The National AIDS Control Programme

REPUBLIC OF LEBANON
MINISTRY OF PUBLIC HEALTH

A Case Study on Behavior Change Among Female Sex Workers: Interventions from 2001 – 2007

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Acknowledgments

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
FC	Field Coordinator
FGD	Focus Group Discussion
FSW	Female Sex Worker
HIV	Human Immunodeficiency Virus
IDI	In-Depth Interviews
IDU	Injection Drug User
IEC	Information, Education, Communication
MARPS	Most-at-risk-Populations
MDG	Millennium Development Goals
MENA	Middle East North Africa Region
MOH	Ministry of Health
MSM	Males who have Sex with Males, Men who have Sex with Men
MSW	Male Sex Worker
NAP	National AIDS Control Program
NGO	Non-Governmental Organization
OPEC	Organization of Petroleum Exporting Countries
OW	Outreach Worker(s)
PAF	Project Accelerated Funds
PLHIV	People Living with HIV/AIDS
SIDA	Síndrome de Inmunodeficiencia Adquirida (AIDS)
SIDC	Soins Infirmiers et Développement Communautaire
STI	Sexually Transmitted Infection
SW	Sex Worker
TB-MOH	Tuberculosis Center under the Ministry of Health
TOR	Terms of Reference
UNAIDS	Joint United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
UNRWA	United Nations Relief and Works Agency
VCT	Voluntary Counseling and Testing
WHO	The World Health Organization

Lebanon currently has a low prevalence of HIV/AIDS infections, with 1056 reported cases of HIV as of December 2007 (1). The majority of these cases has been through heterosexual contact and occur in males (1). Few studies have been conducted among female sex workers (FSW) to determine the prevalence of HIV within this population. However, as international literature points out, sex work in itself is a risky behavior that can lead to increased risks of HIV transmission (2). Additionally, many FSW face other risks both within and outside their control that can increase their vulnerability to HIV acquisition (3) (4) (5).

In order to increase awareness and prevention efforts among FSW regarding HIV, the National AIDS Control Program (NAP) of Lebanon, through the financial and technical support of UNAIDS, launched three consecutive interventions in 2001 in collaboration with UNFPA, WHO and other international and local non-governmental organizations (NGOs). The main target of these interventions was HIV prevention and awareness among vulnerable groups in the country, including FSW, men who have sex with men (MSM), injecting drug users (IDU) and youth. The main activities for each phase are delineated in Figure 1.

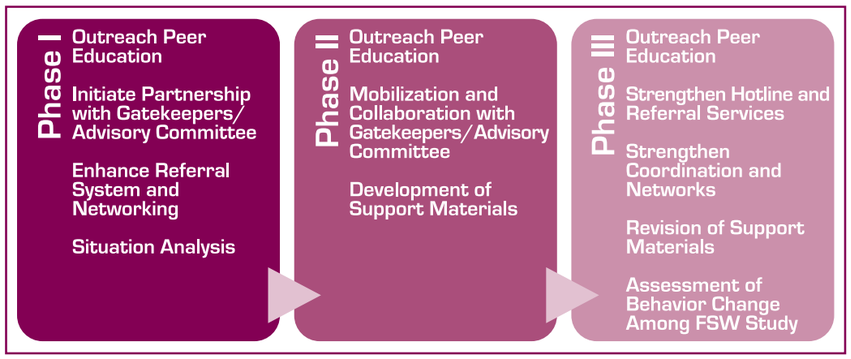


Figure 1: Main Activities for Phases I, II and III of the Intervention

Phase I
The first project launched in 2001 was entitled 'HIV/AIDS Prevention through Outreach to Vulnerable Populations in Beirut, Lebanon' and lasted 18 months. This was considered Phase I of the overall project, and it sought to assist vulnerable populations in adopting HIV/AIDS risk reduction behaviors as well as to create a more supportive environment. Outreach was conducted by peer outreach workers (OW) recruited through three local NGOs: SIDC, Dar al Amal and Caritas-Migrants. The OW engaged FSW in personalized, open discussions regarding HIV/AIDS and other STIs.

Phase II
'HIV/AIDS Awareness among Youth and Vulnerable Groups in Lebanon' is considered phase II of this series, and began in 2003. UNFPA, UNAIDS, NAP and NGOs were partners in this phase which was supported through OPEC funding, and aimed to enhance awareness of HIV/AIDS and prevention among youth and vulnerable groups.
A peer-based approach was taken to the project and focused on (a) increasing knowledge of the target groups (b) enhancing the capacity building of these groups, (c) strengthening networking with relevant groups, and (d) maximizing outreach and prevention (6). Work was expanded to all five regions of Lebanon, with a network of NGOs being created to facilitate communication and overall coordination.

Phase III
The last phase of the project, 'Outreach for HIV/AIDS Prevention Targeting Populations at Risk in Lebanon', consisted of two main activities carried out from 2005 to 2007. This project was funded through the UNAIDS Program Accelerated Funds (PAF) and was conducted by various NGOs under the overall guidance of the NAP. Phase III focused on strengthening and expanding outreach to the vulnerable populations and developing the capacities of local NGOs.

Overall Findings
Throughout the three phases, 1767 FSW were reached through outreach, the situation analysis in Phase I and the final rapid assessment study in Phase III. The rapid assessment included both quantitative and qualitative sections. The main findings show that although some FSW are aware of HIV/AIDS and other STIs, and they know methods of preventing transmission of these infections, this knowledge does not reflect in their behaviors regarding safe sexual practices. Even though many women knew the importance of condom usage with all partners, the majority were willing to accept to have unprotected sex if a client was willing to pay more money. It is interesting to note that although the knowledge level regarding condom use as a preventive method decreased in the rapid assessment, condom use behavior increased. Explanations for these apparent contradictory findings are provided within the discussion.

However, from 2001 to 2007, there were statistically significant increases in condom use with non-regular clients and non-client sexual partners, as well as a significant increase in the proportion of women who would refuse sexual intercourse when a partner objected to using a condom or was physically or verbally abusive. There was also a significant negative change, in that the percentage of women having been tested for HIV in the past year has declined.

While the changes in condom use, which was the main behavioral change noted, were statistically significant, the numbers were still small. The study showed that there were numerous factors that played into this finding including pressure from clients and work lords, peer pressure, embarrassment in buying condoms, and fear of imprisonment if the women were found to be possessing condoms.

Strengths
Numerous strengths have been noted for the overall outreach program. These include:

- The Advisory Committee composed of UNFPA, NAP and the NGOs assured that work progressed smoothly and created a system of accountability
- The networking of collaborating NGOs assisted in the overall coordination of the work and created a sense of ownership in the outcome of the project, thus enhancing durability
- Inclusion of religious leaders in meetings and input regarding the projects, enhanced the effectiveness and acceptability of the project in more conservative areas
- The OW were highly motivated to conduct these sessions and believed in the importance of the information that they were imparting to the FSW
- Effective training of OW and continuous follow-up upon returning from the field
- Use of peer OW enhanced the project through their familiarity with the target population and their locations, and facilitated trust between the FSW and OW
- Back-up measures for safety were important, as well as police clearance and involvement in the project
- The distribution of free condoms was found to be the best tool for FSW to accept the intervention

Obstacles
It is important to note that within the strengths and obstacles, there are issues that are mentioned that came up only in one or two of the phases that were corrected in the next interventions. These strengths and obstacles have been included here, as it was felt that this is the best way for others to be exposed to the difficulties that were encountered in these interventions.

- Additional time was required to redesign the structure of the project, strengthen the referral system and make recommended improvements, which led to less time and money being spent on other important aspects of the project
- Unclear explanations of roles and responsibilities and commitment required was seen as a problem for some of the field coordinators, as well as the inability to hire field coordinators in some regions
- Problems with the referral centers and hotline availability surfaced, which caused concern as to whether the services spoken of during outreach were actually available for the FSW population
- Expenses for the referral process and for hiring of field coordinators were not covered by the program in some of the phases, which caused problems for some of the NGOs in reaching their goals
- Lack of experience with outreach and exposure to peer-to-peer activities outside of Beirut and Mount Lebanon areas
- Resistance to the outreach by FSW and their work lords[1]
- High mobility of the FSW population

Recommendations

It is recommended to increase activities at all levels of influence as all of these levels affect the ability of FSW to make behavior changes to protect themselves from HIV and other STIs. The recommendations from this case study include the need to intervene at many levels, including with the FSW, her clients, and the work lords, in addition to increasing institutional and community involvement and a change in policy. In order to increase the amount of change, we cannot focus solely on the FSW, as there are numerous larger factors that influence her ability to make changes within her life. A commitment needs to be attained at all levels in order to limit the spread of HIV among the FSW population and among the greater population of the country. Additionally, a flow chart has been included as a suggestion for future outreach.

Intrapersonal

- Work on building the capacity, confidence, self worth, and self efficacy of FSW
- Take a more participatory approach to all future programs by involving FSW on all levels of a project
- Work on increasing the perceived susceptibility and severity of acquiring HIV
- Work on increasing the benefits of and decreasing barriers to condom use
- Work on strengthening SW coping skills including how to manage peer, pimp and client pressure
- Enhance FSW skills to better negotiate condom use with both clients and work lords
- Within outreach and awareness sessions, address factors outside of the sex workers' professional lives which may increase their risk factors for HIV transmission.

Interpersonal

- Work on strengthening a positive relationship between peers to have a positive peer to peer effect
- Work on increasing the perceived susceptibility and severity of HIV among the clients by establishing contact with, and working with clients and non-client sexual partners of FSW through outreach
- Work on convincing the work lords on the use of condoms among the FSW by increasing the benefits over the barriers of consistent condom use
- Work with OW on building and enhancing the trust with SW
- Work on enhancing the dynamics between the police members and SW by sensitizing them to their hardship situation and vulnerability to acquiring HIV

[1] The term 'work lord' is synonymous with the term pimp.

Institutional

- Mobilize resources and ensure funding to sustain HIV prevention projects, such as outreach and awareness
- Work with ISF on sensitizing the police on MARPS, HIV and AIDS issues
- Involve target groups on all levels of the outreach project
- Extend and maintain outreach activities on a continual and systematic basis
- Extend outreach to work lords
- Extend outreach to clients
- Create a mobile clinic and mobile outreach vehicle
- Strengthen and expand hotline, VCT and referral system beyond current network of NGOs and health care facilities
- Increase support to NGOs and build capacity of NGOs to work with the FSW population.
- Decentralization of NGOs
- Strengthen collaboration and coordination of NGOs
- Increase access to HIV-related services, and to affordable and sensitive health, social and legal services
- Improve monitoring and evaluation of all programs
- Establish or enhance existing drop-in centers and shelters for sex workers
- Conduct further studies to increase knowledge of the target population and their perceived needs
- Disseminate results to all interested parties and publish results to make the data available to individuals in all institutions

Community

- Work with the media to sensitize various communities and the general population on HIV and AIDS issues
- Involve various communities to enhance outreach
- Work with the municipalities, barber shops, hotels, etc... on disseminating messages that could decrease stigma and discrimination on HIV and issues surrounding sex work

Policy

- Advocate for decriminalizing sex work and sex workers
- Advocate for laws that protect sex workers and provide opportunities for them
- Promote sex workers' rights to work in a safe environment free from discrimination and stigma
- Correct or remove laws that support discrimination

Conclusion

It is important to work with the female sex worker population at all levels of influence, beginning with the sex worker herself. There are various people and factors that influence her choices and actions, and each of these factors needs to be included for consideration in further interventions. This is especially important in the case of the work lords and clients of the sex worker, as these individuals often have the most influence on her sexual behaviors. It is imperative that additional resources are provided to work with this population and other vulnerable populations in order to prevent the further spread of HIV within the country, including encouraging additional organizations to work with and provide services for them. In addition to ensuring funding and other resources for these projects, collaboration and coordination between NGOs should be promoted. It is crucial to acknowledge the existence and lives of the FSW, and advocate for the decriminalization of their profession, as this is the only way that true changes will be made in creating a safe and supportive work environment.

Introduction

Beginning in 2001, three consecutive interventions were launched targeting HIV prevention and awareness among vulnerable groups in Lebanon. These vulnerable groups included MSM, IDU, FSW and youth. Throughout this paper we will be focusing solely on the projects within each intervention that emphasize FSW. These interventions were overseen by NAP in collaboration with UNAIDS, UNFPA, WHO. Various non-governmental organizations (NGOs) were involved in the projects, with Soins Infirmiers et Développement Communautaire (SIDC) taking a major role.

The first project, 'HIV/AIDS Prevention through Outreach to Vulnerable Populations in Beirut, Lebanon', lasted 18 months and began in 2001. The project sought to assist vulnerable populations in adopting HIV/AIDS risk reduction behaviors as well as to promote health-seeking behaviors. It was hoped that this intervention would help to create a more supportive environment for the vulnerable populations.

'HIV/AIDS Awareness among Youth and Vulnerable Groups in Lebanon' is considered phase II of this series, and began in 2003. The goal of this intervention was to enhance awareness of HIV/AIDS and prevention among youth and vulnerable groups in Lebanon, as well as to increase the amount of information available to these groups. This phase widened the outreach area to include all areas of Lebanon, not solely Beirut. This phase of the project continued until early 2005.

The last phase of the project, 'Outreach for HIV/AIDS Prevention Targeting Populations at Risk in Lebanon', was set to run for one year from late 2005 until late 2006. Unfortunately, during the summer of 2006, many of the planned projects were delayed due to instability in the country, which made conditions unsafe for the team. Therefore, the intervention was then extended into 2007. This phase focused on strengthening and expanding outreach to the vulnerable populations and building the capacities of local NGOs.

Lebanon and the Lebanese Context

Lebanon – The Country

Lebanon is a small country situated on the eastern shores of the Mediterranean Sea, with a population of approximately four million people (7). Throughout history, Lebanese people have enjoyed the mobility that living on the Mediterranean has brought for them. This love of travel has continued today, and it is thought that there are approximately three times as many Lebanese people living in the diaspora, as there are residing in the country itself (8). This mobility is often blamed for bringing the HIV epidemic to the country (8) and numerous myths abound that people do not become infected with HIV in Lebanon; only when citizens travel abroad are they exposed to the risk of HIV infection. However, the reality is quite different, only 48% of all reported cases of HIV in Lebanon have been among 'travelers' or 'migrants', with the rest being among citizens who have not traveled abroad (1).

HIV/AIDS

Since the first case of AIDS was diagnosed in Lebanon in 1984 (9) until the end of 2007, NAP has confirmed a total of 1056 cases of HIV/AIDS; the estimated number is 2500-3000 cases (1). During this same time, approximately 300 adults were receiving antiretroviral therapy through the MOH (1). HIV is primarily spread through heterosexual contact in Lebanon, accounting for approximately 53% of the cases. Around 16% of cumulative cases are due to homosexual or bisexual contact, 7% due to blood transfusion, 6% to IDU and 3% to vertical transmission. The remainder are of unknown origin. One important aspect to note is that the majority of people living with HIV (PLHIV) in Lebanon are men, consisting of 82% of all known cases of HIV (1).

In December of 2007, through the financial and technical support of the World Bank, NAP launched an initiative to open voluntary counseling and testing (VCT) centers all throughout Lebanon. Now nearing the one year anniversary, NAP has opened 19 VCT centers including TB-MOH Centers, Governmental Hospitals and local NGOs. In the near future 13 VCT centers are going to open in the Palestinian refugee camps in coordination with UNRWA, in addition to increasing coverage in Sidon and the Bekaa area through various NGOs.

Sex Work

There are numerous factors that come into play when considering sex work in the country. Although Lebanon is considered an upper-middle income country by the World Bank classification system (8), the economic situation is not stable, partially due to political and regional instability. With this and Lebanon's location and temperate weather drawing many tourists, the sex work is a quick way to make money, and is seen by many FSW as the only way for them to make a living (3).

In addition to these factors, the history of instability in the region has been detrimental to the economic and social situations of many of these women. Many studies have shown that in times of crisis, upheaval sex work increases, whether through forced sex or through the sex trade (10).

> "In the period of the 2006 July war, sex workers were overloaded with work. In addition, pressure and stress prompt people to engage in more sexual activity than they would in normal times."
>
> (Director of Dar al Amal)

Many of the women who become involved in the sex trade seem to have no other options available to them (4), and some have a history of violence or abuse that has led them to this vocation (3) (4). Many women have been forced into providing sex in exchange for money by their husbands or other male relatives (3). Still others feel that sex work is the only way for them to make enough money to survive or to feed their families (3).

Sex work in itself is a risky behavior that can lead to increased risks of HIV transmission (2). However, many FSW face other risks both within and outside their control that can increase their vulnerability to HIV. Many FSW are victims of violence and rape. Some FSW engage in drug use (4). Each of these risks, in addition to unprotected sex, multiplies the level of risk of HIV infection that each woman is faced with in her everyday life as a sex worker (5).

Past Research Conducted in Lebanon on FSW

Research about the sex trade in Lebanon is still in its early stages. Very little data has been collected regarding who is involved in the trade, the prevalence of HIV and other STIs in the population, and patterns of movement or migration within the population. However, two studies have been completed in the last year, one on mapping the population of FSW in Beirut, and the other, an IBBS study looking at HIV prevalence among vulnerable populations, including FSW. An additional study was completed in 2005 regarding condom use, knowledge, and behaviors among FSW.

Mapping

In early 2008, through support from the World Bank and NAP, SIDC conducted a mapping assessment of FSW and IDU in Beirut. Most of the data that follows is from the information they received through interviews, focus group discussions (FGD) and fieldwork (11). FSW are found in most popular areas of Beirut, usually standing alone or with a friend, also a FSW. They can be found on major roads, under bridges, and along the sea front in summertime. There are also FSW that work specifically in the night clubs and pubs. Although these are the locations where they recruit their clientele, most of the FSW perform their work either in their homes, hotels or in rented furnished apartments (11).

Within Lebanon, there are generally four types of sex workers[2]. There are street FSW who recruit their clients in public settings, such as on the highway or sea front. The next category includes those women who work for an institution that has been established for the purpose of providing commercial sex, though generally they are under the cover of a different establishment (bar, snack shop, night club). The FSW usually has to give the institution a certain percentage of her fees. Call girls are the next grouping of FSW; these women work for an agency that makes all of the appointments for the women, and sends them to the client. These women often are considered 'higher-class' FSW, and are the hardest to reach for outreach and interventions (12). The last type of FSW, are those women who use sex in order to fill a need, generally an urgent financial need. They usually do not consider sex work as their profession, and are performing sexual acts in exchange for money or other goods on an occasional basis (3).

FSW begin working early in their lives, often starting by the time they are 13 years old. The FSW in Lebanon are not all Lebanese. Many of the FSW are from neighboring countries or other countries from the MENA region. Additionally, there are many FSW that come in to Lebanon as 'artists' from Eastern European countries who generally end up working in the super nightclubs. Most FSW are managed by a pimp, either male or female. Most female pimps, or madams, are ex-FSW. The men who become pimps vary, and sometimes are the father, husband or boyfriend of the FSW (11).

MISHWAR Study

On August 1, 2007, 'Mishwar', Lebanon's first integrated bio-behavioral surveillance study, was launched. The study was implemented by a research team at the American University of Beirut in collaboration with several community-based NGOs that serve the most at risk populations (MARPS) in Lebanon. The study was conducted in partnership with NAP and was funded by the World Bank, with the NGO Dar al Amal serving as the main contact for the FSW population.
The study consisted of an interview and a quantitative questionnaire exploring themes such as risky sexual behavior, knowledge and attitudes pertaining to HIV, and stigma. After the questionnaire, each participant was offered a rapid HIV-test, with pre- and post-test counseling, as well as information, education and communication (IEC) material (13).

The study did not achieve its desired sample size of 880 FSW, but it assisted NGOs working with SW to become more competent in their counseling skills and research capabilities. The study was also able to assist the NGOs in connecting with a sub-population of FSW that they had not previously been in contact with. Out of the 150 recruited FSW, none of the participants tested positive for HIV (13).

Condom Feasibility Study

A condom feasibility study was conducted in 2005 that focused on FSWs' attitudes towards and utilization of condoms. The study assessed the prevalence of condom use and factors which determine the use of condoms. Individual interviews were held using a questionnaire adapted and translated from behavioral survey surveillance guidelines. 301 FSW were interviewed in the Beirut and Mount Lebanon areas.

As the study focused on 'bar girls', the majority interviewed were from Eastern European countries (70%), with only 16% being from Lebanon. Most of the FSW reported seeing three to seven clients each week, while some (12%) also had non-paying sexual partners. The range of fees paid per client ranged from US $65 per client to over US $500, with the majority receiving between US $35 and US $65 per client (12). Almost one-quarter of the women received income from another source in addition to sex work, with the sex trade being the sole income generating activity for two-thirds of the women. More than half of the respondents used this money to support others as well as themselves (12).

[2] It is important to note that there are also male sex workers (MSW) in Lebanon, though this document focuses solely on FSW.

Concerning condom use, 80% of the women interviewed stated that they had used a condom with their last client, and in 42% of the cases, condom use was suggested by the client. Almost half of the women reported using condoms with most of their clients in the past month. When the women did not use condoms, it was generally because the client objected. However, around one-third of the women mentioned that they did not like using condoms, and another one-third did not believe it was necessary. The price of condoms was never mentioned as a reason for not using them, although availability was mentioned in approximately 15% of cases (12). Three-quarters of the women had at least one condom with them at the time of the interview, and most (83%) stated that they could get a condom within 30 minutes (12).

The existence of STIs was common knowledge among the women (96%), with more than 2/3 of the women knowing the symptoms of some STIs in both men and women, and over a quarter self-reporting having an STI in the last year. Two-thirds of the women with STIs did not inform their partners about the disease, but most stopped having sex or used a condom when they were having symptoms. Most of the women received a prescription for medication to treat the symptoms but could not afford the medication (12).

All of the women knew about HIV/AIDS, with 17% of the women having known someone living with HIV. Most of the women (87%) know that you cannot tell if someone is infected by looking at them, and 94% knew that it was possible to get a confidential test for HIV in Lebanon. 96% of these women had been tested for HIV[3], and knew the result of at least one of their tests within the last year. However, there are still persistent misconceptions regarding HIV among FSW, especially pertaining to its transmission (12). It is important to note that this study pertains solely to 'bar girls', whose situations are very different from FSW on the street, and those working for agencies.

Problematic Issues

Numerous issues arise when dealing with sex work when it is illegal. The social context surrounding the sex trade creates taboos that are difficult to work around. Women who are involved in the sex trade are often seen as disreputable (14) (15) and may be disowned or kicked out of their homes and communities (3). This is partially due to the view that sex work, and therefore FSW are deviant and abnormal, and go against the standard of relegating sex to marriage that is so prominent in this society and others (15). FSW are seen as the perpetrators of the sex trade (14) and also as agents of HIV transmission. While the FSW often gets the blame, her clients and the larger sex trade are generally not implicated (14).

Women are more vulnerable to HIV and other infections due to their biological make up (16), and those women who are involved in sex work are at an even higher risk due to their contact with multiple partners, and exposure to unprotected sex and possible violent behavior (17) (14). Many FSW do not feel that they can seek support or assistance when they are in trouble, because of the illegality of their professions, and they may be taken advantage of because of this lack of ability to seek assistance (18).

Women who work on the street are more likely to become infected with HIV than other sex workers (19). They often have more problems with drugs and alcohol and a history of violence and poverty which makes them more vulnerable to infection and the risk factors associated with it (19). Many sex workers find it difficult to negotiate condom use with all of their partners, whether clients or lovers, thereby increasing their risk of HIV acquisition even more (14).

[3] 'Artists' who work in the super night clubs in Lebanon are under a special contract which requires them to undergo HIV and STI testing every few months.

NGOs Commitment to FSW

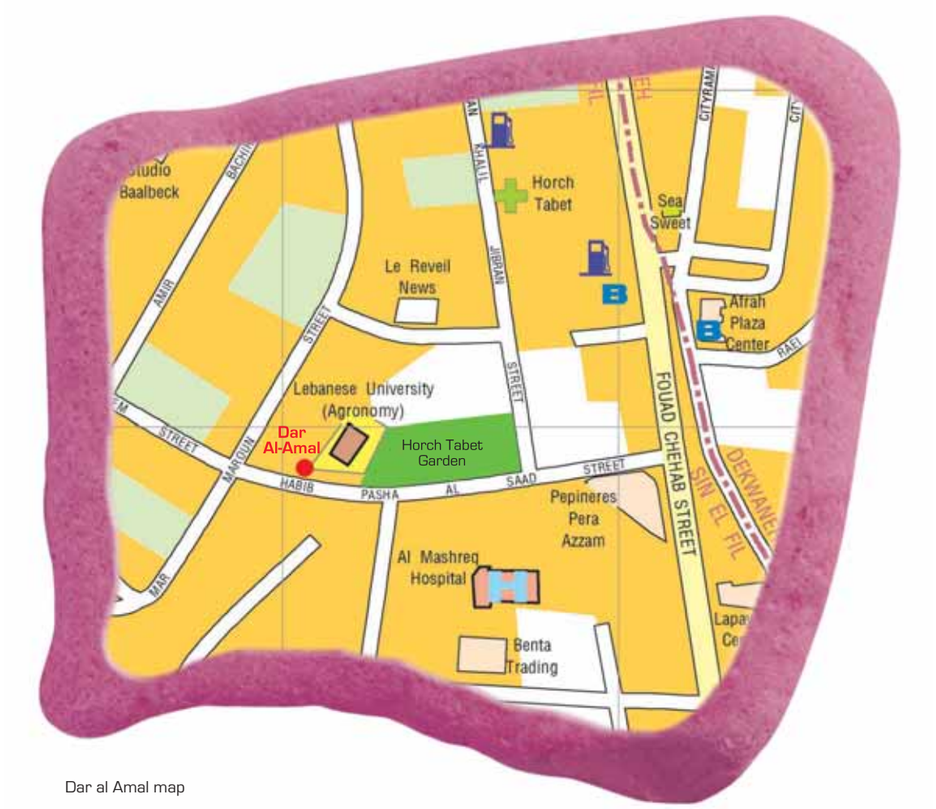
There are few NGOs that work with FSW in Lebanon. Dar al Amal is a local NGO that began offering support to women and girls who were in need of assistance in 1970 (20). Dar al Amal is the only NGO in Lebanon that works specifically with women who have been exploited through sex work and offers them medical and psychological care, vocational training and other opportunities for social development. They focus more on the women who wish to leave the sex trade, and try to build a functional base for them to begin their lives anew (20). Since beginning the outreach services in 2001, the director of the organization estimates that they have been able to offer services to around 700 FSW[4]. Dar al Amal worked as the main contact for the FSW population in these interventions in collaboration with SIDC.

SIDC is another organization that works with the FSW population in Lebanon. While the organization is not devoted solely to this population, much of their work surrounds HIV prevention and awareness among vulnerable populations, including FSW. SIDC was initially created in 1987 to address the public health needs of the Lebanese population amidst the context of the civil war. While the context has changed, SIDC still believes in taking a community-based approach to health, and focuses their work on the 'neediest and most marginalized populations' (21).

Laws

Numerous articles have been issued within the Lebanese Penal Code regarding sex work in Lebanon (Appendix A). In 1931, one area of Beirut was specified for allowing women to work in the sex trade. Along with this specification, these women were supposed to get licensed on a regular basis. Since the civil war and other wars, this licensing has stopped, and there is little regulation. Although this law has not been updated, the sex trade is now considered illegal in Lebanon, though there are some regulations for 'artists' working in the 'super nightclubs'. Anyone caught selling sex or forcing someone into the sex trade can face time in prison, generally up to one year, as well as a small fine. Due to the illegality of the sex trade, most FSW work clandestinely in order to avoid the law. When FSW are caught and imprisoned, most are bailed out by their work lord almost immediately (22).

[4] The director of Dar al Amal also estimates that there are approximately 5000 FSW in Lebanon.



Dar al Amal map

Phase 1

3 Phases of the Intervention 2001 – 2007

HIV/AIDS Prevention through Outreach to Vulnerable Populations in Beirut, Lebanon: 2001 – 2002

Beginning in 2001, a project was launched entitled 'HIV/AIDS Prevention through Outreach to Vulnerable Populations in Beirut, Lebanon'. The project was funded by UNAIDS and implemented by NAP, UNFPA , and various NGOs within the context of the regional project on 'STIs and HIV/AIDS Prevention and Control in Selected Countries of the Arab Region', and was designed to last 18 months. This project targeted vulnerable groups, including MSM, IDU and FSW for HIV/AIDS prevention through outreach. The main objective of the project was to facilitate the adoption of HIV/AIDS risk reduction and health-seeking behavior among these vulnerable groups, as well as to create a supportive environment where prevention practices could be sustained and could become the norm (23).

The project had many additional objectives, including undertaking a situation analysis on sex work, developing strategies of outreach with vulnerable populations, identifying and training peer outreach workers (OW) for outreach, and initiating regular outreach. Establishing or enhancing existing drop-in services as well as referral networks for these populations was an additional goal. The project also hoped to initiate collaboration with various gatekeepers to facilitate reaching these vulnerable groups and to propose policy changes that could decrease the vulnerability of these populations (23).

Situation Analysis

It was determined that a situation analysis study needed to be completed in order to learn more about the population of FSW in Lebanon. As the study team gained access to FSW in the field, and began to observe and identify key informants, they held informal interviews and discussions. This helped to identify various subgroups within the FSW population, as well as to determine how the qualitative and quantitative tools should be designed. 15 qualitative, semi-structured, in-depth interviews were held with informants, as well as 101 FSW being surveyed using quantitative questionnaires. Many of the interviewers were members of the target group itself, which helped to establish trust and empathy with the participants. Although the snowball sampling method utilized did not create a representative sample, it did help to give a general idea of the situation that the intervention would be dealing with.

Findings from the Situation Analysis

FSW meet clients in a variety of ways, through client referrals, at cabarets and bars, or through roaming the streets.

> "I meet them in the cabaret, in the night-club. In the cabaret, usually I give my number to the customer. I make the deal, myself, only for me. I am a personality you know."
> (FSW)

> "I walk in the streets without a precise destination, and I'd sleep with those who ask for it."
> (FSW)

FSW in Lebanon gain their income from both regular clients and non-regular clients. On average, each FSW has three non-regular and two regular clients each week. This brings around 44% of the FSW a weekly income of between US$100 and US$500 (23). FSW are aware of HIV/AIDS and other STIs; 99% of interviewed FSW were conscious that having sex with an infected partner could result in HIV transmission. Knowledge of other methods of transmission was also high (Table 1). However, this high level of

Table 1: Knowledge of HIV Modes of Transmission and Prevention Among FSW, 2001

Modes of transmission	%
Unprotected sex with an infected partner	99%
Infected blood transfusion	87.8%
Vertical transmission (Mother to child)	76.5%
Sharing of incisive and cutting instruments	75.5%
Means of prevention	
Consistent use of condoms	94.8%
Avoidance of sharing incisive and cutting instruments	77.3%
Faithfulness to one un-infected partner	90.7%

awareness did not reflect in their behaviors regarding safe sexual practices, and the women varied widely in their risk perceptions. Nearly a quarter of the women believed that there was no chance that they had been exposed to HIV. Yet, 20% of the FSW stated that they had already changed their behavior patterns in order to prevent HIV, and an additional 34% were intending to change their behavior in the future (23).

Although 45% of FSW stated that condoms were either unavailable or inaccessible when needed, less than a third stated that they always used condoms with non-regular clients, and over 20% of FSW stated that they never used condoms (Table 2). Most declared that if the clients insisted on not using a condom, and they were able to negotiate a higher price, they would accept to have unprotected sex, regardless of the status of that client, as a regular or non-regular client. Therefore, even though 95% of the women identified the consistent use of condoms as a means of protection against HIV transmission, very few women actually practiced the consistent use of condoms (23).

Table 2: Condom Use Behavior Among FSW, 2001

Consistent Use of Condoms	%
With non-regular clients	28%
With regular clients	35%
With non-client sexual partners	12%
Never use condoms	21%

"I often use the condom with my clients; except when I like the head of the client."

(FSW)

"I don't use the condom with my boyfriend. I need to feel him."

(FSW)

In addition to this lack of condom use, only 22% of the interviewed FSW had ever tested for HIV, and only 30% of the women felt comfortable revealing their profession to health professionals, which indicates that they may not be receiving appropriate care. This finding is disconcerting as over half of the women (53%) had experienced STI symptoms in the last year, and 85% had visited health professionals for this or other health-related problems in this same time period (23).

Outreach and Peer Education

From the situation analysis, it was established that outreach was imperative for the FSW population. It was determined that communication during outreach should be person-to-person through the use of OW, who are both current and ex-FSW, and should include straight-forward messages that promote safer sex. The objectives of the outreach intervention were multi-faceted. OW communicated information about HIV/AIDS and other STIs to the FSW, in addition to distributing condoms and other IEC material. The outreach aimed to encourage FSW to adopt safer sexual behaviors. Additionally, it was hoped that the OW would be able to encourage the FSW to seek out VCT services.

Dar al Amal NGO

Peer OW were recruited through two NGOs, Dar al Amal, which works specifically with FSW and ex-FSW, and Caritas-Migrants, which recruited FSW from among the migrant communities. Safety of the OW was ensured by continual communication of location and destination, as well as the OW being followed up on a daily basis by social workers and field coordinators (FC) at the NGOs. The OW always worked in pairs in order to ensure their safety as well.

OW try to reach FSW in both bars and on the streets, although they stated that reaching women in the bars was easier than on the streets, as well as less dangerous. In the bars, the outreach pair would introduce themselves to the bar owner as members of an awareness team that seeks to raise the awareness of all people regarding HIV/AIDS and STIs. They used this approach so as not to stigmatize the FSW. If the bar owner agreed to let them speak with 'his girls', they would reintroduce themselves to the women and offer them information and brochures on HIV and STIs. If the FSW were open to discussion, the OW would bring up condom use, and have the women simulate putting a condom on their fingers. They would also talk to the FSW to have them consider the possibility of leaving the sex trade, and let them know about NGOs that are available to assist them.

> "The best way to approach her [the FSW] is to gain her trust. We should show them that we really care, boost their self image, and teach them how to love and protect themselves. By raising the benefits of condom use and testing and explaining to them the consequences of lack of its [condom] use and testing, they get scared and automatically ask us where they should go and get tested. It is a must that we assure them that they are not going to be arrested and that the test is for free."[5]
>
> (OW-4)

On the streets, the situation is more tenuous, as FSW are approached when they are working and trying to get clients. Many of the FSW get angry with the OW, as the OW drive away clients, and are therefore costing the FSW money. An example of how a conversation on the street may begin follows:

> OW: "Please, may we have a few moments with you, we are..."
> FSW: "I don't want to talk to you. I know about diseases, and I get tested regularly. You made me lose a client. Get out of here! You want to steal my client?"
> OW: "You may be giving up a client worth 50,000LL [US$33], but you are giving yourself a chance to improve your life and to learn how to protect yourself and the ones you love."

It often takes awhile for the OW to gain the trust of the FSW, as most think that they are either competing for clients or that they are working for the police. After trying to convince the FSW of the importance of this conversation and establishing her trust in them, the discussion proceeds similarly in the bars. Upon completion of the discussion, OW would leave brochures and condoms as well as the hotline number of SIDC or Dar al Amal in case the FSW had further questions or concerns.

Outreach and Peer Education Impact

The OW saw the outreach as a success, and believed that the interventions had a positive impact on the FSW reached. One OW who worked with a group of around 50 street FSW stated that the women are more consistently using condoms since the intervention and are insisting on the use of condoms with their clients. She said they showed her that they all had condoms in their bags, and that many stated that they had taken a voluntary HIV test and were planning on continuing to do so regularly. Additionally, a FSW came to Dar al Amal for assistance after being contacted by an OW. In addition, most FSW (84%) were open to the discussions, however 11% refused to talk with the OW. The most successful part of the intervention was the condom distribution, with 98% of the women contacted receiving condoms from the outreach team (24).

[5] Some of the quotes within the first three phases are taken from the rapid assessment completed after the interventions. They have been placed within these sections to illustrate or clarify the point.

HIV/AIDS Awareness among Youth and Vulnerable Groups in Lebanon: 2003 – 2005

As the initial project, 'HIV/AIDS Prevention through Outreach to Vulnerable Groups in Lebanon' was being completed in 2002, the NAP received funding to continue the project while expanding the activities to allow for national coverage. This project, 'HIV/AIDS Awareness among Youth and Vulnerable Groups in Lebanon' is considered phase II of the overall program. The partners of this phase were UNFPA, UNAIDS, NAP and NGOs and it was supported through OPEC funding.

The overall goal of the project was to contribute to improving the quality of life of the Lebanese people by increasing the availability of information regarding HIV/AIDS to youth and vulnerable groups as well as by enhancing awareness about HIV/AIDS prevention in Lebanon. A peer-based approach was taken to the project and focused on (a) increasing knowledge of the target groups (b) enhancing the capacity building of these groups, (c) strengthening networking with relevant groups, and (d) maximizing outreach and prevention (6). Other objectives included increasing awareness about condom use and selection, and promoting the adoption of lower-risk behaviors. Additionally, the project aimed to promote VCT for HIV and other STI testing as well as to involve members of the target population in the prevention of HIV and STIs in order to ensure sustainability (6).

This phase was developed by a coordinated effort between NAP, UNFPA, and SIDC. It was designed based on the results of the situation analysis that was performed during the first phase of the project as well as the outreach experience of the peer education team during that time. The project was executed mainly by the local NGO, SIDC, which performed all project activities in close coordination and partnership with the UNFPA and NAP. Other NGOs were also involved, including Dar al Amal, which focused on outreach to the FSW population.

Outreach and Peer Education

Outreach was seen as a very important element of the first phase of this project, and was continued during the second phase as well. The work was expanded to other districts outside of those reached during the initial phase, and additional OW were trained. Preparatory steps were taken in the new districts including the development of partnerships with NGOs to facilitate access to FSW, and to acquire greater knowledge of the actual situation for these women. These NGOs also assisted in recruiting OW from their respective areas. The protocols for field surveillance, coordination and reporting used previously were revised and updated to be adapted for each new region.

Officially, outreach activities began in March 2004. After attending training workshops, OW were provided with identification cards, brochures, a supply of condoms and referral cards, a reference booklet and their field reporting forms. Outreach activities involved person-to-person contact as well as group encounters for peer education, condom distribution and referral of the target groups to relevant services. Coordination between field supervisors was facilitated in order to allow for sharing of information among the different districts as well as the ability to continuously evaluate the fieldwork process.

Weekly follow-up meetings were held by the SIDC team to continuously build the capacity of the outreach team. These meetings were an opportunity for sharing experiences and stories from the field and for discussing cases and obstacles encountered. Some of the meetings were used to evaluate the materials and documents distributed, as well as to remind the OW about the importance of fieldwork, to plan for their interventions and to reinforce security measures.

Mobilization and Involvement of Gatekeepers/Reactivation of Advisory Committee

The Advisory Committee established under the first phase of this project was reactivated. Their responsibilities included supporting the Project Team with technical and expert advice as well as facilitating contacts with gatekeepers and discussing and recommending policy issues. Gatekeepers were identified who could facilitate access to the FSW; these gatekeepers included police, various NGOs, bar owners and others. The gatekeepers were contacted for support with technical advice, facilitating access to members of the target groups and other gatekeepers, as well as providing feedback on trainings and outreach that had been completed. These alliances were crucial; especially the alliance with the police, as they ensured the safety of not only the OW, but also the safety of the target group during outreach campaigns.

Strengthen Networks

A network was established between various NGOs throughout Lebanon that would be taking part in this intervention. The NGOs included SIDC, Dar el Amal and Caritas Migrants who had been involved in the first phase of the project, as well as new members from all regions of Lebanon. This network facilitated communication between the groups and provided overall coordination.

Support Materials

Materials were developed to facilitate the outreach process. Referral cards (Figures 2a & 2b) were developed indicating names, phone numbers, and opening hours of NGOs offering services. Field reporting forms were developed for use by the OW covering topics such as demographic information of target populations, type of intervention performed, and the type of information provided by the OW. In addition, a reference booklet for the OW (Figure 3) was developed by the project team to cover various topics related to the definition of, transmission of, and scientific information on HIV/AIDS and other STIs, condom use, safe sex, and life skills. The reference booklet was prepared with the help of the OW involved in Phase I. Condoms, lubricants (Figure 4) and NAP brochures were also provided for outreach activities.

Results

Outreach Findings

OW were able to reach a total of 1103 FSW in all regions of Lebanon. The majority of these women were contacted in the Mount Lebanon area (385) and the North (347), with the least number of women being reached in the South (76). Since the areas outside of greater Beirut and Mount Lebanon are generally more conservative, the OW had a more difficult time accessing the target populations in these locations. Although MSW were not a target group initially, OW were able to reach 95 MSW. The majority of the FSW were contacted through Dar el Amal and SIDC, while the MSW were reached through the NGO, Helem (25).

Only 15% of the FSW stated that they would stop a relationship with a sexual partner when faced with violent behavior. It was assumed that this was due to the need for money, and therefore the need to accept clients regardless of the consequences. This need for business was evident in the following statistic as well; only 23% of women would stop sexual relations with a client if he refused to use a condom. The inspiring aspect of this finding was that the percentage was higher than that of the initial situation analysis (17.4%). This showed that there were fewer women who were willing to accept unprotected sex with clients in 2004 than there were in 2001. The number of FSW who had taken an HIV test in the last year had also increased to from 21.8% to 34%. It cannot be stated that these are true statistical differences, as analyses have not been conducted and the samples were not randomly chosen. However, the trend is interesting to note[6].

[6] It is also interesting to note that between 2005 and 2007, the percentage of FSW having been tested for HIV in the past year actually decreased. (See upcoming section on analysis of data)

Figure 2a: Guide to HIV/AIDS Resources in Lebanon

Figure 2b: Referral Pamphlet for Outreach

Figure 3: Reference Booklet Created for Outreach

Figure 4: Lubricant Packet Created for Outreach

While 18% of the FSW contacted denied that they participated in any risky behaviors, it was refreshing that 87% of the women accepted to be part of the intervention, and over half of the women contacted found the intervention useful. The FSW were most interested in receiving condoms from the OW, and least interested in the brochures that were offered (26). Many FSW were excited to receive the condoms for free and requested that the OW come back on a daily basis to distribute condoms.

> "Where have you been all this time? Why have you disappeared? Why did you boycott us and stop giving us condoms?"
>
> (OW-3)

Some members of the target groups accompanied an OW to the government hospital to take a free HIV test. The police were encouraging OW when they saw their identification cards, and did not cause any problems. Additionally, some of the work lords were enthusiastic about the outreach and encouraged the OW to come back at another time to speak with other FSW (26).

Evaluation

This program was monitored in a variety of ways to provide for a more comprehensive evaluation mechanism. Members of the research team visited the field periodically to monitor the OW and to identify technical or operational issues that could be improved. Regular reports from the field were provided by the FC and OW and were continuously reviewed for monitoring. Reports were also collected during regular meetings between the FC and the OW in each district. Activity reports were completed for all trainings and awareness related activities. Mid-term and final reports were completed to delineate the activities completed, their outcomes and recommendations or comments. Evaluation was based on predetermined indicators that were linked to the project goals, purposes and outputs.

Dar al Amal NGO

Outreach for HIV/AIDS Prevention Targeting Populations at Risk in Lebanon: 2005 – 2007

The last phase of the overall intervention, entitled 'Outreach for HIV/AIDS Prevention Targeting Populations at Risk in Lebanon', consisted of two main activities carried out from 2005 to 2007. The project was planned to finish in 2006. However, due to the unfortunate crisis in July 2006, all of the activities were postponed and were not continued until Lebanon was deemed stable and safe for the outreach team. This project was funded through the UNAIDS PAF Funds and conducted by SIDC under the overall guidance of NAP. One of the main activities of this project included strengthening and expanding outreach to the vulnerable populations, including developing the capacities of local NGOs. The other main activity was a rapid assessment study to assess the behavior change of FSW since the beginning of the project in 2001 (27). The evaluation study will be discussed as a separate study after the other activities of this phase have been laid out.

Strengthen Coordination and Networks

In order to implement this last phase of the project, the coordination mechanism between all key players needed to be strengthened. Meetings were held between the three key players of the project, UNFPA, NAP and SIDC, to determine the best method for coordinating, monitoring and implementing the work plan. It was determined that one important aspect would be to reactivate and expand the advisory committee and to gain increased collaboration between all of its members. Lastly, meetings were held with members of the private sector community in an attempt to involve them in the planned HIV prevention activities. These meetings were also held in order to seek support for the production of the brochures and for procuring the tests for both HIV and hepatitis.

In order to strengthen the capacities and performances of the local NGOs in reaching vulnerable populations through outreach and other activities, many similar activities were completed as during the previous two phases. 25 new OW were trained, as well as refresher trainings for those who had worked previously. These sessions included sensitization training for OW and NGOs, which had been a recommendation of the OW during the last phase. The network of NGOs initiated in the last phase was strengthened as well (27).

Strengthen Hotline and Referral Services

Through the previous phases, it was recommended to strengthen both the referral services and the hotline services offered by NGOs. In order to achieve this, a four day training workshop was held with 32 participants (12 men and 20 women) from 22 NGOs and health care service centers. All of the participants were health care providers who were highly motivated to work with vulnerable groups and came from all regions of Lebanon (27).

Hotline Services

It was planned to increase the capabilities of the hotline operators, as well as to expand the availability of the hotline. Thus, NGOs that wished to be involved in the hotline services were recruited. Members of these NGOs were invited to participate in a four-day training workshop for hotline operators. 15 people attended the workshop, and learned about the principles of the hotline services as well as obstacles they could face, and how to counsel individuals over the phone.

Referral Services

It was recommended in both of the previous phases to strengthen the referral services and update the referral cards that were being distributed. An operational protocol was developed for the referral process, and health care facilities and NGOs were invited to participate in the referral system. Each facility that wished to be involved in the referral system was subject to evaluation of their services.

Referral centers were provided with training focusing on the referral process, sensitivity to vulnerable populations and their life situations, and the need for confidentiality in providing services. It was also emphasized that the beneficiaries of these services should receive the same high-quality care that the providers give to all other patients or clients. Training was given through a three-day training workshop, held concurrently with the hotline operator workshop.

Outreach and Peer Education

The main objectives relating to outreach work within this phase were to enhance the capacity of the OW and to increase the number of FSW reached. An operational protocol was developed for the OW on improving their outreach skills as well as how outreach should be conducted. The training module was also updated, and the training workshops were improved through the input of knowledgeable resource people and the experienced OW.

Outreach work was planned to begin on the first of August, 2006, however was postponed until after the hostilities of the July war had ceased[7]. 12 new OW joined the team, including six PLHIV who were motivated to participate in the outreach activities. Their HIV status was not shared with the other members of the outreach team in order to ensure confidentiality and respect for their privacy. Follow-up meetings were held with OW, and taking into account recommendations from the previous phases, these meetings were held every other week (27).

Support Materials

Three brochures were developed on prevention of HIV/AIDS and other STIs with a specific focus on the vulnerable populations of IDU, MSM, and the prison population. These were developed in order to replace the multitude of materials distributed in the previous phases and to make the materials more sensitive to and appropriate for the target populations. However, tailored brochures were not created for the FSW population. The reference book was redeveloped with assistance from the OW. In addition, an operational protocol for three sections of the project was developed, including a guide for referral, hotline and outreach work. All of the materials were pretested with the assistance of the OW, members of the vulnerable groups and the participating NGOs.

Results

There were a total of 12 OW that worked with the FSW population. These OW worked throughout Lebanon, though most were centered in Beirut. Four NGOs were involved in the outreach process, which ended up reaching 563 FSW, in addition to 50 MSW. The referral system was updated with listings for 21 health care associations and provided training for 20 health care providers. Nine NGOs were involved in establishing the hotline project, although only eight hotline operators were trained (27).

[7] In July 2006, Lebanon experienced a month-long conflict with Israel that disrupted activities around the country.

Overall Evaluation

It is important to note that within the strengths and obstacles, there are issues that are mentioned that came up only in one or two of the phases that were corrected in the next interventions. These strengths and obstacles have been included here, as it was felt that this is the best way for others to be exposed to the difficulties that were encountered in these interventions. In general, it is not noted which phase these were encountered or corrected in, for ease of reading. Additionally, some of these were also noted and clarified in the rapid assessment study, and some were not identified previously; these are also included here.

Strengths

Preparatory Phase

The committee composed of UNFPA, NAP and SIDC that oversaw the project assured that the work progressed smoothly and was followed on a continual basis. This created a system of accountability that ensured that the work was conducted in a high quality manner. Follow-up meetings at each of the various levels were also important for this reason.

The coordination and partnership created by the network of collaborating NGOs helped to develop the outreach activities and apply the skills necessary for the project. By allowing the network members to participate in developing the tools for the project, including the monitoring system, it helped to create more ownership and a feeling of responsibility for the project and assisted in creating a more durable outreach program. The FC at each NGO were dedicated to their work and motivated to make the project a success. The coordination between the FC and SIDC created an atmosphere of mutual respect, and also provided the OW with some autonomy. By developing the reference booklet and field reporting forms in collaboration with the OW, they were encouraged to take a more active approach. Involving OW who had worked during Phase I and II in the process of the training workshops and encouraging them to recruit others made the intervention stronger, and enhanced the learning process.

Outreach and Peer Education

The outreach program was seen as a successful strategy by the OW, and was believed to have had a positive impact on the behaviors of the FSW that were reached.

> "When we first started outreach, the project was on a small scale, then it was scaled-up in the second outreach as we were reaching sex workers in more locations. In the third outreach it was mostly on the streets, and we did not reach many girls in the night clubs. Sometimes we get exposed to physical abuse in the street outreach; it happened to me once in the first outreach. The good thing is that we feel that there is a positive attitude towards condoms; better than the previous outreaches."
>
> (OW, Rapid Assessment)

Some of the strengths of the program mentioned included the effective training of the OW and the continuous follow-up with the OW upon returning from the field. The weekly meetings were seen as beneficial as they allowed the OW to share their experiences and to learn from one another.

> "The last time, when I told you what I did in the field and you corrected my intervention, I learned to always introduce myself clearly and honestly to the procurer of the sex workers."
>
> (OW)

Other aspects of the project that assisted in creating a successful outreach program included the OWs' enthusiasm for the project and their insistence on delivering the information, due to their belief that this information was very important for all FSW. Additionally, the OW noted that their knowledge and familiarity with the locations of the target groups, and of the people themselves helped facilitate trust among the targeted group. These OW have experienced similar situations and know what risks to expect when completing outreach and how to avoid them. They know how to communicate with the population and are able to use the same language, while also being able to understand and empathize with them. Many of the OW mentioned that they felt more involved in the intervention because it had affected them personally, as they had previously been involved in the sex trade themselves, they were more concerned with each individual case and considered the outreach work as a personal mission.

The outreach team was selected based on specific criteria including their commitment to the outreach intervention, which enhanced their effectiveness. The OW were able to acquire necessary communication skills through the trainings and to build a solid base of trust with the target group members. This ability to approach the FSW without discriminating against them was critical for the success of the intervention.

They also mentioned the benefit of having back-up measures for safety, including police clearance for the project to proceed.

> "When I was talking to the sex worker on the street, a police car stopped by and asked me if I'm new working here. I showed them my identification, so they wished me luck and left."
>
> (OW)

While conducting outreach, the distribution of condoms was found to be the best tool for attracting FSW to become involved in the intervention. The reference booklet proved especially useful for the OW, as they were able to show illustrations of STI symptoms to the women allowing for a greater impact than words alone, as well as to look up information if they did not remember the details.

Obstacles

Preparatory Phase
For each of the three phases, the advisory committee was (re)activated. During phase II, the advisory committee met only once at the beginning of the project, and was unable to meet again, which may have led to important issues being overlooked within the intervention.

Some FC felt that they had not been fully prepared for their positions of monitoring and responding to the needs of the OW, and were unclear as to their roles and responsibilities. Some also felt that their job was too time-consuming and required too much overtime. The Bekaa area did not have a FC, which necessitated multitudes of phone calls to the SIDC director for field monitoring purposes.[8] Additionally, many OW felt that the content and material of the training workshops were too condensed, with not enough time spent on valuable topics such as vulnerability, harm reduction and sexuality.

Services and Referral
Between the phases, redesigning the structure of the project took time due to recommended improvements, including the strengthening of the referral system. It was desired for the referral system to cover all of the needs of the vulnerable groups. The process for building the referral system was more time intensive than expected, with building contacts, holding meetings and motivating groups to work with HIV prevention and vulnerable populations. Several meetings were also held between the facilitating team of UNFPA, NAP, and SIDC to make amendments prior to implementation.

[8] This obstacle is only pertinent to phases II and III, as the first phase did not include areas outside of Beirut.

There was concern over whether the services mentioned for referral were actually available and reliable. It was noted that the hotline numbers were often busy, and that calling the hotlines were not free of charge for the caller. Additionally, some of the services requested by the FSW were not obtained or followed up by the NGOs. VCT services in some areas were not easily accessible, and some target group members became anxious as they thought they might be discriminated against or referred to the police by the staff members of the center.

Some of the obstacles encountered through the intervention process were due to a lack of resources, including financial resources. For example, due to insufficient funds being available, the NGOs were not provided financial support for hiring FC, so the work of monitoring and evaluation was left to current employees, often social workers, who were already overworked. This led to some problems with the outreach process and interventions as a whole.

Outreach
In the second phase, outside of the Beirut and Mount Lebanon areas, outreach to vulnerable groups was a new approach. Few organizations had experience with these populations and were not experienced in peer-based approaches. Difficulties were encountered in locating peers in these areas who were willing to conduct outreach work. Additionally, some NGOs were unwilling to work in the streets, and felt that the issue of sex work was too sensitive to be dealt with in these locations. One organization, Caritas Migrants, did not feel the need to participate in the outreach work. They were convinced that a large proportion of the foreign population was coming to their center, and therefore they did not need to reach additional FSW through outreach. The OW recruited through this organization thus felt that they were not able to provide much of the help that was needed for the migrant FSW.

OW had troubles finding transportation in order to complete their outreach work as well. Most OW do not own their own personal vehicles and some of the areas were not accessible by public transport. Transportation was especially difficult on rainy days.

The FSW resisted the outreach in many ways; they denied engaging in risky behavior, stated that they knew everything they needed to know about HIV and other STIs, and they also tried to intimidate the OW or to seduce them into working in the sex industry again. In some instances, the FSW were suspicious of the intentions of the OW and believed that they were working for the police, or that they were competing FSW trying to steal their clients.

> "They used to be embarrassed when we first approach them, then they would tell us that we are there to take their clients."
>
> (OW, Rapid Assessment)

> "Now that you're out of it [sex work], you're coming to preach to us?"
>
> (FSW, Rapid Assessment)

During outreach, many of the target population members did not take brochures, in part due to the large number of brochures that were being offered. In addition, some were afraid that if others saw them with the brochures that they would be discriminated against. Others were unable to read the brochures due to the high level of illiteracy among the FSW population. Some of the OW expressed concern over distributing condoms without providing information about their methods of use or characteristics.

Time spent with members of the target population was often inadequate for the intervention due to a variety of factors, including presence of the work lord or police and being in a public location. Some of the OW did not feel comfortable taking the field reporting forms into the field, and therefore filled out the forms after the outreach sessions were over. The combination of these factors led to some of the information on the field reporting forms to be estimated or not entered, such as the age and education level of the women. In addition, some OW were afraid that asking too many personal questions might scare the FSW away, especially regarding questions such as reactions to violent behavior, that the FSW might see as too personal or confidential to share. It was also felt that the field reporting form was too long.

Additionally, many obstacles were encountered due to the interventions being conducted in a public place, especially on the street. FSW are on the street for work and the time spent talking to the OW is time that she would rather spend making money with clients. Her work lord is usually standing close by as well, which increases her stress and distractions, thus decreasing the amount of information that she may be able to comprehend at that moment. There are many fears that a FSW is dealing with at the moment of outreach that create a barrier to her ability to listen and respond; her fear of losing a client, the presence of her work lord, fear of imprisonment, fear of a positive HIV-test result and the consequences of that result, and the lack of trust between her and the OWs. These all play a part in the effectiveness of the outreach.

> "They [FSW] are standing on the street waiting for a client, scared to be caught by the police and their pimp is watching them. What do you expect her to tell us? 'Go away!' We are going to be talking to her about SIDA, a sensitive topic. You know what I mean? Before talking about anything, she [the FSW] has to feel more comfortable and relaxed."
>
> (OW-1, Rapid Assessment)

Many of the OW recognized the risks of their job. Some were afraid of going back to their old environments as they were afraid of relapsing back into their old routines and habits.

> "We are vulnerable deep inside. We are all prone to returning to sex work when we're under stress. No matter what we do, nothing can change the fact that we are prostitutes in the core. People will always see us as prostitutes. We will always see ourselves as prostitutes."
>
> (OW, Rapid Assessment)

In certain areas, to ensure safety, it was necessary for a male and female team of OW to conduct the outreach. The dangers of working in some of these areas must not be underestimated. Due to situations that were encountered by a few OW, the necessity of properly identifying the objectives of their visit to people at the site immediately upon arrival was reinforced; this included not only to the FSW, but to their work lords as well. Some of the OW faced resistance from work lords who refused to allow them to talk to the FSW under their control.

> "The most important factor for the sex worker is to make money, this is her priority. She sees that making money is much more important than wasting her time with people she does not know, people who gave her a list of organizations that she is not familiar with. She is scared that these organizations would call the police to get her arrested. She has lots of fears, plus the money issue which is very important. She is scared from going to the NGOs, getting tested for HIV, having a positive result. Then what would she do? She would be worried on how is she going to live the rest of her life and her only source of income is from sex work? Would she still be able to work? The girl has fears that she thinks of and in my opinion these fears are the obstacles that interfere with her choice of going and seeking help from NGOs or any other organizations. Plus the transport expenses are a burden on her in case she is located in an area that is distant from the NGO. For example, Dar al Amal is the only center in Lebanon that offers such a service [works with SW]. If she is in Tripoli or any other place that is distant, it would be costly."
>
> (Director of Dar al Amal, Rapid Assessment)

An additional obstacle had to do with the high mobility of the FSW population. The street FSW move around a lot, not only within the locale they are based out of, but also around Lebanon. In addition, the women may move from the street to a bar, or other organization. Therefore, with the outreach being conducted for short periods of time, and not continually, many of the FSW are only reached once, and are not located again. In addition, the trust that was beginning to form from the first outreach is interrupted by the large amount of time between meetings.

> "It is hard to relocate the girl [FSW]. The girls do not work in the city they come from, as they are scared for their identity to be revealed. As you know, Lebanon is a small county and the girl from the south would rather work in the north and vice versa. This is why you see the girl from the north is in the south, and the girl from Bekaa is in Beirut. Plus, if she is working in the north, a client would pick her up on his way and take her to Beirut, another one would pick her up and take her to the Bekaa."
>
> (Director of Dar al Amal, Rapid Assessment)

A rapid assessment study was completed in order to assess the extent of behavior change among FSW since the implementation of the first phase of the intervention in 2001. Within this study, a rapid assessment was completed focusing on condom use, negotiation skills, the impact of work lords and resistance to peer pressure. This study served to highlight the impact that these projects have brought about for FSW and any ensuing behavior change. This study was implemented by NAP.

Methodology, Data Collection and Data Analysis

This study employed both qualitative and quantitative methods[9].

Qualitative

The qualitative study included in-depth interviews (IDI) and Focus Group Discussions (FGDs). Within qualitative research, IDI and FGD are conducted until a saturation of data is reached.

Therefore, two FGDs were conducted with FSW and OW, as well as two IDI held with FSW, and one IDI with the director of the Hirish Tebit Center of Dar al Amal. Through the IDI and FGDs, the researcher asked a set of open-ended questions in colloquial Arabic. The questions were pilot tested by experts in the field to ensure that they best served in answering the research question and meeting the study's purpose and objectives.

All discussions were recorded and transcribed immediately following the sessions. Notes were also taken throughout and findings were transcribed and analyzed. Thematic analysis was performed in order to develop the emerged themes from the discussions. These FGD and IDI assisted the researcher in better understanding the various factors that enhanced or deterred behavior change among FSW.

Quantitative

The quantitative part of this study utilized a questionnaire concerning the current risky behaviors of FSW in order to assess the impact of the first two phases of the project on behavior change. The questionnaire was validated through consultation with several experts in the field of HIV research and with the FSW themselves. This structured questionnaire was then administered to 539 FSW from all regions of Lebanon. With this number of subjects, the researcher was able to detect a change of at least 5% with 90% power and a 5% significance level. Moreover, it is possible to estimate prevalence with a margin of error of at most 4%.

Statistical Analysis- Quantitative analysis was performed via statistical analysis, using mainly frequency distributions computed for all variables. Comparisons between prevalence over years were completed using the chi-squared test. When comparing prevalence between the years 2001 and 2007, two tests were performed, one using the entire data set (collected from all regions of Lebanon) for 2007 and the other using only the data from the Beirut region as the study in 2001 was conducted only in Beirut. This was not necessary when comparing the years 2007 and 2005 as both were conducted in all regions of Lebanon.

Ethical Considerations in Administering the Study

A letter of consent was prepared before conducting the study. The researchers were required to obtain the verbal consent of the participants before administering the questionnaires or conducting the IDI or FGDs. The researchers also confirmed with the participants that they have agreed to participate in the study on a voluntary basis and that their participation was not imposed on them by any official party. The researchers assured participants complete anonymity and confidentiality. They also informed them that they had the right to refuse to answer any of the questions and the right to withdraw from the study at any point if they felt the need to.

Researchers were trained to be as reflexive and reflective as possible. In addition they did not put themselves or any of the participants in any physical, emotional or psychological distress or danger. Researchers did not promise participants any unattainable or inaccessible interventions or reform and they did not raise their expectations and hopes with respect to any of their concerns.

[9] Qualitative research aims at understanding the participants' holistic perceptions, views and experiences (37). Within qualitative methods, FGD involve a small number of participants and allow for 'conversation with a purpose' (35), while IDI allow participants to discuss their personal thoughts and feelings (35).

Qualitative Emerged Themes

Outreach Effect

Most of the participants felt that the outreach had a positive effect on behavior change, especially among new and young FSW. It was felt that these women were more affected by the outreach as most of them aspired.

> "To get married, and did not want to contract sexually transmitted diseases [sic] and cause themselves a bad reputation."
>
> (OW-4)

Outreach Effect: Increased Condom Use

The participants believed that the outreach program manifested in more listening and comprehension among the FSW as well as increased condom acceptance, demand and use. Access to condoms was increased as condoms were distributed for free during outreach. This also led to less embarrassment among the FSW in requesting condoms from pharmacies. The OW felt that with the last phase of outreach, the acceptance of condoms increased greatly.

> "There is less embarrassment. Some [FSW] have even approached us and asked us for more condoms, 'I cannot come every day and look for you to get condoms. Could you give me the whole box?'"
>
> (OW- 2)

> "Some girls [FSW] feel guilty when they do not use condoms with their client. Now they are scared to get HIV, after our [outreach] work."
>
> (OW)

Outreach Effect: Positive Peer-to-Peer Effect and Increased Trust

The outreach also had a positive peer-to-peer effect, as the FSW shared information with each other, which energized the outreach effort and assisted in spreading the information to a larger number of FSW. This also helped the OW to gain the trust of the FSW, as through the sharing of information amongst the FSW, the next time the OW came, the FSW were more ready to listen and to engage in the outreach process.

> "I have told my friend that you all [OW] came and talked to us and what you have told us. I gave her the information and she listened."
>
> (FSW)

> "The girls [FSW] started to request condoms by themselves, and they are bringing other girls with them from X [a locality in greater Beirut] and even males to ask for a condom. This means that the awareness and outreach is starting to have an effect."
>
> (FSW)

Outreach Effect: Positive Effect on Outreach Workers

Outreach had a positive effect on the OW themselves, including an increase in their knowledge on HIV and other STIs. Those OW who participated in more than one outreach intervention felt that the outreach was having a positive effect on decreasing their own risky behaviors. Working on the outreach campaigns has increased their self-confidence and self-respect and they feel that with this information they have been able to make a change in their own lives. Outreach has also caused some OW to examine their own situations, to doubt their own HIV sero-status and consequently to seek HIV testing.

> "I took an AIDS test to confirm that I have not contracted HIV."
>
> (OW)

> "Some [FSW] feel that there is hope, because of us [OW]."
>
> (OW)

Outreach Effect: Perceived Negative Effect on FSW
Some participants felt that the outreach was having a negative impact on their work as they were insisting on condom use and were thus losing some clients. Some of the FSW are afraid to work without using condoms now that their awareness level and knowledge of HIV issues have increased.

> "The increased fear of 'catching AIDS' has caused them [FSW] to demand condom use and thus [they are] losing clients."
>
> (FSW)

> "Some [FSW] are leaving their job [sex work] because of their fear of AIDS."
>
> (IDI-FSW)

Referrals and Seeking Medical or Social Assistance

There were contradictory statements among participants as to whether FSW seek medical help when they think they may have an STI. Some FSW seek treatment immediately, while others feel that it is a waste of time and money, and that they would rather be out with their clients. Some of the women were afraid to seek treatment, as they feared that they would be turned into the police and arrested, especially in the case of women who also use drugs. They also felt the same regarding HIV testing. In instances when the FSW do not seek medical assistance for infections, they often self-prescribe medication, or ask other FSW what medications they have used in the past.

> "Our job was to assure her [the FSW] that none of this [arrest and imprisonment upon positive HIV results] would happen to her, and gave her a list of the NGOs where she could go and seek help."
>
> (OW)

Other factors that deter FSW from seeking medical and social support are time and money. They have noted that the medications that doctors prescribe are too costly for them, and that they feel that they waste a lot of time waiting in lines at the doctor's office.

> "The long waiting hours at the doctor's office cause me to lose clients and money."
>
> (FSW)

Many of the FSW do not trust the referral system and are suspicious of the OW. They wonder why the OW would want to help them. This fear and mistrust is reinforced for them when they see the Ministry of Health logo on the brochures, as they are afraid of government facilities due to the illegality of their profession. However, some of the FSW have sought assistance from the NGOs mentioned during outreach. A few had been to VCT centers[10] and mentioned that they received very professional treatment.

> "Some girls [FSW] were referred and accompanied by us [OW] to receive VCT at the NGOs offering the service. One of the outcomes of the intervention was to get tested for HIV and know the results. The free and voluntary testing encouraged the sex workers to proceed forward with the testing."
>
> (OW- 3)

Some of the FSW reached through the outreach intervention had misconceptions of HIV-testing, and believed that a regular blood test conducted at a doctor's office would reveal their HIV status. Many of the women did not know that there are specific centers for both VCT and other services.

> "When seeking medical help, she [the FSW] didn't tell the doctor she wanted to test for HIV as she thought that a regular blood work would confirm her sero-status. She had no idea that there is a specific test for HIV and that there are NGOs, including Dar al Amal, who offer the VCT service."
>
> (Director of Dar al Amal)

[10] All three of the phases of outreach occurred prior to the national launching of VCT centers in Lebanon. At that time, there were 4 VCT centers available in the country, with three of these in the greater Beirut area; one was in a government hospital, the other 3 were located in NGOs.

However, other FSW had a negative experience with the referral process. This was mentioned in particular in regards to seeking rehabilitation for drug addiction, as the NGOs that provide this service have specific criteria for accepting participants, and the FSW did not fit these criteria, even though she was ready to make a change in her life.

> "X was a 'drug addict' and she was in a miserable situation. She reached a point where enough was enough and wanted to get rid of her addiction. She was very serious and assertive, but the NGO did not accept her, which made her more devastated. She thought she had a chance, but all her dreams disappeared and evaporated. She went back to drug use and to the streets. She thought she had a chance of being helped and she was not helped."
>
> (OW)

Peer Pressure

FSW can have both a positive and negative influence upon each other. Some FSW give advice and support while others let competition and jealousy guide their interactions. Jealousy, competition, shared experiences, leadership skills, bad intentions and lack of trust are the key factors that fuel peer pressure and gear it towards either a constructive or destructive interaction.

Peer Pressure: Shared Experiences and Positive Effects
When FSW share similar problems or experiences such as STIs, pregnancy or abuse, they are more likely to try to provide helpful advice. Some girls help each other by giving each other a place to sleep, providing food, or leading each other to clients who may pay larger amounts of money. In such cases, a mutual trust is built; thus advising, informing, educating and influencing each others' behavior is easier. In these cases, when a FSW gives advice, they listen and try to learn from each other's mistakes.

> "A girl might share the way she felt when she had to go through an abortion, or when she was heavily infected, or how she ran away from her pimp. We listen. We share the same miseries. Who would understand us better? No one can feel with you and help you if they were not in your shoes."
>
> (FSW)

Sex workers tend to learn from each others' experiences and from observing the consequences of peers' risky behaviours.

> "We learned the lesson from another FSW. She was infected with heavy microbes, and she lost all her clients as they ran away from her. Those who used to love being with her no longer did after her infections."
>
> (IDI-FSW-2)

However, they sometimes unintentionally give each other wrong or faulty ideas, especially concerning HIV issues, due to low level of knowledge and information. An example of this is the following quote of advice given to one of the FSW participants.

> "Swallow the semen, then you won't get AIDS."
>
> (FSW)

> "Some [FSW] think AIDS is caused by lack of hygiene, and hence advise others to make the client wash his sexual organ before intercourse, and to wash their own sexual organs after intercourse."
>
> (Director of Dar al Amal)

Peer Pressure: Jealousy and Competition
A large number of the FSW focus solely on money, and of ways to gain more. Due to this, they do not look out for other, and are suspicious when others offer advice or assistance. There is a high level of competition among the FSW as they are all contending for the same clients. While some learn from others mistakes, money continues to play a major role in how most FSW make decisions.

> "Girls [FSW] are often jealous of each other. Their main concern is to make more money than the others. Not one girl gives advice to the other in this profession. Girls are competing with each other on a regular basis. A girl might accept having sex without a condom just to keep her clients and not lose them to others."
>
> (IDI-FSW-2)

> "Girls influence each other, but not in condom use, because there is competition. They are scared that other girls might take their client. She would say, 'If I do not take him, the other one would,' so she accepts having sex with him without a condom."
>
> (FSW)

While some FSW do not try to give advice or influence others, some intentionally try to influence other FSW. However, it is unknown whether they think they are giving good advice or not.

> "Why is she telling me to use a condom? She wants to rip my client off. Why would she care anyways? Everyone is out for herself. No one is there for anyone in this business."
>
> (FSW)

For the most part, the FSW believe that these cases of exploitation are few and far between, and that they try to respect each other, even if it does not lead to friendship, as they are all facing the same situations.

> "Although there might be competition between the girls, and one might convince the other to do something wrong, but you feel that this is not highly prevalent. Most likely they would not hurt each other. There's a particular code of ethics amongst them which probably came about because they all live in similar situations, thus they tend to sympathize with each other."
>
> (Director of Dar al Amal)

Peer Pressure: Exploitation and Abuse
Some FSW exploit and abuse their peers, and may even try to get them into drug use so they could control their actions and manipulate them. While this happens more often with the work lords, some FSW take advantage of others as well.

> "Some girls [FSW] are bad; even pimps are not as bad as they are. She would know that this girl has no one to turn to and has run away from her family and would not go back to her mom and dad, and pressures her to be with clients without condoms as she would be making money out of her. These girls usually work for the pimps. They even go and bring girls from X [another country] that are very young and abuse them. There is high demand from clients for young girls."
>
> (IDI-FSW)

Pressure and Exploitation by Work Lords

FSW feel pressure, not only from their peers, but also from the work lords. In general, there are two types of work lords; those who are concerned about the women working for them, and those who exploit the FSW and try to dominate and control their every move. The influence that work lords attempt to have over their workers depends highly on their level of care for the women, and the level of their awareness regarding HIV and other STIs and the consequences of these infections. Some of the work lords, especially those who manage and own bars, want to maintain a good reputation of being disease free, so they enforce condom use and may actually provide condoms for the FSW, while others verbally and physically abuse the FSW.

> "When he [the work lord] found out about our infections, he had to pay for our medical bills, as he started to lose clients. Now he gives us the choice of using or not using the condom. This way he would save his money instead of spending it on our medications and save time spent at the doctor."
>
> (FSW)

In the super night clubs[11], some work lords make sure that the women use condoms, and have personnel that are specifically appointed to ensure condom provision and use. They tell them never to have sex with a client without the use of a condom no matter how much he pays. While some of this may be out of concern for the women, another reason is that under the decision 1/99 that was updated on March 25, 1992 from decision 1/236 and based on the decree 861, women working in these establishments must be tested every three months for HIV and other STIs. By ensuring condom use, they are guaranteeing that the women are complying and will not become infected.

The more that the work lord provides for the FSW, the more control he has over her. For example, some work lords offer the FSW a place to live in exchange for her work. Usually these women have no one to turn to as they have run away from their homes. These girls suffer the most from the work lords' mastery, domination and control. Some work lords attempt to get their 'girls' addicted to drugs so they exchange their work for drugs that he provides, thereby increasing his profits.

> "Some pimps get the girls into drug use and work her to death without giving her a penny."
>
> (FSW)

In addition to drug addiction, some work lords exploit the FSW in other ways. Most of the work lords sleep with their 'girls' and take advantage of them through this act. Some of the FSW stated that the work lord gets the women pregnant on purpose and then sells their babies for profit, others were mentioned as trafficking women into the country for the purpose of sex work.

> "Yesterday X [a work lord] said that he brings girls from X [another country] and he gets them pregnant, and sells their children as well. He is selling the children, yes."
>
> (FSW)

> "The one who sleeps the most with her [FSW], is the pimp. He sleeps with his girls. He is the first one to try her out, of course. He sleeps with them, with or without a condom, despite his knowledge of her lack of consistent condom use. Yes, he [the work lord] sleeps with them without a condom; he lives with them in the same house."
>
> (Director of Dar al Amal)

[11] Women who work in super night clubs are usually known as artists and dancers; they are not announced as being FSW.

Interference by Work Lords During Outreach
In many cases during outreach sessions, the OW encountered interference by the work lords. The OW noted that the work lords would not allow them to have direct contact with their 'girls', and therefore they felt it was necessary to inform and include the work lords in future outreach efforts to enhance the effects of the outreach. However, this is easier said than applied, as most of the OW are ex-FSW and find it extremely difficult to approach the work lords to obtain their permission before working with the FSW on the streets. The OW still feel controlled by the work lords and intimidated by them, even though they have left the trade.

> "He [the work lord] does not allow you [OW] to talk to his girls [FSW] without his permission. The girls are continuously watched by them, and I find it difficult to approach work lords when doing outreach."
>
> [OW]

> "I cannot talk to him [the work lord]. I tried, but he tells me that it is not any of my business."
>
> [OW]

Client's Influence and Pressure

Clients, in the long run, often have the most control over the FSW, as they are the ones that provide the women with the money that they need.

> "Greater than the effect of the pimp, is that of the client. ... 90 to 95% of clients lead the sexual relationship, because the client is the 'king'. He is the one who has the money, so he leads the act."
>
> [Director of Dar al Amal]

The work lord may pressure the women to comply with whatever the client wants, as gains from the transaction as well.

> "When the client offers to pay more for unprotected sex, the pimp pressures us [FSW] to comply with the client. His [the work lord's] prime interest is to have as many clients as possible. He does not care if the girl is sick or not. He works his girls to death even if they were dying from pain. All he cares for is the client and money."
>
> [FSW]

There is a wide variety of clients; some clients refuse to have sex with a condom, and may become abusive if the woman does not comply, while others may simply request a FSW who is willing to have sex without a condom. Some of these clients will offer the FSW extra money for sex without a condom as well.

> "Some of the clients are nice and do not tell the boss about the girl [SW] refusing to have sex without a condom. They make up an excuse that he did not like the girl, and prefers another one."
>
> [FSW]

Other clients will accept a FSW's request to use condoms, or may insist on using condoms, regardless of what the FSW thinks. A few clients even try to influence the FSW in a positive way and advise them to always use condoms, and inform them of the danger of HIV and other STIs.

Dar al Amal NGO

> "I knew about AIDS from a client. He was telling me that there is AIDS in Lebanon, and advising me to use a condom. He said, 'Do not go with anyone without a condom.' My friend was also convinced, and started to use condoms because of a client, and got tested [for HIV] as well in Sidon. He convinced her to do it, if not for herself, for her children and her family."
>
> [FSW]

However, there are also clients whose own risky behaviors put both the FSW and her future clients at higher risk. Some clients only seek girls who are on their menstrual cycle and refuse to use condoms, other clients run away from their wives when they are on their menstrual cycle so they could have sex without the use of a condom. Some clients are IDU, and refuse to use a condom and ask the FSW to share needles with them. Some clients give the girls cocaine so they can exploit them even more.

> "Some clients cheat on their wives with the sex worker whenever their wives are on their menstrual cycles. They [clients] would not want to have intercourse with them [their wives] at the time when they are on their period, so they come to us. They [clients] come because they want to have sex without a condom, so he would enjoy his act. Others go with a million [FSW] regardless if their wives were on their period or not."
>
> [FSW]

Factors that Influence Condom Use Decisions

Condom use is highly affected by various factors including the need of money, fear of imprisonment, and the influence of clients and work lords. Despite the fact that some of the FSW know that HIV can be transmitted without the use of protective methods, if they are offered a higher amount of money, most would accept these risky behaviors.

> "It is useless, as there are circumstances where she [the FSW] would have to accept sex without the use of a condom."
>
> [OW]

Disregard for Self
Many FSW lack self-confidence and have lost hope in their lives. Due to this, some have become careless with their lives and well-being; they feel that nothing could be worse than their current situation, and therefore they do not care about what happens to them in the future.

> "Some girls do not care at all about their health. They do not care about catching AIDS [sic]. They actually want to destroy themselves because of certain problems that they have faced throughout their lives, beginning with their childhood."
>
> [Director of Dar al Amal]

> "We do not want to use condoms. Is AIDS going to be worse than our lives that we have been living?"
>
> [FSW]

Nationality of the Client
There is wide spread belief among the FSW population that people from Lebanon and other parts of the Middle East are not susceptible to HIV/AIDS, and therefore they only have to be worried about wearing condoms if they have sex with foreigners.

> "The Arabs and Lebanese do not have AIDS; the foreigners do, as this is a disease from the West."
>
> [FSW]

Views of Condoms and Access to Condoms
Some of the FSW find it embarrassing to go to a pharmacy to look for condoms, and for those who have tried to buy them, some pharmacies have refused to sell to them. Some of the women said that they felt ashamed when buying condoms. Others are afraid that their parents or other people will see the condom, and so they remove the outside cover of the condom and hide it somewhere until they need to use it. It was also noted that some sexual relationships start very quickly so they do not have time to buy a condom, and hence have unprotected sex.

> "Sometimes you have a sexual relationship quickly, and it is not expected, and you are out of condoms. So, you are not going to stop and go to the pharmacy. Some [FSW] have substituted the condoms with a nylon bag."
>
> (FSW)

> "If I do not have the condom, I won't go the pharmacy to get [the condom] as I am embarrassed. Once, I went and they did not sell me the condoms."
>
> (SW-4)

Most of the women said that the distribution of free condoms through the outreach has played a major role in prompting them to use condoms. It allows them to use condoms without feeling the shame or embarrassment from having to purchase them.

> "Lack of easily accessible condoms causes its lack of use."
>
> (FSW)

Economic Conditions
Due to the hardship of the economic situations of many FSW, money is often their major concern. The FSW will often do anything to keep a client, as they are in need of the money.

> "Sex workers would rather make the US$100 from a client than losing him to another one. When more money is involved, no one cares. They accept the clients that are willing to pay more for the unprotected sex, despite their knowledge of SIDA."
>
> (FSW)

Money is the main motivation for most of the women, as they generally are supporting others, as well as themselves. They will often try to make money in whatever way possible.

> "A sex worker has children who are in need of milk, so she goes with a client as she is obliged for her kids sake, and if he tells her to take US$100 more, would she not accept to be with him without the use of a condom? They mostly say, 'I will do it for one time and it will pass.'"
>
> (FSW)

Knowledge Level and Misconceptions Regarding HIV/AIDS
According to most participants, the level of knowledge regarding HIV/AIDS has increased among the FSW population in the last few years. However, misconceptions regarding HIV and a FSW's susceptibility to HIV transmission abound.

> "I do not use condoms, but I wash myself with Dettol[12] after sex to prevent the contraction of "AIDS" [sic]."
>
> (IDI-FSW)

This belief in washing after intercourse to prevent infection is common, and was also noted by participants who said that they use condoms more often when they have sex in cars as there is no place to shower afterwards.

> "Where are we going to take a shower or wash, so let us use it [condom]. It is cleaner this way."

There are also FSW who do not know anything on HIV/AIDS, as some of them did not recognize the terms, or acknowledge their existence. Lack of perceived susceptibility of acquiring HIV is highly prevalent as most FSW have stated that they have not been consistent in using condoms and have had unprotected sex since they entered the sex trade. They believe that they aren't infected with the virus, even though they have not been tested, and that this is proof that condom use really isn't that important.

> "I have been working for all my life, if I were to have AIDS, I would have contracted it [HIV]. As long as the client is paying, I do not care."
>
> (IDI-FSW)

However, even with all of the above misconceptions, it was noted that consistent behavior change takes time. Small changes in the level of knowledge, or even small levels of behavior change do not signify a complete change of behavior.

> "I took one [FSW] to the [VCT] center and she did her [HIV] test and while she was leaving, the person in the center [service provider] asked her, 'if someone stops you now to go with him and tells you that he wants to be with you without a condom, would you be with him?' She [the FSW] told her 'Yes, I would.'"
>
> (OW)

Knowledge Level of Proper Condom Usage
Many FSW and their clients are uninformed as to the proper and consistent usage of condoms. They often believe that as long as you use a condom, you will be protected. Additionally, condoms are seen as necessary only at certain times in specific sexual acts. This is shown in the finding that condoms are seldom used in oral and anal sex, and sometimes are only used during the moment of ejaculation and not throughout the entire sexual act.

> "Some clients penetrate without the use of condom, and they come back to wear it at a later stage before ejaculation, only to prevent pregnancy."
>
> (OW)

> "Sometimes a sex worker would have vaginal sex with the client with the use of a condom, then she stays over for one or two more hours, and during this time she might perform oral and anal sex without the use of a condom. She might even be with him the first time with a condom, and the second time without a condom."
>
> (Director of Dar al Amal)

Work Lords and Clients
Work lords and clients play a major role in the use of condoms. Some work lords pressure their girls to have sex with the client without a condom and others have unprotected sex with their girls as well. Many clients refuse to use condoms on the grounds of not wanting to lessen their pleasure.

> "The pimp has sex with his girls [FSW] without a condom despite the fact that they have unprotected sex with other men [clients]; all this is because of a lack of awareness among pimps."
>
> (FSW)

> "Three-quarters of the girls [FSW] do not wear condoms when having sex with the mouth, because the client would not accept, as it decreases his pleasure and for some it makes them lose sensation."
>
> (FSW)

[12] Dettol is a household disinfectant.

In some cases the work lords enforce condom use as they do not want to pay for medical bills and waste time in the physician's office. In the case of super night clubs the work lords enforce condom use as they do not want the girl to lose her license and for the bar to have a bad reputation.

> "Our boss at the club was a female, and she used to remind us continuously to use condoms. She used to tell us to be careful and to never accept having sex without a "preservative" [condom] regardless of the amount of money that is offered or paid by a client."
>
> (FSW)

> "If one of the girls contracts a disease, it would be his [the work lord's] responsibility to provide and pay for her medical treatment. In bars, the pimp is the one who makes sure that his girls are wearing condoms, as they have to get tested [for HIV and other STIs] every three months. If any of the girls test positive, she will lose her work license and his bar would have a bad reputation."
>
> (IDI-FSW)

Condom use with clients varies depending on the type of relationship between the client and the FSW. FSW feel more confident in their ability to negotiate condom use with irregular clients, and often feel that with regular clients, condom use is not necessary. With non-client sexual partners, condom use is generally even less frequent, as there is a trust between them, and therefore they do not feel the need to use condoms. For those FSW who do use condoms with their non-client partners, they admit to being scared of transmitting HIV or other STIs to their partner.

> "She only uses it [the condom] with other sex partners, as she is scared to transmit the disease [HIV] to her lover."
>
> (IDI-FSW)

Young clients, and married clients, are the easiest to negotiate with on condom use; generally they do not resist the FSWs' suggestions and are easily persuaded.

> "The young ones [clients] follow the sex worker on the streets as they are in need for sex. They would have sex with any woman that crosses their way, with or without a condom. They do not care. Usually the sex worker could persuade them very easily. Moreover, married men are very careful about condom use, because they tend to be worried about questioning from their spouses in case of disease contraction."
>
> (Director of Dar al Amal)

Condom Use Initiation

Although many FSW try to initiate condom use with at least some of their partners, their attempts are very timid, and they lack confidence in their ability to convince a partner of condom use. An example of how they might initiate condom use includes:

> "I have a condom let us use it; or, there is a nearby pharmacy, let us go and get a condom."
>
> (FSW)

> "She [FSW] would initiate condom use by telling him [the client] that 'I have the condom in my purse. Let us use it.' If he initiates the use of a condom, the condom would be of an easy access. It would be in her purse. The only thing that is worrisome for her is the police, as if caught, the condom would be an evidence of her sex work and thus imprisonment."
>
> (Director of Dar al Amal)

In most cases where condoms are used, it is the client who initiates the use of the condom. However, some FSW feel insulted when a client asks them to use a condom, as they feel that he must think that they are infected.

Marital Status of the FSW

Both married and single sex workers would rather use condoms than not, however they have different motives behind their desire to use them.

> "Single sex workers do not want to test positive for HIV, as she has plans to get married. Married sex workers do not want their spouses to know their identity [as a FSW] in case of testing positive for HIV, and they also have worries of transmitting the virus to their children in case of pregnancies. But, money is still the most powerful tool in affecting their behaviors."
>
> (Director of Dar al Amal)

> "Those [FSW] who are married would say, I am already married with children and do not need any further tests; whereas the single sex worker would most likely want to get married, undergo the tests[13] and would want to get pregnant. So, it is more problematic for her to have AIDS. She would say, 'What do I want with this whole thing. Let me use condoms.'"
>
> (FSW)

Previous Experience with Pregnancy or Infection

FSW tend to use condoms more often if they have had a previous experience with an unwanted pregnancy or STIs. This experience would empower her to make a decision to use condoms in any situation. In this case, no matter what a client pays, she would be less likely to accept not using a condom.

> "Some sex workers have experienced being infected with one or multiple STIs, and others got pregnant, so they learned their lesson. Even if a client gives her US$1000, she would not accept [to not use a condom]."
>
> (FSW)

Fear

Fear plays a large role in the use, and non-use, of condoms. In promoting the use of condoms, fear plays a role through the fear of HIV, STIs and pregnancy as mentioned above, as well as a fear of someone in their family discovering their involvement in the sex trade. However, there are often even more fears that come in to play to dissuade FSW from using condoms. The largest of these fears, is the fear of imprisonment. As sex work is illegal in Lebanon, the possession of a condom is taken as evidence of being a FSW. For this reason, many FSW are afraid to carry condoms, and therefore do not have them accessible when they need them.

> "Sex workers never, or rarely, carry their condoms because of police search. Condom possession is considered an indirect evidence of prostitution. They hide it in the street underneath a stone, or behind a car in the parking lot. They retrieve it once they secure a customer."
>
> (OW)

Fear from their work lord can play a role in both directions, depending on the outlook of the work lord. However, most FSW stated that a fear of the work lord would lead to less use of condoms. In some cases, the work lord is actually the father or another relative of the FSW.

> "One thing that used to affect my decision in using or not using a condom, was the fear from the client. Some of them yell at you. Some of them hit you, and others call the pimp for you."
>
> (OW)

> "Some girls are forced by their fathers to work [in the sex trade] to provide him with the money. If they refuse to work, or to have unprotected sex, or disobey him in any way, they would be beaten and tortured."
>
> (FSW)

[13] HIV testing is mandatory before marriage in Lebanon.

Verbal and Physical Abuse
While many of the FSW stated that they would refuse to have sex with a client when faced with verbal or physical abuse, some FSWs undergo physical and verbal abuse from both clients and work lords. They also noted that many FSW engage in activities which they would not accept otherwise because of the need for money and the miserable poverty conditions they live in.

> "Once I had to have sex with a man without a condom because he forced me to. I got so scared from him, because he was vicious. At that point I did not know anything about AIDS."
> (IDI-FSW-2)

> "I know a male pimp who forces the sex workers to comply with whatever the client request. If one refuses to have sex without a condom, she would be punished, yelled at and beaten."
> (IDI-FSW-2)

At other times the work lord is the father himself or another person that is related to her.

> "Some of us are into sex work because we have families and children to feed. Sometimes we are faced by clients who may be under the effect of drugs, and are not conscious of what they are doing and the way they are yelling and behaving. Sometimes they are violent and coerce the girls to have harsh and unprotected sex with him and other crazy stuff such as beating and burning. We do suffer. What can we do? When your baby is crying for food, you would do anything."
> (FSW)

Some FSW continue to have sex with their clients despite the physical or emotional abuse that they undergo. The reasons behind their acceptance or refusal are due to the various factors that take part during this process. Some FSW associate violence with masochism, and consider it a normal occurrence without which the sexual act cannot progress. Other FSW may be ashamed to admit that they have accepted violence from clients. Experienced FSW have learned through their years of practice how to adapt to different behaviors and say "no" and reject violent behavior; whereas fresh FSW who are at the beginning of their careers, accept violence out of fear and lack of awareness.

In general, it was believed that there has been an increase in awareness when it comes to violence; which came about because of the large number of organizations working in the field on human rights and not because of the outreach program in particular.

> "The one [FSW] who is new in sex work accepts to be beaten. The one [FSW] who has been around for ten years, has the experience and the means to say "no". The new ones are shy and embarrassed to say that they have been beaten by a client."
> (Director of Dar al Amal)

FSW - Specific Factors
There are some factors that pertain specifically to characteristics of the FSW herself, or her relationship to other FSW, that also are important in the condom use decision. The level of status that a FSW has attained plays into the ease of the decision, as it has been noted that 'higher class' FSW use condoms more often, and are able to convince their clients to use them more readily.

> "I was able to reach "high class" sex workers, and they were easier than the sex workers on the street, and a majority used condoms more than other sex workers."
> (OW)

Additionally, if a FSW is also a drug user, most participants agreed that she was less likely to use condoms, or to think that condom use is important.

> "Girls [FSW] who are drug users have access to condoms, but do not use it."
> (FSW)

> "People [clients] who do drugs, especially heroin, do not care about using a condom when having sex. They would not be aware. Some of them have the condom but do not put it on. If the girl [FSW] is on drugs as well, she would be too lazy to even ask for it. Some clients pay the sex worker more money in order to make her do drugs with them."
> (FSW)

Lastly, peer pressure, jealousy and competition between FSW are factors that affect the use of condoms. Many FSW are afraid of losing their clients to another FSW in case they refuse to have sex without a condom, which pushes them to consent to unprotected sex.

Negotiation Skills

FSW negotiate the use of condoms by using both verbal and non-verbal techniques. In general, the verbal negotiations surround three topics of concern to the client: pregnancy, infection, and revelation of cheating behaviors. The non-verbal negotiations are generally more subtle and are tangible skills that the FSW has obtained through experience. For example, the FSW may use various professional, erotic techniques and slip the condom on without the client's consent. Additionally, participants have noted that beauty plays a role in a woman's ability to negotiate.

Beauty
An attractive, beautiful FSW can demand that a client pay her a large amount of money, and will tell the client that she will not accept to have unprotected sex. She knows that she can easily find another client if one leaves.

> "If she is beautiful and costs a lot, she could manipulate the client as she wishes. She is the one in power. She does not have to try to persuade him in any way. It does not take her much to control the whole situation."
> (IDI-SW)

On the other hand, the unattractive, 'not so pretty' women who cannot make these demands know that they cannot afford to lose a client because she may not be able to find another one soon enough. These women often come up with other ways to negotiate condom use.

Erotic Touch and Cleverness
FSW often try to come up with their own ways of convincing clients to use a condom. Many women will be clever in using their touch and certain sexual and erotic moves to convince the man that using a condom can increase the sensuality of the act and will not decrease his satisfaction or pleasure. Other women come up with 'witty' ways of convincing their clients.

> "Some girls, even if ugly, have a special way in convincing the client that pretty girls do not have; they use their own touch and moves. They are clever, as they end up using the condom and satisfying the client as well."
> (IDI-SW-2)

Previous Pregnancies or Infections
The main technique that was mentioned for negotiating condom use was telling her client that she might have an infection and she doesn't want to pass it on to him. She might say that she has already slept with plenty of men before him, which increases her risk of getting infected with STIs and other infections and thus she could infect him. Although this will work with some clients, others respond that she does not look infected, and they will still push her to not use a condom.

> "She might try to scare him off by telling him that 'I have slept with 100 men before and I might have a disease.'"
> (Director of Dar al Amal)

In addition to the argument of infections, many women will bring up the prevention of pregnancy as a reason to use condoms. However, this will work only for vaginal sex, and other sexual acts will not be protected, such as anal or oral intercourse.

Revelation of Cheating Behavior
This technique involves bargaining skills, and will only work with married clients, or those who have girlfriends. It has been noted to be a very successful technique, as men do not want their wives to find out that they have been cheating on them. The FSW will use the same risk of pregnancy or possible infections, but put a spin on it that these consequences would reveal to the client's wife that he has been cheating on her.

> "I tell him, 'if you catch a disease from me, or if I get pregnant then what would you tell your wife? You are going to infect her and she is going to find out that you are cheating on her. If I get pregnant, what would we do with the baby?'"
>
> (FSW)

Strong Will and Personality
While this is not necessarily a negotiation technique, many of the OW and FSW stated that some FSW have made up their minds to always use condoms and have stuck to their decision. For women with a strong will and personality, they do not negotiate with clients; rather they tell the client that they will not have sex with him without a condom.

> "If a client did not have a condom, I would make him leave and would not have sex with him, unless he goes to buy one."
>
> (FSW)

Other Sources of Information on HIV/AIDS
Participants stated that they have also received information on HIV/AIDS from the television, mainly from talk shows and movies. Some also mentioned receiving awareness sessions in a private residence in Sidon.

> "Television plays a significant role in promoting AIDS awareness, especially when presenting real stories in either tele-movies or talk shows."
>
> (SW-1)

Quantitative Findings
Characteristics of the sample are presented in Table 3. The study sample consisted of 539 FSW from all five regions of Lebanon. The majority (50.9%) of the FSW were between 21 and 30 years of age, and another quarter of the women (28.6%) were under 20 years old. The vast majority of the women were either illiterate or had reached only the primary level in school.

Table 3: Sample Characteristics

Variable	n (%)
Area of Intervention	
Beirut	177 (32.8%)
Mount Lebanon	53 (9.8%)
South	143 (26.5%)
North	90 (16.7%)
Bekaa	76 (14.1%)
Education	
Illiterate	200 (37.8%)
Primary	235 (44.4%)
High School	60 (11.3%)
University	16 (3.0%)
Technical	18 (3.4%)

Variable	n (%)
Age	
Less than 15	12 (2.2%)
Between 15 & 20	139 (26.4%)
Between 21 & 30	268 (50.9%)
Between 31 & 40	92 (17.5%)
Between 41 & 50	16 (3.0%)
Place of Intervention	
Street	267 (49.6%)
Private Residency	193 (35.9%)
Night Club/Club	33 (5.9%)
Group Hangout Place	21 (4.1%)
Other	24 (4.5%)
No Answer	1 (0.2%)

Table 4 summarizes results regarding condom use. In the past year, over a third of FSW always used condoms, with the percentage varying with the type of sexual partner. The FSW were asked questions regarding their own and their partner's condom use during specific sexual acts as well. Condom use is more often initiated by the FSW's partner than by herself, and in the majority of cases, a FSW would agree to intercourse if her partner refused to use a condom.

Table 4: Condom Use

Variable	n (%)
Condom use	
Always	184(34.7%)
Sometimes	300 (56.6%)
Never	46 (8.7%)
Condom use with non-regular client	
Always	141 (34.9%)
Sometimes	230 (56.9%)
Never	33 (8.2%)
Partner use of condom during oral sex*	
Never	287 (56.6%)
Sometimes	173 (34.1%)
Always	47 (9.3%)
Partner use of condom during anal sex*	
Never	108 (21.8%)
Sometimes	247 (49.8%)
Always	141 (28.4%)
Partner use of condom during vaginal sex*	
Never	39 (7.4%)
Sometimes	323 (61.6%)
Always	162 (30.9%)
Condom Initiation	
Sex worker	138 (27.7%)
Partner	182 (36.5%)
Neither	4 (0.8%)

Variable	n (%)
Condom use with regular client	
Always	125 (32.3%)
Sometimes	209 (54.0%)
Never	53 (13.7%)
Condom use with non-client sexual partner	
Always	102 (26.2%)
Sometimes	168 (43.2%)
Never	119 (30.6%)
Use of condom during oral sex†	
Never	153 (50.5%)
Sometimes	108 (35.6%)
Always	42 (13.9%)
Use of condom during anal sex†	
Never	71 (23.5%)
Sometimes	122 (40.4%)
Always	109 (36.1%)
Use of condom during vaginal sex†	
Never	28 (8.9%)
Sometimes	177 (56.0%)
Always	111 (35.1%)
Attitude when partner refuses condom	
Refuse sexual intercourse	129 (24.5%)
Accept Sexual intercourse	276 (52.5%)
Try to convince partner	121 (23.0%)

†These questions were asked to the FSW about her behaviors with clients.
*These questions were asked to the FSW about how she perceives how her clients act with other sexual partners.

Results on HIV knowledge and testing are summarized in Table 5. The majority of the women were able to correctly cite multiple modes of transmission of HIV and STIs, although a quarter of the women were unable to identify any modes of transmission for either HIV or STIs. However, two-thirds of the women identified the use of condoms as a preventive measure. Around one-quarter of the women had been tested for HIV in the last year, with most of the tests being conducted in a hospital setting. Additionally, around a quarter of the women had experienced an STI in the past year, with most of these women receiving treatment for their symptoms.

Table 5: Knowledge Regarding HIV and Other STIs and HIV Testing

Variable	n (%)	Variable	n (%)
Knowledge regarding HIV		Mode of transmission of HIV	
fatal, sexual, infectious disease	333 (61.8%)	sex, blood, needles	299 (55.5%)
Disease, from Africa, by blood	23 (4.3%)	sex without protection	70 (13.0%)
I don't know	150 (27.8%)	homosexuality	10 (1.9%)
other (irrelevant or wrong)	33 (6.1%)	I don't know	139 (25.8%)
		other (irrelevant or wrong)	21 (3.9%)
HIV prevention		HIV test during the last year	
condoms	359 (66.6%)	Yes	128 (24.2%)
don't know	129 (23.9%)	No	400 (75.8%)
other	51 (9.5%)		
Where HIV test was conducted		Knowledge about STIs	
hospital	68 (55.3%)	AIDS, syphilis, fungus, infectious	212 (39.3%)
community clinic	27 (22.0%)	I don't know	210 (39.0%)
private/doctor clinic	16 (13.0%)	other(irrelevant or wrong)	117 (21.7%)
Laboratory	8 (6.5%)		
I don't know	4 (3.2%)		
Mode of transmission of STIs		STI prevention	
sex, lack of hygiene	345 (64.0%)	condoms, hygiene, abstinence	371 (68.9%)
I don't know	158 (29.3%)	I don't know	138 (25.6%)
other (irrelevant or wrong)	36 (6.7%)	other	30 (5.6%)
Symptoms of STI in past year		Been treated for STI past year	
Yes	147 (27.9%)	Yes	126 (83.9%)
No	379 (72.1%)	No	18 (16.1%)

Just over a quarter of the women (25.8%) interviewed stated that they had a bad relationship with their work lords, with slightly less (16.5%) reporting that their relationship with their work lord was good. Almost half of the women (47.9%) stated that they would refuse to have intercourse with a verbally abusive client, and 57.5% would refuse with a physically abusive client. The main reason that women (92.5%) accepted abuse from their clients was because they needed the money (Table 6).

When asked about personal issues that they may be experiencing, personal, family and social problems were all mentioned by between 40 and 50% of the women (Table 6). Around half (45.8%) of the FSW felt depressed, sad, or desperate; while others reported problems of addiction or of problems with their families. Over a quarter of the women (28.0%) said that they had no relationship with their families, and the rest of the women had bad relationships. Over half of the women (56.3%) indicated that they hate the way other people treat them.

Table 6: Relashionships and Violence

Variable	n (%)	Variable	n (%)
Relation with work lord		Attitude towards verbal abuse	
No relation	32(9.9%)	Continue Sex	277 (52.1%)
Good/positive	53(16.5%)	Refuse Sex	255 (47.9%)
Bad relation	83 (25.8%)		
Business/Money relation	45(14.0%)	Attitude toward physical abuse	
Fear relation	5 (1.6%)	Continue Sex	226 (42.5%)
I Don't know	98 (30.4%)	Refuse Sex	306 (57.5%)
Otherwise	6(1.9%)		
Reasons for continuing relation in cases of violence		Existence of peer pressure among sex workers	
Money	244(92.5%)	Yes	150 (29.2%)
Pimp influence/afraid	8(3.0%)	No	356 (69.1%)
Likes violence/sexual pleasure	11(4.2%)	I don't know	9 (1.7%)
Otherwise	1(0.4%)		
Type of peer pressure		Who can also have pressure on the sex worker?	
Good, share experiences & clients	78 (52.0%)	Client	42 (28.0%)
Bad, steal clients & jealousy	55 (36.7%)	Pimp	18 (12.0%)
other	17 (11.3%)	Nobody	25 (16.7%)
		Other	65 (43.3%)
Reason for having influence		Personal Problems	
Money	65 (83.3%)	Yes	214 (40.2%)
Fear	13 (16.7%)	No	319 (59.8%)
Family Problems		Social Problems	
Yes	257 (48.4%)	Yes	213 (40.2%)
No	274 (51.6%)	No	317 (59.8%)

Table 7: Drug Use

Variable	n (%)	Variable	n (%)
Do you do drugs?		Relationship between drugs &HIV	
Yes	72 (13.4%)	Needle transmits the virus	90(16.7%)
No	464 (86.6%)	No relationship	296(54.9%)
		Other answer	153(28.4%)
If yes, type of drug		Mode of Drug use	
Amphetamine	13(18.1%)	Inhale	10 (13.9%)
Hashish	13 (18.1%)	Smoke	12 (16.7%)
Cocaine	6 (8.3%)	Swallow	31 (43.1%)
Heroine	2 (2.8%)	Swallow and Smoke	12 (16.7%)
Substance Inhale	1 (1.4%)	Combination	5 (6.9%)
Alcohol	12 (16.7%)	Injection	2 (2.8%)
Combinations of above (> 2)	23 (31.9%)		
Others	2 (2.8%)		
Sharing needles			
Always	0		
Sometimes	1 (16.7%)		
Never	5 (83.3%)		

Analysis: Behavior Change from 2001 to 2007

The following data comparison (Table 8) shows that there was a significant change in some behaviors among FSW in Lebanon in the time period of 2001 to 2007; in particular, regarding condom use. Except for condom use with a regular client which remained practically unchanged, there were significance increases in condom use with non-regular clients and non-client sexual partners. Additionally, there was a significant increase in the refusal of sexual intercourse when a partner objected to using a condom, as well as in cases of verbal or physical violence. There was also a significant decrease in the prevalence of STI symptoms.

However, there was a significant decrease in the amount of women identifying condom use as a mode of preventing HIV transmission, as well as in the number of FSW who were tested for HIV in the past year.

Table 8: Behavior Change from 2001 to 2007

	2001*	2005**	2007***	p-value*** (2001-2007)	p-value (2005-2007)
Condom use with non-regular client	28.2%	_____	34.9% 49.1%	**.002** **001**	
Condom use with regular client	34.8%	_____	32.3% 47.7%	**.302** **<.001**	
Condom use with non-client sexual partner	11.9%	_____	26.2% 40.7%	**<.001** **<.001**	
Refusal of sexual intercourse when partner objects to condom use	17.4%	23.0% _____	24.5% 33.9%	**<.001** **<.001**	**<.001**
Refuse verbal violent behavior from partner	_____	15.0%†	52.1%	**<.001**	
Refuse physical violent behavior from partner	_____	15.0%†	42.5%	**<.001**	
HIV test in the past 12-months	_____	34.0%	24.2%	**<.001**	
STI symptoms in the past 12-months	53.0%	_____	27.9%	**<.001**	
Found intervention useful	_____	51.0% _____	95.8% 95.3%	**<.001** **<.001**	
Mentioned condom use as measure of HIV prevention	94.8%	_____	66.6% 66.5%	**<.001** **<.001**	

*Data for 2001 is from Beirut only
**Data for 2005 is national prevalence data only
***The upper number represents a comparison of National prevalence data, while the lower number represents a comparison between Beirut data (2007, n=177).
†In 2005, there was no distinction between verbal and physical violence.

Limitations of the Comparison Analysis

In the situation analysis of phase one, the questions were quite different from those in the rapid assessment despite attempting to create similar questions, due to the need to have standard indicators that could be used for global reporting and comparison; in addition there was a paucity of baseline data to compare the questionnaire of the rapid assessment to. Also along these lines, a questionnaire was not included in the second phase of the outreach, although few questions were asked of the FSW during outreach. Due to this, the qualitative part of the assessment attempted to ask questions retrospectively in order to glean more information about the changes that had occurred since the interventions began, especially those that are pertinent to negotiation skills, the impact of work lords and resistance to peer pressure as there was no baseline data to be compared those to on these specific issues.

An additional limitation to the study was the comparison of the data between the phases as Phase I was completed solely in the Beirut area, while Phases II and III included all areas of Lebanon. Furthermore, it was difficult to find FSW who had previously received information from the outreach interventions, due to the high mobility of the population. This was seen in the finding that 95% of the women who were reached for the rapid assessment had not been contacted before in outreach (Table 9).

Table 9: Condom Use

Variable	n (%)	Variable	n (%)
Does partner use same condom more than once		Do you use the same condom more than once	
Never	439 (84.3%)	Never	296 (93.7%)
Sometimes	74 (14.2%)	Sometimes	13 (4.1%)
Always	7 (1.3%)	Always	6 (1.9%)
Don't know	1 (.2%)	Don't know	1 (0.3%)
Partner use of condom until end of intercourse		Do you use condom until end of intercourse	
Never	49 (9.4%)	Never	40 (12.7%)
Sometimes	282 (53.9%)	Sometimes	147 (46.5%)
Always	191 (36.5%)	Always	128 (40.5)
Don't know	1 (0.2%)	Don't know	1 (0.3%)
Know of Female condom		Usage of female condom	
Yes	89 (16.8%)	Yes	9 (10.6%)
No	440 (83.2%)	No	76 (89.4%)
Involved in other high-risk behaviors?*		First experience with outreach	
No	516 (95.7%)	Yes	497 (95%)
Yes	23 (4.3%)	No	26 (5.0%)

*Other high-risk behaviors include drug use, injecting drug use or homosexual behavior.

It has been mentioned in numerous studies, that there is often a discrepancy between what people say they do when responding to a questionnaire or an interview, and what they actually do in the situation (28). Additionally, within the qualitative data, there were instances where a FSW answered a question one way at the beginning of the interview, only to answer or contradict that statement further along in the discussion. This may be explained due to the finding that participants often respond in a socially desirable way (28), in other words, they may answer the questions how they believe the researchers want them to answer. For the quantitative study, many of the findings were taken from questionnaires that were completed in the public arena when the FSW were distracted by their jobs and their need to find a client. These all pose limitations to this study, and limit the amount of speculation that is possible.

Discussion of Behavior Change between 2001 and 2007

The findings from the study show interesting developments in the behavior change of the FSW since the outreach interventions began in 2001. While there are contradictory findings within the data, such as the decrease in knowledge on condom use as a preventive tool and its increased use, the trend shows that there has been a positive change in condom use behavior as well as in the FSWs' stated refusal of sexual intercourse in cases of violence or non-condom usage.

Increase in Condom Use

The increase in condom use among FSW and most of their sexual partners is apparent in these findings. While most of the comparisons show a statistically significant change, the actual change is not as high as would be hoped. These changes may be attributed to an increase in the availability of condoms due to the outreach intervention, an increased acceptance of condoms, as well as some increase in awareness of the importance of condom usage. These changes are attributed to the outreach sessions, as well as peer-to-peer sharing of information.

> "I feel that this year [2007] there is a change [in condom acceptance] more than any other year, around 50%. Now they knock on my door at night so I would give them a condom."
>
> (OW- 1)

The reason that these numbers show smaller than expected changes, may be because awareness and availability are not enough, at this moment, to raise the proportions much higher, as there are so many other factors influencing condom use, such as embarrassment, pressure from work lords and clients, misconceptions regarding HIV and STI transmission, and especially money and economic pressures. These influences were mentioned throughout the qualitative section of the study. Additionally, this may be due, in part, to the outreach being interrupted, not solely due to the brief amount of time spent conducting outreach, but also because of the highly mobile characteristics of the community. The base of FSW that are being worked with is not a continuous base; newer FSW generally have a lower level of information regarding the topics of HIV and STI transmission, but they are easier to convince to use condoms.

Looking more specifically into the data, it shows that there was a slight change in condom use with regular clients[14]. This may be explained by the belief of many FSW who state that they trust their regular clients, and since they have not been infected by these clients previously, they do not need to worry about using condoms with them now. This statistic, however, could also be explained that they may find it harder to convince a regular client of the necessity of condom use, when they have a history of unprotected sex.

> "We have a strong relationship; we have known each other for two years now; I trust him".
>
> (FSW)

[14] This finding in particular is interesting as comparing data from Beirut, there is a slight negative change, while comparing the Beirut data from 2001 to the national data of 2007, there is a larger, significant positive change in the condom use behavior.

There was an increase in condom use with both non-regular clients and with non-client sexual partners. With non-regular clients, FSW may find it easier to convince these clients of condom use as they do not have a history of unprotected sex, and they may feel that they have more control with these clients than with their regular clients. There is also a lack of trust between the FSW and the non-regular client, as she may have suspicions that he could be infected with HIV or STIs and vice versa. This is in contrast to the regular clients, as the FSW trusts her regular clients, especially if she has never been infected by them.

In regards to non-client partners, FSW state that they feel more comfortable not using condoms with these partners because of established trust and love; however, they also feel a need to protect these partners from the possibility of becoming infected unintentionally. This sentiment of shielding their lovers from harm may be leading them to use condoms more often with them. Additionally, some of the lovers, husbands or boyfriends may know her status as a FSW, which could also increase the use of condoms between the pair, as they want to protect themselves. However, there is also an obstacle in using condoms with non-client sexual partner, as the partner may not know that she is a FSW, and therefore he may think that she is cheating on him, or does not trust him if she asks to use a condom.

Most of the FSW and OW interviewed believe that the easy accessibility of condoms and the free distribution of condoms during outreach greatly enhanced the FSW ability to use condoms during their sexual encounters. Having condoms readily available could account for this increase in condom initiation and use.

> "Lack of easily accessible condoms causes its lack of use."
>
> (FSW)

Refusal of Sexual Intercourse in Cases of Unprotected Intercourse or Violence

There was a statistically significant change in the percentage of women who would refuse sexual intercourse with partners who objected to condom use, as well as with clients who were physically or verbally abusive. These findings could be explained through a variety of reasons.

FSW who stated that they would refuse sex without a condom may be responding to information that they gained through the outreach intervention and peer-to-peer exchange. It is possible that there has also been an increase in the number of pimps who are encouraging condom use, as they do not want to pay for increased medical costs. It is also plausible that the women are becoming more concerned about protecting themselves from HIV and other STIs, and from becoming pregnant. Previous experiences with STIs or pregnancy could be leading them to make this change as well. It is likely that these changes have come from a combination of information from the intervention as well as other sources, as FSW have stated within the qualitative and quantitative parts of the study that they did obtain additional information regarding HIV and condom use through the media and other sources.

Regarding the increase in the FSWs' refusal of violence, there have been several campaigns on human rights and violence in the country that have taken place during this time period. Additionally, within the outreach intervention, the OW asked the women about their experiences with violence, and if they reported any violence, the FSW were referred to the NGO, KAFA. This finding could also be due to the comments made during the qualitative interviews that FSW may be ashamed to admit that they have accepted violence from clients, and therefore they may not report it to the OW.

Decrease in STI Symptoms

It is heartening to note that there has been a decrease in the percentage of FSW reporting symptoms of STIs in the past year. However, it is also important to note that many STIs are asymptomatic, and therefore the FSW may not know that she (or her partners) has an STI (29).

This reported decrease could be due to the increased use of condoms mentioned above, or through a possible increase in women seeking medical assistance when they do have STIs. This could prevent the further spread of the infection and reinfection, as well as making the infections less resilient. Additionally, if the FSW have had previous infections, they may self-prescribe medications that they have previously taken, which could lead to a decrease in the amount of STIs reported. In the findings, 80% of the women stated that they received treatment from a doctor (Table 10). It is likely that the women then 'prescribed' the same medication to other FSW experiencing similar symptoms, as there is peer to peer influence, as well as a desire to not waste time and money at the doctor's office.

Table 10: Regarding STI symptoms and treatment received in the past year, and HIV/STI knowledge

Variable	n (%)	Variable	n (%)
Type of STI symptoms		Prescription given by	
fungus/infections	128 (90.1%)	doctor	98 (79.7%)
pelvic pain	6 (4.2%)	midwife	5 (4.1%)
don't know	8 (5.6%)	Pharmacist	9 (7.3%)
		Partner/friend	11 (8.9%)
Place of treatment		Has Received information regarding HIV and STIs	
doctor's/specialist/ private clinic	52 (47.7%)	Yes	180 (45.2%)
community clinic	43 (39.4%)	No	218 (54.8%)
pharmacy	10 (9.2%)		
hospital	4 (3.7%)		
Location where HIV/STI information received		Do you think that there are centers that offer services to AIDS patients?	
TV	86(48.0%)	Yes	85 (21.3%)
Social worker	38 (21.2%)	No	310 (77.7%)
Friend	39 (21.8%)	I don't know	4 (1.0%)
Doctor	9 (5.0%)		
Other	31(17.3%)		
Do you think that there are centers that offer services to patients with an STI?			
Yes	81 (20.2%)		
No	315 (78.8%)		
I Don't know	4 (1.0%)		

Decrease in HIV Testing

Explanations on the decrease in HIV testing may lead to various speculations. First off, the FSW may be afraid of receiving the results of an HIV test, as they do not know how to proceed if they receive a positive test result, or what they could do with their lives in this case. It is also possible that the political situation in 2006 and resultant instability led to a decrease in the amount of

FSW who felt comfortable and safe seeking HIV testing services. According to the director of Dar al Amal at that time, the demand for sex work increased during the instability, which could have led to less ability to take the time to get tested.

It has also been hypothesized that there may have been a larger police presence on the streets during this time, which led to an increased fear within the women to seek services, including testing. Many women also mentioned within the qualitative study that they did not trust the personnel conducting the test, and were afraid that they would be reported to the police. There is a possibility that the women who had been tested had an unpleasant experience with the centers/organizations delivering HIV testing, as this rapid assessment took place before the launching of the national VCT centers on the 1st of December, 2007; in addition staff members may not have been trained to provide sensitive and friendly services at that time. However, these results could also be due to a lack of perceived susceptibility to HIV infection among the women.

One last note on this finding is that during the first outreach, many of the FSW believed that a blood test at their regular check up would detect HIV, and so they mentioned that they had been tested for HIV. However, there was greater knowledge among the women in the third interview regarding proper testing, and therefore the number of women who inadvertently reported being tested, when they hadn't, decreased.

Decrease in Knowledge of Condom Use as Preventive Tool

The most puzzling finding within this comparison is the decrease in knowledge of condom use as a preventive tool. It is plausible that this finding is due to possible errors in the data collection technique in the first phase of the outreach. It is possible that the outreach workers conducting the first intervention were not fully trained on not leading the women to provide certain answers. This cannot be confirmed, as there was little direct monitoring of the OW conducting the initial situation analysis. As field reporting forms were often not taken into the field by the OW, many of the forms were filled out after the outreach sessions; therefore, it is possible that the OW incorrectly filled out the forms. Again, this is all conjecture, and cannot be proven. Also, during the first outreach, the questionnaire provided possible answers for some of the questions; for example, in asking about methods of HIV prevention, there were multiple choice answers, with condom use as one of the choices. Therefore, the FSW were able to choose the answer based on provided answer choices. In the rapid assessment questionnaire, the questions that were pertinent to HIV prevention were open-ended and therefore the women had to state the methods from their memory.

Increase in Positive Reaction to the Intervention

There was a significant change in the amount of people who believed that the intervention was useful. This is a positive finding, in that it shows that the outreach workers were better trained and monitored. This means that they were better able to provide useful information, pinpointing at the specific risky behaviors of each FSW and referring the women to the relevant services. This is probably also due to more appropriate materials and a better approach to the outreach.

Recommendations

In order to effect behavior change regarding HIV prevention among FSW, one must work on multiple levels of the FSW's surrounding environment. One ecological model of health behavior recognizes five levels of influence that are pertinent for changing health-related behaviors; these include intrapersonal, interpersonal, institutional, community and policy factors (30)(Figure 5). The recommendations set forth in this document follow this outline[15]. It is important to note that these recommendations came out of all three phases, as well as from the rapid assessment study conducted after the third phase.

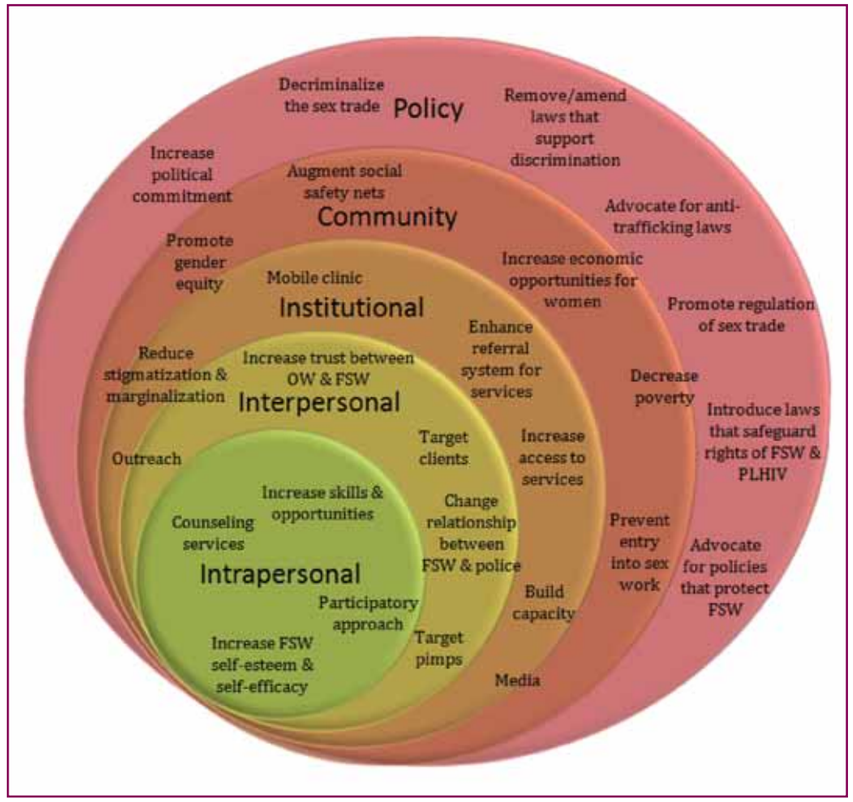


Figure 5: An Ecological Model of Health as Applied to Recommendations for Working with the FSW Population in Lebanon on HIV/AIDS Awareness and Prevention

[15] Some of the recommendations overlap two or more of the levels. For example, outreach work can be seen at both an institutional and an interpersonal level. In cases such as these, the recommendation will be stated at the level that seems most appropriate, though the work needs to be done at both levels.

Intrapersonal Level

When working with FSW, it is important to remember the vulnerability of their situations including their vulnerability to HIV, that they often have low self-esteem and low self-confidence, and that they may feel ineffective at making changes within their own lives. Due to this, it is important to work at building the skills and confidence of these women, in order to reinforce their ability to make positive changes in their lives. One avenue to work on this would be to utilize a more participatory approach to the entire outreach and research processes. By involving FSW in the design, implementation and evaluation of these projects, their feeling of self-worth and value would be reinforced. Additionally, these women would be seen as agents of change, and could become examples to motivate other women in similar situations. This would also help to ensure that their needs, as a population, are addressed in a way that is truly beneficial to them.

By strengthening the referral process to include social workers, and psychologists, the FSW would be able to receive assistance in working through some of the issues they have in their lives. Additionally, this could help them work through some of the deep-seated problems that have pushed them into the sex trade in the first place. These professionals could be reached through NGOs or through health facilities that are involved in the referral process.

Outreach is a possible contact point to refer the FSW to awareness sessions (see Figure 8) specifically designed to meet her needs. Awareness sessions could empower the FSW, and work on teaching them the skills that they need to be able to protect themselves, and to increase their self-efficacy. These sessions could include working with the women to increase their level of knowledge of HIV/AIDS issues, HIV and STI testing, condom initiation and use, and condom characteristics, in addition to increasing their perceived susceptibility to HIV and their perceived severity of the infection.

Awareness sessions could work on negotiation skills surrounding condom use and violence, on increasing their ability to seek support, and on reinforcing information regarding the confidentiality and safety of the NGOs and VCT centers. This is especially important, as many women fear that they will be imprisoned if they go to seek help, they think that a regular blood test will determine their HIV status, and they do not know that the MOH provides free anti-retroviral therapy to PLHIV in Lebanon. It is also imperative that sessions work on building the coping skills of the FSW, as it was noted that currently, alcohol intake and drug abuse are used by many of the FSW in order to deal with their situations, which may increase their vulnerability to HIV infection.

> "...social circumstances have pushed me to use drugs, to forget."
>
> (FSW)

> "Everyone [FSW] is getting drunk now, everywhere."
>
> (FSW)

One of the most important recommendations is to reinforce positive condom use behavior, and to increase the availability and accessibility of free, high-quality condoms, as well as the provision of information regarding proper condom use. This includes emphasizing that, in order for condoms to protect against HIV transmission, condoms need to be used for all sexual acts, and not solely for vaginal sex. It also includes providing information on condom characteristics, properties and usage to ensure that they are being used consistently, properly and effectively (Table 11). It is also important to stress that infections can occur from one incidence of unprotected intercourse, and that STIs can increase the possibility of HIV infection and infertility, and therefore a condom should be used with all partners, at all times (Figure 6). It is important to increase the perceived benefits of condom use, and decrease the perceived barriers to condom use[16]. In addition, it is important to reinforce that using condoms does not necessarily mean that the pleasure of the sexual act will be decreased. By doing this, the FSW may be more likely to use a condom.

[16] These concepts are based on the Health Belief Model of individual behavior change. This theory basically states that a person is more likely to change their behavior if they perceive themselves as susceptible to a condition, if they believe the consequences of the condition to be severe, and if the benefits of making the change are more than the barriers preventing them from making the change (36).

Table 11: Knowledge of Important Condom Characteristics

Variable	n (%)	Variable	n (%)
Expiration Date		Oil-Based	
Yes	180 (33.9%)	Yes	157 (29.6%)
No	76 (14.3%)	No	69 (13.0%)
I don't know	275 (51.8%)	I don't know	305 (57.4%)
Electronic Examination		Water-Based	
Yes	147 (27.7%)	Yes	89 (16.8%)
No	71 (13.4%)	No	133 (25.0%)
I don't know	313 (58.9%)	I don't know	309 (58.2%)
Latex			
Yes	156 (29.4%)		
No	61 (11.5%)		
I don't know	313 (59.1%)		

> "When a sex worker comes into the organization, we do not tell her that she needs to do an HIV test. We explain to her everything about AIDS, increase her knowledge on the issue according to the sex worker's level of education, make her feel the need to do this test, and inform her that it is for free. This way she would ask to do the test on her own."
>
> (Director of Dar al Amal)

While it is important to let FSW know about their options outside of the sex trade, it is imperative that the women feel free to make up their own minds regarding this issue. The essential point is to offer options to make her work in the sex trade safer, and to offer her skills to build her capacity.

Interpersonal Level

There are numerous people who come into contact with a FSW on a daily basis. It is at the level of these relationships, that her positive condom use behavior (and other safer sex practices) can be reinforced. These relationships include clients, non-client sexual partners, work lords, OW, and other FSW (Figure 7).

Clients and Non-Client Sexual Partners

First, it is important to establish contact with both clients and non-client sexual partners of the FSW. It has been noted that the client is the one who controls the sexual situation, including condom use, as he has the money that the FSW needs. Therefore, it is important to reach him and to see his perception on condom use, as well as to pinpoint the obstacles that prevent him from using condoms. Through this, it will be easier to work with him on his perceived susceptibility to HIV and other STIs, and to convince him of the positive benefits of condom use and other safer sexual practices. Initially, this work would need to be conducted by the FSW themselves, at least to establish contact with the clients.

> "The clients have very low knowledge on HIV and its transmission, even lower than the sex workers themselves. If he [the client] does not know any better, how do you expect him to change? This is why it is important to provide the client with the necessary knowledge and awareness that might alter his behaviors, and make him take the right choices and decisions, especially in relation to the use of condoms."
>
> (Director of Dar al Amal)

Condom Use

- Increase availability of condoms
- Provide sensitivity training to pharmacies to increase access to condoms
- Teach negotiation skills to FSW (regarding negotiation with both work lords and clients)
- Increase perceived susceptability of FSW to HIV infection and perceived severity of HIV
- Explain proper/effective condom use and condom properties/characteristics
- Increase explanation of necessity of consistent condom use, for ALL sexual acts
- Provide explanation for short-term costs and long-term benefits of condom use (ex: short-term: may lose some clients initially, greater cost for condoms; long-term: less medical costs, less profitability of infection, and consequences of infection for her and family

Condom Use Initiation

- Keep condom in purse
- Overt mention of condom accessibility when with a client
- Negotiation skills
- Increase self-esteem and self-efficacy of FSW

Negotiation Skills

- Infection (HIV, STIs)
- Consequences of a positive HIV test
- Pregnancy
- Medicall bills (for infection or pregnancy), including time lost at doctors office
- Revelation of cheating (especially for clients who are married or have girlfriends)
- Clever sexual moves (to put on condom, or increase pleasure with the condom)
- Condom use initiation

Increase HIV Testing

- Learn HIV serostatus
- Early detection can improve health consequences and decrease viral load
- Avoid transmission of HIV to clients, spouses or mother-to-child transmission
- Decrease fear of arrest and imprisonment
- Increase knowledge of VCT center availability and locations (provide maps and discuss transportation options)
- Emphasize Confidentiality and Sensitivity of Testing Services (ensure sensitivity and confidentiality of their services prior to outreach)
- Emphasize that the MOH provides free antiretroviral medications for all citizens infected with HIV, free of charge

Importance of Seeking Medical Assistance

- Decrease of infections, duration and severity
- Decrease of possibility of infertility due to untreated infections
- Increase availability of sensitive and appropriate services (provide training for NGOs and health care providers that are currently listed, or wish to be listed in the referral service on sensitivity to and background of FSW)

Referral to Awareness Sessions through Outreach

- Provide awareness sessions for FSW due to lack of time to convey all information, and outside influences, during outreach
- Awareness sessions should be provided on a systematic and continuous basis
- Should be located in a safe, comfortable location that is easily accessible to the FSW population

Figure 6: Promoting Condom Use at an Intrapersonal Level

Working with the Client

- Work with the clients to determine their perceptions of condom use, and obstacles to condom use (and other risk behaviors). Pinpoint obstacles and how to overcome them
- Consequences of infection/pregnancy, negotiation skills
- Reinforce necessity of condom use with ALL partners

Working with the Work Lords

- Work with the lords to determine their perceptions of condom use, and obstacles to condom use (and other risk behaviors). Pinpoint obstacles and how to overcome them
- Medical bills, waste of time and money
- Loss of clients if FSW are continually ill
- Bad reputation
- Time lost if women are pregnant or ill

Increase Specific Knowledge of FSW, Work Lords and Clients

- Increase knowledge of HIV transmission and prevention methods (need to emphasize that HIV can be transmitted orally, anally and vaginally)
- Raise specific awareness of condom use and characteristics
- Utilize various media channels to increase possibility of reaching work lords, FSW, and clients with information
- Utilize FSW to reach and teach their Clients

Enhance Referral System, VCT, Hotline Services

- Assess and enlarge current referral network of NGOs, governmental facilities and healthcare services
- Create an agreement with all institutions that will provide services within the referral system
- Training-of-the-trainer for all professionals who will be involved in the referral system on specific problematic issues (those encountered at all levels of outreach and prevention) assessed in the rapid assessment, pinpoint obstacles and their resolution. Provide information on the target population, understanding their background, and how to work on gaining their trust
- Work with social workers in the referral system to increase their capacity to work on empowerment with the FSW
- Coordinate between hotline, referral system and VCT services in order to increase utilization of all services
- Clearly explain the benefits of the referral system, including the benefits of the hotline and VCT services (to the FSW). Provide map to the services, including knowledge on transportation options, benefits of utilizing the services, and decrease fear of imprisonment of other perceived consequences

Gain Trust of FSW

- Offer money for their time (make up for lost client)
- Offer relief of immediate needs (ex: blanket for warnth, sandwiches for hunger)
- Provide continuous and durable outreach to enhance the relationship between OW and FSW

Figure 7: Promoting Condom Use at an Interpersonal Level

Other ways to target the clients include working through shops, hotels and taxis that are in the areas where the sex trade is more established. Brochures and pamphlets on HIV/AIDS and other STIs, and safer sexual practices could be placed in these locations. Although this would be an indirect route of reaching clients, it would be a way to reach them without singling them out. It may be difficult to work with non-client sexual partners of the FSW, as many of the FSW interviewed stated that their partners or spouses do not know that they work in the sex trade. Due to this, we would not want to disclose her profession against her wishes to keep it secret. For those FSW whose partners are aware of their profession, and who may possibly be involved in their work (through being a work lord, or previous client), it is important to work with them on their negotiation skills, so that it is possible to reach him as well.

Work Lord

The next relationship to work on would be that between the FSW and her work lord. Although not all FSW have a work lord, a large percentage of the women do work for someone, and this person usually has a lot of control over the woman and her sexual experiences. The work lord has also been mentioned as taking advantage of the women and having sex with 'his girls'. By reaching the work lords and learning their perceptions of condom use and other sexual practices, it will be easier to convince them of the importance of and the benefits of condom use and safer sexual practices, as well as increasing the rate of positive behavior change among the FSW.

> "Maybe it is time to convince the pimp [of condom use]. If every pimp tells his girls that they are not allowed to be with their clients without a condom, it would be the best as all girls obey their pimps."
>
> (FSW)

In the case of male work lords, it is important to increase their sense of perceived susceptibility of acquiring HIV or other STIs as well, as they often have sex with the FSW under their control. A few ways to enhance the work lords' (both male and female) beliefs that condom use would be a good initiative, would be to convince them that increasing the use of condoms would save them money in a variety of ways. These include a decrease in the amount of STIs among the FSW, and therefore a decrease in their vulnerability to HIV, and a decrease in the amount of money spent on medical bills, and time spent at doctor's offices. With this decrease in the possibility of becoming infected with HIV or other STIs, the work lord would be able to retain a good business reputation, as the clients would see that the FSW are not infected, are well taken care of, and therefore, clients would want to continue coming to the work lord for his services. In addition, condom use will likely lead to a decrease in the amount of unwanted pregnancies among the women. In order to reach the work lords, however, the situation will need to be studied thoroughly, including a situation and needs assessment. It would be important to gain their input on how to work with this population of work lords as well.

> "If one of the girls [FSW] gets infected, no matter how much the client likes her, when he sees that she is infected he is going to run away from her and get disgusted. He won't go with her and request her the other time. Thus, you will be losing clients."
>
> (FSW)

According to the interviewee, by increasing the level of awareness on HIV/AIDS and STIs the work lord might help in either providing the message to his girls or allowing the OW to talk more freely with the SW.

> "By reaching out to the pimp, this would facilitate our work, as they usually make our lives miserable in outreach. They do not allow us to come close to the girls [FSW] and to try to talk to them. They [pimps] think they [FSW] are their property. Increasing their knowledge on these topics might facilitate and enhance our work."
>
> (Director of Dar al Amal)

As many of the OW mentioned that they were afraid of the work lords, and were not comfortable confronting them because of their previous involvement in the sex trade, this connection may be better conducted by a social worker from the NGO or a FC on the project. This will also lend additional credibility to the intervention from the outlook of the work lord.

Outreach Worker

Next, it is important to increase the level of trust between the OW and the FSW. In the current system of interrupted outreach campaigns within a highly mobile community, this is not possible. Therefore it is important that there is continuous and durable outreach. It is also important to note that the summer is the high season for the sex trade, and therefore, it is especially crucial to provide outreach services during this time.

> "Those who I see have changed their behavior towards condom use are those who frequently come to the center. You need to keep reminding the girl [FSW] and reinforcing the benefits of use of condoms. They all know that they should use a condom, but we have to keep reminding them."
>
> (Director of Dar al Amal)

Within the current system, each time the OW go to the field, they need to rebuild these relationships, which takes time away from more productive aspects of the intervention. Time would be better spent explaining the referral system in more detail, increasing the self-esteem and self-confidence of the FSW, and increasing the FSW perceived susceptibility to HIV. By providing continual outreach, these relationships, and this trust can grow, and the FSW can benefit even more from the repetition of the information, and a deepening of her knowledge and skills regarding safe sexual practices and negotiation skills, among others. Through this sharpening of knowledge, she can then begin to pass this knowledge on to other FSW that she encounters, increasing the effectiveness of the outreach through a snowball effect. In order to work at this level, first the OW must be trained, systematically and continuously, and their skills in providing these services must be enhanced. It is important to provide continuous training, especially as new OW come on board, and need to receive training. Next, it is important to involve current FSW in the process of outreach, as they are in the areas around other FSW more often, and can spread this information, possibly in an easier way. It is also important to provide support meetings for the OW to overcome obstacles that they encounter in the field, and to support them with any issues that may come up for them within this process.

Peer to Peer

Lastly, it is important to work on the peer-to-peer relationships between FSW. If FSW are encouraged to work together and cooperate, the efforts at changing the sex trade into a safer working environment would be made more straight-forward. It is the competition and jealousy that appears between some FSW that causes some of the problems, and some of the safer sexual messages to be ignored. If FSW were encouraged to come together, and to work together to solve their problems, the issues of condom use and unsafe practices would become less apparent. Through concerted, coordinated effort, FSW can change the practices surrounding the sex trade to their benefit. This is shown in the cases of FSW in both Bangladesh and India, who have changed the systems surrounding the sex trade, have increased the visibility of issues they face, and in the case of Bangladesh, through the determined efforts of the FSW, brought about the decriminalization of the sex trade (31).

It is also important to work at the individual level with as many FSW as possible, in a systematic manner, in order to increase the level and quality of their knowledge regarding HIV and other STIs. This is important, as FSW often share information between themselves, and if their knowledge levels are low, or they have misperceptions regarding the topics, they will continue to pass these misperceptions and distorted information on to others.

Institutional Level

The institutional level deals with government and non-governmental facilities and organizations that play a role in the environment surrounding the sex trade. This can include the media, capacity building of NGOs, and working with the police force.

Police and Internal Security Forces

An important relationship that needs to be worked with is the relationship between the police force and the FSW population. It is important to sensitize the police on the importance of their support during the outreach process, as well as their understanding of their unintentional role in the promotion of risky sexual behaviors. As FSW have stated that they believe they will be arrested and imprisoned if they are caught carrying condoms, then they are less likely to carry them, especially if they perceive that there is a large police presence on the streets. For this, we need to work with the Internal Security Forces (ISF)[17], and conduct awareness sessions for police officers, so that they see the importance of making the sex trade a safer environment, and therefore there will be less opportunity of HIV transmission.

In order to change the perceptions and relationship of the police and the FSW population, it is crucial to involve them in the outreach intervention. While this may not be feasible on the ground level, the ISF is involved in the Task Force that oversees the outreach intervention, and they should be invited to participate in workshops on the dissemination of results and workshops of live testimonies to enhance their understanding of the background and situations that FSW live in.

Additionally, trainings could be held at the ISF Academy in order to enhance police officers knowledge of HIV/AIDS, the role that the sex trade plays in the transmission of HIV, and the people who are involved in the sex trade. It is important to not only enhance this understanding, but also to inform the police of the outreach interventions, and the importance of these interventions in preventing the spread of HIV and other STIs. The understanding needs to go deeper than this as well, to include information on the specific obstacles that surround the sex trade and HIV and STI transmission, and solutions to these obstacles.

Referral System and Access to Services

FSW are afraid to seek services, as they fear being turned over to the police, they fear discrimination from the personnel at these services, and they lack trust in governmental and non-governmental institutions. It is important within the outreach intervention to ensure that services will be provided with sensitivity and understanding, and that the institutions offering services for the referral will not harm the FSW in any way, nor will they inform the police. However, in order to state these things to the FSW, it should be ensured that this is truly the case, and that all of the services that are being mentioned as available for the FSW are functional, strong, and ready to serve this population. If these services are not available, it can increase the distrust felt by the FSW, as well as affect the integrity of the entire outreach process. Within the referral process, it would be sensible to create an agreement with NGOs offering services to relax their service criteria when a FSW seeks assistance from them, and to better serve the MARPS. For instance, the example was given of a FSW who used drugs who was referred to an NGO that provided drug rehabilitation services. Upon going to the NGO to seek this service, she learned that they would not accept her into the program as she did not fit their acceptance criteria.

The referral system needs to be expanded beyond the current network of NGOs and health care facilities to include additional services for counseling and legal support, for preventive services, and for social assistance. It is important to also encourage further NGOs to become involved in providing services for the FSW population, as there are currently only two organizations serving their needs in the country. These NGOs additionally need to expand their services and decentralize their facilities, especially as their opening hours do not serve the FSW at certain times when they may need the assistance[18].

[17] The ISF manages the police force, and conducts all of the trainings.

[18] For example, Dar al Amal is only open from 8am to 3pm on weekdays.

It is important to increase the availability of VCT services in all areas of the country. This is currently occurring in Lebanon, as more VCT centers are being opened throughout the country, especially in the south and east of the country. Additionally, hotline services should be free for beneficiaries, and available 24-hours a day, all-year round. In order to achieve this, funding will need to be earmarked specifically for these services. Existing shelters and drop-in centers should be improved, as well as the creation of additional shelters specifically for the FSW population.

In order to expand the services that are provided, it is important to offer services at different times of the day. For example, one NGO that is currently working with the FSW population is only open until 3pm, and it is not open during the weekends. Additionally, it was recommended that the NGOs currently working with the FSW population be decentralized. For those FSW who are not living or working near the NGOs, these services are not available for them, as the cost and time of transportation to the center is prohibitive. By decentralizing, and opening offices in various areas throughout the country, the NGO can increase the availability of their services to all of the women working in these areas. This may also decrease the costs of outreach, as there would be less travel involved in the outreach process.

> "We need to open in other Mouhafazat [regions of Lebanon]; we need to be in Beirut, the Bekaa, North, South, Mount Lebanon and all. The girl [FSW] is careless of her health. You cannot force her to seek treatment. We need to be active, and not passive, waiting for them to come and ask for help, and pay so much money in an impossible mission. We need not forget that they are careless of their lives and initiating such a process is in the least of their concerns."
>
> [Director of Dar al Amal]

For those NGOs that are currently working with FSW, or who wish to work with this vulnerable population, it is important to assist in building their capacities regarding this work, as well as to assist them financially. It is essential to obtain additional financial resources from the government and funding agencies to support these organizations and the critical work that they are doing. This would help these organizations to provide a better, more comprehensive response to the needs of the population.

It is important to strengthen collaboration and coordination between institutions that offer services pertinent to HIV and risk reduction behaviors for FSW and other MARPs in order to enhance the referral system. For instance, if a FSW seeks services at an NGO, and the NGO is either far away from her location or does not offer these services, it would be prudent to refer her to another NGO that is closer to her, or that offers these services. This coordination and lack of competition between organizations can increase access to VCT services and other services as well.

> "Why are other NGOs not referring the girls [FSW] to us [Dar al Amal]? Ok, they have offered them the health service, allow us to offer them the social and psychological support. We [Dar al Amal] are the only NGO that works with sex workers in Lebanon besides SIDC, who mainly work with drug users and a few sex workers. Why this coordination is not happening? We did not use to have the VCT service before, and we used to refer our girls to SIDC, and they were not obliged to say that they were referred by us. They were free to say whatever they wanted. We did not care as long as they got the needed service."
>
> [Director of Dar al Amal]

Lastly, it is important to increase access through this referral process to affordable health, social and legal services that are sensitive to the needs and background of the FSW population. It is crucial that we increase the amount of opportunities and funding for the training of health care professionals and facilities so that they are better able to care for the FSW population. This is also important for those organizations already providing VCT or other services, that all employees are trained to provide sensitive, confidential care. It is important to ensure continual refresher training for these organizations as well as to decrease stigmatization and discrimination towards this population. This is needed to ensure the sustainability of the program, and to make sure that new employees benefit from this training as well. It is imperative that FSW are ensured that having the support of the MOH (and therefore their logo on brochures) does not mean that they will be arrested. It is important to build trust between the FSW population and these institutions, not only by trying to convince the FSW, but by training these institutions on building trust and bridging the gaps between the institution and the FSW (see Figure 4 for additional details).

Mobile Clinic

One way to increase the availability and accessibility of services to the FSW population is to establish a mobile clinic/outreach vehicle. This clinic could provide basic medical services, as well as VCT, and could offer referrals to other services, such as to an infectious disease physician. This mobile outreach vehicle could also help to provide some of the basic needs of the FSW, including blankets for warmth, or small amounts of food. This could serve as an entry point to talking with the FSW about HIV and other STIs, and harm reduction techniques, including behavior change. This would greatly assist the outreach programs, and would help with the issue of transportation, as the clinic, and outreach services would be coming to meet the needs of the population.

> "You have to work on dispersing her fears and gaining her trust. Then she would give more time to you and would listen better. All you have to do is to make her feel that you really care. If she has a headache, give her Panadol. If she is hungry, give her a sandwich. Give her a blanket if she is cold. Do you think she is going to care about SIDA, when all she is worried about is how to make a living? By giving a service now and here, you would be filling one of her needs. If she is hungry, how is she going to listen and concentrate with you? If she has a headache, how is she going to react to you? You have to make her feel comfortable. You have to make her feel that you really care. Then she would take you seriously. She would not feel that you are wasting her time. She would concentrate better and listen to you. Then, it would be easier for you to tell her, 'I am going to give you the phone numbers and addresses of some agencies and NGOs,' and assure her that the test is free, her test results would be anonymous, and that no one is going to hand her to the police. She would believe you, as you have gained her trust."
>
> (OW)

This is especially important, as when approached on the street the FSW may be cold, hungry, or have a headache, and may not be able to concentrate on the information being provided because these basic needs are not being met. This also brings up the issue of the location of the intervention. Many FSW do not feel comfortable talking about their problems, or even speaking to others about their profession in public places; therefore it may be more appropriate to conduct outreach sessions in private residences, or in a place, such as the mobile outreach vehicle.

> "Female sex workers do not feel very comfortable speaking of their personal intimate issues in front of everyone. However, if they were in a house, they would feel more privacy and hence better trust the person talking to them. This is in addition to alleviating fear of being arrested by the police."
>
> (Director of Dar al Amal)

Involvement of the Target Population

It is important to involve members of the target population in all aspects of interventions, whether they are outreach based or not. FSW could be involved in a variety of levels, from design and creation of the intervention to supervision of certain aspects of the project, to data entry, analysis and evaluation of the project. While some of these roles would have to be filled by those who have higher education levels, FSW can assist in the oral analysis of data, and can inform the researchers on why things are occurring as they are, as they generally know the community better than the researchers. This will increase the effectiveness of the intervention as it would ensure the appropriateness of the planned activities as well as increasing the skills and abilities of the target population. It would also be valuable to include FSW in the sensitivity training that is provided for NGOs and health care professionals and facilities who may be providing services.

Working with the Media

It is important to work with the media to increase the awareness of the FSW, as one of the findings from the study showed that the main source of information regarding HIV/AIDS for the FSW was on the television; they mentioned that they received information through talk shows, movies and daily shows. These media outlets can also be used to target the clients and work lords of the FSW.

Although this does not pertain specifically to the media, tailored IEC materials should be created specifically for the FSW population. This is especially important, as the current materials are not relevant to their situation. It is crucial that certain characteristics of the FSW population be kept in mind, and it is possible that a variety of materials will need to be created for the various subpopulations of the FSW community, as they differ greatly regarding their educational level, level of knowledge regarding HIV, and in their current condom use behaviors.

Community Level

It is important to increase the awareness of society regarding the situations of the women involved in the sex trade in order to reduce discrimination and stigma. This can be done through systematic and continuous awareness campaigns utilizing a variety of media resources. Additionally, it would be worthwhile to work within the municipalities, schools and universities to increase their awareness, and to highlight the need to work with the FSW population, and not against them. It is important to delineate the role that the sex trade plays in HIV transmission if not properly prevented, and the importance of creating a safer work environment for FSW. Campaigns such as these would need to stress the sensitization of society to the background of FSW as well as the importance of the provision of information, support and services. It is vital that this information be spread, not only to assist the FSW in improving their own lives, but in preventing the spread of HIV within the country and into the general population.

In order to decrease the vulnerability of FSW to HIV infection, it is imperative that we work at this larger community level to reduce stigmatization and marginalization of the FSW. It is essential that this work is context and culture specific, as even within a small country such as Lebanon, the techniques and strategies used in to achieve this in the north of the country will be different than those used in Beirut, or the south, and so on. The information also should be tailored specifically to the audience that it is being provided to; for instance, the information will be different for NGOs, municipalities and schools.

The next step would be to address specific barriers at the community level in order to create an 'enabling environment' for the FSW. An example of this would be to provide training for pharmacies to sensitize them to the plight of the FSW. It would be necessary to ensure that the pharmacies sell condoms to FSW when asked, and encourage them in this process.

Another suggested area to be worked on is to prevent the entry of women into the sex trade. In order to attain this, the situation of these women would need to be improved at multiple levels, and this will take much time and effort. The issues that lead women into the sex trade would need to be tackled, such as decreasing poverty (in line with MDG 1), increasing economic opportunities for women, confronting gender inequities (MDG 3) (32), and creating social safety nets for women and children, especially those women and children who have been abused or rejected by their families and communities.

Policy Level

The recommendations within this section regard the advocacy of amending, relaxing, or removing laws that are detrimental to FSW, as well as promoting laws that protect their basic human rights. These recommendations are in line with the call from the Report of the Commission on AIDS in Asia calling for the decriminalization of sex work (33).

By decriminalizing the sex trade, many of the problems inherent within the sex trade would become more visible. This decriminalization would increase opportunities for FSW to seek needed social and medical services without a fear of imprisonment. The women would be able to carry condoms in their purses without this fear, thus enabling them to have the condoms accessible when they are needed. This change in the law could allow FSW additional opportunities to change their situations if they so desired, and would enable them to create safer work environments, environments that are more conducive to the prevention of infection and the overall safety of the FSW. As the fear of imprisonment would no longer hold sway over these women, they would be more likely to seek support when they need it, and would no longer be faced with the levels of discrimination that they currently experience.

However, while the decriminalization of this trade may take time, there are steps that can be taken now that can reduce the risks for FSW. It is important to advocate for a political commitment to change these laws, and to promote the basic human rights of all people. It is vital that laws be advocated that protect FSW and increase opportunities for them. Currently in Lebanon, anti-trafficking laws do not exist (34). Therefore, it is important to advocate for the creation of anti-trafficking laws to prevent women from being forced into the sex trade against their will. All of these strategies will take strategic and systematic advocacy and the building of relationships with local and political leaders.

Within this time, laws that support discrimination or heighten behaviors that increase risk for HIV infection need to be corrected or removed. For example, the practice of arresting women who possess condoms, and using this possession as evidence of sex work needs to be stopped. This promotes risky behavior, and makes the situation of FSW much more tenuous. We need to promote the FSW's right to earn a living free from stigma, discrimination and exploitation.

> In the end, "...living as a sex worker needs acknowledgement, acceptance and decriminalization. It's only by this approach that rights of those who enter sex work will be protected and safeguarded and rights of sex workers within the profession to practice sex work freely and safely will be ensured (18)."

Flowchart for Future Outreach

The following flowchart (Figure 8) has been created as a guide for future outreach interventions with the FSW population regarding HIV/AIDS awareness and prevention. The flowchart takes into consideration the strengths, obstacles and recommendations delineated above to create a more concise picture of the actions that need to be taken to create an effective intervention with this population of women. It is important to always conduct a situation and needs assessment within your own community before adapting this to your context, as the situations will differ, not only across different countries, but also across different areas of one country, and across time.

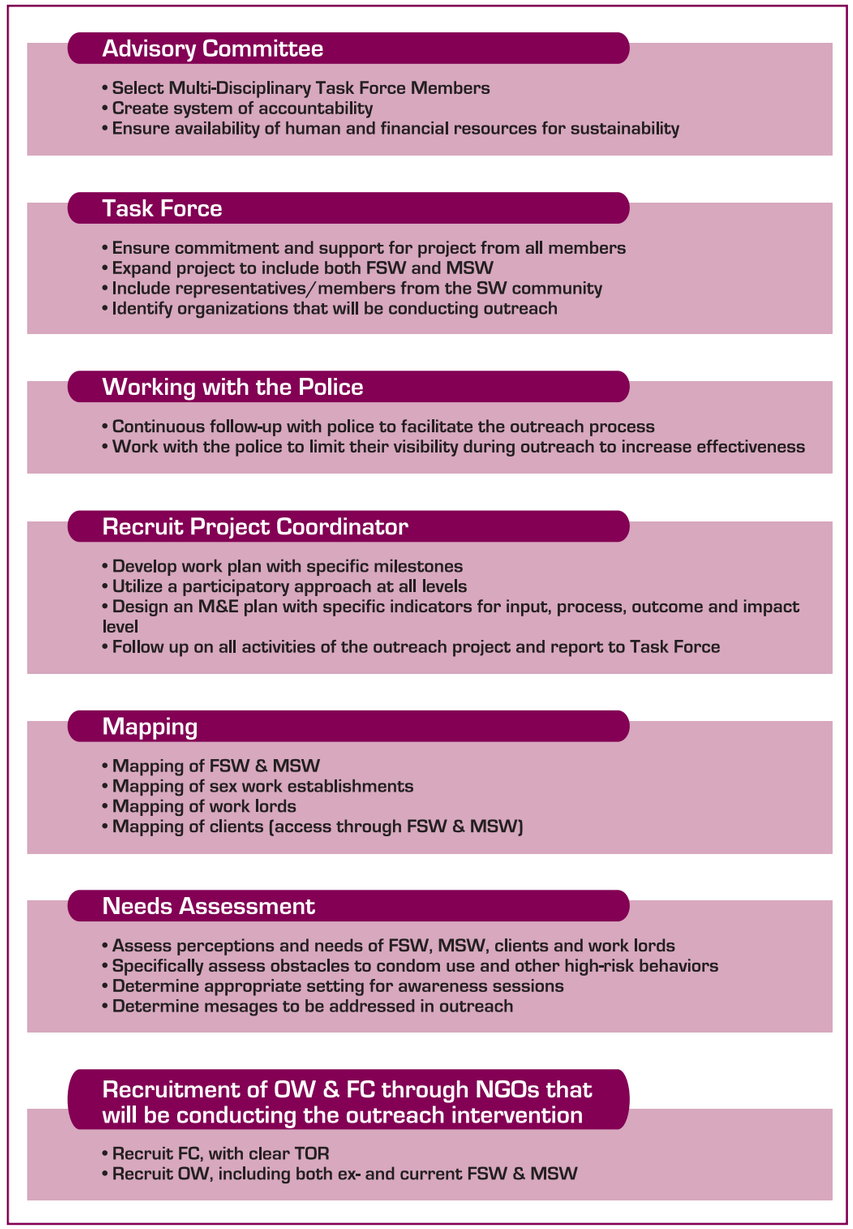


Figure 8: Flow Chart For Future Outreach Interventions Using a Participatory Approach

Training

- Conduct trainings for previous and new OW and FC
- Pinpoint obstacles that may be faced, and how to overcome these obstacles (use rapid assessment results)
- Conduct training on sexuality, sensitivity, initiation and negotation skills for condom use with messages tailored according to the needs assessment
- Conduct frequent refresher and follow-up meetings
- Reinforce the need to take forms with them into the field for data collection purposes, train the OW to take field notes
- Enclose the IEC material in an envelope to decrease stigma associated with the possession of HIV/AIDS materials
- Develop identification system for OW for coverage and support by police

Outreach Planning (from Needs Assessment)

- Condom initiation, use, and properties
- Negotiation skills for condom use and other behaviors
- Work lord, client, and peer relationships
- Timing of outreach and trust issues
- Additional needs that are addressed in the needs assessment
- Develop tailored IEC material for this population

Raising Awareness

- Conduct awareness sessions specifically for the FSW and MSW populations in a safe, easily accessible location as proposed in the needs assessment
- Utilize media, municipalities, and placement of brochures in hotels, barber shops and taxis to increase sensitization to HIV and raise perceived susceptibility among FSW, MSW, clients and work lords

Execute Outreach

- Plan for continuous, systematic outreach
- Work on gaining the target population's trust
- Tackle the vulnerabilities if SW to HIV/AIDS, and concentrate on issues identified from the needs assessment
- 3 levels of outreach - FSW and MSW, clients, and work lords
- Use outreach as a tool to inform FSW and MSW about awareness sessions
- Increase awareness of hotlines and referral services, work to decrease fear relating to these services and distribute relevant IEC material

Follow-up meetings

- Conduct follow-up meetings on outreach process with FC and OW to identify and overcome obstacles
- Conduct frequent evaluations to ensure quality outreach programming

M & E

- Develop specific indicators for evaluation
- Continuous M&E of the entire outreach process (input, process, impact and outcome)

Dissemination of Results

- Dissemination of results among the FSW, MSW, clients and work lords
- Dissemination of results among the NGOs, OW, and relevant ministries, including the ISF and the police officers
- Publication of results in international journals

Figure 8: Continued

Conclusion

Sex workers live difficult lives on the edge of society. They are constantly looking over their shoulders, seeking to protect themselves from unforeseeable predicaments and consequences. They are fighting to gain an advantage, whether in society as a whole, or within their own communities. They live in fear; of HIV/AIDS and other STIs, of imprisonment, and of violence from their pimps and sexual partners.

This case study has illustrated the benefits of outreach and peer education as a method of conveying information to FSW and other vulnerable groups. This approach has led to increased awareness among the targeted population as well as a small amount of behavior change. Peer education is advantageous in that peers are generally more familiar with the locations of the targeted population, as well as their habits and modes of communication. This study has pinpointed obstacles and strengths at all levels of the intervention, has assessed the behavior change among the target population, and has suggested a set of tailored recommendations on how to improve future interventions. All of this has been conducted in order to increase the level of prevention and awareness of HIV/AIDS among FSW in Lebanon.

The recommendations from this case study include the need to intervene at many levels, including with the FSW, her clients, and the work lords, in addition to increasing community involvement and a change in policy. In order to increase the amount of change, we cannot focus solely on the FSW, as there are numerous larger factors that influence her ability to make changes within her life. A commitment needs to be attained at all levels in order to limit the spread of HIV among the FSW population and among the greater population of the country.

While FSW live on the edge of society, their lives overlap ours in innumerable ways. They deserve the same rights and opportunities as the rest of us. In order to guarantee these rights, the sex trade needs to be decriminalized so that these opportunities are available to them. Additional interventions and studies must be focused on this marginalized population in order to gain more knowledge on ways to assist them, and how to pursue proper advocacy for a change in the laws criminalizing the profession.

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Appendix A: Regulatory Laws Regarding Sex Work in Lebanon

في الحض على الفجور والتعرض للأخلاق والآداب العامة
النبذة 1- في الحض على الفجور
(المواد 523-530)

المادة - 523 اعتياد الحض على الفجور

عدل نص المادة 523 بموجب القانون 53/1948 على الوجه التالي ثم عدلت الغرامات الواردة فيه بموجب القانون رقم 239 تاريخ 1993/5/27:

من اعتاد حض شخص أو أكثر ذكراً كان أو أنثى لما يبلغ الحادية والعشرين من عمره على الفجور أو الفساد أو على تسهيلهما له أو مساعدته على إتيانهما عوقب بالحبس من شهر إلى سنة وبغرامة من خمسين ألف إلى خمسمائة ألف ليرة.

ويعاقب العقاب نفسه من تعاطى الدعارة السرية أو سهلها.

المادة - 524 اغواء الغير على اغواء فتاة بالخداع أو العنف أو التهديد

عدلت الغرامة الواردة في المادة 524 بموجب القانون رقم 239 تاريخ 1993/5/27 على الوجه التالي:

يعاقب بالحبس سنة على الأقل وبغرامة لا تنقص عن مائتي ألف ليرة من أقدم إرضاء لأهواء الغير على إغواء أو اجتذاب أو ابعاد امرأة أو فتاة دون الحادية والعشرين من عمرها ولو برضاها أو امرأة أو فتاة في الحادية والعشرين من العمر باستعمال الخداع أو العنف أو التهديد أو صرف النفوذ أو غير ذلك من وسائل الاكراه.

المادة - 525 اغواء على تعاطي الدعارة

عدلت الغرامة الواردة في المادة 525 بموجب القانون رقم 239 تاريخ 1993/5/27 على الوجه التالي:

يعاقب بالحبس من شهرين إلى سنتين وبالغرامة من خمسين ألف إلى خمسمائة ألف ليرة من أقدم باستعماله الوسائل المذكورة في المادة السابقة على استبقاء شخص رغماً عنه ولو بسبب دين له عليه في بيت الفجور أو اكرهه على تعاطي الدعارة.

المادة - 526 الاغواء العامة على ارتكاب الفجور بقصد الكسب

عدلت الغرامة الواردة في المادة 526 بموجب القانون رقم 239 تاريخ 1993/5/27 على الوجه التالي:

من اعتاد أن يسهل بقصد الكسب اغواء العامة على ارتكاب الفجور مع الغير ومن استعمل احدى الوسائل المشار اليها في الفقرتين الـ 2 و 3 من المادة الـ 209 لاستجلاب الناس إلى الفجور يعاقب بالحبس من شهر إلى سنة وبالغرامة من عشرين ألف ليرة إلى مائتي ألف ليرة.

المادة - 527 دعارة الغير

عدلت الغرامة الواردة في المادة 527 بموجب القانون رقم 239 تاريخ 1993/5/27 على الوجه التالي:

كل امرئ لا يتعاطى مهنة بالفعل فاعتمد في كسب معيشته أو بعضها على دعارة الغير عوقب بالحبس من ستة أشهر إلى سنتين وبغرامة من عشرين ألف إلى مائتي ألف ليرة.

المادة - 528 معاقبة على محاولة حض الغير على الفجور

يعاقب على المحاولة في الجنح المنصوص عليها في المواد الـ 523 إلى 525.

المادة - 529 تشديد عقوبة جرائم الحض على الفجور

تشدد بمقتضى حكم المادة الـ 257 العقوبات التي تنص عليها المواد المذكورة اذا كان المجرمون ممن وصفوا في المادة الـ 506.

المادة - 530 اخراج من البلاد وحرية مراقبة في الجنح المتعلقة بالحض على الفجور

يمكن القضاء بالاخراج من البلاد وبالحرية المراقبة عند الحكم في احدى الجنح المنصوص عليها في هذه النبذة.

ويقضى أيضاً باقفال المحل.

النبذة 2- في التعرض للآداب والأخلاق العامة
(المواد 531-534)

المادة - 531 تعرض للآداب العامة

يعاقب على التعرض للآداب العامة بإحدى الوسائل المذكورة في الفقرة الأولى من المادة 209 بالحبس من شهر إلى سنة.

المادة - 532 تعرض للأخلاق العامة

عدلت الغرامة الواردة في المادة 532 بموجب القانون رقم 239 تاريخ 1993/5/27 على الوجه التالي:

يعاقب على التعرض للأخلاق العامة بإحدى الوسائل المذكورة في الفقرتين الثانية والثالثة من المادة الـ 209 بالحبس من شهر إلى سنة وبالغرامة من عشرين ألف إلى مائتي ألف ليرة.

المادة - 533 اتجار بالأشياء المخلة بالحياء

يعاقب بالعقوبات نفسها من أقدم على صنع أو تصدير أو توريد أو اقتناء كتابات أو رسوم أو صور يدوية أو شمسية أو أفلام أو اشارات أو غير ذلك من الأشياء المخلة بالحياء بقصد الاتجار بها أو توزيعها أو أعلن أو أعلم عن طريقة الحصول عليها.

المادة - 534 مجامعة على خلاف الطبيعة

كل مجامعة على خلاف الطبيعة يعاقب عليها بالحبس حتى سنة واحدة.

Articles 523 - 534 of the Lebanese Penal Code

[illegible]

المستشفى المستوفاة قانونياً من أصحاب أو صاحبات بيوت الدعارة ولا خدمهم ولا النساء المعاينات لا بمناسبة المعاينات الطبية ولا بمناسبة المعالجة الطبية.

المادة 93

على طبيب الحكومة أن لا يتجاوز التحقيقات الطبية ولا يتدخل بشؤون نظام بيوت الدعارة ونزيلاتها وبيوت الفنون والنساء العوائق.

المادة 94

يكلف تنفيذ هذا القرار كل ما يتعلق به الطبيب المفتش العام لدوائر الصحة والهيجان والاسعاف العمومية ودوائر الحجر الصحي والمندوب الاداري لمنطقة الغربية ورئيس المراقبة الادارية للمنطقة الشمالية.

بيروت في 19 نيسان سنة 1920

Articles 68 - 94 of the Lebanese Penal Code