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An exploratory study of HIV risk behaviours and testing among male sex workers in Beirut, Lebanon

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Abstract

Male sex workers (MSW) are a particularly high-risk subset of men who have sex with men in Lebanon and report higher numbers of sex partners and lower rates of condom use. The purpose was to explore the factors influencing sexual risk behaviors and HIV testing among MSW. Qualitative interviews were conducted with 16 MSW living in Beirut and working in bathhouses (hammam) or as escorts; content analysis identified emergent themes. Escorts reported more consistent condom use with clients and HIV testing than hammam MSW, with influential factors including HIV risk knowledge and perceived risk susceptibility, job security, and internalized stigma and related feelings of self-worth and fatalism regarding health and HIV risk. In contrast, both groups of MSW typically opted not to condoms with nonclient sex partners, in an effort to differentiate sex for work versus pleasure. The uptake of HIV testing was limited by concerns about the confidentiality of the test results and fear of repercussions of a positive test result for their health and employment. The respondents described an insular existence within the sex work culture, in part to limit exposure to stigma, which has implications for access to support as well as the influence of peer norms regarding sexual risk behavior and health seeking behaviors such as HIV testing. Further research is needed to tailor prevention and HIV testing efforts to reflect the distinct sexual health “cultures” that distinguish these two populations of MSW in Lebanon.

Keywords

Male sex workers; HIV risk behavior; HIV testing; Special Populations/Gay/Bisexual men; Middle East and North Africa

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BACKGROUND

Although HIV prevalence is comparatively low in the Middle East and North Africa (MENA), understanding the sources of new HIV infections is important to prevent a dramatic epidemic in this region. Between 2001 and 2011, HIV incidence rates has increased by more than 35%, bringing the total HIV prevalence rate to an estimated 300,000 in 2011. Only 15% of people living with HIV/AIDS access HIV treatment (Joint United Nations Programme on HIV and AIDS [UNAIDS]),. According to UNAIDS (2010), the HIV epidemic in MENA is concentrated among men who have sex with men (MSM), sex workers, and injection drug users. In Lebanon, MSM were identified as a key population at higher risk, and some evidence suggests that MSM account for most new HIV infections in the Levant region of MENA (UNAIDS, 2014). HIV prevalence among MSM in Lebanon is reportedly 3.6% (Afifi et al., 2008)—much higher than the 0.1% prevalence rate in the general population (UNAIDS, 2014)—however, other studies of MSM in MENA have revealed HIV prevalence rates between 5% and 10% (Elrasheid, 2006; Family Health International & Egyptian Ministry of Health, 2006). The prevalence estimates may be an underrepresentation as good HIV surveillance data in MENA is generally lacking, and HIV testing rates are low (Mahfoud et al., 2010).

Studies in MENA suggest that sex work among MSM may be relatively common. A meta-analysis of the HIV epidemic in MENA estimated the prevalence of sex work among MSM to be 20% to 75% in the region (Abu-Raddad et al., 2010), and 36% within Lebanon (Afifi et al., 2008). However, many of these studies used respondent driven sampling, and it is possible that the recruitment chains may have tapped into networks of male sex workers that led to a disproportionate representation of sex workers among MSM (Mumtaz et al., 2011). Given the nature of their work, male sex workers report having a high number of sex partners, averaging two to three clients per day (Mumtaz et al., 2011), as compared to an average of 10 annual sex partners among MSM who do not sell sex (Nakib & Hermez, 2002; World Health Organization, United Nations International Children's Emergency Fund, & UNAIDS, 2011). However, male sex workers are reportedly less likely to use condoms and access health services, including HIV testing, due to structural and social factors including poverty, stigma, and legality issues in MENA (Ballester, Salmerón, Gil, & Gómez, 2012; Kong, 2008; Mariño, Minichiello, & Disogra, 2003).

Although MSM and male sex workers are viewed as vulnerable, high-risk populations that may serve as bridges to the mainstream heterosexual population (Abu-Raddad et al., 2010), no study in MENA has focused on male sex workers with respect to HIV. In Lebanon, male sex workers face stigmatization for selling sex and having same-sex relations. These deviations from religious and culturally ordained sexual practices, and resulting stigma, may affect their sexual health and health-seeking behaviors (U. S. Agency for International Development [USAID], 2012). In addition, "unlawful sexual acts," including homosexual sex, are illegal under Article 534 of the Lebanese penal code and are punishable by up to one year of imprisonment, though this law is generally not enforced. Furthermore, the Lebanese government stopped licensing sex work venues in the 1970s (IRIN, 2009), and consequently the majority of sex work occurs in unlicensed, and thus illegal, institutions. Given their dual identities as gay men and sex workers, the social drivers rendering male sex

workers vulnerable to HIV/AIDS are different and necessitate a separate research agenda to better understand the social environment and the risk and health seeking behaviors of this subgroup of MSM. It is also important to acknowledge the heterogeneity within the male sex workers in Lebanon, including the sex workers at the *hammam* (bathhouses) and escorts.

The aim of this inquiry is to gain a better understanding of disclosure, condom use, and HIV testing behaviors practiced by two groups of sex workers in Lebanon, which can then inform unique points of intervention to prevent HIV transmission among male sex workers working in a highly stigmatized environment in Lebanon and more broadly in the MENA region.

METHODS

Sample

In late 2011, in-depth, semistructured interviews were conducted with 16 male sex workers currently living in Beirut. The qualitative data presented in this article are part of a larger mixed-methods study exploring the characteristics associated with high-risk sexual behaviors among MSM in Beirut, Lebanon. In addition to qualitative interviews with male sex workers, the overall study included interviews with more conventional MSM and transgendered persons, and a social networking survey with all three subpopulations.

To reflect the two primary forms of sex work in Lebanon, men who work as escorts and those who work at the hammam were purposively recruited. Although both subpopulations practice sex work, they work in different environments and have unique characteristics. Escorts are generally of Lebanese descent and typically belong to a higher socioeconomic stratum, whereas the male sex workers who work in the hammam are typically from bordering countries, such as Syria and Iraq, and come from a lower socioeconomic class. The male sex workers from the hammam are employees of the business owner who assigns clients and handles payment. Escorts generally find their clients independently, often using online social networking platforms like Manjam, and typically service wealthier clients and tourists. For the purposes of analysis, sex workers were classified as hammam sex workers or escorts based on where they worked at the time of the interview. If men reported working in the hammam and also having their own clients on the side, they were grouped with the hammam sex workers.

Participants were recruited through referrals from a collaborating local nongovernmental organization with HIV/STI (sexually transmitted infections) prevention and outreach to male sex workers, and through participant referrals. Men interested in participating contacted the study coordinator for detailed information about the study, provided verbal consent, and scheduled an interview time. Interviews were conducted in a private room in the language of the participant’s choice (Arabic, French, or English) by author R.M., an outreach worker from Beirut who was known by most participants. The interviewer was experienced with conducting qualitative interviews and received comprehensive training on the use of the interview guide. With the participants’ permission, the interviews were audio-recorded. Participants were compensated $30 for completing the interview.

Instrument

The interviewer used a semistructured guide, containing open-ended questions and follow-up probes, to conduct in-depth interviews exploring factors that influence disclosure, condom use, and HIV testing. The semistructured framework promoted the open-ended elicitation of ideas and experiences while allowing for quantitative counts and comparisons across the interviews. In addition to asking some basic demographic questions, the interview examined (a) disclosure of sexual orientation and sex work, (b) sexual behavior (including condom use) with client and nonclient partners, (c) attitudes and behaviors regarding HIV testing, and (d) perceived norms among male sex workers regarding condom use and HIV testing. All study procedures were approved by the ethical review boards of RAND Corporation and Lebanese American University.

Analysis

Audio-recordings of the interviews were translated into English and transcribed verbatim by the interviewer. Two researchers (including author F.M.A.) used Atlas.ti 7 to code contiguous blocks of transcript text pertaining to major themes, including disclosure of sexual orientation, sex behavior, attitudes toward HIV testing, and perceived norms regarding condom use and HIV testing (Bernard & Ryan, 2009). To ensure inter-reader reliability, the two researchers coded the same five transcripts, compared coding applications, discussed any discrepancies, and identified any questions that needed clarification from the interviewer (Bernard, 2002; Ryan, 2004). Results were aggregated to identify common themes across respondents by characteristics such as age group, sexual self-identification, consistent use of condoms, and HIV testing (Lincoln & Guba, 1985; MacQueen, McLellan, Kay, & Milstein, 1988). In addition, the interviewer was regularly consulted throughout the coding and analysis phases to ensure the validity of the results and to aid with interpretation.

RESULTS

Description of the Sample

The sample included 16 male sex workers, nine of whom work in the hammam, and seven of whom worked as escorts outside of the hammam. Table 1 provides the demographic and background characteristics of the whole sample by type of sex worker. Participants ranged from age 19 to 31 years and averaged 24 years (*SD* = 3.9); escorts were slightly older than the male sex workers from the hammam. On average, participants reported initiating sex work when they were age 19 years. The male sex workers from the hammam had significantly more annual sex partners than the escorts, reporting an average of 1,015 unique clients per year (median = 1,095), as compared to an average of 343 annual clients among the escorts (median = 313). All but one of the sex workers from the hammam were Syrian, but more than one half of the escorts were Lebanese. Overall, the male sex workers at the hammam were less educated than the escorts (all but one having less than a high school–level education). Most of the male sex workers from the hammam relied on sex work as their only source of income whereas more than one half of the escorts also had another income generating activity. The majority of the participants who worked at the hammam

self-identified as bisexual or heterosexual, whereas the majority of the escorts identified as homosexual or gay.

Disclosure of homosexuality and engagement in sex work

Because the majority of participants immigrated to Lebanon from other countries in the region, it is not surprising that 13 of the 16 male sex workers did not live with their families, and many of the men reported having limited contact with those outside of the sex work industry. One sex worker from the hammam said, “Only those of my friends who are sex workers know I have sex with men. They are the only friends I have in Lebanon.” This level of separation made disclosure to family members less likely and, thus, experiences of stigma in reaction to disclosure less common. A sex worker from the hammam explained that, “No one knows apart from the clients and my friends who are sex workers”; a point echoed by several sex workers. The majority of the respondents’ friends were also sex workers, and many of them reported sharing housing, suggesting that their work, home life, and overall social network may revolve primarily within the sex worker environment.

Four of the sex workers reported that at least some of their friends knew about their engagement in sex work and explained their varied reactions,

> My gay friends are aware of what I do, and they consider it personal and my own business. But they advise me to be careful from getting in trouble with the police. Others tell me that I am prostituting myself and this is troublesome. Ultimately, I have to get the money. After all, this is a job.

Another male sex worker from the hammam said that his colleague ultimately remained uninvolved,

> One of my colleagues in the restaurant knows [that I engage in sex work]. He supports me and he said that I am free to do what I do as long as I don’t hurt others. He envies me when I tell him how much money I make, but he has never hurt me.

An escort explained how the opinions of his peers did not affect his decision making, “My gay friends know about [my engagement in sex work], but it is my personal life and my choice and my freedom to do what I want with my life.”

Although some male sex workers reported some level of disclosure of sexual orientation to friends, few men told their families about their sexual orientation or engagement in sex work. Only two of the respondents (both escorts) believed their parents knew they had sex with men, and none of the men had told any of their family members that they engaged in sex work. An escort explained his mother’s reaction to finding out he was gay, “My mother knows, and when I told her she was sad and she suffered a lot, but then she accepted it. But she only knows that I am in a relationship with a man; nothing more, nothing less.” The sex workers at the hammam and escorts expressed significant concerns with their families discovering they engage in sex work. “This might affect my life negatively if my family knew about it, especially my mother. This would kill her and I will be devastated, physically, emotionally, and psychologically. I hope this never happens.” The fear of a negative reaction to disclosure contributed to a reluctance to talk about their sexual orientation or share the nature of their work.

Condom use with clients and non-client partners

Overall, the male sex workers from the hammam reported having riskier sex than the escorts. Only one of the men working at hammam consistently used condoms with clients. Although the male sex workers from the hammam seemed to consider the risks of unprotected sex, the information informing their decisions was not always entirely accurate. For example, one respondent from the hammam reported "never" using condoms based on the assumption that the insertive partner is not at risk of contracting sexually transmitted infections or HIV. "I understand from friends and from health information brochures that it carries a risk to have sex without a condom, but I know that only the passive person (bottom) is at risk, [so] I am not."

The male sex workers at the hammam often assessed the risk profile of a client based on their appearance and social class, making the assumption that male clients from lower social classes were more likely to be infected. One respondent reported rarely using condoms and thought he was not at risk for contracting HIV because his clients were from a higher social class, "I am not concerned about the clients not using the condom because they all come from a high social class and they are rich, and of course they are disease-free." Another male sex worker said he did not use condoms with female clients because "they are clean and can't be carrying any infection." In addition, financial gain was primary driver in condom negotiation with clients, which further discouraged condom use with higher class clients. Several male sex workers from the hammam reported not using condoms with clients, "especially if they pay extra money."

Among the male sex workers at the hammam, the predominant barriers surrounding condom use centered on the desire to appease their clients' and maintain job security. Several participants cited that "most clients don't like to use condoms," and another sex worker from the hammam implied that limited access to condoms was a barrier to use, saying that he does not use condoms "because the clients don't bring them." Sex workers at the hammam also felt pressure to appease their clients to maintain their jobs, which for one sex worker, included foregoing using condoms,

> My main goal in the hammam is to keep my clients happy so the owner will keep me at work. Once a client insulted me, saying, "Do it well, you animal, otherwise I will tell the owner you're not doing a good job." I felt threatened and kept quiet about [using condoms]. I don't want any troubles.

Other commonly endorsed barriers to condom use included that they, "affected my erection" making it difficult to perform sexually, and that sexual intercourse was more "erotic" and "pleasurable" without condoms.

Although the sex workers from the hammam reported predominantly low condom use with clients, the majority of the escorts (five of the seven escorts) reported always using condoms with their clients. One escort who used to work at the hammam explained how his condom use changed between working in the two environments, "I always use the condom ever since I left working at the hammam. Back then, I never used the condom because it wasn't available, and I didn't have an idea about protection." As compared to the male sex workers from the hammam, the escorts seemed to recognize the importance of safe sex and had more

agency in condom negotiation. Several escorts mentioned asking their clients to bring and/or use condoms, and one explained how he would rather lose the client if he would not agree to use a condom, “If the client asks me to have unprotected sex, I try to talk to him and convince him [to use a condom]. If he insists [on having unprotected sex], I would rather not continue the sex.” They seemed to place more weight on the potential negative outcomes of unprotected sex. One escort explained how his future health and financial stability were motivators for condom use. “I don’t want to gain money over my health because eventually I will lose the money.” Another escort explained how he consistently uses condoms with clients so he could protect his girlfriend’s health.

Although there appeared to be different trends in personal condom use with clients between the male sex workers from the hammam and escorts, there was the cross-cutting perception that other male sex workers infrequently used condoms with clients. Twelve sex workers, including four of the six escorts (all of whom reported consistent condom use with clients), believed that other male sex workers never or rarely use condoms with their clients. Consistent with their own barriers to condom use, this was attributed to lack of pleasure, client preference, and difficulty maintaining an erection. One escort explained, “What I know is that most of them don’t use the condoms at all, and that they don’t feel the pleasure using it, regardless if they sleep with men or women.”

Regardless of their condom use with clients, the majority of sex workers at the hammam and escorts reported rarely using condoms with their nonclient sex partners. Having unprotected sex with a romantic partner seemed to be a sign of love and commitment, and a way to differentiate having sex for work versus pleasure,

> I always use the condoms with the clients, but never with my boyfriends. We love each other and we enjoy having sex without the condom. As I use [condoms] with the clients, there is no problem not using it with my boyfriend.

As one escort explained his preference for not using condoms with a romantic partner, “If I am in a relationship with someone, I will never use a condom. My partner will have to accept it; otherwise, he can find someone else.” Another respondent (from the hammam) explained how he does not use condoms when having sex with women,

> We all have sex with women as well and we don’t use protection. One time I got a woman pregnant, and she had to have an abortion because the woman she works for found out about it and forced her.

HIV and STI Testing

Similarly to condom use, the uptake of HIV testing among sex workers at the hammam was limited by the priorities of the hammam owners, and the potential for losing their jobs or deportation should they test positive. Less than one half of the hammam sex workers had ever had an HIV test, and only one reported testing regularly. The five sex workers from the hammam who had never had an HIV test expressed little interest in testing. HIV testing was not a priority among the hammam owners who organized and assigned clients to the sex workers, and the sex workers from the hammam were concerned with the confidentiality of the test and potential repercussions of a positive test result. One respondent described how

the business owner influenced his decision not to test for HIV, “In the hammam, we are never asked to do a mandatory test. The business owner doesn’t care much about our HIV status; all he cares about is the size of my penis because this is what brings the clients.” However, he continued to explain that should a sex worker choose to test, “the business owner will insist on knowing the results.” This served as a deterrent to testing because a positive test result could cause them to lose their job in the hammam. In addition to the potential of losing their job if they test positive, concerns of legal status and potential deportation also limited testing uptake, “I know that some places are available in Lebanon and that the test is free. It might be a problem for those who are illegal immigrants, especially if they test positive.”

In addition to structural deterrents from testing, several sex workers from the hammam were nervous to take an HIV test because they engaged in unprotected sex and felt there was a possibility that they were HIV positive. One participant who works in the hammam described his reservations, “I have never had the test, and I am afraid of doing it. I have had a lot of unprotected sex and I think I am at risk.” Another sex worker from the hammam explained how a positive HIV test would be devastating, “If I ever contract HIV, I will commit suicide. Why waste time on testing and treatment.” This fatalistic attitude was not uncommon among participants.

In contrast to the male sex workers who work in the hammam, there was strong uptake of HIV testing among the escorts; all of the escorts had been HIV tested, and one half reported testing regularly. Overall, the escorts seemed more at ease in the testing environment. One regular tester said he tested because “my health is important to me,” and another regular tester reported feeling “totally comfortable in these [HIV testing] centers” and “with the providers.” Two escorts were HIV tested at the UN center because it was a requisite for their Syrian immigration application, and not strictly out of concern for their health. Although there was more uptake in testing with the escorts than the sex workers at the hammam, escorts shared the concern with confidentiality of the test, and one escort said he preferred not to know his status, “Even if I am HIV positive, I prefer not to know. When my time to die comes I will die. I don’t force people to sleep with me.”

Discussing STI/HIV status with clients did not appear to be a priority among either the escorts of sex workers from the hammam. Out of all 16 sex workers, only one reported “always discussing [STI and HIV status] with my clients,” and the rest reported rarely or never discussing this with their clients. Discussing STI/HIV status was not the priority of the exchange, as explained by one respondent from the hammam, “My goal is to get the money and satisfy the client. My point is not to take a health lesson or to give one. I don’t waste my time with this.” Levels of trust influenced the sex workers’ comfort level in talking about STI/HIV status, and two of sex workers (both escorts) reported they talked about STI/HIV status with their nonclient sex partners. “When I was with my boyfriend, we trusted each other and we always discussed health issues.”

DISCUSSION

Consistent with other studies of male sex workers (Clatts, Giang, Goldsamt, & Yi, 2007; Guadamuz et al., 2010; Lau et al., 2011; Mor & Dan, 2012; Vuylsteke et al., 2012), our findings reveal the vulnerability of this population to HIV and STIs. The data showed overall high levels of sexual risk behavior, relatively poor knowledge of HIV transmission risk, and high levels of stigma and other structural barriers that contribute to poor access to social support and information and low self-efficacy regarding condom negotiation and sexual health. Our data also reveal stark differences between the men who work in the hammam and escorts with regard to the context in which they work and live, as well as condom use and HIV testing, which highlight the distinct sexual health "cultures" that distinguish these two populations.

Several of the escorts reported consistent condom use with clients, whereas nearly all the hammam sex workers reported low condom use with clients. HIV risk knowledge and perceived risk susceptibility, concern about loss of clients or employment, and internalized stigma that translated into fatalistic attitudes regarding health and HIV risk were all contributors to condom use behavior. All the men had an awareness of HIV in general terms, but the sex workers in the hammam had completed less formal education than the escorts and seemed to have lower HIV risk knowledge. Consequently, the male sex workers from the hammam often evaluated their risk assessments and decisions about whether to use condoms based on misconceptions. Many of the respondents, and in particular the sex workers from the hammam, cited exclusive insertive anal sex as rationale for not using condoms, given the perception that being the "top" did not carry any risk or not enough risk to warrant the use of condoms and concluded that their clients were from a higher socioeconomic status were less likely to have HIV. This is a dangerous assumption, particularly given that Beirut has become increasingly popular for sex tourism (McCormick, 2011) and clients who participate in sex tourism generally belong to a higher socioeconomic status may carry a greater transmission risk because they have more mobility and can travel to countries with higher HIV prevalence rates (Alary & Lowndes, 2004; Miller et al., 2004).

Economic pressures and financial hardship also influenced condom use decisions with clients. A number of the respondents, in particular the men working in the hammam, described a willingness not to use condoms if the client preferred unprotected sex or was willing to pay more for unprotected sex, revealing a greater value on the benefits of higher payments compared to the risk of HIV exposure. Because the sex workers who worked in the hammam were more dependent on the financial gains, they seemed to have less agency or little negotiating power in determining the terms of sex. As compared to the male sex workers who work in the hammam, the escorts generally had higher socioeconomic status, and greater commitment and confidence in their ability to require condom use with clients. The majority of the escorts reported that they would require their clients to use condoms, and often said that they would rather lose the client than have unprotected sex.

Although the escorts and sex workers from the hammam differed in their condom use with clients, both groups of men reporting rarely using condoms with nonclient sex partners. The escorts' nonclient partners tended to be men with whom they were in relationships. Trust

and commitment entered into the decisions not to use condoms and also provided motivation to use condoms with clients. Also, it is important to note that several of the men, and particularly the men working in the hammam, had sex with female as well as male nonclients, highlighting the potential that these men have for serving as a bridge between high-risk populations for HIV infection and the general population (El-Sayyed, Kabbash, & El-Gueniedy, 2008).

The sex workers in general seemed to experience high levels of internalized stigma regarding their involvement in sex work. This could be stemming from their religious guilt associated with engaging in same-sex sexual behavior and sex for money, and pressure to marry from their parents. All participants indicated that their parents did not know about their involvement in sex work, and they often feared their families would have a negative reaction or be disappointed if they knew about their involvement in sex work, and this contributed to the desire to keep their sex work life separate from their family life.

The majority of the hammam sex workers came from Syria and the majority of all participants did not live with their families (unlike most nonmarried Lebanese), but alone or with partners or other sex workers. This separation from their family made it easier to keep their sex life a secret from the family but also led to the majority of their social relationships and interactions revolving around their sex work, either with clients or fellow sex workers. This relatively insular existence within the sex work culture and environment may somewhat protect them from external stigma but also limits access to other forms of social support and information. The implications for sexual health and risk behavior are that the attitudes, beliefs, and practices related to condom use and sexual health of their sex worker peers may be particularly influential. In this regard, it is noteworthy that most participants perceived that their sex worker peers rarely if ever used condoms.

Several of the sex workers had a fatalistic view of contracting HIV, which influenced decisions regarding HIV testing. Although greater perceived risk susceptibility among the escorts resulted in more consistent condom use with clients, it also increased anxiety surrounding HIV testing. Although the majority of the sex workers knew where to access HIV testing, structural barriers deterred them from testing. Many of the sex workers at the hammam said they were reluctant to take an HIV test because the hammam owner would insist on knowing the test results. If the test result came back positive, the sex worker could lose his job. Because the majority of the sex workers who work in the hammam and one half of the escorts are from countries other than Lebanon and thus may not be legal residents of Lebanon, there was also a fear of deportation. Although escorts were generally more comfortable with being tested for HIV, they too expressed concerns about confidentiality, highlighting the need for testing venues and health care providers that prioritize confidentiality and are sensitive to and respectful of the unique sexual health needs of sex workers.

As with all qualitative research, our analysis is influenced by our interpretation, though we made an effort to assess inter-reader reliability and to reach consensus on any potentially discrepant points. Our findings are limited by our small sample size, especially given the two different subgroups in the sample. Given the sample size, the differences between the

hammam sex workers and escorts reflect trends and not statistically significant differences. Additionally, our study findings are not transferrable to all sex workers in MENA because the region is extremely culturally diverse, and Beirut is one of the more progressive cities. Despite these limitations, these study findings shed light on male sex workers in the region, and demonstrate the need for more research.

Male sex workers in Lebanon do not appear to be a homogenous population, given the differences between the sex workers who work in the hammam and the escorts in this sample. It is necessary to tailor appropriate interventions for different types of sex workers and ranges of national culture to increase HIV prevention and transmission education, promote safer sex and HIV testing behaviors, and connect male sex workers with available resources. There are currently no interventions addressing HIV risks behaviors among male sex workers in MENA published in peer reviewed literature, and the illegality of same-sex sexual activity and commercial sex creates a challenge for government-sponsored programs to provide targeted outreach to these populations. The primary source of lesbian, gay, bisexual, transgender (LGBT) support in Beirut is through Helem, a nongovernmental organization and our community-based partner for this study, which advocates for the annulment of Article 534 of the Lebanese penal code and raises awareness about STI/HIV within the LGBT community, including sex workers. Helem has a specific outreach program that sends field workers into the community to make contact with sex workers (in the hammam and with escorts) to promote sexual health, make referrals for STI treatment and HIV testing, and distribute condoms.

Given the scarcity of intervention programs for male sex workers, community organizations looking to work with this population might benefit from adapting programs geared towards female commercial sex workers in other regions (Blankenship, Biradavolu, Jena, & George, 2010; Chiao, Morisky, Ksobiech, & Malow, 2009; Kerrigan et al., 2006; Reza-Paul et al., 2012). Risk reduction programs for female sex workers have focused largely on structural interventions addressing insular living and working environments of sex workers, which also characterize the male sex workers in this study. Increased HIV prevention and sexual health programs are critical for male sex workers, in MENA as well as other regions, for without such programs STI and HIV rates will increase in this population and likely spill over into the broader society, particularly in settings such as MENA where male sex workers serve as a bridge for the heterosexual population (Abu-Raddad et al., 2010).

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Table 1

Description of the 16 individuals who participated in the in-depth interviews

	Hammam (n=9)	Escort (n=7)	Total (N=16)
Age			
Mean (Range)	22.7 (19–27)	25.7 (23–31)	24 (19–31)
Age of Sex Work Initiation			
Mean (Median)	19.3 (18)	19.6 (19)	19.5 (18)
Nationality			
Lebanese	1 (11.1%)	4 (57.1%)	5 (31.3%)
Syrian	8 (88.9%)	3 (42.9%)	11 (68.7%)
Education			
<= High School	8 (88.9%)	4 (57.1%)	12 (75%)
Some college	1 (11.1%)	3 (42.9%)	4 (25%)
Other Source of Employment	3 (33.3%)	4 (57.1%)	7 (43.7%)
Household Makeup			
Alone	5 (55.6%)	2 (28.6%)	7 (43.7%)
With Family	2 (22.2%)	1 (14.3%)	3 (18.7%)
With Others	2 (22.2%)	4 (57.1%)	6 (37.6%)
Religious Affiliation			
Muslim	8 (88.9%)	2 (28.6%)	10 (62.5%)
Christian	0	3 (42.9%)	3 (18.7%)
Atheist	0	2 (28.6%)	2 (12.5%)
Single Relationship Status	9 (100%)	5 (71.4%)	14 (87.5%)
Sexual Orientation			
Homosexual	1 (11.1%)	5 (71.4%)	6 (37.5%)
Bisexual	5 (55.6%)	2 (28.6%)	7 (43.7%)
Heterosexual	3 (33.3%)	0	3 (18.8%)
Undisclosed to Family about MSM	9 (100%)	5 (71.4%)	14 (87.5%)
Undisclosed to Family about Sex Work	9 (100%)	7 (100%)	16 (100%)
Number of Sex Partners per Year			
Mean (SD)	1015 (537.8)	343.2 (151.3)	704.9 (525.0)
Median	1095	313	521
Condom Use with Clients			
Always Use	1 (11.1%)	5 (71.4%)	6 (37.5%)
Don’t Always Use	8 (88.9%)	2 (28.8%)	10 (62.5%)
HIV Tested	4 (44.4%)	7 (100%)	11 (68.7%)