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KNOWLEDGE, ATTITUDE AND PRACTICES TOWARDS THE USE OF POST-EXPOSURE PROPHYLAXIS AMONGST BAR ATTENDANTS AGED 18 TO 35 YEARS IN KAJJANSI TOWN COUNCIL. A CROSS-SECTIONAL STUDY.

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Abstract.

Background.

Post-exposure prophylaxis (PEP) is recommended for HIV-negative persons at high risk of acquiring HIV after occupational or non-occupational HIV exposure. Bar attendants are a risk group for HIV/AIDS due to risky lifestyles such as alcoholism, smoking, rape, and commercial sex. This study aimed at assessing knowledge, Attitude, and Practices towards the use of post-exposure prophylaxis amongst bar attendants aged 18 to 35 years in Kajjansi Town Council.

Methodology.

A descriptive cross-sectional design was used, involving the quantitative method of data collection using a snowball nonprobability sampling technique to select the study sample. All persons, aged 18+ years who attended bars in the town at the time of the study were included. Data was collected on a daily basis for 7 days and this was from bar attendants in Kajjansi Town Council.

Results.

Majority of respondents were males 92(92%), 35[35%] of the participants were aged between 25-31, (40%) of the respondents were single. 78 (78%) of participants reported having heard about PEP, and 13 (16.7%) of participants correctly identified occupational exposure as a reason for using PEP. Regarding the attitude, 60 (76.9%) reported that they believe PEP is safe for use, 54 (69.3%) of the participants believed that PEP can prevent HIV/AIDS. Concerning the practices, 42(53.8%) of the participants reported a history of PEP usage and 21(50.0%) of the participants said they obtained PEP from hospitals.

Conclusion.

Most of the participants had good knowledge about PEP as they very well knew the indications for PEP but had less information about the duration and the exact timing of utilization of PEP.

Recommendation.

Policymakers should consider public sensitization and awareness Campaigns as a cause to implement the HIV/AIDS reduction and prevention strategies.

Keywords: *Post-Exposure Prophylaxis, Kajjansi Town Council, Bar Attendants Aged (18-35), Knowledge Of Pep Use.*
Submitted: *2024-09-22* ***Accepted:*** *2024-11-29*

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Background.

Post-exposure chemoprophylaxis can prevent human immunodeficiency virus (HIV) infection in risk healthcare workers; however routine adoption of these practices by the workers has been limited. Acquired Immune Deficiency Syndrome (AIDS) is one of the most serious public health problems costing the lives of many people, particularly in sub-Saharan Africa where even healthcare workers (HCWs) are affected and at risk.(Chauhan et al., 2019)

Globally an estimated 37 million people are living with HIV amidst intense and continued response to the pandemic HIV continues to spread. According to WHO, globally 33.9-43.8 million people are living with HIV. An estimated 0.7% (0.6-0.8%) of the adults aged 15-49 years worldwide are living with HIV although the burden of the epidemic continues to vary considerably between countries and regions with Eswatini having the highest HIV rate at 19.58% followed by Lesotho at 18.72% and Samoa is one of the most fortunate countries with the smallest number of HIV cases reporting

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ONLY 12 cases, with Saudi Arabia and Afghanistan being reported to have the lowest prevalence of the disease among reported nations at approximately 0.01% of their populations respectively.

According to WHO, the African region is the most affected region with 25.7 million people living with HIV by the year 2018. The African region also accounts for almost two-thirds of the global total of new HIV infections. African countries such as Botswana, South Africa, and Namibia have a high prevalence of 15.75%, 14.75% and 8.9% respectively. A secondary analysis from the Rwanda AIDS Indicator & HIV Incidence Survey (2013-2015) showed that recent PEP recipients (those who received PEP in the 12 months before the survey): Had 6.5 times higher odds of being HIV positive than non-recipients. (Report, 2012).

The prevalence of HIV among adults aged 15-64 in Uganda is 6.2%-7.6% among females and 4.7%among males. This corresponds to approximately 1.2 million people aged 15-64 living with HIV in Uganda (Bhattacharya et al, 2022). Uganda for the period of 2010 to 2020 recorded a tremendous improvement in the fight against the HIV/AIDS epidemic. It is among the Eight countries in the world that had fully achieved the 90-90-90 targets by the end of 2020, the others being Eswatin, Switzerland, Rwanda, Qatar, Botswana, and Malawi. (UNAIDS, 2021)

According to the Uganda MOH Estimates 2020, 37% of all the new HIV infections were among young people aged 15-24 years with 79% of these new HIV infections among young women. 29% of all new infections by adolescent girls and young women despite representing just 10% of the total population. From the special interest groups, a total population of 130,000 sex workers, the prevalence of HIV is 31.3% with 65% ART coverage and only 69.4% condom use. (Yumbe, 2021)

HIV/AIDS remains one of the major Epidemics in Uganda with the number of people living with HIV/AIDS increasing from 1.2m to 1.4m (MOH Estimates 2020) and this figure contributes to a global burden of 37m people living with HIV/AIDS. Among the high-risk groups for HIV/AIDS are the Bar attendants comprising a youthful population with so many risk factors for unsafe and risky sex due to lifestyle and risky behavior. This group of people is therefore eligible for PEP (Report, 2012). Post Post-exposure prophylaxis (PEP) currently is the only way to reduce the risk of HIV infection in individuals exposed to the virus. Currently, there is limited data on PEP in Sub-Saharan Africa. In Uganda PEP is generally offered for occupational exposure (Musomba et al., 2016).

Data from animal studies suggest that the efficacy of post-exposure prophylaxis in preventing transmission is time-dependent (Sultan et al., 2014), and every effort should be made to provide post-exposure prophylaxis as soon as possible following exposure. Although some studies reported favorable knowledge about PEP, there remains a knowledge gap among healthcare workers. In Cameroon, 73.7% and in Zimbabwe, 65% of HCWs had poor knowledge. Similarly, inadequate knowledge of PEP is up to 83.9% among HCWs in Ethiopia. Furthermore, among the exposed respondents, 81.6% did not use PEP; 33.8% of whom did not use PEP because of lack of information (Eticha & Gemeda, 2019a).

Kajjansi Town Council being a very busy town in the central region found in Wakiso district one of the districts with a high prevalence of HIV/AIDS yet with so many nightclubs and bars with a high population of bar attendants provided a good study area. According to the MOH, Wakiso has a prevalence of 8.0% compared to the national prevalence of 6.2%.

Despite the efforts by the MOH to scale up the availability, accessibility, and use of PEP, more new HIV infections are occurring weekly, and currently, there is no documented data regarding PEP knowledge among bar attendants in Kajjansi Town Council. Post-exposure prophylaxis (PEP) is recommended for HIV-negative persons at high risk of acquiring HIV after occupational or non-occupational HIV exposure. Bar attendants are a risk group for HIV/AIDS due to risky lifestyles such as alcoholism, smoking, rape, and commercial sex. This makes them eligible for PEP to reduce the number of new HIV infections. Therefore, this study aimed to assess knowledge, Attitude, and Practices towards the use of post-exposure prophylaxis amongst bar attendants aged 18 to 35 years in Kajjansi Town Council.

Methodology.

Study design.

A cross-sectional descriptive study design was used. This design aimed at quantifying the distribution of certain variables the study population had at one point in time. A descriptive study was adopted because it allows to description of the distribution of one or more variables, without regard to any causal or other hypothesis. In addition to that, a cross-sectional descriptive study design involves the collection of information on the presence or level of one or more variables of interest

as they exist in a defined population at one particular time. In respect to this study, the health characteristic of the use of post-exposure prophylaxis amongst bar attendants.

Study area.

The study was conducted in Kajjansi Town Council town. The township is situated on the tarmacked, all-weather Kampala - Entebbe Road. Kajjansi Town Council is located approximately 16 kilometers (9.9 mi), by road, south of Kampala, Uganda's capital and largest city. This location is approximately 25 kilometers (16 mi), by road, north of Entebbe International Airport, Uganda's largest civilian and military airport. The coordinates of Kajjansi Town Council

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are:0°12'54.0"N, 32°33'00.0"E (Latitude:0.2150; Longitude:32.5500). Country: Uganda.

Study population.

The population for this study was made up of 133 respondents who were bar attendants in Kajjansi Town Council aged 18 to 35 years. This category of respondents was chosen because they are a youthful community at risk of heterosexuality but not limited to occupational contraction of HIV with the need of usage of PEP. This population enabled the researcher to obtain the necessary data that was required for this particular study.

Sample Size Determination.

The sample size of the study was determined using Slovin's Formula. With regard to the level of accuracy, a confidence level of 95% means that there are 95 chances in 100 (or .95 in 1) that the sample results represent the true condition of the population within a specified precision range against 5 chances in 100 (or .05 in1) that it does not (Res, 2018).
This formula was adopted because it is a random sampling technique formula to estimate sampling size. The sample size was therefore calculated using the formula.
(Res, 2018)
Where;
n is the number of samples
N is the total population
e is the error of margin equivalent to 0.05
For this study, N was 133 giving us a sample size of 100 respondents.

Sampling technique.

The study employed a simple random sampling technique to select the study population. Simple Random Sampling is defined as the method of selecting a sample, in which the sample is selected unit by unit, with equal probability of selection for each unit at each draw. (Noor & Tajik, 2022). This technique was adopted because it allowed a test with a large number of participants which eventually led to precise generalizable results. It was preferred to other techniques because it ensured that each member of the target population had an equal and independent chance of being included.

Sampling procedure.

The study employed a snowball nonprobability sampling procedure to select the study sample. It was preferred to other techniques because it allowed new units to be recruited by other units to form part of the sample since the bar attendants should by law be above 18 years of age, they also associate and can easily be traced from one bar to another giving a range of views. The population also was more prone to HIV infection and may need to take up the PEP due to the modes of fast infections they are prone to.

Data collection method.

The survey method was conducted on bar attendants above 18 years of age. This method was used to collect Primary Data by use of questionnaires with both closed and open-ended questions. A questionnaire was used due to its ability to collect a large amount of information in a reasonably quick period and economical manner. Closed-ended questions were part of the questionnaire to capture data consistently. This was because closed-ended questions can be more specific, thus more likely to communicate similar meanings and questions to the respondents. (Coll et al., 2013).
The questionnaire obtained information on demographics and the use of post-exposure prophylaxis amongst bar attendants in Kajjansi Town Council town. The study tool was preferred because data was to be collected for a short period from all study participants. (Coll et al., 2013)

Data collection Instrument.

A structured questionnaire was used.

Data collection procedure.

Before collecting data, all ethical and cultural issues were considered like freedom from harm and respect for human dignity. Firstly, permission was sought from the Mild May Institute of Health Science. Thereafter, permission was sought from the local chairperson LC3 and the mayor. The study team introduced themselves and explained the purpose of the research to the study participants to ensure that they clearly understood the purpose of the study. Each study participants were interviewed for about 20-25 minutes. The respondents were asked questions following the interview guide. For those who were not able to understand English; the questions were translated into the local language.

Study variables.

The study variable in this study was Knowledge, attitude, and practices towards the use of post-exposure prophylaxis amongst bar attendants in Kajjansi Town Council.
The use of post-exposure prophylaxis was the dependent variable.

Quality control.

Pretesting of research tools.

A pilot study was carried out among a few members of the population to assess validity and reliability. The questionnaire was reviewed by colleagues and my supervisor in the town and any adjustments were made.

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Training of research assistants.
Assistants were subjected to tests so that they fully understood their roles.

Giving ample time for data collection.
Buffer time was included to cover delays that might come up during the process of data collection.

Inclusion.
All persons, aged 18+ years who attended bars in the town at the time of the study and those willing to take part in the study were included after obtaining consent.

Data analysis and presentation.
Data was analyzed manually by simple tallying and addition, and later data was entered in Microsoft Excel to generate tables, pie charts, and bar graphs.

Ethical consideration.
Before the collection of data for the study, written permission was obtained from the Mild May Institute of Health Sciences to the Kajjansi Town Council town mayor's office. An introductory letter from Mayor Kajjansi Town Council town was shown to the registered bars who agreed to collect data.

Results.

Table 1 Showing Participants Social Demographic Characteristics. N=100

Variable	Variable options	Frequency(N100)	Percentage (%)
Sex	Male	92	92
	Female	8	8
	TOTAL	100	100
AGE	18-25	22	22
	25-31	35	35
	32-38	20	20
	39-45	23	23
	TOTAL	100	100
RELIGION	Catholic	43	43
	Protestant	20	20
	Muslim	3	3
	Others specified	34	34
	TOTAL	100	100
LEVEL OF EDUCATION	Primary	17	17
	Secondary	24	24
	Tertiary	20	20
	None	39	39
	TOTAL	100	100

Source: Primary Data (2023)

Table 1 shows that the majority of respondents were males 92(92%). The age range (25-31), was mostly found in the bars 35(35%), and the other ranges as statically classified were 18-25; 22(22%), 39-45; 23(23%), 32-38; 20(20%). Most of the participants were Catholics 43(43%) attributed to the freedom of alcohol from the religion and the minority only 3(3%) were Muslims. Most of the bar attendants in Kajjansi Town Council had not attained education 39(39%), with those having up to a tertiary level of education being 20 (20%), primary level 17(17%), and secondary level only 24(24%).

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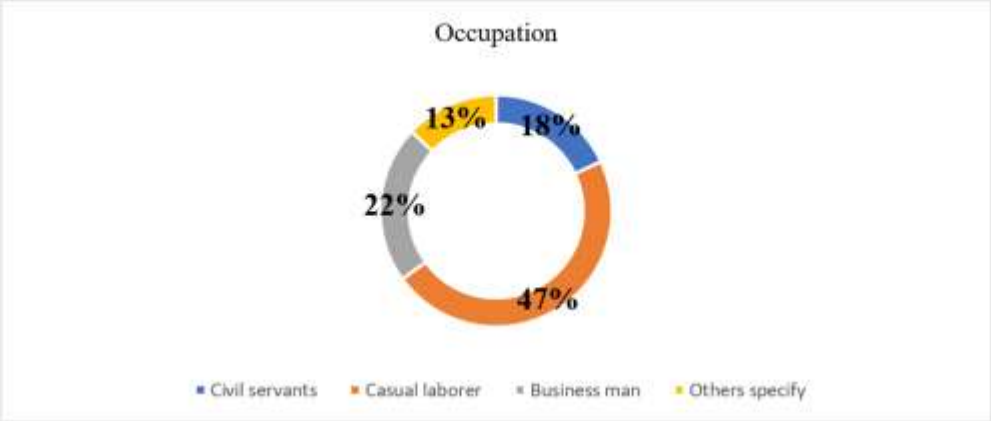
Figure 1: showing the Participants' Marital Status.

(Source: Primary Data, 2023)

Figure 1, shows that most of the men presented with a single status (40%), with the married and widowed (35%), (25%) respectively.

Figure 2: showing the Participant's Occupation.



Source: Primary Data, 2023)

Figure 2, shows that most of the participants were casual laborers (47%), 22% were businessmen, 18% were civil servants and only 13% had specific jobs that were specified to them.

Respondent's findings on the level of knowledge towards the use of post-exposure prophylaxis.

Table 2: showing participants knowledge about the use of post-exposure prophylaxis

Variable	Variable options	Frequency	Percentage (%)
heard about PEP	YES NO TOTAL	78 22 100	78 22 100
indications of PEP	Occupational Non-occupational I don't know	13 38 27	16.7 48.7 34.6

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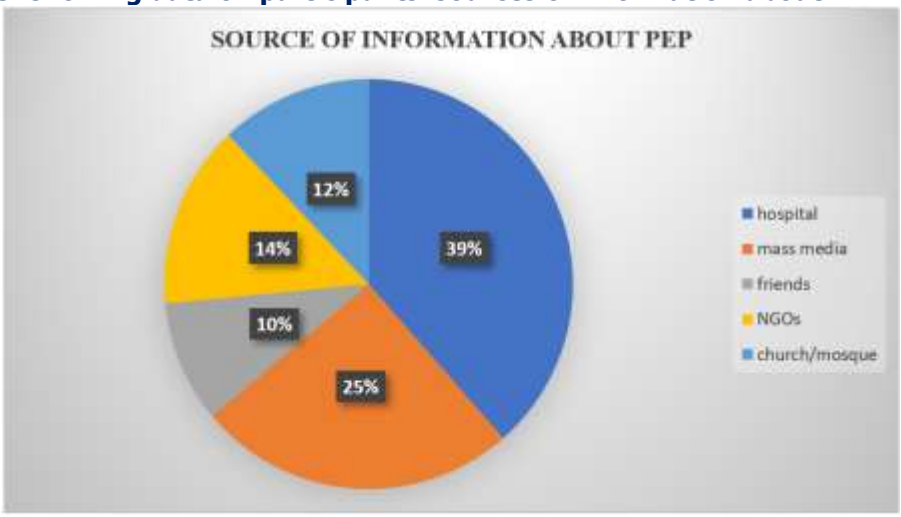
	TOTAL	78	100
Does PEP provide full protection against HIV infection?	Yes No I DON'T KNOW TOTAL	23 37 18 78	29.5 47.5 23.0 100
Is any other HIV prophylaxis method known?	PrEP Aspirin I don't know Other specify TOTAL	17 42 10 9 78	21..8 53.8 12.8 11.5 100

Source: Primary Data (2023

Table 2, indicates that 78 (78%) of the participants reported having heard about PEP, while 22 (22%) had not. When asked about the indications for PEP, 13 (16.7%) participants correctly identified occupational exposure as a reason for using PEP, 38 (48.7%) identified non-occupational exposure, and 27 (34.6%) did not know. Regarding the effectiveness of PEP, 23 (29.5%) participants believed that it provides complete protection against HIV infection, while 37 (47.5%) believed that it does not. 18 (23%) participants were unsure. Participants were asked if they knew of any other HIV prophylaxis methods, and 17 (21.8%) reported knowledge of Pre-Exposure Prophylaxis (PrEP), 42 (53.8%) did not report knowledge of any other method besides PEP, 10 (12.8%) did not know, and 9 (11.5%) specified other methods. 23[29.4] agreed that PEP could offer full protection against HIV,37[47.4%] did not, meanwhile 18[23.0%] did not know. On the other HIV prophylaxis, most stated Aspirin 42[53.6%] would be used, 17[21.8%] said PrEP, 10[12.8%] didn't know, while others specified, poison were 9[11.5%]

Figure 3: showing data on participants' sources of information about PEP. N= 100



Source: Primary Data, 2023).

Figure 3, shows that the highest source 32[39%] was from hospitals and other related health facilities, mass media 21[25%], NGOs 12[14%], churches 10[12%], and friends 8[10%].

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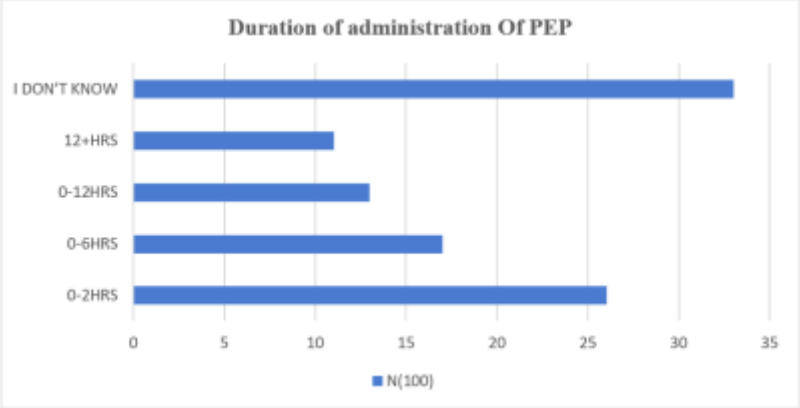
Figure 4 : showing Participants Knowledge on the duration and timing of administration of PEP. N=100.



(Source: Primary Data, 2023)

Figure 4, shows that the largest number (33%) responded that they actually didn't know the exact duration and only 26% knew the actual time of immediate administration of PEP.

Findings on the respondent's attitudes towards the use of post-exposure prophylaxis

Table 3: showing participants' attitudes toward the use of PEP

Variable	Variable options	Frequency	Percentage
Is PEP safe for use	Yes	60	76.9
	No	18	23.1
	TOTAL	78	100
Do you think post-exposure prophylaxis can prevent HIV/AIDS?	Yes	54	69.3
	No	24	30.7
	TOTAL	78	100
Would you accept to use of post-exposure prophylaxis?	Yes	63	80.8
	No	15	19.2
	TOTAL	78	100
Would you encourage anyone to use post-exposure prophylaxis?	Yes	63	80.8
	No	15	19.2
	TOTAL	78	100

Source: Primary Data (2023)

Table 3, shows that Out of the 78 participants, 60 (76.9%) reported that they believe PEP is safe for use, while 18 (23.1%) did not. When asked if they believed that PEP can prevent HIV/AIDS, 54 (69.3%) participants answered yes, while 24 (30.7%) answered no.

Regarding participants' willingness to use PEP, 63 (80.8%) stated that they would accept its use, while 15 (19.2%) said they would not. Finally, participants were asked if they would encourage others to use PEP, and 63 (80.8%) responded positively, while 15 (19.2%) said they would not.

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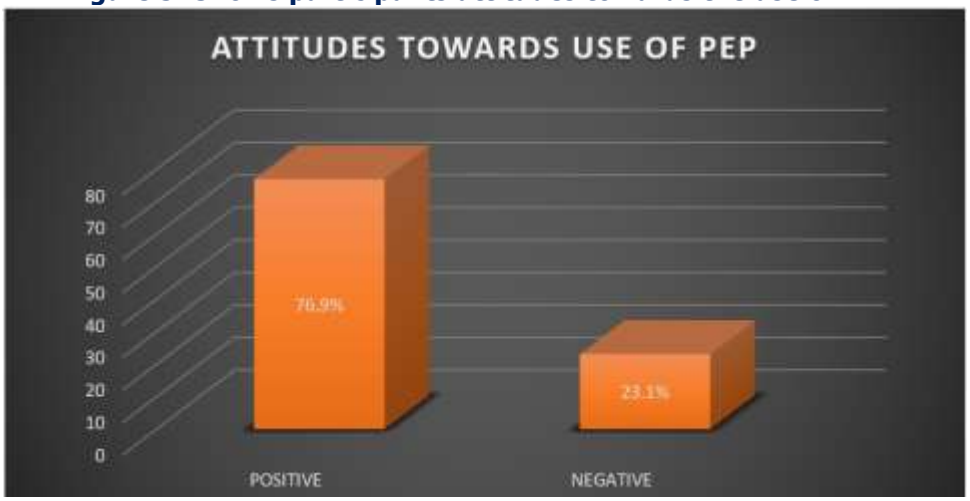
Figure 5: Shows participants attitudes towards the use of PEP.



(Source: Primary Data, 2023)

Figure 5, shows that 76.9% of the participants had a positive attitude about it being safe for use, while the remaining (23%) didn't conform to the safety and effectiveness of PEP and therefore had a negative attitude towards the use of PEP.

Findings on the respondent's practices on the use of post-exposure prophylaxis.

Table 4: Showing participants practices of use of PEP

Variable	Variable options	Frequency	Percentage
Ever used PEP	Yes	42	53.8
	No	26	33.3
	TOTAL	78	100
From where?	Hospital	21	50.0
	Clinic	13	30.9
	Home/Village	2	4.8
	Outreach/camps	6	14.3
	TOTAL	42	100
What was the reason for the use of PEP?	Medical practice	8	20
	Belief HIV	1	2.5
	prevention	33	82.5
	TOTAL	42	100

Source: Primary Data (2023)

Table 4, shows that among the 78 participants, 42 individuals (53.8%) reported a history of PEP usage, while 26 participants (33.3%) had not utilized PEP. Regarding the source of PEP, 21(50.0%) obtained it from hospitals, 13 (30.9%) from clinics, 2 (4.8%) from home or village, and 6 (14.3%) from outreach programs or camps. Furthermore, participants were questioned about their motivations for using PEP. Eight participants (20%) reported using PEP based on medical advice, 1 (2.5%) due to personal beliefs, and a majority of 33 participants (82.5%) utilized PEP primarily for the prevention of HIV.

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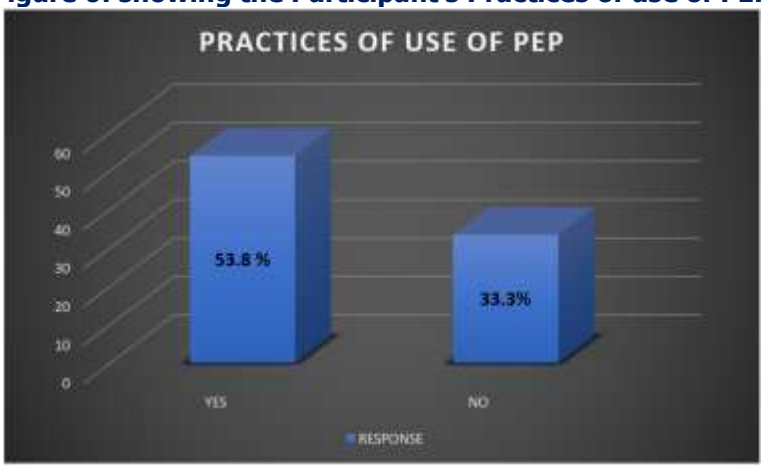
Figure 6: showing the Participant's Practices of use of PEP



(Source: Primary Data, 2023)

Figure 6, indicates that 53.8% (42) of the participants had used PEP before, whereas 33.3% (26) had never used PEP.

Discussion of results.

Knowledge of the use of PEP among bar attendants.

Regarding the knowledge of the participants about PEP, the majority 78[78%] of the participants had heard about and known PEP, meanwhile minority, 22[22%] didn't know anything about PEP and these couldn't proceed to further knowledge questions on PEP. This study revealed a related bigger percentage of PEP awareness, unlike some other studies in Cameroon, 73.7%, and in Zimbabwe, 65% of HCWs had poor knowledge. Similarly, one study documented inadequate knowledge of PEP in up to 83.9% of HCWs in Ethiopia. Furthermore, among the exposed respondents, 81.6% did not use PEP; 33.8% of whom did not use PEP because of lack of information (Eticha & Gemeda, 2019b).

Furthermore, from the 78 that knew about PEP in my study, 17[34.6%] didn't know the actual indication for PEP some of them suggested other STIs before they could clearly remember, others said occupational, and then most of the participants 37[48.7%] suggested non-occupational causes that included rape, serodiscordant couples, PMTCT and organ transplantation while only 13[15.4%] suggested occupational causes. Since the research was conducted in a community-based setting, most indications were not directly attributed to the occupational cause but rather non-occupational that matches their setting unlike the previous research, most people at risk of occupational exposures are in developing countries where there is a paucity of standard reporting protocols. This underscores the need for an exploratory study such as this one which will increase the awareness of doctors for non-occupational indications for PEP. (Agbulu et al., 2013)

From the study, 23[29.4%] agreed that PEP could offer full protection against HIV, the majority 37[47.4%] did not, and the minority 18[23.0%] did not know. Little literature review is known about this, and this was the indication for adding this to our research, policymakers should consider more public awareness about the efficacy of PEP in HIV prevention strategies.

On the other HIV prophylaxis, most stated Aspirin 42[53.6%] would be used, 17[21.8%] said PrEP, 10[12.8%] didn't know, while others specified, poison was 9[11.5%], this may also be attributed to the misinformation of the people that Aspirin would be used to prevent HIV meanwhile those that went to specify gave partially irrelevant prophylaxes some went to suggest that ' the only would be next solution after acquiring HIV would be poison' this also even revealed the stigma in people and misconception that no prophylaxis exists on HIV.

Regarding the participant's knowledge about the immediate time duration from which PEP should be administered as a deviation the largest number (33%) responded that they didn't know the exact duration and only 26% knew the actual time of immediate administration of PEP. Unlike the previous research studies carried out, regarding the timing and duration of PEP for HIV, 87.46% of the total respondents stated that PEP should be taken within one hour and 91.32% of them knew the correct duration of PEP against HIV/AIDS (28 days). A study conducted among Interns of a Medical College in West Bengal, India, indicated only 68.5% stated PEP should be started within an hour of exposure and only 46.9% conveyed the appropriate duration of PEP (28 days) (Eticha & Gemeda, 2019b). The difference might be due to differences in the work

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experience as more than 50% of our participants had professional experience of greater than one year.

Awareness of the time of administration of PEP within the first 72 hours with high effectiveness in the uptake in the first 2 hours of exposure for the occupational indication would elevate the actual effectiveness of PEP and also allow for its utilization.

Regarding the issue of the source of information about PEP, only 39% of the respondents mentioned hospitals and other related health facilities as the major source of PEP, this agrees with the previous studies for the source of information that attested hospitals and health-related facilities suggesting more efforts in the education and awareness campaigns to the people about PEP.

Attitudes towards the use of PEP.

Regarding the attitudes of the participants towards the use of PEP, the majority 76.9% had a positive attitude about PEP being safe for use, and the minority 23% didn't conform to the safety and effectiveness of PEP. In addition, 54% of the participants also agreed that PEP could prevent HIV/AIDS infection. This study further showed that 80.8% of the participants would accept to use of PEP and they would also encourage others to use PEP. These findings are in agreement with previous studies such as a study conducted at the Gondar University Hospital (Eticha & Gemeda, 2019b) indicated that 98.5% agreed on the importance of PEP for HIV, which is even greater than our study findings. Our findings are probably so because of the good levels of knowledge are increased awareness levels in the communities.

Furthermore, on the effectiveness and the will to uptake PEP, the majority 63(80.8%) accepted to use of PEP, and a minority 15(19.2%) would not accept. These findings are in agreement with a previous study conducted by Futumu, the effectiveness of PEP for HIV prophylaxis was accepted by the respondents with 219 (73%) respondents accepting to use PEP if the need arises. 142 (47.3%) of the respondents have sustained needle stick injury in their medical practice while 158 (52.7%) have never sustained needle stick injury. However, only 123 (87.0%) of the 142 respondents with needle stick injuries reported to the appropriate authority while 19 (13.0%) did not report (Futumu S et al 2019). The positive response towards the uptake of PEP was because of the good knowledge and hence very good attitudes.

Practices towards the use of PEP among bar attendants.

From the study, the practices of use and practices of PEP utilization findings revealed that the majority 53.8% (N42) of the participants had used PEP before, from which 21(50%) of them had it from the hospitals. The main reason for most of them (82.5%) using PEP was for the prevention of HIV/AIDS. This gives a conclusion from the results that most of the participants used and thinks PEP could be used effectively for the prevention of HIV/AIDS infection. This corresponds with the previous studies conducted supporting the practice of use of PEP. Among 38 HCWs on ART for PEP, 21 (55.3%) of them were exposed to the blood of known HIV-positive patients, which is comparable to a study from the Gondar University Hospital (57.1%). (Eticha & Gemeda, 2019b) Even though 71.7% of the exposed respondents took PEP for HIV in this study, only 68.4% of them were able to complete the duration of prophylaxis which requires 28 days. The main reason for no adherence of these individuals was fear of adverse effects. This indicated that it is lower than the findings of the study conducted among HCWs of governmental health institutions in Mekelle Town, Ethiopia (80.6%) (Gebreslase & Abera, 2014). However, a study conducted in Gujarat, India (Gebreslase & Abera, 2014), showed that their respondents had better practice in this regard than our study participants in which more than 94% were able to complete the regimen. This fact alerts us that the practice of PEP for HIV in this study area needs improvement. Reasons for the observed difference in findings between different research results might be due to the difference in the level of awareness among the different populations, economic difference of the study population, and time difference of the studies.

Conclusion.

Most of the participants had good knowledge about PEP, they very well also knew the indications for PEP but had less information about the duration and the exact timing of utilization of PEP, a weakness that the policymakers would pick interest in case of addressing the low utilization of PEP and minority did not know about PEP.

The participants had a summative positive attitude about the use of PEP and would take up the idea of PEP for utilization in cases of exposure to HIV/AIDS. An overall agreement with consent in the practice and utilization of PEP if exposed to HIV/AIDS and would agree to it mainly for the prevention of HIV/AIDS infection was also observed among the sampled participants and the minority 23.1% had a negative attitude towards PEP.

An overall agreement with consent in the practice and utilization of PEP if exposed to HIV/AIDS 80.8% and would agree. The main reason for most of them using PEP was for the prevention of HIV/AIDS and the minority would not use PEP.

Recommendations.

The populations require more PEP awareness and policy makers should consider the public sensitization and

awareness Campaigns as a cause to implement the HIV/AIDS reduction and prevention strategies.
PEP is an immediate prophylaxis that is effective if all procedures for its use are followed and in cases of HIV exposure should seek immediate PEP action from hospitals.

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Data availability.
Data used in this study is available upon request from the corresponding author.

List of abbreviations.
AIDS - Acquired immunodeficiency syndrome
ART - Antiretroviral therapy
CDC - Centre for Disease Control
DHS - Demographic and Health Survey
HIV - Human Immunodeficiency Virus
KAP - Knowledge Attitude Practice
MOH - Ministry of Health
PEP - Post-Exposure Prophylaxis
PrEP - Pre-Exposure Prophylaxis
STI - Sexually Transmitted Infection
USAID- United States Agency for International Development
WHO - World Health Organization
PMTCT - Prevention of mother-to-child transmission
UAHEB - Uganda Allied Health Examination Board

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