Perceptions of HIV Pre-Exposure Chemoprophylaxis among HIV-Negative, Post-Incarcerated, African American MSM

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ABSTRACT

Aims: To explore barriers and facilitators to using and adhering to Truvada, among HIV-negative, post-incarcerated, African American men who have sex with men (MSM). Background: African American MSM represent only 2% of the U.S. population, yet account for 73% of new HIV infections among African American men. Truvada was FDA approved in 2012 for chemoprophylaxis in HIV-negative persons at high HIV risk. According to CDC guidelines, Truvada is most efficacious when used daily in addition to consistent condom use from the beginning to end of sex, and with 2-3 month medical checks and counseling. Methods: In this qualitative ethnographic study we used convenience and snowball sampling. Participants were recruited from Men's Central Jail in Los Angeles in collaboration with the Center for Health Justice. Data were gathered using semi-structured questions in one and one half hour, audio-recorded, focus group sessions. Analysis: Transcripts were analyzed using AtlasTi qualitative software. Findings: 1. HIV-related stigma continues in African American communities 2. Post-incarcerated HIV-negative African American MSM may not consistently use or adhere to Truvada 3. Use of Truvada may mean that the user is HIV positive or gay, and 4. African American MSM may not use condoms with Truvada. 5. Truvada should be given to men who are incarcerated.

Key words: Truvada, African American, HIV

Introduction

The HIV/AIDS public health crisis in African American U.S. communities remains perplexing. African American men account for 70% of all new HIV infections within their race/ethnicity[1] (CDC, 2012). However, there is cause for even more pressing concern among African American men who have sex with men (MSM). African American MSM represent only 2% of the U.S. population, yet they account for 73% of new HIV infections among African American men.[1]

A unique critical context in which HIV acquisition and transmission occurs is that of social injustice leading to historically higher rates of African American male incarceration and recidivism. It is noteworthy that some men do have sex with men while incarcerated, and that there is a high correlation between incarceration and high-risk sex behaviors.[6] Prison HIV rates in 2002 were 3.5 times that of the U.S. general population and HIV risk is even higher among African American incarcerated men.[7] CDC (2015)[8] reports indicate that jailed African American men are 5 times more likely than White counterparts to be diagnosed with HIV. Sexual networking patterns of African Americans noted earlier may transfer to incarceration settings, thus increasing HIV risk. In addition, activities such as tattooing without clean needles and injection drug use that can occur during incarceration increase HIV risk.[9]

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Further complicating the HIV public health problem among African American MSM is perceived HIV stigma and homophobia in the health care system that perpetuate secrecy and diminish health-seeking behaviors while increasing risk.[10] Moreover, racism and sexual discrimination within the health care system can lead to less access to health care, and to Truvada. This may be so particularly for those holding a double minority status as being both African American and being a man who has sex with men. The problem is that Truvada providers may hesitate to prescribe this medication for such individuals, while the provision of Truvada is heavily reliant upon prescriber discretion. This is evident in reports that providers may be less likely to provide Truvada to Black MSM than White MSM.[10] This racism and discrimination may be based on assumptions by prescribers that Black men would be more likely than White men to increase their participation in unprotected sex if prescribed Truvada[11] However, some reports indicate that high HIV rates in Black communities may not be attributable to Black MSM participating in more frequent acts of risky sex than others.[12] Nevertheless, inconsistent use and adherence to Truvada is associated with developing drug-resistant mutations that can be transmitted to others, and can increase HIV infections among individuals and within communities, rather than decreasing it. Together, these contextual factors place African American MSM at high risk for acquiring HIV and transmitting it in their communities.

Overall, interventions have not been successful in effectively reducing HIV rates in the African American population. A fairly recent FDA-approved strategy for HIV prevention is to use Truvada also known as PrEP, as HIV pre-exposure chemoprophylaxis. In clinical trials Truvada, which is a combination of antiretrovirals—namely tenofovir and emtricitabine—in a fixed-dose tablet, showed efficacy to protect against HIV infection[13, 14] Consequently in July, 2012 the FDA approved Truvada for daily oral use among adult persons at high risk for HIV and who are confirmed to be HIV-negative. Truvada, as HIV pre-exposure chemoprophylaxis, is an intensive approach that requires strict use and adherence.[15, 16] Though not a first line of defense against HIV, Truvada is recommended as part of a comprehensive set of strategies to prevent HIV infections in individuals who have high-risk sex and do not use effective barrier prevention methods consistently.[15, 16]

These guidelines[15,16] for the use of Truvada are intended to increase efficacy thus mitigating the risk of acquiring HIV, and reducing morbidity. The guidelines indicate that Truvada has the best efficacy when taken daily and with consistent use of condoms from start to end of sex. HIV and sexually transmitted infection checks with a primary care provider, along with counseling to provide support for medication adherence and risk-reduction behaviors occurring at least every 3 months is recommended. Additionally, Truvada is not recommended for coitally-timed and other non-continuous daily use.

These rigorous guidelines alone can discourage those at high risk for HIV from using and adhering to Truvada. Yet, adherence to these recommendations is critical to the efficacy of the medication regimen to prevent new HIV infections. Suboptimal Truvada adherence can produce less effectiveness as demonstrated in the iPREX study[14] where HIV acquisition risk was 21% among participants with less than 90% adherence versus 73% among participants with greater than 90% adherence. The PARTNERS Truvada study also had similar findings.[13] Although Truvada holds promise as a tool in the arsenal of HIV prevention strategies, the potential emergence and spread of drug resistant strains resulting from suboptimal adherence can negate the benefits[17] while inadvertently increasing community HIV viral loads.

Theoretical Framework

The unique structural violence[18] experience in the U.S. has been the context in which sexual risk behaviors occur particularly for inner city African Americans. Within the concept of structural violence 'structural' refers to social structures, specifically economic, political, legal, religious and cultural forces. 'Violence' refers to avoidable oppression and domination that manifest in social inequities and injustices, and cause emotional and even physical injury. Structural violence is a chronic affront to human wellbeing, harming or killing people slowly through relatively permanent social arrangements that are normalized and deprive some people of basic need satisfaction.[19]

Truvada holds promise to reduce HIV acquisition particularly for highly at-risk groups. However sex risk behaviors of African American MSM occurs within a context of structural violence that must be considered. To our knowledge no studies have examined Truvada use and adherence in—post-incarcerated, HIV-negative, African American MSM. This population is unique in both its high prevalence of HIV—given the three risk factors of being a man who has sex with men, African American, and formerly incarcerated—and in their experiences of structural violence. In this study interpersonal and socio-cultural factors that can influence use and adherence to Truvada will be examined within the context of structural violence, where sex risk behavior occur and within which HIV rates continue to proliferate in African American communities.

Methodology

Once approval from California State University Los Angeles' Institutional Review Board was secured, the study was conducted collaboratively with the Men's Central Jail

in Los Angeles (MCJ) and the Center for Health Justice (CHJ), a community-based organization located in close proximity to the MCJ. Convenience sampling was used to recruit participants from the K6G unit of the MCJ that houses gay, bisexual, and transgender persons. Two CHJ staff that interacted regularly with inmates in education sessions they conducted at the MCJ informed inmates who were MSM of the study and gave them a telephone number to call a study-related researcher for eligibility screening after release from incarceration. Men who called to be screened were informed that the purpose of the study was to understand the perceptions of taking Truvada, an HIV prevention medication, among African American MSM. Recruitment also occurred through snowballing techniques whereby participants were asked to refer other MSM for screening. Before conducting focus groups participants were asked to read the consent form, then it was read to them out loud. Questions clarifying expectations about their participation were answered before they signed the form and each participant was given a copy of the consent form.

A total of 8 focus groups were held (n=47). The challenge was in recruiting the desired 6-8 participants for each group according to Crabtree and Miller's (1999)[20] metric for most effective focus group sizes. Participants explained that many MSM released from MCJ had difficulties financing transportation to the CHJ where focus groups were conducted. Often times they did not have access to a vehicle or money for public transportation. In other instances drug and/or alcohol use or prostitution interfered with their ability to keep focus group appointments. Nonetheless, data collection was discontinued after saturation was reached. Focus groups were held at the CHJ in a room that afforded privacy. Participants were told that they are free to say what they think and feel using any language with which they are comfortable, without reservations. They responded by being vocally explicit. Participants were encouraged to maintain confidentiality about all information revealed in the focus group discussions. Each focus group was audio-recorded, and lasted one and one-half to two hours. Semi-structured questions were used in all focus groups. An iterative process was used whereby data from each group informed the efficacy of conducting subsequent groups as it pertained to understanding how best to communicate effectively with participants and interacting comfortably and genuinely with them.

In order to help the men understand how Truvada should be used the CDC guidelines were explained. They were told that best efficacy with Truvada meant that this medication should be taken daily by adults to prevent HIV infections as a woman takes birth control pills daily to prevent unwanted pregnancies. Consistent use of condoms from start to end of sex is also necessary. In addition, medical checks every 2-3 months to be certain that there was no conversion to HIV-positive status, and checks for acquisition of sexually transmitted infection, as well as counseling are also necessary. Open-ended questions were then asked. Each participant received $40.00 in cash for focus group participation.

Participants

Participants were self-identified African American MSM, were HIV- negative, and recently post-incarceration. Ages ranged from 22-58 years with a mean age of 43; 45% completed high school; one had earned a master's degree. Most had participated in transactional sex. All were unemployed. All used street drugs either currently or in the past. All men whether homeless or not resided in the city of Los Angeles or West Hollywood where HIV rates were 46.3% and 18.4% respectively of the percentage of Los Angeles County HIV cases in 2009.[21]

Analysis

Focus group data collected from November 2011 to July 2012 centered on the following core questions: *What attitudes do African Americans have about HIV medications? What would interfere with using and adhering to Truvada**?*** *What would interfere with using condoms with Truvada? What would cause a man who has been incarcerated to take Truvada?* Facilitators used probes to further clarify participants' responses.

Data were professionally transcribed verbatim, all identifiers were removed and after multiple readings transcribed data were entered into ATLAS.ti, a qualitative research computer software package. Three study-related researchers independently coded, then met regularly to compare the codes and thematic patterns for agreements and inconsistencies. A constant comparative method was used from the beginning of data collection.

Findings

To our knowledge this is the first study to examine Truvada use and adherence among post-incarcerated, HIV-negative, African American MSM. The participants in this study are men at high risk for HIV. All men acknowledged engaging in high-risk sex. They engaged in receptive and insertive condom-less anal sex with multiple partners, participated in sex for compensation with drugs, and had sex under the influence of various street drugs. Of the 47 MSM, two had prior knowledge of Truvada. They had knowledge that the medication is known as Truvada or PrEP, and that it is used to prevent HIV, however they had no knowledge of the guidelines for using this medication. This is similar to other reports.[22] These authors also reported little increase in knowledge of Truvada over time, albeit in a sample that included a small number of African American MSM. The following five major themes emerged from the current

study:

1. *HIV-related stigma continues in African American communities.*
2. *Post-incarcerated HIV-negative African American MSM may not consistently use or adhere to Truvada.*
3. *Use of Truvada may be interpreted to mean that the user is HIV positive* or gay.
4. *African American MSM may not use condoms with Truvada.*
5. *Truvada should be given to men who are incarcerated.*

HIV-related Stigma Continues in African American Communities

The participants in this study indicated that in African American communities, and particularly among gay African American men, there is still difficulty talking about HIV and HIV-related matters including HIV medications. One man stated with agreement from the other participants, "*HIV is still a sensitive subjective."* Another said, *"African Americans have a hard time saying 'HIV*,' *and talking about anything related to it."* Another said, "*HIV and HIV medications are not discussed*." Another participant's statement related to a generalized perception of lack of acceptability of gay African Americans that might contribute to social marginalization and HIV stigma: *"To be considered part of the, I don't even know the initials, gay and lesbian and transgender community you have to be White. It is acceptable in White communities. Otherwise you are just a punk."* This finding that HIV stigma is still problematic in African American communities is similar to other reports.[23] These researchers also found a higher level of stigma among persons taking antiretroviral medication, and that stigma can be related to high-risk sexual behaviors. Others have reported a positive correlation between HIV stigma and depression, low social support, low self-esteem, and loneliness, indicating that the experience of stigma can cause psychological effects.[24] Difficulty talking about HIV may help explain the association between lack of partner disclosure of HIV status and increased sexual risk-taking behaviors.[25] In that study, African Americans who were able to disclose their HIV status were less likely to engage in unsafe sex. The CDC (2011)[26] has also indicated that stigma is related to HIV health behaviors.

Although HIV prevention strategies including increased awareness, testing, and condom use help to reduce HIV transmission and acquisition, HIV stigma can undermine these efforts since an inability to talk about HIV related matters directly affects the ability to garner support for safe sex behaviors from partners. Yet there are few culturally based interventions to reduce HIV stigma in African American communities. The finding that HIV-related stigma continues in African American communities indicates that there is still a need for interventions to help reduce HIV stigma. Culturally tailored interventions for African Americans to encourage freer discussions with their family, friends, and sexual partners and may help increase safe sex behaviors, thereby potentially reducing HIV infection rates.

Post-Incarcerated, HIV-Negative, African American MSM May Not Consistently Use or Adhere to Truvada

Not using and adhering to Truvada according to the CDC guidelines can cause HIV acquisition and transmission[21] however more than 75% (35 of 47) of the men in this study indicated that they would not use or adhere to Truvada. The task of having to take Truvada daily was seen as problematic by most men, reflecting HIV medication use and adherence problems that are already prevalent among African Americans.[27] As stated earlier, these men used street drugs either currently or in the past, and the use of street drugs can alter judgment and behavior such that persons who use street drugs may not adhere to HIV medications,[28] therefore adherence to Truvada could be problematic for some groups. Using and adhering to Truvada was an area of extensive discussion among the participants who gave several reasons why they may not use and adhere to Truvada. One participant indicated, as others agreed:

"Black men, African American men we all don't. It's already statistically shown that we do not go to the doctors, we do not take medications. Just like with stuff like diabetes and other kind of illnesses we don't even take meds for that. I don't see us doing the HIV pill. That's asking a lot, you know what I mean?"

Another explained, *"Because we are already suffering high blood pressure. That's just another pill."*

Another explained, *"I think the youth. That's the one we should focus on because they are having sex anywhere, any place, anytime."*

Another explained, *"Three fourths of Black men that have sex with men are not going to do so. They're not going to take a pill everyday."*

Another added, *"The only thing is taking it everyday."*

Another questioned, *"Do you take it in the morning, afternoon or dinner? It's just another job you gotta do."*

One participant explained, *"See most people who need that drink and smoke… That's why I am saying I wouldn't take it because when I'm not in the recovery mode I drink and I smoke, and I'm not talking about smoking weed. I'm talking about hard stuff, you understand me? I want to know if it would be effective if I was smoking crack or something like that? Have you guys went out to crack heads, people smoking meth to see if it was effective?"*

Another agreed, *"Like my man here was saying, there are other little medications, your personal stuff. A lot of people see psychiatrists for psych, you know. If you mix those pills together and they don't connect…"*

Another questioned, *"Can you take it with alcohol?"*

Another added, *"If I am taking this I plan to catch it [HIV]."*

Another participant questioned, "*What happens if you've been taking this medication all this time then all of a sudden you somehow catch HIV, then you are resistant to what you've been taking? And then what's gonna help you?"*

One participant stated and others agreed about beliefs in an HIV conspiracy theory that would prevent them from using and adhering to Truvada:*"I mean if it is something that is actually beneficial where contracting AIDS is concerned, or not contracting it then it's a great idea. But the thing about it is that a lot of us, we as people feel like it was like HIV and AIDS was formulated somewhere and the government had a big hand in it or whatever. And I mean I would be afraid to take anything that had anything to do with HIV and AIDS."*

Another added*, "The bible said that the government is corrupt anyway."*

For the aforementioned reasons another participant concluded, *"I ain't taking that shit."*

Participants offered several other reasons for not using and adhering to Truvada. One participant stated and others affirmed, "*…the side effects that one person might get, how you know your body can handle that? Everybody body not the same so then my head is like why would you take this medicine?"* Some participants had concerns that a proper diet may be necessary with Truvada. One participant stated, "*You have to eat right to take HIV medication. If you're on the streets and you are taking HIV medication [Truvada] and you are not eating right that could be a problem."*

One participant who may consider using Truvada stated, *"I think I would. Only if it came in the same package with condoms."*

One of the participants offered an explanation of its usefulness to persons engaged in transactional sex with affirmative nods from the other participants: *"I think it would be really, really good like for a sex worker. Somebody who is a sex worker and they do that on a daily basis because that way every time they bust open that condom they will be able to take their pill for that day. They will be more likely to say, okay, I'm a hoe, but I am going to go ahead and take this pill and use this condom in case I slip up or the person slip up, I've still got a little barrier."*

Another participant offered an explanation for when a man should use Truvada: "*Now, if a man was messing around with somebody else, he should use it if he was messing around with somebody else, he should use condoms and still take the pill, but if it was just you and your partner...*"

Men were also concerned about the cost of Truvada. *"Who is gonna pay for this if you want to take this medicine? Who's gonna pay for it? If they're trying to help us to prevent it in the African American environment why should we have to pay for it because they know our circumstances. You know most Blacks, African Americans, we are on low-income, Section 8. But why would you put it out there to help us if our income and our capability, how would we pay for it? I don't even know if I would do it if it was free so having to pay for it at all?"*

Finally one man explained, *"Hell, I smoke weed and I drink and get high so I'm going to die from something. So it might as well be from that shit [HIV/AIDS]."*

The many reasons offered here help explain why the men in this sample would not be likely to use and adhere to Truvada. This finding is in contrast to other reports that most African American MSM would use Truvada.[22,29] This incongruence may be explained by the dissimilarities between the samples. The samples in these studies had a higher socio-economic and educational status than the men in the current study, and were not recently post-incarcerated. In addition each of these studies had small African American samples.

Use of Truvada May Be Interpreted to Mean That the User Is HIV Positive or Gay.

Sexual risk behaviors can be influenced in person-person relationships where they occur, and on sociocultural levels as well. These interpersonal influences could cause a person to not use and adhere to Truvada. Participants indicated that the possible misperception by a partner—that taking medication to prevent HIV would mean the individual had HIV—was one factor that could interfere with using and adhering to Truvada.

One man said "*I think it is going to be hard to take this medication because the reason why I think it's going to be hard because then the other person will think you have HIV even though you don't."*

Another offered, "*The other person will think you are positive and you're not and he's going to say why are you taking this medication."*

Another offered, "*Why you taking this medication? Even though you're going to be honest and to say to that person I'm not positive. Well, why you have this medication. And you are going to have a big old argument right there."*

On a socio-cultural level, participants indicated other forms of assumptions friends and family may have about taking Truvada: the judgment, isolation, secrecy and potential threats to relationships that could occur although the medication is being used as HIV chemoprophylaxis.

One participant stated, *"People might think you gonna get a pill so you can mess with them boys."*

Another stated*, "I don't think people would like people knowing what you're taking because they have so many thoughts about what is he doing, why is he taking this, what is that."*

Another offered, *"Is he gay or is he not gay. What I mean, why is this guy taking this. That you might be ill [have HIV infection]. You know they wouldn't want to drink*

after you, smoke, anything after you. They might not even want to talk to you."

In agreement another participant stated, *"Exactly what he said is people looking at you taking certain medicine, even though it is Truvada it's still HIV medication you are taking."*

Another participant talked about perceived interpersonal and socio-cultural challenges to taking Truvada saying, *"That would be another stumbling block for me. People asking me what the hell are these? You got something? Something wrong with you?"*

Another echoed similar opinions, *"If somebody see you taking them, they go, what are you taking, you got AIDS. If you taking this pill everyday this means something is wrong with you. This means you've got to try to hide it or you know, just keep it away from people."*

Another participant stated, *"So a person sees you takin' the same pills as an HIV person they automatically thing you got HIV no matter what you tell 'em. They are not going to have sex with you because they are going to be too afraid that you actually have HIV, and you are just lying to them."*

The importance of the finding that someone taking Truvada may be assumed to be HIV-positive or gay could interfere with a person using and adhering to this medication, which is meant to prevent HIV acquisition and transmission. The statements by participants underscore how both interpersonal interactions and socio-cultural influences can impact health behavior. These statements also underline a lack of knowledge about Truvada among the participants. The implication here is that including Truvada education at both individual and community levels, when designing interventions for the HIV/AIDS public health crisis in African American U.S. communities, may be helpful.

African American MSM May Not Use Condoms with Truvada

Condom use alone has long been known as an efficacious means of reducing the risk of acquiring HIV. As indicated earlier, efficacy to prevent HIV with Truvada requires strict adherence to the CDC guidelines, which include not only using Truvada daily, but using condoms from start to finish of each sex act[21] Additionally, Truvada could be useful for persons who do not use condoms consistently. Whether persons using Truvada would also use condoms at each sex act has been an important question among researchers. Not using condoms with Truvada, which has been referred to as "risk compensation," "behavioral dis-inhibition," or "condom migration" is concerning since this behavior could offset the preventive benefits of Truvada, thus increasing HIV rates instead of decreasing it.[30,31] However, participants questioned the logic of using condoms along with using Truvada, and rationalized how inconsistent use of Truvada and condoms could occur.

One participant questioned, *"Why not just use condoms, what is the point?"*

Another also questioned, *"Why would I have sex and have to use medication and condoms anyway? I'm using condoms now, I'm going to take medication and I have to use a condom to have sex. That just don't make sense."*

Another agreed, *"Thank you because I was trying to understand that because if I'm taking the medication to not get HIV that should be all there is if I'm not going to get HIV."*

Another added, *"I have been trying to find a way around condoms, so if I have Truvada I may not use condoms."*

Another explained, *"Only if somebody is getting to know me, only if I'm going to be involved with this person in a relationship I wouldn't use it, but if it is a booty call or something I'll just take my pill and just use my condoms."*

Another explained hypothetically how some may engage in sex risk behaviors that could put them at risk by not using condoms consistently when they are taking Truvada: *"It's gonna be like, oh man I got this pill, I'm good. I don't got to use no condom, you know. People will just be like going out there having sex because they got the pill."*

Another explained, *"Because they're going to say, why am I using a condom, or they're going to say, why am I taking the pill when I have the condom."*

Another explained, *"It will be like fuck the condom. I'm not going to use a condom, I'm just going to take this pill and go out and pound something because I've got the pill. They say it is going to protect me."*

The finding that African American MSM may not use and adhere to condoms with Truvada is similar to other reports. Brooks et al. (2012)[32] found that 64% of participants in their study indicated a likelihood of engaging in sexual risk behaviors, and 60% indicated a likelihood of non-condom use with HIV pre-exposure chemoprophylaxis. Although the men in the current study were at high risk for HIV acquisition most did not seem to see the benefit of adding Truvada to a sexual routine that may already have included using condoms that have known efficacy. Additionally, the findings suggest that intimacy may play a part in condom use since partners may question its use with Truvada.[33] However, participants' comments imply that condom use with Truvada may depend on the type of interpersonal relationship a person may have with another person.[29]

Truvada should be given to men who are incarcerated.

Sex among male inmates occurs and between 20% and 26% of people living with HIV/AIDS in the United States have spent time in the correctional system.[34] This positive association between HIV and incarceration[35] coupled with higher incarceration rates for African Americans (4,777 per 100,000) as compared to White males (727 per 100,000)

increase HIV risk more so among African Americans.[36] In addition, it has been reported that 51% of incarcerated men engage in unprotected sex on the first day of release and 81% by the first week.[37] At the K6G unit of the MCJ where the sample for this study was recruited, there have been reports of oral and anal sex among male inmates.[38] In response to Truvada use and adherence among incarcerated MSM, participants indicated that HIV chemoprophylaxis should be provided to them because men have sex with each other while incarcerated.

One man began by describing how sex between incarcerated men can occur:

"You push two bunk beds together and you have two [sheet]covers hanging over so can't nobody see. So it's like a queen sized bed on the bottom. You hang your sheets so it's like you're enclosed…"

Others concurred with one man's statement that *"There's a lot of sexual activity that goes on in there."*

Another added, *"And they ain't using condoms."*

Another added, *"They [incarcerated MSM] should have it [Truvada] because I've known some people that went in jail and came out positive..."*

Another concurred, *"My uncle went to prison and when he came out he had HIV."*

While men felt incarcerated MSM should have Truvada, using and adhering to this medication was seen as problematic. Condom use with Truvada again surfaced as a problem since condom use with Truvada is necessary however access to condoms while incarcerated is problematic, making it difficult to adhere to CDC guidelines for Truvada. Also, the same concern mentioned earlier, that partners could question Truvada use surfaced again.

One man stated as others concurred, "*They [partners] will think you're sleeping around."*

Another explained the difficulty in using Truvada if you are re-connecting with a partner upon release from incarceration, and gave an anticipated partner's response: "*You will have to hide it. You're hiding it because you've been in jail or prison and if you only been messin' with me and I haven't messed with anybody since you've been gone, why are you taking that and you just got out?"*

Discussion

Findings in this study help the understanding of factors that may influence use and adherence to Truvada in a subgroup of African American people that are highly at risk for acquiring and transmitting HIV, that is, post-incarcerated, African American MSM. Implied in the findings, and also indicated in other findings, is that sex risk behaviors can be influenced on interpersonal as well as on sociocultural levels.[39,33] However, African American sex risk behaviors occur within a unique history of longstanding structural violence, yet these behaviors are often examined in isolation and without this context. The men in this study could only respond to Truvada use and adherence in the context of structural violence in which they exist, having poverty of material and informational wealth, limited trust in the health care system caused by a history of unethical treatment in research, and limited access to the health care system. Poor treatment in the health care system driven by racism and homophobia is compounded for African American MSM. A deeper impact is meted out to those who have a history of incarceration and must manage racism and homophobia along with post-incarceration disenfranchisement that ensures recidivism and a likelihood of permanent location on the fringes of American society.

While the findings in this study have significance for use and adherence to Truvada, which can be helpful in reducing HIV acquisition and transmission in post-incarcerated, African American MSM, these contextual factors function to interfere with use and adherence to HIV chemoprophylaxis. The majority of these men had no information about Truvada. Reasons given for not being likely to use and adhere to Truvada included the inconvenience of taking it daily, and the lack of logic for using condoms with Truvada when condoms have known efficacy to prevent HIV when used properly and consistently. They also indicated that drug use and passion could deter condom use with Truvada. However, limited access to Truvada due to unmanageable cost also surfaced as a reason participants may not use and adhere to the medication, as did a lack of trust in the health care system, causing the participants to consider Truvada as a conspiracy to intentionally infect them with HIV given past transgressions in U. S. research exemplified in the Tuskegee Syphilis study.

The finding of continued stigma and the implication that there is still a lack of HIV-related discussions could prohibit disclosure of HIV status, hence the continued need for HIV education. Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information. [40] This is necessary in order to make effective health care decisions for oneself. In as much as Truvada can be useful in persons with similar characteristics as participants in this study sample, health illiteracy as it regards Truvada—being uninformed about this medication, and lacking the capacity to access and use it according to the guidelines—can prohibit the actualization of any benefit this drug can offer as a prevention option for HIV. The finding that Truvada use may be interpreted to mean the user is HIV positive or gay, as well as the finding that participants may not use condoms with Truvada if they had access to this medication also signal the need for education regarding Truvada. This education must be culturally tailored to the needs of specific high-risk groups in order for it [HIV chemoprophylaxis] to be used and adhered to as intended. The preponderance of HIV infections among African American MSM calls for an urgent focus on those that are at high risk, particularly subgroups such as African American MSM with a history of incarceration.

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