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ACCESS TO MENTAL HEALTH IN RURAL WOMEN VICTIMS OF GENDER-BASED VIOLENCE: A COMMUNITY PERSPECTIVE

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ABSTRACT

Introduction: *Gender-based violence and its impact on mental health represent a critical public health priority, particularly in rural areas of developing countries. In Ecuador, where 64.9% of women have experienced some form of violence, this study examines barriers to access and quality of mental health services for rural women victims of gender-based violence from a community perspective. The objective is to identify structural, cultural, and institutional factors limiting care and propose evidence-based solutions.* ***Methodology:*** *The research employed a mixed-methods (quantitative and qualitative) design with a descriptive-correlational approach. A structured questionnaire combining closed-ended (Likert scales) and open-ended questions was administered to 349 rural women in Ecuador. Analysis included descriptive statistics for quantitative data and thematic coding for qualitative responses, ensuring a comprehensive understanding of the phenomenon.* ***Results:*** *Findings reveal significant structural barriers, with 70.8% of women reporting a lack of specialized centers in their communities and 69.3% noting insufficient trained professionals. Geographic inaccessibility affects 76.7% of respondents, requiring lengthy travel. Notable sociocultural obstacles include social stigma (78.8%) and restrictive gender roles (87.2%), which hinder help-seeking behaviors. Only 11.1% of women regularly access professional services, while 75.4% do so rarely. Participants proposed improvements such as service decentralization, telemedicine implementation, intercultural training, and community awareness campaigns.* ***Discussion:*** *The intersection of geographic, economic, and cultural barriers creates a scenario of multiple exclusions for rural women. Urban-centralized services, inadequate gender-sensitive training for staff, and lack of cultural adaptation in services explain the gap between care needs and system responsiveness. These findings align with previous studies in similar contexts but emphasize the importance of incorporating community perspectives in intervention design.* ***Conclusions:*** *The study highlights the urgent need for comprehensive policies addressing both infrastructure/human resource expansion and cultural barriers. Mobile units, telemedicine strengthening, professional training in gender-based violence and intercultural approaches, and locally-led awareness campaigns emerge as key strategies. These measures should be developed with active participation from rural women, ensuring their voices and needs guide interventions. The results provide valuable evidence to inform public policies guaranteeing equitable access to quality mental health services in rural areas.*

KEYWORDS: Mental Health; Gender-Based Violence; Rural Women; Access to Services; Social Stigma; Public Policies.

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1. INTRODUCTION

The right to mental health, recognized as a fundamental component of holistic well-being in the WHO Plan of Action, faces serious challenges in contemporary health systems. Globally, there is an alarming gap between care needs and response capacity, particularly in low- and middle-income countries where between 76% and 85% of people with severe mental disorders do not receive treatment. This situation is aggravated by insufficient investment (less than US$2 per capita per year) and a critical shortage of specialized professionals, with ratios as low as one psychiatrist per 200,000 inhabitants (World Health Organization, 2021).

In the Ecuadorian context, this problem acquires particular nuances. Despite the constitutional recognition of the right to mental health as part of the Sumak Kawsay, Art. 32 of the Constitution of the Republic (2008), structural barriers persist that limit its effective realization. The National Health System presents a marked segmentation (INEC, 2020), with an inequitable distribution of resources that manifests itself in ratios of just 0.08 psychiatrists per 10,000 inhabitants in the Comprehensive Public Health Network(Wong-Ayoub et al., 2022). This situation is especially critical in rural areas, where access to specialized services is practically non-existent (Vera, 2020)

Gender-based violence emerges as a determining factor that aggravates this situation. The data are conclusive: in Ecuador, 64.9% of women have experienced some type of violence, with psychological (56.9%) and physical (35.4%) being the most prevalent forms (INEC, 2019). This problem has profound repercussions on mental health, with rates of depression reaching 50% and post-traumatic stress rates between 10-15% in victims of violence, significantly higher than in the general population (3-8%). Where only 30% of rural women receive psychological treatment, in contrast to 60% in urban areas (Samaniego et al., 2024). Rural women face a double vulnerability. On the one hand, the scarcity of specialized services forces them to rely on informal community networks or traditional medicine (Friederic, 2024). On the other hand, important cultural and institutional barriers persist, evidenced by the fact that only 5.4% of rural women report cases of violence, compared to 12% in urban areas (INEC, 2019). This gap reflects not only geographical isolation, but also a deep distrust of institutions and a lack of cultural adaptation of existing services.

Despite the advanced legal framework, including the Comprehensive Organic Law to Prevent and Eradicate Violence against Women (National Assembly, 2018), its implementation in rural areas has serious deficiencies. Citing examples, studies in Babahoyo (Spain & Galarza, 2020) and Chimborazo (Alvarado-Vélez, 2023) They document the absence of specialized centers, the lack of training of personnel, and the lack of community prevention mechanisms. These gaps translate into fragmented and ineffective care, which does not respond to the specific needs of rural women.

This study seeks to analyze this problem from a community perspective, focused on the voices and experiences of rural women themselves. The analysis is structured around three fundamental axes: (1) systemic barriers in access to mental health services, (2) the social determinants that perpetuate gender-based violence, and (3) gaps in the implementation of public policies.

2. METHODOLOGY

This study adopted a mixed approach (quantitative and qualitative), with a cross-sectional non-experimental design, which allowed the analysis of barriers to access and quality of mental health services for rural women victims of gender-based violence in Ecuador. The research combined the statistical analysis of quantitative data with the interpretation of qualitative testimonies, providing a comprehensive view of the problem. The type of research was descriptive-correlational, aimed at identifying patterns and relationships between variables such as access to services, social stigma and gender roles. Its scope was national, with emphasis on rural areas of Ecuador, although the sample was more representative in provinces such as Guayas, El Oro and Pichincha (Table 1).

We worked with a non-probabilistic sample of 349 rural women victims of gender-based violence, selected for accessibility and inclusion criteria: (1) residence in rural areas, (2) experience of gender-based violence, and (3) age ≥18 years. The demographic distribution included diversity in age, educational level, and marital status.

As data collection techniques, a structured survey was used and a questionnaire of 79 questions grouped into 14 categories was used as an instrument, from which 27 questions from 6 key categories were analyzed: access to services, coping strategies, availability of services, awareness of resources, social stigma and gender roles), in order to respond to the three axes of the study: systemic barriers, social determinants and gaps in public policies. The questions combined formats:

- Quantitative: 18 closed questions (Likert scales

and multiple choice) to measure frequencies and percentages.

- Qualitative: 9 open questions to collect testimonies and proposals from the participants.

Quantitative data were analyzed with descriptive statistics (frequencies, percentages) using Excel software. The results were presented in tables and graphs (Figs. 1-6). The questionnaire was validated using the criteria of experts in gender violence and mental health. Qualitative data (open-ended responses) were coded using thematic content analysis. The study guaranteed informed consent, confidentiality and gender focus.

3. RESULTS

3.1 Biosociodemographic profile of the population studied

The distribution of the sample (Table 1) reflects demographic and sociocultural characteristics that allow the identification of relevant patterns in the population studied.

Table 1: Distribution of the participant sample of rural women victims of violence.

Variable	Range	%	Range	%	Range	%	Range	%
Age of the respondent	18-22 years old	8.3%	33-37 years old	18.0%	48-52 years old	5.7%	over 63 years old	1.4%
	23-27 years old	12.6%	38-42 years old	13.4%	53-57 years old	8.8%		
	28-32 years	16.0%	42-47 years old	12.3%	58-62 years old	2.8%		
Educational level	Complete primary school	9.4%	Completed secondary school	32.6%	Complete Superior	18%	None	28.5%
	Incomplete primary school	3.4%	Incomplete secondary school	0.1%	Incomplete Superior	8.0%		
Housing Province	Bolívar	0.3%	Emerald	2.9%	Loja	2.9%	Santo domingo de Tsáchilas	9.50%
	Chimborazo	2.9%	Guayas	44.5%	Pichincha	11.8%	Others	2.60%
	Gold	14.4%	Los Ríos	5.7%	Sucumbíos	2.6%		
Marital status	Married	32.0%	Single	34.7%	Free union	22.6%	Widow or widower	3.10%
	Divorced	7.1%						

Source: Prepared by the author

In terms of age, a predominance of young and middle-aged adult women was observed, with the ranges of 28-32 years (16.0%) and 33-37 years (18.0%) as the most representative. The 18-27 age group also has a considerable proportion (20.9%), suggesting a significant participation of young women. On the other hand, the oldest ages (over 58 years of age) are underrepresented, accumulating less than 5% of the total, which could indicate limitations in the coverage of certain age segments.

In relation to educational level, the data show a marked polarization. Although more than 50% of those surveyed have completed at least secondary school (32.6%) or completed higher education (18.0%), there is also a high percentage (28.5%) who have no formal education at all. This contrast highlights the heterogeneity in access to education within the population analyzed. Likewise, the low proportion of individuals with incomplete secondary education (0.1%) suggests that those who start secondary education tend to finish them.

Regarding geographical location, there is a significant concentration in the province of Guayas (44.5%), followed by El Oro (14.4%) and Pichincha (11.8%). However, other provinces have notoriously lower percentages, even close to 1%, which shows an imbalance in territorial representation and could limit the generalization of the results at the national level.

Finally, in terms of marital status, there is a slight predominance of single women (34.7%) over married women (32.0%), while 22.6% are in a common-law union. The marital statuses of divorced (7.1%) and widowed (3.1%) are in the minority, although their presence is relevant when considering possible social or cultural implications.

Overall, the biosociodemographic data offer a descriptive view of the composition of the sample studied, highlighting trends related to youth, single-sex education, and regional concentration, aspects to be taken into account when interpreting the general results of the study.

3.2 Access to mental health services

Figure 1 shows the results of the closed-ended questions in the Access to Mental Health Services category that explores the main barriers faced by rural women victims of gender-based violence to

obtain psychological support.

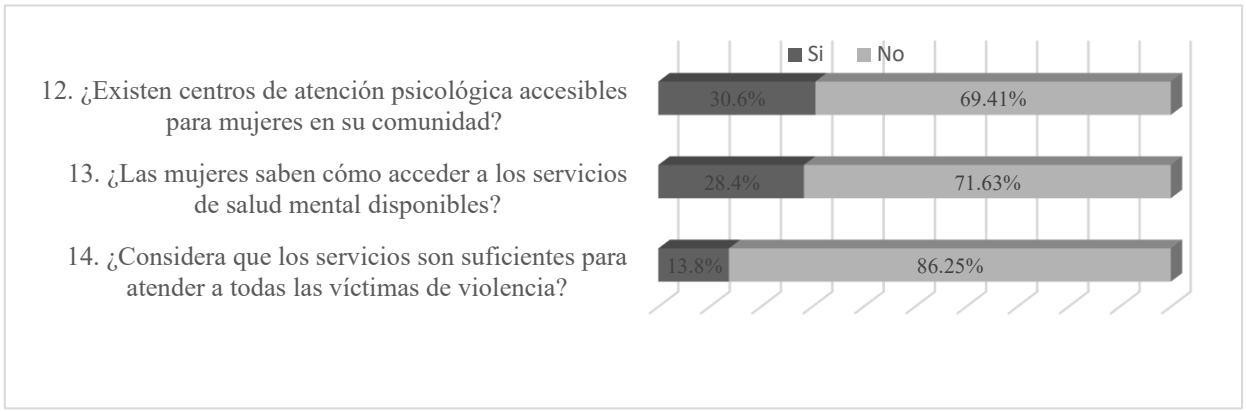

Figure 1: Access to mental health services- In original Spanish language.
Source: Prepared by the author

The data reveal that 69.41% of rural women victims of violence surveyed say that there are no psychological care centers accessible to women in their communities, compared to 30.6% who say the opposite. This finding reflects a marked insufficiency in the availability of specialized mental health services aimed at rural women, evidencing that local health systems do not guarantee equitable territorial coverage or adapted to the specific needs of this population group. In addition, 71.63% indicate that women do not know how to access available services, which reveals a significant deficit in communication and dissemination of information about existing resources. On the other hand, 86.25% of the women surveyed maintain that current services are insufficient to attend to all victims of violence, in contrast to 13.8% who think the opposite. This perception shows a high level of dissatisfaction with the problem-solving capacity of the mental health system, with problems of saturation and a deficient adequacy of resources in terms of quantity, quality and specialization.

The analysis of the answers to the open question: What obstacles do women face in receiving psychological care in their community? It identified ten main categories. The most mentioned, with 25.3% of the responses, was the lack of nearby infrastructure and services, since many communities lack specialized centers, forcing women to make long journeys. It is followed by economic barriers (18.7%), related to the cost of therapies and the absence of medical insurance that covers these services; and social and cultural stigma (16.4%), which includes fear of collective judgment and the misperception that therapy is exclusive for severe cases. Other relevant obstacles are time constraints associated with traditional gender roles (12.1%), lack of knowledge about how to access services (9.5%), fear of reprisals by the aggressor (8.2%), lack of trained professionals (5.8%), transportation difficulties (4.6%), machismo and economic dependence (4.1%), and delays in care (3.3%).

They emerge from the answers to the open question: What changes would you propose to improve the availability of these services? five main axes. The expansion and decentralization of services was the most recurrent option (35% of the mentions), with suggestions such as the creation of free or subsidized centers, mobile units, and integration of services in health subcenters, along with teleconsultation options. The second axis focused on economic and logistical accessibility (25%), highlighting the need for state subsidies, medical insurance that covers mental health, free transportation and reduction of waiting times. The third axis proposed raising awareness and reducing stigma (20%), through educational campaigns led by community leaders and local media, as well as talks in schools and public spaces. The fourth axis prioritized professional strengthening (15%), proposing training in intercultural and gender approaches, training of primary health personnel and teachers, and incentive programs for professionals in rural areas. Finally, the fifth axis promoted comprehensive care and a community approach (5%), with local support networks, culturally adapted services—including indigenous languages—and effective inter-institutional coordination. Taken together, these proposals reflect the need for a multisectoral approach that integrates investment in infrastructure, community education, and sound public policies, aimed at improving access to and quality of mental health services for rural women victims of gender-based violence.

3.3 Coping strategies

The Coping Strategies category focuses on the analysis of how rural women victims of gender-based violence manage the emotional impact of their experiences.

Table 2: Frequency of use of professional services to manage emotional impact.

Scale	%
Frequently	11.1%
Rarely	75.4%
Never	13.4%

Source: Prepared by the author

The analysis and interpretation of the results of this question reflected in Table 2 leads to the affirmation that 75.4% of rural women victims of gender violence rarely resort to professional mental health services, while 13.4% have never done so, and only 11.1% use it frequently. This pattern indicates a low generalized use of professional psychological support, which is directly linked to the structural, cultural, and economic barriers identified in the rural context. The lack of adequate infrastructure, the scarcity of nearby services, the high costs and other obstacles identified in the previous questions make it extremely difficult to access specialized care. This situation highlights a critical gap between the real need for psychological intervention and the effective response capacity of the health system in the rural context. This low participation in professional services may be contributing to the aggravation of emotional and psychological problems, perpetuating cycles of unattended suffering.

3.4 Availability of quality specialist services

The Availability of Services category presents an analysis of access to quality specialized mental health centers for women victims of gender-based violence in rural areas.

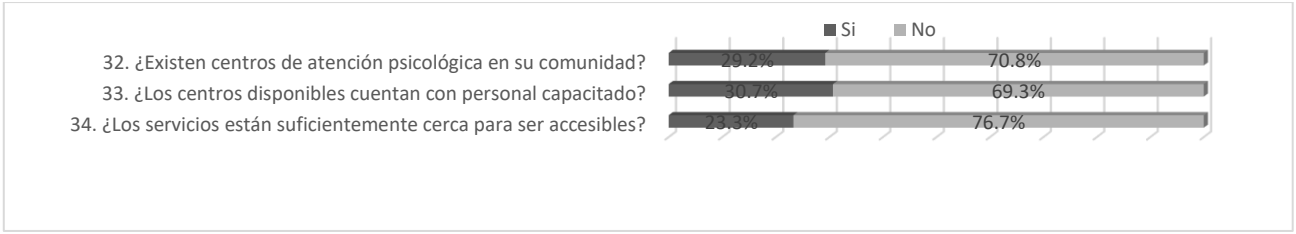

Figure 2: Availability of mental health services- In original Spanish language.
Source: Prepared by the author

The results presented in Figure 2 reveal a critical situation in terms of the availability of specialized mental health services for women victims of gender-based violence in rural areas. The data show that only 29.2% of the respondents confirm the existence of psychological care centers in their communities, while an alarming 70.8% report the absence of these services. This marked disparity shows a serious lack of specialized infrastructure in rural areas. As for the quality of the services available, the results are equally worrying. Only 30.7% of the participants consider that the existing centers have adequately trained personnel, compared to 69.3% who perceive deficiencies in professional preparation. This situation raises serious questions about the real capacity of the services available to provide specialized care that considers the particularities of gender-based violence and the specific cultural contexts of rural communities. Geographic accessibility emerges as another significant obstacle, with only 23.3% of respondents indicating that services are sufficiently close to their communities, in contrast to 76.7% who consider them inaccessible due to their location. This problem is aggravated by the lack of adequate transportation and the costs associated with travel, factors that end up becoming almost insurmountable barriers for many women who need psychological care. These findings paint a picture of triple exclusion: first, due to the scarcity of specialized centers; second, because of deficiencies in the training of available personnel; and third, because of the geographical difficulties in accessing existing services. The combination of these factors not only limits access to psychological care, but also perpetuates situations of violence by not offering women the necessary tools to break the cycle of abuse.

The analysis of the collected testimonies related to the answers to the open question How accessible are mental health services in terms of distance and cost? It allows us to identify that the accessibility of mental health services for rural women victims of gender-based violence is clearly affected by geographical and economic barriers, which limit their ability to obtain timely and specialized psychological support. First, in terms of distance, 78% of responses explicitly mention remoteness as a major obstacle. Most of the specialized

centers are located in urban areas, which requires long journeys that can take between 3 and 4 hours by public transport. In some extreme cases, women must move to large cities such as Guayaquil or Machala, which increases both the time and cost of access. These distances reflect a highly centralized and urban-centric system, which does not respond to the territorial distribution or the real needs of rural communities. 45% of the total mentions correspond to this type of barrier, which makes it the most frequently cited by the respondents. Second, cost represents a significant limitation to access these services. Private consultations range from $20 to $50, a high amount considering that it is equivalent to a week's admission for many of these women. Although there are free options, 92% report waiting lists of more than three months, which makes such free of charge formally viable but functionally inaccessible. In addition, transportation accounts for 25% to 30% of total spending per visit, with average costs of $3 to $5 each way, significantly increasing the economic burden associated with access. This economic factor affects 40% of those surveyed, consolidating itself as the second most cited barrier. These results show that, although 68% recognize the existence of free services, 82% consider them inaccessible due to this combination of distance and cost. The paradox between availability and real accessibility highlights a model of care that reproduces structural inequalities, without addressing socioeconomic conditions or the territorial dispersion of rural populations.

Regarding the results related to the answers to the open question, what improvements would you propose to expand the coverage of these services? reveal a clear and consistent demand to improve access to mental health services for rural women victims of violence, grouped into five main axes. 42% of the responses emphasize the decentralization of services, with proposals such as the creation of community centers, mobile units and integration of psychological support in existing health subcenters, highlighting that 78% of the participants consider it a priority to have a service close to their communities. 28% of the suggestions are oriented towards economic accessibility, with the urgent need for state subsidies, free services and health insurance that covers mental health, where 65% explicitly mention the importance of reducing costs. 15% of the proposals are focused on the training and professionalization of personnel, including local training of psychologists and updating of primary health personnel, with the aim of offering more specialized and empathetic care. Technological innovation was pointed out in 10% of the responses, prioritizing options such as telepsychology, virtual platforms and helplines, although only 12% reported having reliable access to the internet. Finally, the remaining 5% highlight the importance of community awareness through door-to-door campaigns, educational workshops and support groups. The key findings show a paradox: although 89% recognize that services exist, 76% perceive them as inaccessible due to the average distance of 3 hours of travel, the cost equivalent to 2 to 5 days of admission per consultation and waiting lists ranging from 3 to 6 months in public services. In addition, proposals vary by geographic profile: peri-urban areas prefer telemedicine (43%), remote areas require mobile units (68%), and indigenous communities demand culturally adapted care (12%). Finally, implicit barriers were identified, such as social stigma (23%), gender roles that limit autonomy (18%) and digital illiteracy (41% in women over 40 years of age), factors that deepen exclusion and hinder effective access to essential services.

3.5 Awareness of services

The Service Awareness category analyzes the level of knowledge and dissemination that rural women victims of gender-based violence have regarding the mental health services available.

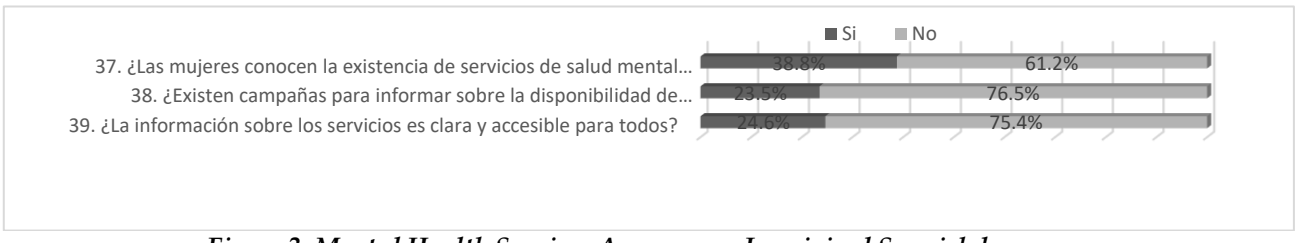

Figure 3: Mental Health Services Awareness- In original Spanish language.
Source: Prepared by the author

The data shown in Figure 3 show that the lack of knowledge about mental health services is widespread and persistent in rural communities, which is aggravated by the lack of information campaigns and unclear and accessible communication. The analysis of knowledge and

perception about mental health services in rural communities reveals a low visibility and dissemination of these resources among women. Only 38.8% say they are aware of the existence of these services, while more than 61.2% are not clear about them, which suggests a significant information gap.

In addition, less than 25% perceive that campaigns or communication actions are carried out aimed at informing about these services, which reflects a lack of active awareness-raising strategies in the community environment. This lack of initiatives limits the ability of women to know, understand and access available psychological support options.

Likewise, only 24.6% consider that the available information is clear and accessible, compared to 75.4% who express the opposite. This indicates that, even when some type of communication exists, it is not being effective due to its complexity, cultural inadequacy or lack of appropriate channels to reach the target population.

The results related to respondents' responses about What strategies would be effective in increasing awareness of services? reveal a clear pattern in the proposals of Ecuadorian rural women to improve the dissemination of mental health services, highlighting strategies that prioritize the community and the local. 38% of the responses were grouped under the axis of Community Strategies, with 47 mentions of informative talks (12.7%), 29 of home visits (7.8%), 22 of local workshops (5.9%) and 18 proposals on community leadership (4.9%). It is followed by 32% of responses related to the Media, where 68 mentions of social networks (18.4%), 53 references to radio or television (14.3%) and 31 cases of printed support such as brochures (8.4%) stand out. 21% of the suggestions are oriented towards institutional actions, including 58 proposals for public campaigns (15.7%), 29 mentions of school integration (7.8%) and 17 ideas about mobile units (4.6%). Finally, the remaining 9% are linked to technological innovation, including 13 references to telemedicine (3.5%), 9 mentions of helplines (2.4%) and 7 cases on the use of real testimonials (1.9%). The key findings show a marked digital divide in the face of rural reality: 72% of women prioritize face-to-face methods such as talks and visits, while only 28% of those over 40 years of age trust social networks as their main means of information. Likewise, 61% mention local radio as their preferred channel, underlining the relevance of traditional media in rural contexts.

As for the open question: How would you describe women's level of knowledge about the available resources? The respondents' responses summarize that the level of knowledge among Ecuadorian rural women about the resources available in mental health is largely limited, as reflected in the 82% of the responses that describe their knowledge as low, non-existent or scarce. Recurring phrases such as "We don't know the services" (45 mentions) and "They totally don't know" (32 mentions) illustrate this reality. Only 12% report having partial knowledge, generally acquired indirectly, for example, through neighbors or local rumors, while only 6% manifest adequate knowledge, mainly concentrated in women with urban residence or higher educational levels.

Several factors have an impact on this information deficit. Geographical barriers affect 67% of rural women, whose ignorance is due to the lack of local dissemination of the available services. Stigma and fear also play a central role, as 58% of respondents mention silence as a response to fear of reprisals or shame, exemplified in comments such as "We keep quiet so as not to be hit" or "They prefer to suffer in silence". In addition, 73% indicate that there are no clear, accessible or adapted campaigns to their cultural contexts, which contributes to the invisibility of existing resources.

Institutional distrust is also significant: 41% express distrust towards existing services, citing previous negative experiences or the perception of a lack of confidentiality, as in the response recorded: "In the institutions they do not provide good service". From a qualitative perspective, relevant patterns are identified. For example, 60% of those who have some knowledge about resources obtained it through oral information – "word of mouth" – rather than through institutional channels or official campaigns. In addition, a marked urban-rural gap persists: 89% of women in rural areas report total ignorance about services, compared to 54% in peri-urban areas. It also highlights the lack of cultural adaptation of the information materials, since they are mostly in Spanish and use technical language, making it difficult to understand them in communities where indigenous languages are spoken or where access to formal education is limited.

3.6 Social stigma

The Social Stigma category examines how negative perceptions and collective judgment influence the decision of rural women victims of gender-based violence to access mental health services.

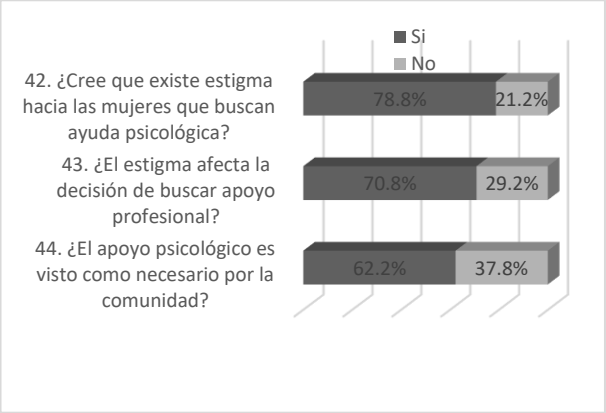

Figure 4: Social stigma- In original Spanish language.
Source: Prepared by the author

The findings shown in Figure 5 suggest that social stigma remains a key factor affecting rural women's perception of and access to mental health services. A high percentage, 78.8%, recognizes that there is stigma towards women who seek psychological help, which reflects a generalized attitude of devaluation or fear of collective judgment around those who break with the expected patterns of silence and emotional resistance. This rejection or social criticism directly influences personal decisions, since 70.8% consider that this stigma impacts the decision to seek professional support, further limiting the possibility of accessing spaces of containment and emotional recovery. On the other hand, although more than 60% perceive that psychological support is necessary, almost the remaining 40% do not consider it a priority, suggesting that limited views or lack of knowledge about the importance of mental health persist.

In relation to the perception of the respondents in How does social stigma affect women who need psychological care?, according to the responses collected, social stigma has a profound and multidimensional effect on women who require psychological care. Fear of judgment and rejection is the most mentioned barrier, appearing in 120 responses (33% of the total). Phrases such as "They are afraid of being judged, rejected" (Answer 7) or "Fear of rejection and finger-pointing" (Answer 32) reflect how the fear of social criticism deters women from seeking help. This fear is intensified by stereotypes such as the association between mental health and "insanity," mentioned in responses such as "The stigma of believing that psychology is only for crazy people" (Response 153). Another recurrent impact is social isolation, indicated in 85 responses (24%). Women describe how stigma leads them to hide their suffering, as in "Stigma can lead to social isolation" (Response 54) or "A lot of social isolation" (Response 97). This isolation, combined with low self-esteem (78 responses), creates a cycle of silence and hopelessness. Phrases such as "Low self-esteem is the first problem" (Answer 40) and "It affects personal self-esteem" (Answer 60) underscore how stigma erodes self-confidence. Shame and guilt are also determining factors, present in 65 responses (18%). Expressions such as "Shame and guilt" (Answer 44) or "Are ashamed of what others think" (Answer 130) show how the internalization of stigma leads women to feel responsible for their situation. This is aggravated by the normalization of violence (45 responses), where phrases such as "They believe it is normal" (Response 11) or "They continue to suffer violence and normalize it" (Response 159) reveal a dangerous resignation. In addition, the delay in seeking help (58 responses) and the lack of institutional support (35 responses) worsen the situation. Comments such as "Stigma delays seeking help" (Response 39) and "No support" (Response 219) highlight the need for accessible and bias-free systems. In extreme cases, some women resort to risky behaviors, such as self-medication (15 responses), described in "They resort to alcohol or drugs" (Response 57).

The analysis of the answers to the question: What measures could reduce the stigma towards mental health? reveals four main lines of action in the opinion of the respondents. 45% of the mentions (162 responses) focus on education and awareness, highlighting the need for informative talks, mass campaigns and inclusion of the theme in schools "Educating from childhood" (Response 362). These proposals reflect a clear consensus: misinformation is the root of stigma, and only through pedagogical strategies can mental health be normalized as a fundamental aspect of well-being. Secondly, 30% of the responses (108 mentions) advocate strengthening community and professional support. Here the creation of support groups "Safe spaces to share experiences" (Response 265), the training of professionals to eliminate prejudices "Psychologists who attend without judging" (Response 73) and the use of inspiring testimonies "Women who have overcome violence with psychological help" (Response 340) stand out. These ideas underscore the importance of solidarity networks and accessible services, as one participant points out: "Let victims know that they are not alone" (Response 239). 15% of the proposals (54 responses) require actions from public policies and institutions. The urgency of protective laws "Promote rights in mental health" (Response 46), more care centers "Access to free and

confidential services" (Response 15) and the participation of the media "Positive representation in social networks" (Response 251) are mentioned. These measures point to structural change, as one respondent summarizes: "Without access to services, stigma persists" (Response 93). Finally, the remaining 10% (36 responses) identify cultural changes as key. Of particular note are the fight against machismo "Educate men about the consequences of violence" (Answer 253), the use of respectful language "Avoid criticism and judgment" (Answer 120) and social normalization "Going to the psychologist should be as normal as going to the doctor" (Answer 330). These responses emphasize that stigma feeds on deep social norms, as one participant warns: "Change begins by ceasing to judge" (Response 296). In summary, the proposals reveal that stigma is a multidimensional problem. 85% of the solutions prioritize collective actions (education and community), while 15% demand institutional interventions. This reflects that, although systemic barriers are recognized, cultural transformation is seen as the cornerstone. As one response concludes: "Reducing stigma is not only the task of the victims, but of society as a whole" (Response 301). Moving forward requires an integrated approach that combines educational campaigns, community support, public policy and a change in social discourses.

3.7 Gender roles

The Gender Roles category explores how social norms and traditional stereotypes restrict the autonomy of rural women victims of violence when seeking psychological support.

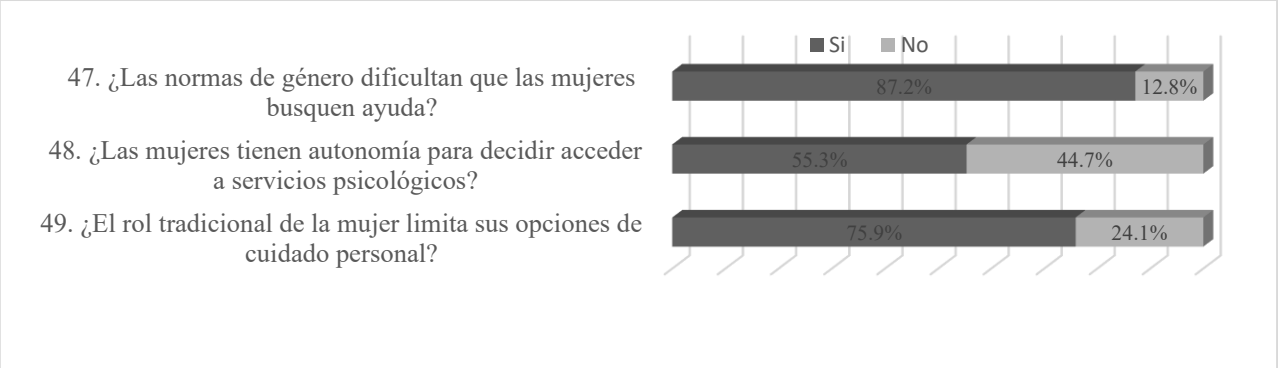

Figure 5: Gender roles- In original Spanish language.
Source: Prepared by the author

The results in Figure 6 show that a high percentage, 87.2%, recognize that gender norms make it difficult for women to seek help, which reveals how entrenched stereotypes act as cultural barriers to access to professional support. More equally, 55.3% consider that women do have autonomy to decide to access psychological services, while almost half (44.7%) think the opposite. This data suggests that, although many women make decisions about their mental health, factors such as partner control, family pressure or fear of social judgment restrict that freedom to a significant extent. In addition, 75.9% perceive that the traditional role of women limits their personal care options, which highlights how the responsibilities associated with the home, upbringing and cultural submission reduce time, space and the prioritization of their emotional well-being. This contributes to the fact that many continue to endure situations of violence and psychological distress in silence without seeking external support.

Regarding what gender roles do you think affect the search for professional support?, the testimonies collected reveal an alarming pattern: traditional gender roles act as the main barrier for women to seek professional help. 45% of the responses (160 mentions) highlight how domestic and care roles limit this search, as expressed by one participant: "Women should be at home taking care of the family" (Response 349). These culturally assigned responsibilities leave little time and space for self-care, perpetuating cycles of silence. Machismo appears in 72 responses (20% of the total), emerging as the second determining factor. Phrases such as "The man does not allow her to seek help because he considers it inappropriate" (Answer 168) illustrate how expectations of submission (30% of the mentions) normalize dependency. As another respondent points out: "They prioritize appearances, making people believe that everything is fine" (Answer 108), demonstrating how stigma operates even in self-imposition. Economic dependence

represents another critical obstacle, mentioned in 54 responses (15%). Testimonies such as "Without economic independence, there is no freedom to seek help" (Response 329) expose the material trap that complements psychological oppression. This reality is aggravated by stereotypes of strength (10% of the mentions), where women internalize that "Seeking help is a sign of weakness" (Response 53). 85% of the testimonies agree that these roles perpetuate violence by naturalizing female submission. As one participant crudely summarises: "As long as women continue to be seen as the weaker sex, the stigma will persist" (Response 288). The solution requires breaking this cycle through economic empowerment, gender education from childhood, and accessible services that prioritize well-being over cultural mandates.

With regard to the question "How could communities promote greater autonomy for women?", the allegations collected reveal a clear consensus: 35% of the proposals (126 mentions) revolve around education and training as a basis for autonomy. Women emphasize the need for "female empowerment workshops" (Response 1) and "job training to develop skills" (Response 24), highlighting that knowledge is the tool to break cycles of dependency. As one participant summarizes: "Education is the key for women to make informed decisions" (Response 136). This demand is complemented by 108 responses (30%) that prioritize economic empowerment, where phrases such as "Microcredits for entrepreneurship" (Response 90) and "Fairs to market our products" (Response 56) illustrate how financial independence is seen as an escape route from violence. 72 of these responses directly link economic resources with the possibility of leaving the aggressor. The creation of support networks emerges as the third pillar, with 72 mentions (20%). Proposals such as "Self-help groups among women" (Response 290) and "Community centers with psychological care" (Response 105) reflect the desire for safe spaces. "When we unite, we stop feeling alone" (Answer 117), shares one respondent, underscoring the value of sisterhood. 10% of the responses (36 mentions) advocate including women in community leadership, with calls for "Representation in local councils" (Response 185) and "Leadership workshops" (Response 60), while 18 responses (5%) require gender awareness, especially aimed at men: "Workshops that challenge machismo" (Response 28). These data reveal three main barriers: lack of economic resources (45%), social isolation (30%) and lack of knowledge of rights (25%). A specific request resonates: "That psychologists come to our homes" (Response 38), showing how limited mobility aggravates vulnerability. 85% of the proposed solutions are collective (education + economy + networks), while the remaining 15% require deeper institutional changes. As one participant concludes: "Autonomy is not just getting out of violence, it is being able to decide without fear" (Answer 200). Communities have in their hands – as expressed by the women themselves – the tools to make this transformation possible through concrete, collaborative actions focused on their real needs.

4. DISCUSSION

The results of this study confirm that rural women victims of gender-based violence in Ecuador face systemic barriers to accessing mental health services. 70.8% report the absence of specialized centers in their communities, and 86.25% consider that the existing ones are insufficient. These figures reflect a failure in the implementation of public policies, despite the current legal framework (Nivicela-Cedillo et al., 2023). The urban centralization of services forces commuting of up to 4 hours, with costs that represent 25-30% of women's weekly income, exacerbating inequalities (Madrid Miles et al., 2022).

Social stigma emerges as a key obstacle: 78.8% of respondents perceive that seeking psychological help is judged negatively. This finding is consistent with previous studies linking stigma to the normalization of violence and fear of retaliation (Friederic, 2024). In addition, traditional gender roles restrict female autonomy, as expressed by 75.9% of participants, who point out that domestic responsibilities limit their ability to prioritize their mental health.

Coping strategies reveal a dependence on informal networks: only 11.1% of women frequently resort to professional services, while 75.4% rarely do so. This gap between need and access is related to the lack of dissemination (61.2% are unaware of the available services) and the lack of campaigns adapted to rural contexts. Proposals such as mobile units, telepsychology and community workshops (35% of the mentions) underline the urgency of decentralised and culturally relevant models.

5. CONCLUSIONS

The study shows that rural women victims of gender-based violence face significant structural barriers, such as lack of infrastructure, shortage of trained professionals, and geographic inaccessibility, which severely limit their access to mental health services. These obstacles are compounded by cultural

factors, such as social stigma and traditional gender roles, which perpetuate silence and mistrust of available services. To address these problems, the participants highlighted the need to decentralize services, implement educational campaigns, strengthen professional training, and adapt care to cultural contexts. It also highlights the urgency of multisectoral public policies that integrate investment in infrastructure, community education and awareness-raising strategies to reduce the inequalities identified. In conclusion, this study underscores the importance of combining community and institutional actions to improve the emotional and social well-being of rural women, ensuring accessible, equitable, and culturally relevant mental health care.

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