

Accessing Sexualized Violence Services and Supports for Women in Rural Nova Scotia: A Qualitative Study

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Abstract

Introduction: Both rural and urban women who experience sexualized violence can face significant barriers to accessing services and supports, including fear of victim blaming, stigma, and re-traumatization. To date, there is a paucity of research that specifically examines the experiences of women accessing sexualized violence services and supports in rural places and the unique or additional barriers they may face. **Objectives:** The purpose of this qualitative study was to understand the experiences of women living in rural Nova Scotia who accessed services or supports after experiencing sexualized violence. **Methods:** Participants were recruited through community organizations and social media. Interviews were conducted with nine women in Fall 2019. Data were analyzed using feminist-thematic analysis. **Results:** Findings indicate that the women shared experiences of navigating a fragmented system of services and supports, and many reported harmful experiences with the justice system and formal health care system. Some women also experienced positive experiences with community-based services. Enhancing community-based services is recommended as one key strategy for improving access to sexualized violence services and supports in rural communities.

Keywords: sexualized violence, health care, women's health, sexual health, qualitative

Introduction

It is estimated that one in three adult Canadian women will experience some form of sexualized violence in their lifetime (Cotter & Savage, 2019). Sexualized violence is a broad term used to describe any physical or psychological violence that is carried out through sexual means (Jewkes et al., 2002).

Although it is known that women may experience barriers to accessing sexualized violence services, relatively little is known specifically about the experiences of women living in rural areas and their potentially unique experiences when accessing sexualized violence services and supports (Wuerch et al., 2019). Sexualized violence services and supports

include, but are not limited to, sexual assault nurse examiners, sexual assault centres, mental health professionals, victim services, police, residential support (e.g., transition houses), and peer support (Break the Silence NS, n.d.-a).

Rural areas may lack the breadth of formal services available in urban areas (Garasia & Dobbs, 2019; Wilson et al., 2020). In this study, a formal service was defined as a service that is funded and mandated to provide resources. In a rural area, this might include hospitals, clinics, women's centres, and other related community-based organizations. An informal support was defined as existing outside of formal supports and could include friends, family, informal women's groups, and online communities. The services that exist in rural places may be overburdened in efforts to service a large geographical area and may come at a greater travel and/or time cost to women. Women in both urban and rural places may also fear being seen when they access sexualized violence-related services; this fear may be exacerbated in rural communities, as these communities are small and often close-knit. This qualitative study aimed to explore the experience of women living in rural communities in Nova Scotia accessing formal services or informal supports after experiencing sexualized violence. There is relatively little literature on the experiences of women living in rural communities accessing sexualized violence services or supports. The perspective of women living in rural places is valuable and needed to inform service and support provision in rural contexts, as these women may experience accessing services differently than women in urban communities.

Background

Existing research has shown that women who experience sexualized violence can face significant barriers to accessing both formal services (e.g., hospital-based services, community organizations) and informal supports (e.g., friends and family; O'Dwyer et al., 2019; Sualp et al., 2021). These barriers may include fear of victim blaming, stigma, and a re-triggering or traumatic experience (Gravelin et al., 2019; Milesi et al., 2020; Ullman, 2010).

Rural areas are generally defined as communities smaller than, and significantly distant from, larger urban communities (Lutfiyya et al., 2012). In Canada, communities with a population of less than 1,000 and outside of major population centres (e.g., towns) are rural (Statistics Canada, 2015). In general, there are fewer services in rural places than urban centres, and transportation is often a major barrier to accessing rural services (Peek-Asa et al., 2011; Smith et al., 2008). There are also fewer primary and secondary health care services in rural communities, with communities often having a limited number of hospitals, clinics, and/or family physicians (Shah et al., 2020; Youngson et al., 2021).

There is a growing body of evidence on the experiences of women in rural areas who are experiencing intimate partner violence (IPV), with IPV defined as "violent offences that occur between current and former partners who may or may not live together ... ranging from emotional and financial abuse to physical and sexual assault" (Cotter, 2021, p. 4). Barriers to accessing IPV services in rural areas include a general lack of services (Edwards, 2015; Youngson et al., 2021), a lack of trust in existing services (Anderson et al., 2014), and a slow emergency response time in crisis situations (Moffitt et al., 2020). IPV and sexualized violence intersect (Jaffray, 2021), but there are differences in the service needs of women experiencing sexualized violence and/or IPV. IPV services typically include risk assessment, risk management, safety planning, and emergency housing (Jeffrey et al., 2019). In contrast, sexualized violence services typically include an immediate medical response and/or treatment from a sexual assault nurse examiner or other professional, along with long-term mental health supports (University of Kentucky Centre for Research on Violence Against Women, 2011). There is less known about the experiences of rural women accessing sexualized violence services specifically. Existing literature has identified poor transportation availability, limited community resources, lack of knowledge about services, and a lack of anonymity as main barriers to accessing

sexualized violence services (Averill et al., 2007; Carter-Snell et al., 2020; Logan et al., 2005).

Study Context

This study was conducted in Nova Scotia, where 43% of the population currently lives in rural areas, compared to the national average of 19% (Statistics Canada, 2018). Nova Scotia has a total population of 923,598, with approximately 51% of the population identifying as women (Statistics Canada, 2019). With an aging population, out-migration of youth, and overall economic insecurity, rural communities in Nova Scotia are experiencing declines in infrastructure and service provision, including health care services. Many emergency departments in rural areas are operating at reduced hours (Province of Nova Scotia, 2019). In general, Nova Scotia is experiencing a family physician shortage; this is exacerbated in rural communities, as family physicians are concentrated in Halifax, the capital city and largest urban centre in the province (Doctors Nova Scotia, 2018). In 2016, Nova Scotia had the highest prevalence of low-income households among all provinces in Canada (Statistics Canada, 2017), with rural areas in Nova Scotia reporting higher rates of low-income households than Halifax (Statistics Canada, 2020). A lack of public transportation in rural Nova Scotia impedes access to critical services (Canada Without Poverty, 2015).

Historically, many rural communities in Nova Scotia have been dependent on resource extraction-based economies (e.g., coal, steel, fishing; Gibson et al., 2015). While some rural communities continue to benefit from these industries, they directly employ fewer people (Gibson et al., 2015). As industries have waned or ceased completely, rural communities in Nova Scotia are navigating job loss and/or new low-pay work and the need to diversify economies. Given that poverty and economic precarity increase women's likelihood of experiencing sexual violence (Gurr et al., 2008), the economic situation of many communities in the province may mean increased risk for many women (Women's Action Coalition of Nova Scotia, n.d.).

There are currently only three sexual assault centres in Nova Scotia, the largest and most urban of which announced in 2019 that it would temporarily stop accepting new clients due to capacity constraints (Bethune, 2019). Break the Silence, a provincial government-funded sexualized violence prevention initiative, maintains a map of services related to sexualized violence as part of the provincial sexualized violence strategy (Break the Silence, n.d.-b). However, this map includes generalized services such as all local RCMP detachments and family services offices, making it challenging to accurately assess the number and type of services related to sexualized violence across the province.

Methodology

Study Design

This qualitative study was rooted in critical feminist theory. Rhode (1990) defines the shared "commitments" of critical feminist theorists as the following: centring gender in analysis, describing experiences in a way that corresponds to women's experiences, and identifying change necessary for greater gender equality/equity. It is important to put the voices of women who have experienced sexualized violence first and foremost as the experts of their needs and wants, a role that may have been denied to them throughout various service and support interactions. The methodology of this study aims to reflect this by elevating the voices of women living in rural places.

To be included in the study, participants must have accessed or attempted to access a service or support in a rural area after any experience of sexualized violence in the previous two years. Participants were recruited via information sharing at nine women's centres and nine transition houses in rural areas across Nova Scotia, and on social media by sharing information about the study on Facebook, Twitter, and Instagram. Participants were given \$20 to thank them for their time.

Sample

Nine participants were recruited and interviewed for this study. Research on the suggested minimum sample needed for

qualitative thematic analysis varies (Braun & Clarke, 2012). Guest et al. (2006) suggest that conducting up to 12 interviews is ideal, although themes can be present with as few as six. Boddy (2016) argues that sample sizes as low as one can be justified by the context of the research. For this exploratory study, the goal was to speak to a small number of women (eight to 10) about their experiences.

Participants ranged in age from 21–50 years old and represented seven different geographical counties within Nova Scotia. We did not specifically ask about such demographic characteristics as race and sexual orientation, but some participants disclosed demographic information during the interview as it related to their experience of accessing services and supports.

Data Collection

The lead researcher conducted all interviews in Fall 2019 and Winter 2020. Participants were given the option of an in-person or telephone interview, and interviews were audio-recorded with the consent of the participants. Interviews lasted 30–45 minutes. We designed open-ended questions and probes to encourage participants to speak to the experience of accessing services and supports in rural Nova Scotia, and to generate discussion with respect to what services and supports are needed. Questions asked about what formal services and informal supports participants accessed, what they would have liked to access, and what recommendations they had for services and supports. This study was approved by the Dalhousie University Research Ethics Board.

Due to the sensitive nature of the interview questions, procedures were put in place in the event of the participant needing support post interview. A list of resources and community supports was distributed at the end of each interview to participants who wanted the resource. A guidebook to researching violence against women (Ellsberg & Heise, 2005) was referred to throughout the data collection process to ensure maximum participant safety. The lead researcher also

completed the Nova Scotia Sexual Violence Strategy training on Supporting Survivors of Sexual Violence. This prepared the researcher to better listen and respond to any participants' disclosures of sexualized violence. The interview guide did not ask about the experience of sexualized violence, only the experience of accessing services and supports.

Data Analysis

Data were analyzed for key themes using Braun and Clarke's (2006) six-step process for inductive thematic analysis. Thematic analysis is a theoretically flexible method for analyzing data, allowing it to be used in a variety of contexts and with a variety of theoretical frameworks (Braun & Clarke, 2006). A feminist approach to data analysis acknowledges that pure objectivity in analysis is both impossible and undesirable (Gatenby & Humphries, 2000), and reflection on researcher positionality is necessary (Burgess-Proctor, 2015; Philip & Bell, 2017). All members of the research team identify as women living in urban areas, and acknowledged that their positionality impacts data interpretation.

Key Findings

Participants spoke about their experiences attempting to access and/or accessing a variety of formal services, including both individual and group counselling, primary care, and hospital-based services. Informal supports, including peer support and family and friends, were also discussed by participants. We identified four key themes: (a) Context of accessing services and supports, (b) Navigating formal services and associated burdens, (c) What women wanted to access, and (d) What women accessed. See Table 1.

Theme 1: Context of Accessing Services and Supports

Living in a Rural Community

Living in a rural community had various influences on participants' ability to access both formal services and informal supports. They spoke about confidentiality concerns, a pervasive culture of silence around sexualized

Table 1
Summary of Themes and Subthemes

Theme	Subthemes
1: Context of accessing services and supports	Living in a rural community Narratives surrounding sexualized violence in a rural place
2: Navigating formal services and associated burdens	Navigation Burdens of navigation
3: What women wanted to access	Long-term, trauma-informed mental health services Peer support Education
4: What women accessed	Justice system services Health system services Community-based services Informal supports

violence in rural communities, and a lack of anonymity. One participant described the anxiety-ridden experience of accessing a counselling service in her community:

I would always be nervous when I was going in. I'd be nervous about bumping into somebody I knew if I was leaving. I'd have to really make sure I looked like I wasn't crying. I would be embarrassed if someone were to see me. (P8)

Living in a rural area also made the process of navigating services and supports difficult in a practical sense. Often there were few formal services available, or none at all; several women stated plainly that there were no services (including general health care services) to access in their community. Several participants reported that while there were general health care services, there were no specialized options (e.g., trauma therapy, support groups), and some services had limited hours.

In contrast, other participants did report that living in a rural place *facilitated* access. For example, one participant believed that knowing the service providers in her rural area helped her to obtain appointments. Another woman expressed appreciation for living in a tight-knit community of strong women who provided support by helping her access services when her car stopped working:

I had car trouble. Every single one of them [women in community] emailed to say, can I give you a ride? Just to have community like that and to be around a group of women was so meaningful. (P9)

Narratives Surrounding Sexualized Violence in a Rural Place

Women also spoke about dominant narratives that influenced their ability to access services and supports, including terminology, pervasive ideas about who perpetrates sexualized violence, the question of what is considered to be a legitimate experience of sexualized violence, and community stigma. Several women reported that while services typically used the term “sexualized violence,” they did not feel that term accurately described their experiences and instead used a variety of terms to describe their own experiences, including “a non-consensual experience” and “sexual assault.” Several women said they felt guilty about using services that they believed were for women who had experienced sexualized *violence* because they perceived their experience to be less overtly violent, and therefore not a legitimate experience of sexualized violence. As one woman explained:

I had a hard time feeling like I was entitled to any of the resources that were around. Because it's always about sexualized violence and that wasn't exactly how I would have labelled my own

experience. And part of it was that I still felt a little guilty around the level of severity of my incident and I felt that there were a lot of other women that were more deserving of those resources. I think I just carried that guilt and didn't want to seek out the resources that I needed because of that. (P6)

Some of the participants reported that narratives about sexualized violence perpetuated in the media prevented them from feeling comfortable accessing formal services. Negative perceptions of survivors of sexualized violence in the media interacted with a culture of silence toward sexualized violence in their rural communities. Several participants reported that coverage of high-profile celebrity perpetrators of violence discouraged them from accessing services. Hearing how people in their communities blamed the victims, they assumed they would not be believed if they disclosed their own experience. For example, one participant described how media coverage of Jian Ghomeshi, a prominent Canadian celebrity charged with sexual assault in 2014 (and eventually acquitted), impacted her:

When I had been dealing with all this stuff, Jian Ghomeshi was happening. The micro-aggressions I would hear would be like "trigger warning" or "Oh, I just got raped by that exam..." I hear that, it was just like someone stabbed me in the chest. It was so painful. (P8)

Theme 2: Navigating Formal Services and Associated Burdens

Navigation

Every woman spoke about the difficulty they experienced in identifying what services they could possibly access, and then navigating access to the service. In general, the participants knew little about what services were available after an experience of sexualized violence. To seek information, many participants contacted general health services (e.g., a walk-in clinic) to ask what services were available in their communities, and found that health professionals were also unaware of what services were available. All participants felt that

staff at these services were not aware of other services in the community and were not equipped to help them. Participants expressed feelings of helplessness that they had taken a (sometimes daunting) step to seek help and were, ultimately, offered nothing. This is exemplified in one woman's experience at a walk-in clinic where she asked the physician who or what services she could contact to get help. The physician suggested she pay out-of-pocket for a private therapist to obtain timely support, even though there was a free, trauma-informed sexualized violence therapy service in her community. The physician was not aware of this service. The participant described her negative experience:

The doctor had no idea of what was going on. He was just kind of helpless. He basically recommended me to the public mental health services. He was like you're going to have to wait forever. And then he recommended me to a private therapist. But there was no mention of [community-based organization]. (P9)

Burdens of Navigation

In the process of navigating services, women described being required to retell the story of their trauma repeatedly, which they found to be re-traumatizing and distressing. In some cases, the expectation that they would have to retell a traumatic event repeatedly was what prevented them from trying to access a service. They often felt passed around by different service providers. According to one participant, "I don't really want to be passed around and I don't really want to have to inform and retell the story of every past trauma I've had to every human being I encounter" (P6).

In addition to the emotional stress of navigating services, participants reported that they experienced time, transportation, and economic burdens. All women reported experiencing significant wait times to receive formal services, ranging from three weeks to a year. Some women were so discouraged when they were informed about a wait-list that they chose to pay out of pocket for private services. In cases where there was not a service to access

within their local community, having access to transportation to travel to other communities was necessary. Most communities in rural Nova Scotia have no public transportation.

Participants reported additional economic burdens associated with the process of navigating services. Seeking safety, one woman moved away from the person who assaulted her. She felt that there should be more housing supports integrated into other services. Another woman had to leave her employment because she had experienced sexualized violence in the workplace. She reported that service providers seemed ill-equipped to help her access both sexualized violence services and assistance with leaving her job and receiving income support.

Theme 3: What Women Wanted to Access Long-Term, Trauma-Informed Mental Health Services

All participants stated that the service they most wanted to access was long-term, one-on-one mental health support that was specific to sexual trauma or, at the very least, utilizing a trauma-informed approach. Participants wanted services to take less of a “one size fits all” approach and provide more collaborative and individualized options, and wanted services to have a flexible timeline (e.g., not a maximum of six sessions). Some rural places have a limited number of specialized mental health professionals, or even none at all, impeding the women from having choices between different approaches. Participants wanted to be able to choose a therapeutic approach and provider that worked for them, rather than having to make do with whatever they could access.

Peer Support

All the participants reported wanting to access peer support. The term “peer support” was not explicitly defined by participants, but they spoke about wanting support from people with shared experiences of sexualized violence, who were not close friends or family. Women said they felt alone and isolated living in a rural place and that connecting with other women in the community would have been helpful. Although women could access informal

support through family and friends, they reported wanting to access a formalized peer support, where peers might have some training and could connect them to other formal services if needed. In general, women felt that peers with similar experiences would be understanding and would be able to validate their experiences of sexualized violence. As one participant described:

I think it's a great idea to have a peer who has experienced these issues. They live it everyday ... I think that people would feel comfortable and that they're not alone and these people can relate to them, they've gone through similar situations in their lives. I would trust somebody more with lived experience than without. One hundred percent. (P5)

Education

Several women wanted more education on consent and sexualized violence. This is not necessarily something they wanted to access *after* experiencing sexualized violence; in most cases, the participants would have liked to learn about consent as youth. Several women reported that it took them a long time after experiencing sexualized violence to process and understand the violation, and having education on these and similar issues could have shortened that process and allowed them to start seeking services sooner. As one woman explains, “We didn’t get educated on consent in high school and I didn’t know until my counsellor gave me a sheet on it that silence is not consent” (P2).

Theme 4: What Women Accessed Justice System Services

Several women reported negative and harmful interactions with the police and/or justice system. For example, one woman went to the police immediately after the experience of violence. She requested a female officer and was denied, which she stated made her feel unsafe and uncomfortable. She felt that the officer who took her statement doubted her and implied that she was lying. She was not offered any health or support services by anyone in the police

department. She describes her traumatic experience as follows:

They didn't give me any information. They didn't even tell me about the sexual assault centre. They treated me like they didn't even care what I had to say. And that was awful. I hope another woman does not have to go through that. It is re-traumatizing. It makes you feel worse. It's really, really hard to get help in the first place. When you feel like you're just being treated like you're nothing it's not a fun feeling. Or they don't believe you. It feels like nobody really cares. And what happened to you was brutal and wrong and against the law. (P3)

Health System Services

Many participants also described experiencing negative and harmful attitudes from staff and providers when accessing formal health services. They reported that the therapists to whom they were referred were not able to provide adequate support for dealing with their experience(s) of sexualized violence, due to both attitude and a perceived lack of experience with clients who had experienced sexualized violence. Women reported feeling blamed and judged by health professionals for what had happened to them. They felt that although the therapists and counsellors were trained to treat trauma, they seemed uncomfortable and inexperienced with discussing and treating trauma stemming from sexualized violence. One participant describes feeling treated in a dismissive manner:

I told him about [experience of violence] and I think almost exactly after I told him what happened he received a phone call and proceeded to answer it. That would happen quite often in our appointments. He was okay with the family trauma stuff that I was talking to him about. But when I tried to talk to him about the sexual violence it was awful. (P6)

Community-Based Services

Several participants reported mainly positive experiences with community-based,

non-profit organizations with an explicit aim to support women, such as women's centres and sexual assault centres. They attributed this to the attitudes of the staff, including trauma therapists, nurses, and non-clinical support workers. Women described staff attitudes as non-judgmental, supportive, friendly, and kind, and felt that community-based services were "easy" to access. Some women found community-based services to be straightforward about what services they offered, what services they did *not* provide, and approximate wait times. Women also found that the physical environment of a women's centre was comfortable and made them feel less fearful of disclosing and discussing sexualized violence, compared to the environment of a hospital. Women who had accessed services at women's centres reported that the explicitly feminist mission and values of the centres made them comfortable because they could anticipate that the staff and providers would respond to their experiences in a supportive and validating way. Many participants explicitly praised their local women's centre staff and suggested that there should be more funding for the centres, a testament to the value they see in these community organizations.

Informal Supports

All women reported relying on friends and/or family in some capacity. In most cases, they found friends and family were able to provide support. However, relying on friends and family for support was complex. The ability of friends and family to provide support was limited by their experiences and biases, their capacity to provide support, and by the participants' own desire to protect their family and friends. Women felt hesitant telling some family and friends about their experiences of sexualized violence because they did not want to burden or worry them. This was especially true with respect to participants' parents. Women also reported that they found participating in activities such as advocacy, volunteering, activism, yoga, and spirituality provided them with informal types of support. Despite these informal supports providing some help, participants felt they were not adequate

supports on their own and reported that they still wanted access to some type of formal service.

Discussion

The purpose of this qualitative study was to understand the experiences of women living in rural Nova Scotia who accessed services or supports after experiencing sexualized violence. Women attempted to access a range of both formal services and informal supports. Generally, women wanted to access formal mental health services, through community-based organizations. Participants faced a number of barriers to accessing services and supports, most of which are consistent with those found in the existing literature, such as a fear of victim blaming, lack of awareness of services, and anonymity concerns (Averill et al., 2007; Carter-Snell et al., 2020; Logan et al., 2005). Our study adds to this literature by highlighting the role of narratives around sexualized violence in a rural place, the difference in experiences between community not-for-profit services and non-community-based services (e.g., public health care system), and the challenges of navigating some services.

Societal and Rural Context

Women's access to services was influenced by the realities of living in small, rural communities and by societal narratives about sexualized violence such as what "counts" as sexualized violence. Pervasive ideas about what is and is not sexualized violence have been referred to as the "rape myth." Heath et al. (2013) described the elements of the "classic rape" or "rape myth" as including "abduction, the perpetrator being a stranger, severe force, and serious injury" (p. 1066). Whatley (1996) found that the general public is more likely to see the "classic rape" as a crime, and more likely to ascribe blame and responsibility to victims who experience sexualized violence outside of the "classic rape." However, all widely available statistics on sexualized violence point to perpetrators most often being known to the victim, unlike the "classic rape." In our study, women reported discomfort with the terminology of sexualized violence. Some felt undeserving of services and contrasted their

experiences of violence to other "more severe" experiences. This suggests that internalization or acceptance of the "classic rape" myth impacts women's service use.

Women also reported a pervasive culture of silence surrounding sexualized violence in their rural communities. While the #MeToo movement broadly increased awareness of sexualized violence (O'Neil et al., 2018), such awareness-focused campaigns may not always translate well in rural contexts. The public declaration of having experienced sexualized violence intrinsic to #MeToo (intended to destigmatize and engender solidarity) may not always be an option in a small community if women have concerns about confidentiality, and less reliable internet access may also influence participation in digital-based movements (Rotenberg & Cotter, 2018). Access to early education about consent and sexual health may also be lacking. In Nova Scotia, the provincial sexual education curriculum currently does not include any discussion of consent, and the curriculum on prevention of gender-based violence is not comprehensive, according to Action Canada's *The State of Sex-Ed in Canada* report (Action Canada for Sexual Health and Rights, 2020). Participants reported lacking a basic understanding of consent and power dynamics, which led them to blame themselves for not asserting themselves in the situation and to avoid seeking services or supports. Access to more comprehensive early sexual education could help to dismantle the pervasive culture of silence that women described.

Formal Services

Existing literature on formal services tends to focus on the experiences of women accessing hospitals and/or reporting to police (O'Dwyer et al., 2019). There is a relative lack of research examining community-based services (e.g., non-profit organizations with a mission to serve women and/or survivors of violence). One study (Campbell et al., 2001) did find that women reported "healing" and positive experiences with both community-based services and mental health professionals. The women we interviewed did not report

consistently positive experiences with mental health professionals. They only reported positive experiences with mental health professionals who were based in a community organization, such as trauma therapists working at a women's centre. Women also reported positive experiences with non-clinical staff at community organizations, such as the administrative staff. This suggests that community-based services remove or mitigate some of the barriers commonly experienced by women accessing formal services by virtue of their trauma-informed approach to service delivery. The principles of a trauma-informed approach are safety, transparency and trustworthiness, choice, collaboration and mutuality, and empowerment. While non-community-based services may employ a trauma-informed approach, there are aspects of the current health care system in Nova Scotia that prevent it from fully adopting a holistic, collaborative, and trauma-informed approach, such as non-open-ended session duration (e.g., six sessions maximum; Rubin, 2008).

All community-based services accessed by the participants appeared to have an explicitly feminist mission and/or value statement that recognizes women as experts of their own lives and centres clients' experiences and wishes (Women's Centres Connect, n.d.). Participants did not report experiencing stigma, victim blaming, or a fear of re-triggering or traumatic experience with respect to accessing community-based services. They reported the opposite: they felt validated and heard, and indicated that they did not experience fear or anxiety accessing the service because they could anticipate a positive reaction from staff.

Fragmented Services

Challenges in accessing formal services were highlighted by all participants in our study. Every woman interviewed expressed a desire or need to access a range of health and social services, including mental health counselling, medical attention, peer support, police, justice system, education, housing support, and employment supports. Women found navigating a fragmented service system distressing, re-traumatizing, and economically taxing, and

shared experiences of health professionals having little-to-no ability to assist them in accessing other resources. They felt they bore alone the emotional toll and economic costs of navigating a fragmented health care and social support system.

Existing literature has identified fragmented services as a barrier to accessing services and supports for women who have experienced sexualized violence (Gregory et al., 2021; Logan et al., 2004). In Canada, where the fragmentation of health and social services is a growing issue, researchers and clinicians have called for action on integration of services (Misra et al., 2020; Ravenscroft, 2005). In the absence of high-level service integration, health navigation or "patient navigation" programs can mitigate the impacts of a fragmented system, such as lack of awareness of services, logistical barriers (e.g., transportation), and difficulty negotiating/maintaining relationships with providers (Carter et al., 2018; Dohan & Schrag, 2005). In a scoping review of 34 papers that included a navigation program involving both the health care system and community-based services, Carter et al. (2018) found no examples of navigation programs for survivors of sexualized violence. This study highlights the need for some form of navigation support.

Peer Support

There is limited discussion in the existing literature about peer support for women who have experienced sexualized violence. Although other fields, such as mental health and addictions, have adopted peer support programs (Tracy & Wallace, 2016), there appear to be few established programs in the field of sexualized violence. A number of women in our study wanted to access peer support, but they also felt that the value of peer support is limited by lack of capacity to refer to clinical/professional services (e.g., referrals, prescriptions, diagnosis).

Strengths and Limitations

Study participants were diverse in age and spoke to a variety of services and supports. There are, nevertheless, several limitations to this study including the fact that beyond

diversity in age, diversity among participants may be limited, as we did not collect socio-demographic information beyond age. In Nova Scotia, racialized women have reported feeling unwelcome and unheard in “mainstream” spaces for survivors of violence, including community-based services (Creating Communities of Care, n.d.). Our study also does not speak to the experiences of trans and nonbinary populations, who face both a greater risk of experiencing sexualized violence (Jaffray, 2020) and additional barriers to accessing services (Du Mont et al., 2020; Sualp et al., 2021). Future research should explore the service access experiences of diverse and marginalized populations.

Recommendations

Based on our findings, we can make several recommendations to improve access to sexualized violence services and supports in rural places.

Practice

Invest in community-based services. A meaningful investment in community-based services could help improve access in rural places by increasing capacity for community-based organizations to support more clients and/or provide mobile/outreach services to women.

Research

Explore peer support and patient navigation programs. Peers can provide safe and validating support that women cannot access through a professional who may lack lived experience. Women in our study suggested that peer support should be “formalized” so they could be referred to other services. A peer support program delivered in partnership with a formal service or with a trained facilitator might be ideal. A patient navigation program may also be useful for women living in rural places who face a highly fragmented system and unique challenges to accessing services, such as extensive travel. More research is needed to understand how women in rural places would want to access peer support and/or patient navigation programs.

Education

Continue to challenge stigma and shift narratives surrounding sexualized violence.

Women’s ability to access services was impacted by stigma and dominant narratives. Women made several suggestions to address this, including education on consent and sexualized violence starting at an early age and increased community dialogue on sexualized violence. This education and dialogue must consider the local, rural context of the community to be relevant and effective.

Conclusion

This study aimed to explore and understand the experiences of women accessing sexualized violence services and supports in rural communities in Nova Scotia. Women navigated a fractured and complex health and social support system, influenced by both their local community context and broader discourses surrounding sexualized violence. Although women reported several barriers to accessing services and supports, women also reported positive experiences with community-based organizations and presented a few suggestions to provide collaborative and trauma-informed care in their communities. The data were collected prior to the COVID-19 pandemic, which has amplified existing barriers and created new barriers to access for women experiencing sexualized violence. There is strong global evidence that COVID-19 has driven increases in gendered violence (Bettinger-Lopez & Bro, 2020; Canadian Women’s Foundation, 2020; John et al., 2020; UN Women, 2020). During lockdown measures, people experiencing violence may not be able to connect safely and confidentially to services while confined to their homes (Evans et al., 2020). Beyond lockdowns, evidence suggests that the economic crisis spurred by COVID-19 will continue to drive increased gendered violence (Sharma & Borah, 2020). This study highlighted a need to meaningfully invest in community-based services in rural communities to support women who have experienced violence, and this need may be increasingly urgent given the COVID-19 pandemic.

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