ISSN: 2753-359X

Journal of Sexual Medicine & Research

SCIENTIFIC Research and Community

Review Article

Open Access

HIV Pre-Exposure Prophylaxis and Sexual Health in the Light of the Health Belief Model: Meanings Attributed by Users

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SUMMARY

With the improvement of HIV prevention tools, pre-exposure prophylaxis stands out, a care strategy that deserves to be better studied and understood. In this qualitative study, we seek to understand the meanings attributed by PrEP users about HIV prevention and their care for sexual health. Conducted with 19 PrEP users from Porto Alegre, represented by: gay men, other men who have sex with men, Trans people, sex workers, serodiscordant partnerships. The interviews took place between December 2021 and March 2022, using a semi-structured instrument, based on the health beliefs model. It allowed the analysis of prevention behavior, starting from four axes: susceptibility, severity, benefits and barriers to prevention. The NVivo program was used for organization and coding. The mean age was 33.1 and there was a predominance of whites, with more than 12 years of schooling, CIS men, homosexuals, MSM. The participants with frequent events without condoms recognized the susceptibility to HIV and there was a consensus that it is a severe condition when left untreated. The benefits of prevention were associated with the perception of a clear conscience, quality of life and the possibility of collectively reducing transmission. However, there is exposure during oral sex, anal sex, and inconsistent condom use. Users know their risks, they are appropriate for prevention, but the search for pleasure is paramount. In conclusion, regardless of the offer of care for HIV control, there is a need to include, in the prevention processes, a dialogue about sexuality and sexual health.

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Received: August 26, 2022; **Accepted:** August 29, 2022; **Published:** September 08, 2022

Keywords: Pre-Exposure Prophylaxis, HIV, Sexual Health, Sexual Behavior

Introduction

The Human Immunodeficiency Virus (HIV) continues to be a major threat to global public health [1]. There are an estimated 37.7 million people living with HIV/AIDS in the world, with 1.5 million new cases of HIV infection and 680,000 AIDS-related deaths being identified in 2021. By 2020, 84% of estimated people with HIV knew their diagnosis and 73% received antiretroviral therapy [2].

The first records of HIV date back four decades and, even after this period, they still arouse different thoughts of fear and stigma [3]. Prevention, diagnosis and treatment have been highly developed over time, and many achievements can be recorded. The main strategy is prevention, which in recent years has included important tools such as rapid testing, pre- and post-exposure prophylaxis to HIV, and failure to detect viral load as a non-transmissible factor. This series of elements makes it possible to envision the elimination of AIDS by 2030, according to the main international goals proposed by the Joint United Nations Program on HIV/AIDS (UNAIDS) [4] . The same strategy was launched in 2015

by the United Nations (UN), in the Sustainable Development Goal (SDG) 3 [5].

PrEP was introduced into the Unified Health System (SUS) in 2017, with the aim of reducing HIV infections in high-risk populations. It emerged as a prevention technology due to its multiple character of care that involves not only the pharmacological, but keeping the protocol of constant counseling, the frequent performance of exams and the systematic contact with health care spaces [6]. In this sense, PrEP includes topics such as sexuality, sexual health and sexual rights in the debate. The concept of sexual health brings the focus to the integrality of physical, mental and social well-being related to sexuality. There is an emphasis on respect for the sexual experiences lived by people, free from any form of prejudice, stigma or discrimination. It provides an opportunity to legitimize sexual rights and sexual pleasure, treating a set of actions that lead to a healthier and more pleasurable sex life [7].

In view of the complexity and different factors involved, when dealing with the mentioned themes and the need to understand the behaviors, the Health Belief Model (MCS) is included in this study. The instrument was created in 1950 by social psychologists in the United States and aimed at analyzing prevention behavior based on four thematic axes: susceptibility to a disease condition, understanding of the severity and damage caused by the illness, benefits in adopting behavioral changes and recognition of the barriers that affect the adoption of positive health behaviors [8]. The MCS was born in an attempt to analyze the prevention behaviors adopted by individuals, considering the challenge of accepting people to adopt prevention behaviors, in the face of certain diseases. This situation led to the construction of a theory that seeks to explain preventive behaviors [9].

To understand HIV prevention in PrEP users, we used the theoretical framework of the MCS, building reflections in the light of its three basic assumptions: the recognition of susceptibility to illness; the understanding that at some point the illness can be serious and affect some element of life; believing that, by developing some action, it can reduce the susceptibility or reduce the severity of the disease, if it is already installed (Rosenstock et al., 1988) [10]. It is believed that an analysis based on the dimensions of the MCS makes it possible to understand the universe of prevention and the search for safer behaviors. In this way, it makes it possible to propose targeted interventions with the objective of achieving more feasible results in prevention, especially in the most vulnerable populations [11].

The MCS presents constructs that make it possible to understand prevention from the individual dimension, including reflection on the plans and goals adopted by people for their sexual health [7]. This issue is important, as it makes it possible to recognize obstacles to prevention that go beyond the availability of access to information, supplies, care and health services. There are important gaps, including: the understanding of individual and/or collective factors that lead individuals to situations of exposure to HIV, even with instruments for their protection and awareness of the existing risks [12].

In this way, this study seeks to understand the meanings attributed by PrEP users about HIV prevention and its relationship with sexual health, so that it is possible to deepen this analysis, based on the perceptions of those involved and their experiences on the subject. prevention and transformations after introducing PrEP into their lives.

Methods

A descriptive research with a qualitative approach was carried out according to Minayo's assumptions. This choice is due to the possibilities posed by the method when working with topics that need to extract subjectivities such as meanings, beliefs/values, perspectives, allowing for situated analyzes and the construction of new approaches to the topic under study [13].

The participants were 19 users of HIV/AIDS Specialized Assistance Services (SAE) from the Vila dos Comerciários Health Center, the Instituto de Aposentadorias de Pensões dos Industriários Health Center and the Santa Marta Health Center, references for PrEP in the municipality of Porto. Happy. Data generation took place from December 2021 to March 2022. Inclusion criteria were: age over 18 years, be registered in the PrEP system, follow-up in Porto Alegre. PrEP users participating in other research protocols in force in the city and starting less than three months were excluded from the study.

Participants were personally approached at the health service to carry out the PrEP follow-up and, at this moment, invited to participate in the study. To broaden the understanding of the topic, the greatest possible representation of the population segments eligible for this care was sought. Eligible populations are described in the Clinical Protocol and Therapeutic Guidelines for Pre-Exposure Prophylaxis (PrEP) of Risk to HIV Infection, such as: gay men and other men who have sex with men (MSM), transgender people and transvestites, sex workers and HIV serodiscordant partners. The quantity was defined by data saturation, when the answers obtained are satisfactory to understand the meanings attributed by PrEP users about HIV prevention and its relationship with sexual health [14].

The interviews were conducted virtually, through a link on the Google Meet platform. The average duration of the interviews was 40 minutes. A semi-structured instrument was constructed based on the MCS, the analytical framework in this study. At this point, all recommended procedures were performed for the return of consistent and reliable results.

To ensure the quality criteria of qualitative research, the Consolidated Criteria for Reporting Qualitative Research (COREQ) recommendations were followed. It is a checklist with three domains and 32 items, used to guide the research in relation to the components and steps that need to be in the study for greater organization and reliability [15].

The content analysis adopted was thematic according to Minayo's precepts [13]. The analysis process began with the transcription of the interviews in full in digital media. After this moment, an exhaustive reading of the material was carried out, in order to identify the central themes and the data that stood out for the frequency of citation and the connection with the axes of the MCS. Subsequently, the organization and codification of the findings proceeded through theoretical categories in the NVivo program, covering the four axes of the MCS: Susceptibility, Severity, Benefits, and Barriers. Subcategories were also launched, according to the interview questionnaire script.

All participants provided informed consent and sent, by e-mail, the signed Free and Informed Consent Term. This project was approved by the Research Ethics Committee (CEP) of the Federal University of Rio Grande do Sul, under protocol 4,867,259, and by the CEP of Porto Alegre City Hall, under protocol 2,750,306.

Results

The 19 respondents had a minimum age of 21 and a maximum of 62 years, the average was 33.1 years, 15 (78.9%) indicated that they were white and had more than 12 years of education. Regarding gender identity and sexual orientation, 15 (78.9%) were CIS men and 12 (63.2%) were homosexuals, respectively. As for the population segment, 9 (47.4%) were MSM, 6 (32.6%) were gay, 2 (10.5%) were trans women, 1 (5.3%) were trans men and 1 (5.3%) transvestite.

An analytical matrix is presented below (Chart 1) with the four dimensions of the Health Belief Model (susceptibility, severity, benefits and barriers to prevention) and the interviews of the participants, listed in numerical format, respecting their anonymity. Then, a summary text is presented, highlighting the themes raised by the participants in each category.

Interviews of participants referring to the four dimensions of health belief models. Porto Alegre, RS, Brazil- 2022.

Category	Subcategory	Participant interviews
Susceptibility	Meaning of HIV	*It means fear, it means a nightmare. (Interview 2)* *HIV, to me, means a lot of things, because I'm a gay man! And HIV has impacted and disproportionately impacts my community. (Interview 5)* *Since I started, my sex life has been a ghost. That possibility is hovering around, turning around. (Interview 10)* *The entire Lesbian, Gay, Bisexual and Transgender community (LGBT) have a common ancestral trauma which is HIV*. (Interview 13)
	Risk Situations	*What led me to take PrEP was that I ended up putting myself at risk for not using condoms. (Interview 1)* *Unprotected sex and contact with someone else's blood, such as sharing syringes. (Interview 19)* *Submission issue: in addition to wanting to please the other so as not to be abandoned, there is also the issue of substance abuse, such as alcohol, marijuana, cocaine*. (Interview 6)
	Risk Assessment	*During oral sex I got STIs*. (Interview 3) *I realized that alcohol, it made me a little more oblivious to the need to protect myself*. (Interview 10) *Anything that affects the state of consciousness leaves you vulnerable to a situation of contracting the virus*. (Interview 11) *It's having sex without a condom*. (Interview 16) *Today, she is discharged because I use PrEP, and I have difficulty using condoms. The partner talked, he didn't want to use it and I couldn't face it. Afraid to say no*. (Interview 19)
Severity	What is HIV	*The dynamics of HIV is precisely to attack the defense cells of the human body*. (Interview 1) *I have lots and lots of friends who are living with HIV. All of them fortunately and are able to have adequate treatment*. (Interview 4) *HIV is hidden and it is hidden. He has no face and is hidden. So prevention has always been to use condoms*. (Interview 13) *It is a serious disease, even compared to cancer*. (Interview 15) *It is a disease that has no cure*. (Interview 17)
	Risks of Getting Infected	*My risks are very low, not to say zero, because I know the treatment and I would do it to the letter, as I do today with PrEP*. (Interview 3) *It would affect my mental health, to share with people. It is a risk of imbalance in my life and in my self-esteem*. (Interview 6) *I would have difficulty having a more serious relationship, fear of being discriminated against*. (Interview 9) *Too scared to be positive. The issue of stigma is very intense in this regard, and when it comes to gay men, trans women, anyway...* (Interview 12) *I have a chance of being discriminated against for this and thus having a psychosocial impact of the infection*. (Interview 18)

Benefits	Importance of Prevention	*To avoid contagion, evolution and transmission.* (Interview 4) *It is of paramount importance, HIV is an important burden that I would not like to have. Personally, but also collectively.* (Interview 7) *It is very important for the person to be able to have quality of life, to be able to better understand the risks they run.* (Interview 11) *It's living a healthy life, keeping a clear conscience, knowing that your body is fine.* (Interview 15) *It's living not only free from STIs, it's living free from other diseases. I have a healthy body. I take care of myself.* (Interview 17)
	Protection methods	*Regular testing and condoms.* (Interview 1) *I think it has PEP. Testing people is a very good prevention strategy. Undetectable viral load is part of prevention because those who are undetectable do not transmit the virus.* (Interview 6) *PrEP, PEP, treatment as prevention too. The use of lubricating gel.* (Interview 10) *Condoms, lubricants, awareness, campaign against discrimination, prejudice, breaking the barrier to access to health.* (Interview 19)
	Motivations for Prevention	*I had three condom breakages.* (Interview 3) *I was motivated by the experience with my ex-boyfriend (cheating) and the PEPs I had taken earlier in my life.* (Interview 8) *What motivated me to continue the treatment was my partner being positive and understanding that what bothers me most about being positive is the stigma of society in relation to the disease.* (Interview 10) *My integrity and health. The psychological issue. And not being HIV positive, not having to be on a list of people with HIV. Protect myself and others.* (Interview 17)
	Plans for Sexual Health	*Most of the prevention behaviors I adopt. PrEP completes the forms of prevention that I have been adopting in my sexual life.* (Interview 1) *I'm going to keep using condoms with people I don't have much contact with because I don't really know who they are.* (Interview 5) *I am careful and take precautionary measures, there are no risks. And even more so now I combine PrEP and condoms.* (Interview 8) *In my case, I'm not using a condom, because I live in a solid and monogamous relationship, but you have to use a condom if you're single and have several partners.* (Interview 12) *Nowadays, we meet people on apps, and they've written about whether people take PrEP and whether they're positive or not.* (Interview 13) *Always before meeting someone, you have a conversation.* (Interview 15) *It's very rare for me to have sex without a condom, I have sex without [condoms] with people I've really known for a long time, who I trust.* (Interview 18)
Barriers	Prevention Difficulties	*Tendency to engage in unprotected sex.* (Interview 1) *Regarding oral sex.* (Interview 3) *For me, it's more about the condom.* (Interview 6) *There are issues of family barrier, support network.* (Interview 15) *Sex is better, it's more pleasurable. That's a fact, that's why people have sex without a condom.* (Interview 18)

	Types of Difficulties	*It's not the condom, we have access to all of that.* (Interview 3) *I don't use condoms, sometimes it's uncomfortable. And the relationship is more pleasurable, without the condom.* (Interview 8) *I have no barriers. It's more a matter of choice, of risk management.* (Interview 13) *I really like having sex without a condom, I can't use all the prevention.* (Interview 19)
	Psychological Barriers	*I find it difficult to talk to those people who don't want to use condoms.* (Interview 5) *I sometimes have a psychological barrier in relation to condoms, which I can't always use when I play the active role.* (Interview 6) *Sometimes this barrier is also due to being under the influence of some substance, such as alcohol, marijuana.* (Interview 10) *There are psychological barriers that prevent me from having sex that includes condoms.* (Interview 17)

Source: Own Elaboration (2022)

Susceptibility

In this dimension, the testimonies were grouped based on the questions that dealt with the meaning of HIV, the level of exposure and the risk situations to which the participant has already been exposed. The following elements emerged: HIV recognized as a virus, causing fear, liable to death, a deadly disease in the past and currently treatable. The 19 participants presented, in their speeches, HIV linked to stigma and prejudice, being a problem seen socially as an issue related to gays and the Lesbian, Gay, Bisexual and Transgender community.

All participants who were exposed to risks recognized susceptibility to HIV. Among them, there were relationships without condoms, the difficulty in negotiating the use of prevention methods, for fear of displeasing or losing the partner. As well as the fact of being under the influence of alcohol or other substances that affected the power of decision. However, the perception of susceptibility was reduced and, in some statements, annulled with the introduction of PrEP in the participants' lives.

Severity

To understand the severity of HIV in the participants' lives, they were asked about their knowledge of the disease, how they perceive it, its severity and what would happen if (if) they became infected with HIV. There was consensus on the understanding that HIV causes AIDS. The explanations regarding its pathophysiology and form of transmission stand out, a fact that demonstrated mastery and knowledge among the interviewees. It was presented as a severe condition, but in contexts of lack of follow-up and treatment. At many times, it was compared to other chronic diseases such as cancer, highlighting the lack of cure.

In the possibility of becoming infected with HIV, the participants presented experiences and fear of discrimination, due to the existing stigmas. Mental health was frequently mentioned, and the psychological and social impact of living with the disease was often considered. There were reports of difficulty in telling people about the diagnosis, socializing and maintaining affective and sexual relationships.

Benefits

Understanding the benefits of adopting prevention practices was sought, such as the importance of prevention, known protection methods and the motivation to adopt safer behaviors and their main plans for their sexual health. To counteract the elements that denote the severity of HIV, the interviewees asked about the importance of prevention to avoid the disease. Individual and collective reasons were presented, such as maintaining a clear conscience, living free from sexually transmitted infections (STIs), having quality of life, and collectively avoiding the transmission and spread of the disease. The most well-known and cited prevention methods were the internal and external condom, lubricating gel, post-exposure prophylaxis, regular HIV testing, relationship with people living with HIV/AIDS with an undetectable viral load, and PrEP.

The main motivations for prevention were recurrent sexual exposures, difficulty in negotiating condom use and experiences of infidelity in previous relationships, including relationships with HIV-positive partners.

The plans established for sexual health unanimously included maintaining PrEP for as long as possible, using condoms with unknown or low-contact partners. The elimination of condoms in monogamous relationships was very present, as was the previous conversation with unknown partners, both considered important elements to guarantee protection against HIV and other STIs. Another recurring piece of information was the new modality of dating through apps, which are used to search for partnerships for sexual practices and the relevance of being able to cite the serological status and the use of PrEP. There was a small number of interviewees referring to the maintenance of condoms in their sexual health plans.

Barriers

Regarding barriers, we sought to understand the understanding of the existence of barriers to the adoption of prevention behaviors and practices. Respondents were asked about the existence of difficulties in adopting prevention practices and the most frequent types. And the existing psychological barriers to prevention.

The most evident difficulties are related to protection during oral sex and the maintenance of condoms in all relationships. The most pleasurable sex when condom-free was highlighted. More than half of the participants stated that PrEP made it possible to remove condoms from their sexual relations, to feel safe with its use, and to have the freedom to live their sexuality.

Regarding the psychological barriers to carrying out prevention, contexts that are not favorable to negotiation with the partnership for the use of condoms and drug use were again indicated.

Discussion

Among the participants in this study, the emphasis is on MSM, a population with an increasing trend of HIV infection in different countries of the world. UNAIDS points out that the risks of HIV infection are increased in certain population segments, being 34 times higher in trans women, 26 times higher in sex workers and 25 times higher in gay men and MSM [2]. This finding is related to the observation of behaviors considered to be of greater risk, which include anal sex without a condom and failure to use condoms in relationships [16]. It is also noteworthy that LGBTphobia hinders the experience and free expression of sexuality and gender identity, and can potentiate sexual exposure in environments with less family support and in situations of fear, discrimination, prejudice, stigma and violence. The significant presence of this population segment in prevention programs, such as PrEP, indicates a positive character in HIV control strategies [10]. Such achievements concatenate with advances in confronting and fighting for the human rights of the LGBTQIA+ population, especially the MSM segment, although there are many challenges, to the point of not observing other priority population groups, with the same adhesion and/or equal reach of access. combined prevention strategies [17].

The search for understanding the discourses in the scope of susceptibility is expressed in the recognition of the forms of transmission, severity of the disease, in the clarity of behaviors that increase the risks of infection by HIV and other STIs. According to the MCS, the individual's recognition of susceptibility to some disease involves different personal factors. It is possible to identify extreme postures with the total denial of the possibility of illness, while there are people who recognize the potential risks and express the possibility of being affected by the disease. It is observed that the perception of susceptibility to HIV is heterogeneous, pointing to the importance of building different approaches to prevention [10].

In this way, these findings corroborate the constructions of the MCS, pointing out that, even if the susceptibility and severity involved in the illness are recognized, the decision to carry out a transforming action in the context will depend on the individual's belief in the benefits of acting on the problem [10]. Participants' responses demonstrated certainty in the benefits of prevention and presented consistent motivations for the development of safer sexual practices.

It appears that the participants of this study contemplate the three assumptions of the MCS, which are: understanding their susceptibility, understanding the severity of the disease and knowing the actions and benefits for prevention [9]. However, even in the face of compliance with these requirements, with the advent of PrEP, participants do not adopt all the combined prevention measures recommended by institutions such as UNAIDS and the Brazilian Ministry of Health. These findings are linked to evidenced barriers that are directly linked to sexuality, in which there is a need to experience sex with pleasure, free from judgments and guilt. In this way, it is clear that PrEP provided more than protection against HIV, but also the possibility of talking about their own sexuality [18].

This study showed that the adoption of HIV prevention practices and other STIs is not restricted to measures of knowledge of the problem, perception of the seriousness of the issue and available actions to prevent infections. However, different barriers were mentioned for prevention to actually occur. There is a need to expand dialogue and reflections on topics that encompass sexual health, recognizing its nuances and established power relations, such as gender, for example. Such findings reinforce that people's health policies and care need to expand their scope, especially in relation to sexuality and gender issues [19].

There is the importance of understanding sexual health as an integral factor - which must be unfocused from the illness and contemplated in the different areas of a person's life -, which encompasses the physical, social, mental and emotional. This concept encompasses sexuality, which is a necessary issue for human beings and which involves different dimensions for their full development, including internal factors such as: sex, pleasure, gender, sexual orientation, reproduction and external interferences (social, economic, political and religious). In this sense, sexual rights arise to guarantee the preservation of human rights with regard to the expression of sexuality and the maintenance of sexual health [20].

This study pointed out some important barriers to prevention, even in the face of the reach of the three main assumptions of the MCS. Among them, the difficulty facing the use of condoms. When it comes to the consistent use of condoms, there are barriers that outweigh the benefits, that is, the advantages of safer sex practices are not enough to guarantee protection. The justification lies in the fact that the negotiation of condom adoption would impact on trust between partners, gender equality, intimacy and sexual pleasure [11]. Therefore, there is a need for a greater understanding of sex in an integral way, which includes, in addition to safe sex, psychological and physical satisfaction. This is associated with the need to implement proposals aimed at sex education. Although there is a growth in debates involving sexual rights, there are significant gaps involving the programmatic systems responsible for structuring policies and actions. It is possible to verify some tensions on the part of academia and civil society, but there is still a distance from the theme [21].

International institutions such as the World Health Organization (WHO) and the International Planned Parenthood Federation (IPPF), have long launched awareness-raising initiatives in the field of sexual and reproductive rights, demonstrating that incentives - which recognize the importance of sexual health - have reduced stigma on the subject. However, it is known that there is a long way to go in order to understand that sexual rights are closely linked to fundamental human rights [24].and, in this line, it is necessary to understand how sociocultural, structuring and vulnerabilizing processes are linked to the distancing of some groups to full access to these rights, directing them to a greater risk of harm and less favorable health outcomes, such as those related to a higher prevalence of HIV/AIDS and STIs. This reflects on the need to improve prevention approaches, with consideration of sex, gender and sexuality, as well as the importance of zero discrimination strategies in health services, as central themes for effective behavior reduction involving health risks [20].

Sexual pleasure involves physical and psychological satisfaction, through individual or shared experiences, which includes eroticism from thoughts, dreams and desires. In this act, autonomy, privacy, consent, intimacy, security must be guaranteed and involve a positive act of well-being [22]. In view of this, it is important to highlight the importance of providing information that

contains sexual messages that contemplate pleasure and that are remembered more easily, building better attitudes and possibilities of communication between partners. Consequently, there are safer behaviors and practices established, such as the recognition of risks to STIs, main forms of transmission, preventive measures, among others [23]. It is observed that dialogues based on risk and on the negative and excluding aspects of pleasure are not consistent for the adoption of prevention behaviors. They end up producing opposite effects [24]. This is because the availability of information and access are not enough, when thought of in isolation in HIV prevention policies. It is understood that the provision of information is essential, but that it includes the expansion of knowledge with offers of opportunities for dialogue and recognition of the diversities of experiences involving sexuality.

The social, economic, political, cultural, religious, gender and sexuality contexts impact the way information is interpreted and, consequently, the safe behavior of each individual. Public prevention policies, aimed at fighting HIV, need to reach different people, ways of living, physical/sexual needs and life circumstances [25].

The practice of anal sex without condoms with regular partners was frequent among the interviewees. This attitude was considered, by its practitioners, as something without risk. This route presents a 10 times greater risk of HIV infection when practiced without a condom. However, it is not uncommon to perform it in an unprotected way, an act justified by the expansion of pleasure in the relationship. It is evident that there is awareness of the risks and the intention of performing anal sex without condoms [26].

However, it is clear that there is no lack of prevention input and access to it. Condoms are available in different spaces and their effectiveness has already been tested and known many times. Thus, it is understood that a significant measure lies in the strengthening and reformulation of prevention approaches. These should consider the different axes of combined prevention, emphasizing PEP and PrEP with the elimination of barriers, as well as the promotion of counseling with consistent approaches on sexuality and sexual health [25].

Conclusion

From the findings and analyzes from the perspective of the MCS, carried out in this study, it was possible to understand the perceptions of PrEP users about prevention and sexual health. It was evidenced that the participants recognize their susceptibility to HIV, including mentioning its risks. There is a desire to live their sexuality in a pleasant way, although they recognize the contexts of living with HIV and the benefits of prevention, they choose practices in relationships, even if insecure, that provide them, above all, with pleasure and company.

It is observed that the use of PrEP eliminated feelings of guilt and fear, allowing users greater freedom and well-being regarding their sexuality. In this way, it is concluded that PrEP users seek to guarantee their sexual health and are protected from HIV infection. They put pleasure as a central issue, even though they are exposed to other STIs. And they make this choice, consciously or not, in order to experience more pleasurable sexual experiences and enjoy sexual partnerships.

The relevance of this research is centered on the creation of subsidies that allow the renewal and construction of prevention approaches that reach the main barriers listed and focus on the most exposed populations. It is identified how much the enhancement of public policies can drive actions that allow the insertion of the theme about sexuality in formal spaces of care. By updating and innovating approaches, such as more assertive communication and closer to people's needs.

In this research, it was possible to contemplate different population segments, however, a cut was configured with a high level of education and prevalence of white race/color, which may be configured as a limitation of the study or an indication that PrEP is not yet accessible to all priority population, such as those who live in contexts of lack of access to health services, lack of information, low education and other situations of violation of rights.

It is worth noting, in relation to the sociodemographic profile of the interviewees, that it is necessary to carry out similar studies on a larger scale, expanding the sample space, with greater ethnic/racial diversity, of gender identities and sexual orientations, within the scope of the priority population, reaching, thus, other socioeconomic conditions and access to education.

The use of the MCS to organize, produce and analyze the research data allowed a systematic understanding of the behavior of PrEP users, encompassing factors to be considered in the processes of recognizing sexual health. It also made it possible for the perceptions to be narrated from a scientific context, without disregarding the uniqueness of each experience.

The present study promoted a reflection on sexual health, sexuality, PrEP and combined prevention, to expand the recognition and importance of approaches on these topics to guarantee comprehensive health care and face the HIV/AIDS epidemic. In Brazil [27, 28].

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