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Factors Affecting Adherence to HIV Post-Exposure Prophylaxis among Victims of Rape and Defilement in Vihiga County, Kenya

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Abstract: ***Sexual assault, particularly rape and defilement, is a global public health problem. Vihiga County, with a high HIV/AIDS prevalence, reports high rates of these crimes. There is high HIV transmission risk after rape, necessitating HIV Post-Exposure Prophylaxis (PEP) use. However, most victims don't seek or complete the treatment. This study in Vihiga County, Kenya assessed PEP adherence among sexual assault victims and influencing factors. The research used a descriptive cross-sectional design at three healthcare facilities, focusing on victims seeking care in 2021. Data collection involved interviews with healthcare providers and a review of medical records. Analysis methods included percentages, tables, thematic analysis, Pearson's Chi-square test, and simple linear regression.74.4% of victims were under 19, with 68.3% being adolescents (10-19). Victim age significantly affected PEP adherence (p = 0.018). PEP adherence was positively associated with drug side effects, pill burden, and lost follow-up (p < 0.001). Adherence barriers included side effects, pill burden, stigma, lack of support, and service coordination issues. Adolescents and school-going children were at higher risk of both sexual assault and PEP non-compliance. Study recommended promotion of post-rape care and PEP awareness in schools and communities and development of low-side-effect PEP regimens, preferably a single-dose option.***

Keywords: Sexual assault, HIV PEP, Adherence

1. Background

Sexual assault ranks among Kenya's top 10 risk factors for disease burden [1]. National statistics show that 13% of women and 7% of men aged 15-49 have been sexually assaulted [2]. Reported national prevalence is even higher among children and young adults, with 62.6% of females reporting having experienced some form of sexual violence during their childhood [2]. According to the 2020 National Crime Research Centre report, Vihiga County has one of the highest prevalence of defilement (40.8%) and a relatively higher [3] prevalence (7.9%) of rape too [3]. Despite the county efforts to control the vice, the area still reports an average of five defilement and incest cases each day [4], [5].

Sexual assault violates human rights, leading to stigma, psychological trauma, and physical injuries [6]. It also increases the risk of unplanned pregnancies, psychological issues, and sexually transmitted diseases, including HIV/AIDS[7]. High sexual assault rates are associated with HIV prevalence [8]. Vihiga County is one of Kenya's top 10 counties with the highest prevalence of HIV/AIDS[9]. As a result, there may be a high risk of HIV transmission following sexual assault in the area.

HIV Post-Exposure Prophylaxis (PEP) is recommended by WHO to reduce HIV transmission risk after sexual assault [10], [11]. PEP use began in western Kenya in 2001[12]. Gender-Based Violence Recovery Centers (GBVRC), hospitals and specialized clinics that offer healthcare, counseling, support, and HIV testing play a vital role by providing counseling, education, PEP treatment and other post-rape services. However, PEP utilization remains a concern, with many victims not seeking healthcare [13] or completing treatment [14].

PEP adherence rates vary by exposure type. However, the limited available data reveals that the rates are generally low (57%) for all populations [7] and lowest (below 35%) for adolescents and individuals who have been sexually assaulted [14]–[17]. Completing the full 28-day course PEP treatment is essential for its effectiveness [18].

Limited data exists on why many rape victims in Kenya do not complete PEP treatment, or why some are not initiated on therapy even after hospital visits [19]. According to a few studies, factors like financial constraints, limited resources, lack of knowledge, and forgetfulness may all be contributing factors [7], [15], [17], [20], [21]. According to resources, a lack of training in sexual violence management, poor service coordination, inadequate referral protocols, expenses for survivors, stigma, and a lack of active follow-up, side effects population-level data, individual characteristics like age, marital status, residence area, occupation, education level, and whether or not one has been assaulted both sexually and physically may affect the extent to which someone seeks help for sexual violence from formal or informal sources [22].

To tailor the intervention to change and promote healthcare-seeking behaviors and treatment adherence of victims of rape and defilement in Vihiga County, Kenya, a better understanding of the reasons many victims refuse or default PEP treatment is required. Little is known about the traits of rape victims who are most likely to refuse PEP treatment, default, or not access post-rape care services in Kenya. Therefore, the perspectives and views of post-rape care service providers are key to understanding the gaps in care for victims who seek medical care. This study, therefore, sought to understand the rates of adherence to HIV PEP in victims of sexual assault belonging to different age groups and the factors that affect them.

2. Methods

Setting
The study was conducted in three facilities in Vihiga County, Kenya: Emuhaya sub-county hospital, Hamisi sub-county hospital, and Vihiga County Referral Hospital. Vihiga County is in the western part of Kenya, with five sub-counties: Emuhaya, Luanda, Sabatia, Hamisi, and Vihiga. Emuhaya sub-county hospital serves its sub-county and Luanda, Hamisi sub-county hospital serves its sub-county and Sabatia, and Vihiga County Referral serves Vihiga Sub-county. The county has a population of 590,013 as per the 2019 Census and covers an area of 563 square kilometers [23].The target population included all victims of rape and defilement who had sought post-rape care services in the selected facilities in the period of one year prior to the commencement of the study.

Design
The study adopted a descriptive, cross-sectional design using both quantitative and qualitative data collection methods. Quantitative methods included a retrospective review of the medical records of rape and defilement victims who had accessed post-rape care services one year prior to the commencement of the study. Qualitative methods included in-depth interviews with professional health care providers with experience in providing care to victims of rape and defilement.

Data Collection and Analysis
The study used both primary and secondary data collection methods. Primary data was gathered through in-depth interviews with 12 healthcare providers (4 from each facility, including counselors, social workers, clinical officers, and nurses directly involved in victim care and follow-up). Secondary data was obtained by retrospectively reviewing hospital records in the three study hospitals, including Post Rape Care (PRC) forms, counselor and departmental records, sexual and gender-based violence (SGBV) registers, pharmacy records, and DHIS2 data. In total, 164 entries of rape and defilement cases from the year preceding the study were abstracted for analysis.

Field data were coded and analyzed using Statistical Package for Social Sciences (SPSS version 22). The information collected from the Key Informants was arranged and analyzed using a thematic analytical approach. Presentation of results was done through frequency tables and percentages. Pearson's Chi-square for goodness of fit test and simple linear regression analysis were carried out to test for relationships between variables.

Ethical Approval
The study received authorization from the Jaramogi Oginga Odinga University of Science and Technology's postgraduate board, ethical approval from the Jaramogi Oginga Odinga Teaching and Referral Hospital Institutional Ethics Review Committee (JOOTRH IERC), and a research license from the National Commission for Science, Technology, and Innovation (NACOSTI). Additionally, permissions were obtained from the county director of health and relevant hospital authorities.

3. Study Limitations

Financial Constraints: The self-sponsorship of the researcher occasionally slowed down research activities, particularly data collection in the field. However, despite these constraints, the process eventually proved successful.

Data Tracking Difficulty: Given the study's nature and data sources, tracking records from survivor registration to their final visit was time-consuming. The lack of complete documentation posed challenges in analyzing hospital data. Multiple data sources were used to address gaps.

Key Informant Suspicions: During interviews, key informants expressed suspicions that the study aimed to expose post-rape service providers' failures. To allay concerns and ensure unbiased information, detailed explanations clarified the study's intentions, satisfying respondents.

Limited Generalizability: The study was conducted in three hospitals in Vihiga County, potentially limiting its representativeness for the entire country. Data relied on documented self-reports and provider accounts, making generalizations to the broader Kenyan population of sexual assault survivors cautious.

Small Sample of Healthcare Professionals (HCPs): While the number of interviewed HCPs was limited, they were carefully selected for their expertise in caring for sexual violence survivors. This focused approach may have constrained qualitative data but provided valuable insights.

Overall, these challenges were managed to ensure the study's success and gather meaningful insights into the subject matter.

4. Results

Socio-demographic characteristics of the victims
The majority, 160 out of 164 (97.6%) were female. The mean age was 19 years, with the majority (68.3%) being adolescents (10-19 years). The majority of the victims were single 126 (76.8%), followed by married 25 (15.2%), separated 8 (4.9%) and widowed 5 (3.0%).

The majority of the victims, 126 out of 164 (76.8%) were school going (primary and secondary schools). Most, 106 out of 164 (64.6%), of the victims knew the perpetrators. Close relatives 39.6%, boy/girlfriends 5.5% and neighbors 7.3%, were among the most common known perpetrators.

The socio-demographic characteristics of the victims are summarized in the table 1.

The Prevalence of Defilement and Rape across Age Groups
Almost three quarters of the victims (74.4%) were aged 19 years and below with age group 10-19 years (adolescents) taking 68.3% and 0-9, 6.1%. In other words, the highest prevalence was observed in adolescents. Find the summary of the results in table 2.

PEP Adherence Rates across Age Groups

Out of the 164 victims, 100 of them (61%) were initiated on HIV PEP Treatment. The remaining 64 (39%) were not given the treatment. From the 100 victims given HIV PEP treatment, **only 20** of them **(**20%) completed the treatment. 80 (80%) did not complete PEP treatment. Age group 10-19 had lowest PEP completion rate (15.3%) followed by 0-9 years with a completion rate of 20%, 20-49 with 22.2% and finally 50+ with 62.5%.Table 3 shows the summary of PEP adherence rate of the victims at different ages.

Table 1: Socio-demographic Characteristics

Gender	Frequency	Percent (%)
Male	4	2.4
Female	160	97.6
Total	164	100
Age in Years		
0-9	10	6.1
10- 19	112	68.3
20- 49	31	18.9
50+	11	6.7
Total	164	100
Marital Status		
Single	126	76.8
Married	25	15.2
Widowed	5	3.1
Separated	8	4.9
Total	164	100
Occupation		
Pupil	76	46.3
Student	50	30.5
Others	38	23.2
Total	164	100
Perpetrator		
Close Relative	65	39.6
Boyfriend/Girlfriend	9	5.5
Neighbor	12	7.3
Unknown	58	35.4
Other known	20	12.2
Total	164	100

Table 2: Rape Prevalence

Age in Years	Frequency	Percent (%)
0-9	10	6.1
10-19	112	68.3
20-49	31	18.9
50+	11	6.7
Total	164	100.0

Table 3: PEP Adherence Rate

Age Groups in Years	Completed PEP		Total	Completion Rate (%)
	No	Yes		
0-9	4	1	5	20.0
10-19	**66**	**12**	**78**	**15.3**
20-49	7	2	9	22.2
50+	3	5	8	62.5
Total	**80**	**20**	**100**	**100.0**

The Pearson Chi Square test indicated a significant association between age and PEP treatment adherence (p = 0.018).

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	10.097[a]	3	.018
N of Valid Cases	100		

Factors Contributing to Low Pep Adherence

Several factors affecting PEP treatment completion among victims of rape were identified through in-depth interviews and informal conversation with post rape service providers and review of victims' medical records.

Quantitative Findings on barriers to PEP treatment Adherence

According to the medical records, victims who had at some point defaulted had earlier complained of the treatment side effects and pill burden. Majority, 42 (52.5%) didn't have complains documented anywhere in their medical records but were documented as lost follow-ups. To mean they defaulted care and the care providers couldn't reach them or didn't follow up. Majority, 30 (37.5%) had complained of adverse treatment side effects and a few, 8 (10%) had pill burden (many pills) documented as a challenge.

Barriers to PEP Completion

	Frequency	Percent (%)
Treatment Side Effects	30	37.5
Pill Burden	8	10.0
Lost follow-up	42	52.5
Total	**80**	**100**

A logistic linear regression indicated a significant relationship between these factors and PEP treatment adherence ($p<0.001$).

Analysis of Variance (ANOVA) Results

Model	Sum of Squares	df	Mean Square	F	Sig.
Regression	14.964	3	4.988	462.425	<0.001

Qualitative Findings on Services Barriers to Treatment Adherence

The perspectives shared by healthcare providers (HCPs) in the in-depth interviews served provided insights into the underlying reasons for the observed low PEP treatment adherence.

Factors leading to low HIV PEP adherence, revealed in interviews and informal conversations with healthcare providers, encompass service coordination issues, treatment side effects, stigma, resource constraints, trauma, knowledge gaps, denial, cultural/spiritual beliefs, and lack of active follow-up.

Limited Resources

Availability and accessibility of post-rape services emerged as a key concern, encompassing medication, enough equipment, trained providers, transportation, and counseling services.

Trained providers were lacking, with only a few adequately trained staff members in each department. Even though children were common victims, none of the healthcare providers were trained to care for child survivors.

"Continuous medical education and workshops are essential for all healthcare workers to handle sexual violence cases effectively. Relying on one trained colleague isn't sustainable. We should all receive proper training." (Professional healthcare provider, HCP1)

A shortage of essential equipment like speculums and rape kits hindered comprehensive care, impacting specimen collection and treatment. Limited HIV test kits prompted survivors to seek testing elsewhere.

"At times, we have a shortage of HIV test kits, and currently, I am the only one who has them. Since I only have a limited number, if other counselors need to perform tests on survivors, they must request them from me. Unfortunately, we sometimes run out of test kits, and in such instances, we advise survivors to get tested elsewhere and bring their results to us." (Professional healthcare provider, HCP2)

This scarcity of equipment and skilled personnel led to treatment delays and wait times, restricting the level of care that could be given to survivors.

Stigmatization

Stigma greatly influences health-seeking behavior, particularly among male victims of sexual violence. Men are underrepresented among those seeking treatment due to fear of social stigma and how others will perceive them. Only 4 out of 164 reported rape cases were male victims (2.4%). Healthcare providers acknowledge that male victims exist but often remain silent due to this stigma.

"Male victims are there, but they often don't speak out about their experiences due to the social stigma and the concern about how others will perceive them. And for that reason they don't show up for care and treatment" (Professional Health Care Provider, HCP5).

Stigma is also a significant barrier to PEP uptake and adherence for adult female survivors. Victims often face blame, both self-inflicted and from society, leading to reluctance in seeking medical care and taking medication. Certain occupations, clothing choices, and cultural values contribute to victim-blaming and stigma.

"Victims of sexual violence are often blamed for what happened to them, and this stigma can be really hard to deal with. Some victims are afraid to seek medical care because they worry about being judged or mistreated." (Health Care Provider, HCP6).

Many rape victims, particularly from underprivileged backgrounds and specific communities, delay seeking medical attention due to cultural factors and lack of education about sexual and reproductive health rights. This delay in seeking care can result in ongoing abuse and underreporting of sexual violence cases.

To address these challenges, healthcare professionals emphasize the importance of community awareness campaigns. These campaigns aim to reduce stigma, inform individuals about available services, and stress the significance of seeking and completing treatment after sexual assault.

"It is important to increase awareness among people so that they don't feel embarrassed about seeking medical help after experiencing sexual assault. Although there may not be a strong social stigma surrounding it, there are still some cultural beliefs that make it uncomfortable for people in rural areas, especially those who come from urban backgrounds. To address this issue, community health workers could initiate campaigns to educate people and promote awareness about the importance of seeking medical attention after a sexual assault" (Professional healthcare provider, HCP10).

Poor Coordination of Services

Poor coordination of services negatively impacts PEP uptake and adherence. Delays in accessing care, long waiting times, inadequate patient-staff interactions, and subpar service quality hinder victims from returning for follow-up appointments. These factors, compounded by compromised privacy and confidentiality, discourage victims from seeking post-rape care.

"Some victims are afraid of coming back for follow-up because they missed one of the visit appointments fearing they will be scorned by the service providers. In addition to this, the departments responsible for offering post-rape services do it in a manner that compromises the privacy and confidentiality of the victims." (Professional Post-rape care Provider, HCP11).

Hospital facilities also pose challenges. Victims are often treated in different locations across the hospital complex, leading to confusion and cases of victims getting lost.

Despite hospital policies prioritizing rape and defilement victims, they still experience long waiting times due to clinicians' busy schedules and departmental delays. This further deters victims from seeking timely care.

"The problem of timeliness persists because we are not observing the desired speed in attending to patients. There may be various reasons for delays, such as the victim needing to see a clinical officer who may be busy with another patient. Additionally, there are occasional delays in the lab." (Professional healthcare provider, HCP8).

Denial and Lack of Support from Families and Friends

Denial and lack of support contribute to low PEP adherence. Victims may struggle to accept what happened, blame themselves, or lack emotional, financial, and practical support from their families and friends.

"Some patients don't want to believe that they were raped or defiled. They may try to ignore what happened or blame themselves. This can make it hard for them to seek medical care and stick to the treatment plan." (Professional healthcare provider, HCP7).

"Some patients don't have enough support from their families and friends, which can lead to denial and reluctance to take PEP. Some even lack the transport to present

themselves to the facility in time and come for follow up visits" – Post-rape Service Provider (HCP4).

Pill Burden and Treatment Side Effects

Some of the interviewees identified pill burden and adverse side effects of PEP treatment as contributing factors to low PEP adherence. This includes the fear of experiencing adverse side effects, the complexity of medication regimens, and the length of treatment.

"Some of the patients we have seen find it hard to take the post-exposure prophylaxis drugs as prescribed because of the side effects. Some of them experience nausea and vomiting, which makes it difficult to adhere to the treatment regimen." (Professional healthcare provider, HCP6).

"Some of the patients fear taking the medication because of the side effects and the burden of taking the medication for a long time which keeps reminding them of what happened when they just want to forget about it" – Post-rape Service Provider (HCP2).

Lack of Active Follow Up

Effective follow-up of sexual assault victims is essential for PEP adherence. According to most respondents, the hospitals lacked a structured approach to monitor the recovery of patients and ensure they finished their treatment, resulting in only 20% of the victims returning for follow-up care. Healthcare providers emphasize the need to involve community health workers for better community-level follow-up.

“I believe that community involvement is crucial for successful patient follow-up. As a clinician, it is difficult to keep tabs on every patient without a specific interest or desire to do so. Even for general patients, I often lack knowledge about their progress unless I have a particular interest in their case.” (Professional healthcare provider, HCP12).

Lack of Knowledge and Training about Post Exposure Prophylaxis

The interviewees reported that lack of knowledge and training about post-exposure prophylaxis was a significant issue and a barrier to PEP adherence. This was attributed to inadequate training awareness on the use and importance of post-exposure prophylaxis drugs, leading to low levels of awareness among victims of rape and defilement.

"Sometimes, even the patients don't know what PEP is or why it's important, and this makes it difficult for them to adhere to the medication regimen" - Service Provider (HCP11).

Trauma

The impact of trauma on survivors was identified as a key factor contributing to low PEP adherence. This includes mental health issues such as depression and anxiety, as well as physical health problems such as pain and fatigue.

"Victims of rape and defilement are dealing with a lot of trauma, both physical and emotional. This can make it hard for them to keep up with the medication regimen, especially if they are also dealing with mental health issues like depression or anxiety." (Professional Post-rape care Provider, HCP10)

Spiritual Beliefs

Spiritual beliefs can discourage medical care and medication adherence. Some patients stop treatment, believing they've been spiritually healed.

"Some patients rely on spiritual healing instead of conventional medical treatment. We have seen cases where patients stop taking the drugs after feeling better because they believe they have been healed spiritually and are protected by God or a certain supernatural power against any disease." - Post-rape Care Provider (HCP6)

Culture of Silence

Society tends to blame and force silence on victims of rape and defilement by shaming them for what was done to them. For instance, if a child accuses a relative, neighbor or a teacher of defilement, she is called a liar and asked to stop “tarnishing” the perpetrator’s image or she is asked to remain silent about it so as to avoid bringing shame to the family if the abuse becomes known to the public.

“Some victims do not come for follow- up visits because they’ve been asked by their family to remain silent about what happened so as not to “air their dirty laundry in public”. So they don’t want to be seen visiting the hospitals because it will be suspected and people may ask about it.” (Post-rape care Provider, HCP6)

5. Discussions

The results suggest a high prevalence of defilement and rape among individuals aged 10-19 years (adolescents). This aligns with other studies indicating similar patterns globally. The findings back reports that over 68% of school-aged children experienced coerced sex[23]. Furthermore, data supports the idea that individuals aged 12-19 are most susceptible to rape[24], contrasting with those aged 50 and above, who had the lowest prevalence at 6.7%. This corresponds with statistics showing older individuals are less likely to be victims of sexual assault[25].

PEP Adherence Rate across Age Groups

Our study findings indicate that 61% (100 out of 164) of victims were initiated on HIV PEP treatment, consistent with similar studies reporting initiation rates ranging from 57% to 95%[17], [26]–[28]. Around 39% (64 victims) were not put on PEP, with 75% of them presenting after 72 hours, mostly being children and adolescents. The remaining 15% presented themselves to the health facilities within 72 hours but didn’t have clear reasons documented for not being put on HIV PEP. This is concerning given Kenya's 6% HIV prevalence [29] and the heightened risk from sexual assault [30].

Among the 100 initiated, only 20% completed the PEP treatment, reflecting low adherence rates as per other studies [16], [20]. The youngest group (10-19 years) had the lowest adherence at 15%, agreeing with the findings that PEP completion rates are especially poor in adolescents who have

experienced sexual assault [7]. Those aged 50+ had the highest at 62.5%, supporting other studies that have found older people more likely to start and adhere to PEP treatment [19], [31].

The Pearson Chi Square test confirmed the significant relationship between age and PEP adherence. Despite many victims being under 19, over 90% of child/adolescent victims, per the Violence Against Children Survey, don't seek medical help, with some arriving too late for necessary care, emphasizing the lasting effects of sexual violence on minors [32].

Factors Contributing to low PEP Adherence

Treatment side effects and pill burden (daily tablets for 28 days) was one of the identified barriers to PEP treatment completion., with nearly half of non-completing victims citing these issues . Logistic regression affirmed the link between side effects/pill burden and completion. Qualitative input from healthcare providers echoed this, emphasizing side effects as a significant concern for victims. This aligns with a Ghana study where adverse events were the primary reason for stopping PEP among exposed healthcare workers [33]. [7], [16] similarly found medication side effects hampering HIV PEP completion.

Another significant challenge to PEP adherence was losing follow-up. Our data indicated that over half of non-completing victims were lost to follow-up, implying they discontinued care and didn't return. This is consistent with a Nigerian review reporting extremely low follow-up rates in patients seeking nPEP, including rape victims[34]. While there was no documented reason for this issue or details about service provider follow-up, qualitative insights pointed to various factors contributing to victims becoming lost follow-ups. Stigma, trauma, side effects, limited resources, spiritual beliefs, coordination challenges, lack of support, survivors' PEP knowledge gaps, and inactive follow-up were identified as factors leading to high lost follow-up rates.

Poor coordination of post-rape services led victims to miss follow-up visits and default on care, as per key informants. Long waits, weak patient-staff interactions, and referral issues were challenges noted. Delayed counseling due to waiting in hospital corridors caused stigma and hindered victims' mental well-being. Some faced difficulties with healthcare providers over missed appointments or minor mistakes. Scorned, they feared returning, leading to disappearing act.

For comprehensive care, collaboration among healthcare providers, justice, and social services is crucial, aiming to retain survivors [35]. Sadly, this has been undermined, seen not just in this study, but in others like [19] work on barriers to comprehensive treatment for sexual violence survivors in Kenya.

Qualitative data suggests improving hospital services and enhancing healthcare provider skills through training due to limited resources and untrained staff. The World Health Organization recommends training for healthcare professionals attending to rape survivors, covering clinical care, legal guidelines, ethics, confidentiality, and reporting [11]. However, interviews showed few professionals received such training for sexual violence care. Particularly, training is lacking for child and adolescent victims despite their majority. Specialized services and an adapted approach are needed for these groups, given their unique needs [30]. Our quantitative data also revealed incomplete documentation, hindering clinical management.

Our findings align with Wangamati's 2020 case study, highlighting that Kenyan healthcare professionals lack essential skills for minor sexual assault victims' care[36]. Training more providers is necessary to ensure prompt and quality care for rape and defilement victims.

Lack of knowledge contributes to low PEP adherence rates. Qualitative data shows most rape and defilement victims lack information about PEP administration, its importance, and how it works. A study by Aminde et al. (2015) on medical students' awareness in a high endemic setting aligns with our findings [37]. This knowledge gap extends to different regions [7], [38]–[40], emphasizing the urgent need for widespread HIV PEP training and awareness.

Stigma also impedes HIV PEP acceptance and continuity, echoed by Gatuguta et al. study [19]. Stigma surrounding rape and antiretroviral drugs leads some to fear seeking medication publicly, especially when confidentiality is compromised. Blame-shifting culture further hinders victims' health-seeking behavior, impacting even healthcare workers' treatment. This stigma-driven dynamic often causes victims to disappear from care.

6. Conclusion

This study identifies several factors and characteristics independently associated with PEP treatment adherence after rape. These factors and characteristics can pinpoint patients at risk of low compliance and guide targeted interventions. Treatment side effects, pill burden, lack of follow-up, stigma, and limited resources were key adherence barriers. Adolescents and school-going children faced both rape risk and PEP non-compliance. In conclusion, community awareness, support, trained staff, and active follow-up care are vital for boosting adherence to HIV PEP among rape and defilement victims.

The study **recommends** the following:

- Raise awareness in schools and communities about post-rape care and proper PEP utilization.
- Collaboration of the Ministry of Health and WHO to develop single-dose PEP regimens with milder side effects.
- Train all personnel interacting with rape survivors to handle cases comprehensively, including psychological and social aspects.
- Assess and enhance the effectiveness of girl child and women empowerment programs in the region.

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