

Saying “Yes” to PrEP: Examining PrEP acceptance among urban men who have sex with men
(MSM) at a Seattle public sexual health clinic.

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Abstract

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Pre-exposure prophylaxis (PrEP) is extremely effective at preventing HIV, but uptake has been below targets. PrEP acceptance and uptake are commonly examined through hypothetical acceptability and active use, but the act of accepting a PrEP recommendation from a clinical provider is under-studied. This cross-sectional study used patient survey data and health records from the Public Health—Seattle & King County Sexual Health Clinic in Seattle, WA to examine how PrEP acceptance differed by key covariates among men who have sex with men (MSM). Among 1721 patient visits where a provider recommended PrEP to an MSM, PrEP was accepted at 1168 (68%) visits. Prevalence of PrEP acceptance was lower among patients aged 25 years or older compared to patients under age 25 (PR = 0.92, 95% CI = 0.85, 0.99) and higher among patients who reported greater numbers of recent sexual partners compared to those reporting one

or fewer (PR = 1.38 95% CI = 1.13-1.68), but was lower among Black patients compared to White patients (61%, PR = 0.85, 95% CI = 0.76-0.96) and patients identifying as bisexual compared to those identifying as gay (PR = 0.84, 95% CI = 0.75-0.93). According to visit notes recorded by providers, patients who declined commonly believed their risk of HIV exposure was too low to warrant daily PrEP, were concerned about side effects, or preferred to discuss with their primary care provider, while some preferred to abstain from sex altogether following the HIV/STI exposure which brought them to the clinic. To increase PrEP uptake, future work should identify and test strategies to maximally support some MSM who have an indication for but less often accept PrEP.

Introduction

Pre-exposure prophylaxis (PrEP) is a critical tool to end the HIV epidemic, but use of PrEP among people who can benefit from it remains significantly below targets in the United States and globally. [1] Though uptake has steadily increased in the U.S. since its FDA approval in 2012, only 36% of people indicated for PrEP were prescribed it in 2022. [2] Opportunities to increase PrEP use exist at each step of the PrEP care continuum. [3] This begins with raising awareness among indicated populations, both of HIV risk and of the existence and benefits of PrEP. To enable uptake, individuals and communities who can benefit must receive access to PrEP, link to PrEP care, receive a PrEP offer, and obtain and initiate a prescription. Finally, patients may require support to adhere to their PrEP regimen and remain in follow-up care.

Acceptability of and willingness to use PrEP has been well-examined in many populations and is impacted by numerous factors, most notably self-perceived HIV risk and concerns about cost, side effects, and social stigma. [4–6] However, while PrEP acceptability is well-studied, less is understood about enacted acceptance: the act of actually accepting PrEP when it is offered to the patient. In contrast to hypothetical willingness outside of the clinical context, the choice to accept or decline PrEP from a provider is an active decision by a patient who has already sought care and has been counseled to take PrEP by a clinician.

Patients who decline PrEP are to be distinguished from those who are theoretically unwilling. Research in vaccine hesitancy shows that many patients who are initially hesitant or unwilling to take a preventive vaccine go on to accept it when recommended by a trusted healthcare provider. [7–9] This parallel suggests that additional factors influence whether a PrEP-hesitant patient will go on to accept and initiate after a provider visit. Therefore, it is necessary to

understand the frequency, motivations, and predictive factors behind a patient's choice to accept or decline PrEP after a clinician recommends it.

Awareness of and access to PrEP care are two of the most important facilitators of uptake, [3] but they are less applicable to the decision to accept PrEP since such patients by definition are aware of and have access to it. Other factors form barriers to uptake which may also influence PrEP acceptance. The impacts of structural racism, including socioeconomic disparities, discrimination, and medical distrust have limited uptake for Black and Latinx people relative to epidemic need as PrEP use has increased in the U.S. [10,11] Uptake has also been low among other groups who have the greatest need, including people living homeless, immigrant groups, [12–14] sex workers, [15–17] and people who use methamphetamine and/or injection drugs. [18] To form a complete picture of barriers to PrEP uptake across the care continuum, it is necessary to investigate how PrEP acceptance may be influenced by these and other demographic factors.

Existing literature on PrEP uptake has primarily focused on rates of use among populations who can benefit rather than on the act of acceptance. [4] This step in the care continuum merits study, as multiple studies and real-world clinical experience suggest that patients often decline PrEP when it is offered in a clinical setting. Only 58% of patients at a sexual health clinic in Mississippi accepted an offer for PrEP. [19] In the HPTN 073 study, where Black MSM were offered PrEP across three U.S. cities, 21% of participants never initiated. [21] An examination of this crucial junction in the PrEP care continuum is needed to understand what barriers and facilitators influence the choice to accept PrEP, as well as how to identify and target effective counseling strategies for PrEP-hesitant patients.

This study aimed to examine acceptance of PrEP among cisgender MSM patients at a Washington State municipal sexual health clinic. We analyzed patient visits where PrEP was recommended to assess factors associated with acceptance; to quantify how many patients progressed from an offer to acceptance to obtaining and initiating a prescription; and to understand reasons and contexts for why patients declined.

Methods

Study setting. This cross-sectional study included electronic health record data from the Public Health - Seattle & King County Sexual Health Clinic in Seattle, WA.

Study population. The population examined in this study consisted of cisgender male patients aged 18-75, who attended the clinic between 2017 and 2024, who reported at least one male sexual partner in the last twelve months (henceforth described as MSM), who were offered PrEP at their clinic visit. The analysis included MSM patients who met criteria for PrEP eligibility according to the clinic guidelines for MSM at the time of their visit, which expanded over the course of the study period. [22] In 2017, clinic guidance indicated PrEP for Black and Latino MSM and all patients who in the last 12 months had been diagnosed with rectal gonorrhea or syphilis, used methamphetamine and/or amyl nitrite, exchanged sex for money or drugs, and/or had ongoing sexual relationships with non-virally suppressed HIV-positive partners. In 2020, these guidelines expanded to include all sexually active MSM.

Data sources. The study combined two sources of clinic data for each patient. Sociodemographic and behavioral data were drawn from the Sexual Health Clinic's self-administered kiosk questionnaire, which is administered to all patients via REDCap. Additional data were drawn from the Epic electronic medical record (EMR), with demographics and PrEP provision information recorded in structured fields, and visit notes recorded in free text. The

provider visit notes included information about whether PrEP was discussed and recommended at the visit and indicated when patients declined. Reasons for declining PrEP were extracted from these visit notes to examine them qualitatively.

Defining PrEP recommendation, acceptance, and declination. A PrEP recommendation was defined as a visit where a patient was counseled to take PrEP and was offered to start it at the visit. Of all MSM patients who were eligible for PrEP, we excluded visits where patients attended with the intention of starting PrEP, either according to self-report on the intake questionnaire or clinician report in the visit notes. Therefore, we assumed that any patient who accepted PrEP had been recommended by the provider. Subjects were included if they received a PrEP prescription at the visit, indicating PrEP had been recommended, or if the patient visit notes recorded making a PrEP recommendation, whether or not PrEP was prescribed. PrEP acceptance was defined as agreeing to a PrEP prescription and was indicated by a record of PrEP prescribed at the visit, a binary field in the EMR. PrEP declination was defined as not accepting PrEP and was indicated where a provider recorded recommending PrEP to the patient in the visit notes but PrEP was not prescribed.

Data analysis. Data were analyzed using R. We used descriptive statistics to compare variables of interest for patients who accepted and declined PrEP. To assess the association between acceptance and covariates identified a priori through a review of prior literature, Poisson regression with robust standard errors was used to estimate unadjusted and adjusted prevalence ratios (PR) and 95% confidence intervals (CI) in a complete-case analysis, that is, including only cases with data for all variables. Variables found to be significant in univariate analysis ($\alpha = 0.05$) were included in the multivariate model. Acceptance was examined per visit rather than per patient, meaning repeat visits with repeated PrEP offers were treated individually. We accounted

for potential correlation of data related to patients having multiple visits through the use of robust standard errors.

Visit notes were analyzed thematically to uncover reasons and contexts for declining PrEP. Visits were manually reviewed by BP for mentions of reason for declining. Qualitative analysis was performed using Dedoose 9.0. A codebook was developed inductively through review of all applicable visit notes and used to analyze text excerpts for salient themes. This de-identified analysis was deemed exempt from institutional review board by the University of Washington Human Subjects Division.

Results

Between January 2017 and December 2024, there were 1721 encounters where a provider recorded recommending PrEP to an MSM patient, representing 1537 unique patients (Table 1). Forty-three percent of these 1537 patients identified as non-Hispanic White followed by 24% Hispanic or Latino (any race) and 13% Black. A majority of patients identified as gay (71%), followed bisexual or pansexual (19%), with 2% of patients identifying as heterosexual. Most were born in the United States (72%), and most were stably housed, i.e. not homeless (96%). PrEP was accepted at 1168 visits (68%) (Figure 1).

The multivariate analysis included 1629 visits with the covariates of age group, racial identity, sexual orientation, number of sexual partners in the last 12 months, housing status, birthplace in the United States, transactional sex, drug use, suspected HIV, and suspected STI. PrEP acceptance was lower among older patients (aged 25 or older) than among patients under 25 years of age (Table 2, PR = 0.92, 95% CI = 0.85, 0.99). PrEP acceptance was highest among non-Hispanic White and Asian patients (71%). Black patients were least likely to accept (61%, PR = 0.85, 95% CI = 0.76-0.96) relative to non-Hispanic White patients. Bisexual men were less

likely to accept PrEP compared to gay men (PR = 0.84, 95% CI = 0.75-0.93). MSM identifying as heterosexual had a lower prevalence of acceptance compared to men identifying as gay, but the difference was not statistically significant (PR = 0.72, 95% CI = 0.45-1.16). Greater numbers of recent male sexual partners were more strongly associated with PrEP acceptance. Compared to patients with one or no partners in the past year, those with 2-5 partners (PR = 1.26, 95% CI = 1.03-1.53), 5-10 partners (PR = 1.24, 95% CI = 1.01-1.52), and greater than 10 partners (PR = 1.38, 95% CI = 1.13-1.68), were more likely to accept PrEP.

Multiple variables were not associated with PrEP acceptance, including unstable housing, birth outside the United States, transactional sex, or reported drug use. Similarly, history of STI diagnosis was not associated with acceptance, although patients who attended because they believed they might have an STI, whether due to symptoms or a recent exposure, were less likely than other patients to accept (PR = 0.90, 95% CI = 0.84, 0.96). Among patients who initially declined PrEP, 18% went on to eventually accept it at a subsequent visit (Table 3).

Reasons for Declining

Reasons or context for not accepting PrEP were recorded for 207 of 553 or 37% of visits in which patients declined PrEP. The most commonly cited reason for declining PrEP was a self-perception of having low HIV risk, whether due to reporting consistent condom use, low sexual frequency, safer practices, or otherwise. Many patients felt that because they practiced only insertive anal or oral sex, their risk was too low to warrant taking PrEP. Others reported being in a monogamous relationship at the time of the visit; often the choice to become monogamous prompted the visit for HIV/STI screening.

Providers noted that patients also commonly preferred to discuss and initiate PrEP with their primary care provider (PCP) rather than a sexual health clinician. Some patients lived too

far from the clinic or were visiting from out of state and frequently affirmed that they would follow up with a provider closer to home. Other patients did not have time to discuss PrEP or have labs drawn on the day of the visit. Most of these patients did not return for a PrEP appointment, although it was unknown whether they went on to engage in PrEP care outside the clinic.

Many patients reported concern about the health impacts of PrEP. Some were concerned about potential side effects such as weight gain or impact on liver health or bone density. Some patients who had used PrEP in the past were hesitant to restart because of previous adverse experiences, most commonly gastrointestinal issues. Others declined due to a comorbid health issue such as chronic kidney disease.

Some patients declined because they did not prefer oral emtricitabine/tenofovir disoproxil fumarate (EMT/TDF also branded as Truvada), which was the recommended form of PrEP prescribed in the clinic. Some declined for dislike of daily pills and concern about ability to adhere to the medication, while others experienced side effects such as headaches while taking EMT/TDF (previously?) and wanted to take a different oral PrEP medicine (emtricitabine/tenofovir alafenamide, also branded as Descovy) instead.

Finally, some patients expressed a desire to pause or cease sexual activity after their visit rather than start PrEP. Some reported that the circumstances leading to their visit led them to want to remain abstinent at least for a time in order to refocus on their personal wellbeing. Others said they felt that taking PrEP would facilitate sexual behaviors they wished to avoid.

Discussion

We found that more than two-thirds of MSM patients accepted a PrEP offer when recommended by a clinician in an urban sexual health clinic in Seattle. Demographically,

acceptance was lowest among patients who were Black, who were aged 25 years or older, and who identified as bisexual or pansexual. Factors previously associated with HIV and/or lower PrEP uptake in other studies were not associated with lower PrEP acceptance in this population, including homelessness, birth outside the United States, transactional sex, or reported drug use. This suggests that work to increase uptake in these priority groups should focus on connecting patients to care and supporting adherence after PrEP is prescribed. Patients who declined commonly reported low perceived risk of HIV or side effect concerns, preferred to start PrEP with their PCP, or expressed a desire to modify their sexual practices rather than start PrEP.

Most published studies relating to PrEP acceptance have measured hypothetical willingness or acceptability or examine rates of current use among populations who can benefit. This study differs by examining the specific health behavior of accepting a recommendation for PrEP from a provider. Previous studies of PrEP acceptance in similar U.S. populations have found a wide range of proportions of acceptance vs. non-acceptance, suggesting considerable heterogeneity between geography, clinical sites, or which aspects of acceptance are examined as outcomes. [19–21] A study PrEP clinic in Mississippi examined PrEP acceptance at a visit, similarly to the present study. Fifty-eight percent of patients accepted PrEP in their study compared to 68% of patients in the present one. [19] Another study examined acceptance of a PrEP referral (though not a PrEP prescription itself) and found that one-third of PrEP-eligible visitors to an urban emergency department accepted the referral. [20] The HPTN 073 study, which followed Black MSM across three U.S. cities, found that 79% of participants initiated PrEP following their initial offer. [21] As noted, accepting a PrEP offer and going on to initiate are distinct outcomes, and individuals participating in a PrEP clinical trial may be more motivated to start than the general population.

An acknowledged limitation of the most comparable study to the present one [19] was their inability to distinguish encounters where patients attended for the purpose of seeking PrEP, which could bias the proportion of acceptance. Our analysis accounted for this risk of bias by excluding patients who were attending specifically to start PrEP, in order to more accurately estimate the response from patients who received a recommendation for PrEP.

It was notable to find that bisexual patients were less likely to accept PrEP than patients identifying as gay. It is uncertain what may influence this trend for bisexual men. The prevalence of PrEP acceptance was lower among straight-identified MSM than for other groups defined by sexual orientation, but this association was not statistically significant. This could be due to the small number of straight-identified men in the sample ($n=36$). Previous research has suggested that MSM who self-identify as straight may exhibit lower willingness to engage in HIV testing [23] and PrEP care. [24]

Reasons for declining PrEP as recorded in patient visit notes commonly included factors widely reported in acceptability literature, especially low perceived risk of HIV and concern for side effects. [4] Though all patients in our sample met the clinic's PrEP eligibility criteria, levels of risk varied widely. Some patients who believed themselves to be low risk had relatively fewer partners or wore condoms consistently, and providers sometimes affirmed that a patient was not an urgent candidate for PrEP. In other cases, patients may have underestimated their own risk of exposure. A frequent justification for not taking PrEP was that the patient typically or exclusively topped, i.e. performed the insertive role in anal sex. While the risk of per-act transmission is considerably lower for the insertive vs receptive partner, condomless insertive anal sex is still associated with HIV acquisition. [25] This and other beliefs about one's personal risk may have caused some patients to perceive a low benefit to PrEP even after a discussion with a clinician.

Many patients were interested in PrEP but preferred to discuss and initiate with their primary care provider rather than a sexual health clinician. These results suggest that, for some patients, engaging in long-term PrEP care with routine screening may be preferable with a patient's own PCP than at a sexual health clinic. As primary care providers now write the majority of PrEP prescriptions in the US [26], future work can examine PrEP acceptance in the primary care office in addition to specialty clinics.

We hypothesized that attending a visit for a suspected HIV/STI, whether due to symptoms or a recent exposure, would be associated with an increased likelihood of PrEP acceptance, but this was not the case. Patients who suspected they may have HIV were no more likely to accept PrEP, and patients who suspected an STI were slightly more likely to decline. This suggests that rather than being uniformly driven to start PrEP after a potential exposure to HIV or STI, patients may have varied psychological reactions which could either motivate or demotivate the decision to uptake PrEP. A patient may be as likely to be motivated to take PrEP as they are to avoid sex altogether in response to an HIV/STI exposure. Thematic analysis of patient visit notes highlighted this tension between PrEP use and attitudes about sex during the clinical encounter. In response to their HIV/STI exposure, several bisexual or straight-identified patients expressed an intention to stop having sex with men. Other patients stated their desire to practice a period of abstinence rather than to start PrEP, the HIV/STI exposure prompting a reevaluation of their relationship to sex. A deeper examination of PrEP discussions during an encounter for HIV/STI exposure might inform strategies for counseling patients navigating a stressful sexual health event.

Limitations

This study has several limitations. First, PrEP recommendation and acceptance were not recorded systematically in the EMR. Recommendation could be inferred for visits where a new PrEP prescription was given, but for visits where PrEP was not prescribed, it was necessary to rely on provider notes to distinguish visits where PrEP was recommended but declined and visits where PrEP was not recommended, which could be subject to error compared to a structured field. Similarly, reasons for declination were not recorded systematically by providers and were missing for the majority of cases. Further, they were not reported directly by the patient, but rather were recorded by the provider, who may have filtered information when deciding what information was pertinent for the clinical record. The set of reasons recorded may not be missing at random and might also miss key rationales. Second, bias could have been introduced as the criteria for PrEP eligibility were expanded in the second half of the study period. Third, 92 individuals were excluded from the complete case analysis because they were missing data on number of male sex partners and/or suspicion of an STI. This exclusion could have led to bias. Finally, while acceptance is the first step to initiation, after PrEP is prescribed the patient must also obtain their prescription and return for follow-up. Due to incomplete data, an in-depth analysis of factors associated with completion of all steps of PrEP initiation was not possible.

It is important to contextualize that the act of declining a PrEP offer is not inherently a failure of PrEP uptake. Patients make decisions about their sexual health in tandem with their providers, and for many patients, not taking PrEP may be the most appropriate choice for their situation, whether due to health impacts, acceptably low level of HIV risk, or concern for social harms. Years of health and safety data have established an extremely favorable risk-to-benefit ratio for most indicated patients, [29] but patients may still experience side effects they attribute to PrEP and choose to stop it. Emerging long-acting formulations for PrEP are a promising

preferred option for patients who face difficulties with adherence or social harms due to daily oral PrEP. [30] As more options for PrEP become available, more and more patients will likely accept a PrEP option that suits their individual circumstances.

By understanding which subgroups of MSM are less likely to accept PrEP, clinicians can develop tailored approaches to communication with PrEP-hesitant patients during a visit. This may include targeted strategies to support patients starting out on PrEP, as well as ways of framing HIV risk, combatting misinformation, and addressing concerns about common side effects and how they can be managed. The results of this study can inform interventions to increase acceptance of PrEP among MSM patients who can benefit.

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Table 1. Characteristics of PrEP-eligible MSM attending the Public Health—Seattle & King County (PHSKC) Sexual Health Clinic, January 2017 - December 2024.¹

Characteristic	Total N=1537
Age	
Median (IQR)	29 (25, 36)
Race	
American Indian & Alaska Native	17 (1%)
Asian	152 (10%)
Black	191 (12%)
Native Hawaiian & Pacific Islander	63 (4%)
White	823 (54%)
Multiracial	42 (3%)
Unknown	167 (11%)
Declined to answer	82 (5%)
Ethnicity	
Hispanic/Latino	352 (23%)
Not Hispanic/Latino	1,092 (71%)
Not reported	93 (6%)
Sexual Orientation	
Gay	1,100 (72%)
Straight/Heterosexual	294 (19%)
Bisexual/Pansexual	109 (7.1%)
Queer/Other/Not specified	34 (2.2%)
National origin*	
Within United States	1,121 (73%)
Outside United States	348 (23%)
Unknown	68 (4%)
Housing status	
Stably housed	1,475 (96%)
Unstably housed/homeless	62 (4%)
Substance use, past year	
Marijuana	49 (3%)
Methamphetamine	65 (4%)
Opioids (Heroin, fentanyl or other)	20 (1%)
Cocaine	108 (7%)
Injected drugs in past year	

Yes	68 (4%)
No	1,469 (96%)
Number of male sex partners, past year (Cisgender men)	
<=1	96 (6%)
2-5	592 (39%)
5-10	388 (25%)
>10	386 (25%)
Not reported	75 (5%)
Sex with partner with HIV, past year	
Yes	134 (9%)
No	1,403 (91%)
Transactional sex, past year	
Had sex in exchange for money or drugs	55 (4%)
Gave money or drugs in exchange for sex	13 (1%)
None	1,469 (96%)
History of STI diagnosis	
>1 year	431 (28%)
<1 year	575 (37%)
Never	516 (34%)
Unknown	15 (1%)
Suspects HIV²	
Yes	104 (6.8%)
No	1,433 (93%)
Suspects STI³	
Yes	697 (45%)
No	825 (54%)
Not reported	15 (1%)
Sexual position, past year	
Exclusively receptive/bottom	237 (15%)
Exclusively insertive/top	311 (20%)
Versatile	817 (53%)
Exclusively non-anal	159 (10%)
Not reported	13 (1%)
Accepted PrEP	
Yes	1,067 (69%)
No	470 (31%)

1. Summary of unique patients on their first clinic visit.

2. Attested “yes” on the intake survey: “Did you come to the clinic because you think you might have acute HIV?”
3. Attested “yes” on the intake survey: “Sex partner was recently diagnosed with, or has symptoms of, an STD” OR “Have symptoms.”

Table 2. Prevalence of PrEP acceptance by eligible MSM attending the PHSKC Sexual Health

Clinic by predictor.

	Total¹ N=1721	Accepted n=1168 (68%)	Did not accept n=553 (32%)	PR (95% CI)	Adjusted PR (95% CI)
0.84 (0.75, 0.93)					
Age					
18-24	373	265 (71%)	108 (29%)	Reference 0.94 (0.87, 1.02)	Reference 0.92 (0.85, 0.99)
25+	1348	903 (67%)	445 (33%)		
Race					
White, non-Hispanic	748	531 (71%)	217 (29%)	Reference 1.00 (0.89, 1.11)	Reference 1.01 (0.90, 1.13)
Asian, non-Hispanic	161	114 (71%)	47 (29%)	0.85 (0.76, 0.96)	0.86 (0.75, 0.97)
Black, non-Hispanic	223	135 (61%)	88 (39%)	0.92 (0.85, 1.00)	0.93 (0.85, 1.01)
Hispanic/Latinx	402	263 (65%)	139 (35%)	0.94 (0.84, 1.05)	0.94 (0.83, 1.05)
Other	187	125 (67%)	62 (33%)		
Sexual Orientation					
Gay	1,229	863 (70%)	366 (30%)	Reference 0.91 (0.71, 1.17)	Reference 0.72 (0.45, 1.16)
Straight/Heterosexual	36	23 (64%)	13 (36%)	0.84 (0.76, 0.92)	0.84 (0.75, 0.93)
Bisexual/Pansexual	334	196 (59%)	138 (41%)	1.00 (0.89, 1.13)	0.96 (0.84, 1.10)
Queer/Other/Not specified	122	86 (70%)	36 (30%)		
National origin					
Within United States	1,246	847 (68%)	399 (32%)	Reference 1.01 (0.94, 1.10)	
Outside United States	393	271 (69%)	122 (31%)	0.90 (0.75, 1.07)	
Unknown	82	50 (61%)	32 (39%)		
Housing status					
Stably housed	1,650	1,117 (68%)	533 (32%)	Reference 1.06 (0.91, 1.23)	
Unstably housed/homeless	71	51 (72%)	20 (28%)		
Methamphetamine use, past year					
Yes	78	49 (63%)	29 (37%)	0.92 (0.78, 1.10)	
No	1643	1,119 (68%)	524 (32%)	Reference	
Any non-marijuana drug use, past year					
Yes	180	110 (61%)	70 (39%)	0.89 (0.79, 1.00)	
No	1541	1,058 (69%)	483 (31%)	Reference	
Injected drugs in past year					

Yes	74	50 (68%)	24 (32%)	1.00 (0.85, 1.17)	
No	1647	1,118 (68%)	529 (32%)	Reference	
Number of male sex partners, past year					
≤1	103	53 (51%)	50 (49%)	Reference	Reference
2-5	665	431 (65%)	234 (35%)	1.26 (1.04, 1.53)	1.26 (1.03, 1.53)
5-10	428	284 (66%)	144 (34%)	1.29 (1.06, 1.57)	1.24 (1.01, 1.52)
>10	444	330 (74%)	114 (26%)	1.44 (1.19, 1.76)	1.38 (1.13, 1.68)
Sex with partner with HIV, past year					
Yes	158	107 (68%)	51 (32%)	1.00 (0.89, 1.12)	
No	1563	1,061 (68%)	502 (32%)	Reference	
Transactional sex, past year					
Had sex in exchange for money or drugs	61	44 (72%)	17 (28%)	1.06 (0.90, 1.24)	
Gave money or drugs in exchange for sex	15	6 (40%)	9 (60%)	0.59 (0.32, 1.09)	
None	1645	1,118 (68%)	527 (32%)	Reference	
Most recent STI diagnosis					
>1 year	494	333 (67%)	161 (33%)	1.00 (0.92, 1.08)	
≤1 year	664	453 (68%)	211 (32%)	1.01 (0.93, 1.09)	
Never	548	371 (68%)	177 (32%)	Reference	
Suspects HIV²					
Yes	119	84 (71%)	35 (29%)	1.04 (0.92, 1.18)	
No	1602	1,084 (68%)	518 (32%)	Reference	
Suspects STI³					
Yes	797	508 (64%)	289 (36%)	0.89 (0.84, 0.95)	0.90 (0.84, 0.96)
No	909	649 (71%)	260 (29%)	Reference	Reference
Sexual position, past year					
Exclusively receptive/bottom	258	176 (68%)	82 (32%)	Reference	
Exclusively insertive/top	352	218 (62%)	134 (38%)	0.91 (0.81, 1.02)	
Versatile	927	647 (70%)	280 (30%)	1.02 (0.93, 1.12)	
Exclusively non-anal	171	116 (68%)	55 (32%)	0.99 (0.87, 1.14)	

1. Per encounter. Includes repeat visits by the same patient.
2. Attested “yes” on the intake survey: “Did you come to the clinic because you think you might have acute HIV?”
3. Attested “yes” on the intake survey: “Sex partner was recently diagnosed with, or has symptoms of, an STD” OR “Have symptoms.”

Table 3. Number of visits until eligible MSM patients accepted PrEP at the PHSKC Sexual Health Clinic.

PrEP acceptance for all patient visits (n=1537)		
	n	%
Accepted PrEP at first visit	1067	69.4%
Accepted at subsequent visit	52	3.4%
<i>2nd visit</i>	73	
<i>3rd visit</i>	9	
<i>4th visit</i>	2	
Never accepted	418	27.2%
PrEP acceptance patients who initially declined (n = 418)		
	n	%
Accepted at a subsequent visit	52	11.1%
Never accepted	418	88.9%

Figure 1. Flowchart of outcomes of PHSKC Sexual Health Clinic visits where patients were recommended to take PrEP.

