WESTERN MANITOBA
WOMEN'S CENTRE

# Advancing the Rights of Women Experiencing Gender-Based Violence in Southwestern Manitoba

# Report

# Acknowledgements

On behalf of the Western Manitoba Women's Centre (WMWC), we would like to acknowledge that this project took place on Treaty 1 and Treaty 2 Territories, the ancestral lands of the Anishinaabeg, Anishininewuk, Dakota Oyate, Denesuline and Nehethowuk Nations, and the Homeland of the Red River Metis. We acknowledge northern Manitoba includes lands that were and are the ancestral lands of the Inuit. We respect the spirit and intent of the Treaties and Treaty Making and remain committed to working in partnership with First Nations, Inuit, and Metis people in the spirit of truth, reconciliation, and collaboration. We remain steadfast to honouring the United Nations Declaration on the Rights of Indigenous Peoples, and the findings in the Truth and Reconciliation Commission of Canada, and The National Inquiry into Missing and Murdered Indigenous Women, Girls, and 2SLGTQQIA+ People.

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*The opinions and recommendations in this report, and any errors, are those of the Western Manitoba Women's Centre, and do not necessarily reflect the views of the funders or partners of this report.*

# 1. Introduction

In 2022, The Government of Canada's Women and Gender Equality (WAGE) department made an investment of $539.3 million over five years to enable provinces and territories to enhance services and support within their jurisdictions to prevent gender-based violence (GBV+) and support survivors (Government of Canada). Using The National Action Plan to End Gender-Based Violence and its five pillars as a guiding strategy, bilateral agreements with each province were developed to address the unique needs and nuances of survivor experiences from coast to coast. In Manitoba, $22.3 million dollars was committed by the federal government over four years (Government of Canada). This amount was matched by the Province of Manitoba, bringing the total investment to more than $44.6 million for WAGE related projects that aim to improve the economic, legal, social, and health status of women and 2SLGBTQI+ persons, address violence, raise awareness, and promote equal involvement of all persons in all aspects of society (Government of Manitoba).

In rural regions of Manitoba, the experience and needs of GBV survivors are unique. The landscape of available and accessible services and resources–like rural geography itself–are spread like wells dug kilometres apart, some with water and some without, and collectively unreachable to drink from. The *Advancing the Rights of Women Experiencing Gender-Based Violence in Southwestern Manitoba* project, led by the Western Manitoba Women's Centre (WMWC), aimed to assess the experiences of survivors in relation to the state of existing services and resources in southwestern Manitoba. WMWC travelled to six communities–more than 1395 kilometers–to speak with both service providers and community members in facilitated focus group sessions. The project looked to gain a deeper understanding of specific challenges within these communities. It also looks to survey the strengths that could enable opportunities for increasing service provider capacity, public awareness and prevention, survivor

resources, and sustainable, unrestricted funding. This project employed a form of research called “practitioner research,” which is “a form of inquiry conducted by professionals within their own field who look to integrate theory and action to generate new local knowledge, improve practices, and contribute new understandings to their respective field. It is a powerful from-the ground-up approach that prioritizes collaboration, participatory methods, qualitative reflection, and is utilized frequently in fields such as social work, education, and nursing” (Sheikhattari, Wright, Silver, Van der Donk, & Van Lanen, 2022).

This project’s findings illustrate both known and novel information regarding the gaps in rural services and resources in southwestern Manitoba. Service providers occupy a wide constellation of fields–mental health workers, educators, health professionals, law enforcement, CFS, faith-based organizations, etc– that both directly and indirectly engage with individuals experiencing GBV. Consequently, a creative and strategic response that uses the assets of each of these fields are needed to compensate for the deficits created by geography.

Community members interviewed in this project who are experiencing GBV belong to a spectrum of identities, cultures, ages, economic brackets, and care giving responsibilities. The intersection of these identities creates a complexity of barriers to leaving their situation, as well barriers to accessing sufficient and discreet supports. This report provides an analysis of these findings and suggests recommendations to eliminate barriers experienced by survivors and service providers. Ultimately, significant investments are needed in rural regions to address the seismic inequity of timely, accessible, and culturally relevant services. This report paints a collective vision for a coordinated, survivor-centered GBV ecosystem and response plan in rural Manitoba. The goal: a future in which no woman must shoulder the weight of isolation or entrapment, but can step into the open prairie with the steadiness and resolve that safety and community make possible.

## 2. Context: Rural Life and Existing Literature on GBV

We cannot examine rural experiences of GBV without first understanding the cultural norms that shape life on the Manitoba prairies. Rural living is not merely a lifestyle choice but an embodied connection to land, lineage, and self-sufficiency. People choose it for the autonomy found in space, for the quiet distance from urban intensity, the wellness of clean air and homegrown food, and the continuity of traditions such as farming, hunting, fishing, and stewardship. Often generational, rural life carries deep anthropological roots—from First Nations who have long called these lands home for thousands of years, to Hutterite colonies balancing communal heritage with modern agricultural practice, to families whose settler ancestors first broke prairie soil–rural life is history, kinship, and nature intertwined. It is an inheritance that shapes identity even as it upholds strong familial roles and gendered expectations.

At the same time, rural life is molded by persistent structural constraints. Employment opportunities are limited and often seasonal or precarious; post-secondary education is frequently inaccessible without relocation; reliable wifi remains uneven or absent; and public transportation is chronically insufficient. Together, these conditions produce cycles of low wages, constrained mobility, and heightened health and safety risks (Gladu 2021). Within this context, GBV in rural Manitoba emerges at the intersection of geographic isolation, stigma, cultural norms, housing precarity, and fragmented service systems. Survivors often navigate violence in profound isolation, without clear or confidential pathways to support. In small communities where “everyone knows everyone,” fear of exposure, retaliation, and social exclusion becomes a powerful deterrent to disclosure.

National data highlights the severity of this context. Rural areas, home to approximately 16% of Canada’s population, account for an estimated 38% of femicides, with disproportionately higher rates of severe violence and emergency interventions than in urban centres (Sheppard-

Perkins & Darroch 2025). Yet despite these alarming statistics, GBV research remains overwhelmingly urban-focused. Existing rural studies are fraught by underreporting, limited sample sizes, and methodological challenges associated with confidentiality and access (Sheppard-Perkins & Darroch 2025). As a result, the lived realities of rural survivors, and the conditions under which services attempt to respond, remain insufficiently theorized and under-resourced.

Existing literature further highlights the role of political culture in shaping both responses to GBV and the organization of social services. Rural Canada has historically been characterized by more homogenous populations and stronger conservative political orientations. Empirical research consistently shows that Conservative Party support in Canada is disproportionately drawn from rural, older, and predominantly white voters, and is closely associated with ideological commitments to the “traditional” family, gender complementarity, and personal responsibility (Farney & Rayside; Thomas 2020). These value systems can reinforce silence around intimate partner violence, normalize gendered power imbalances, and generate resistance to state intervention—particularly when violence is framed as a private family matter rather than a structural human rights issue.

Manitoba, however, complicates these narratives. The province possesses distinctive demographics that reshape rural socio-economic dynamics. Manitoba is home to approximately 237,190 First Nations people, representing 18% of the provincial population. There are 257,620 immigrants who also live in Manitoba, representing nearly 20% of the provincial population (Statistics Canada). Winnipeg holds the largest urban Indigenous population in Canada, and some Indigenous scholars have described the confluence of the Red and Assiniboine Rivers as Canada’s origin story (Sinclair 2024). Increasingly, immigrant and newcomer families—often enticed by employment pathways, affordability, or sponsorship networks—are settling in rural and semi-rural communities rather than urban centres. These populations bring rich cultures

and stories of resilience. They also bring traditional gender norms, language barriers, immigration-related precarity, and, in some cases, heightened vulnerability to violence and state intervention (Haque & Kawashima, 2020; Menjívar & Salcido, 2002). As a result, rural Manitoba's growth is not demographically or culturally uniform. Instead, it represents a complex social terrain where colonial legacies, Indigenous sovereignty, immigration, faith traditions, and rural conservatism intersect. The existing GBV literature and practical responses has only begun to grapple with this complexity, often treating rural communities as static or culturally monolithic. This gap obscures how violence is experienced differently across Indigenous, immigrant, and settler populations, and how service systems may inadvertently reproduce harm through culturally mismatched or inaccessible interventions.

Our findings are consistent with the scholarship on service systems, which consistently identifies rural scarcity as a defining feature of GBV responses (DeKeseredy & Schwartz, 2009; Logan et al., 2005; Burnett et al., 2016). We found that services are geographically dispersed, chronically underfunded, and heavily reliant on short-term project-based funding models that privilege urban settings and measurable outputs over relational and preventative work. Both survivors and service providers identified major structural barriers, including transportation limitations, lack of childcare, privacy concerns, and housing shortages. Critical service gaps, such as dedicated advocacy, trauma-informed counselling, and safe housing, have contributed to fragmented pathways and inconsistent outcomes. Notably, this study also reveals a significant discrepancy between services that are known to exist and those that are actually used. Awareness of available resources was inconsistent among both survivors and service providers, indicating a profound failure in the dissemination of information. This finding reflects broader scholarship on rural service delivery, which suggests that under-resourcing, staff turnover, and siloed funding streams undermine coordination and trust across systems (Sheppard-Perkins, S., & Darroch, F, 2025, Burnett et al., 2016). The result is not simply a lack

of services, but a lack of functional access that renders the efficacy of all existing services insignificant. This distinction becomes a critical discussion in later chapters.

Capacity and confidence among service providers also varied widely. While many demonstrated deep commitment and relational skill, others reported limited training, unclear mandates, and insufficient organizational support. The literature points to the importance of standardized, cross-sector training in rural contexts, particularly for professionals in healthcare, education, policing, housing, and income assistance who are often first points of contact for survivors (Public Health Agency of Canada, 2019; Wathen et al., 2012; Government of Canada, 2022). Without this infrastructure, responsibility for navigating complex systems is frequently shifted onto survivors themselves. Collectively, the literature makes clear that rural GBV cannot be addressed through urban models retrofitted for rural contexts. The convergence of rural culture, demographic change, and structural underinvestment demands a strategically distinct approach, one that recognizes GBV as both a manifestation of interpersonal harm and a systemic violation of fundamental rights protected under international and regional human rights frameworks, including the Universal Declaration of Human Rights (United Nations, 1948; United Nations, 1993; World Health Organization, 2012).

This chapter establishes the social, cultural, and structural conditions within which rural GBV services operate. The chapters that follow build on this foundation by examining the context of the workforce tasked with responding to these conditions while illuminating how systemic underinvestment in people directly shapes survivor outcomes.

# 3. Methodology

## 3.1 Process

This project used a mixed-method approach, combining quantitative and qualitative tools in the form of surveys, long answer questionnaires, and guided focus groups to gather information and data from service providers and community members. Focus group sessions were facilitated across six rural communities: Killarney, Minnedosa, Neepawa, Virden, Carberry, and Hamiota. Community members were recruited through the use of posters placed in high traffic areas like libraries, community recreation centres, and schools. The criteria for participating in the focus groups was specified on the poster. It indicated survivors, their friends and families, and anyone affected by the violence were invited to participate in the public community member sessions. For the purpose of this report, ‘community members’ and ‘survivors’ will be used interchangeably as all community member participants indicated that they are survivors of GBV. Service providers were recruited through email invitations and network groups. Social media platforms including the WMWC Instagram and Facebook pages were also used to recruit participants.

The focus groups included an introduction of the scope and goals of the project and open discussions on topics related to GBV in rural areas. A group activity titled the “Newspaper Headline Activity” was facilitated where participants had to design a front page newspaper headline and article. Participants were asked to look forward five years in the future and brainstorm about the services and support for survivors of GBV in their communities. The newspaper article needed to reflect their ideal support systems and services their community would benefit from to provide a strong foundation of support for survivors.

Two versions of the survey were created. The first survey was intended for service providers who interact directly and indirectly with individuals experiencing GBV to assess the strengths and challenges of existing services in rural communities. The second survey was

created for community members where the goal was to collect information on the accessibility of supports in their respective regions, while also assessing knowledge and use of existing resources. Surveys were administered after focus groups for those wishing to complete them with staff members' present once rapport was built. Surveys were also distributed electronically via email to distribution lists of service providers to allow for flexibility in how and where the survey could be completed. Surveys were also made available online with a link shared on the WMWC social media pages. In total, 34 individuals completed the service provider survey, and 11 individuals completed the community member survey. A total of 47 people participated in the focus group meetings across all six communities.  All data was processed through qualitative data software Nvivo, where key themes and trends were identified and coded.

### 3.2 Ethical Considerations and Confidentiality

This project qualifies as a form of inquiry called "practitioner research," a form of research conducted by professionals within their field to contribute new understandings, advance policy, and illuminate better practices. The project was conducted by a non-profit organization that does not have connections with an institutional research ethics process. Despite this, our research team reviewed and complied with the ethical principles outlined by the Tri-Council Policy Statements on Conduct for Research Involving Humans (TCPS2 2022). Engagement in this project was entirely voluntary, and all participants could refuse participation at any point during the focus groups sessions, or during the survey portions if they felt uncomfortable. Participants were verbally informed prior to participation that they could decline to answer any questions asked in the focus group or within the survey, and were allowed to leave the engagement process at any time without penalty. Due to the intensely sensitive nature of the subject, the project team was staffed with the WAGE Project Coordinator and experienced GBV counsellors from the WMWC, and the consultant, all of whom are well versed in trauma-informed practices. The team ensured safety by creating an anticipatory safety plan

should any participant feel triggered or uncomfortable. All participants were provided with contact information for the WMWC staff in the event they had questions after their participation, or if they wished to withdraw their participation altogether.

Confidentiality was maintained by creating a process that was entirely anonymous. No personal identifying information was collected in the focus groups or within the surveys, and participants were not asked to disclose any specific details about their experiences. All meetings were held at neutral locations like libraries, community centres, and recreation halls. All survey data and observations notes are stored in password protected cloud storage DropBox, while hard copies are kept in a locked filing cabinet. All collected materials will be held for five years, after which they will be destroyed.

### 3.3 Limitations and Challenges

There were some limitations and challenges in this project that have impacted data collection and scope of information. First were the small sample sizes. A combination of geography and the sensitive subject matter created barriers to recruitment that were not unexpected. As discussed in Chapter 2, historical discourse and sentiment around GBV is often described as a “private family matter” rather than a systemic experience of violence. Moreover, seeking support or participating in projects such as these can be risky for some individuals. Discretion can often feel impossible. The limited sample size does not suggest the experience of GBV isn’t universal or severe in rural communities, in fact, it echoes known evidence and on-going challenges rural people face in disclosing, seeking support, stigma, and privacy in smaller communities. We can deduce this is the case as service providers often referred a higher number of clients to the community member sessions than those who attended. Additionally, the number of rural clients regularly accessing GBV services at the WMWC also indicates that GBV experiences in rural communities is pervasive.

# 4. Community Member Profile: Who Is Most Impacted?

## 4.1 Profile

GBV in rural communities spans age, class, and cultural identity. While all surveyed survivors identified as women, participants ranged from youth under 18 years old to adults over 66, and included Indigenous women, persons with disabilities, visible minorities, newcomers, and members of the 2SLGBTQIA+ community. More specifically, 8% of respondents identified as newcomers and 15% identified as Indigenous. These compounded identities forge barriers that are shaped by structural inequities, cultural exclusion, and service systems that often fail to reflect their realities. The intersection of GBV, rurality, and marginalization intensifies isolation, erodes trust in institutions, and limits access to timely, appropriate care.

Experiences of violence were not confined to those traditionally perceived as vulnerable. Forty-one percent of respondents reported a bachelor's degree as their highest level of education. Forty-six percent of respondents owned their homes, yet housing instability remained a common concern. In rural contexts, financial abuse, coercive control, and shared or immovable assets—such as land and livestock—can make leaving unsafe situations difficult for homeowners, as described by participants. Deep place-based ties are prominent with 69% of respondents indicating that they were born in the communities where they currently live, adding further complexities to leaving violent relationships. This reflects generational roots that heighten social visibility and deter support-seeking. As one community member noted, without local advocacy or support groups, "people [wouldn't] know it's okay to speak up; the majority of people here feel they are being judged" (Community Member 1, Survey, February 2025)

## 4.2 Experience Seeking Supports

Survivors' confidence to seek support was split, with 50% of respondents stating they felt equipped to seek support, 40% did not feel equipped, and 10% were unsure. Community members consistently described rural service pathways as fragmented, difficult to navigate, and poorly coordinated. Trauma-informed care is vital to providing survivors with adequate support and cultivates a safe, trusting, client-centered environment. In the absence of trauma-informed care, survivors are routinely required to repeat their experiences across multiple services, increasing re-traumatization and producing uneven, unreliable support. These barriers are intensified by the social dynamics of small communities, where anonymity is limited and stigma is pervasive. Many survivors reported avoiding services altogether due to fear of being seen, identified, or discussed by neighbours. This information was stated during focus group sessions by participants based on their own lived experiences. This risk is heightened in contexts where their perpetrators hold social, economic, or institutional power within the community and use coercive control to reinforce silence.

Fifty percent of respondents sought supportive services while experiencing GBV. Some accessed counsellors, however, most noted these counsellors were only available in urban settings. Others reported school-based supports were beneficial for their children and helped navigate systems. Survivors articulated that they value relational, consistent, and emotionally grounded support. When services provide validation, navigation, and safety planning, survivors describe feeling seen and capable of moving forward.

Survivors also shared harmful experiences while seeking support through the RCMP. Respondents described RCMP interventions that escalated danger, or instances where the RCMP failed to act. One individual shared: "RCMP was not helpful and continues to make my situation worse". (Community Member 2, Survey, April 2025) Re-traumatization due to having to

re-tell experiences on multiple occasions to various service providers, long wait times, being blamed, shamed, or judged by community members, and lack of confidentiality in small, close-knit towns were common themes articulated among those surveyed and in focus groups. These system-harms compound the violence survivors experience at home. Lack of trauma-informed responses, gaps in mandated reporting, and understaffing in rural jurisdictions jeopardize survivor trust and safety. A community member described the services they received as “they weren’t very good, but they were free”. (Community Member 3, Survey, Apr 2025)

# 5. Service Provider Profile: Who Is Responding?

## 5.1 Profile

Service providers in this study reflect a cross-sectoral network of professionals. Providers came from community agencies, health and mental health services, education, law enforcement, government, and faith-based organizations. Participants ranged from Child and Family Services and Prairie Mountain Health public health nurses to school administrators, RCMP officers, and homeless shelter staff. Collectively, they work across a vast rural landscape that crosses health regions, agency mandates, and jurisdictional boundaries. This geographic and administrative spread shapes existing GBV responses in fundamental ways, requiring providers to navigate distance and limited local resources while maintaining continuity of care.

## 5.2 Experience Providing Supports

Of the 34 service providers surveyed, 71% reported providing direct services to survivors of GBV, yet only 6% expressed feeling very confident in their ability to adequately support someone experiencing violence. This gap between responsibility and confidence points to a systemic capacity issue and lack of training rather than individual reluctance.

In question 3 of the service provider survey, participants were asked, “which of the following services are you aware of in your community or the rural communities you serve that provide support to someone experiencing GBV?”, the most frequently identified services were mental health supports, medical care, financial assistance, and legal services. Some communities also reported access to emergency shelter or housing, crisis counselling, and transportation support. Despite this range, 52% of respondents rated overall service accessibility as poor. Gaps were most acute in relation to sexual assault response: only 9% of respondents indicated that their local health centre could complete a forensic exam following a sexual assault. Focus group discussions further revealed that in at least one rural community, a nurse had completed Sexual Assault Nurse Examiner training but was unable to practice due to infrastructural limitations. The local health centre reported insufficient physical space to conduct forensic exams, rendering the training unusable and leaving survivors without access to forensic care despite existing clinical expertise.

In question 15 of the service provider survey, participants were asked “to describe the value their community would gain if there was a dedicated GBV counsellor or advocate available.” One individual described it as “invaluable, advocates are needed to provide emotional support to start the healing process”, (Service Provider 1, Survey, April 2025) while another stated, “the community would be able to grow in trust and relationships, to reduce barriers in accessing services.” (Service Provider 2, Survey, April 2025)

Many specific policy and systemic barriers limiting the effectiveness of services in their communities were identified by service providers. These include funding constraints affecting transportation, staffing, and long-term programming. Additional notable barriers that were identified were limited resources and information. Centralized health care in rural towns is almost non-existent, creating immense obstacles to accessing medical care, with wrap-around services only available in larger centres such as Brandon or Winnipeg.

# 6. Integrated Findings: A Systems-Level Picture

When examined collectively, the findings from survivors and service providers reveal a coherent systems-level narrative. Across all data sources, GBV in rural Manitoba emerges not as an isolated interpersonal phenomenon, but as a condition shaped and sustained by structural, geographic, institutional, and cultural forces. The convergence of perspectives across groups—despite differences in role, power, and proximity to formal systems—shows that the barriers survivors face are not isolated or individual, but rooted in the very structure of rural systems. Survivors' accounts, service provider surveys, and facilitated focus groups consistently point to the same underlying conditions: limited service availability, fragmented systems, housing precarity, pervasive stigma, and lack of anonymity. In this sense, the findings echo existing scholarship that situates violence within broader socio-political arrangements, where access to safety is unevenly distributed along lines of geography, gender, income, and social networks.

## 6.1 Infrastructure & Housing

A central theme emerging from the integrated analysis is the role of rural housing availability and options—or more accurately, the absence of it—in shaping both the experience of violence and the feasibility of seeking support. Survivors repeatedly describe living in environments where the material conditions required to leave or interrupt violence are largely unavailable. One service provider noted that "[supports] need to branch out of Brandon to help [people experiencing] GBV". (Service Provider 3, Survey, May 2025) Housing shortages, multi-year waitlists, lack of transitional options, and the absence of pet-friendly or family-appropriate accommodations in rural communities function as major constraints, effectively tethering survivors to abusive situations. Importantly, housing insecurity is not limited to those without

property; even homeowners report instability due to financial abuse, coercive control, and shared assets.

### 6.2 Transportation and Mobility

Transportation and mobility emerge as equally critical determinants through all data sources. The requirement to travel long distances for counselling, forensic exams, court proceedings, or specialized health care introduces both practical and psychological barriers. Without access to vehicles, funds for travel, childcare, or time away from work, many survivors are effectively excluded from services that technically exist but are functionally inaccessible. “Our community would benefit from a designated person to provide support, information, safety planning, and advocate for transportation services to access needed services in the city,” (Service Provider 4, Survey, May 2025), a service provider described in a survey. Distance, combined with limited public transit, transforms access into a privilege rather than a right. While virtual services are often proposed as a remedy, the data complicates this assumption, highlighting issues of unreliable internet access, lack of privacy, and the inadequacy of remote support during acute crises. As a result, both service providers and survivors were emphatic for the need of ‘mobile services’ that could provide on-demand-like support when safe opportunities present themselves.

### 6.3 Stigma & Power

Social isolation, amplified by small-town dynamics, further inhibits help-seeking. Survivors consistently articulate fear of being seen, recognized, or judged when accessing services, particularly in communities where personal and professional relationships overlap. Rural closeness–often celebrated as community cohesion—can function as a form of surveillance, increasing the social costs of disclosure. In a survey, a service provider stated “awareness would be pivotal in building community to prevent GBV from happening.” (Service

Provider 5, Survey, May 2025) This project reinforces that insight, demonstrating how stigma, gossip, and concern for family reputation suppress reporting and reinforce silence, particularly when perpetrators hold social, economic, or institutional power within the community.

### 6.4 Siloed Landscapes

Institutional fragmentation compounds these challenges. Survivors and providers alike describe navigating a landscape of siloed mandates, inconsistent protocols, and unclear lines of responsibility across policing, child welfare, health care, education, and victim services. Rather than experiencing a coordinated response, survivors often become the sole navigators of systems, responsible for repeating their stories, tracking appointments, and managing risk across multiple agencies. This burden is especially pronounced in rural contexts, where understaffing, staff turnover, and geographic dispersion limit opportunities for inter-agency collaboration. A service provider described their hope for the future on the survey as a “one stop shop..not getting sent everywhere..immediate support when you’re in trauma.” (Service Provider 6, Survey, April 2025) The findings resonate with systems-level analyses in the GBV literature that critique reliance on fragmented service models and emphasize the harms produced when coordination is treated as optional or superfluous, rather than foundational.

### 6.5 Police and Forensic Responses

Policing and forensic responses further illustrate systemic inconsistencies. Survivors’ detailed their experiences with law enforcement during the focus group sessions and frequently reflected delayed responses, limited recognition of coercive control, and interactions perceived as escalating rather than mitigating harm. Service providers corroborate these concerns, citing understaffing, lack of specialized training, and organizational cultures that deprioritize domestic and sexual violence. One service provider stated, “Officers aren’t recognizing coercive control… sometimes they don’t call CFS until weeks later.” (Service Provider 7, Survey, December 2024)

Similarly, the absence of local forensic exam capacity and the limited awareness of forensic pathways among both survivors and providers creates critical delays in care and reduces the likelihood of reporting. The implications of this leave survivors with diminished access to justice due to uneven distribution of medical and legal care.

### 6.6 Culture and Identity

Cross-cutting these structural and institutional dynamics are persistent inequities related to culture, language, and identity. This was revealed during focus group discussions in Minnedosa for example, where service providers noted an increase in newcomer and immigrant populations in the area due to large industrial jobsite in the region. Indigenous and newcomer women encounter additional barriers rooted in historical mistrust of institutions, racism, language access challenges, immigration-related fears, and culturally incongruent services. The lack of Indigenous-led and newcomer-informed supports identified in this study reflects broader critiques within the literature regarding the failure of mainstream GBV systems to account for colonial histories, migration contexts, language barriers, and culturally specific understandings of safety and family. These inequities underscore the necessity of culturally grounded approaches that move beyond one-size-fits-all models.

### 6.7 Survivor-led

Despite the systemic shortcomings described above, the integrated findings also reveal significant assets and readiness for change. Survivors demonstrate resilience, insight, and a strong desire to support others, with many expressing confidence in their ability to navigate systems on behalf of peers. In a survey, one community member named “a peer network” as something the community needs to better serve survivors of GBV, while another suggested “support groups.” (Community Member 3 & 4, Surveys, April 2025) Service providers, while stretched thin, articulate a clear vision for more coordinated, relationship-based models and

express willingness to collaborate across sectors. Community members independently articulate similar aspirations, often converging around the idea of localized hubs, navigators, and shared pathways. This convergence suggests that the problem is not a lack of understanding of what is needed, but rather a lack of structural investment and system design aligned with rural realities.

## 7. Community-Driven Vision

Collectively, the integrated findings demand a shift from individualized, crisis-oriented interventions toward a structural approach to creating and maintaining safety. Housing instability, transportation barriers, legal precarity, limited counselling access, and the absence of culturally safe services are not stand-alone challenges. Rather, they are fundamental conditions that shape vulnerability to violence and constrain survivors' ability to leave their abusers. In this sense, Rural GBV is reproduced through policy choices, institutional fragmentation, uneven public investment, and inadequate prevention education. This framing aligns with the Missing and Murdered Indigenous Women, Girls, and 2SLGBTQQIA people (MMIWG2S) Calls for Justice, which identify violence as rooted in systemic racism, colonialism, economic marginalization, and institutional failures (Calls for Justice 1.1, 1.7). Meaningful change requires more than adding programs onto overstretched systems. It requires coordinated governance, cross-sector accountability, and Indigenous-led approaches to safety (Calls for Justice 2.3, 5.1).

Providing survivors with culturally driven pathways to healing that challenge the status quo and address historical and intergenerational trauma is integral to meaningful healing (Calls for Justice 3.2, 3.7, 7.2). The following recommendations illustrate a powerful direction for future system design. This vision includes a rural GBV ecosystem rooted in service navigation, wraparound care for survivors, and collaboration amongst agencies.

# 8. Recommendations

### 1. Embed Local, Trauma-Informed GBV Navigation Services Into Existing Systems

**Insight**

Survivors describe fragmented pathways across RCMP, CFS, healthcare, counselling, schools, and housing. Requiring survivors to navigate these systems independently contradicts the MMIWG2S Calls for Justice, which emphasize coordinated, trauma-informed, survivor-centred services (Calls for Justice 3.2, 4.1, 16.7).

**Calls to Action**

a. Create a funded “Rural Advocate” position to support disclosure, accompany survivors through systems, and ensure continuity of care.

b. Integrate Advocate into multi-agency teams (CFS, RCMP, housing, health, schools) to prevent service fragmentation and re-traumatization.

c. Prioritize Indigenous-led Advocacy consistent with Calls for Justice 2.3 and 5.1.

### 2. Develop Safe, Affordable, and Flexible Housing Pathways

**Insight**

Housing stability consistently appears as the *core determinant* of whether survivors feel able to leave violence and access services. This is not limited to renter households, Homeowners report instability due to financial abuse, coercive control, or shared-living constraints. The MMIWG2S Calls for Justice identifies safe, affordable housing as foundational to violence prevention and survivor safety (Calls for Justice 4.5, 16.7).

**Calls to Action**

a. Partner with rural housing providers to secure transitional units, pet-friendly options, and emergency safe accommodations specific to GBV survivors.

b. Fund flexible rental and relocation supports and eliminate administrative delays for violence-affected families.

c. Expand second-stage and long-term social housing options in rural and northern communities, consistent with Call for Justice 4.5.

### 3. Expand Access to Local Counselling & Mental Health Services

#### Insight

Counselling is the most commonly used support but is often inaccessible due to cost, distance, waitlists, or low quality. Survivors repeatedly request trauma-informed counselling available *locally* and *immediately.* The Calls for Justice emphasize accessible, trauma-informed, culturally safe healing services grounded in community leadership (Calls for Justice 3.2, 7.2)

#### Calls to Action

a. Create a funded “Rural Counselling” role (adult and youth) embedded in community hubs, schools, and family resource centres.

b. Introduce mobile or rotating counselling schedules to enhance privacy and reach remote areas.

c. Support land-based, culturally grounded healing options in partnership with Indigenous communities.

### 4. Improve RCMP Response Through Specialized Training & Coordination

#### Insight

Service providers identified the need for targeted GBV education and coordinated protocols. The MMIWG2S Calls for Justice explicitly call for mandatory trauma-informed policing reforms, education on coercive control, and accountability mechanisms (Calls for Justice 5.4, 9.2, 9.3).

**Calls to Action**

a. Deliver mandatory training on coercive control, trauma-informed response, MMIWG2S Calls for Justice, risk assessment, and newcomer family dynamics.
b. Develop shared inter-agency protocols to ensure coordinated responses to protection order breaches and domestic violence calls.
c. Establish transparent accountability and data tracking mechanisms in line with Calls for Justice 9.2 and 9.3.

**5. Build Rural GBV Hubs with One Intake & Coordinated Care**

**Insight**

Survivors and providers envision a single-entry, coordinated hub model. This reflects the Calls for Justice emphasis on wraparound, survivor-centred, integrated services (Calls for Justice 1.7, 4.1, 16.7).

**Calls to Action**

a. Create a “Rural GBV Hub” with co-located services (CFS, RCMP liaison, counselling, EIA, housing, legal support).
b. Implement one shared intake process to reduce repetitive storytelling and improve confidentiality.
c. Fund discreet transportation and mobile outreach to eliminate geographic access barriers.

**6. Strengthen Cultural Safety & Newcomer-Specific Supports**

**Insight**

Indigenous and newcomer survivors face distinct barriers, including systemic racism, immigration precarity, language barriers, and distrust of institutions. The Calls for Justice require culturally safe, Indigenous-led and culturally responsive services (Calls for Justice 2.3, 3.2, 7.2, 15.1).

**Calls to Action**

a. Embed Indigenous-led and newcomer-informed services within rural hubs, including interpreters and cultural navigators.

b. Develop culturally grounded education on rights, healthy relationships, and navigating Canadian systems.

c. Partner with Indigenous governments and newcomer-serving agencies to co-design services.

**7. Survivor-Led Peer Support Networks**

**Insight**

Survivors identified peer support as a trusted access point. The Calls for Justice affirm the importance of survivor leadership, community-driven solutions, and lived-experience expertise (Calls for Justice 2.3, 15.8).

**Calls to Action**

a. Establish a paid, structured rural survivor peer network to support disclosure, accompany survivors, and inform service design.

b. Provide ongoing training, supervision, and wellness supports for peer leaders to ensure sustainability and safety.

# 9. Final Thoughts

The intention of this project was straightforward: to sit with rural people, listen carefully, and allow their experiences to guide what comes next. From the beginning, it was essential to gather stories and insights from those who live and work in the communities we hoped to better understand. This included survivors navigating violence, control, and isolation; family members supporting loved ones through crisis; and service providers who know rural realities well, carrying large caseloads across long distances with limited resources. These individuals hold the expertise that meaningful intervention must be built upon.

Reflecting on why this work mattered, Julia Krykavska, Director of Operations & Development at the WMWC, described the WAGE grant “as a strategic opportunity to explore and better understand the distinct challenges faced by women in rural communities. Recognizing gaps in existing data and services, we saw this research as a vital step toward gathering comprehensive, evidence-based insights.” While it has long been clear that additional support is needed in the Westman region, this project looked to deepen the organizations’ understanding of the intersecting forces—geography, culture, infrastructure, gender, and community identity—that shape safety and access in rural contexts.

As staff travelled across Southwestern Manitoba, meeting with communities in homes, halls, offices, and schools, certain patterns emerged. Kim Iwasiuk, Director of Counselling & Advocacy, reflected on these encounters: “We have been welcomed with open arms and have had the privilege to hear the narratives of many individuals who have shared their journeys. There have been tears, laughter, and a tremendous amount of knowledge gained through discussion and the sharing of hopes and dreams.” These conversations, though honest and generous, form the backbone of this report.

From this work, several lessons have become clear. We cannot assume what rural communities need; we must ask, listen, and respond alongside them. Relationship-building is not peripheral but foundational to any service the Western Manitoba Women's Centre may offer in the future. Survivors' insight, providers' dedication, and the resilience woven into rural communities are not incidental strengths, they are essential resources that must shape system design. And perhaps most importantly, meaningful progress requires not only new programs but sustained advocacy for structural change. We must address the barriers that constrain safety and the conditions that make violence harder to escape.

Rural communities hold many strengths: connection, ingenuity, reciprocity, a sense of shared history. Our hope, which echoes what survivors and service providers voiced throughout this project, is that the future of rural living more fully includes safety, care, and collective wellbeing. Julia concludes, "Ultimately, this research will strengthen our capacity to advocate effectively and implement meaningful initiatives that address the unique realities of women in rural community contexts." That vision, rooted in the stories shared with us, is what guides the work ahead.

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# 11. Appendices

- Appendix A: Service Provider Survey
- Appendix B: Community Member Survey
- Appendix C: Lesson plans for focus groups

## Appendix A: Service Provider Survey

The purpose of this survey is to gather important information regarding support for survivors of gender-based violence in your community.

Gender-based Violence (GBV) refers to harm directed at an individual based on their gender. It can include physical, sexual, verbal, emotional, or financial abuse, and can take different forms such as intimate partner violence, domestic violence or sexual violence.

Responses to this survey are voluntary and remain anonymous. Data collected from this survey will be used by The Women's Resource Centre in a final report publication at the end of the project. Our goal is to procure additional resources and support for survivors in rural areas.

### Section 1: Service Provider Demographics

1. What sector do you work in? (select all that apply)
   - ( ) Community-based Organization (nonprofit resource centre, shelter, etc)
   - ( ) Mental Health Services (counsellor, psychiatrist, social worker)
   - ( ) Health Services (clinic, hospital, EMS, community nurse practitioner etc.)
   - ( ) Education System (public schools, university)
   - ( ) Law Enforcement (police, RCMP, victim services)
   - ( ) Legal Services
   - ( ) Faith-based Organization
   - ( ) Housing Provider or Landlord
   - ( ) Government Agency (CFS etc)
2. Does your organization provide direct services to survivors of GBV?
   - ( ) Yes
   - ( ) No
   - ( ) I'm not sure

### Section 2: Knowledge of Existing Services

3. Which of the following services are you aware of in your community that provide support to someone experiencing GBV? (Select all that apply, and indicate who provides the service you are aware of):
   - ( ) Emergency shelter/housing _____
   - ( ) Crisis counselling _____
   - ( ) Transportation services _____
   - ( ) Legal Assistance _____
   - ( ) Medical care and forensic exams _____
   - ( ) Mental health supports _____
   - ( ) Child advocacy services _____
   - ( ) 2SLGBTQIA+ support services _____

( ) Language access/translation services _____

( ) Financial assistance/employment support _____

( ) Other (please specify): _____

4. How would you rate the accessibility of these services for survivors of GBV?

( ) Excellent

( ) Good

( ) Fair

( ) Poor

5. Of the services you selected above in question 3, are you aware of which services regularly interact with each other, or work to coordinate their services for victims of GBV?

6. Which services or sectors do you see as an opportunity for better coordination and how, in your opinion, could this coordination be implemented?

7. Are you familiar with the Rural Manitoba Sexual Assault Network (RMSARN)?

( ) Yes

( ) No

8. Does your local Health Centre have the ability to complete a forensic kit after a sexual assault?

( ) Yes

( ) No

( ) Unsure

## Section 3: Assessing Gaps and Barriers in Services

9. In your opinion, are there specific populations that you see face barriers to accessing services? (ex. rural residents, non-English speakers, Indigenous individuals, people with disabilities etc.)

( ) Yes (please specify): _____

( ) No

( ) Unsure

10. What services do you believe are lacking for survivors of GBV in your community? (select all that apply):

( ) Access to counselling services

( ) Access to advocacy support to help navigate agencies/services

( ) Protection order designates to assist with the P.O application process

( ) Third party reporting

( ) Safe and affordable long-term housing

( ) Culturally specific services

( ) Local food bank

( ) Legal representation in court

( ) Employment and skills training

( ) Transportation services

( ) Child care

( ) Language/interpretation services

( ) Trauma-informed care

( ) Supports for 2SLGBTQ+ survivors

( ) Other (please specify): _____

11. Are there specific policy or funding barriers that limit the effectiveness of services in your community?

( ) Yes (please specify): _____

( ) No

12. In your opinion, what would your community need to better serve survivors of GBV?

## Section 4: Service Provider Input

13. On a scale of 1-5, how confidently do you feel in your job in adequately supporting someone who is experiencing GBV?

( ) 1 (not confident)

( ) 2

( ) 3 (fairly confident)

( ) 4

( ) 5 (very confident)

14. What would improve your confidence? (eg. specific GBV training, workshops, etc)

15. Describe the value your community would gain if there was a dedicated GBV counsellor or advocate working in your community.

16. Do you have any additional information, comments, or feedback to share at this time.

Thank you for your participation in the Community Partner Survey. Your responses are valuable and will play a vital role in the WAGE project.

**Please forward any questions or your completed survey to:**

Jamie Brown

Women and Gender Equity Project Coordinator

The Women's Resource Centre

729 Princess Ave

Brandon, MB R7A 0P4

jamie.WAGE@thewomenscentrebrandon.com

204-726-8632

## Appendix B: Community Member Survey

The purpose of this survey is to gather important information regarding support for survivors of gender-based violence in your community.

Gender-based Violence (GBV) refers to harm directed at an individual based on their gender. It can include physical, sexual, verbal, emotional, or financial abuse, and can take different forms such as intimate partner violence, domestic violence or sexual violence.

Responses to this survey are voluntary and remain completely anonymous. You may skip questions you do not feel comfortable answering and no personal health information will be collected. Data collected from this survey will be used by The Women's Resource Centre in a final report publication at the end of the project. Our goal is to procure additional resources and support for survivors in rural areas.

If at any point during the survey you feel upset or become triggered, please inform a staff member to receive support.

### Section 1: Demographics

1. What is your age?

( ) Under 18

( ) 18 – 25

( ) 26 – 35

( ) 36 – 45

( ) 46 – 55

( ) 56 – 65

( ) 66 +

( ) Prefer not to disclose

2. How do you self-identify your gender? (select all that apply)

( ) Woman

( ) Man

( ) Non-binary/genderqueer

( ) Transgender

( ) Two-Spirit

( ) Another, prefer to specify:

_____

( ) Prefer not to disclose

3. Do you self-identify as a member of any of the following underserved groups? (select all that apply)

( ) Woman

( ) Indigenous Peoples – First Nations, Metis, Inuit

( ) Persons With Disabilities

( ) Visible Minority

( ) Immigrant/Newcomer

( ) 2SLGBTQAI+

( ) Other, please specify: _____

( ) None of the above

( ) Prefer not to disclose

4. Were you born in the town you currently reside in?

( ) Yes

( ) No

( ) Prefer not to disclose

5. Were you born in Canada?

( ) Yes

( ) No – if no, where were you born? _____

( ) Prefer not to disclose

6. What languages do you speak? _____

7. Do you have dependents/children under the age of 18 living with you?

( ) Yes – if yes, how many? _____

( ) No

( ) Prefer not to disclose

8. What's your highest level of education completed?

( ) Completed middle school

( ) Completed some high school

( ) Completed high school (grade 12) or GED

( ) Completed some post-secondary courses

( ) College diploma/certificate

( ) Trades, Red Seal/technology/apprenticeship

( ) Bachelor's degree

( ) Master's degree

( ) PhD

9. How would you describe your current housing?

( ) I own my house

( ) I rent my house/apartment

( ) Subsidized unit/social housing

( ) Living with a relative, friend or partner

( ) Transitional housing

( ) Couch surfing

( ) Houseless/shelter

( ) Houseless/on the street/rough sleeping

( ) Other, please specify: _____

10. If you have housing, on a scale of 1 to 5, how would you rate your current housing?

( ) 1 (very unstable)

( ) 2

( ) 3 (fairly stable)

( ) 4

( ) 5 (very stable)

11. What are your main sources of income? (select all that apply)

( ) Employed

( ) Employment & Income Assistance/Welfare

( ) EIA disability benefit

( ) CPP/Pension/OAS

( ) Employment Insurance

( ) Workers Compensation

( ) Panhandling

( ) Sex Work

( ) Other, please specify: _____

( ) None

( ) Prefer not to disclose

## Section 2: Knowledge of Services/Agencies in your Community

12. What services/agencies are you aware of in your community that provide support to someone who is experiencing GBV? (select all that apply)

( ) Private counselling agencies

( ) Mental health services

( ) Addiction services

( ) CFS

( ) RCMP

( ) Local hospital/clinic (nurse practitioner, nurse examiner etc)

( ) Victim services

( ) MB housing

( ) School counsellor/social worker

( ) Local food bank

( ) Other, please specify: _____

13. How did you learn about these organizations and the services they offer (select all that apply)

( ) Referral from another agency

( ) Self-referral/researched on my own

( ) Word of mouth

( ) Local advertisement

( ) Other, please specify: _____

## Section 3: Lived Experience

14. Have you personally experienced any form of gender-based violence?

( ) Yes

( ) No - If no, please skip to question 21.

( ) Unsure - If unsure, please skip to question 21.

( ) Prefer not to disclose – if prefer not to disclose, please skip to question 21.

15. If you answered yes to question 14, did/do you feel equipped to seek support?

( ) Yes

( ) No

( ) Unsure

( ) Prefer not to disclose

16. If you answered yes to question 14, what services/agencies (if any) did you utilize for support?

( ) Counselling (crisis, private, non-profit etc)

( ) CFS

( ) RCMP

( ) Local hospital/clinic (nurse practitioner, nurse examiner etc)

( ) Victim services

( ) MB housing

( ) School counsellor/social worker

( ) Local food bank

( ) Other, please specify: _____

( ) None, I did not receive support from services/agencies

( ) Prefer not to disclose

17. What did you find most supportive about the services that you used?

18. Was there anything you felt was *not* helpful about the services that you used?

19. Are there services/agencies you would like to access for support, but are unable to due to certain barriers?

( ) Yes

( ) No - If no, please skip to question 21.

( ) Prefer not to disclose

20. If you answered yes to question 19, what barriers limit your access to services/agencies? (select all that apply)

( ) The services/agencies don't exist in my community

( ) Lack of awareness of services/agencies that can help

( ) Hours of operation

( ) Travel to access services/agencies (cost, time, access to vehicle etc)

( ) Child care

( ) Fear of stigma, being judged, or shamed

( ) Safety concerns

( ) Language barriers/access to interpretation services

( ) Other, please specify: _____

21. Would you feel equipped to support someone else (a friend or family member) who has experience GBV? (ex: navigating services, referring to agencies, limiting barriers)

( ) Yes

( ) No

( ) Unsure

( ) Prefer not to disclose

22. Have you heard of third-party reporting?

( ) Yes

( ) No

( ) Unsure

( ) Prefer not to disclose

23. Have you personally used third-party reporting for yourself or someone else?

( ) Yes, for myself

( ) Yes, for someone else

( ) No, I've never used it

24. Have you personally applied for a Protection Order?

( ) Yes

( ) No – if no, please skip to question 27.

( ) Prefer not to disclose

25. If you answered yes to question 24, please describe your experience with the application process.

26. Were you successful in getting the Protection Order?

( ) Yes

( ) No

( ) Prefer not to disclose

27. What would your community need to better serve survivors of GBV?

28. Describe the value your community would gain if there was a dedicated GBV counsellor or advocate working in your community.

29. Do you have any additional information, comments, or feedback to share at this time?

Thank you for your participation in the Community Member Survey. Your responses are valuable and will play a vital role in the WAGE project.

Please forward any questions to:

Jamie Brown

*Women and Gender Equity Project Coordinator*

The Women's Resource Centre

729 Princess Ave.

Brandon, MB R7A 0P4

jamie.WAGE@thewomenscentrebrandon.com

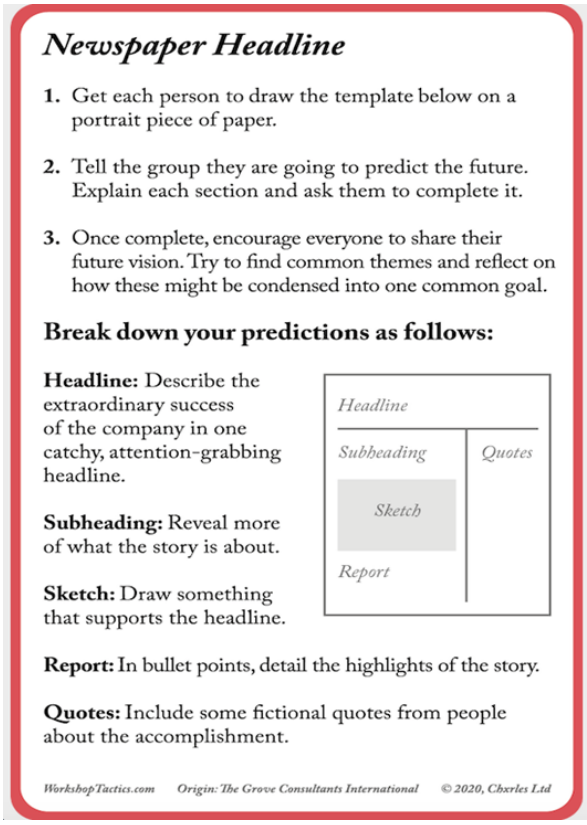
204-726-8632

## Appendix C: Lesson Plan For Focus Groups

1. Who are you? Organization you represent?  Why have you joined us today? (10 minutes)
2. Brief introduction to this project, and what this meeting will look like. (2 minutes)
3. “Newspaper Headline” Activity (90 minutes)

   Looking forward to 5 years, I want you to dream about the future of services and support for survivors of GBV in your community. Your town has made the front page of all major newspapers in the province, what would the headlines say?

   - 5 groups of 5
   - 30 minutes to create
   - 30 minutes to present
   - 30 minutes to talk about similarities, inspirations, finding common ground
   - Sort Headlines into Passion Themes



*Newspaper Headline*

1. Get each person to draw the template below on a portrait piece of paper.
2. Tell the group they are going to predict the future. Explain each section and ask them to complete it.
3. Once complete, encourage everyone to share their future vision. Try to find common themes and reflect on how these might be condensed into one common goal.

**Break down your predictions as follows:**

**Headline:** Describe the extraordinary success of the company in one catchy, attention-grabbing headline.

**Subheading:** Reveal more of what the story is about.

**Sketch:** Draw something that supports the headline.



**Report:** In bullet points, detail the highlights of the story.

**Quotes:** Include some fictional quotes from people about the accomplishment.

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