



Community Preparedness, Acceptability, and Uptake of UTT Services in PHC Facilities

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Abstract

Background: The Universal Test and Treat (UTT) strategy ensures that people test and initiate early treatment in health facilities. Communities have benefited from this strategy to help manage HIV and prevent the spread of the disease, but the way people perceive the strategy and their experiences of testing and initiating antiretroviral therapy (ART) on the same day have an impact on their remaining on treatment and on their adherence. **The aim of the study:** The aim of this study was to describe the perceptions and explore the experiences of newly enrolled patients regarding the UTT strategy employed in health facilities in Kgetleng sub-district. **Method:** This is a qualitative study that used in-depth interviews to describe the perceptions and explore the experiences of newly enrolled patients regarding the UTT strategy employed in health facilities in Kgetleng sub-district. The twenty-seven participants were purposefully selected from three health facilities in the sub-district. The data were collected and transcribed verbatim. The transcripts were analyzed using thematic content analysis. **Results:** The participants reported that they were not knowledgeable about or aware of the strategy until they tested positive in their clinics. HIV testing services (HTS) are still underused, as the participants presented to the facilities only when they were seriously ill, had various symptoms, or were pregnant. They described accepting their status and treatment because they were already sick, and there was nothing that they could do but take treatment. Despite the different emotions they experienced, the participants were able to accept their treatment and their status. Surprisingly, those who were still in denial also accepted treatment. Some were able to disclose and received support from their family, partners, and friends, but others had not disclosed. The data also showed their fear of stigmatization if they were seen coming to the clinic frequently. **Conclusion:** Being diagnosed with the human immunodeficiency virus (HIV) is still a source of embarrassment. There is still a need to educate communities about the virus, encourage them to use HTS, and empower them with information to minimize stigma and promote social support.

Keywords: Community; Preparedness; Acceptability; Uptake; UTT & Primary HEALTH CARE (PHC) Facilities.

1. Introduction

"South Africa's practice of same-day ART initiation reveals a precarious duality: while aiming for rapid treatment, the country also invites higher losses and heightened risks". In 2015, the World Health Organization (WHO) launched the UTT strategy to boost the effect of ART with a view to ending the HIV epidemic by the year 2030, and the Joint United Nations Programme on HIV/AIDS (UNAIDS) report has indicated that since 2010, ART has contributed 30% to reducing HIV infections and 24% to reducing the mortality rate related to HIV [1].

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Ford et al. [2] confirm that rapid ART initiation for HIV-positive people, together with same-day ART initiation upon HIV diagnosis, has resulted in improved outcomes. Studies done on pregnant women in Eswatini have reported a sharp increase in ART initiations among pregnant HIV-positive women after the introduction of Option B+ [3]. Further, it has shown positives such as ensuring maximal and durable viral load suppression, increasing access to ART, restoring and preserving immune functions, improving the quality of life, and preventing the further transmission of HIV. El-Sadr & Goosby [4] report that evidence indicates that there has been a decrease in morbidity and mortality and a reduction in new infection cases in the most severely affected countries, as more than 20 million people who are living with HIV have access to HIV treatment. Additionally, the UTT strategy has been seen as acceptable and held well among transgender women and men having sex with men at community-based organizations [1, 5].

Despite of the positive impacts of the UTT strategy on the population, it seems like the HIV pandemic has continued to burden the health system with people living with HIV (PLWHIV) globally for the past four decades [6]. There are several challenges, such as lack of information regarding ART and readiness to start the treatment, that were noted as hinders. In prior studies by Nhassengo et al. [7], health care service providers and clients indicated a lack of information about ART as the main barrier to starting ART. It was also discovered that being ready was a psychosocial factor that made pregnant women able to accept ART on the same day as a diagnosis at ANC [6]. It seems like there is low uptake of the UTT program, leading to increased attrition and poorer retention among PLWHIV who are on this program [8]. According to Chauke et al. [9], UTT was strongly related to loss to follow-up (LTFU) in South Africa because those who began using it had higher rates of LTFU than people who began using pre-ART. Furthermore, Onoya et al. [10] discovered that client attrition rose after the introduction of ART in South Africa, rising from 27.8% prior to UTT to 48.4% in UTT and 57.2% in same-day initiation groups. Several factors influence UTT behavior, including healthcare worker-related problems, PLWHIV age, and gender, with women being more prominent in PHC settings. Young women worldwide, particularly in the SSA region, are at increasing risk of HIV infection, with a 20% annual new infection rate [11]. Maluleka et al. [12] discovered that impediments to successful UTT applications in South Africa and the SSA region included client loss, service funding, a scarcity of health personnel, and insufficient ART treatment stock.

If these issues relating to the UTT strategy are not attended to and addressed, there will be an increase and continuity of adverse outcomes such as the prevalence of HIV infectivity and transmissibility, virologic non-suppression, ongoing resistance to ART treatment, and an increase in HIV-related morbidity and incidence rate [10, 13]. Little is known regarding how the community is prepared, ready to accept, and uptake the UTT services. Most studies focus on the challenges and experiences of the UTT program/strategy. Hence, the study aimed at exploring and describing the perceptions and experiences of newly enrolled patients regarding the UTT strategy employed in health facilities in Kgetleng sub-district.

2. Materials and Methods

2.1. Study Design and Setting

A qualitative exploratory design was used in this study. The research was carried out in the North-West province's Bojanala district, specifically in the Kgetleng sub-district. The Kgetlengrivier local municipality makes up part of the Bojanala Platinum District municipality and is situated in the south-eastern portion of North-West Province. It is made up of three distinct towns: Koster, Derby, and Swartruggens. Swartruggens CHC, Reagile Clinic, and Mathopestaad were chosen for the purpose of this research. Minor ailments, managing chronic illnesses such as TB, infectious and noncommunicable illnesses, mental health, the well-being of mothers and children, women's health, nutrition services, HIV/AIDS, dental health care, prenatal services, and referrals to other health care providers are all available at all institutions.

2.2. Population, Sampling Procedure, and Sample Size

The study's population of focus included 27 individuals, both male and female, who had recently been diagnosed with HIV and had begun ARV medication. Participants from the three chosen facilities were interviewed. To answer the study questions, non-probability purposive sampling was used. This method of sampling was appropriate for the investigation since the participants and facilities chosen on purpose informed the comprehension of the phenomena. Due to the prevalence of infections in all three regions, three facilities were purposely chosen for the study, and study participants were easy to recruit because these are the facilities where patients go for their monthly treatment visits. Throughout the interviews, sampling and data collection proceeded until data saturation was declared.

2.3. Inclusion and Exclusion Criteria

Participants who satisfied the eligibility criteria were freshly initiated UTT strategy patients, those started on the same day falling within 1–12 months and recorded on Tier.net, patients aged 18 and up, pregnant and nonpregnant, male and female. Patients under the age of 18, those who tested positive but were postponed for some reason, as well as those who had been taking ART for over a year, had been excluded from the study.

The flowchart of the research methodology that was used to achieve the study's aims is shown in Figure 1.

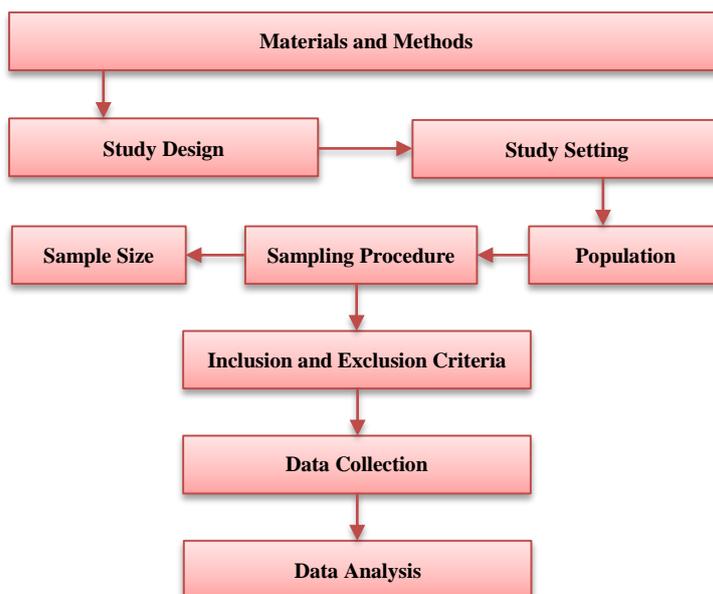


Figure 1. A flowchart the workflow for the process of the methodology

2.4. Data Collection

In this study, data was gathered through in-depth, one-on-one interviews with semi-structured questions. Each interview lasted about 30–45 minutes. The interviews were conducted using both Setswana and English tools. A voice recorder was utilized for recording the interviews with all of the selected participants throughout the interviewing procedure to guarantee that no vital information was missed. A questionnaire was also utilized to obtain participant socio-demographic information.

2.5. Recruitment of Study Participants

Participants were recruited after SMUREC granted ethical approval and authorization to conduct the study in the three chosen health facilities. The researcher scheduled a meeting with the Operational Manager (OPM) of each of the three selected health facilities. On different occasions, the researcher met with the OPMs of three different health facilities and discussed the study and its aim with them.

The data capturers of the three selected health facilities were notified that they would be assisting with tier.net to identify the patients who were eligible, and patient files were obtained to check appointment dates for the eligible patients. The participants were contacted one by one in a private office on their appointment dates, and the goal of the study was conveyed to them. Those who expressed an interest were given a consent form to sign, while those who did not express an interest were not included.

The researcher and the consenting participants decided on a suitable date and time to conduct the in-depth interviews. To avoid unintentional exposure of the patient's status, various time frames were assigned.

2.6. Data analysis

A thematic content analysis was used to analyze the data in this study. The audio recording was transcribed word for word, and the Setswana information was in English. To ensure that data was coded consistently, a code book was created. Transcripts have been imported into NVivo 12 software for analysis, and participants' socio-demographic data was acquired using a questionnaire and documented in an Excel spreadsheet before being imported into STATA software and their frequencies calculated. Transcripts were organized into categories, and themes were found and used to convey data.

3. Results

3.1. Study Participants' Sociodemographic Characteristics

This study recruited 27 participants. Out of the twenty-seven interviewed participants, the majority of them were females (n = 17) 63% and the minority (n = 10) 37%, were males. The majority of the participants were between the ages of 18-35 years, then 36-49 years, and 50-59 years. The summary of the participants is outlined in the table below, along with additional sociodemographic data.

Table 1. Sociodemographic Characteristics of the Study Participants

Variables	Categories	Frequencies	Percentages (%)
Gender	Male	10	37%
	Female	17	63%
Age categories (Years)	18-35	18	69%
	36-49	6	23%
	50-59	2	8%
Level of education	No education	2	7%
	Primary school	5	19%
	High school	20	74%
Employment status	Self-employed	2	7%
	Employed	12	44%
	Unemployed	13	48%
Duration on ART	Minimum Months	12 months	-
	Maximum Months	30 days	-

3.2. Emerged Themes

During the data analysis, six main themes and nine related sub-themes emerged. Table 2 summarizes the main themes and sub-themes. All these are presented and outlined in Table 2.

Table 2. A summary of emerged themes and related sub-themes

Themes	Sub-themes
Perceptions of UTT	-
Acceptance of UTT	Denying HIV-positive status.
	Using prayer to cope and accept.
	Accepted HIV-positive status.
Preparedness and readiness	Complying with and adhering to treatment.
	Reluctant to start taking treatment.
	Contemplating starting treatment.
	Importance of taking treatment.
Views about the service received	Benefits of HIV treatment.
	Health care provider’s attitude.
Attitudes toward immediate uptake of ART	-
Experiencing side-effects	-

Theme 1: Perceptions of UTT

UTT was viewed as a good strategy that saves lives, improves health, prevents and delays the progression of illness, and could delay HIV-related deaths. The UTT method received an extraordinarily positive response from participants who are HIV positive. The method was considered to have proved its ability to save lives, improve health outcomes, and give people living with HIV a new lease on life. Participants' strong support for UTT coincides with the strategy's broader goals of reducing HIV transmission rates and improving the overall quality of life for people infected with the virus. It indicated that this technique not only saved lives but also had the ability to change the HIV management landscape. The participant's experience demonstrates the advantages of prompt intervention, such as weight management and good sickness control. A feeling of thankfulness and optimism, stressing UTT's positive impact on their health and their hopes for broader access to this life-changing treatment. This is illustrated by the quotes below:

“On my side it is good. Eeh! It is good. Yoh! Mind you, I had lost weight, lost a lot of weight and I lost it in 2 months. So, starting immediately is good once you find that you are HIV-positive. Start treatment. Do not waste time.” (Participant 16, 31 years old).

“I perceive it as good. It’s wonderful. I wish everybody can take it. I don’t wish that it changes. I’m lucky because at least I don’t have something that’s going to be like kill me right now. So, it was good for me to take the pill.” (Participant 13, 47 years old).

While some people welcome the rapid treatment method for its potential benefits, others express doubts owing to emotional issues and the practical difficulties of treatment adherence. According to the study, the quick commencement of treatment following diagnosis may have been overwhelming for this individual, leading to anxiety. As a result, the participants were not in accord with the method, but they had to come to terms with taking treatment and accepting their position with difficulty, and the program left them afraid.

“In the beginning it did not sit well with me that I test and take treatment same day because I was scared.” (Participant 6, 21 years old).

“I am not in agreement with it because Ey! It is difficult and a lot because you have to accept first on the other hand you have to drink pills or the treatment that we drink which you are talking about.” (Participant 26, 35 years old).

Theme 2: Acceptance of UTT

Some participants accepted UTT for the improvement of the state that they were already in. It is evident that finding out that they already have the virus left them no choice but to accept it and start treatment immediately.

Sub-theme 2.1: Denying the HIV-positive Status

Among the 27 participants interviewed, there were those who mentioned being in denial and disbelief of their HIV status. Denying the HIV status emanated from previously testing negative whenever the participant tested for HIV. The data also show that participants between the ages of 18-31 were reluctant to accept their HIV status. Participants discussed some of the psychological difficulties they confront when dealing with an HIV diagnosis. Common reactions include denial, fear, and trouble accepting the truth of the diagnosis, all of which can have an impact on mental well-being and treatment adherence.

“I have not accepted well that I am sick so every month when I have to come to the clinic it clicks to me that I am sick.” (Participant 8, 18 years old).

“To be honest I am still in denial, but reality somewhere wants to tell me that this is it.” (Participant 1, 29 years old).

Sub-theme 2.2: Using Prayer to Cope and Accept

Meanwhile some found accepting the positive status difficult. Prayer was being used as a coping mechanism and for acceptance by both male and female participants. The importance of spirituality and prayer in the lives of people living with HIV was emphasized by all. As they negotiate the complexity of their health journey, many people find consolation, courage, and a sense of purpose in their faith. Participants' reliance on both supernatural assistance and medical intervention illustrates the participants' holistic approach to controlling their ailment.

“I always pray that I accept properly.” (Participant 17, 54 years old).

“That day I did not feel well. You will never accept but where I am I prayed to God and said God please help me accept that I am living this kind of life so that I live well.” (Participant 4, 30 years old).

“I told myself that God help me accept this disease just as I have accepted and just as I am infected. So, I am accepting it. Just as you have given me life, I will also give myself life by killing the disease with the medication that they are giving me, and God be the most powerful one than these pills that one day when I test it would no longer be there.” (Participant 18, 47 years old).

Sub-theme 2.3: Accepting the HIV-positive Status

Although accepting their status was not an easy thing to do, the participants knew they had no choice in taking the treatment. The psychological process that people living with HIV go through, often ranging from shock and denial to acceptance, was underlined. Furthermore, individuals discussed the emotional challenges they had in accepting their HIV status. However, the participant's acceptance originates from their knowledge of the need of controlling their health through therapy, and their realization that acceptance was the best route forward emphasizes their recognition of the importance of embracing their diagnosis as a step toward effective management.

“I accepted that no Eish! This is it so I have to do this Eeh! Even when I never thought someday, I will be on treatment but accepting only I accepted. There is nothing that I can do. I have to do that.” (Participant 2, 41 years old).

“It was never easy, but it was better, so I ended up accepting that I have HIV. There is no other way.” (Participant 5, 26 years old).

Sub-theme 2.4: Complying with and Adhering to Treatment

The importance of the approaching treatment regimen was demonstrated by the participants' attention to not missing a single medication. Furthermore, the participants' commitment to effective treatment management was demonstrated by their proactive attitude toward maintaining their health and adherence to drug take-back schedules. The participants made great efforts to take the treatment properly, as advised by the clinicians. Even those who had not fully accepted their status were compliant and adhering to the treatment. The data illustrate that the participants were doing their best to comply with the treatment by honoring their monthly appointments, taking the treatment on time, and having reminder systems that assist them.

“Now what is happening is that I use them all the time. I do not skip a single day. There is never a time where I do not drink treatment. I make sure that I do not miss my dates because in between the time I check my things to check if I forgot it. I check it on the card to see which date they gave me.” (Participant 10, 50 years old).

“I drink them properly on time; I take care of myself. I do not wander around. I take good care of myself.” (Participant 21, 35 years old).

Theme 3: Preparedness and Readiness

This sub-theme related to how prepared and ready the participants were to take the HIV treatment given to them.

Sub-Theme 3.1: Reluctant to Start Taking Treatment

Nonetheless, some participants were reluctant to take the ARVs, or doubtful about taking them. The participants described their internal tensions that develop as a result of living with HIV and the requirement for lifetime therapy. Some individuals admitted to considering stopping treatment in order to confirm the diagnosis. Some participants reflected the complicated feelings and tensions that some people may face as a result of their treatment regimen. This is shown by the following responses:

“Other days I don't feel free when I drink the pills. I would hold it and think of taking it and throw it in the toilet.” (Participant 3, 18 years old).

“I thought if I stopped taking the pills and not take them that day and come again so that they test me again then if it says the same story that's when I will take treatment.” (Participant 6, 21 years old).

Sub-theme 3.2: Contemplating Starting Treatment

Besides the counselling provided to the participants, they kept on thinking about where the virus could have come from. The diverse emotional responses that people may have after receiving an HIV diagnosis were highlighted. Participants described the initial shock and confusion they felt after receiving an HIV diagnosis. Furthermore, some participants exhibit discomfort and reluctance about taking ARVs.

“I was not OK. What came to my mind was how come. How did I get it?” (Participant 8, 18 years old).

“My spirit is still down towards them like when I think that I am still young, and I am drinking ARVs like it's still embarrassing me. Like I haven't accepted that I have to drink it and be relieved.” (Participant 6, 21 years old).

Sub-theme 3.3: Importance of Taking Treatment

One of the issues was the life-or-death decisions that people make when it comes to HIV treatment. Participants shared their feelings of anxiety, doubt, and eventual acceptance of the need of treatment in sustaining health and prolonging life. However, taking ARVs was seen as an important step in order to prolong life for the sake of raising their offspring, accomplishing goals and the participants also had the fear of death.

“I had that anxiety when I started, took it, and drank. It I was still scared but because there is nothing that I can do. That is, it! Without taking them there is no life for me.” (Participant 7, 22 years old).

“I thought it's either treatment or I lose my life. So, I thought it's better I take treatment than cost my health or cost my life.” (Participant 2, 41 years old).

“I saw that I should come because if I dodge them that would be my death.” (Participant 19, 49 years old).

Sub-theme 3.4: Benefits of Treatment

The impact of HIV treatment on physical health and overall outlook was explored. Participants reported improved health after beginning HIV therapy, with some expressing a sense of restoration and a return to a healthier state. Participants who were already sick or experiencing physical pain experienced improvements in their health from the day they first started taking the treatment, with some participants reporting that they were able to sleep were relieved of pain from that particular day.

“Right now, I am OK. It’s no longer like before. I was weak and had headaches before I drank them. When I drank them, I started feeling better.” (Participant 19, 49 years old).

“Right now, I am going back to my normal. I’m getting my body, I can see the complexion, I can see that I can eat because I was not able to eat, yah. And I see happiness.” (Participant 3, 18 years old).

It was demonstrated how HIV treatment adherence can affect both the individual's health and the health of their unborn child. Furthermore, the participant's priority is to safeguard their child from HIV transmission. They realized that sticking to treatment not only protects their personal health but also safeguards the wellness of their breastfeeding infant. Some of the pregnant women and those who were breast feeding were ready to take treatment on the same day to stay healthy and protect their babies from contracting the virus. Although not entirely ready to start treatment, they felt responsible for protecting their babies by taking the treatment immediately.

“I was already pregnant, so I thought that since I am pregnant, giving them to me on time is to help me so that it does not affect the baby.” (Participant 4, 30 years old).

“I will protect my baby because I am breastfeeding. She won’t get HIV and that I live healthy.” (Participant 3, 18 years old).

Theme 4: Views about the Services Received

The participants perceived the services they received being good. This helped to motivate the participants to openly take the HIV test and had an impact on the participants’ willingness to start treatment on the spot. The participants, for example, acknowledged the importance of healthcare experts discussing the implications of treatment discontinuation, and several participants expressed gratitude for the quality of healthcare services and the assistance received from medical professionals.

“I was helped. They started educating me first, that once you stop if they are already used to your body, once you stop there will be changes. This nice body will no longer be the same.” (Participant 20, 33 years old).

“I found good services. They counselled me well, and the doctors that were helping me helped me well. I was welcomed.” (Participant 5, 26 years old).

Staff attitude also played a pivotal role in encouraging and discouraging patients to start treatment and remain on treatment. Participants emphasized the importance of helpful relationships, assistance from staff members, and the impact of meeting someone who offered information and understanding.

“There was a woman who spoke to me and was not talking to me the way I liked. We ended up exchanging words and I got help from others. They spoke to me well and gave me advice that you can be able like this, you can do this. Right now, I am a proud that yah this is me. I am able to know that at eight I must go drink my night sweets.” (Participant 3, 18 years old).

“I found someone who had a good heart, who explained with love to a person you see. Yes, that person explained that when you are like this and has this AIDS disease it does not mean the end of the world.” (Participant 21, 35 years old).

Theme 5: Attitudes towards Immediate HIV Treatment

The participants’ attitude towards the HIV treatment seemed to be good because of its benefits, but some raised concerns such as the size of the pill and the embarrassment attached to having the treatment. Also, there are those that still feel annoyed when they look at the treatment. The participants discussed the physical and psychological changes that come with taking medication, as well as the difficulties that people may face while starting a new medication regimen. Furthermore, some participants disclosed the emotional weight of HIV treatment's long-term nature and raised concerns about the lifelong commitment to medication. However, several participants reported feelings of humiliation as a result of using ARVs.

“It was just that they are different. It is a pill that is big so when you drink it. It brakes because you are not used to drinking it. Yah, it’s just that you must learn. You will get used to it.” (Participant 22, 41 years old).

“I do not feel OK. I do not feel OK because I will be drinking these pills for the rest of my life. That is the problem.” (Participant 23, 25 years old).

“My spirit is still down towards them like when I think that I am still young, and I am drinking ARVs, like it’s still embarrassing me.” (Participant 6, 21 years old).

Theme 6: Experiencing Side-effects

Participants are aware of the potential physical and mental negative effects of HIV treatment. The side effects differed from person to person and had an impact on their everyday functioning, sleep, and eating habits. Severe side-effects

were experienced, especially on the first day of taking the treatment, but the benefits of the treatment outweighed the side effects, which encouraged the participants to continue with the treatment.

“I have experienced on my first treatment. I have experienced that when I drank, it made my stomach loose. Then I also felt that it was stuck on my throat. I was someone who did not eat, right now they make me eat. They make me eat a lot.” (Participant 27, 35 years old).

“I am unable to sleep and not eating well. I only sleep for two hours. After two hours I have no sleep. Even the food, I have no appetite.” (Participant 5, 26 years old).

4. Discussion

The participants valued the benefits of treatment and recognised its importance, especially those who were already feeling sick and were physically deteriorating. The benefits of treatment included feeling better after taking the treatment and experiencing physical gains. These among others played a role in determining their preparedness and readiness to start and continue with treatment. In this regard, their major concern was death. They wanted to avoid premature HIV-related death by any available means. It is indeed evident from the literature that ART through UTT program can reduce death rates, this was apparent from literature that following UTT, mortality was considerably reduced [14-16].

Despite their HIV status and their current circumstances, not all of the participants felt ready to start treatment, as they were experiencing different emotions. Due to the variety of their emotions, some participants contemplated death and were reluctant to start and continue with treatment even when aware of the benefits of the treatment and its importance. Our findings are in line with different studies like Ross et al. [17] which indicated that participants reported feeling scared and burdened by their HIV diagnosis, making it hard to accept their HIV status. Our study found that participants shared their different experiences of HIV testing and treatment initiation. The data showed that they did not know what to do when they found out that they were HIV-positive. This was accompanied by emotions of embarrassment, shock, anxiety, stress, wanting to die, and fear, while some found relief and were proud of themselves for taking the initiative to come and test. Moreover, some studies showed participants being shocked by the results and having mistrust of the result [18].

Accepting one's status and agreeing to start treatment seemed to be unavoidable. The participants had the desire to be healed from the condition that was inflicting physical pain on them. Some wished to prevent the aggression of the virus and also to protect their babies from mother-to-child transmissions. The study also found that physical pain and pregnancy were the major facilitators of accepting one's status. Moges et al. [18] also argues that a declining health status, the desire to stay healthy, clinics that are patient friendly, and the fear of dying are facilitators to early acceptance.

Most the participants acknowledged that the virus is already there; therefore, they should accept their HIV status. Some participants accepted their status on the same day while others took days to accept it, and yet this did not stop them from taking the treatment. In this regard their families, partners and the clinic played a role in helping them to accept their status and providing them with words of encouragement and the necessary support. The disclosure process for these participants was easier. This is consistent with a study by Adams et al. [19] that the importance of being optimistic and a positive outlook on life allowed adolescents to overcome internalized stigma and generated an internal motivation to stay healthy that facilitated ART adherence. However, the same study by Adams et al. [19] showed that a disclosure to family and other trusted individuals strengthens support systems for ALHIV. For example, many adolescents living with HIV (ALHIV) shared positive experiences with disclosure and described the support they received upon opening up to family or friends. Furthermore, ALHIV who had disclosed to their families noted that they were supported in their treatment adherence. Support, especially from mothers and aunts, was vital in driving resilience and motivating adherence; the role of fathers or male guardians was described less frequently.

On the other hand, participants of a younger age found it difficult to accept their HIV status, which led to their denying their HIV-positive status and being reluctant to drink the medication even when they had accepted being initiated on ART in their clinics. Contrary, a study by Lilian et al. [20] indicated that same-day ART initiators were younger than older people. Govere et al. [21] found that being in denial can cause one to start treatment late and can also contribute to poor adherence if started on treatment.

Prayer is being used to help participants cope with and accept their situation. For those who had contemplated death and for the pregnant women, relying on prayer had assisted them and allowed them to be at ease with being infected with the virus. Studies on religion have found that using religion as a coping mechanism is common among individuals faced with an illness, disability, or death. Additionally, Moges et al. [18] indicated that some participants believed in using holy water to heal them which was one of the barriers of starting ART in the same day of diagnosis. The physical and psychological issues that people living with HIV/AIDS (PLWHA) face urge them to employ religious coping mechanisms like as praying, dhikr, and prayer [22]. Furthermore, religious coping has a relaxing effect, which aids in the reduction of physical complaints and the resolution of psychological issues [22]. Similarly, a study by Grill et al. [23] determined different latent categories of religiousness/spirituality for adult people living with HIV (PLWH) and

connections among latent class membership and health-related quality of life (HRQoL) and discovered that patients in the privately religious group had the lowest mental health and HRQoL.

Good tests and treatment were experienced by some who reported that they had received good services from the friendly staff, who had tested them and provided them with the necessary information and counselling. Staff attitudes have their pros and cons, which have an impact on the participants' desire to initiate or not to initiate on treatment. An acceptable staff attitude encourages participants to accept an HIV test and initiate on treatment, while a bad attitude towards patients discourages them from taking treatment, even when they have already agreed to take an HIV test. Professionalism, showing empathy, a caring attitude and dedicating enough time to counselling patients are key to facilitating ART initiation [7]. Studies on pregnant women also found that due to a good staff attitude and counselling, they were able to actively participate in the Prevention of Mother to Child Transmission (PMTCT) activities [3, 7]. Moreover, a study by Adams et al. [19] concurs that a supportive clinic environment promotes continuous adolescent engagement in HIV care. That is, most ALHIV felt supported by their health clinics and clinic staff. ALHIV and peer leaders agreed that youth-friendly services were essential for engaging adolescents in care and providing a sense of belonging and age-specific support. Another study by Pascoe et al. [24] highlighted that some healthcare providers were friendly and respectful, and they listen to patients, implying that the client's experience at the clinic is heavily influenced by which staff members are seen. They believed that such strategies could improve adherence behaviors, but they saw packed clinics and a lack of staff attitude as barriers.

Moreover, some participants who had accepted the HIV test and treatment initiation felt that despite the strategy being a good strategy that does not waste time, it was coercive in nature, and that not enough time or space was given to them to decide whether or not to take treatment. This is consistent with other studies where the participants felt coerced to test and treat and felt that they were not given enough time to decide [3,7].

Most of the participants in this study perceived UTT as a good strategy for them because timely treatment initiation was perceived as a life saver. Most of the female participants perceived ART as a huge positive determinant of their well-being and long-term survival. Also, the men conceived of early ART initiation as a determinant of their long-term survival [7]. Regardless of their HIV stages, they described a variety of benefits and physical improvements they began to see after starting treatment. Although the strategy was new to the participants, they acknowledged its importance and praised the government for the initiative, and the healthcare workers for its implementation.

Conversely, not all participants had good perceptions of the strategy. They thought that it was difficult to deal with the diagnosis and simultaneously with the burden that comes with taking the pill. A discussion between concerned patients and healthcare professionals regarding the benefits of early ART initiation could promote adherence among concerned patients [25]. On the other hand, the participants who said they were not happy with the strategy said they forced themselves to take the treatment to see how it would go. Additionally, Pascoe et al. [24] reported that new HIV patients found counseling helpful, but intervention respondents reported sub-optimal counseling and privacy concerns as barriers to initiation, whereas healthcare providers felt insufficiently trained for this intervention and were confused by the simultaneous rollout of the UTT strategy.

Regardless of what participants and clients in our study say, a study by Onoya et al. [26], which focused on healthcare providers, showed support to what the client's belief, for example, healthcare providers indicated that they were concerned that clients' social and emotional preparation for ART would be overlooked and that ART starting on the day of HIV diagnosis would be overwhelming and too sudden for some patients, meaning that only highly motivated patients would start ART on the day of HIV diagnosis and remain in treatment as needed. Furthermore, healthcare providers were concerned that rushing patients who needed time to process the new diagnosis could result in disconnection from care after the initial acceptance of ART and favored giving patients the necessary time to absorb the diagnosis and deal with the social prerequisites for sustainable ART adherence, such as disclosure to a spouse/partner or family member, and arrangements for proper antiretroviral drug storage in their homes or workplaces.

5. Conclusion

In conclusion, this study investigated individuals' perceptions and attitudes toward the immediate initiation of HIV treatment. The findings revealed a variety of viewpoints on the UTT strategy. Many participants recognized its importance as a method that has the ability to save lives, promote health, and postpone the progression of sickness. Some people, however, had qualms about the technique but agreed to start therapy since it was medically necessary. Acceptance of one's HIV-positive status elicited a range of reactions. Some individuals readily accepted their predicament, motivated by the desire to protect their own and others' health. Others, on the other hand, struggled with unbelief and denial, navigating these complicated emotions through religious coping methods such as prayer. Healthcare experiences influenced individuals' perceptions significantly. Positive staff attitudes were connected to higher treatment acceptability, showing the importance of the interaction between compassionate care and patient participation. Some participants, however, believed that the strategy's rapid deployment could be forceful, underlining the importance of informed decision-making.

Despite their different perspectives, participants recognized the necessity of sticking to therapy for their health and longevity. Severe adverse effects were recorded, particularly at first, although the perceived benefits of treatment overcame these difficulties. Pregnant and breastfeeding women were especially motivated to begin therapy in order to safeguard their infants from contracting the virus. Furthermore, the study emphasizes the importance of individualized treatments that consider individual readiness, beliefs, and coping mechanisms to ensure a holistic approach to HIV care and treatment. In order to build on these findings and enhance HIV treatment methods, future research should be conducted to explore the opinions and experiences of newly recruited patients. Furthermore, the Department of Health must continually and often improve outreach initiatives, with a focus on the UTT program.

6. Declarations

6.1. Author Contributions

Conceptualization, M.D.B., M.M.M., and N.M.M.; methodology, M.D.B., M.M.M., and N.M.M.; software, M.D.B. and M.M.M.; validation, M.D.B., M.M.M., and N.M.M.; formal analysis, M.D.B.; investigation, M.D.B.; resources, M.D.B.; data curation, M.D.B.; writing—original draft preparation, M.D.B., M.M.M., N.M.M., and R.J.S.; writing—review and editing, M.M.M., N.M.M., and R.J.S.; visualization, M.D.B., M.M.M., N.M.M., and R.J.S.; supervision, M.M.M. and N.M.M. All authors have read and agreed to the published version of the manuscript.

6.2. Data Availability Statement

The data presented in this study are available on request from the corresponding author.

6.3. Funding

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6.4. Acknowledgements

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6.5. Ethical Approval

An ethical clearance approval was sought from Sefako Makgatho University Research Ethics Committee (SMUREC) ethical number (SMUREC/H/206/2021:PG) and permission to conduct the study from the department of health (DoH) and NHRD was obtained.

6.6. Informed Consent Statement

All participants gave their informed consent for inclusion before they participated in the study.

6.7. Declaration of Competing Interest

The authors declare that there is no conflict of interests regarding the publication of this manuscript. In addition, the ethical issues, including plagiarism, informed consent, misconduct, data fabrication and/or falsification, double publication and/or submission, and redundancies have been completely observed by the authors.

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