Facilities and HIV Prevention in Bathhouse and Sex Club Environments

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This project evaluated the extent to which businesses with a primary purpose of providing opportunities for sexual encounters between men (e.g., bathhouses and sex clubs) have implemented strategies that target their customers with important HIV and STD prevention messages. Between October 1996 and February 1997, we conducted structured telephone interviews with 63 businesses throughout the United States in order to describe their facilities and their HIV education and prevention efforts. Types of facilities offered were related to what businesses called themselves and the kinds of sex space they provided. All of the businesses reported that they provided condoms and lubricant on site; 95% provided educational materials such as posters and flyers about HIV/AIDS; and 40% provided HIV testing on site, with half of these also providing some type of STD testing. Although some level of HIV prevention and educational efforts by these businesses are described, further investigation into their efficacy is required.

Person-environment theory posits that behavior may be explained not only by individual characteristics, but also by the environment in which the behavior occurred (Walsh, Craik, & Price, 1992). Research in the area of HIV risk behavior has tended to focus on person factors, though some researchers have given attention to particular contexts, settings, and situations (Diaz, Stall, Hoff, Daigle, & Coates, 1996; Fullilove, 1995; Heckathorn, 1995; Koopman, 1996; Leap, 1999; Tawil, Verster, & O'Reilly, 1995). Among men who have sex with men (MSM), gay baths and sex clubs have been related to disease risk since the first cases of AIDS were identified among gay men in the early 1980s (Turner, Miller, & Moses, 1989). Nevertheless, very little research on contextual factors of bathhouses has been reported. Studies that have been conducted measured two separate spheres of behavior: sexual risk and visiting bathhouses (Bolton, Vinke, & Mak, 1992; de Wit, de Vroome, Sandfort, & van Griensven, 1997; Martin, 1986; McKusick, Horstman, & Coates, 1985; van de Ven et al., 1998) or any of a wide variety of public sex environments (Church, Green, Vearnals, & Keogh, 1993; Coates et al., 1996; Dowsett, 1996; McCoy & Inciardi, 1995; Ridge, Plummer, & Minichiello, 1994a, 1994b). Only one of these studies examined a bathhouse setting (McCoy & Inciardi, 1995), and only two (Elwood, Williams, & Bowen, 1996; Richwald et al., 1988) assessed sexual behavior that took place within these settings. Although there are some descriptions of the social/sexual context of bathhouses and sex clubs, with one exception (McCoy & Inciardi, 1995) these descriptions predate the HIV epidemic (Brodsky, 1993; Delph, 1978; Weinberg & Williams, 1975).

To consider adequately the context of bathhouses and sex clubs, it is important to provide some background and to detail their similarities and differences. Early in the 20th century, bathhouses frequented by men in search of sex with men were not promoting safe havens for sexual activity but rather were public baths, Turkish baths, saunas, and the like, which generally frowned on any sexual behavior on their premises (Chauncey, 1994). By the late 1970s gay bathhouses (referred to in the gay vernacular as "the baths") were a significant part of the gay subculture and gay pride, celebrating gay sexuality (Berube, 1996). Some of these gay baths provided orgy rooms and mazes, clearly allowing overt sexual activity not only in closed private rooms but also in open areas of the facility (Rumaker, 1979; Weinberg & Williams, 1975). At about the same time gay sex clubs appeared (Brodsky, 1993). A sex club is usually distinguished from the baths by several features. In the baths, sex may occur in a privately rented room. Sex can also be had in a number of open areas, such as orgy rooms or mazes (similar to a traditional maze, except the intricate passageways are usually dark to pitch black), sometimes

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equipped with glory holes (holes of varying sizes used to allow oral sex between men on opposite sides of a wall or door) or slings (suspended in the air in such a way as to provide easy maneuvering for multiple oral and anal sexual encounters). Sex clubs have been compared to a cross between a bathhouse and a backroom at a bar (Lindell, 1996). (A backroom is an open area, usually dark to pitch black, used by bar patrons for sexual activity.) Like a bar, patrons of a sex club generally wear their street clothes throughout (at the baths, men remove their street clothes in exchange for a towel wrapped around their waists). In sex clubs the option for sex lying down is less likely than in the baths since, like backrooms, sex clubs generally have no closed rooms. In sex clubs, open areas tend to be similar to those found in the baths (i.e., with glory holes and mazes). Both venue types provide opportunities to find a large number of men looking for sexual encounters and to engage in numerous, episodic sexual encounters.

Even before AIDS, public health authorities and gay leaders reported concerns about alarming rates of STDs among gay men, and the number of partners gay men could accumulate facilitated by the gay bathhouses and sex clubs (Merino, Judson, Bennett, & Schaffnit, 1979). Thus, with the onset of the AIDS epidemic, the stage was set to target these venues for closure by public health officials, journalists, and politicians, including some within the gay community itself (Bayer, 1991; Rotello, 1997; Shilts, 1987). In 1984, the debates about closing the baths reached their full force, resulting in an attempt to shut down completely all bathhouses and sex clubs of San Francisco, California (see Bayer, 1991; Helquist, 1984; Shilts, 1987). Some businesses ordered to close took their case to court. The judge ruled that the local government could not force businesses to close as long as anyone could monitor customer behavior to ensure that they did not engage in unprotected anal intercourse (Bayer, 1991; Helquist, 1984). Thus, in San Francisco, owners could remain in business by providing only spaces where all sex was in the open. Ironically, in New York the state legislature formulated an opposite policy, such that businesses that allowed sex to occur in the open could be closed down by the health department (Bayer, 1991). Though neither policy relied on any research evidence, they clearly assumed that the structural environment might have contributed to individual behavior and risk practices.

On the other side of the debate, one of the more compelling arguments raised for keeping these venues open has been that they can provide important prevention messages to men at risk for HIV as a result of having sex with other men (Auerbach, Wypijewska, & Brodie, 1994; Berube, 1996; Helquist & Osmond, 1984a). Though context may play a role in behavior in a wide variety of ways (see Walsh, Craik, & Price, 1992), a number of specific suggestions were recommended to businesses to help patrons reduce their risk of acquiring HIV (Berube, 1996; Helquist & Osmond, 1984a, 1984b; Shilts, 1987). For instance, it was deemed appropriate for businesses to provide condoms, preferably free of charge. Further, flyers and posters were recommended as a means of providing information and reminders of the risk of exposure to AIDS through sexual practices. Berube (1984) suggested special safe-sex education efforts in the baths. As part of their journalistic investigations on the bathhouse debate, Helquist and Osmond (1984b) assessed seven San Francisco baths by describing whether the businesses provided these prevention materials, as well as whether there were orgy rooms, glory holes, and other structural amenities (e.g., mazes, steam rooms, gyms, social areas). Since the time of the debates HIV testing has become available, and it is reasonable to add testing to any prevention program offered in these businesses, since STD testing in the baths began before the onset of HIV (Merino et al., 1979).

Despite two decades of an AIDS epidemic among MSM, there has been no thorough, systematic assessment of these businesses similar to that conducted by Helquist and Osmond (1984b). This paper provides a national assessment of context, at a level similar to Helquist and Osmond (1984b), in U.S. bathhouses.

Methods

Businesses

We attempted to identify the total population of businesses that had as their primary purpose the intention to provide space for men to meet other men for sex. Although these businesses traditionally call themselves either a bathhouse or a sex club, we quickly found that a number of these businesses call themselves by other names (e.g., health club, gym). As a result, no one word captures the variety of businesses that exist primarily to provide opportunities for sexual encounters between men. In some studies these businesses have been lumped together in the category of public sex environments (PSEs) or sex on premise venues (SPVs). However, sexual behavior is decidedly not public in many bathhouses and, in any case, is quite different from public sex that occurs in parks and public restrooms, which are also considered PSEs or SPVs. The term *commercial sex environments* (CSE) also fails to capture the nature of these businesses because they are different from adult bookstores and movie houses, which might also be considered CSEs. Since almost all these businesses require membership, *sex club* would be a good generic term to use, but it is the term already used to differentiate a particular type of business from bathhouses. We have not found a suitable word or phrase, so, throughout this paper, we use the term *businesses* when we want to include both bathhouses and sex clubs and similar facilities called something else.

The population of businesses was operationally defined using two strategies. First, and primarily, businesses were identified through listings in two guides for gay men, the *Damron Address Book* (1996), and the *Spartacus Guide for Gay Men* (Gmunder & Stamford, 1996). Both guides publish an updated edition annually and are widely avail-

able in bookstores, and are resources widely known to gay men. Listings under "men's clubs" (in *Damron*) and "saunas/gay baths" (in *Spartacus*) were used to generate our list of businesses. Both guides list all venues in U.S. cities that could be identified regardless of whether a venue chose to advertise in the publication. Listings typically provide both an address and phone number that allowed us to initiate contact; when phone numbers were not provided we contacted colleagues in those localities to assist in obtaining a phone number. We used a second strategy to account for businesses that might have opened between the time these guides were prepared for publication and the time our study began. Therefore, we also included in our survey any business that we knew or heard of through our contacts with these businesses, their patrons, or our colleagues around the country. While this second approach was limited to learning of places that were familiar to our contacts, it nevertheless provided the best available option for identifying new and unlisted businesses. Although it is not possible to confirm that this approach truly captured the total population of businesses, it is certainly a very close approximation of it.

We identified 104 businesses (guides = 91, contacts = 13) in 22 different U.S. cities. Of the businesses listed, 20 had closed, and 4 reported that they did not operate as a business providing space for sexual activity (we discovered later that at least 2 of these businesses provided space for sex), leaving a population of 80 venues. Of these, 63 completed the interview, 5 refused to participate without giving an explanation, and 12 could not be reached by phone, for a response rate of 79%. We considered this an acceptable response rate given that the nature of this business is such that owners and managers often may not want to discuss details of their facilities and operations; 19 were located in states that still had antisodomy laws. Additionally, an 80% response rate is considered excellent in standard survey practice (Burke & Virag, 1996; Groves & Lyberg, 1988). Nine businesses were located in the Midwest region of the US, 13 in the South, and 14 each in both the Northeast and the West.

Data Collection

Interviews were conducted by phone between October 1996 and February 1997, using a structured interview developed by the investigators. A single interviewer conducted all interviews. The 63 key informants were owners (16%), managers (65%), or staff (19%) from the businesses we surveyed. Whenever possible the interviewer attempted to speak with an owner or manager, although the more important consideration was that the person interviewed worked on-site (to ensure as much as possible that the person was truly familiar with the facility and its day-to-day operations). In cases where a staff person was interviewed, the staff person indicated that an interview with an owner or manager would not be possible (e.g., an owner of a bathhouse in a Southern state lived in a state in the West). Though we did not measure for differences in job title, we were aware from our interactions with these businesses that some owners had a hand in day-to-day operations of their businesses and others did not. Similarly, some managers may have had a large staff, while others may have run their operation with a staff of a few additional men, though we did not measure these factors.

Measures

The instrument had 10 sections: The first of these identified the key informant by name, position, and length of time worked in the facility. Facility information was updated in terms of name, address, phone number, and the names of the owner(s) and the general manager. The key informant was asked to identify the type of facility in terms of bathhouse, sex club, or some other type, and how long the business was in operation.

We next asked for a description of the physical layout in terms of types of facilities and amenities provided. Specifically, we asked about permitting sex in open spaces, and providing closed rooms for sex (meaning small rooms that have doors and provide privacy). We also asked about *water amenities* (e.g., sauna, steam room, hot tub) and *sexual amenities* (e.g., glory holes, mazes, slings) sometimes available in bathhouses and sex clubs.

A number of possible practices, facilities, and policies were considered to fall into the category of HIV/STD education and prevention. We included in this category the following: the availability of condoms, lubricants, safer sex ads (flyers and posters), and testing for HIV and STDs; and the production of special events to promote safer sex (e.g., outreach work and events sponsored by community-based organizations). We asked if condoms and lubricants were available at all, and if so, were they provided free and at what locations within the business. We also asked about specific HIV education and prevention efforts (displaying of safer sex posters, availability of safer sex fliers, special events and other efforts, HIV and/or STD testing, and special health programs). Showers, though measured as a water amenity, were also considered a prevention facility since "showering after each sexual encounter" was part of STD prevention in the 1970s (Helquist & Osmond, 1984b).

Interviews took an average of 10 minutes to complete. Interviews of key informants from businesses that had a more extensive HIV prevention program required more time, since follow-up questions were required. Nevertheless, informants from businesses with no HIV prevention program were asked specific questions about each area of HIV prevention.

Procedures

Recruitment was conducted by first sending a letter of introduction to the attention of the owner/manager. The letter introduced the study, its purpose, and the investigators, serving as part of an informed consent process. A week after the letters were sent, the interviewer began calling businesses directly to schedule an interview with a key informant. At the time of the interview, key informants were asked to

review the letter with the interviewer and to provide verbal consent to proceed with the interview. If the informant did not have a copy of the original letter providing consent information, one was faxed to him before the interview began. A single interviewer conducted all data collection.

Information about the state in which a business was located was added to the protocol. First, states were coded for region: Northeast, Midwest, South, or West. Each state was coded as to whether it had an antisodomy law, based on what was reported in the *Damron* guide.

Analysis Plan

Chi-square and Fisher's exact tests (Snedecor & Cochran, 1989) were used to test for significant difference between the two samples. All statistical analyses were performed with Stata, version 5.0 (1996).

Results

Description of Businesses

The establishment of these businesses had an intermittent pattern. Two facilities were in business since before 1900, while the next group of businesses was not established until the era associated with gay liberation (i.e., after 1969). There was another break in openings during the early years of the AIDS epidemic, with businesses starting up again in the late 1980s. Those in operation longer were more likely to provide only private rooms. Those opened during gay liberation tended to provide both open space and private rooms. The newest businesses, opening after the AIDS epidemic began, were more likely to permit sex in open spaces and to not provide private rooms.

Businesses participating in this survey called themselves by a number of different names, including bathhouse, sex club, health club, men's club, gym, sauna, spa, and other names. A third of the businesses labeled themselves bathhouse, and another 16% used the term sex club. Most businesses (51%) labeled their facilities with other terms that did not suggest a sexual dimension to the environment (e.g., health club, gym, spa). Hereafter we use *health club* to indicate the group that included all terms other than bathhouse or sex club. There were significant regional variations in what businesses called themselves (Fisher's exact test $p < .05$). Most facilities in the South were called health clubs (85%) rather than bathhouses (15%). Facilities in the West were more likely to be called bathhouses (44%) and least likely to be health clubs (30%). There was no business called a sex club in either the South or the Midwest regions of the country.

We combined information on availability of closed rooms (81%) with information on permissibility of sex in open areas (43%) and characterized facilities based on these characteristics to create a threefold classification (see Table 1). Fifty-seven percent provided only closed rooms where sex could occur, 17% provided only open space for sex, and 25% of businesses provided closed rooms *and* permitted sex in open spaces. This classification was associated significantly with business type (Fisher's exact < .001). That is, health clubs tended to provide closed rooms and did not permit sex in any open areas of the facility. Sex clubs tended to

Table 1. Type of Space for Sex by Business Type, Region, and Amenities

	All businesses (N = 63)		Space for sex: Closed only (n = 36)		Open only (n = 11)		Closed & open (n = 16)	
	n	(%)	n	(%)	n	(%)	n	(%)
Business type**								
Bathhouse	21	(33)	8	(22)	1	(9)	12	(75)
Sex club	10	(16)	0	(0)	8	(73)	2	(13)
Health club	32	(51)	28	(78)	2	(18)	2	(13)
Region of the U.S.								
Northeast	13	(21)	8	(22)	3	(27)	2	(12)
South	13	(21)	11	(31)	1	(9)	1	(6)
Midwest	10	(16)	6	(17)	0	(0)	4	(25)
West	27	(43)	11	(31)	7	(64)	9	(56)
Water amenities								
Steam rooms**	45	(71)	32	(89)	2	(18)	11	(69)
Saunas**	42	(67)	29	(81)	2	(18)	11	(69)
Hot tubs	33	(52)	22	(61)	1	(9)	10	(62)
Showers*	55	(87)	36	(100)	4	(36)	15	(94)
Any amenities[a]**	55	(87)	36	(100)	4	(36)	15	(94)
Sex amenities								
Glory holes**	20	(32)	3	(9)	7	(64)	10	(62)**
Mazes*	16	(26)	3	(9)	5	(45)	8	(50)*
Slings**	12	(19)	1	(3)	3	(27)	8	(50)**
Any amenities[a]**	23	(37)	3	(9)	8	(73)	12	(75)**

[a] Includes an affirmative response to any of the above listed amenities within the category.
*$p \leq .01$. **$p \leq .001$.

allow sex in open spaces, but did not have private rooms. Bathhouses both allowed sex in open areas and provided private rooms. There were no significant interactions between types of spaces and geographical region.

There were several types of amenities offered at various businesses (see Table 1), and these were divided into two types: water amenities (steam rooms, saunas, hot tubs, showers), and sex amenities (glory holes, mazes, slings). Of the 63 businesses, 53 (84%) had some kind of water amenity. The kinds of space businesses provided for sex also was associated significantly with water amenities; in general, businesses providing closed space were more likely to have water amenities. Thus, having water amenities also was associated significantly with what a business called itself, such that having these amenities increased the likelihood that a business called itself a bathhouse or a health club (Fisher's exact $p < .001$).

Concerning sex amenities, 23 facilities (37%) provided at least one of these amenities. All establishments with mazes also had glory holes, and three quarters of those with slings also had glory holes. Those businesses that provided open spaces for sex were more likely to have sex amenities than businesses that did not (see Table 1). Having sex amenities was associated significantly with what a business called itself (Fisher's exact $p < .001$); almost all sex clubs had sex amenities, as did about half the bathhouses, while few health clubs provided them.

Description of HIV/STD Prevention at the Businesses

As shown in Table 2, various categories of education and prevention efforts were assessed. Both condoms and lubrication were available at 100% of the facilities we surveyed. Further, 100% of the businesses provided condoms free of charge, and 67% provided lubricant for free. Also, it was typical that condoms were provided throughout an establishment in open spaces; however, only 45% of those with closed rooms provided condoms in these rooms. Although a majority of the businesses provided facilities for showering, businesses with closed space were significantly more likely to provide showers than those providing only open space for sex.

All but one facility reported having rules for safer sex behavior in their venue. The vast majority also provided HIV/AIDS education through flyers and posters. Although businesses with only open spaces were significantly less likely to report having flyers and posters available, the number of businesses that did not have these materials was quite small. Many of these businesses further promoted safer sex behavior through special events; the number and caliber of these special events were not adequately measured in our interview.

Some businesses (40%) offered HIV testing on site. HIV testing was significantly associated (Fisher's exact $p < .01$) with region of the country. Clubs in the Northeast were least likely (8%), and clubs in the South (69%) and Midwest (60%) most likely, to provide HIV testing, with clubs in the West falling in the middle (33%). About half of those offering HIV testing also offered STD testing. STD testing was associated significantly with region of the country (Fisher's exact $p < .05$). Businesses in the Northeast were least likely (0%), and businesses in the Midwest most likely (50%), to offer STD testing compared with the South (23%) and West (19%). A greater proportion of health clubs (44%) and bathhouses (43%) offered HIV testing than sex clubs (20%), although about a fifth of each business type offered STD testing.

Discussion

Results from this phone survey suggest that a minimum HIV/STD prevention effort of condom and lubricant distribution were in place at establishments across the United States. In general, businesses were generous in their distribution procedures by supplying free condoms in public areas throughout a facility. Condom distribution in closed rooms and lubrication availability were less liberal. Similarly, HIV/AIDS information brochures and posters were reported to be available in the vast majority of venues, although we collected no information that would indicate to what extent these materials were easily accessible and actually acquired or viewed by patrons. Concern that condoms and information about HIV/AIDS would not be tolerated by owners and would scare away patrons did not hold true into the 1990s (Shilts, 1987).

Table 2. Type of Space for Sex by Categories of HIV/AIDS Education and Prevention Provided

HIV/AIDS education & prevention provided	All businesses (N = 63)		Space for sex: Closed only (n = 36)		Open only (n = 11)		Closed & open (n = 16)	
	n	(%)	n	(%)	n	(%)	n	(%)
Condoms	63	(100)	36	(100)	11	(100)	16	(100)
Lubricant	63	(100)	36	(100)	11	(100)	16	(100)
Rules for safe sex	62	(98)	35	(97)	11	(100)	16	(100)
Flyers*	61	(97)	36	(100)	9	(90)	16	(100)
Posters*	60	(95)	36	(100)	9	(82)	15	(94)
Showers**	55	(87)	36	(100)	4	(36)	15	(94)
Special events	50	(79)	31	(86)	7	(64)	12	(75)
HIV testing	25	(40)	15	(42)	3	(27)	7	(44)
STD testing	13	(21)	5	(14)	3	(27)	13	(21)

*$p \leq .05$. **$p \leq .001$.

A number of businesses reported additional prevention efforts, producing special educational programs that offered patrons specific events related to HIV and STD risks (e.g., condom demonstrations by local community-based organizations), or provided testing services on site for HIV or for both HIV and STDs. Although many of these activities were in place throughout the country, an assessment of their efficacy was beyond the scope of this project. Posters and fliers may be reaching the same populations who have access to them elsewhere, while those whose only connection to HIV education might be through these businesses could be passing up the information provided. There are also no data from our study regarding the value of providing testing at sex venues or the extent to which patrons accessed testing services available at these venues. The impact of rules on safe sex was hard to assess given the large number of factors that would influence their efficacy, such as consistency and verifiability of informing patrons of rules, patron comprehension of and adherence to rules, and consistent enforcement of rules.

Current public policy is contradictory. For example, in San Francisco (CA) closed rooms with lockable doors are not permitted, since it is believed that such an environment promotes unsafe sex. The opposite policy was enacted in New York State, where any public sex was considered a risk to public health; thus, sex was only permitted in closed rooms (Bayer, 1991). Without attempting to resolve such contradictions, we measured the extent to which businesses we interviewed provided closed rooms and permitted sex in open areas of their establishments. Whether closed rooms were available and whether sex was allowed in open areas was not associated with other efforts in HIV prevention. It seemed that the larger issue for businesses was providing the kinds of spaces the law permitted while still attracting patrons. It could be argued that the kinds of environments created for sexual activity will likely influence the kind of sex that men engage in (e.g., glory holes and mazes tend to promote oral sex between patrons rather than anal sex). Continued investigation into the issues involved in this debate about type of space (closed vs. open) would facilitate formulating appropriate public policy and law.

Finding a suitable name to capture all varieties of businesses providing environments for male patrons to have sex with other male patrons was only the beginning of the naming difficulty for this study. There were trends in the kinds of spaces businesses offered for sex and what amenities they provided. For instance, water amenities were typical in establishments with closed rooms (which tended to be called bathhouses and health clubs) and sex amenities were typical in those with open space for sex (which tended to be called bathhouses and sex clubs). Thus, businesses providing both open and closed spaces for sex (which tended to call themselves bathhouses) were more likely to provide both water and sex amenities. Nevertheless, just because a business was called a bathhouse did not mean that one could be certain that sex would be permitted in the open areas of a business. Rather, what businesses called themselves was related more to the region in which a business was located (e.g., places in the South tended to be called health club or gym regardless of the kind of space and facilities they provided).

All information was collected through a survey of one key informant at each site, without any observational or secondary source verification. For example, due to social desirability, respondents may have exaggerated condom availability and distribution. Conducting additional key informant interviews or observations could have reduced the bias and identified problem variables; however, these options were not physically or fiscally possible. It also is possible that responses may have been different for a given site if a different key informant had been selected. Also, it is possible that we received refusals from clubs that are not providing education/prevention efforts that we found in clubs that did participate.

There may have been some misunderstanding of what is meant by open spaces for sex. Three businesses reported providing glory holes or mazes but also said that sex was forbidden in open areas. This raises the question of whether glory holes are in fact always in open areas and if the term *maze* is too ambiguous. Rules on safer sex may be important and useful in reducing HIV risk behavior in these venues; however, we did not measure the wide range of possible differences in how rules were communicated to their patrons and how they were enforced. Therefore, the true significance of the finding that most businesses have rules about safer sex is hard to calculate.

In summary, we found that condom distribution was the primary prevention service provided in these venues. A large number of businesses also extend their HIV/STD education and prevention programs by providing fliers and posters, though only a few provide more time consuming efforts such as special events and HIV/STD testing. A number of important questions remain unanswered, especially regarding the efficacy and value of these programs in reducing disease transmission among patrons. Nevertheless, these data suggest that the willingness of many businesses to do more in regard to HIV/STD prevention can be used as a model for those businesses that do much less. Further, while these results do not describe the response of patrons to these efforts, it is at least clear that businesses that provide HIV/STD prevention continue to attract patrons.

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