs remain unaddressed. These ongoing unmet needs are deeply rooted in broader structural and systemic determinants of health, issues that exceed the program's scope, resources, and mandate. As such, while the DBNC-CHA program cannot be expected to resolve all the complex social, economic, and health challenges faced by communities, its CHA model and community-focused program have proven to be an effective and trusted approach.

The findings support the need to continue investing in and expanding or adapting CHA-like program models. Such community programs are uniquely positioned to improve health and social outcomes in diverse local communities. However, their impact can only be sustained and maximized if structural gaps are addressed through coordinated, adequately resourced services and policies, as well as commitment at the governmental and system levels.

Figure 30 presents the four main structural unmet need themes identified, which are briefly described below.

Daily Living Needs & Economic Insecurity

Data shows that local communities in Peel face significant **financial and material resource strains** due to unstable income sources, including **unemployment and job insecurity**. Inadequate financial support, especially for certain groups such as refugee communities, further exacerbates this situation. These challenges impact their ability to meet everyday needs, including paying bills, covering rent, and supporting childcare and family well-being. One key consequence of financial hardship is **food insecurity**, a critical indicator of both health and poverty. The data indicate that food insecurity remains a pervasive health and social concern across diverse communities and families in Peel, as served by the DBNC-CHA program (**Figure 30**).

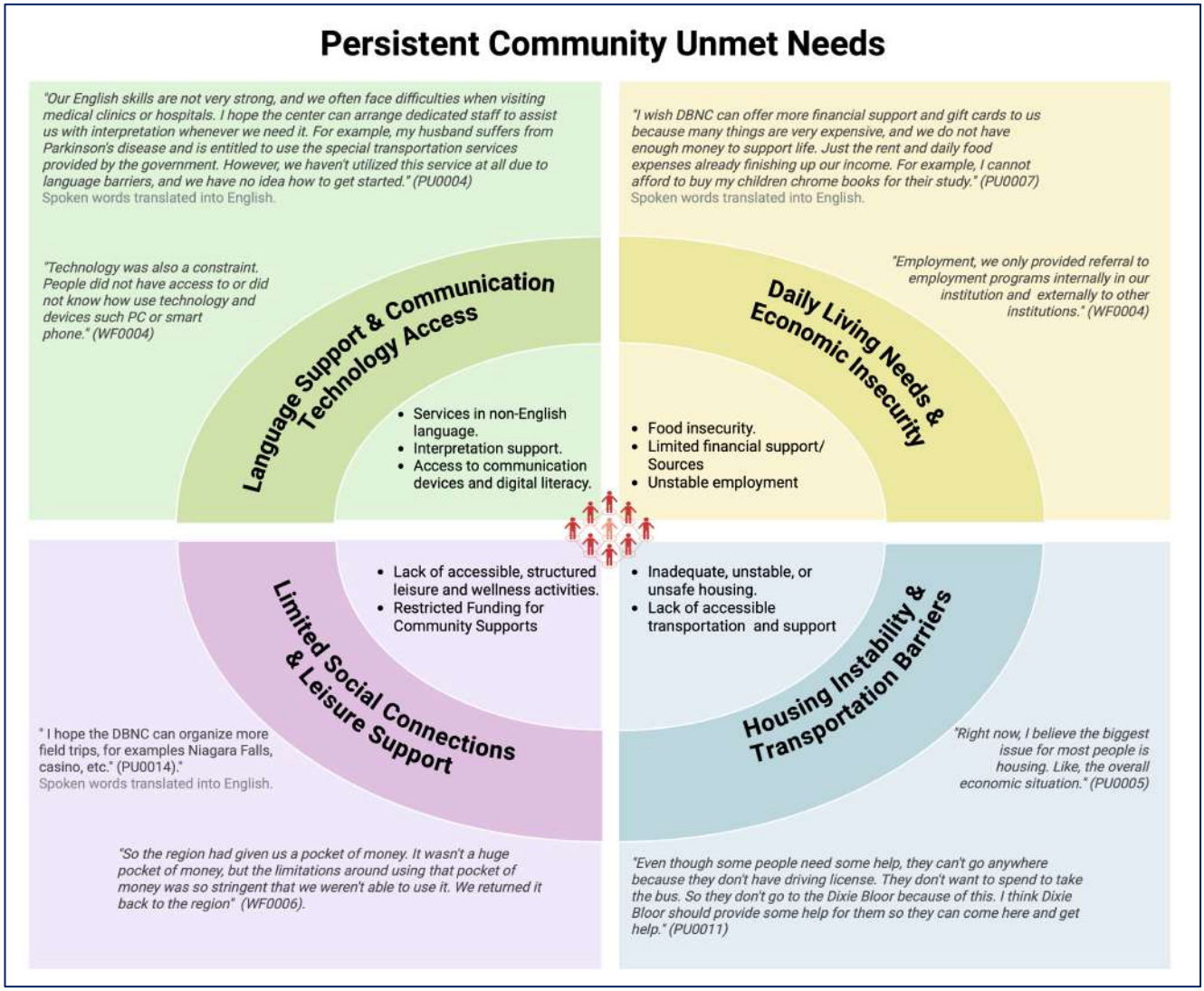


Figure 30. The main ongoing structural unmet needs among local community members served by the DBNC-CHA during the COVID-19 pandemic response and recovery periods(January 2021 to March 2024).

Housing Instability & Transportation Barriers

Housing instability and overcrowding were also identified as major concerns (**Figure 30**), tied to issues of housing accessibility, affordability and financial constraints (previously described). The narrative data revealed that many families and individuals in Peel lack access to safe and stable housing. Multigenerational families lived in small, inadequate spaces that were neither safe nor sufficient to accommodate all household members. This not only impacted housing and family well-being but was also seen as a serious public health concern during the pandemic, as it limited people's ability to quarantine or isolate when exposed to COVID-19 (**Figure 30**).

In this same category, **transportation accessibility and affordability** were also identified as critical unmet needs (**Figure 30**). These challenges are closely linked to financial constraints and the

availability of appropriate means of transportation, as many Peel community clients and frontline providers emphasized that access to affordable transportation remains a significant gap. This need is especially pronounced among seniors, who require both financial support and suitable transportation services to access health and social services, as well as to meet daily needs such as shopping and leisure activities. (**Figure 30**).

Limited Social Connections & Leisure Support

Local communities served by the DBNC-CHA program expressed that many of their **leisure and broader well-being needs remain unmet**. Community members expressed a desire for more structured and accessible leisure and wellness activities that extend beyond local neighbourhood programs or those offered by community initiatives, such as DBNC-CHA (**Figure 30**). They emphasized the importance of affordable opportunities to participate in activities such as trips to natural areas or cultural landmarks, which can enhance their well-being and foster social connection both within and beyond their immediate communities.

Feedback from DBNC program leadership also highlighted that many social and health-related well-being needs continue to go unaddressed. A contributing factor was the **inflexible funding policies** associated with local, provincial, and federal financial support. These rigid expenditure rules usually prevent resources from being allocated toward the structural and intersecting needs observed during the pandemic response and ongoing program adaptation needs that local communities continue to face. This limits the program's ability to respond effectively to the social, leisure, health, and financial challenges experienced by diverse communities in Peel (**Figure 30**).

Language Support & Communication Technology Access

Despite strong efforts to provide services in languages beyond English, **a significant gap remains in the availability and accessibility of health and social supports in other languages** (**Figure 30**). Many community members in Peel speak and function in languages other than English, and the linguistic diversity is so vast that structural investments are needed to meet these communication needs. There is also a strong call for more **consistent access to interpretation services** across social and healthcare pathways, as language barriers directly affect individuals' ability to access timely and appropriate services (**Figure 30**). Additionally, since the onset of the pandemic, many health and social services transitioned to online platforms for booking, delivery, and follow-up. However, **local communities lack access to communication devices (e.g., phones, computers) or the necessary digital literacy** to navigate these systems. These digital barriers further limit their access to services and participation (**Figure 30**).

Community-Driven Strategic Recommendations for Program Sustainability, Adaptation, and Impact

This section presents the primary strategic recommendations for further enhancing the DBNC-CHA program's improvement, sustainability, and community impacts. These recommendations are grounded in leadership and management insights, frontline provider observations, and program user narratives, guided by questions such as: *"How can community-driven strategies ensure program sustainability, adaptation, and impact?" and "How can local organizations address emerging public health or social challenges, as seen during the COVID19 pandemic?"*

The evidence from the previous sections, combined with the collaborative, data-driven recommendations in this section, demonstrates the transformative role that these programs' services have played and continue to play in the social and health wellbeing of local Peel communities. Both program leadership and the workforce, alongside the communities they serve, call for sustaining and expanding the program's social and health services and impacts, considering their recommendations. Before the COVID-19 pandemic, DBNC focused primarily on social service delivery. During the pandemic response, the organization, through the DBNC-CHA program, expanded into a community health provider role and continues to do so today. Supporting and enhancing these inclusive, community-based health services is essential to overcoming access barriers and extending care to where people already live.

Community organizations are uniquely positioned to offer holistic, intersectional social and health supports that are culturally sensitive and tailored to local needs. These approaches are not only vital for responding to future public health or social crises but also for ongoing health promotion, disease prevention, and management within diverse Peel communities and beyond, as illustrated in **Figure 31**, which outlines the recommendations.

Figure 31 illustrates the community-based collaborative and strategic recommendation organized into five pillars, each with specific strategies for program enhancement and sustainability. The main pillars are briefly explained below.

Figure 31. Key community-informed recommendations for program improvement, adaptation, and sustainability to enhance social and health impacts in the local communities.

Structural and Social Challenges

This pillar addresses three major structural and public health concerns facing Peel communities: food insecurity, poverty, and interpersonal violence. These issues intersect, and while the DBNC-CHA program has helped alleviate immediate needs, such as connecting community members to financial aid, employment supports, and essential food resources, these challenges require broader structural policies, actions, investment and resources. As a single community-based organization, DBNC cannot fully resolve socioeconomic conditions alone; systemic policy changes are needed to sustain and scale improvements in these structural areas of the community, as shown in **Figure 31.**

Infrastructure, Access, and Inclusion

This pillar focuses on strengthening the infrastructure needed to expand DBNC-CHA services throughout Peel. First, it calls for increased physical spaces, both fixed facilities and mobile clinics, to support a diverse range of activities, from social connection and leisure programs to health promotion and disease prevention services. Such strategies can increase the reach of seniors with limited mobility and other community members who are unable to attend fixed sites. Second, the pillar emphasizes the importance of improving digital capacity and access. By providing community members with communication devices, reliable internet access, and technical support, the community see that technology-driven disparities in service utilization can be reduced. This is critical, as the COVID-19 pandemic has accelerated the shift to online social and health service accessibility, delivery, and usage. Finally, robust language and transportation supports (including interpretation services and transit assistance) are seen as essential to ensure equitable access to programs not only at initial contact points but across the entire service pathway (**Figure 31**).

Accessibility, Delivery, and Continuity of Health Services

This pillar calls for supporting the DBNC-CHA program in expanding and sustaining its role in health promotion, preventive care, and primary care services for local communities. While originally focused on social services, the DBNC agency, through its DBNC-CHA program, has earned a trusted reputation as a community health provider among the communities it serves, positioning it to continue providing diverse health services beyond the COVID-19 pandemic response. Community members recognize the program's impact on pandemic preparedness and recommend integrating primary care providers into existing DBNC-CHA facilities to ensure seamless access to ongoing care in a one-stop service entry (**Figure 31**).

To support this enhanced health care role, participants suggested leveraging internationally educated health professionals, many of whom share cultural and linguistic ties with Peel's diverse communities and offering emergency and priority services within the community organization. These strategies could strengthen the community-based program model, address local health priorities, and solidify community organizations, such as DBNC, in providing holistic, accessible care (**Figure 31**).

Workforce Capacity, Training, and Well-being

These recommendations outline strategies to strengthen and sustain the workforce involved in the ongoing adaptation and delivery of the DBNC-CHA program's social and health services. Drawing on lessons learned from the COVID-19 pandemic response led by the program, it emphasizes the importance of ensuring the community-based workforce has access to ongoing training and capacity-

building opportunities to better address both the social and health needs of the communities they serve during the acute response and recovery phases of the pandemic, as well as beyond. This includes training on mental health, trauma-informed care, and culturally responsive practices (**Figure 31**).

The collaborative recommendations also call for robust and sustained funding commitments to enhance employment security and foster long-term engagement among frontline workers. Since the implementation of the DBNC-CHA, it has faced funding constraints and a lack of consistent financial support, resulting in ongoing employment insecurity and hiring constraints for the frontline, outreach, and coordination workforce. Additionally, the recommendations call for establishing robust mental health and wellness supports for frontline workers, who often carry the emotional burden of supporting individuals with complex social and health needs. Finally, there is a strong call to create pathways for internationally trained professionals to contribute meaningfully as recognized health providers within community-based health initiatives. Supporting their integration and professional recognition can promote sustainable employment, financial stability, and social inclusion, while also enriching the local health workforce with culturally and linguistically relevant skills (**Figure 31**).

Community Engagement, Leadership, and Policy

This recommendation component calls for enhanced efforts to meaningfully engage often-overlooked community representatives and leaders, including cultural, faith, and religious influencers, as well as those in more formal structural and systems-level positions, such as public health agencies and local political representatives. These individuals can play a key role in amplifying the work and impact of community-based programs like DBNC-CHA, especially in diverse regions such as Peel, where communities represent a range of ethnocultural, economic, religious, and cultural identities that directly or indirectly shape their health-seeking behaviours and participation in social and health initiatives. In addition, initiatives such as DBNC-CHA require strong and ongoing inclusive marketing and supportive communication campaigns to raise awareness, increase service uptake, and encourage community participation, thereby expanding reach and amplifying impact. Finally, there is a strong recommendation to ensure that these trusted and vital community-based initiatives receive sustained, adequate, and appropriate financial resources, as well as system-level support. This is particularly important for programs addressing multidimensional and intersecting social and health needs, often for populations who, due to structural, systemic, and individual barriers, may only be able to access services provided by their local community organizations (**Figure 31**).

Evaluation Limitations

This evaluation presents a robust and detailed analysis of the implementation and impact outcomes of the DBNC-CHA program's COVID-19 response from July 2021 to March 2024.

While the evaluation utilized program administrative data recorded during the evaluation period, it is essential to note that this data was collected in accordance with pre-defined reporting requirements established by the funder (the government). Such key implementation and impact outcomes were not selected or developed in partnership with the DBNC program team. This limited the ability to conduct a deeper or more tailored evaluation that distinguishes between implementation and impact outcomes. This approach would have allowed for a better understanding of the project's impacts and helped guide appropriate project adaptation, scaling, and funding sustainability.

A mixed-methods approach was applied only to selected sections—specifically, *DBNC-CHA's Impactful Response to the Response Phase of the COVID-19 Crisis* and *From Crisis to Resilience: Program Adaptation During the Recovery COVID-19 Period*—by drawing on both the administrative data (numeric and text-based) and narrative data collected through interviews conducted as part of this evaluation. Primary quantitative data were not available to support the quantitative part of the remaining sections of the report (*Perceived Community Impacted Outcomes from the Perspective of the DBNC-CHA Program's Clients; Core Enablers of the DBNC-CHA Program During the Pandemic; Barriers To Success; Community Needs Requiring Expanded Support Beyond the DBNC-CHA Program; Community-Driven Strategic Recommend)*; however, they are informed by first-hand experiences and include the perspectives of diverse program-related shareholders—such as program leadership, management, frontline workforce, and a sample of clients served from various communities across Peel.

The experiences of the DBNC-CHA program workforce and clients, as captured through interviews, may be subject to various biases, such as recall(memory) bias or influence stemming from their relationship with the program, which could potentially limit the diversity of perspectives. Furthermore, despite efforts to include a broad range of voices from clients across the communities served in Peel, time and funding constraints limited participation to those from the most frequently served groups. As a result, the experiences and impacts of clients from less-represented communities may not be fully reflected in this evaluation.

Finally, this evaluation covers the period from **January 2021 to March 2024**. Any recent program adaptations or shifts in funding and service delivery models that occurred after March 2024 are not reflected in this report. Continued evaluation of the program's adaptations and sustainability moving forward will be important to support its ongoing development.

Evaluation Conclusion

The DBNC-CHA program played a critical and significant role in addressing the diverse and intersecting social and health needs of local communities in the Peel region during both the response phase (2020–2022) and the recovery phase (2022–2024) of the COVID-19 pandemic. The program maintained its workforce, leadership, and financial commitment during a time of significant funding uncertainty, while also successfully assuming a new role as a community health provider. The organization served as both a direct service provider and a connector to health services, strengthening access through referrals, joint service delivery, and cross-sector partnerships with diverse organizations and providers.

Recommendations derived from the experiences of the program leadership, staff, and service clients underscore the importance of continuing to support DBNC-CHA's dual role as both a community social and health service provider. As such, they provide key strategic recommendations for program enhancement and adaptation, which require sustained and ongoing funding commitments from both government and non-governmental sources. This will ensure that local communities, especially those facing the greatest and intersecting needs, such as seniors, newcomers, refugees, and communities from diverse ethno-cultural backgrounds, identities and lower socio-economic positions, can continue to have access to the inclusive, culturally and linguistically sensitive, and trusted social and health services the program provides.

Finally, as the DBNC-CHA continues to adapt and scale, it is crucial to integrate continuous programming evaluation approaches to inform ongoing adaptation, ensure sustainability, assess impact, and support quality improvement.

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Appendices

Appendix A

Evaluation title: DBNC-based Community Health Ambassador Program (DBNC-CHA) Evaluation: Informing Program Quality Improvement to Enhance its Adaptation and Sustainability

Individual Semi-structured Interview Guide[1]: DBNC-CHA Program Leadership/Managers and Service Providers

Evaluation introduction

Thank you for agreeing to participate in this individual semi-structured interview. This interview is part of an evaluation of the Peel Community Health Ambassador program also known as DBNC health team, led and delivered by Dixie Bloor Neighbourhood Centre (DBNC). The DBNC-CHA Program aims to gain valuable insights into the implementation, adaptation, and impacts of the program during the acute (Jan 2021–Mar 2023) and recovery (Mar 2023–Mar 2024) COVID-19 pandemic periods. The goal is to identify any changes needed to enhance the program's quality of services, adaptation and sustainability and to ensure its role in supporting the diverse users' needs.

We are interviewing you to understand your experiences of planning better, delivering, adapting and managing the DBNC-CHA Program (DBNC health team). We are especially interested in your insights on the program's success, limitations, challenges, and contributing factors. We are also interested in learning about any adaptations and strategies associated with the program since its implementation during the acute COVID-19 pandemic. Additionally, we would like to understand better how the program has positively impacted or addressed local communities' social, financial, health, and other unmet needs. To inform the program's quality improvement, we are keen to understand how the program has impacted you as a leader or service provider, as these are critical elements in enhancing the program's success and capability at the frontline, leadership, and institutional levels. Finally, we would like your perspective on which aspects of the DBNC-CHA program (DBNC health team) can be improved further to enhance its adaptation, sustainability, and impact.

As you can see in the copy of this conversation guide, we shared with you, we will ask some questions to help guide the conversation, but we are flexible and will adjust based on our discussion to explore different points. The interview will last between 40 to 60 minutes. Please feel free to share any insights or ideas relevant to the topic, even if a direct question is not asked. Also, if you need a break, please let us know.

[Ask: Do you have any questions so far?] [If yes, please address interview participant questions].

Check consent and agreement to participate in the interview

Let us begin by reviewing your consent form together. Then, you can decide if you wish to participate in today's interview.

[Check whether the participant has completed the consent process and agreed to participate in the interview.] If the participant has already consented, confirm again that they are happy to participate in the interview and ask if they have any questions.

[If the participant has not completed the consent process, please review the information letter and consent form with them and obtain their verbal (virtual interview) or written (in-person) consent] and document it accordingly, as protocol]

Do you have any questions before we begin the interview?

[After confirming participants' consent] We will start the external tape recorder to record our interview discussion. Please remember that if you do not want to share your opinions or experiences on any question, you can skip it or ask for clarification. Also, if you would like to use a pseudonym, please share it with us now, and we will use it to refer to you during the interview.

[Start the audio recorder] [If the participant decides not to be recorded, please prepare to take notes of the conversation and inform the participant that you will be noting down the main points of the discussion.]

Interview Guide[1]: DBNC-CHA Program's Leadership and Service Providers

1. **Role-played DBNC-based Community Health Ambassador Program**

   a. Please tell us a little bit about your role with the DBNC-based Community Health Ambassador Program (DBNC health team).
      i Prompts: How long were or have you been in such a role?
      ii Prompts: What were/are your responsibilities?
   b. What were/are the main three successes you experienced in such a role?
      - Which factors contribute to such successes?
   c. What were/are the main three challenges you experienced in such a role?
      - Which factors contribute to such challenges?

2. **Characterize the CHA Program implementation and delivery model during the acute COVID-19 pandemic.**
   a. Can you describe the expected goals and impacts of the DBNC-CHA program (DBNC health team) during the acute COVID-19 period (2021-2023)?
   b. Have these goals and impacts been achieved?
      - What factors contributed to the achievement of these goals and impacts?
   c. What were the main services and support offered CHA program beneficiaries during the acute COVID-19 period?
      - Were these services relevant for the community/user served?
         i Prompts: Can you explain how these services were important?
   d. What services do you think communities needed during the acute pandemic that you could not provide?
      - What would you say were the main reasons for not providing these services?
   e. What would you do differently to enhance its success if you were to implement and deliver the same program under a similar public health emergency?

3. **Identify factors enhancing DBNC-CHA program implementation and adaptation.**

   a. Have the DBNC-CHA program(DBNC health team) services evolved since the acute pandemic (2021 onwards)?
   b. What adjustments or adaptations were made to the program model over time?
      - Which factors have informed such an adaptation process?
         ii Prompts: Were there specific strategies or initiatives that facilitated program adaptation during COVID-19 changing circumstances, such as the pandemic recovery period?
         iii Prompts: Were there factors (e.g., community-institutional-, financial-, or political-based) that challenged the program adaptation during COVID-19 changing circumstances, such as the pandemic recovery period?

4. **DBNC-CHA program impacts leadership and frontline workforce well-being.**

    a. Working under challenging circumstances, such as the COVID-19 pandemic, and putting in all efforts to address the community's multidimensional needs can impact the workforce. Therefore, we would like to learn whether, in your role as a leader or frontline provider (if applicable), the CHA program (DBNC health team) had any impact on your personal or professional life.
        - Could you please share how you were supported during such a period or in your role?"

5. **Informing quality improvement recommendations.**
    a. What are the top three CHA program (DBNC health team) areas that need further improvement or enhancement to ensure its impact, adaptability, and success?
    b. What steps or strategies should be taken to ensure these improvements' implementation, tracking, and evaluation?
    c. If you had the opportunity to receive sustainable and sufficient funding to scale the CHA program(DBNC health team), which services would you expand?
    d. d. Which community groups would you include in this service expansion?

6. **Overall:**
    1. Would you like to share any additional insights or perspectives that have not been covered in our discussion?

Fill in the Participant Demographic Survey

Thank you so much for sharing your insights and contributions to this project.

This is the end of our conversation, and we are pausing the recording now.

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1. These questions will be used to guide the semi-structured conversations with our study participants. They are based on our research objectives. Given the iterative nature of qualitative inquiry, these questions are expected to evolve over the interview process.

Self-reported socio-demographic information

1. What is your immigration and residency status in Canada?

1) An immigrant or refugee with a temporary resident _____
2) An immigrant or refugee with permanent residency status _____
3) A Canadian citizen _____
4) Other residency status, please specify_____

   a. How long have you been living in Canada, only for non-Canadian citizens? Years_____ Month_____

2. What is your level of education?

1) Primary school_____
2) Secondary or high school _____
3) University or higher education _____
4) Other studies (Specify)_____

3. What is your current employment status?

5) Full-time employed_____
6) Part-time employed_____
7) Unemployed _____
8) Other (Please specify) _____

   a. Only for those employed. Which sector do you work in?_____

4. What gender do you identify with the most? _____

5. Ethnicity: Ethnic origin refers to a person's ethnic or cultural origins. Ethnic groups have a common identity, heritage, ancestry, or historical past, often with identifiable cultural, linguistic, and/or religious characteristics[2]. Given this, **which ethnicity do you self-identify with the most?**

_____

6. Race: The concept of race was a social construct created to categorize people into different groups based on visual traits (e.g., skin colour, facial features, hair type), and has been and is still used to mark certain groups for exclusion, discrimination, and oppression. Therefore, racism, racial categorization and racial discrimination continue to shape the lives and opportunities of those who are categorized as "racialized people[2]. Considering this, is there a race group you are often identified with?

_____

7. What is your age in years? _____

8. Do you live in Peel? Yes_____ No_____

a) For those living in Peel, which municipality do you live in? _____

i. For those not living in Peel: Which city or municipality do you currently live in?_____

_____

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Appendix B

Evaluation title: DBNC-based Community Health Ambassador Program (DBNC-CHA) Evaluation: Informing Program Quality Improvement to Enhance its Adaptation and Sustainability

Individual Semi-structured Interview Guide[1]: DBNC-CHA Service Users

Evaluation introduction

Thank you for agreeing to participate in this individual semi-structured interview. This interview is part of an evaluation of the Peel Community Health Ambassador program also known as DBNC health team, led and delivered by Dixie Bloor Neighbourhood Centre (DBNC). This DBNC-CHA Program evaluation aims to gain valuable insights into the type of services delivered, the associated impacts and limitations of the program during the acute (Jan 2021–Mar 2023) and recovery (Mar 2023–Mar 2024) COVID-19 pandemic periods. The goal is to identify any changes needed to enhance the program's quality of services, adaptation and sustainability and to ensure its role in supporting the users' and community's needs.

We are interviewing you to understand better your experiences with the services you have received from the DBNC-CHA Program (DBNC health team). We are especially interested in having your insights on the program's success (positive impacts) and limitations in supporting your social, financial and health needs. Which services did you find valuable for you, and which ones less? We are also interested in learning about any unmet needs that you, your family, or your community have and that you think the program could help with, as well as which strategies could contribute to making it a reality. Finally, we would like to have your perspective on which aspects of the DBNC-CHA program (DBNC health team) can be improved to further enhance its value and impact for you as users or for your community, as well as its sustainability.

As you can see in the copy of this conversation guide, we shared with you, we will ask some questions to help guide the conversation, but we are flexible. We will adjust based on our discussion to explore different points. The interview will last between 40 to 60 minutes. Please feel free to share any insights or ideas relevant to the topic, even if a direct question is not asked. Also, if you need a break, please let us know.

[Ask: Do you have any questions so far?] [If yes, please address interview participant questions].

Check consent and agreement to participate in the interview

Let us begin by reviewing your consent status together. Then, you can decide if you wish to participate in today's interview.

[Check whether the participant has completed the consent process and agreed to participate in the interview.] If the participant has already consented, confirm again that they are happy to participate in the interview and ask if they have any questions.

[If the participant has not completed the consent process, please review the information letter and consent form with them and obtain their verbal (virtual interview) or written (in-person) consent] and document it accordingly, as protocol]

Do you have any questions before we begin the interview?

[After confirming participants' consent] We will start the external tape recorder to record our interview discussion. Please remember that if you do not want to share your opinions or experiences on any question, you can skip it or ask for clarification. Also, if you would like to use a pseudonym, please share it with us now, and we will use it to refer to you during the interview.

[Start the audio recorder] [If the participant decides not to be recorded, please prepare to take notes of the conversation and inform the participant that you will be noting down the main points of the discussion.]

Interview Guide[1]: DBNC-CHA Program Users

7. **DBNC-based Community Health Ambassador Program utilization**
   a. Could you please tell us about your experience as user of the DBNC-based Community Health Ambassador Program also known as DBNC health team? Specifically, we want to know how long you've used the program.
      iv Prompts: Did you use the program during the acute COVID-19 pandemic (2020–2022)? Or more during the pandemic recovery period (2023–2024)?
   b. Which services or assistance did you access through the DBNC-CHA program (DBNC health team)?
      v Prompts: Did you receive any health-related services, such as help accessing primary care, getting medicine, or receiving prevention information?
      vi Prompts: Did you receive financial aid services, such as economic support, to cover everyday living needs (e.g., buying food, paying for services or goods)?
      vii Prompts: Did you receive social support, such as connecting with other community services, child or family care support, or participating in community or group-based activities?
   c. On a scale of one to seven, how would you rate the quality of the services you received from the DBNC-based Community Health Ambassador Program (DBNC health team), with seven representing the highest quality and one representing the lowest?
   d. What aspects of the program's services did you find most helpful?
   e. What aspects of the program's services did you find least helpful?
   f. What aspects of the program should be improved to better address your needs?
   g. What aspects of the program should be improved to better address the needs of your family or community?

8. **Main positive impacts experienced through the DBNC-based Community Health Ambassador Program.**
   a. What are the three main positive impacts you or your family experienced through the services you (have) received through the DBNC-based Community Health Ambassador Program (DBNC health team)?
   b. What needs or areas has the program less impacted you, your family, or your community?
      - Which factors do you believe contributed to this lesser impact?
      - What improvements or services, if any, would you suggest to meet such needs?

c. Are there any needs or priorities that you, your family, or your community have for which you still need help or assistance and that you believe the DBNC-based Community Health Ambassador Program (DBNC health team) could address?

9. Informing quality improvement recommendations.

a. What steps or strategies should the CHA program leadership take to ensure the program's improvements and sustainability beyond the COVID-19 recovery?
b. How can local community organizations contribute to addressing the needs of local communities in similar public health or social challenge situations, like those experienced during COVID-19?
c. If you had the opportunity to ask the government for support to help with your everyday needs and the needs of your family and community, what would you ask for?

10. Overall:

2. Would you like to share any additional insights or perspectives that have not been covered in our discussion?

Fill in the Participant Demographic Survey

Thank you so much for sharing your insights and contributions to this project.

This is the end of our conversation, and we are pausing the recording now.

---

3. These questions will be used to guide the semi-structured conversations with our study participants. They are based on our research objectives. Given the iterative nature of qualitative inquiry, these questions are expected to evolve over the interview process.

Self-reported socio-demographic information

9. What is your immigration and residency status in Canada?

5) An immigrant or refugee with a temporary residency status _____

6) An immigrant or refugee with permanent residency status _____

7) A Canadian citizen _____

8) Other residency status, please specify_____

a. How long have you been living in Canada, only for non-Canadian citizens? Years_____ Month_____

10. Do you live alone or with other family or relative members?

- Alone_____
- Other family members (Please specify who, e.g., Spouse, mother) _____

_____

11. What is your level of education?

9) Primary school_____

10) Secondary or high school _____

11) University or higher education _____

12) Other studies (Specify)_____

12. What is your current employment status?

13) Full-time employed_____

14) Part-time employed_____

15) Unemployed _____

16) Other (Please specify) _____

a. Only for those employed. Which sector do you work in?_____

13. What gender do you identify with the most? _____

14. Ethnicity: Ethnic origin refers to a person's ethnic or cultural origins. Ethnic groups have a common identity, heritage, ancestry, or historical past, often with identifiable cultural, linguistic, and/or religious characteristics[2]. Given this, **which ethnicity do you self-identify with the most?**

_____

15. **Race:** The concept of race was a social construct created to categorize people into different groups based on visual traits (e.g., skin colour, facial features, hair type), and has been and is still used to mark certain groups for exclusion, discrimination, and oppression. Therefore, racism, racial categorization and racial discrimination continue to shape the lives and opportunities of those who are categorized as "racialized people[2]. Considering this, is there a race group you are often identified with?

_____

16. **What is your age in years?** _____

17. **Which municipality do you currently live in within Peel?** _____

MacMaster University. Guidance on Demographic Questions. https://research.mcmaster.ca/home/support-for-researchers/ethics/mcmaster-research-ethics-board-mreb/guidance-on-demographic-questions/

Appendix C

Letter of Information and Consent to Participate in a Semi-Structured Interview: Users of the Community Health Ambassador Program at the Dixie Bloor Neighbourhood Centre

Title of Evaluation project: DBNC-based Community Health Ambassador Program (DBNC-CHA) Evaluation: Informing Program Quality Improvement to Enhance its Adaptation and Sustainability

Principal Program Evaluator	Ian Spencer Zenlea, MD, MPH Family and Child Health Initiative, Institute for Better Health, Trillium Health Partners, Mississauga. Ian.Zenlea@thp.ca
Co- Evaluators	Cilia Mejia-Lancheros (RN, MPH, Msc.GHP. PhD). Family and Child Health Initiative, Institute for Better Health, Trillium Health Partners, Mississauga. Dianne Michelle Fierheller, PhD. Family and Child Health Initiative, Institute for Better Health, Trillium Health Partners, Mississauga.
Community Evaluator Partners	Priyanka Sheth, CEO, Dixie Bloor Neighbourhood Centre. Hameed Shaheer, Project Manager, Dixie Bloor Neighbourhood Service.
Funding Sources	This program quality improvement evaluation is funded by the Dixie Bloor Neighbourhood Centre.

Introduction

As a user of the Community Health Ambassador Program (DBNC-CHA program) also known as DBNC health team provided by Dixie Bloor Neighbourhood Centre, you are invited to participate in a semi-structured interview. This interview is part of a quality improvement evaluation aimed at gaining valuable insights into the implementation, adaptation, and impacts of the program during the response (Jan 2021–Mar 2023) and recovery (Mar 2023–Mar 2024) COVID-19 pandemic periods. The goal is to identify any additional changes needed to enhance the program's quality of services, adaptation and sustainability and to ensure its role in continuing to support the needs of the diverse users served by Dixie Bloor Neighbourhood Centre.

Before agreeing to participate in the interview, you must read and understand this consent form. It includes details about the evaluation team and its purpose, methodology, risks and benefits, confidentiality, and dissemination of findings. Also included in this form is information about the compensation for your participation. Taking part in this interview is completely voluntary. Before you sign this form, you may also wish to discuss the study with a family member, close friend or worker. If you have any questions, please ask the evaluation team members.

Information on the DBNC-CHA program Evaluation Interview

Purpose of the interview: The aims of the interview are:

3) Characterize the DBNC-CHA Program's implementation, delivery strategies, challenges, and success factors during the acute (response) COVID-19 period (Jan 2021–Mar 2023) and its adaptation during the pandemic recovery period (Mar 2023–Mar 2024).
3) Assess the impact of the DBNC-CHA Program on the social, health and economic well-being of program users, including staff and frontline workers (ambassadors).
3) Provide recommendations for improving the DBNC-CHA Program's quality, sustainability, adaptability and scalability based on the findings from objectives 1 and 2.

How many people will participate in this program evaluation interview process?

We will aim to engage 16 users of the DBNC-CHA Program to participate in a virtual or in-person, individual, semi-structured interview that will last 40 to 60 minutes.

What will the Interview process look like?

Depending on your preference, the individual semi-structured interview can be conducted virtually using the Teams app or in person (at the DBNC facilities or Institute for Better Health, Trillium Health Partners facilities) on a date that suits your availability. The format of the interview will be more conversational, allowing you and the facilitator to discuss the following main topics.

- We are interested in understanding your experiences with the DBNC-CHA Program, including the services you received and providers who offer such services, during both the COVID-19 response (Jan 2021–Mar 2023) and the recovery (Mar 2023–Mar 2024) phases.

- We would like to learn about the areas where the program has benefited you, your family, and your community, as well as any needs that the program did not address and the factors that contributed to this.
- We also welcome your perspectives or ideas for improving the DBNC-CHA services to better meet the priorities and needs of yourself, your family, or your local community.
- Additionally, at the end of the interview, we will ask for socio-demographic information such as gender identity, age group, ethno-cultural background, and the approximate amount of time you have received support or services from the DBNC-CHA Program. This information will help us characterize and analyze the data more appropriately.

Your participation in the interview is voluntary. You have the right to decide not to participate or to withdraw at any time before or during the interview. You may also withdraw your data after the interview, provided you do so before the findings are made publicly available in outputs, such as reports, academic papers, event presentations. Once the main findings are published, removing your data from the already disseminated results will be difficult.

During the virtual or in person interview, you also have the right not to answer any questions you are asked and to freely express your ideas, opinions and perspectives on the topics discussed. If you want, you can choose a nickname you would like to use during the interview process when the interviewer poses questions to you. The interview will last approximately 45-60 minutes. With your consent, the interview will be audio-recorded, and notes will be written. If you choose not to consent to the audio recording, a member of our evaluation team will be present at the virtual interview to document your responses.

What are the potential risks of participating in the interview?

By participating in this study, we expect you would not experience any significant risks to your overall well-being or your status as user of the DBNC. DBNC is committed to hearing the perspectives and inputs of their users of the DBNC-CHA Program. However, if you experienced circumstances during the COVID-19 pandemic that were challenging, you may recall such challenges or emotions. If you find a question or any part of the interview experience produces distress or uncomfortable feelings, you do not need to answer any question you do not want to answer. In addition, you can ask the interviewer to have a break if you need it or withdraw from the interview at any point**.** You can also contact the DBNC health team for advice and support or ask the interviewer to provide information on external health services if you feel you need additional support.

What are the potential benefits of participating in the interview?

By participating in this study, you may not experience any direct benefits. However, your participation will help us to understand the success and challenges of the DBNC-CHA Program and any improvements that can be made. This may bring future benefits for yourself as a service provider as the findings from this interview and program evaluation may inform additional services and resources to better support you and your community.

How will the confidentiality and privacy of the collected information be ensured?

Your details, such as name, date of birth and contact details, will be kept confidential and protected as governed by current local privacy law and international ethical principles in Canada.

Your personal identifying information will not be associated with the information you provide during the interview and the findings from the evaluation. The written information gathered during the interview will be kept separate in secured and password-protected Trillium Health Partner (THP) servers that is only accessible using encrypted and secure login. Similarly, the audio-recorded interview will be kept separate in secured and password-protected folders in password-protected THP servers. A transcript of the interview will be identified by alphanumeric code number, and you will be given the option to choose a nickname you would like the interviewer to use during the virtual or in-person interview. Any potential identifiers recorded during the audio-recorded interview or note-taking will be removed to ensure your privacy and confidentiality. Only authorized evaluation team members will have access to your identifying information and the information collected during the interview.

All audio and paper files collecting the interview data will be deleted upon transcription. In contrast, the electronic and paper files will be kept for five years from the end of the study.

Anonymized quotations (spoken words) extracted from the transcript of audio-recorded interviews may be used to illustrate the evaluation findings when communicating them in reports, papers or public or academic events. These quotations will not have any personal information that can be linked to your identity.

What are the options for participation and withdrawal?

Your participation in this interview is voluntary, and you have the right to decide whether you do not want to take part at any time before or during the interview without giving a reason. Your decision to take part or not will not affect your relationship with your employer. The evaluation team will inform you if any new information might affect your decision to participate. However, suppose you change your mind three months after your interview date. In that case, we will not be able to exclude your interview data from evaluation outputs (e.g., report, academic paper, public presentation) because, after that time, it will not be possible to remove your data from the analyzed data and published findings.

Will there be compensation for participation?

You will be given an e-gift card of $30/hour for your contribution and time in the interview.

Where will the interview take place?

The interview process will happen online using the Microsoft Teams platform or in person at the DBNC facilities or the Institute for Better Health, THP, Mississauga. The online or in-person interview facility will be in a private place so that the confidentiality of the information you provided is guaranteed.

How will the results be used or shared?

A summary of the interview and program evaluation results can be sent to you once all the data has been analyzed. This will likely occur by January 2025. You can let the interview facilitator or evaluation team know if you want to receive a copy of the results. The findings from this study (excluding your identifiers) will be shared with Dixie Bloor Neighbourhood Centre's leadership. In addition, the findings from this evaluation and interview may be shared in public events, as well as be published in academic journals or reports.

Who can be contacted if further information is required?

This study has been reviewed by the Trillium Health Partners Research Ethics Board and determined not to be human participant research.

If you have any questions about this program evaluation or interview, you may contact Dr. Cilia Mejia-Lancheros, the FCHI Research Lead, by email at Cilia.Mejia-Lancheros@thp.ca or by telephone at 437 216 6209. You can also contact, Dr. Ian Zenlea, the program evaluation lead, by email at Ian.Zenlea@thp.ca or by telephone at 905-813-4120.

DOCUMENTATION OF INFORMED CONSENT

Title of Evaluation project: DBNC-based Community Health Ambassador Program (DBNC-CHA) Evaluation: Informing Program Quality Improvement to Enhance its Adaptation and Sustainability

Participant

I have received a signed and dated copy of this **Informed Consent Statement**. I have read it or had it read to me and understand it. It describes my involvement in the program evaluation interview and the information to be collected from me.

1. **I agree and consent to participate in a virtual (online) or in-person interview**

   Yes_____ No_____

2. **I agree and consent to have the virtual (online) or in-person interview audio-recorded and field notes recorded.**

   Yes_____ No_____

3. **I understand and agree that anonymized quotations from interview may appear in published reports or papers, or at public or academic events.**

   Yes_____ No_____

Participant's signature Name (printed) Date

I was assisted during the consent process by having the consent form read to me.

☐ Yes ☐ No ____ (initial)

If yes, please check the relevant box and complete the signature space below:

☐ The consent form was read to me, and the person signing below attests that the study was accurately explained to me, and I have understood what was said.

Consent Witness

WITNESS DECLARATION OF PARTICIPANTS INFORMED CONSENT: *If a participant is unable to read independently for any reason or unable to sign, a witness should be present during the entire informed consent discussion and sign below. The witness may be a family member who is able to read.

By signing the consent form I (the consent witness) attest that the information was accurately explained to and apparently understood by the participant and that consent was given freely.

Signature of Witness	Name of Witness	Date

Signature of the Evaluation Team Member Explaining Study

Signature of Evaluation Team Member Explaining Study	Name of Evaluation Team Member Explaining the evaluation interview	Date

Type of Consent

Verbal _____ Written _____ Verbal & Written _____

Appendix D

Letter of Information and Consent to Participate in a Semi-Structured Interview: Leadership and Frontline Workforce of the Community Health Ambassador Program at the Dixie Bloor Neighbourhood Centre

Title of Evaluation project: DBNC-based Community Health Ambassador Program (DBNC-CHA) Evaluation: Informing Program Quality Improvement to Enhance its Adaptation and Sustainability

Principal Program Evaluator	Ian Spencer Zenlea, MD, MPH Family and Child Health Initiative, Institute for Better Health, Trillium Health Partners, Mississauga. Ian.Zenlea@thp.ca
Co- Evaluators	Cilia Mejia-Lancheros (RN, MPH, Msc.GHP. PhD). Family and Child Health Initiative, Institute for Better Health, Trillium Health Partners, Mississauga. Dianne Michelle Fierheller, PhD. Family and Child Health Initiative, Institute for Better Health, Trillium Health Partners, Mississauga.
Community Evaluator Partners	Priyanka Sheth, CEO, Dixie Bloor Neighbourhood Centre. Hameed Shaheer, Project Manager, Dixie Bloor at the Dixie Bloor Neighbourhood Centre.
Funding Sources	This program quality improvement evaluation is funded by the Dixie Bloor Neighbourhood Centre.

Introduction

As a leader or service worker of the Community Health Ambassador Program (DBNC-CHA program), also known as DBNC health team provided by Dixie Bloor Neighbourhood Centre, you are invited to participate in a semi-structured interview. This interview is part of a quality improvement evaluation aimed at gaining valuable insights into the implementation, adaptation, and impacts of the program during the response (Jan 2021–Mar 2023) and recovery (Mar 2023–Mar 2024) COVID-19 pandemic periods. The goal is to identify any additional changes needed to enhance the program's quality of services, adaptation and sustainability and to ensure its role in continuing to support the needs of the diverse users served by Dixie Bloor Neighbourhood Centre.

Before agreeing to participate in the interview, you must read and understand this consent form. It includes details about the evaluation team and its purpose, methodology, risks and benefits, confidentiality, and dissemination of findings. Also included in this form is information about the compensation for your participation. Taking part in this interview is completely voluntary. Before you sign this form, you may also wish to discuss the study with a family member, close friend or worker. If you have any questions, please ask the evaluation team members.

Information on the DBNC-CHA program Evaluation Interview

Purpose of the interview: The aims of the interview are:

3) Characterize the DBNC-CHA Program's implementation, delivery strategies, challenges, and success factors during the acute (response) COVID-19 period (Jan 2021–Mar 2023) and its adaptation during the pandemic recovery period (Mar 2023–Mar 2024).
3) Assess the impact of the DBNC-CHA Program on the social, health and economic well-being of program users, including staff and frontline workers (ambassadors).
3) Provide recommendations for improving the DBNC-CHA Program's quality, sustainability, adaptability and scalability based on the findings from objectives 1 and 2.

How many people will participate in this program evaluation interview process?

We will aim to engage three participants from the DBNC-CHA Program leadership/management and three DBNC-CHA Program providers to participate in a virtual or in-person, individual, semi-structured interview that will last 40 to 60 minutes.

What will the Interview process look like?

Depending on your preference, the individual semi-structured interview can be conducted virtually using the Teams app or in person (at the DBNC facilities or Institute for Better Health, Trillium Health Partners facilities) on a date that suits your availability. The format of the interview will be more conversational, allowing you and the facilitator to discuss the following main topics.

- DBNC-CHA Program implementation and adaptations.
- Success, challenges and limitations of the DBNC-CHA Program and contributing factors.
- Your perspective on the project's social, health, economic and other impacts on service users or yourself at the organizational and local community level.
- There are opportunities to improve the DBNC-CHA programming and further enhance its contribution to meeting the priorities and needs of the local communities/users DBNC serves.
- Additionally, at the end of the interview, we will ask for demographic information such as gender identity, age group, ethnocultural background, your role in the project, and the amount of time you have been involved with it. This information will help us characterize and analyze the data more appropriately.

Your participation in the interview is voluntary. You have the right to decide not to participate or to withdraw at any time before or during the interview. You may also withdraw your data after the interview, provided you do so before the findings are made publicly available in outputs, such as reports, academic papers, event presentations. Once the main findings are published, removing your data from the already disseminated results will be difficult.

During the virtual or in person interview, you also have the right not to answer any questions you are asked and to freely express your ideas, opinions and perspectives on the topics discussed. If you agree to participate in the interview, we will conduct one audio-recorded interview guided by a semi-structured interview format. If you want, you can choose a nickname you would like to use during the interview process when the interviewer poses questions to you. The interview will last approximately 45-60 minutes. With your consent, the interview will be audio-recorded, and notes will be written. If you choose not to consent to the audio recording, a member of our evaluation team will be present at the virtual interview to document your responses.

What are the potential risks of participating in the interview?

By participating in this study, we expect you would not experience any significant risks to your overall well-being or your role or work at the DBNC. DBNC is committed to hearing the perspectives and inputs of their workforce on the DBNC-CHA Program to inform more comprehensive and inclusive quality improvements. However, if your experiences working with users of the DBNC were challenging, you may recall such challenges or emotions. If you find a question or any part of the interview experience produces distress or uncomfortable feelings, please note that you do not need to answer any question you do not want. In addition, you can ask the interviewer to have a break if you need it or withdraw from the interview at any point**.** You can also contact the DBNC health team for advice and support or ask the interviewer to provide information on external health services if you feel you need additional support.

What are the potential benefits of participating in the interview?

By participating in this study, you may not experience any direct benefits. However, your participation will help us to understand the success and challenges of the DBNC-CHA Program and what and how improvement can be implemented to enhance its impacting the DBNC-CHA Program workforce and users, and local communities. This may bring future benefits for yourself as a service provider as the findings derived from this interview and program evaluation may inform additional services and resources to better support workforce and user more effectively and sustainably.

How will the confidentiality and privacy of the collected information be ensured?

Your details, such as name, date of birth, and contact details, will be kept confidential and protected as governed by current local privacy law and international ethical principles in Canada.

Your personal identifying information will not be associated with the information you provide during the interview and the findings derived from the study. The written information gathered during the interview will be kept separate in secured and password-protected Trillium Health Partner (THP) servers that is only accessible using encrypted and secure logging. Similarly, the audio-recorded interview will be kept separate in secured and password-protected folders in password-protected THP servers. A transcript of the interview will be identified by alphanumeric code number, and you will be given the option to choose a nickname you would like the interviewer to use during the virtual or in-person interview. Any potential identifiers recorded during the audio-recorded interview or note-taking will be removed to ensure your privacy and confidentiality. Only authorized evaluation team members will have access to your identifying information and the information collected during the interview.

All audio and paper files collecting the interview data will be deleted upon transcription. In contrast, the electronic and paper files will be kept for five years from the end of the study.

Anonymized quotations (spoken words) extracted from the transcript of audio-recorded interviews may be used to illustrate the evaluation findings when communicating them in reports, papers or public or academic events. These quotations will not have any personal information that can be linked to your identity.

What are the options for participation and withdrawal?

Your participation in this interview is voluntary, and you have the right to decide whether you do not want to take part at any time before or during the interview without giving a reason. Your decision to take part or not will not affect your relationship with your employer. The evaluation team will inform you if any new information might affect your decision to participate. However, suppose you change your mind three months after your interview date. In that case, we will not be able to exclude your interview data from evaluation outputs (e.g., report, academic paper, public presentation) because, after that time, it will not be possible to remove your data from the analyzed data and published findings.

Will there be compensation for participation?

You will be given an e-gift card of $30/hour for your contribution and time in the interview.

Where will the interview take place?

The interview process will happen online using the Microsoft Teams platform or in person at the DBNC facilities or the Institute for Better Health, THP, Mississauga. The online or in-person interview facility will be in a private place so that the confidentiality of the information you provided is guaranteed.

How will the results be used or shared?

A summary of the interview and program evaluation results can be sent to you once all the data has been analyzed. This will likely occur by January 2025. You can let the interview facilitator or evaluation team know if you want to receive a copy of the results. The findings from this study (excluding your identifiers) will be shared with Dixie Bloor Neighbourhood Centre's leadership the

main requestor and funder of this evaluation. In addition, the findings from this evaluation and interview may be shared in public events, as well as be published in academic journals or reports.

Who can be contacted if further information is required?

This study has been reviewed by the Trillium Health Partners Research Ethics Board and determined not to be human participant research.

If you have any questions about this program evaluation or interview, you may contact Dr. Cilia Mejia-Lancheros, the FCHI Research Lead, by email at Cilia.Mejia-Lancheros@thp.ca or by telephone at 437 216 6209. You can also contact, Dr. Ian Zenlea, the program evaluation lead, by email at Ian.Zenlea@thp.ca or by telephone at 905-813-4120.

DOCUMENTATION OF INFORMED CONSENT

Title of Evaluation project: DBNC-based Community Health Ambassador Program (DBNC-CHA) Evaluation: Informing Program Quality Improvement to Enhance its Adaptation and Sustainability

Participant

I have received a signed and dated copy of this **Informed Consent Statement**. I have read it or had it read to me and understand it. It describes my involvement in the program evaluation interview and the information to be collected from me.

1. **I agree and consent to participate in a virtual (online) or in-person interview**

   Yes_____ No_____

2. **I agree and consent to have the virtual (online) or in-person interview audio-recorded and field notes recorded.**

   Yes_____ No_____

3. **I understand and agree that anonymized quotations from interview may appear in published reports or papers, or at public or academic events.**

   Yes_____ No_____

Participant's signature Name (printed) Date

I was assisted during the consent process by having the consent form read to me.

☐ Yes ☐ No ____ (initial)

If yes, please check the relevant box and complete the signature space below:

☐ The consent form was read to me, and the person signing below attests that the study was accurately explained to me, and I have understood what was said.

Consent Witness

WITNESS DECLARATION OF PARTICIPANTS INFORMED CONSENT: *If a participant is unable to read independently for any reason or unable to sign, a witness should be present during the entire informed consent discussion and sign below. The witness may be a family member who is able to read.

By signing the consent form I(the consent witness) attest that the information was accurately explained to and apparently understood by the participant and that consent was given freely.

Signature of Witness	Name of Witness	Date

Signature of the Evaluation Team Member Explaining Study

Signature of Evaluation Team Member Explaining Study	Name of Evaluation Team Member Explaining the evaluation interview	Date

Type of Consent:

Verbal _____ Written _____ Verbal & Written _____