UNIVERSITA DEGLI STUDI DEL PIEMONTE ORIENTALE

Dipartamento di scienze Della salute

Master's Degree in Medical Biotechnology

Barriers to timely healthcare access after sexual violence in females: a literature review

Supervisor: Prof. Federica Collini

Candidate: Nahom solomon

Matricola: 20058377

Academic year: 2025/26

Table of Contents

Abstract

Sexual violence is a serious global societal health concern, and it is estimated that it occurs in approximately 1 in 3 women; however it remains inadequately reported. This literature review reveals a significant gap between the incidence of sexual violence and access to healthcare and services, as medical treatment in the first 72 hours is most effective, but survivors, on average, take 10.4 months to access medical treatment. The review is based on the application of the Socio-Ecological Model (SEM) to describe the multi-layered barriers at individual, interpersonal, institutional**,** and societal levels, by examining the findings of 47 peer-reviewed articles published between 2000 and 2025. The main barriers are individual emotional barriers, i.e., shame, guilt, and self-blame; cognitive barriers, i.e., the minimization of assault; and a crucial deficiency in knowledge about the provision of support services and the urgency of forensic and prophylactic treatments. These psychological barriers are further enhanced by societal stigmatization, cultural norms, and the failure of the system. The results highlight that to overcome these overlapping barriers, more effective education of the population, providing special training to the healthcare staff, and policy changes are necessary to close the gap between victimization and recovery.

1. Introduction and background

Sexual violence is a serious social health problem and has far-reaching physical, psychological, and social impacts [1]. It is estimated that approximately 1 in 3 women worldwide have experienced either physical or sexual violence at some point in their lives [2,3]. Despite the high prevalence of sexual violence, most of the cases remain under-reported. As a result, many survivors fail to receive the medical, psychological, and legal services they need following an assault [4,5,6,7]. Sexual violence is defined as “any sexual act, attempt to obtain a sexual act, or other act directed against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting”. The definition of sexual violence includes any inappropriate sexual contact, attempted or completed rape, sexual harassment, unwanted touching, and also sexual abuse of children, and rape within marriage [1]. Sexual violence increases the lifetime risk of experiencing unwanted pregnancy, sexually transmitted infections, pregnancy complications, and depression [8]. Another study [9] discovered a strong correlation between experiences of violence and suicidal tendencies. The psychological consequences of sexual

violence are profound, with around 56% of the victims developing PTSD (post-traumatic stress disorder) [2].

This review examines barriers to access to timely healthcare services by female victims of sexual violence. The issue of timely care is very crucial given the severe health effects which may follow from late care delivery.

1.1. Importance of Healthcare Access after Sexual Violence

Timely and appropriate medical intervention is essential for survivors of sexual violence. Components of immediate care after sexual assault include assurance of safety and privacy, followed by treatment of injuries and risk identification and prevention of pregnancy and sexually transmitted infections (STIs), including human immunodeficiency virus (HIV), self-harm, and suicide, as well as safeguarding children and vulnerable adults [10]. Early hospital presentation after sexual assault significantly improves prophylaxis effectiveness (for both HIV and pregnancy) and injury documentation, potentially improving legal outcomes [11].

Delayed reporting of sexual violence can lead to partial or complete loss of forensic evidence and delays in accessing treatments for sexually transmitted infections, post-exposure prophylaxis for HIV, and emergency contraception, all of which are most effective when provided immediately after sexual assault [12].

1.2. Scope and Purpose of the Literature Review

Despite the significant importance of timely healthcare access after sexual violence, only a small percentage of women seek help from family, friends, and institutions such as Health Services and the Police [5,13,14]. Palermo et al.'s analysis of Demographic and Health Surveys revealed low reporting, with only 7% of sexual assault victims seeking formal assistance. In one of the studies conducted in the Democratic Republic of the Congo, it is reported that only 12 percent of sexual assault victims sought medical attention within 72 hours of the assault, with the rest seeking it thereafter [14,15]. This is just as it is observed in other studies, which have observed that only 12 percent of the women had sought care within the first month after the sexual assault. The average duration of time before access to services was 10.4 months, with the median of the same standing at 7 months [16]. These findings demonstrate that there is a severe disparity between the rates of

sexual violence and the multidisciplinary post-assault care. The barriers to formal reporting of sexual victimization are several, such as psychological, sociocultural, and systemic ones [17].

The purpose of the literature review is to synthesize the content of available research on the topic of healthcare access barriers in female victims of sexual violence. The literature review is based on the findings of other studies that have been performed in different geographical regions and healthcare systems. Barriers are analyzed across several levels, including individual/personal, social/cultural, interpersonal, institutional/systemic, accessibility, legal/policy, and population-specific factors [10]. In this review, the barriers have been extensively explored to present the necessary information to healthcare providers, policymakers, and advocates on the obstacles faced by the survivors of sexual violence.

1.3. The Global Burden of Sexual Violence.

Sexual violence is considered a widespread global social determinant of health with disastrous physical, psychological, and social consequences. According to current estimates, about 30 percent or 1 in 3 women around the world have been either physically or sexually assaulted at one time or another [18]. This number, though appalling, is a generalized average worldwide figure. There **are** significant regional differences**.**

Data provided by the World Health Organization (WHO) and the UN Office of the High Commissioner for Human Rights showed that it is usually prevalent in areas where there is both systematic gender inequality or where there is an ongoing conflict. Complex socio-political factors and local instances of humanitarian crisis in Sub-Saharan Africa, in particular, have frequently created circumstances in which intimate partner violence is especially prevalent, and non-partner sexual violence is even more widespread than in the rest of the world [18, 19]. Contrarily, the reporting rate can be higher in certain areas of Europe, but the real incidence is a severe issue, under-reported and obscured by rape myths. Cultural taboos about sexuality in South-East Asia tend to result in a lower disclosure rate, which makes it even more difficult to measure the actual burden. Whether it happens across geographic boundaries or not, sexual violence raises the possibility of unwanted pregnancy, sexually transmitted diseases (STIs), and serious mental health issues such as depression and suicidal behaviour [20].

The Clinical Significance of the 72-Hour Window.

The critical window of the medical intervention in cases of sexual assault is classified as the first 72 hours. The timely presentation to a medical institution can greatly enhance the efficiency of prophylaxis and the quality of forensic record keeping [21].

HIV Post-Exposure Prophylaxis (PEP): PEP should be administered immediately, preferably within hours, and not exceeding 72 hours after exposure. Beyond this period, antiretroviral drugs lose their capacity to prevent the incorporation of the virus into the immune system of the host at a very high rate [22].

Emergency Contraception (EC): The use of emergency contraception in the aftermath of an assault in the immediate period is critical to prevent unwanted pregnancies. Some EC methods are also effective for up to five days, but they prove more effective when delivered within the first 24–72 hours [20].

Forensic Evidence and Degradation of DNA: Forensic evidence, like DNA samples and injury documentation, should be collected immediately after the medical examination. The result of delays in reporting is the partial or total loss of biological evidence through natural degradation or hygienic measures, or through healing of minor injuries on the body, directly affecting the legal outcomes and prosecution of offenders [23].

1.4. Neurobiology of Trauma and Help-Seeking.

The mental health effects of sexual violence are immense, as many of the victims develop Post-Traumatic Stress Disorder (PTSD). At the heart of the explanation of the delay in seeking care by survivors is the neurobiology of trauma. The brain will commonly react to extreme fear during an attack by activating a freezing response or tonic immobility, which is a biological reaction that cannot be controlled. This condition of the neurobiological state may result in disjointed memories or so-called memory gaps, which survivors tend to interpret as a lack of evidence and therefore avoid reporting [24].

Moreover, the high levels of anxiety and fear that occur after the event may make the survivors avoid any circumstance that reminds them of the trauma, including clinical settings where the survivors are required to talk about the assault to therapists. It is an internal psychological condition

of shame, guilt, and fear of disbelief that forms a strong cognitive barrier that does not allow immediate help-seeking behaviour [25].

1.5. Problem Statement

Even though there are set medical guidelines and emergency treatment is life saving, there is a considerable gap between the incidence of sexual violence and healthcare service use. Studies show that a very small percentage of the survivors seek formal help in a health or legal facility.

The gap is evident: medical interventions are most effective in the 72-hour range, whereas it has been studied that the average time it takes the survivors to seek services is up to 10.4 months. Lack of medical solutions does not cause such lag but rather a complex interaction of personal, social, and systemic hurdles that overwhelm survivors. These barriers were identified in this review so as to have a road map that the policies and health care providers could utilize to bridge the gap in the recovery and victimization.

2. MATERIALS AND METHODS

2.1. Literature search

To have an extensive literature review, the current study sought to identify suitable papers/publications between January 2000 and April 2025 in three large databases, which included PubMed, Scopus, and Google Scholar. Each database had particular Boolean search strings that were created to ensure the use of a reproducible and systematized search method. The primary search string employed was:25

((("Sex Offenses"[Majr] OR "Sexual Violence"[TiAb] OR "Rape"[TiAb]) AND ("Health Services Accessibility"[MeSH] OR "Barriers"[TiAb] OR "Healthcare seeking"[TiAb] OR "Help-seeking behavior"[MeSH]) AND ("Female"[MeSH] AND ("Adolescent"[MeSH] OR "Adult"[MeSH])) AND (2000/01/01:2025/03/31[dp])) was used for PubMed.

(TITLE-ABS-KEY ("sexual violence" OR "sexual assault" OR "rape") AND TITLE-ABS-KEY ("health care access" OR barrier* OR "help-seeking" OR "healthcare seeking") AND TITLE-ABS-KEY (female OR women OR adolescent OR adult) AND TITLE-ABS-KEY (delay* OR outcome* OR sequelae)) AND PUBYEAR > 1999 AND PUBYEAR < 2026 was used for Scopus.

A supplemental search was conducted via Google Scholar to identify gray literature and relevant studies not indexed in MEDLINE or Scopus using the string "sexual violence" AND "healthcare access" AND (barriers OR obstacles) AND female AND (adolescent OR adult).

The chosen period focuses on modern evidence that demonstrates changes in clinical guidelines and shifts in social perspectives and legal systems about healthcare obstacles faced by sexual violence survivors throughout the previous 25 years.

The search strategy combined keywords and Medical Subject Headings pertaining to four key concepts.

The four critical concepts were: 1) sexual violence events, 2) female victims of sexual violence, 3) obstacles to healthcare accessibility for these victims, and 4) negative outcomes resulting from delayed medical treatment.

In addition to the database search, policy documents and reports, along with non-indexed evidence, were gathered by reviewing literature from leading humanitarian organizations working on sexual

violence response and healthcare access, such as the World Health Organization, United Nations High Commissioner for Refugees, Médecins Sans Frontières, and the United Nations Entity for Gender Equality and the Empowerment of Women.

Targeted search approaches were applied to locate information matching four conceptual focus areas, which included sexual violence, women/girls, healthcare barriers, and delayed care consequences.

2.2. Eligibility criteria: Inclusion and Exclusion Rationale

The eligibility criteria were defined to ensure that there was a coherent narrative focus on the particular challenges the female population was struggling with.

2.2.1. Inclusion Criteria:

The inclusion criteria involve articles that focuses women and girls (12 years and above) as the victims of sexual violence, the articles covering structural, systems, or individual-level barriers to healthcare access in a timely manner, and articles covering the outcomes of late healthcare access (medical, psychological, legal, and social). The inclusion criteria were applied to select the most informative materials out of the large number of non-peer-reviewed reports and publications available.

2.2.2. Exclusion Rationale:

Articles that only discuss male sexual violence victims or children (less than 12 years of age), as well as literature that discusses only the long-term medical or psychological consequences and is not related to care delays, and opinion pieces, editorials, or commentaries were not included in our review.

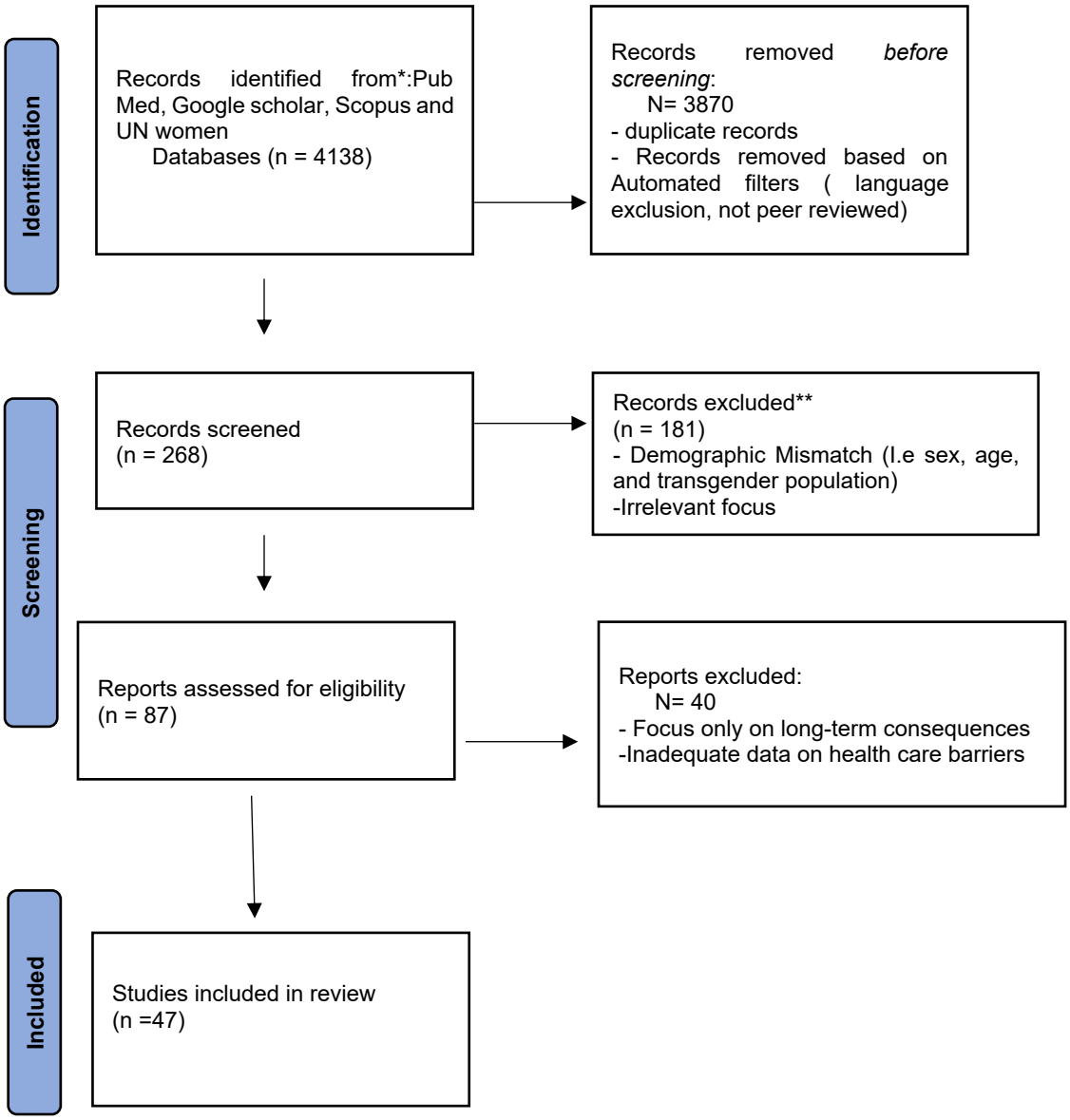
2.3. Data Extraction & Quality Appraisal:

The systematic literature search was done on PubMed, Scopus, and Google Scholar from January, 1, 2000, and March 30, 2025, by using the keywords that included: female sexual violence, barriers to healthcare access, and consequences of delayed care after sexual violence. The systematic search resulted in the first pool of 4,138 records, which included 499 records found at PubMed, 499 at Scopus, and 3,140 at Google Scholar.

After screening the initial records, data concerning the location of the study, methodology, and barriers were collected by means of a standardized data extraction form. To ensure that the data were reliable, the quality of the 47 selected articles was evaluated with the help of the Critical Appraisal Skills Programme (CASP) tool. This evaluation ensured that the few items that were to be included in the final discussion were relatively sound studies with well-established methodologies and reported outcomes.

2.4. PRISMA Flow Diagram and Filtering Results

Selection was done according to PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines. The table below summarizes the filtering process used to narrow down the high volume of initial database hits:


Identification
Records identified from*:Pub Med, Google scholar, Scopus and UN women
Databases (n = 4138)
Records removed *before screening*:
N= 3870
- duplicate records
- Records removed based on Automated filters (language exclusion, not peer reviewed)
Screening
Records screened
(n = 268)
Records excluded**
(n = 181)
- Demographic Mismatch (I.e sex, age, and transgender population)
-Irrelevant focus
Reports assessed for eligibility
(n = 87)
Reports excluded:
N= 40
- Focus only on long-term consequences
-Inadequate data on health care barriers
Included
Studies included in review
(n =47)

3. DISCUSSION

3.1. Socio-Ecological Model of Barriers

[17] In their analysis of tweets under the hashtag "WhyIDidNotReport," they categorized the identified barriers into individual, interpersonal, and sociocultural levels. Individual barriers included shame and embarrassment, fear of disbelief, self-blame, and anxiety. Interpersonal barriers included the perpetrator relationship, negative reactions to disclosure, and power imbalances. Sociocultural barriers involved broader societal attitudes, cultural norms, social structures, and beliefs that reporting would not lead to justice.

In a similar manner, [33] also examined tweets under the hashtag "WhyIDidntReport" and identified seven themes related to stigmatizing and criminal-justice-related factors. Stigmatizing barriers consisted of internal reactions that comprised shame, guilt, and fear. They also involved other negative reactions by people, such as conformity to rape myths and social norms, and protecting the perpetrator. Some of the criminal concerns involved perceived lack of evidence by way of memory gaps, delayed reporting, and power imbalance.

The victims of sexual violence among women have serious personal and individual obstacles to obtaining the necessary healthcare services. A combination of the inner psychological ailments, emotional responses, cognitive perceptions, and knowledge restriction underline these barriers are [4,27,28,29,30]. The current discussion is based on the Socio-Ecological Model (SEM) to offer a detailed discussion and analysis of multi-layered barriers faced by female survivors. The framework shows that the decision that a survivor makes to seek care does not occur in a vacuum, but is founded on four overlapping levels, and these include Individual, Interpersonal, Community/Institutional, and Societal/Structural. The analysis of these levels allows us to see how the intersection of barriers can explain why internal shame of the survivor (Individual) can be reinforced by a husband (Interpersonal), the absence of a nearby clinic (Community), and laws that support the perpetrator (Societal).

3.1.1. Emotional Responses

The way individuals emotionally respond to sexual violence determines their likelihood of seeking treatment after an assault. Several studies indicate that shame and embarrassment **are** the most commonly reported emotional barriers that prevent people from obtaining timely help

[4,16,27,28,29,30]. In a study by [30] involving 215 college students, 13 barriers to female victims reporting sexual assault were identified. Shame and embarrassment were reported as the most common barriers to reporting. This is further supported by research that has shown that internalized and externalized shame, together with offender–victim stratification and sexual violence minimization, form the core barriers that prevent people from seeking healthcare. Notably, shame appears to be a unifying factor that connects the other two themes [4].

The combination of guilt and self-blame also creates substantial barriers that prevent victims from accessing healthcare services. Besides external barriers that keep the survivors away from accessing the supportive services, other barriers that the survivors have to address are the internalized barriers. Often, personal social networks, as well as society, send messages to the survivors that accuse them of the assault through the way they dress or the location they were during the attack, or even their profession. As a result, survivors experience severe self-blame and guilt in addition to shame, which results in the idea that they caused or provoked the attack and consequently prevents them from seeking the required care [31,32]. Another group of emotional barriers is fear and anxiety. The survivors can develop fears associated with the medical exam itself, and the fear of sharing their traumatic experiences, which in turn causes survivors to avoid circumstances that can produce triggers associated with the attack, including healthcare centers [28].

The psychological factors that encompass sexual violence are high degrees of shame and embarrassment, which have been referred to as some of the toughest psychological hindrances to medical care. A meta-analysis of college students revealed 13 obstacles, with an aspect of shame, which remains the most significant in defining why students fail to report and utilize clinical services. This personal situation is even worse by the association between the victim and the perpetrator, which may cause the victim to minimize the violence as a coping mechanism. Shame, being a binding element among the various emotional responses, constitutes a continuous interior veil that does not allow survivors to receive health care, which is vitally needed during the immediate post-assault period [30].

Coupled with the sentiments of shame, survivors are often plagued by a sense of great guilt and self-condemnation, and any negative messages in their circle of friends only serve to strengthen these feelings. Such victims can introject victim-blaming discourses that exist in society, and they

might think that it was their dressing, their place at the time of the attack, or even their job at that time that made them become victimized. The belief that they are the cause of it, or that they were the cause or instigators of the violence, places a strong internal barrier that would not prompt them to obtain medical or psychological help, as they would not believe they deserve such care. This kind of self-incrimination maintains a significant number of survivors in isolation at a time when health assistance is most likely to be useful [32].

The third component of emotional barriers is fear and anxiety, which can most often be in the form of fear of the procedure itself when a medical examination is conducted. Even the thought of discussing a traumatic experience in a clinical setting can be incredibly anxiety-inducing, which makes the traumatised individuals avoid the places they find associated with the trauma. This process can be attributed to the neurobiology of trauma in that intense fear of a specific attack can lead to a freezing or tonic immobility reaction, leading to increased vigilance. As a result, the mere prospect of a visit to the hospital can cause a sense that it poses a risk to psychological security, which only postpones access to treatment further [28].

3.1.2. Cognitive Barriers

Survivors encounter cognitive obstacles that stem from their thinking patterns and beliefs that prevent them from accessing healthcare services. One of the cognitive obstacles is failure to recognize the experience as sexual assault. Survivors of sexual assault whose stereotypical views about violence (i.e., being forced, through the use of a weapon, etc.) are not observed often would not refer to their experience as sexual assault. This hindrance to identifying the assault results in the late or total evasion of healthcare visits [33]. Another common cognitive barrier involves downplaying the severity of assault incidents [4,5,34]. The analysis of 1,297 tweets under the hashtag “WhyIDidntReport” revealed that college students did not report because they minimized and normalized sexual violence [4]. The study by [30] revealed that youth victims failed to recognize medical treatment needs because they underestimated the health consequences of assault.

The presence of cognitive barriers is deeply embedded in the thoughts of the survivor and their failure to appropriately classify the experience as sexual violence. A large number of survivors have a stereotypical image of rape involving violence, a gun, another weapon, or a dark alley. Where there is assault in an intimate relationship or the assault is not successfully resisted, the

victims do not always perceive that as a crime or health crisis. This incapacity of naming the experience causes dangerous naturalization of the violence, which prompts the survivor to think that his or her situation is not to be subjected to any official medical or legal action [33].

The practice of decreasing the nature of the attack is one of the prevalent mental obstacles that lead to severe delays in seeking help. The analytic content of social media, like an analysis of the WhyIDidntReport hashtag, proves the idea that many survivors, in particular, college students, are trivializing their experiences as a coping mechanism to deal with the trauma. This understatement is normally coupled with an underestimation of the potential health consequences, like the potential to contract sexually transmitted diseases or an unplanned pregnancy . The survivor might fail to seek treatment within several months since he/she does not feel threatened about their health, yet at that time, emergency prophylaxis is already useless [35].

In addition, neurobiological consequences of traumatic events can lead to lapses in memory or piecemeal memories about the incident, which survivors will unconsciously treat as a lack of evidence. The perception is like a wall, where, if the survivor is also incapable of showing that anything has taken place, it makes them believe that a medical examination would not help. This stereotype is supported by the rape myths that are even more common in society and suggest that a real victim has to present a clear and linear narrative and demonstrate traumatic injuries. In instances where the survivors do not meet these internalized and externalized expectations of victimization, survivors may opt to remain silent, where the time period within which the forensic evidence can be taken may expire [17].

3.1.3 Knowledge Barriers

The barriers to knowledge arise due to a lack of information regarding sexual violence, health complications, and resource and support services. This ignorance regarding medical treatment, counselling, and reporting alternatives after being attacked can diminish their chances of getting proper intensive medical treatment [7,28,29,32]. In their research focusing on survivors of sexual violence in Kenya, [31] has shown that the society was generally ignorant and unaware of sexual violence as well as the resultant consequences. Moreover, other victims lacked information on the healthcare and other support services, and where the information was available. This lack of awareness was stronger in the country and with the disadvantaged groups [36].

The victims have not received adequate information about the health complications that may occur as a result of the assault. Most of the victims lack education on sexually transmitted diseases or on becoming pregnant as a result of rape. In addition, the individuals knew nothing about the possibility of consulting a medical professional to take care of their ailments, or were not familiar with the work of health professionals [28]. The absence of such information may further lead to a lack of appreciation by the victims to seek medical attention within a reasonable time.

Poor medical and psychological literacy about effects, accompanied by limited awareness of support services offered, makes the health-seeking behaviour challenging. The respondents pointed to the lack of awareness of the complications of sexually transmitted infections after sexual violence. As such, after some period had passed, they felt that preventive care was no longer effective. Consequently, seeking treatment was not of significance. This emphasis shows the necessity of increased awareness-raising efforts [7].

The knowledge barriers lie mostly in the lack of information on the health complications of sexual violence and the existing resources to be used as a point of support. Many victims are not aware of medical support, counselling, and legal advice that can be obtained following an assault, and this fact can have a massive impact on the desire to receive timely medical care. An example is a study conducted in Kenya where they found that there is no community-level awareness creation of the effects of sexual violence in that country; hence, the individuals affected do not know where to address. This information gap is more pronounced in rural and marginalised communities, where healthcare rights educational resources are not as widespread as they should be [31].

A lack of awareness regarding the time-sensitive characteristics of medical interventions is also another significant factor in this barrier. Certain victims are unaware that they can seek medical services even when there are no visible injuries, or that the doctor plays an important role in providing care after an assault. Victims who do not know the dangers of pregnancy or contracting HIV after an assault may not feel the urgency to consult a hospital. Also, there is a common misbelief that after some period of time has passed, it will no longer be possible to provide preventive care and the survivors will refuse any efforts of treatment [28].

An incomplete understanding of the psychological effects of sexual violence is also one of the obstacles, because for survivors, it might not be acknowledged that the emotional pain they are experiencing is a medical issue that can be treated. When left unaware of the presence of Post-

Traumatic Stress Disorder (PTSD) counselling or other mental health support services, survivors are left to manage the serious psychological effects of the violence and suffer in isolation. These knowledge gaps translate into structural failures and an argument for intensifying the campaign to educate and raise awareness and close the distance between victimization and recovery. Without an explicit care pathway, survivors will have to go through an intricate healthcare system without sufficient guidance [7].

3.1.4 Intersection with Other Barriers

The different individual barriers that prevail do not act in isolation but interact with social, cultural, and structural factors. As an illustration, society stigmatizes, and victim-blaming attitudes maintain emotional barriers like shame and self-blame [37]. Moreover, the lack of knowledge regarding sexual violence and associated services can result in knowledge barriers among the population. These barriers differ in their effect on various populations. The impact of cultural aspects on the emotional reactions of the Syrian refugees residing in Jordan was observed in another study. These convergences indicate the multidimensionality and complexity of obstacles to post-sexual violence healthcare access [38].

Conclusively, the interplay of personal and individual barriers poses significant problems in the health-seeking behaviour of female sexual violence survivors. To overcome these barriers, it is essential to consider the emotional effects of sexual violence and enhance the awareness of existing services and their advantages. The providers must be trained to identify and respond to these barriers with proper sensitivity so that the survivors can experience a conducive environment where they do not feel vulnerable, disrespected, or powerless.

The personal obstacles the survivors face are never perceived in a vacuum but are continually reinforced with overlapping effects as indicated by the Socio-Ecological Model. Such as internal shame and self-blame (Individual level) are commonly supported by the involvement of the victim-blaming attitudes in the community (Societal level). Survivors also face cognitive barriers that stem from their thought processes and beliefs that prevent them from obtaining healthcare services. The inability to identify the experience as sexual assault stands as a major cognitive barrier. Survivors who experience sexual assault in ways that differ from traditional stereotypes about violence (e.g., without physical force, without weapons, and by intimate partners) tend to avoid

labeling their experiences as sexual assault. The failure to recognize the assault leads to delayed or completely avoided healthcare visits [33].

The other typical mental obstacle is the minimization of the seriousness of cases of assault [4,5,34]. By analyzing 1,297 tweets with the hashtag #WhyIDidntReport, the results showed that the undergraduates failed to report because they justified and normalized sexual violence [4]. In the research conducted by [30], the youth victims never knew that they needed medical attention because violence and victim-blaming had been normalized in the community (Societal level).

This cross-section effectively results in the situation when the state of mind of a survivor is confirmed by extraneous stigma, and the decision to get help is nearly inconceivable. It is important to appreciate that these barriers can be further enhanced by the absence of local clinics and the existence of laws that ensure that perpetrators are not captured, thus escalating fear and ignorance of survivors [37].

The cultural factors are also critical factors that define the emotional and cognitive responses of the survivors, especially those who form part of displaced communities. In Jordan, for example, the Syrian refugees can experience emotional reactions whereby cultural standards of honour and family honour focus on their emotional reactions. These intersections show that the process of healthcare-seeking behaviour is complicated by the personal, social, and systemic barriers interacting to drown out the needs of the survivors. The one barrier, like knowledge, would be a limited way out when the cultural taboos support new emotional barriers like shame [38].

Finally, these overlapping barriers are significantly varied in their impact on individuals and geographic areas. Healthcare providers need to be taught to identify how the various forms of influence (i.e., abusive partner, social intimidation, or lack of available infrastructure) interact to ensure that the victims will not receive care. Having an understanding of the complications of such intersections, the practitioners will be in a better position to create more accommodating spaces that consider the contexts and lived experiences of survivors. By doing so, the focus of this approach is to create a recovery road map that takes into consideration the fact that survivor decision-making is influenced by a multi-layered web comprising individual, interpersonal, and structural constraints [16].

3.2. Social and Cultural Barriers to Healthcare Access after Sexual Violence

One of the challenges in accessing healthcare services by female survivors of sexual violence is the social and cultural barriers. These obstacles are a result and extension of wider societal attitudes, cultural constructs, and social organization that influence the social perception and response to sexual violence [39]. In this section, the author explores the different social and cultural impediments that influence the healthcare-seeking behaviours post-assault.

3.2.1. Stigma and Social Judgment

The sexual violence stigma is an important obstacle to healthcare access in the entire world [7, 15, 16, 28, 37]. Three types of stigma were determined in one study. Internalized stigma includes negative beliefs that have been internalized by the individual in society, resulting in shame and poor self-assessment. The anticipated stigma is the insecurity that victims have regarding how society will respond to sexual violence. Cultural stigma is the perceived ideologies of the larger community and their influence on help-seeking [40].

In most societies, women who report sexual assault are socially judged and victim-blamed [31], and this prevents the survivors from accessing healthcare. Certain cultures also place a major taboo on losing virginity without a marriage partner, and such acts have severe consequences on the future marriage and honour of the victim. This usually leaves the victim feeling ashamed of having lost her virginity. Lack of support in the society and family set-ups, as there is stigma against loss of virginity and pregnancy after rape, denies the victims the opportunity to continue receiving help, by getting access to medical care resources [37].

The findings of another study showed that misconceptions about rape and the inflexible social norms discriminating against women are connected to the stigmatization of sexual violence victims. These stigmas are also tied to the fear of the transmission of sexually transmitted diseases, shame, and guilt of families and communities of survivors [41]. There is also stigmatization by the husband of the victim. Sexual misconduct against a married woman is deemed to be non-marital rape, which is commonly viewed as an acceptable basis of separation. Consequently, sexual violence survivors, female, might decide not to reveal the incident, or even to receive care, because they are scared of adverse emotional responses from their husbands and the possibility of a divorce [7, 15].

The concept of sexual violence stigma has been identified as a global challenge that has a lot to do with healthcare accessibility among the victims of sexual violence. This stigma can be categorized into three, namely, internalized stigma, anticipated stigma, and a cultural stigma. Internalized stigma is the incorporation of negative beliefs within the society into the survivor, leading to low self-esteem and abject shame. Anticipated stigmas have to do with the fear of the reactions of others after the assault has been reported, and cultural stigmas have to do with cultural ideals that dishearten help-seeking behaviour. A combination of these forces presents a scenario where the survivor believes that his or her social status is being challenged when seeking medical care [40].

Reporting an attack in most communities is accompanied by extreme social stigma and blame on victims, which is a major deterrent to healthcare. This is particularly harsh in cultures where virginity is highly valued; the loss of virginity before marriage is a big taboo that has repercussions on the honour of the victim and the chances of getting a second husband. Shame feelings about the perceived loss of virginity often engulf the victims, and the inability to access medical resources is facilitated by the lack of family support prompted by the fear of stigma and unwanted pregnancy. The perceived social cost of care-seeking, in this regard, has been viewed to be larger than the physical effects of injury [37].

The other issue is the stigmatization factor within martal relationship, and in this case, non-marital rape is a very common factor that leads to separation. Consequently, a high percentage of non-reported female survivors do not report the rape or seek health services because they fear a response from their husbands or may be forced into divorce. This stigma is also supported by the strict social conventions and the fear of spreading sexually transmitted infections in the Democratic Republic of the Congo, which also places women at a disadvantage. This interpersonal stratum of stigma is the way to make sure that survivors are not affiliated with informal support networks as well as formal services [7].

3.2.2. Cultural Norms and Beliefs

Cultural norms and beliefs on sexuality, gender, and violence have a strong impact on healthcare-seeking behavior after sexual assault. Sexual issues are seen across many cultures as personal and secret to be discussed publicly, and, therefore, this does not allow victims to seek assistance. Victims may feel pressured to adhere to strict societal standards and avoid the stigma associated

with sexual violence. As a result, some victims may seek out illegal or unauthorized solutions in an attempt to address their situation and avoid further marginalization by their community [37].

The idea of deriving women's honour and dignity from their virginity or chasteness, in addition to the victim's faith and religion, affects a woman's decision on whether to report or not among Syrian refugees in Jordan. Some participants mentioned the fear that an "honour-based" killing could occur even if the woman were a victim of sexual violence; this factor, together with the fear of being stigmatized by their community, hindered women from reporting to authorities [38].

Cultural norms and beliefs about sexuality, gender, and violence define the extent to which healthcare-seeking behavior is influenced. Sexual issues in many cultures are regarded as highly sensitive and kept secret, and are considered taboo for any kind of discussion with other people; thus, this prevents victims from seeking formal assistance. Fear of stigmatization by society and the need to follow the norms of that society can make survivors seek illegal or unauthorized medical care to preserve their privacy. Such cultural limitations push survivors to the periphery, where they are criticized by their own communities over a crime they have not perpetrated [37].

Religion and the importance of faith are also influential factors that affect whether a woman will report an attack. Religious beliefs in certain contexts might be construed in a way that encourages forgiveness of the offender or even the maintenance of the family at all costs. This can also give out a culture of silence where the victims are taught to pray the trauma off, rather than consulting a professional medical or psychological assistance. The method used to solve these obstacles incorporates the healthcare provisions like change of cultural values and establishing a conducive environment that does not interfere with the right of the survivor to care but considers the cultural origins of the survivor [28].

3.2.3. Family-Related Barriers

Responses of family members may also serve as obstacles to post-sexual violence healthcare. A survey revealed that most women received unfavourable responses from their family and friends when they shared their sexual assault experiences, including reactions that demanded secrecy, victim-blaming, and the minimization of the severity of their assault. Negative social responses to sexual assault disclosure, regardless of their positive intentions, can have a negative psychological impact and increase self-blame [28]. A researcher conducting a study in the DRC noted the dual role of families in the help-seeking behaviour of victims. Despite the importance of timely care,

the stigmatization by community and family members, specifically by husbands, towards female survivors of sexual violence deters many victims from seeking medical care [7]. On the other hand, there was also significant support by community members to bring victims to hospitals and legal institutions. A retrospective registry-based study conducted in the same place found the mean delay of presentation to the hospital following sexual violence to be 10.4 months. This was partially due to the negative reaction exhibited by the community and family towards sexual violence victims [16].

Some survivors were apprehensive about seeking healthcare because they were worried that the process could trigger mandatory law enforcement involvement that might damage their family dynamics. People who became victims mainly within their domestic environment showed hesitation to file charges against their attackers since they did not want the perpetrators to receive punishment. Formal reporting of victimization led some individuals to worry about being removed from their homes or being separated from their support system [28]. In some cultures, family members have an interest in keeping sexual assault private to protect or defend the honour of their family [37].

Family members' response is one of the most important factors that may either help or hinder a survivor's access to healthcare. Regrettably, a large number of women report that their family and friends have responded negatively, often requesting them to maintain secrecy and downplay the extent of the assault. Although the intent of such responses generally is protective, the psychological effects are usually counterproductive, making the survivor feel more guilty and discouraging them from seeking formal help. In this way, the family, which is supposed to be the main provider of support, becomes a secondary provider of trauma and silence [28].

Studies in the Democratic Republic of the Congo have shown the dual role of families; some of them are supportive, but many husbands and other community members stigmatize survivors and discourage them from visiting hospitals. Research has established that the median time to present to a hospital was 10.4 months, with most of this delay being due to adverse family and community responses. Others may even fear that access to healthcare will make them obligated to involve law enforcement, which may ruin family life permanently or result in the punishment of a family member who is also a perpetrator [16].

The fact that the family is economically as well as socially dependent also adds complexity to help-seeking, since a survivor may be afraid of being evicted from their home or having their children taken away. On the domestic front, where the attacker is a relative, the victim might not be willing to press charges because they may lose their main lifeline. Moreover, some families have a vested interest in maintaining the secrecy of the assault to preserve the honour of the household, thus placing the survivor in a conundrum where they cannot even take a trip to a doctor without betraying their family members. Such pressures within the family create a wall of silence that is difficult to overcome by healthcare providers [28].

3.2.4. Intersection with Other Barriers

Individual, institutional, and structural barriers are intertwined with social and cultural barriers to influence the provision of healthcare in a complex and multiple manner. In the case of a man, cultural stigma may exacerbate the personal level of self-blame and shame, whereas institutional obstacles, like insensitive medical care, may enforce social discrimination of survivors [16, 31, 37].

To conclude, social and cultural barriers are significant barriers that do not allow female survivors of sexual violence to obtain healthcare services. To overcome these obstacles, complex approaches are necessary that confront stigma, change negative cultural practices in the families and communities, and establish positive conditions of survivability. The healthcare professionals should be culturally competent and have the knowledge of the social environment affecting survivor decision-making, and society should act to shift attitudes and norms that bar healthcare access to survivors of sexual violence.

Individual and institutional barriers are linked to social and cultural barriers, forming a complex web of resistance to care. As an illustration, cultural stigma may have a huge impact in intensifying the sense of self-blame in survivors, and insensitive institutional attitudes may exacerbate social discrimination against victims. This crossroad shows that the choice of survivors is influenced by their intra-psychological condition, family reaction, and availability and responsiveness of the local healthcare system. These problems should be resolved with the help of the holistic approach embracing all spheres of the Socio-Ecological Model [16].

Structural factors, including the physical site of services to the survivor and language barriers, might increase social and cultural barriers experienced by survivors. Indicatively, in cases where the survivor is already exposed to heavy cultural taboos, a remote health facility, or even this lack of language-sensitive services may turn off care-seeking entirely. These structural constraints are a sign to the survivors that the healthcare system is not structured to address their needs, thus stimulating silence and avoidance. Cultural competence and structural reform should be improved to initiate healthcare systems to start breaking these intertwined barriers [31].

Lastly, the purpose of knowing these intersections is to empower the survivors so that they possess safe, respectful, and accessible care environments. The health workers will need to get acquainted with the complexities of the social life against which the survivors are acting, and understand that the refusal of a woman to seek treatment may be a survival mechanism in the face of a stigmatizing society. To help the societal origin of the stigma issue amplify access to life-saving healthcare, society can focus on the underlying causes of the cultural barriers and engage families in the supportive interventions. This necessitates high-stakes practice in which individual provider responsibility is pooled with change at a larger scale in the wider society [17].

3.3. Interpersonal Barriers to Healthcare Access after Sexual Violence

3.3.1. Perpetrator-Related Barriers

Several researchers have found fear of the perpetrator to be a huge obstacle to access to health care following sexual violence [6, 42, 43]. The survivors were afraid that their attackers were going to take revenge if they approached any official social structure. Such fear was justified by the fact that survivors were not convinced that the existing mechanisms could have sufficient means to defend them against their attackers, and so they would endanger their safety by getting assistance. Consequently, they did not seek assistance in the endeavor of protecting their psychological and bodily conditions [6]. The retrospective study of 534 medical records of victims discovered that fear of attacks by perpetrators as a reprisal was the primary cause of the delay in coming to the hospital [43].

Another perpetrator factor, which is relevant to health-seeking behaviour, is the nature of the relationship between the victim and the perpetrator. Some studies have shown that survivors with knowledge of their attackers delay or decline medical attention, unlike victims who were attacked

by previously unknown people [17, 44]. This obstacle is further exaggerated when the victim is the intimate partner, a relative, or an individual with whom the victim has an existing relationship. This is further compounded by economic and social dependency with regard to the perpetrator. Once the survivors become financially, housing, childcare, or any other needs, the victims might have to focus more on the demands rather than the specific requirements of the survivors. An especially applicable barrier would be to intimate partner violence, where economic abuse represents a major complement to sexual violence [7]. In some countries, one of the worst things is the victims being taken into years of sexual slavery by their assaulters when they abduct them [16].

3.4. Institutional and Systemic Barriers to Healthcare Access After Sexual Violence

Institutional and system barriers are the hindrances in the health care systems and institutions that restrict access to proper care by female survivors. Such barriers include the actions and mindsets of healthcare providers, constraints of the healthcare provision system, and larger systems that undermine access to holistic services. This section discusses how such institutional drivers ensure that the post-sexual assault healthcare access is considerably hindered.

3.4.1. Health provider-related barriers

Attitudes and sensitivity of healthcare providers greatly impact the interactions and willingness to be treated by the survivors. A study in Iran, which was on victims of sexual violence, revealed that the inability of medical personnel to facilitate the needs of the victim, which may include hymenoplasty and abortion as a result of legal and religious barriers and cultural limitations resulted in anger, frustration, and lack of satisfaction. This led to the victims resorting to unlawful means of care acquisition [37]. Poor training and the small number of healthcare personnel who have been trained to handle survivors are a significant stumbling block in the delivery of quality services in certain areas of the world [31].

The issue of not being adequately trained is a systemic issue that several workers in the healthcare industry have not been trained to handle the dynamics of sexual violence. A lack of staff trained in trauma-informed care is likely to cause difficulties with insensitive examinations and an inability to respect patient dignity. The medical personnel will inadvertently potentially re-traumatize the survivors when taking them in and examining them unless the scenario-based

training based on evidence-based principles is applied. This practice shortcoming is one of the primary obstacles to providing quality survivor-centered care [31].

Furthermore, provider insensitivity may also help the survivors lose trust in the healthcare system. These issues with the non-coordinated service delivery usually mean survivors have to go through various facilities and re-tell their stories to different staff members, many times, and in this process, the survivor experiences a form of exhausting and re-victimizing experiences. To handle this, hospitals are in need of compulsory training on informed choice and patient empowerment during the care process. It is equally vital to develop a respectful and safe setting that enhances the willingness of the survivors to revisit the facility to receive the required follow-up treatment [7].

3.4.2. Healthcare System Barriers

The distance between the residences of victims and hospitals can be attributed to access barriers. They also present a shortage of services and an inability to access services because of structural or process barriers. The distance between the hospital and the residence of the victim is a vital element of timely care [14, 15]. These studies revealed differences in access to care within the life-saving 72-hour period between landlocked and non-landlocked health areas in which the victim is residing. Women living in landlocked health zones experience lower access to timely care because there are no viable roads and sufficient transport infrastructure in the remote locations.

Furthermore, service availability stands as a major challenge for women who live in low-income countries. The quality and accessibility of care are compromised because essential equipment and medications needed to perform victim assessments and management, such as post-rape medical kits and speculums, are not available within walking distance of communities, and stock-outs occur frequently [7, 15]. Fragmented service delivery that forces survivors to attend care at different service delivery points, in different buildings, results in long wait times and survivors being lost along in-hospital pathways [31]. Another challenge is the lack of a formal way of following up with survivors to ensure that they return to complete their treatment. As a result, only about 30–50% of survivors return after the initial treatment [31]. Similar to the above findings, the physical location of services, language barriers, transportation issues, and the perceived or real cost of services were noted as significant barriers to accessing healthcare [45].

Physical distance between the victim's home and the nearest hospital is a structural barrier that has a major impact on access to timely care. Research has identified a drastic difference in access to

the critical 72-hour window between urban and landlocked or remote health areas. Since most developing areas do not have viable roads and proper transportation networks, in many cases, it is physically impossible to get survivors to facilities that provide necessary emergency prophylaxis. This geographic isolation means that the most vulnerable populations are also the most affected by delayed care [14].

Even when survivors reach a facility, the required medical supplies are not always in stock. The low-income countries experience a shortage of post-rape medical kits, speculums, and emergency contraception, which inhibits the possibility of proper assessment and treatment. Without these types of diagnosis tools and medications, health care professionals cannot give proper care, and those who survive the illness do not receive anything that could save their lives. In the event that the basic requirements of medical administration are not readily available in the community or by walking, the quality of care becomes highly compromised [15].

Disjointed service delivery and queues also demoralize survivors from following up on their treatment plans. In cases where the services like forensic examination, counselling, and STI treatment are in different buildings, the chances of the survivors failing to finish the process of care are greater. It is discovered that formal follow-up mechanisms are not implemented, and hence only 30-50 percent of the survivors come back to seek follow-up care [31].

3.4.3. Legal and Policy Barriers

Legal and policy barriers are formal systems, regulations, and rules that may hinder access to healthcare services by female survivors of sexual violence. Difficulty in reporting, investigation, prosecution, and sentencing of cases of sexual assault and rape also constitute some of these barriers. A systematic review [13] determined 70 various barriers, the majority of which occurred at the reporting stages, then the investigation, and then the prosecuting and eventual sentencing. International statistics reveal that the attrition rate and the conviction rate of sexual offences are high, with rape having the lowest conviction rate among all sexual offences [13].

Absence of criminal justice law to punish the offenders in the criminal justice system is a major obstacle that needs to be addressed urgently, especially in nations where the legislation permits those involved to remain free by getting married to their victims [37, 38]. This is because of such laws, along with other more pervasive failures in the justice system, which fuel mistrust in the legal institutions. In line with this result, forty-one percent of the posts in which the personal

victimization experience was described cast doubt on the importance of the reporting of sexual violence in contemporary criminal justice systems [17].

Moreover, it was also found that police interpretations of sexual violence and credibility ratings of a victim played a huge role in legal determinations. Such interpretations are usually influenced by presumptions about the so-called ideal victim, according to which the consumption of alcohol or sex work, as well as previous consensual relations with the attacker, might contribute to the inability to consider the survivors seriously [46].

Lastly, legal systems are adversarial, and this poses another major obstacle. Survivors may be subjected to hostile cross-examination that attempts to discredit them so that they have to repeat traumatic events. The effects of such proceedings may involve a secondary victimization that further worsens the psychological damage suffered due to the attack [47].

4. Conclusion

4.1. Synthesis of evidence

Sexually violated women are faced with several barriers that hinder their access to healthcare. These barriers operate at individual, social, institutional, and structural levels. The solutions to these barriers to access are not easy, and as such, to be effective in eradicating these barriers, solutions must consider not just the practice of individual providers but also the healthcare system reforms as a whole, as far as social norms and practices are concerned, on a wider scale. Topicality of the work also should not be underrated because high-quality and timely healthcare is a significant aspect of minimizing the physical and psychological impacts of sexual violence, its recovery, and prevention of chronic morbidity. On the contrary, sexual violence will increase the cost of poor health due to health disparities and access barriers to health care, creating avoidable health disparities in life.

As an individual, survivors have to access quality resources that will help them to deal with the systemic inefficiencies. It is accomplished by means of the creation of clear, sensitive, and comprehensive resources that expand medical rights and support services available in the region in straightforward and natural terms. Several WhatsApp hotlines or local communities with peers are a potential source of advice that one can receive once formed, with the support of survivor advocates, and where one might pose a question regarding medical processes and legal channels. Interventions at the communal level also need to be taken to break the silencing of sexual violence in society. Initially supported by lived experience, local community leaders, including coaches, faith leaders, and hairdressers, can be trained to offer an initial assessment of support and referral.

In the healthcare environment, institutional re-traumatization should be avoided by adopting wholesome policy and practice changes. Among the key elements, there could be a compulsory, situation-based training of the entire medical personnel, which includes the use of evidence-based, trauma-informed methodology and the development of practical skills, including performing sensitive examinations and protecting the dignity of patients and informed choice during the course of treatment. At the same time, medical institutions should have sufficient staff with necessary medications, diagnostic equipment, and medical supplies to provide care in an immediate and sustained form after the assault. The development of one-stop clinics that are integrated (which practice co-location of forensic examinations, emergency contraception, counselling, and legal

aid) has been shown to cut survivor attrition in pilot trials across the world. Moreover, the healthcare systems must also offer anonymous STI-treatment and emergency contraceptives, as identification requirements commonly cause survivors to avoid being treated.

The justice system also needs a great change that will help to avoid further trauma to the survivors. Re-victimization of victims in criminal proceedings might also be minimized by the establishment of special sexual violence courts that have trained judges to preside. Moreover, the criminal justice system should implement a survivor-focused strategy, work to improve transparency, and focus on safety, dignity, and rights of victim-survivors during the judicial process.

4.2. Limitations

Despite the valuable information given in this review on the issue of healthcare access among women who have reported experiences of sexual violence, various limitations have to be noted. The results cannot be applied to any other population of those who survived, including children, men, and transgender or non-binary individuals, since the studies reviewed did not consider any groups other than all women groups. Also, no children and adolescents were involved in it, although it was shown that children and adolescents experience specific institutional and psychological barriers that they would wish to seek post-assault medical care. The other weakness is that survivors with disabilities have been underrepresented, as access to healthcare is influenced by the physical inaccessibility and communication hurdles, which should be studied specifically.

The review was mainly based on peer-reviewed academic references, which could have omitted some valuable information not indexed or because of the grey literature, such as testimony by the survivors and service providers. The English-language limitation to publications could also be viewed methodologically as having left out data there that could be in other parts of the world that are not English-speaking and might have had markedly different healthcare provisions and disparities.

Lastly, although several common themes were found when conducting the review, the study sample consisted mostly of qualitative studies, so quantitative gaps in healthcare access may have been underrepresented. It is recommended that future research ought to be subtle yet intersectional, in which the qualitative and quantitative studies are combined into one another, showing the complexity of the barriers that survivors of sexual violence may encounter in their entirety.

However, this summary is a valueable contribution to future research in an attempt to fill these critical gaps and issues.

REFERENCES:

1. Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, editors. World report on violence and health. Geneva: World Health Organization; 2002. https://iris.who.int/handle/10665/42495
2. Li J, et al. Anxiety and depression symptoms among youth survivors of childhood sexual abuse: a network analysis. BMC Psychology. 2023;11:278. https://doi.org/10.1186/s40359-023-01314-z
3. Xianguo Q, et al. The prevalence of sexual violence against African women: a systematic review and meta-analysis. African Health Sciences. 2023;23(3):117-127. https://dx.doi.org/10.4314/ahs.v23i3.15
4. Griffin VW, et al. Explaining the why in #WhyIDidntReport: an examination of common barriers to formal disclosure of sexual assault in college students. Journal of Interpersonal Violence. 2022;37(15-16):NP14716-NP14745. https://doi.org/10.1177/08862605211025032
5. Palermo T, et al. Underreporting of sexual violence among female survivors in low- and middle-income countries. JAMA Pediatrics. 2014;168(7):652-659. https://doi.org/10.1001/jamapediatrics.2014.263
6. Patterson D, Greeson M, Campbell R. Understanding rape survivors' decisions not to seek help from formal social systems. Health Soc Work. 2009;34(2):127-136.
7. Reinholdz H, et al. Community perceptions about factors influencing access to care after sexual violence in North Kivu, Democratic Republic of the Congo: a qualitative study. Confl Health. 2025;19(1):22. doi:10.1186/S13031-025-00662-4.
8. Ajayi, A.I. and Ezegbe, H.C. (2020) 'Association between sexual violence and unintended pregnancy among adolescent girls and young women in South Africa', BMC Public Health, 20(1), p. 1370. doi:10.1186/s12889-020-09488-6.
9. Devries KM, et al. Who perpetrates violence against children? A systematic analysis of age-specific and sex-specific data. BMJ Paediatrics Open. 2018;2:e000180. https://doi.org/10.1136/bmjpo-2017-000180
10. Cybulska B. Immediate medical care after sexual assault. Best Practice & Research Clinical Obstetrics & Gynaecology. 2013;27(1):141-149. https://doi.org/10.1016/j.bpobgyn.2012.08.014
11. Sachs CJ, Thomas B. Sexual Assault Infectious Disease Prophylaxis. [Updated 2023 Sep 9]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-. Available from: https://www.ncbi.nlm.nih.gov/sites/books/NBK482239/
12. Resnick HS, et al. Predictors of post-rape medical care in a national sample of women. American Journal of Preventive Medicine. 2000;19(4):214-219. https://doi.org/10.1016/s0749-3797(00)00226-9
13. Wieberneit M, et al. Silenced Survivors: A Systematic Review of the Barriers to Reporting, Investigating, Prosecuting, and Sentencing of Adult Female Rape and Sexual

Assault. Trauma, Violence, & Abuse. 2024;25(5):3742-3757. https://doi.org/10.1177/15248380231221415

14. Mukwege D, Mugisho GM, Maroyi R. Obstacles to emergency medical consultation in cases of conflict-related sexual violence. PLoS ONE. 2025;20(1):e0317082. https://doi.org/10.1371/journal.pone.0317082
15. Mseke, E.P., Jessup, B. and Barnett, T. (2024) 'Impact of distance and/or travel time on healthcare service access in rural and remote areas: a scoping review', Journal of Transport & Health, 37, p. 101819. doi:10.1016/j.jth.2024.101819.
16. Bartels SA, et al. Demographics and care-seeking behaviors of sexual violence survivors in South Kivu Province, Democratic Republic of Congo. Disaster Medicine and Public Health Preparedness. 2012;6(4):393-401. https://doi.org/10.1001/dmp.2012.66
17. Orchowski LM, et al. Barriers to reporting sexual violence: a qualitative analysis of #WhyIDidntReport. Violence Against Women. 2022;28(14):3530-3553. https://doi.org/10.1177/10778012221114519
18. World Health Organization (2021). Violence against women. Available at: https://www.who.int/news-room/fact-sheets/detail/violence-against-women
19. United Nations Office of the High Commissioner for Human Rights (n.d.) Women's human rights and gender-related concerns in situations of conflict and instability. Available at: https://www.ohchr.org/en/women/womens-human-rights-and-gender-related-concerns-situations-conflict-and-instability
20. Titisari AS, Mesman J, Dewi KH. Cultural norms and adolescents' sexual and reproductive health in Bali, Indonesia: a narrative review. J Adolesc Young Adult Stud. 2025;8:37-62. doi:10.1007/s43151-024-00145-y.
21. American College of Emergency Physicians. Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient. 2nd ed. Dallas, TX: American College of Emergency Physicians; 2013. Available from: https://www.acep.org/siteassets/new-pdfs/sexual-assault-e-book.pdf
22. U.S. Department of Justice, Office on Violence Against Women. National protocol for sexual assault medical forensic examinations – adults/adolescents. 3rd ed. Washington (DC): U.S. Department of Justice; 2024. Report No.: NCJ 228119. Available from: https://www.justice.gov/usdoj-media/ovw/media/1367191/dl?inline
23. Magalhães T, Dinis-Oliveira RJ, Silva B, Corte-Real F, Nuno Vieira D. Biological evidence management for DNA analysis in cases of sexual assault. ScientificWorldJournal. 2015;2015:365674. doi:10.1155/2015/365674.
24. Oram S. Sexual violence and mental health. Epidemiol Psychiatr Sci. 2019;28(6):592-593. doi:10.1017/S2045796019000106.
25. Marcantonio TL, Hunt ME, Schisler E. Assessing Sorority Women's Perceptions of Barriers to Reporting Sexual Assaults That Occur Within College Campus Greek Organizations. Journal of Child Sexual Abuse. 2023 Mar 13;32(3):1–20
26. Wieberneit M, Thal S, Clare J, Notebaert L, Tubex H. Silenced survivors: a systematic review of the barriers to reporting, investigating, prosecuting, and sentencing of adult

female rape and sexual assault. Trauma Violence Abuse. 2024;25(5):3742-3757. doi:10.1177/15248380241261404.

27. Ceelen M, Dorn T, van Huis FS, Reijnders UJL. Characteristics and Post-Decision Attitudes of Non-Reporting Sexual Violence Victims. J Interpers Violence. 2019;34(9):1961-1977. doi:10.1177/0886260516658756
28. Kamke K, Mullin TM, Goodman KL. Barriers to Seeking Medical Care Among Youth Victims of Sexual Violence. J Adolesc Health. 2023;73(6):1077-1082. doi:10.1016/j.jadohealth.2023.06.034
29. Munro ML. Barriers to care for sexual assault survivors of childbearing age: An integrative review. Womens Healthc (Doylestown). 2014;2(4):19-29.
30. Sable MR, Danis F, Mauzy DL, Gallagher SK. Barriers to reporting sexual assault for women and men: perspectives of college students. J Am Coll Health. 2006;55(3):157-162. doi:10.3200/JACH.55.3.157-162
31. Gatuguta A, et al. Characterizing survivors of sexual violence who present to the hospital and identifying barriers to care: a mixed-methods study in Kenya. BMC Public Health. 2018;18:602. https://doi.org/10.1186/s12889-018-5544-2
32. Murray H, Pethania Y, Medin E. Survivor guilt: a cognitive approach. Cogn Behav Therap. 2021;14:e28. doi:10.1017/S1754470X21000246.
33. Pemberton JV, Loeb TB. The impact of sexual and interpersonal violence and trauma on women: trauma-informed practice and feminist theory. J Fem Fam Ther. 2020;32(1-2):115-31. doi:10.1080/08952833.2020.1793564.
34. Sabina C, Ho LY. Campus and college victim responses to sexual assault and dating violence: disclosure, service utilization, and service provision. Trauma, Violence, & Abuse. 2014;15(3):201-226. https://doi.org/10.1177/1524838013511544
35. Yeo TE, Chu TH. Adaptive self-reflection as a social media self-effect: insights from computational text analyses of self-disclosures of unreported Sexual Victimization in a Hashtag Campaign. Social Science Computer Review. 2025 Apr;43(2):341-55.
36. Campbell R, Wasco SM, Ahrens CE, Sefl T, Barnes HE. Preventing the "Second rape": rape survivors' experiences with community service providers. Journal of Interpersonal Violence. 2001 Dec;16(12):1239-59.
37. Shahali S, et al. Barriers to healthcare provision for victims of sexual assault: a grounded theory study. Iranian Red Crescent Medical Journal. 2016;18(3):e21938. https://doi.org/10.5812/ircmj.21938
38. Lambert JE, Abutaleb H, Odeh R, de Jong J. 'Let it stay in the heart': cultural and gendered experiences of distress among Syrian refugees in Jordan. Front Psychol. 2024;15:1456201. doi:10.3389/fpsyg.2024.1456201.
39. Gobin RL, Gómez JM. The cultural context of sexual assault and its consequences among ethnic minority women. In: Geffner R, White JW, Hamberger LK, Rosenbaum A, Vaughan-Eden V, Vieth VI, editors. Handbook of interpersonal violence and abuse across the lifespan. Cham: Springer; 2022. p. [insert page range]. doi:10.1007/978-3-319-89999-2_216.

40. Open Text BC. Three types of stigma: public, internalized, and stigma-by-association. In: Post-Secondary Peer Support Training Curriculum [Internet]. 2022 [cited 2026 Jan 20]. Available from: https://opentextbc.ca/peersupport/chapter/three-types-of-stigma-public-internalized-and-stigma-by-association/

41. Murvartian L, Saavedra-Macías FJ, Infanti JJ. Public stigma toward women victims of intimate partner violence: a systematic review. Aggress Violent Behav. 2023;73:101877. doi:10.1016/j.avb.2023.101877.

42. Vranda MN, et al. Barriers to disclosure of intimate partner violence among female patients availing services at tertiary care psychiatric hospitals: A qualitative study. Journal of Neurosciences in Rural Practice. 2018;9(3):328-333. https://doi.org/10.4103/jnrp.jnrp_471_17

43. Adefolalu A. Time to presentation and its determinants among female sexual assault survivors in Gauteng, South Africa. African Journal of AIDS Research. 2014;13(2):121-127. https://doi.org/10.2989/16085906.2014.931922

44. McCall-Hosenfeld JS, Freund KM, Liebschutz JM. Factors associated with sexual assault and time to presentation. Prev Med. 2009;48(6):593-595. doi:10.1016/j.ypmed.2009.03.016

45. Ullman SE, Townsend SM. Barriers to Working With Sexual Assault Survivors: A Qualitative Study of Rape Crisis Center Workers. Violence Against Women. 2007;13(4):412-443. https://doi.org/10.1177/1077801207299191

46. Ricciardelli R, et al.-Centering the Victim: Police Perceptions of Victims of Sexual Violence through a Comparative Lens of Evidence Collection and Processing. Feminist Criminology. 2021;16(2):155708512110319. https://doi.org/10.1177/15570851211031959

47. Lorenz K, Kirkner A, Ullman SE. A qualitative study of sexual assault survivors' post-assault legal system experiences. J Trauma Dissociation. 2019;20(3):263-87. doi:10.1080/15299732.2019.1592643.