



# IMPACT REPORT

## A Gender-Based Violence Prevention and Care Cascade

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## Executive summary

Gender-based violence (GBV) remains a critical issue in the Greater Toronto Area (GTA), one of Canada's most diverse regions. In 2023, Toronto and Peel declared GBV an epidemic, reflecting its urgent social and public health impacts. Intimate partner violence (IPV), a prevalent form of GBV, affects survivors' physical and mental health, financial stability, housing, employment, and social relationships (Breiding et al., 2014; Coker et al., 2002; Hayes & Kopp, 2020). Many survivors do not report abuse due to fear of harm from police or courts (Duhaney, 2022).

Over the past two years, the Women's Health in Women's Hands Community Health Centre (WHIWH CHC) implemented a GBV Care Cascade to address barriers faced by racialized women, particularly Black, African, and Caribbean communities. Survivor feedback highlighted challenges in accessing support and justice, while resilience emerged as a key source of hope (Duhaney, 2022; Cénat et al., 2024).

WHIWH CHC's GBV Prevention Care Cascade integrates culturally responsive care, empowerment strategies, and system-level coordination to support the diverse needs of racialized women, particularly Black, African, and Caribbean communities. The model aligns with priorities established by Women and Gender Equality Canada (WAGE), emphasizing trauma-informed practices, prevention, and the dismantling of systemic inequities that contribute to cycles of violence (Persaud et al., 2023; Sayani et al., 2021). By centering survivor voices and embedding culturally attuned interventions, WHIWH CHC seeks not only to enhance immediate safety and well-being but also to foster long-term resilience, empowerment, and social transformation.

This executive summary underscores that addressing GBV in the GTA requires multifaceted, survivor-informed, and culturally responsive approaches. Initiatives such as the WHIWH CHC GBV Care Cascade exemplify evidence-based, community-led strategies that prioritize the lived experiences of racialized women, providing a model for scalable and sustainable interventions across diverse urban settings.



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## Glossary of Terms

**ACB (African, Caribbean, and Black)** – Refers to populations of African, Caribbean, and Black descent; used to highlight culturally specific considerations in service provision.

**Case Management** – A structured approach to providing intensive, individualized support for survivors, including risk assessment, safety planning, and linkage to appropriate services.

**Culturally Responsive Services** – Programs and interventions tailored to the cultural, linguistic, and social contexts of specific communities to improve trust, engagement, and outcomes.

**GBV (Gender-Based Violence)** – Any harmful act directed at an individual based on their gender, including physical, sexual, emotional, or psychological abuse.

**GBV Care Cascade** – A structured framework mapping the progression of individuals through GBV services, from initial outreach and risk assessment to intensive case management, designed to improve access, engagement, and outcomes.

**Low-Barrier Services** – Services designed to reduce obstacles to access, such as complex referral processes, cost, or lack of culturally tailored approaches.

**Risk Assessment Tool** – A digital or in-person instrument used to identify individuals' experiences of GBV, assess safety needs, and guide referrals to appropriate support services.

**Self-Referral** – The ability for an individual to independently access services without requiring a third-party or formal system referral.

**WITHWomen Pathways** – A web-based application that generates personalized safety plans for individuals experiencing unsafe or abusive relationships, serving as the model for adapted GBV risk assessment tools.

## Introduction

Gender-based violence (GBV) is a pervasive and deeply rooted global issue driven by systemic gender inequalities and entrenched power imbalances, and within Canada, disproportionately impacting racialized women. As defined by the United Nations, GBV involves acts that result in physical, sexual, or psychological harm, which includes intimate partner violence and other harmful practices such as genital mutilation/cutting (Mugambi & Michotte, 2021; Cole, 2009). The challenge of addressing GBV is exacerbated in Canada due to the prevalent social constructs of race, gender, and class, which interact to shape the lived experiences of these women (Abraham & Tastsoglou, 2016).

Recent declarations of GBV as an epidemic in parts of the Greater Toronto Area, including Toronto and Peel, underscore the urgency of equity-informed responses. Black, African, Caribbean, and other racialized women experience GBV within intersecting contexts of systemic racism, economic precarity, housing instability, and unequal access to health, legal, and social services, all of which heighten vulnerability to violence and constrain pathways to safety and recovery (Wilson et al., 2015; Reid et al., 2020).

## Barriers to Safety and Justice

Racialized women face persistent barriers when seeking support, rooted in historical and ongoing systemic racism within institutions. This has contributed to deep mistrust of service providers and reduced engagement with formal systems of care and justice (Fante-Coleman & Jackson-Best, 2020). The lack of culturally responsive and trauma-informed services further limits access, often exacerbating isolation, psychological distress, and feelings of hopelessness (Duhaney, 2022; Gichuki et al., 2025). These intersecting forms of discrimination underscore the need for interventions that address both immediate safety and long-term empowerment and resilience (Kahan et al., 2020). Thus, addressing GBV therefore requires comprehensive strategies that both confront its structural root causes and provide survivor-centered support.

## Response through Community-Led Models

Women's Health in Women's Hands Community Health Centre (WHIWH CHC) GBV Prevention Care Cascade was developed in response to these systemic gaps. Grounded in community leadership, trauma-informed practice, and systems-based coordination, the model integrates prevention, care navigation, and empowerment strategies tailored to the lived realities of racialized women. This approach aligns with evidence highlighting the importance of continuity of care and tailored aftercare in supporting long-term recovery for survivors of violence (Macy & Johns, 2010).

## Alignment with WAGE Priorities

WHIWH CHC's GBV Prevention Care Cascade aligns with Women and Gender Equality Canada (WAGE) priorities by addressing both the immediate impacts and root causes of GBV. The model emphasizes culturally responsive, trauma-informed care and considers the socio-economic

determinants shaping GBV risk among racialized communities, supporting prevention, resilience, and sustainable recovery (Persaud et al., 2023; Sayani et al., 2021).

By embedding trauma-informed care within a broader framework that acknowledges systemic inequities, initiatives such as the WHIWH CHC GBV Prevention Care Cascade offer a meaningful pathway toward improved safety, empowerment, and long-term healing.

## Approach and Methodology

WHIWH CHC used a community-based, survivor-centered approach to deliver and evaluate GBV prevention activities. By collaborating with local stakeholders, community leaders, and advocacy networks, WHIWH CHC fostered trust and understanding, ensuring interventions resonated with the lived experiences of ACB, South Asian, and Latin American women (Sikamikami et al., 2023). This methodology prioritized accessibility, cultural responsiveness, safety, and trust, recognizing the systemic barriers many survivors faced in engaging with formal support systems.

Engagement methods were flexible and relationship-based. Data and feedback were gathered through focus groups, small-group discussions, role-play exercises, and lived-experience sharing, allowing participants to contribute in ways that felt safe and appropriate. Survivors were not required to disclose personal experiences of violence; instead, they were supported to share insights at their own pace.

This approach enabled WHIWH CHC to engage individuals across varying stages of awareness, readiness, and need from early prevention to crisis-level support while consistently centering survivor voices and perspectives.



**Figure 1:** Women and gender-diverse participants engaging in a trauma-informed, culturally responsive Kitchen Table Talk, sharing experiences, building peer support, and strengthening community connections.

# Prevention of GBV - Activities and Stakeholders Reach

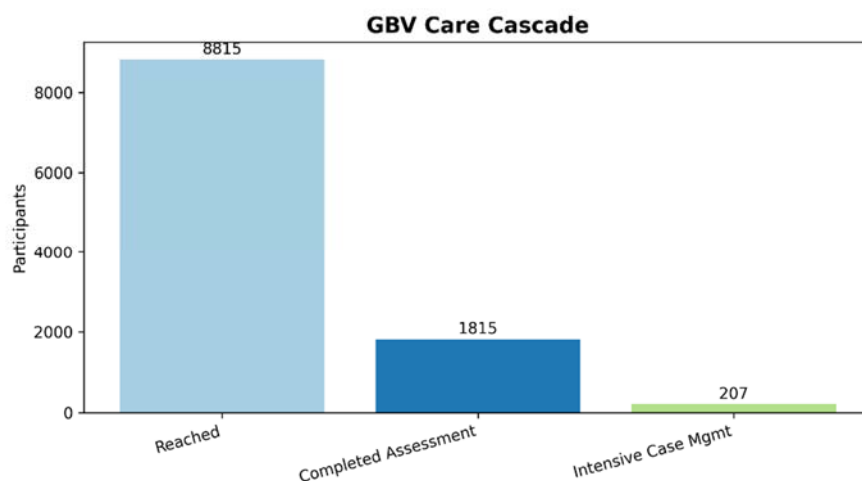
## 1. Risk Assessment Tool

The Risk Assessment Tool, adapted from *WITHWomen Pathways* (WITHWomen, 2023), served as a critical entry point into GBV support services, operating within the broader GBV care cascade developed by WHIWH CHC. Of the **8,815** stakeholders reached, **1,815** individuals (approximately 20%) accessed the online assessment platform to document experiences of gender-based violence and evaluate their safety needs (Figure 2). The tool was designed to facilitate self-referral, enabling participants to independently initiate engagement with support services without requiring prior system navigation or third-party referral.

Among those who completed the assessment, **207** survivors (11.4%) transitioned into intensive case management services. This subgroup reflects individuals presenting with heightened complexity, elevated risk factors, or urgent safety concerns requiring sustained intervention.

Complementing the assessment process, the original *WITHWomen Pathways* web-based application generates personalized safety plans for individuals who identify as being in unsafe or abusive relationships (WITHWomen, 2023). The integration of digital risk screening and individualized safety planning strengthened early identification of vulnerability, supported timely and appropriate referrals, and informed tailored case management interventions grounded in survivor-identified needs.

**Implications:** These findings highlight the importance of low-barrier, accessible tools in improving early intervention, risk awareness, and service uptake. Notably, the 207 survivors who engaged in intensive case management were managed by a single case manager, underscoring both the high intensity of care required for high-risk participants and the critical need for resource allocation to support case management capacity. By capturing a spectrum of risk levels, the tool informs both immediate safety interventions and long-term survivor support strategies, while providing critical data for funders, allies, and stakeholders interested in GBV prevention and care outcomes.



**Figure 2. GBV Care Cascade:** 1,815 participants completed the Risk Assessment Tool (adapted from *WITHWomen Pathways*), with 207 survivors receiving intensive case management from a single case manager.

## Case Management Within the GBV Care Cascade: Utilization, Survivor Pathways

Within this project, WHIWH CHC’s case management program served as a central entry and navigation point within GBV prevention and care cascade. The cascade is structured to provide coordinated, survivor-centered pathways across safety, health, psychosocial support, and long-term recovery. Survivors accessed the cascade through multiple entry points, including formal referrals, self-referrals, and community-based engagement spaces such as forums and Kitchen Table Talks. These multi-entry pathways enhanced accessibility, fostered trust, reduced barriers to disclosure, and facilitated early engagement, particularly for survivors navigating complex trauma.

### Entry Point: Initial Cascade Engagement

Entry assessments revealed survivors presenting with layered and prolonged trauma, including trafficking, coercion, financial control, and isolation. Participants reported pervasive fear, shame, and psychological distress alongside urgent needs for safety, housing, and emotional stabilization.

*“I was trafficked and forced into sex work for years... I never felt safe, and I still struggle with the trauma.”*

*“I’ve faced financial control and isolation from my partner, which made me feel powerless. I have a few friends who know some of what happened, but I don’t share everything with them.”*

At intake, survivors primarily engaged the stabilization tier of the cascade, including:

- Immediate safety planning and crisis response
- Emergency or transitional housing supports
- Trauma-informed intake and trust-building

**Insight:** Multi-entry pathways, including self-referral and community-based engagement, facilitated early utilization of stabilization services and helped build a foundation of trust for survivors navigating multiple systems.

### Early Engagement: Stabilization and Therapeutic Linkages

By the three-month mark, survivors demonstrated increased engagement across cascade components. Physical safety improved, yet trauma symptoms intensified as participants began deeper emotional processing.

*“I’m in a safer place physically, but emotionally I’m still in a lot of pain.”*

Early-stage cascade utilization included:

- Trauma-informed therapy and psychosocial counselling
- Housing stabilization and case management coordination
- Navigation support for legal, medical, and social services

**Insight:** Case management played a critical role in guiding survivors across services, reducing fragmentation, and ensuring continuity of care during intensive psychosocial engagement.

### **Midpoint Utilization: Integrated Recovery with Housing Challenges**

At approximately six months, survivors were engaging more broadly across the cascade, including sustained therapeutic interventions, social reintegration, and long-term recovery planning. However, **housing remained a persistent structural barrier**. While some survivors successfully exited unstable environments and secured safer housing, others continued to navigate precarious living conditions, illustrating uneven progression along social determinants of recovery.

*“I’ve secured a safe place, and I’ve started therapy, but I’m still working through the trauma.”*

Midpoint cascade utilization included:

- Ongoing trauma therapy and emotional regulation supports
- Continued case management coordination across multiple service systems
- Housing navigation and stabilization interventions

**Insight:** Psychosocial recovery and service engagement progressed steadily, yet structural barriers like housing availability constrained full outcomes. Integrated support addressing both psychosocial and social determinants is essential.

### **Exit Phase: Transition, Empowerment, and Forward Planning**

At program exit, survivors demonstrated increased independence, engagement in future-oriented planning, and continued use of therapeutic supports. Participants reported improved autonomy, emotional regulation, and resilience, while acknowledging residual trauma and the need for ongoing support.

*“I’ve gained more independence, but I still feel emotionally fragile.”*  
*“It has been life-changing. I’ve learned tools I can use for the rest of my life.”*

Later-stage cascade utilization included:

- Continued therapy and psychosocial support
- Employment or education planning
- Financial independence and life rebuilding

**Insight:** Integrated navigation across the cascade enabled survivors to move from crisis stabilization toward empowerment and long-term recovery. Survivors who accessed community-based entry points maintained stronger engagement across stages, demonstrating the value of culturally responsive, low-barrier pathways.

## Survivor-Reported Value of Case Management

Across all phases, survivors emphasized the importance of a consistent, trusted case manager to navigate the cascade, reduce retraumatization, and facilitate access to multiple services. Key benefits included:

- Reduced need for repeated disclosure
- Greater clarity in navigating services
- Increased trust and confidence in formal support systems



### Figure 3. Linkage to Care

Figure 3 demonstrates how case management enabled survivors to access coordinated pathways to essential services, including medical care, psychosocial support, counselling, legal aid, and safe housing. Survivors reported that these integrated linkages reduced barriers, improved continuity of care, and were critical to their healing, stabilization, and recovery outcomes.

Overall, case management contributed to measurable outcomes in stabilization, service uptake, and survivor empowerment, positioning it as a critical intervention within WHIWH CHC's GBV prevention and response framework. The findings underscore the importance of sustained investment in case management as a high-impact strategy for supporting survivors with complex needs and improving system navigation and recovery outcomes.

## 2. Kitchen Table Talks and Collaborative Workshops

Kitchen Table Talks engaged 152 participants in trauma-informed, culturally responsive spaces designed to foster open dialogue, peer support, and skill-building around GBV awareness and prevention. These sessions intentionally addressed intersections by including survivors, gender-diverse community members, peers, and service providers acknowledging that those providing services may themselves be survivors or in need of support. This inclusive approach allowed participants to share experiences, reflect on personal and professional challenges, and strengthen empathy and collaboration across roles. Feedback from Kitchen Table Talk participants showed a high level of satisfaction, with 95.12% of respondents either agreeing with or strongly agreeing that the quality of the Kitchen Table Talks was excellent. Participants also noted that the sessions were both engaging and interactive. They expressed strong approval of the facilitators' ability to effectively guide the discussions and provide clear, relevant resources. The key outcomes from these sessions included a deeper understanding of GBV, greater confidence in recognizing and applying skills for safe and secure relationships, and an enhanced awareness of the importance of setting and respecting boundaries in relationships. Participants also reported greater social connectedness, reduced isolation, and improved self-confidence, valuing the opportunity to develop practical skills while deepening their understanding of GBV in a supportive environment.

Feedback highlighted enhanced GBV knowledge, safer decision-making, stronger peer connections, and increased confidence:

*“The sessions gave me the tools to set boundaries and connect with others who understand my experiences. I feel more confident and supported.”*

*“The Kitchen Table Talk gave me a space to share my story and hear others; I realized I wasn't alone.”*

*“Hearing others' experiences helped me learn how to set boundaries in my relationships and feel more confident in saying no.”*

**Cascade Integration:** Kitchen Table Talks served as low-barrier entry points into the GBV care cascade, allowing participants whether survivors, peers, or service providers to self-refer or be referred to case management, therapy, and community services. By recognizing and engaging the dual roles of

participants as both providers and service users, these sessions reinforced pathways to coordinated support, while fostering empowerment, healing, and professional development.

### Impact:

These intersectional spaces demonstrated high relational and community-level impact, cultivating mutual understanding, building solidarity, and strengthening networks that bridge lived experience and service provision. The word cloud in Figure 4 highlights themes of empowerment, connection, learning, and shared support, reflecting the multidimensional benefits of this approach.



**Figure 4. Word Cloud Summary of Kitchen Table Talks:**

Figure 4 illustrates the key themes and values identified by participants in the Kitchen Table Talks sessions. Words such as “resilience,” “support,” “connection,” “boundaries,” “confidence,” and “safe space” reflect the most frequently mentioned benefits, highlighting the intervention’s role in promoting empowerment, social connectedness, and emotional well-being among women survivors of GBV. The word cloud visually emphasizes the aspects of the sessions that contributed most to participant engagement, learning, and community-level resilience.

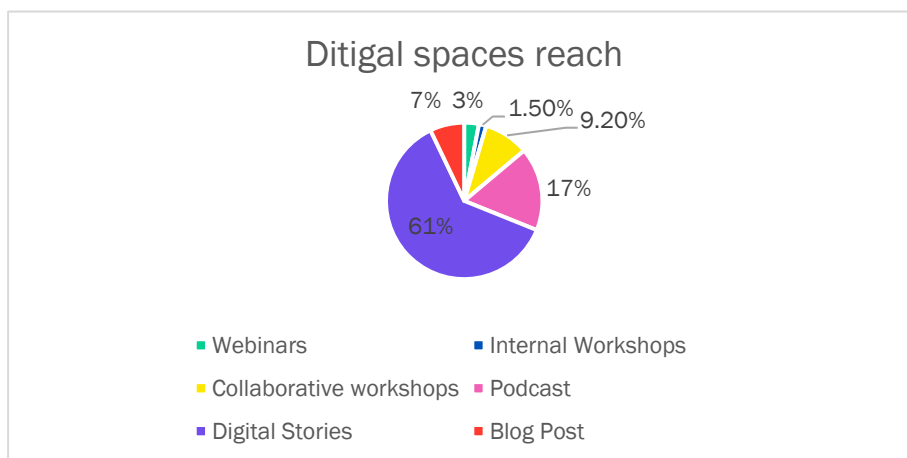
### 3. Digital Activities: Webinars, Podcasts, Digital Stories, and Online Workshops

Digital engagement proved to be a high-impact and scalable strategy for prevention, education, and survivor outreach. Survivors underscored the importance of preventive education and awareness to challenge harmful norms, promote gender equality, and strengthen knowledge of healthy relationships across schools, workplaces, and communities.

Digital delivery significantly expanded reach. A total of 5,026 stakeholders (57%) were reached through social media campaigns, demonstrating the effectiveness of digital platforms in engaging large and diverse audiences. As shown in Figure 4, 61% of participants were reached through digital stories,

17% through podcasts, while internal workshops accounted for 1.5% of reach. These findings indicate that digital storytelling was the most effective modality for engagement and accessibility.

The strong uptake of digital activities reflects increased access to online platforms and the flexibility of technology-enabled learning. Results support continued investment in digital strategies as a cost-effective and inclusive approach to expanding GBV prevention and survivor education.



**Figure 5. Reach of Digital GBV Activities**

Figure 4 shows stakeholder engagement across digital activities. Of **8,815** stakeholders reached, **5,026 (57%)** were engaged via social media, with digital stories reaching **61%**, podcasts **17%**, and internal workshops **1.5%**. The figure highlights digital storytelling as the most effective and scalable method for GBV prevention and awareness.

## 4. Community Engagement and Stakeholder Participation

WHIWH CHC employed a multi-faceted approach to community engagement to inform, evaluate, and strengthen GBV prevention and care cascade. Engagement activities prioritized trauma-informed, culturally responsive spaces where women and gender-diverse participants could safely share experiences, learn, and build social support networks.

### Deliberative Dialogues

Two deliberative dialogues were conducted to gather stakeholder input at key stages of the cascade:

- April 2024 Deliberative Dialogue:** Engaged 20 participants, including survivors, advocates, service providers, and community members. This session focused on presenting the GBV prevention and care cascade and ensuring it met the needs of women from African, Caribbean, Black Latin American, and South Asian communities in the Greater Toronto Area prior to piloting.

- **April 2025 Deliberative Dialogue:** Convened 10 key stakeholders to strategize for the long-term sustainability of the care cascade and ensure continued support for survivors beyond the pilot phase.

## Community Forums

The **September 2025 Community Forum** brought together advocates, survivors, women at risk, and community members for shared learning, healing, and empowerment. This forum provided tools for emotional, mental, and physical well-being while fostering resilience, autonomy, and self-confidence. Forums also highlighted the need for broader cultural and social change, including addressing entrenched gender norms, stereotypes, and power dynamics that perpetuate violence and discrimination.



**Figure 6:** Black Queens of Toronto participants celebrating a successful Kitchen Table Talk, coming together to share experiences, build community, and empower one another.

## Barriers and Challenges

Despite strong engagement and positive outcomes, WHIWH CHC's GBV prevention initiatives revealed several persistent structural and systemic barriers that impact survivor access and program effectiveness:

- **Housing insecurity** – Survivors often face unstable living conditions, limiting their ability to safely access services.
- **Financial precarity** – Economic challenges reduce the capacity to engage fully with prevention and recovery programs.
- **Barriers to timely access** – Complex referral processes, limited service hours, and geographic or language constraints hinder immediate support.
- **Systemic mistrust** – Historical experiences of discrimination and cultural insensitivity in formal systems affect willingness to seek care.
- **Digital access gaps** – Limited access to devices or reliable internet can reduce the reach of digital interventions.

## Mitigation Strategies: Strengthening the Care Cascade

To address identified barriers, WHIWH CHC intentionally applied a care cascade framework that reduced fragmentation and ensured continuity of support across prevention, response, and recovery. Survivors were supported through stepwise, coordinated pathways, beginning with low-barrier entry points such as risk assessment tools and community engagement activities, and progressing to more intensive supports as needs increased.

The cascade model emphasized clear referral pathways and a single, trusted point of contact, minimizing service duplication and reducing the burden on survivors to repeatedly navigate complex systems. Case management functioned as the central connector, linking survivors to medical care, psychosocial counselling, legal advocacy, housing supports, and safe spaces in a timely and culturally responsive manner.

Flexible delivery modalities, including Kitchen Table Talks, digital engagement, and community forums, allowed survivors to enter

## KITCHEN TABLE TALKS



and move through the cascade at different stages of readiness, while language accessibility and community partnerships strengthened trust and sustained engagement. Collectively, this integrated approach mitigated access barriers, improved service uptake, and enhanced survivor confidence, stabilization, and recovery outcomes.

## **Recommendations for Scaling the GBV Care Cascade**

### **Expand Low-Barrier, Community-Rooted Entry Points**

Scale access by leveraging self-referral, community forums, and Kitchen Table Talks across additional neighborhoods and partner organizations. Community-based, culturally responsive engagement increases trust, encourages early disclosure, and supports broader reach.

### **Strengthen Trauma-Informed, Survivor-Centered Case Management**

Expand the case management workforce to ensure sufficient capacity for survivors, minimizing wait times while maintaining high-quality, trauma-informed support. Centralized points of contact should coordinate access to medical, psychosocial, legal, and housing services, with standardized protocols to maintain consistency during expansion.

### **Integrate Peer Learning and Social Support Mechanisms**

Scale structured peer-to-peer spaces to promote skill-building, boundary-setting, and social connectedness. Peer learning can be extended through facilitated workshops, community groups, and digital platforms, enhancing both individual resilience and community-level support networks.

### **Address Structural Barriers at Scale**

Incorporate interventions for housing, employment, and financial literacy alongside psychosocial supports. Strategic partnerships with housing providers, employment programs, and financial institutions can increase reach while addressing systemic barriers across communities.

### **Ensure Multi-Phase, Longitudinal Support**

Build scalable pathways that support survivors from initial stabilization through recovery, empowerment, and long-term planning, including therapy, life skills, education, and employment. Adequate staffing and standardized case management practices will allow larger caseloads without compromising service quality.

### **Leverage Accessible Assessment and Triage Tools**

Utilize online risk assessments and integrated triage platforms to identify high-risk survivors efficiently. These tools allow timely intervention and make scaling to larger populations feasible while maintaining data-informed decision-making.

### **Embed Cultural Responsiveness and Language Accessibility**

Scale services by incorporating culturally tailored programming and multilingual support, enabling engagement with diverse populations across multiple communities. Community input and culturally aligned facilitators enhance both uptake and sustainability.

### **Promote Data-Informed Continuous Improvement**

Expand evaluation frameworks to collect qualitative and quantitative insights across sites. Scalable monitoring tools, such as cascade utilization maps and outcome dashboards, support continuous improvement, transparent reporting, and informed resource allocation.

## Conclusion

WHIWH CHC's GBV prevention initiatives demonstrate the effectiveness of a community-based, survivor-centered approach delivered through a comprehensive care cascade, supporting survivors at every stage from risk identification to stabilization, recovery, and long-term empowerment. Through risk assessment tools, case management, Kitchen Table Talks, digital engagement, and community forums, stakeholders were guided along coordinated, culturally responsive pathways to essential services, including medical care, psychosocial support, legal advocacy, and safe housing.

This integrated approach reduced barriers, strengthened trust, and enhanced engagement, enabling survivors to navigate services confidently. By combining survivor-centered support with community engagement and culturally responsive interventions, the cascade facilitated individual healing, strengthened community resilience, and promoted systemic change. Findings reflect strong participation, high satisfaction, and measurable gains in awareness, confidence, and resilience, while also highlighting persistent structural challenges, including housing insecurity, financial precarity, and gaps in timely access to services. Overall, the care cascade underscores the value of stepwise, integrated pathways linking prevention, education, psychosocial support, and systems navigation, reinforcing WHIWH CHC's model as a scalable, high-impact strategy for GBV prevention and response.



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