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Factors Associated With Delayed Health Seeking Behavior After Sexual Assault. A Case Of The Adult Rape Clinic (ARC) At Parirenyatwa Group Of Hospitals In Harare

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Abstract :
This cross-sectional study investigated factors associated with delayed health seeking behavior among sexual assault survivors presenting to the Adult Rape Clinic at Parirenyatwa Group of Hospitals in Harare, Zimbabwe, to understand barriers to early reporting within the crucial 72-hour window. The study utilized the Health Belief Model as a theoretical framework. The objectives were to identify barriers, explore characteristics related to delayed reporting, and make recommendations for improvement. In a sample of 45 survivors recruited via purposive and convenience sampling, the findings were that, over half were aged 18-20 with secondary education or higher. However, the most significant reported barrier was fear of stigma reported by 42%. Additionally, 33% cited lack of awareness of post assault services and 24% faced travel difficulties. The majority (78%) experienced rape while 10.9% each reported fondling / attempted rape, with younger rural survivors and rape victims perceiving assaults as severely impactful but many encountered greater obstacles to care. Key recommendations included scaling up comprehensive sexuality education targeting adolescents and communities, expanding psycho-social counselling through additional centers and extended clinic hours, and implementing nationwide public awareness campaigns employing diverse channels to disseminate information and reduce stigma. Mobile clinics and tele-counselling were suggested to improve accessibility for remote populations in addition to strengthening transportation support systems. Resolving entrenched socio-cultural and environmental barriers delays survivors face requires coordinated multi-sectoral actions incorporating tailored education, outreach, social support and innovated services aligned with survivors' circumstances to facilitate their recovery prospects through earlier healthcare access following sexual trauma.

Keywords: *Adult Rape Clinic, Delayed Health Seeking Behavior, Sexual Assault*

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I. Introduction

Sexual violence, specifically sexual and gender-based violence (SGBV), refers to acts of violence committed against individuals based on their sex or gender. It involves using violence, coercion, threats, deception, cultural expectations, or economic means to force another person to engage in unwanted activities. Sexual assault is a pervasive social problem that often has far-reaching negative health, psychological and social consequences for victims (Smith & Brown, 2015). Seeking timely medical care following such a traumatic experience can help address injuries, test for sexually transmitted infections, and aid in the collection of forensic evidence to support potential legal cases against perpetrators (Jones et al, 2020). Understanding the factors that influence help-seeking behaviors is important to help address barriers and facilitate greater access to post-assault care and support services (Campbell, et al, 2018).

This study aims to explore reasons for delayed health-seeking behavior among adult sexual assault victims attending the Adult Rape Clinic at Parirenyatwa Hospital in Harare, Zimbabwe. As one of the few specialized facilities offering post-assault services in the country, this clinic sees over 2000 new assault cases annually (Ministry of Health, 2017), making it an ideal setting to gather insights.

Reporting of sexual assault varies greatly around the world depending on socio-cultural, economic, and systemic factors (WHO, 2021). In more conservative societies, survivors often face stigma, blame, and legal consequences for not reporting or pursuing justice (Gupta, et al, 2019). Religious and cultural norms in some Middle Eastern and South Asian countries discourage disclosure and push survivors into silence (Fulu, et al, 2017) The World Health Organization, (2021) further notes that, regions with strong legal protections and trauma-informed support systems tend to see higher reporting rates than regions with weaker institutional capacity. Many high-income countries in Europe and North America have well-established national protocols and a network of sexual assault centers to encourage confidential disclosure (UN, 2018; WHO, 2021). Public

education campaigns actively promote a culture of reporting and access to justice (UN, 2020; CDC, 2021). Survivor advocacy organizations also play a role in supporting disclosure.

In sub-Saharan Africa, reporting rates are hindered by significant inadequacies in healthcare systems and a lack of specialized services available for survivors (WHO, 2021; Gupta, 2018). Understaffed hospitals cannot always provide quality post- sexual assault care or connect survivors to long-term support (Kyamanywa, et al, 2021). However, some countries like Uganda, Malawi, and South Africa and Zimbabwe participate actively in global campaigns against sexual and gender-based violence such as the UN's 16 Days of Activism (UN, 2020). Through national action plans and reforms, they aim to overcome structural barriers and normalize reporting through public education.

In Zimbabwe, the national protocol on the Multi-Sectoral Management of Sexual Violence provides standardized guidance on service provision across sectors. Government hospitals are mandated to offer comprehensive post sexual assault care according to these protocol standards (ZANGO, 2019). Specialized facilities such as Harare's Adult Rape Clinic (ARC) offers medical treatment, counselling, and sample collection services in a safe, private setting. The clinic adheres to survivor-centered practices and confidentiality to encourage reporting

One Stop Centers have additionally been established across the country's provinces to centralize medical, legal and psychosocial post sexual assault services under one roof (UNFPA, 2020). Through providing these integrated services, reporting barriers are reduced through a streamlined and supportive response system. In Zimbabwe, delayed reporting of sexual violence to healthcare facilities remains a critical issue despite ongoing efforts to raise awareness about the importance of timely health-seeking behavior.

In 2021, the Adult Rape Clinic in Harare received 2,114 survivors of sexual assault, yet only 595 reported within the crucial 72-hour window necessary to access post-exposure prophylaxis (PEP) and other essential services (Adult Rape Clinic, 2021 Annual Report). This reflects a staggering 71% of survivors reporting late, increasing their risk of contracting HIV, sexually transmitted infections (STIs), and unwanted pregnancies.

Globally, 69% of survivors seek help after the 72-hour period, further emphasizing the severity of the problem in Zimbabwe. Delayed reporting limits access to timely medical care, forensic evidence collection, and mental health support, which is critical for long-term recovery and legal justice. Despite the awareness campaigns by civil society organizations and government departments, survivors continue to face barriers such as stigma, victim-blaming, and lack of awareness, which contribute to the persistent issue of delayed reporting. This study seeks to understand the factors contributing to late reporting at healthcare facilities like the Adult Rape Clinic, aiming to develop strategies that enhance timely health-seeking behavior among survivors and improve access to essential post-assault services.

Through focusing on the underlying causes of delayed reporting, this research aims to provide actionable insights to inform policy and intervention efforts to support survivors in accessing timely care. This study aims to identify and explore the factors associated with delayed reporting of sexual assault to health facilities, as experienced at the Adult Rape Clinic at Parirenyatwa Hospital Harare.

II. Methodology

This study utilized a mixed-methods approach. This approach combines quantitative and qualitative research techniques to gain a comprehensive understanding of the factors contributing to delayed health seeking after sexual assault.

Study Settings

The study was conducted at the Adult Rape Clinic (ARC), Harare site, located within the premises of Parirenyatwa Group of Hospitals. The clinic is a Private Voluntary Organization (PVO) and is supported by donor funding. The ARC has a network of specialized post-sexual assault clinics in various locations, including Harare, Gokwe, Kadoma, Mutare, and Nemanwa in Masvingo. The location of the ARC Harare site within the Parirenyatwa Group of Hospitals premises ensures convenient accessibility, serving as a specialist referral clinic for patients from Parirenyatwa Group of Hospitals and surrounding healthcare facilities in Harare and its environment. The clinic provides comprehensive prevention and response services for sexual assault survivors.

Sampling and data collection

The target population for this study included female young adult survivors aged 18 to 24 years who experienced sexual assault and sought health care services late (after 72 hours) from the Adult Rape Clinic (ARC) in the period between January 2021 and December 2021. The study utilized purposive sampling for in-depth insights from key staff at ARC. Purposive sampling was used to select key informants, including ARC's Clinic Manager, Nurse Counsellor, Psychologist, Monitoring and Evaluation Officer, and Outreach Officer. The reason for purposive sampling is the better matching of the sample to the aims and objectives of the research,

thus improving the rigor of the study and trustworthiness of the data and results. Furthermore, the study also utilized convenience sampling. Given practical constraints, convenience sampling was used to recruit survivors for semi-structured interviews and quantitative data collection. While this method may introduce some bias, it is the most feasible option considering the sensitive nature of the study.

The determination of the sample size considered factors such as statistical power and significance levels. Initial inquiry with the ARC noted that they received at least 50 survivors for follow up review per month and this study targeted to collect data over one month hence the tentative target for this study was 50 participants. The study then utilized the Rao soft sample calculator in calculating the study sample at 95% degree of confidence as well as 5% margin of error and a response distribution of 50%, the study was therefore having a sample size of 45.

The inclusion criteria included survivors of sexual assault being attended to at the Adult Rape Clinic, Harare Site at Parirenyatwa Group of Hospitals having accessed the clinic after 72 hours from sexual assault. After getting the permission from The Adult Rape Clinic the investigator sampled and collected data from survivors at the clinic. Data was collected using an open-ended questionnaire.

Permission to carry out the study was sought from Parirenyatwa Group of Hospitals Management, The Joint Research Ethics Committee and the Medical Research Committee of Zimbabwe.

Quantitative data collected through a survey were analyzed using the Statistical Package for Social Science (SPSS). Descriptive statistics were used to summarize characteristics of participants and frequencies of responses to individual survey items. Inferential statistics such as chi-square tests were also employed to examine associations and relationships between key categorical variables like demographics and health service utilization factors.

Qualitative data from interviews with survivors and key informants were analyzed using thematic analysis. Verbatim were presented in italics. Confidentiality was ensured through ensuring that participants' names and other identifiable details were removed from interview transcripts and replaced with alphanumeric codes.

III. Results

The age distribution of the study participants was like, 24 (53.3%) of the survivors who experienced delayed health seeking behavior after sexual assault were between 18-20 years of age. The remaining 21 (46.7%) of survivors fell within the 21–24-year age bracket.

16 of participants (35.9%) had attained secondary level education. 10 of them (22.8%) had studied up to the university level. Additionally,10 participants 21.7% and the other 9 being 19.6% were primary level and diploma educated respectively. Overall, more than half of survivors had at least secondary education.

26 participants (57.6%) reported being single. 12 of them (26.1%) were identified as divorced or separated. The data also 30 showed that 5 participants (10.9%) were widowed. Only 2 (5.4%) stated that they were currently married.

22 participants (47.8 %) reported being unemployed. 17 (37.0 %) identified themselves as employed individuals and 7 (15.2%) identified themselves as unemployed

25 participants (78.3%) reported experiencing actual rape. 10 participants (10.9%) indicated being victims of fondling or groping and 10 more (10.9%) stated they experienced attempted rape.

56.5% (25 participants) reported seeking care at the clinic over three months after the assault. 20.7% (9) sought care between eight days to one-month post-assault. 14.1% (6) presented to the clinic from one month to three months following the incident. 8.7% (4) indicated obtaining care within the first week, between three to seven days after the assault occurred.

Key informants at the Adult Rape Clinic noted that they are worried about the level and rise in delays in reporting cases of rape. A Nurse Counsellor in charge of the clinic stated that: "*The length of time it takes survivors to come to us for care is disturbing but understandable given what they have endured. As a nurse and counsellor, I see how physical evidence degrades and treatment becomes less effective the longer someone waits. Over half of our patients' delays beyond 3 months highlight significant barriers out there. We see survivors only coming for healthcare because they now have visible consequences such as pregnancy. The stigma, fear and self-blame can paralyze people even when they know help exists. Our staff do everything possible to make the clinic feel safe and comforting to make up for lost time. It's also worrisome that even in the earliest period after assault, only a small fraction come within the first 72 hours. This is when preventative measures like PEP for HIV and emergency contraception are effective, injuries which provide critical forensic evidence are freshest and visible and can be noted clearly thereby adding weight to the court cases. Clearly more must be done to raise awareness of our services and convince survivors their health and safety deserve urgent attention. Perhaps with more funding, expanding 24/7 telephone counseling and ensuring transportation options can get people here even in the middle of the night would encourage faster response. We will continue finding ways to overcome obstacles to accessing timely assistance,*" Key informant 5

On what ultimately prompted participants to report to the clinic, 12 (26.1%) cited radio / social media or TV / mass media cues while 11 (23.9%) indicated a fear of contracting sexually transmitted infections such as HIV. 9 (20.7%) reported manifesting symptoms of STI. 8 (17.4%) stated they were prompted by having pregnancy resulting from rape. 5 (12%) reported being prompted by fear of pregnancy.

Key informants highlighted the existence and significance of several initiatives and strategies that the Adult Rape Clinic has been running to ensure the message get to the community. One of the informants, Outreach Officer, noted that: "*We find social media and radio to be very effective outreach tools for reaching members of various communities. We run daily posts on platforms like Facebook, Twitter and via local radio stations to encourage people to come to the clinic to get tested. It seems mainly women and young people are actively engaged with those channels and do end up hearing and most importantly sharing our messages. It's positive that so many are paying attention and acting on the information. Early testing is key to stopping further transmission of infections. We also participate in community-based awareness raising campaigns where we create demand for post rape services, and we highlight rape as a medical emergency. Despite this knowledge some survivors still delay the clinic visit. Recently a girl in early 20s visited the clinic's stand at an exhibition. She asked about symptoms of herpes as if enquiring about a friend. She later disclosed having been raped 4 months prior and currently having STI' symptoms She said she had always known about the clinic but was shy to visit. She was referred to us and was successfully treated at the clinic. She is one of many who would benefit from destigmatization of health seeking after sexual assault which is our goal*. "Key informant 1

In terms of information on factors that delayed participants' visit to the clinic, 11 participants (25%) reported being threatened by the perpetrator while 8 (17.4%) did not think it was important. 7 (16.3%) indicated lack of transportation as a barrier and, 4 (8.7%) participants cited cost of services as their barrier .7 participants (16.3%) reported fear / shame delayed their visit. Another 16.3% (7 participants) stated not knowing where to go as a hindering factor.

During key informant interviews, the Monitoring and evaluation officer noted that: "*Many survivors are simply not aware that medical, legal and emotional support services exist to help them in the aftermath of an assault. The stigma and trauma can leave people feeling isolated and unsure of where to turn for help. I find that conducting community outreach is critical to filling this gap. We need targeted health education campaigns to publicize what types of care are offered at facilities like ours. Working with community organizers, schools, religious groups and women's centers, we can spread information about available services through seminars, printed materials and mass media. It's also important for these messages to be delivered sensitively and without further stigmatizing those who have endured such trauma. Just knowing that options exist for things like medical exams, emergency contraception, STI treatment, counseling and even legal advocacy can empower survivors to start healing when they are ready. With better awareness of available support, hopefully fewer people will suffer alone feeling like there is no place to turn for help. Education is key to addressing a major barrier that prevents many from accessing timely, essential care services*" Key informant 3

This was supported by another key informant the counselling psychologist who stated that: "*In my experience working sexual assault survivors, one of the largest barriers to accessing healthcare within 72hours is the threat of retaliation they may face from the perpetrator. All too often, the perpetrator is someone the survivor knows - a family member, intimate partner, breadwinner or someone in their social circle. This creates an understandable fear about the potential consequences of such cooperation which they are not ready to face. Survivors fear that seeking health care early while visible signs are present and one is still very shaken could lead to inevitable disclosure of the crime causing repercussions such as harassment, physical harm or even death at the hands of their abuser. They take time to try and calm down first and come to terms with the ordeal. It takes immense courage for a survivor to seek healthcare under such threatening circumstances. Those fears are justified, as the survivor may have to go back home to the abuser. Provision of safe shelter programs could make a real difference in building confidence for rape survivors to seek health care early. If we had more robust resources to protect survivors, it may alleviate some of their safety concerns associated with seeking healthcare within 72 hours*". Key informant 2

The following information provides feedback on what survivors suggested could help encourage timely seeking help, 21 participants (45.7%) proposed increased community awareness campaigns through mass media.10 participants (21.7%) recommended lowering the costs of transportation services to make clinics more accessible. 8 participants (17.4%) indicated extending clinic hours beyond regular schedules. 7 participants (15.2%) highlighted enhancing outreach efforts to reach more remote rural communities. Views from key informants showed that in the wake of the many challenges they face, survivors are encouraged to utilize various mechanisms to cope with the trauma and challenged associated with being raped or attempted rape. One of the key informants brought out that the first point of call is to ensure that communities are aware of the existence of the adult rape clinic and its services.

"*The clinic staff agree that community awareness is paramount and should include partnering with community leaders, schools, and faith-based organizations to educate people where they gather. This will boost*

their knowledge on available support services and awareness of rape as a medical emergency and the importance of receiving clinical care within 72 hours. When these issues are discussed within the community, the people can freely relate, seek clarity and memorize the given knowledge on services such as ARC and the Police Victim Friendly Unit." Key informant 4.

"*Transportation barriers are a pressing issue for survivors of rape especially those from peri urban and rural areas. Survivors fail to prioritize early healthcare after rape when transport is difficult to access and expensive. There is a need to avail public transport to outlying areas in the evening or weekend hours. Establishing linkages with local taxi cooperatives to ply those routes to ensure that the timely services are provided to all community cadres in need*" Key informant 4.

IV. Discussion

The study found that over half (53.3%) of survivors were between 18-20 years old. This corroborated with literature which identifies and argues that younger women in late adolescence and early adulthood tend to be more vulnerable targets for sexual assault. Research has shown they encounter societal stigma, lack of sexual and reproductive health knowledge, dependence on families, and institutional barriers to accessing support (Andersson et al., 2020). This could be as a result that in patriarchal cultures, the autonomy and consent of late adolescent women are often disrespected which increases risk. As argued by (Abrahams, 2020) blame is more commonly directed at minor survivors in the aftermath by doubting their stories. The trauma of assault at a formative life stage also complicates time taken before reporting. To address this, community-based programs empowering youth and improving sex education are needed. The police and healthcare system must also be reformed through sensitivity training so consent laws are properly upheld and minor patients properly supported

In terms of educational qualifications, the study found that over half of survivors had attained secondary level education or higher. However, despite higher education levels, participants still experienced barriers to early medical care. This is supported by (Abrahams & Jewkes, 2020) who argued that sociocultural factors override knowledge levels in discouraging reporting. They brought out that societal and cultural norms often influence their perceived severity of the issue and the benefits of reporting. This means that interventions focusing solely on information dissemination through mass media or schools may not successfully reshape social norms that ostracize and disbelieve survivors Tackling stigma requires addressing its root causes like rape myths and gender inequality through community mobilization initiatives and open public discussions that promote supportive attitudes rather institutional campaigns hence education must work in tandem with grassroots activism to transform the broader traditional culture that enables victim-blaming attitudes.

The study found that most survivors (57.6%) identified as single. This showed that survivors without a partner or spouse may face amplified difficulties due to lack of familial emotional and practical support networks for reporting early. Research has shown lack of partner support is associated with poorer mental health outcomes for sexual assault survivors (Sabri 2020; Nkwi., 2018). It therefore emerged that there exists a level of importance of empowering women through avenues beyond just economic means, but also by strengthening independent support systems regardless of relationship status. Building coalitions between survivors through community outreach programs can help address isolation. Initiating open public dialogue to raise awareness of privacy rights and legal protections available could empower all women to overcome barriers. Additionally, educating social networks and clinical staff about the realities of surviving alone may encourage a more compassionate and accommodating response from formal and informal networks.

Interventions must consider how the high proportion of unmarried or formerly married survivors identified in this study - 57.6% single and 26.1% divorced / separated - face aggravated vulnerabilities to stigma and lack of allies. Targeted approaches are needed to offset challenges associated with inadequate family structures through social support strengthening and empowerment initiatives as survivors may desperately require validation.

The study findings revealed that the majority (78.3%) of survivors reported experiencing rape while (10.9%) indicated being victims of fondling or groping and attempted rape respectively. This is consistent with previous research that has found that attempted rape was mainly perpetrated by an acquaintance or someone familiar to the victim (Silverman et al, 2011). Knowing the perpetrator makes the assault more traumatizing as trust is violated (WHO, 2021). Survivors may fear retaliation from the perpetrator if they report the crime. They also worry about damaging relationships in their community or family if others find out about the assault (Uthman & Moradi, 2019). These fears can isolate survivors and deter them from seeking support (WHO, 2021). The emotional scars run deeper when the violation is committed by someone the survivor depends on or cares for. Feeling a lack of safety within their own homes and social circles further exacerbates survivors' distress unless assured of confidentiality and protection, survivors may choose to suffer in silence rather than risk irrevocably harming important bonds.

Rape was the most common form of assault experienced (78.3%), followed by fondling and groping (10.9%) and attempted rape (10.9%). This aligns with global trends showing rape as the predominant form of

sexual violence against women (WHO, 2019). Compared to other types of assault like unwanted touching, rape is an extremely violent and invasive form of violation that can cause considerable physical and emotional harm. Several aspects of the Health Belief Model help explain why survivors of rape may be more likely to perceive the need for medical care. Firstly, the severity of potential consequences is higher given the trauma sustained during a rape. Survivors know they are at significant risk of long-term infections requiring prevention and treatment, though not all are aware of the 72-hour timeline for effective prevention of HIV. The model also contends that individuals are more motivated when consequences are perceived as severe. As such, rape survivors may feel urgent pressure to seek care due to concerns over health impacts. Perception of threat is another central HBM construct - the forcible, non-consensual act of rape would understandably provoke enormous feelings of threat in survivors. Combined with effects of victim-blaming in some contexts, these underlying threats could diminish survivors' self-efficacy and control over the situation, heightening their perceived need for professional help and support services.

The most significant barrier reported was fear of stigma and judgment from the community (reported by 42% of survivors). This means that survivors often fear being blamed, disbelieved or disrespected by their community if their assault becomes known This aligns with previous research that found stigma surrounding sexual violence significantly deters survivors from reporting in many cultures (Chimbari, et al, 2019). Through internalizing stigma, survivors come to doubt their worthiness or right to support. Within the HBM framework, high perceived stigma can undermine survivors' self-efficacy to seek care 40 and reduce perceptions of benefits. The findings bring the need for public education to reduce stigma against survivors.

Lack of awareness about the importance of early reporting and available services was cited as a barrier by 33% of survivors. Research shows knowledge gaps widespread among survivors globally regarding timelines for care, STI / HIV prophylaxis and legal protections (WHO, 2021). Such information deficits directly impede care seeking as suggested in studies by Kamke, et al, (2023) using HBM. The findings imply the need for a targeted education to disseminate care guidelines set forth by organizations like WHO in 2021.

Moreover, the study found out that travel difficulties due to cost or distance to the clinic acted as a deterrent to 24% of peri-urban survivors. The study findings corroborated with the arguments by Mashamba et al, (2017) who argued that geographic and economic factors, especially in peri-urban areas are a factor that hinder survivors' access to healthcare facilities globally, this also relates to HBM. Survivors from lower socio-economic backgrounds may encounter additional barriers to seeking timely healthcare services. Factors such as financial constraints, lack of transportation, and concerns about work or childcare responsibilities can contribute to delayed health-seeking (Kearns, et al, 2018). This study highlights the need for innovative access solutions like those outlined in Okenwa et al, (2009) review of maternal health outreach models.

The study notes that the barriers to timely reporting identified in this study, including high levels of stigma, lack of awareness about post-assault care options and geographic isolation of rural communities, point to deep-rooted challenge confronting survivors. Each of these factors is rooted firmly within the sociocultural fabric of society and environmental contexts where resources are scarce. Overcoming their negative influence will require coordinated, thoughtful solutions that place survivors' needs and experiences at the forefront.

Public education must adopt nuanced approaches to transform stigma while disseminating critical health information widely yet sensitively. Awareness campaigns should empower survivors and promote compassion for their circumstances rather than judgement. Innovations in service provision also need to account for how social and rural environments shape access. Outreach models must come to survivors in their communities instead of relying on travel to distant clinics. Only through holistic, survivor-centered reforms addressing these entrenched socio-cultural and environmental realities will barriers to timely reporting begin to erode.

The study findings suggested the need for community awareness. These community campaigns were the most frequently suggested improvement by survivors (45.7%). This corroborates with public health literature which demonstrates that widespread sensitization is needed to educate communities about post-assault care options and normalize supportive attitudes for example Khakbazan, et al, (2020) conducted a study on the effect of education based on the HBM on the prevention of STDs in female victims of sexual assault. The study demonstrates the potential effectiveness of educational interventions as cues to action, empowering survivors with knowledge and prompting them to seek timely healthcare. This means that mass awareness campaigns could help address prevailing gaps in understanding crucial issues like timelines for prophylaxis or psychological support. However, lessons from literature emphasize the campaigns must utilize multi-channel approaches like print, radio and community forums to effectively disseminate information to all demographics including rural populations with limited access to technology. The campaigns should provide standardized content and be coordinated across organizations to ensure consistent messaging reaches the entire country. Public education has been shown to help reduce stigma according to studies by Abraham & Sheeran (2015) thereby encouraging more survivors to seek medical care without fear of judgement. If carefully planned and

continually evaluated for effectiveness, nationwide awareness programs could transform social norms over the long term to establish support as the normative response to sexual assault disclosures.

Furthermore, the study findings brought out that the increase in outreach to rural areas is significant for survivors of rape. This was recommended by 15.2% of survivors as some survivors would have been brought by relatives to urban areas and specifically the ARC, which is a specialized unit. It emerged that limited resources and geographic isolation pose challenges to connecting remote populations to care according to studies from developing nations (Mashamba-Thompson, et al, 2017). Outreach solutions such as mobile clinics proposed colleagues could help wind down barriers caused by long travel distances for survivors in rural Zimbabwe. Mobile services could provide basic medical care, counselling and referrals to local hospitals when needed. However, the sustainability of rural outreach models requires consideration of cost-effectiveness regarding equipment, staffing and maintenance of vehicles required to navigate poor road conditions. Partnerships may need to be formed between government agencies and charitable groups to share the financial responsibility of expanding healthcare into underserved farming communities. Regular evaluations of mobile programs would also help determine optimal service coverage across diverse regions.

The study findings revealed that lowering costs of transportation services can change or improve the time spend before reporting cases of rape by adolescents and young adults most of whom are out of school and unemployed. This was highlighted by 21.7% of survivors as the best strategy to facilitate early reporting. Affordability of travel remains a hindrance across settings according to previous work survivors from lower socioeconomic backgrounds may encounter additional barriers to seeking timely healthcare services. Factors such as financial constraints, lack of transportation, and concerns about work or childcare responsibilities can contribute to delayed health-seeking (Kearns, et al, 2018) This issue is particularly pronounced in the study where rural populations face difficulties in accessing specialized healthcare services such as the adult rape clinic. This means that there is need for an effective way to link survivors in remote areas to specialist medical and counselling services without incurring costs related to travel. While tele-medicine pilot programs show promise for improving accessibility, consideration must also be given to reliable internet infrastructure as well as training local community workers to appropriately support survivors through this virtual modality. Ultimately, adoption of the most contextually relevant and survivor-centered solutions will help address the transportation barrier highlighted by this study's findings.

Author Disclosure

The authors declare that there is no conflict of interest arising from this publication

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