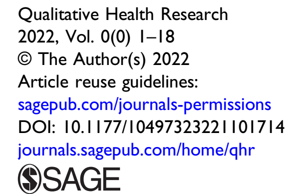
Check for updates

Research Article



Qualitative Health Research
2022, Vol. 0(0) 1–18
© The Author(s) 2022
Article reuse guidelines:
sagepub.com/journals-permissions
DOI: 10.1177/10497323221101714
journals.sagepub.com/home/qhr
SAGE

Attitudes Toward Peer-Delivered Sexual-Health Services Among New York City Sexual and Gender Minority Individuals Who Have Sex with Men and Attend Collective Sex Venues

Étienne Meunier[1], Daniel Alohan[1,2], Stephen Tellone[1,3], Richard Silvera[4], Alwyn Cohall[1], Adam Baran[5], Michael Wakefield[5], Christian Grov[6], and Celia B. Fisher[7]

Abstract

Collective sex venues such as sex clubs are strategic sites to promote sexual health among sexual and gender minority individuals. We present qualitative findings from a multiple-method study on the acceptability of sexual-health services at collective sex venues in New York City (NYC) among attendees who identified as men, transgender, or gender non-conforming. In a survey used for sample selection (n = 342), most respondents (82.7%) agreed that "having outreach workers at sex venues is a good thing." Interviewees (n = 30) appreciated how on-site services could promote sexual health in their community. They felt peer workers should be familiar with collective sex venues and share demographic characteristics with attendees. Some participants felt workers should keep some boundaries from attendees, while others felt they could be fully integrated in the environment, suggesting that either peer outreach or popular-opinion leader types of interventions could be feasible.

Keywords

gay, bisexual, and other men who have sex with men, transgender and gender nonconforming individuals, HIV/STI prevention, sexual health, peer-based work, collective sex venues

Introduction

Collective sex venues (establishments where people can have sex in groups or in the presence of others, such as sex clubs, bathhouses, or sex parties) are strategic sites to conduct sexual-health promotion among sexual and gender minority individuals (Frank, 2019; Meunier et al., 2019). In 2019, 69% of new HIV infections in the US were among gay, bisexual, and other men who have sex with men (MSM), while for transgender individuals, the annual number of new diagnoses had been at its highest since 2015 (Centers for Disease Control and Prevention, 2021a). For MSM, the incidence of several sexually transmissible infections (STIs) has also been increasing in recent years (Centers for Disease Control and Prevention, 2021b). MSM who engage in collective sex are more likely than those who do not to be HIV positive and to report more sex partners, more instances of condomless anal sex, more recreational drug use, and more lifetime

[1]Department of Sociomedical Sciences, Columbia University Mailman School of Public Health, New York, NY, USA
[2]Department of Behavioral, Social, and Health Education Sciences, Emory University, Atlanta, GA, USA
[3]ProHealth, New York, NY, USA
[4]Department of Medicine, Division of Infectious Diseases, Icahn School of Medicine at Mount Sinai, New York, NY, USA
[5]Independent research
[6]Department of Community Health and Social Sciences, Graduate School of Public Health and Health Policy, City University of New York, New York, NY, USA
[7]Center for Ethics Education and Department of Psychology, Fordham University, Bronx, NY, USA

Corresponding Author:
Étienne Meunier, Department of Sociomedical Sciences, Columbia University Mailman School of Public Health, 722 West 168th Street 9th Fl., New York, NY 10032, USA.
Email: e.meunier@columbia.edu

and recent STI diagnoses (Grov et al., 2014c; Hirshfield et al., 2015; Kramer et al., 2016; Meunier & Siegel, 2019; Phillips et al., 2014, 2015; Prestage et al., 2011; Reisner et al., 2009; Rice et al., 2016a, 2016b; Rich et al., 2016; Smith et al., 2010; Solomon et al., 2011; Woods et al., 2000). A U.S.-wide online survey of MSM conducted in 2012 found that 69% had attended a sex party at least once and, of those, 66% had done so in the past year (Grov et al., 2014b). Although fewer data are available about transgender individuals' involvement in collective sex, they sometimes frequent the same events as MSM (Vines, 2020). As such, sexual-health services offered at collective sex venues could help decreasing HIV/STI incidence among sexual and gender minority populations.

On-site sexual-health services in collective sex venues have included the distribution of sexual-health information (Smith et al., 2010b; Woods et al., 2010), establishing safer-sex guidelines for venues (Grov et al., 2014a; Wohlfeiler, 2000; Wohlfeiler & Potterat, 2005; Woods et al., 2013), and on-site HIV/STI testing or counseling (Daskalakis et al., 2009; Debattista, 2015; Gallagher et al., 2014; Huebner et al., 2012; Mullens et al., 2020; Woods et al., 2008). Though their effectiveness has not been tested, on-site HIV testing programs have been able to identify higher rates of positive results or acute (recent) infections compared to clinical settings (Daskalakis et al., 2009; Mullens et al., 2020; Woods et al., 2000). However, some programs reported relatively low utilization (Debattista, 2015), and little is known about how attendees of collective sex venues perceive on-site sexual-health services. Further, most of these studies predate the implementation of biomedical HIV prevention strategies such as pre-exposure prophylaxis (PrEP) and treatment as prevention, which could change what types of interventions attendees would be receptive to.

Few data have been published about collective sex venue attendees' attitude toward the presence of on-site health workers. A qualitative study with MSM who attended sex parties found that 40% would find the presence of outreach workers acceptable at these events, despite concerns that it could be disruptive of the atmosphere (Mimiaga et al., 2010). In another survey, only 9.5% of sex-party attendees said they would like to see peer outreach workers at such events (Grov et al., 2014b). Nevertheless, a study of an on-site testing program at bathhouses found that the presence of outreach workers did not reduce the attendance or turn patrons away (Huebner et al., 2012). Researchers have emphasized the importance for sexual-health services at collective sex venues to enlist workers whose presence will not disrupt the erotic atmosphere of sex venues, such as peers (Mullens et al., 2020; Woods et al., 2008). However, to our knowledge, there have been no studies which examined preferences for peer characteristics or delivery strategies.

In the context of research studies or service provision, peers are individuals who share characteristics with the target population and operate according to specific protocols while not being trained as health professionals (Simoni, Franks, et al., 2011). Peers are often enlisted to provide services related to drug use or HIV in clinical or community settings, as the characteristics or experience they share with participants can improve the credibility or trustworthiness of a program (Callon et al., 2013; Safren et al., 2011). Several peer-delivered HIV interventions in developing countries have demonstrated better outcomes than those not involving peers (Medley et al., 2009; Simoni, Nelson, et al., 2011; Ye et al., 2014), and some have been successful among MSM in high-income countries (Shangani et al., 2017). For example, in a study examining the acceptability of an HIV testing site "run by and for gay men," the majority of participants said they preferred being tested by a peer than by a clinician, one reason being that they felt more comfortable discussing sexual behaviors with peers, whom they perceived as more understanding, less judgmental, and less prescriptive (Leitinger et al., 2018).

Other strengths of peer interventionists are how they can connect with people whom non-peers might have difficulty reaching, work in places that may not be accessible to professional personnel, and intervene at times when services are most needed (Bell et al., 2021; Marshall et al., 2015; Nyamathi et al., 2021; Simoni, Franks, et al., 2011). For instance, several interventions have enlisted peers to provide sexual-health education in gay male community settings (bars or gyms), which have been well-received by participants and venue managers (Elford et al., 2001; Flowers et al., 2002; Kelly et al., 1997; Miller et al., 1998). However, peers can face challenges when conducting outreach or education in such settings, often related to their dual roles as community member and interventionist. For example, some peer educators reported being uncomfortable approaching people to discuss sexual behaviors, which could be perceived as invasive or as a sexual advance (Elford et al., 2002; Flowers et al., 2002). They were also faced with the difficulty of maintaining confidentiality if they learned some people were putting others at risk (Elford et al., 2002). In two intervention studies, such challenges kept peer educators from interacting in depth with participants, which the researchers felt could have prevented the interventions from having significant effects (Elford et al., 2001; Flowers et al., 2002).

In New York City (NYC), due to current laws forbidding sexual activity in commercial establishments, collective sex mostly occurs in clandestine venues known in the community as "private sex parties" or "private sex

clubs" (Meunier & Escoffier, 2021). Emulating commercial sex venues, private sex clubs routinely hold sex parties that charge for admission and can host up to 200 attendees. Sex-party promoters often host events catering to specific subgroups of people, for instance, people of certain body types (e.g., athletic/muscular, or "Bear"), of certain demographics (e.g., parties for younger men, or parties for men of color), or people interested in specific practices (e.g., various types of fetishes). In recent years, some events that were traditionally reserved for cisgender gay/bisexual men have become inclusive of transgender and gender non-conforming individuals. As many of these venues are clandestine and reserve admission to specific groups, peers may be best positioned to access these settings and relate to the clientele.

Private sex clubs operate in limited space, which can pose challenges for the provision of sexual-health services. Upon entering, attendees are usually asked to check their clothing and, at the peak of a night, the space can host a dense crowd of nearly or fully nude guests (Meunier, 2014). Most clubs include a socialization area, in which some will serve drinks and/or provide entertainment such as DJs or performers. The areas for sexual activity are generally open and offer little privacy. As such, sexual-health services in private sex clubs may have to be delivered very close to the social and sexual activities of the venues, making boundaries difficult to maintain for peers. Nevertheless, sex club organizers are often dedicated to promoting sexual health and have been receptive to the provision of services at their venues (Blotcher, 1996; Daskalakis et al., 2009). Learning more about attitudes towards peer-delivered services among attendees of private sex clubs could help improve the effectiveness of sexual-health promotion at these types of collective sex venues.

In this article, we report on qualitative findings from a cross-sectional, multiple-method study on the acceptability of conducting on-site sexual-health promotion at NYC private sex clubs targeted to men and transgender or gender non-conforming individuals who have sex with men. Project aims were to investigate the attitudes of club attendees toward on-site services and about how to best deliver such services.

Methods

Participants and Recruitment

Recruitment and data collection procedures took place between May and October 2020. The initial study design intended to recruit participants at private sex clubs in NYC; however, as these venues stopped their activities due to the COVID-19 pandemic, recruitment was conducted online via paid advertisements on social media and dating/hookup applications, as well as emails sent by local sex-party promoters. Procedures included (1) a short screener questionnaire to recruit participants; (2) an online survey taken by all eligible participants (n = 342); and (3) in-depth qualitative interviews with a subset of survey participants (n = 30), which are the focus of this article.

Advertisements invited sexual and gender minority individuals who had visited collective sex venues to participate in a study about sexual health and redirected them to the screener questionnaire hosted on the web-based survey software Qualtrics. After reading the study's information sheet, potential participants were asked questions about their demographics and behaviors to determine eligibility. At the end of the screener, respondents were invited to provide an email address where they could receive the full survey if they were eligible for the study. Eligible participants had to (1) be at least 18 years old; (2) reside in the NYC Metropolitan Area on March 1, 2020 (this date was set anticipating that some NYC resident temporarily relocated due to the COVID-19 pandemic); (3) identify as a cisgender man or as a transgender, nonbinary, or gender non-conforming individual; (4) report having had sex with a male partner in the prior year; and (5) report having had sex, in the prior 12 months, in a collective sex venue (defined as a bathhouse, bar/nightclub, sex club, sex party, or adult video store/theater).

We emailed a unique (non-shareable) weblink to eligible screener respondents inviting them to complete the online survey for the study (of approximately 20 minutes), for which they would earn a $10 electronic gift card. The first page of the survey presented the study's informed consent form, and only participants who agreed to its terms could proceed with the survey. The form explained the confidentiality of participants' data was protected by relying on encrypted data storage and a Certificate of Confidentiality from the United States government protecting the study team from mandatory release of collected information. At the end of the survey, participants were asked if they would be willing to participate in an in-depth interview of approximately 90 minutes over the phone, for which they would receive an additional compensation of $50. A total of 724 potential participants completed the screener questionnaire and provided contact information to receive the full survey. There were 498 (68.8%) respondents who were determined to be eligible for the study and were sent a link to complete the full survey. Of those, 359 (72.1%) completed the survey but 17 were determined ineligible based on a validity check of their responses, yielding a final survey sample of 342.

Among the retained survey participants, 307 (89.8%) indicated willingness to participate in the in-depth interview. In consideration of budget restrictions and to ensure the diversity of the sample, we chose to interview 30

Table 1. Attitudes Towards Sexual Health Services at Collective Sex Venues Among Men, Transgender, and Gender Non-Conforming Individuals Who have Sex with Men and Attend Sex Venues in New York City (n = 342).[a]

	Entire Sample		Subset of Interviewed Participants			
	n	%	*n*	%		
	342	(100.0)	30	(100.0)	Mann–Whitney *U*	*p* value
It bothers me to see outreach workers at sex venues						
Strongly disagree	197	(57.6)	18	(60.0)	4371.00	.504
Somewhat disagree	40	(11.7)	6	(20.0)		
Neither agree nor disagree	65	(19.0)	4	(13.3)		
Somewhat agree	24	(7.0)	0	(0.0)		
Strongly agree	16	(4.7)	2	(6.7)		
Having outreach workers at sex venues is a good thing						
Strongly disagree	6	(1.8)	1	(3.3)	4107.00	.212
Somewhat disagree	11	(3.2)	2	(6.7)		
Neither agree nor disagree	42	(12.3)	3	(10.0)		
Somewhat agree	85	(24.9)	10	(33.3)		
Strongly agree	198	(57.9)	14	(46.7)		
Outreach workers should be LGBTQ individuals						
Strongly disagree	10	(2.9)	0	(0.0)	4545.00	.782
Somewhat disagree	17	(5.0)	3	(10.0)		
Neither agree nor disagree	65	(19.0)	1	(3.3)		
Somewhat agree	116	(33.9)	16	(53.3)		
Strongly agree	134	(39.2)	10	(33.3)		
Outreach workers at sex venues should wear as little clothing as everyone in the club						
Strongly disagree	44	(12.9)	5	(16.7)	4472.50	.675
Somewhat disagree	49	(14.3)	1	(3.3)		
Neither agree nor disagree	139	(40.6)	16	(53.3)		
Somewhat agree	72	(21.1)	8	(26.7)		
Strongly agree	38	(11.1)	0	(0.0)		
I am okay being approached by an outreach worker at sex venues						
Strongly disagree	16	(4.7)	1	(3.3)	4649.50	.951
Somewhat disagree	35	(10.2)	4	(13.3)		
Neither agree nor disagree	68	(19.9)	4	(13.3)		
Somewhat agree	112	(32.7)	12	(40.0)		
Strongly agree	111	(32.5)	9	(30.0)		
It is okay for an outreach worker to play with other people at sex venues						
Strongly disagree	59	(17.3)	4	(13.3)	4486.00	.701
Somewhat disagree	51	(14.9)	7	(23.3)		
Neither agree nor disagree	95	(27.8)	7	(23.3)		
Somewhat agree	65	(19.0)	8	(26.7)		
Strongly agree	72	(21.1)	4	(13.3)		

[a]The series of items was prefaced with the following: "Some sex venues have outreach workers offering sexual-health services and information (e.g., they may offer testing or information on where to get tested, how to get PrEP, etc.) How much do you agree or disagree with the following statements regarding sexual-health outreach at sex venues?"

participants representing various age groups, racial/ethnic identities, and gender identities, randomly selecting participants among each group. As the study aimed to examine the acceptability of sexual-health promotion at private sex clubs/parties, only participants who reported having attended these specific types of collective sex venues were invited to be interviewed (i.e., those who had only attended bathhouses, bars, or adult stores were not interviewed). To learn if the presence of on-site workers would be acceptable to attendees of different HIV status, we included participants who reported being HIV negative or HIV positive. However, among HIV-negative participants, we only

included those who were not using HIV PrEP daily, as they might benefit more from the program described below. Interview participants had to fill a second informed consent form specifying that the interview would be audio recorded but that the recording and transcripts would not be shared outside of the study team.

Questionnaires

The survey asked about demographics, sexual behaviors, sexual health, and collective sex venue attendance. It also included a series of items developed by the study team to assess attitudes towards the presence of outreach workers at collective sex venues (listed in Table 1).

During the in-depth interviews, participants were asked open-ended questions about their history of attending sex venues, the types of sex venues they attended, the types of behaviors in which they engaged at sex venues, and their experiences with sexual-health promotion at sex venues. Then, the interviewer described the following sexual-health promotion model:

> What would you think of a program where peer outreach workers could be present at events to provide information about sexual-health services in your area (such as free and convenient HIV and STI testing) and also provide info about PrEP and how to get it for free? Two outreach workers would be present in the social area of an event and could casually discuss the services with interested attendees. They could answer any questions attendees might have about PrEP and how to get PrEP for free. They could also schedule an appointment for them with a PrEP prescriber (with the help of a smartphone or tablet). The outreach workers would also be able to address other questions regarding HIV and STIs, such as how to get tested or get PEP.

After hearing the description, participants were asked whether they thought this program could be useful for themselves or others at private sex clubs, how they would feel about the presence of outreach workers at these venues, what type of person should conduct this outreach, what would be the best ways for outreach workers to interact with attendees, and what would be the impact of such a service for sex clubs/parties and their organizers. The interview guide is included as supplemental file.

The study procedures and instrument were developed in collaboration with a community advisory board composed of local sex-club organizers and representatives of community organizations who provided sexual-health services in collective sex venues in NYC. Prior to data collection, the board reviewed the study questionnaires and connected the team with other organizers who helped distribute the study recruitment ad. Then, board members helped with the interpretation of results and their dissemination to relevant community members. All study procedures were approved by the Institutional Review Board at Columbia University Irving Medical Center (Protocol #AAAS6360). All participants provided informed consent for the online survey prior to taking it. Then, participants invited to the qualitative subsample provided informed consent before doing their interview.

Analysis

We used descriptive statistics of the survey data to present the participant characteristics (presented in supplemental file 2) and attitudes towards on-site sexual-health promotion (Table 1) among both the entire survey sample and subset of interviewed participants. To assess whether the attitudes of the subsample of interview participants differed from those of the survey participants who were not interviewed, we conducted Mann–Whitney U tests comparing the mean rank of answers for each group (Table 1).

We used a qualitative descriptive approach to analyze interview data, aiming at presenting a thorough account of the views expressed by participants (Sandelowski, 2000). Qualitative interviews were audio recorded and transcribed, then analyzed using the application Dedoose Version 9. In a first round of analysis, members of the study team conducted structural coding by labeling all sections of the interview transcripts according to the major sections of the interview guide (MacQueen et al., 1998). Then, they examined the sections of interviews about the proposed sexual-health program.

Drawing on a qualitative content analysis strategy, the coding of these sections aimed at producing an exhaustive list of participants' responses organized into categories that best contained the data (Morgan, 1993; Morse, 2008). The coders independently read the excerpted text for a subset of cases and inductively created a categorization of the data. Then, they met to discuss their preliminary inductive coding and worked at establishing a common coding guide. Through an iterative process of code refinement, the team organized all attitudes expressed by participants into overarching and subordinate categories. Finally, they reviewed every excerpt to ensure agreement on the application of the codes for each case. Table 2 lists overarching and subordinate categories and a count of how many participants mentioned each perspective. For the results, the authors selected excerpts that were most representative of each category with an effort to present quotes from as many participants as possible.

Results

Identification of Sample

Supplemental File 2 presents the characteristics of participants for the entire survey sample (n = 342) and for the

Table 2. Categories of interview responses related to on-site sexual-health promotion services at private sex clubs among 30 interview participants.

	n[a]	%
Attitudes about offering on-site services		
Increased accessibility to services		
On-site services are convenient	11	(36.7)
Important for groups who are in need and/or hard-to-reach	16	(53.3)
Could be tailored to the needs of sex-club attendees		
Inform attendees of new prevention strategies	8	(26.7)
Can provide better advice than clinicians	6	(20.0)
Impact on perception of sex clubs		
Fosters positive and healthy environment	18	(60.0)
Shows organizers have good values	12	(40.0)
Preferred characteristics of service providers		
People of similar demographics	12	(40.0)
LGBTQ-identified people	12	(40.0)
People familiar with sex venues	11	(36.7)
Opinions about presentation and behaviors of providers		
Presentation of workers		
Should not be nude	8	(26.7)
Dress/undress as others in venue	15	(50.0)
Should be clearly identified as worker	14	(46.7)
Approach strategy		
Passive only (let attendees approach workers)	8	(26.7)
Workers approaching attendees is acceptable	11	(36.7)
Placement within clubs		
Should remain in outermost areas (e.g., door, lobby)	13	(43.4)
Should have a dedicated space inside clubs	7	(23.3)
Embedded in social area	10	(33.3)
Participation		
Should not participate in sexual activity	4	(13.3)
Participating in sexual activity is acceptable	9	(30.0)

[a]Number of interview participants (out of a total of 30) who expressed each opinion/attitude. Percentages within categories and subcategories do not add to 100 because categories are not mutually exclusive and participants did not have to state an opinion on each aspect.

subsample of interviewed participants (n = 30). The median age in the survey sample was 34 years old and was generally equivalent to the interview subsample. The proportion of participants identifying as non-Hispanic White was lower in the interview sample (53.5% vs. 59.1%) due to an effort to enhance racial/ethnic diversity. Similarly, 90.6% of the survey respondents identified as cisgender men while this proportion was 76.7% among interviewees. Specifically, three interview participants identified as transgender men, two as transgender women, and two as gender non-conforming (one of them reporting being assigned male sex at birth, and the other female). The socioeconomic status of the survey sample was overall high considering that 85.1% of participants had obtained a bachelor's or higher degree and 66.6% earned at least $50,000 in the prior year (proportions that were similar among interviewees).

A little over half of survey respondents (53.2%) reported being HIV negative and using PrEP daily; however, they were not included in the interview sample. Among interviewees, 63.3% reported being HIV negative and 36.7% reported being people with HIV. Two (11.8%) HIV-negative interviewees reported intermittent use of PrEP while the others were not currently using it. Nine (81.8%) of the 11 interviewees with HIV reported being virally suppressed or undetectable.

Attitudes Towards Sexual-Health Outreach Workers at Sex Venues

Table 1 provides the response distribution among survey and interview participants for the six survey items regarding attitudes towards sexual-health outreach workers at sex venues. Among the entire sample (n = 342), the first

two items indicate that the majority of participants found the presence of outreach workers acceptable: only 11.7% strongly/somewhat agreed that it would bother them to see outreach workers at sex venues, and only 5.0% strongly/somewhat disagreed that it is a good thing to have these workers there. Only 14.9% strongly/somewhat disagreed that it would be okay for an outreach worker to approach them at sex venues. The majority (73.1%) strongly/somewhat agreed that an outreach worker should be LGBTQ-identified. Attitudes were more varied regarding how outreach workers should present themselves and behave at sex venues. To the items asking whether outreach workers should wear as little clothing as others in the venues and whether it would be acceptable for them to participate in sexual activity, most participants selected "neither agree nor disagree," with similar proportions selecting strongly/somewhat disagree and agree.

Table 1 also presents the results of comparisons between the attitudes of the 30 participants who were interviewed and the 312 who were not. There were no statistically significant differences among the two groups for any of the attitudinal items, indicating that the views of participants who were not interviewed would likely be similar to those expressed by the subsample of interviewed participants.

In the in-depth interviews, participants further explained their thoughts about the proposed sexual-health service. We grouped the content of their responses into three overarching categories: (1) their attitudes about the provision of sexual-health services at sex clubs, (2) what types of people should deliver these services, and (3) how these workers should present themselves and interact at sex clubs. Categories and subcategories of participants' answers are presented in Table 2 and are further explained below.

Attitudes about Offering Sexual-Health Services. Consistent with the survey results, interview participants expressed positive views about on-site sexual-health services at private sex clubs. They could further describe the benefits of such services, which we organized in three categories: (1) that on-site outreach could increase accessibility to sexual-health services to those in need, (2) that the services could be tailored to the needs of sex-club attendees to be particularly relevant to them, and (3) that such a program could have a positive impact on their perceptions of sex clubs and their organizers.

Increased accessibility to services. Participants said they would appreciate the convenience of having sexual-health resources at sex clubs and thought that the program could be particularly beneficial to those who do not have easy access to such services. For instance, a strength of on-site outreach was that it would remove the burden of having to search for information about how to get PrEP or how to schedule a consultation.

> I think just the ability to get the information right away, get their appointments set up right away while they're thinking about it, rather than having to remember to do it when they get home. I think that's a good idea. There's got to be people at parties who want to get PrEP who don't have it. (30–39, White, transgender woman, HIV-negative)

Participants also felt that providing such on-site services could benefit the community by increasing access to healthcare: "I definitely think it would be helpful to others at parties. Especially people who don't have as much access to healthcare as I do. People who maybe are uninsured or don't have a regular PCP [primary care provider] that they see" (18–29, White, transgender man, HIV-negative).

Increased access could be particularly relevant to certain groups. For instance, the following participant explained that Black men are particularly affected by HIV and STIs and tend to have less access to healthcare, and thus would mostly benefit from an on-site program. Being HIV positive, he felt that such a service might have benefited him in the past.

> I know that if I had attended a party years before and there was somebody who was offering that service, I definitely would have used it, hands down. … Especially in Black communities… our communities aren't getting the access that they need. Black queer men are disproportionately affected by HIV and other STDs. … It would make me a little bit happy to see that because it's something that I would have benefited from, and it also promotes healthy sex practices and makes our communities a lot safer. (18–29, Black, cisgender man, HIV-positive)

On-site services could also be helpful to those who may not be comfortable discussing sexual health with their providers: "Someone who's 18, 19, 20 who may not be out to their families, may not feel comfortable going to their PCP and being like, 'Hey, I want to go on PrEP'" (18–29, Latino, cisgender man, HIV-negative). Even participants who already had access to the resources they needed regarding HIV and STIs felt that on-site services would benefit them by increasing access to sexual-health services among sex-club attendees.

> I would benefit by other people having the information, like people who are not connected to care to treatment. I think those people would benefit because then they have someone to talk to about these things. (30–39, White, cisgender man, HIV-positive)

Could be tailored to the specific needs of sex-club attendees. Another appeal of the on-site program is that it could be tailored to the specific needs of sex-club attendees. Participants felt like there were less-known prevention strategies—such as event-driven HIV PrEP (i.e., taken shortly before and after sex) (Molina et al., 2015) and antibiotic PrEP or post-exposure prophylaxis (PEP) for STIs (Molina et al., 2018)—that would be particularly relevant to sex-club attendees and could be promoted on site.

> Something that actually you don't hear anything about at all: the STI antibiotic that you take a couple hours prior, Doxy [doxycycline] PrEP. That would be something that I would be interested in finding out more about if it was provided at these events. (30–39, Multiracial, cisgender man, HIV-positive)

Being tailored to sex-club attendees, participants thought the program might provide information about prevention strategies that healthcare professionals in clinical settings are less likely to offer: "They'll probably know more than my regular doctor" (40–49, White, cisgender man, HIV-negative). For instance, the following participant had discussed HIV PrEP with his doctor but had never heard, prior to the interview, about the possibility of taking it intermittently.

> Because I've been prescribed PrEP by my doctor, I might not take the time to ask them questions. I assumed that I knew stuff, but I didn't know about intermittent PrEP. That's a really great thing to know and something I'm definitely going to look into after this phone call. (18–29, White, transgender man, HIV-negative)

Participants also felt like on-site services would allow for more thorough discussions about sexual health than in clinical settings. The following participant received sexual health services from their primary care provider and thought they might not benefit from linkage to care at sex venues. However, they felt that being able to discuss sexual health more broadly with someone in the space could benefit them.

> I go to my primary care provider for my testing regularly, so PrEP is accessible to me already. I think that answering questions about sexual health would be something valuable. I mean, I've been talking about what I perceive my risk factors are, but I definitely am not an expert and it's totally possible I'm not aware of something. I think having someone on site, it would be awesome. (30–39, White, gender non-conforming, HIV-negative)

Similarly, the following participant felt like on-site services could be particularly interesting if provided by peers who could share about their own experiences with prevention strategies such as PrEP.

> I think this would be really helpful to me. Maybe to hear about some people's experiences getting started on PrEP. I've only heard a couple of folks talk about having some stomach issues. Just like having some more clear understanding about that would be good. (18–29, White, transgender man, HIV-negative)

Impact on perceptions of sex clubs. Most participants thought they would have a positive view of sex clubs that provide on-site sexual-health services. One perspective was that these services would make venues feel safer: "I guess it would feel a lot safer. Like, 'Oh, this is a safe place'" (18–29, Latino, cisgender man, HIV-negative). Participants did not think that such a program would hinder the enjoyment of sex parties, but rather help doing so while remaining healthy.

> I think having someone like a health professional would give some of these events a little more… not validity, but it will make them safer. It would help people remember, like, "Yeah, we're here to have a good time, but we're also here to make sure that everyone is safe and healthy." They're here for us rather than against us. (18–29, White, cisgender man, HIV-negative)

Another participant expressed how an on-site program could help changing the negative and stigmatized perception of sex clubs as highly risky by promoting sexual health and pleasure: "They're there to promote sexual health and work with us rather than against us to remove stigma and promote pleasure" (30–39, Asian, cisgender man, HIV-negative).

Participants also indicated a sexual-health service would foster open conversations about the potential risks associated with sex-club attendance and how they could be mitigated. According to the following participant, acknowledging and discussing those risks could prevent people from feeling shameful about attending venues.

> If you have outreach workers there, it would only be a sign of this is great. We're not shaming ourselves for being sexual beings. We are out there and we're being aware of the fact that there are risks to that. Just like there are risks to driving a car, there are risks to having sex and we need to discuss those. (40–49, White, cisgender man, HIV-positive)

Participants also felt like offering sexual-health services would show how sex-club organizers care about the health of attendees and the community, and not simply about making money: "I think that that would actually make me feel more comfortable at the event because it

shows that the event cares about the community and wants people to have access to information that makes things safer" (18–29, White, transgender man, HIV-negative). Some participants felt that they would be more likely to go to places that offer such services, as it would show that the organizers care about their clientele.

> I would think that the organizer isn't only concerned about making money off my pleasure, desire, fantasies, but also cares about my health. I think it would make me want to go support that person because they're thinking about how I can have a better time. Because then that's one less thing for me to worry about when I'm there. I think when you're not worrying about those things, you can have a better time. (40–49, Black, cisgender man, HIV-negative)

No interview participants said they would be deterred from attending a sex club if it provided on-site sexual-health services. Though some participants thought there might be others who would be turned off by the services, they believed they would be wrong in feeling that way: "If people think that it's going to ruin the party, then they are wrong in thinking that" (18–29, White, cisgender man, HIV-negative).

Preferred Characteristics of Service Providers. Although participants felt that providing sexual-health services at sex clubs would be positive, they also described several conditions that should be met for such a program to be acceptable and successful. One such condition was to select the right people to deliver the services. Some participants emphasized the importance for the workers to be demographically similar to sex-party attendees, to identify as lesbian, gay, bisexual, transgender, or queer (LGBTQ), or to be familiar with sex clubs.

People of similar demographics. Participants recognized that different clubs/parties were popular among people of specific demographics. For some, it would be important for those providing sexual-health services to share such characteristics with the people attending the venues they would work at.

> They have to fit into the party, you know, a younger person falling within the same age group as the people who normally go to whatever party that is. It would have to be somebody else showing up to the party that happens in the city compared to the party that happens maybe in Brooklyn, because the age is different, the crowd is likely different. So, that person has to blend in to make everybody else comfortable. (40–49, Black, cisgender man, HIV-negative)

Similarly, another participant remarked that some parties are targeted towards specific racial/ethnic groups, and felt that it would be easier to reach out to people of similar demographics.

> The person needs to fit the party. Depending on the demographics of the party, the person should be in that demographic. Say it is a party for Latino men and within a certain age group or a demographic, the person should be within that demographic, because it's easier for you to reach persons that look like you. (40–49, Black, cisgender man, HIV-negative)

Other participants emphasized the importance of being of the same sex or gender as others at venues. For instance, for participants who went to clubs catering to gay men, the program would be less likely to interfere with the atmosphere of events if they were provided by men.

> It's a male-only type of place. So, in that specific situation, I guess it would have to be a man. Not that there's anything wrong with females, it's just that the vibe and atmosphere… it's like a place for men by men. So that would make sense if it was a guy. (18–29, Latino, cisgender man, HIV-negative)

LGBTQ-identified people. Corroborating the survey answers, participants also generally felt that the services should be provided by LGBTQ-identified individuals. Sharing this characteristic would allow workers to better relate to attendees: "I think that they should be LGBTQ. I feel like that adds a layer of understanding" (18–29, Latino, cisgender man, HIV-negative). Also, as expressed by the following participant, "straight" people's knowledge or perspective on sexual health might not be relevant to LGBTQ people, and their presence might be uncomfortable in a queer space.

> Honestly, if I'm at a queer party, I don't want someone that identifies as straight telling me about my sexual risks, especially given that my risks are going to be different. Having the knowledge of that is important. And also just feeling about the sort of boundaries of this space, you know? (30–39, White, gender non-conforming, HIV-negative)

People familiar with sex venues. Many participants also felt like it would be important for the people providing the services to have experience attending sex clubs. As expressed by the following participant, people who have never attended such venues could feel uncomfortable when entering the sexually charged atmosphere of sex clubs, which in turn could be awkward for attendees.

> These are venues where people are walking around naked having sex out in the open, doing all this sort of stuff, so I don't know exactly how comfortable outreach workers would be, being in the middle of that all night. And I don't really know how comfortable customers at these venues would feel around that as well. … It would definitely have to

> be someone who identifies within the community and someone who has been to these sorts of venues before who knows what they're getting themselves into walking through the door. (18–29, White, cisgender man, HIV-negative)

Other participants felt like the workers should be (or appear to be) people who would normally attend the sex clubs: "It shouldn't feel like an outsider in the party, because that'll make people uncomfortable. It should feel like somebody who would go anyway in their own time; they just happened to be doing their job, their work" (30–39, White, transgender man, HIV-negative). If the person appeared to be an outsider, it might make attendees feel judged, observed, or uncomfortable.

> If it's someone that belongs to these environments already, it will be great. You don't want to have someone that makes you feel judged for being there, like basically judged or observed. You need to feel like it's one of the people. (30–39, Latino, cisgender man, HIV-positive)

For such participants, experience with sex clubs would be what characterizes workers as peers: "Someone who kind of knows and is a part of the culture, so it would be more like a peer-to-peer thing rather than, you know, an authority" (30–39, Asian, cisgender man, HIV-negative). Another strength of people who attend sex clubs for providing services is that they would be more credible and better situated to provide advice about sexual health.

> Someone who is comfortable with that scene. Basically, she has maybe been to one of these before, knows the room, knows the vibe of the event. What's more important is that they know what they're talking about. (30–39, White, transgender woman, HIV-negative)

Opinions About Presentation and Behaviors of Providers. Like in the survey, interview participants expressed a range of views regarding how people providing on-site services should present themselves and behave in the space. At one end of the spectrum, some participants emphasized the importance for workers to maintain boundaries from attendees and the events' activity (e.g., they should be fully dressed, limit themselves to a dedicated space in the club, and not actively approach attendees); on the other, participants felt like workers should behave like any attendee (e.g., they could be undressed and actively approach people in the space).

Presentation of workers. A reason for wanting the workers to present themselves differently than attendees was to avoid any confusion about their reasons for being in the space. For instance, the participant below felt people could be misled or deceived if the workers were nude like others in the space.

> I think they should be fully dressed, just have that distinction… So that people know who's a worker and who's not, but also to keep it a little bit professional. For me, it would make me feel sort of sketchy to go up to somebody who was fully naked and start talking about, I don't know, HIV prevention services. Because then I'm like, "Oh, like, are you here for sex? Are you here to give me a service?" Like, it's just confusing to me. (18–29, Black, cisgender man, HIV-positive)

Similarly, another participant felt like workers should not try to fully blend in, and that they should wear something that makes their purpose in the space clear.

> Maybe wear a shirt or a badge or something that says what you are. I don't think you should be blending in, being there for the purpose of that. I think that's, even though your purpose is good and all, you want to be up front about who you are and why you're there. So, some type of identification should be good. (18–29, White, cisgender man, HIV-negative)

However, other participants felt that workers should not be strongly distinguished from attendees: "I wouldn't recommend having the uniform. They have to be able to blend in" (40–49, Black, cisgender man, HIV-negative). A reason to prefer workers to present themselves like others in the club would be to ensure that the services do not clash with the erotic atmosphere of the party. For instance, the following participant felt like he would be unlikely to engage with workers presenting themselves as health authorities, but that he would enjoy receiving health information from someone who fits with the atmosphere of the space.

> If I have someone approach me as I'm entering [name of party] that says, "Hi, I'm so and so from New York Department of Health," I don't want to talk to them. But if it's this tall, sexy guy in a harness, I might be interested in talking to them and being like fun and flirty with them, and hopefully get some helpful information out of it. (18–29, White, cisgender man, HIV-positive)

Presenting like other attendees would increase the feeling that the workers belong to the community: "Don't come dressed in no business suit and tie. Just come the way we're coming dressed for the club. Make us feel like you're us" (40–49, Black, cisgender man, HIV-positive). For example, the following participant was skeptical about the ability of people from the medical community to deliver care to queer and transgender people. The outreach workers being naked would make them come across as trusted peers.

> If they are undressed, it would feel like it's just more incorporated into the event and more trustworthy, in a way. Because, at least my experience with the medical community is that like they're learning… doctors are learning how to provide care to queer people and trans people, but they don't really understand. So, I have that suspicion or skepticism. When I think of the idea of seeing an outreach person at something like this event, I feel like I would want to make them seem as incorporated into the group as possible. (18–29, White, transgender woman, HIV-negative)

Placement within clubs and approach strategy. Participants also had different views regarding whether workers should actively approach attendees to offer services or wait to be approached. As expressed by the following participant, one reason against having workers directly approach people was that it could be a turn off for some attendees. He felt like club organizers could make attendees aware of the services before an event, and let attendees decide whether they want to approach the workers or not.

> I don't think I would necessarily want to be approached. I think they should just be present and visible, and have the attendee approach them as opposed to the other way around, especially since I feel like most people are coming there to have sex, not necessarily discuss sexual health. So, I think if someone was to approach them, that might kill the mood a little bit. But I think in all of the communication from new party promoters they should include a line being like, "As part of the sex party, we will also have onsite public sexual health representative at the event, if any of you are interested." (18–29, Black, cisgender man, HIV-positive)

Similarly, another participant felt like approaching attendees might feel like unwanted solicitation.

> I would not like to feel like something was being advertised or sold to me at a party like this. I would not want it to feel like when you're walking down the street and someone tries to get you to sign that petition. (30–39, White, gender non-conforming, HIV-negative)

Yet, other participants felt like the program would be more successful if workers engaged attendees more actively. Approaching people would be acceptable as long as workers do not observe or intrude on the sexual activity within the club.

> Be more engaging with people. I don't think those people would walk in there and sit there watching while you have sex. They stand by the door, but they should be more engaging with people. As soon as they come in or whatever, "Hey, my name is so and so, I know you're doing your thing, but hey, have you taken an HIV test?" Talk to them like that. (40–49, Black, cisgender man, HIV-positive)

Some participants thought that a way to prevent the program from ruining the atmosphere of parties would be to limit workers to the outermost areas of the clubs such as the lobby. They thought that attendees might be more willing to use services when they entered or exited the venues.

> It will be ideal to have a space dedicated for these, next to the register or something like that. Maybe on the social areas where the people are enjoying the party can be a little bit intrusive for the situation. Like, you don't want to be in the middle of enjoying yourself and have someone tell you, "Do you have five minutes to get an HIV test?" (30–39, Latino, cisgender man, HIV-positive)

In contrast, some participants such as the one below felt that being able to interact with the workers in the social area during the event would be interesting.

> I think that if it's in a really social area, like a place where like you're getting drinks and chatting, I think that having somebody just start to chat me up about PrEP and services, I think I'd be comfortable with that. … Not being behind the table. Somebody with a drink in their hand or something like that. That's something that I would say I'm pretty comfortable with. (30–39, White, cisgender man, HIV-negative)

However, participants who thought that it would be acceptable for workers to be inside the club and to approach attendees still described behaviors that would be inappropriate for the workers. As the following two participants said, scrutinizing or intruding on the sexual activity would be unacceptable.

> If it's in a social area, with no pad or whatever, I mean, they don't go up and say, "Oh, I just saw you having sex with that person. How do you feel about that?" That that would not be helpful. If they're in the common area or social area, I think that's completely acceptable. (40–49, White, cisgender man, HIV-positive)

> I mean, any way [to approach me] is appropriate, as long as they're not doing it offensively and they're not doing at a time that I'm actively engaging in something that could feel like they were interrupting me. (30–39, Black, cisgender man, HIV-positive)

Yet, there were some participants who felt like it would be appropriate for workers to behave following the typical norms of interaction of sex venues, even as they offered services to attendees. For example, the following

participant felt he would be okay with workers flirting with him as a way to approach him.

> If a social worker or someone at these venues were to see me sitting around and came up and, in a very flirtatious way, started the conversation, I would feel comfortable with them saying, “Nice boner, have you gotten tested?” I’d be fine with that. To me, that would be a perfectly acceptable interaction. Or for them to, you know, smile and wave and call me, beckoned me over and to then strike up a conversation that way. Or as I walked in say, “We have flyers about PrEP or Doxy PrEP, if you’re interested later.” They could accost me at the door in a fluffy kind of fun way, and I would be fine with that. (40–49, White, cisgender man, HIV-positive)

Participation. Finally, as with the survey results, interview participants expressed different views regarding whether the workers could participate in the sexual activity of parties or not. Staying separate from the social and sexual activities of the clubs could be a way to maintain a professional distance between workers and attendees, while participating would be a normal extension of their status as peers. Those against participation thought that it might be an obstacle to the delivery of services.

> That’s the person themselves… if they would like to do something like that [have sex], that would be interesting because they’re there for one thing, but seeing them participate in it… I don’t know. That would just be very interesting to see, because like I said, they’re there to promote a certain information. Seeing them partying would probably be a little bit at a slight disadvantage to what they’re there for. (30–39, Multiracial, cisgender man, HIV-positive)

However, if peer workers were recruited from within the community of people attending sex clubs, it could be understandable that they also participate. For the following participant, the appropriateness of workers participating in the sexual activity depended on their status within the community.

> If it’s somebody who’s volunteering for the party, like let’s say for example, “Hey, come volunteer to come talk about Doxy and you’ll get a free ticket out of it,” yeah, that [participating in sexual activity] is okay. But if it’s like a healthcare worker, no, that’s not okay. (18–29, White, cisgender man, HIV-positive)

Another perspective was that the workers should be viewed like any other staff person at the clubs. As the following participant said, people working at parties routinely took breaks to participate in the sexual activity. Thus, the outreach workers, if they were truly peers, should be able to do the same.

> Anyone that works can take a break to do whatever they want to do, whether it’s go get a sandwich or have sex. I don’t care. Maybe it can even be a good thing. Because it would just add to the feeling that they’re not like outside people coming in to tell us what to do or kind of help us or save us from ourselves or something. But that they were actually like members of the community who are participating because they think that the thing is valuable and like it, and that they are just also people who work in public health. (30–39, White, transgender man, HIV-negative)

Discussion

Although studies have documented sexual-health services at collective sex venues for MSM (Daskalakis et al., 2009; Debattista, 2015; Gallagher et al., 2014; Huebner et al., 2012; Mullens et al., 2020; Woods et al., 2008), little has been published about how attendees perceive such programs. In this study, we found on-site sexual-health services to be highly acceptable among men and transgender and gender non-conforming individuals who have sex with men and who attend collective sex venues in NYC. These results contrast with prior studies of MSM who attend sex venues; for instance, a study had found that only 9.5% of a U.S. sample of MSM who attended sex parties would like to see peer outreach workers at sex parties (Grov et al., 2014b). Similarly, Mimiaga et al. reported that only 30% of their sample of sex-party attendees in Massachusetts would find on-site HIV/STI testing or counseling to be acceptable (Mimiaga et al., 2010). Yet, the vast majority of our survey participants felt that on-site services were a good thing and that they would not be bothered by the presence of outreach workers. This difference in attitude might be explained by how sexual-health promotion has changed in the 8–12 years that have elapsed since the studies cited above. With the advent of “New Prevention Technologies” (Klassen et al., 2017) such as PrEP and treatment as prevention, HIV/STI prevention has shifted away from promoting condom use and few sex partners toward emphasizing the importance of testing and treatment (Cortopassi et al., 2019). As shown with the interview data, our participants thought on-site services would benefit their community by increasing access to PrEP and sexual-health resources. In contrast, sex-venue attendees from 10 years ago might have perceived an intervention as aimed to change their sexual behaviors. In the era of biomedical HIV prevention, sex-venue attendees might thus have a different view on the benefits of on-site sexual-health services.

Public health researchers have also been skeptical of the possibility for on-site services to be successful. One concern has been that the private and clandestine nature of many collective sex venues might make the presence of interventionists undesirable (Grov et al., 2014b). There

have also been concerns that HIV/STI prevention interventions at these venues might unintentionally label these sites as high-risk, and be perceived as stigmatizing by attendees (Frank, 2019; Hirshfield et al., 2015). Our study found the contrary: interview participants felt that conducting sexual-health promotion at these venues would be positive because it would emphasize that venues can be safe, potentially reducing the stigma attached to them. By providing sexual-health services, participants also felt that sex-venue organizers would display values of care and responsibility towards the community's wellbeing, which aligns with a recent study with LGBTQ individuals in NYC that emphasized the importance of mobilizing community strengths for health promotion with LGBTQ populations (Hudson & Romanelli, 2020). Participants conveyed that the benefits of on-site sexual-health promotion would outweigh potential negative impacts for sex venues. These findings should thus encourage public health workers to keep developing sexual-health interventions in sex venues.

Though they were generally positive about potential on-site sexual-health services, participants underscored the importance that peers deliver them. There are reports of peer-delivered on-site HIV/STI testing programs at collective sex venues (Mullens et al., 2020; Strömdahl et al., 2019); however, as is common in publications on peer work (Simoni, Franks, et al., 2011), these studies have not defined what characterized these workers as peers, or how these characteristics benefited the interventions. In our study, participants described how sharing demographics (i.e., age, race/ethnicity, or gender) with attendees would ensure workers do not stand out in a way that would be uncomfortable. Participants also felt that peers should share sexual or gender identities with attendees to enhance the credibility and trust of the program. For instance, some participants felt that heterosexual workers might not be appropriate to advise on sexual health to LGBTQ attendees. Transgender participants also stressed the importance of including peers who also identify as transgender or are aware of their distinct circumstances, which they felt was rarely the case among healthcare providers. Finally, many participants felt that peers who attend sex clubs would be the ablest at providing sexual-health guidance among attendees. They were also concerned that workers unfamiliar with these venues would be uncomfortable in the sexual setting, which could negatively impact the atmosphere. These findings indicate that people who qualify as peers in one sex venue may not do so at others. As every collective sex venue or event caters to different clienteles, peer-led services cannot be one-size-fits-all, and efforts should be made to understand who qualifies as a peer in each site.

Conducting peer work about sexual health comes with challenges regarding the boundaries between peer and participant, and how peers can navigate their dual membership as workers and community members (Elford et al., 2002; Flowers et al., 2002). Both in the survey and interviews, participants displayed a range of perspectives about how workers should present themselves and behave in collective sex venues. Rather than revealing disagreement in the population, these differences might be because participants envisioned different modalities of peer work. Indeed, the program presented to interview participants was not fully defined, allowing them to describe the modalities that they would find most acceptable. Some participants might have viewed the program as "peer outreach," while others saw it along a "popular opinion leader" model (Simoni, Nelson, et al., 2011), differences we further describe below.

Participants who thought peer workers should remain dressed, stay in the outermost areas of venues, not actively approach attendees, and not participate in the sexual activity of the venues might have envisioned the service along the "peer outreach" modality, in which peers bridge existing clinical services and resources with people in community settings (Simoni, Nelson, et al., 2011). This model was the one used in documented peer work at sex venues where peers, though they shared characteristics with attendees (e.g., demographics and sexual identity), maintained boundaries from them, for instance, by wearing clothes identifying them with their organization (Debattista, 2015; Mullens et al., 2020). As workers conducting peer outreach are often connected with health organizations, they can be expected (both by their organization and attendees) to maintain a professional boundary from others at sex venues. Participants in our study recognized the value of peer outreach, but generally felt like these peers should be clearly identified as a worker and make themselves discreet at sex venues to prevent being disruptive of the atmosphere and to avoid what could be interpreted as solicitation or deception. Although this model would be acceptable to attendees, the strategy to not reach out to attendees but let them do so could lead to the services being underutilized.

Participants who thought peer workers should also be attendees of sex clubs and be able to participate in parties seemed to favor a "popular opinion leader" type of intervention. Such interventions enlist people who are influential in their communities but who are not associated with health organizations, and train them to provide information to their peers aiming to change specific health outcomes (Simoni, Nelson, et al., 2011). Though we do not know if popular opinion leader interventions have been done within collective sex venues, they have been conducted in gay bars and gyms in urban communities in the US and the UK (Elford et al., 2001; Flowers et al., 2002; Kelly et al., 1997). Interviewees in our study seemed to think that a sexual-health service could be more

engaging by having peers interact with attendees within sex clubs. Being regular attendees of sex venues, these peers would be better suited to advise on sexual-health matters relevant to other attendees, could appear more trustworthy, and their presence would not be disruptive. However, their dual role as venue attendee and peer worker might be challenging to reconcile. Indeed, some participants in this study felt like peer workers should avoid any potential confusion in their intentions when they interact with attendees.

Findings from this study should be viewed considering some limitations. This study relied on a convenience sample and participants self-enrolled via online advertisements posted on social media, hookup apps, and emails from party promoters. Individuals who engage in collective sex but who do not use these online venues are thus not represented in this study and the findings cannot be generalized to the population of men and transgender or gender non-conforming individuals participating in collective sex. Findings are locally specific to NYC and may not apply to other locales where collective sex may happen in different types of venues. Further, individuals who volunteer to participate in a public health study might hold more favorable attitudes towards sexual-health promotion work than those who do not. It is thus possible that individuals who might hold more pessimistic views on peer-led services have been underrepresented in this study. The monetary compensation that participants earned for participating in the survey and interview could also bias the sample by encouraging participation from those who benefit more from it. Social desirability bias could have affected the interviewing process: interviewees might have felt like it was more appropriate to discuss the positive aspects of the proposed sexual-health program during their conversations with interviewers. However, the attitudes expressed by the interview subsample were concordant with responses on the attitudinal items on the online survey, which was confidential and self-administered, and thus less subject to social desirability bias.

Despite limitations, this study found high acceptability of peer-led sexual-health promotion programs in collective sex venues among a sample of sexual and gender minority attendees of such venues in NYC. Considering the high burden of HIV and STIs among this population, developing on-site services such as the ones presented to participants of this study could present important benefits to the public health. Though our study focused on HIV/STI prevention, collective sex venues might also be strategic places to promote other types of health services, such as substance use harm reduction, mental health, or primary care. Results showed that different approaches to peer-led interventions could be acceptable at collective sex venues. The most appropriate modality might vary depending on the desired outcome of an intervention and the target population. Those who want to develop such programs should work closely with stakeholders such as sex-venue attendees and organizers to design services tailored to the specific groups they want to reach. Although further research is needed about sex-venue organizers' attitudes on the topic, findings from this study could help enlisting their support in the development of on-site services. Interview participants in this study had all attended private sex clubs, but the survey sample also included participants who had only attended other types of collective sex venues (e.g., bathhouses and adult stores). Although interviewees spoke about on-site services in the specific setting of private sex clubs, survey results indicate that these services are also acceptable in other types of venues. Future studies could try to assess the effectiveness of different peer-intervention modalities in various collective sex settings.

Authors' Contribution

The study was designed by ÉM under the mentorship of CBF. All authors contributed to the development of the questionnaires. Data collection and coding was done by ÉM, DA, and ST, but all coauthors contributed to interpretation of findings. ÉM wrote the majority of the manuscript with contribution by all coauthors.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This study was supported by a subaward (to Étienne Meunier) from the Fordham HIV and Drug Abuse Prevention Research Ethics Training Institute (RETI), a training grant sponsored by the National Institute on Drug Abuse (R25-DA031608, PI: Celia B. Fisher).

Ethical Approval

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. The study was approved by the Institutional Review Board at Columbia University Irving Medical Center (Protocol #AAAS6360).

Informed Consent

Informed consent was obtained from all individual participants included in the study.

ORCID iD

Étienne Meunier https://orcid.org/0000-0002-2810-8633

Supplemental Material

Supplemental Material for this article is available online.

References

Bell, S., Aggleton, P., Lockyer, A., Ferguson, T., Murray, W., Silver, B., Kaldor, J., Maher, L., & Ward, J. (2021). Working with aboriginal young people in sexual health research: A peer research methodology in remote Australia. *Qualitative Health Research*, *31*(1), 16–28. https://doi.org/10.1177/1049732320961348

Blotcher, J. (1996). Sex club owners. In E. G. Colter, W. Hoffman, E. Pendleton, A. Redick, & D. Serlin (Eds.), *Policing public sex: Queer politics and the future of AIDS activism* (pp. 25–44). South End Press.

Callon, C., Charles, G., Alexander, R., Small, W., & Kerr, T. (2013). 'On the same level': Facilitators' experiences running a drug user-led safer injecting education campaign. *Harm Reduction Journal*, *10*(1), 4. https://doi.org/10.1186/1477-7517-10-4

Centers for Disease Control and Prevention (2021a). *HIV surveillance report, 2019*. (No. 32; HIV Surveillance Special Report). https://www.cdc.gov/hiv/library/reports/hiv-surveillance.html

Centers for Disease Control and Prevention (2021b). *Sexually transmitted disease surveillance 2019*. U.S. Department of Health and Human Services. https://www.cdc.gov/std/statistics/2019/default.htm

Cortopassi, A. C., Driver, R., Eaton, L. A., & Kalichman, S. C. (2019). A new era of HIV risk: It's not what you know, it's who you know (and how infectious). *Annual Review of Psychology*, *70*(1), 673–701. https://doi.org/10.1146/annurev-psych-010418-102927

Daskalakis, D., Silvera, R., Bernstein, K., Stein, D., Hagerty, R., Hutt, R., Maillard, A., Borkowsky, W., Aberg, J., Valentine, F., & Marmor, M. (2009). Implementation of HIV testing at 2 New York City bathhouses: from pilot to clinical service. *Clin Infect Dis*, *48*(11), 1609–16. https://doi.org/10.1086/598979

Debattista, J. (2015). Health promotion within a sex on premises venue: Notes from the field. *International Journal of STD & AIDS*, *26*(14), 1017–1021. https://doi.org/10.1177/0956462414568395

Elford, J., Bolding, G., & Sherr, L. (2001). Peer education has no significant impact on HIV risk behaviours among gay men in London. [Letter]. *AIDS*, *15*(4), 535–538. https://doi.org/10.1097/00002030-200103090-00018

Elford, J., Sherr, L., Bolding, G., Serle, F., & Maguire, M. (2002). Peer-led HIV prevention among gay men in London: Process evaluation. *AIDS Care*, *14*(3), 351–360. https://doi.org/10.1080/09540120220123739

Flowers, P., Hart, G. J., Williamson, L. M., Frankis, J. S., & Der, G. J. (2002). Does bar-based, peer-led sexual health promotion have a community-level effect amongst gay men in Scotland? *International Journal of STD & AIDS*, *13*(2), 102–108. https://doi.org/10.1258/0956462021924721

Frank, K. (2019). Rethinking risk, culture, and intervention in collective sex environments. *Archives of Sexual Behavior*, *48*(1), 3–30. https://doi.org/10.1007/s10508-018-1153-3

Gallagher, T., Link, L., Ramos, M., Bottger, E., Aberg, J., & Daskalakis, D. (2014). Self-perception of HIV risk and candidacy for pre-exposure prophylaxis among men who have sex with men testing for HIV at commercial sex venues in New York City. *LGBT Health*, *1*(3), 218–224. https://doi.org/10.1089/lgbt.2013.0046

Grov, C., Cruz, J., & Parsons, J. T. (2014a). Men who have sex with men's attitudes toward using color-coded wristbands to facilitate sexual communication at sex parties. *Sex Res Social Policy*, *11*(1), 11–19. https://doi.org/10.1007/s13178-014-0145-x

Grov, C, Rendina, H. J., Breslow, A. S., Ventuneac, A., Adelson, S., & Parsons, J. T. (2014b). Characteristics of men who have sex with men (MSM) who attend sex parties: results from a national online sample in the USA. *Sex Transm Infect*, *90*(1), 26–32. https://doi.org/10.1136/sextrans-2013-051094

Grov, C., Rendina, H. J., Ventuneac, A., & Parsons, J. T. (2014c). Partners met via sex parties present significantly greater odds for condomless anal sex among MSM: an event-level analysis of venues where male partners are met. *J Acquir Immune Defic Syndr*, *67*(5), 564–8. https://doi.org/10.1097/QAI.0000000000000343

Hirshfield, S., Schrimshaw, E. W., Stall, R. D., Margolis, A. D., Downing, M. J., & Chiasson, M. A. (2015). Drug use, sexual risk, and syndemic production among men Who have sex with men who engage in group sexual encounters. *American Journal of Public Health*, *105*(9), 1849–1858. https://doi.org/10.2105/AJPH.2014.302346

Hudson, K. D., & Romanelli, M. (2020). We are powerful people": Health-promoting strengths of LGBTQ communities of color. *Qualitative Health Research*, *30*(8), 1156–1170. https://doi.org/10.1177/1049732319837572

Huebner, D. M., Binson, D., Pollack, L. M., & Woods, W. J. (2012). Implementing bathhouse-based voluntary counselling and testing has no adverse effect on bathhouse patronage among men who have sex with men. *International Journal of STD & AIDS*, *23*(3), 182–184. https://doi.org/10.1258/ijsa.2009.009318

Kelly, J. A., Murphy, D. A., Sikkema, K. J., McAuliffe, T. L., Roffman, R. A., Solomon, L. J., Winett, R. A., & Kalichman, S. C. (1997). Randomised, controlled, community-level HIV-prevention intervention for sexual-risk behaviour among homosexual men in US cities. Community HIV prevention research collaborative. *Lancet (London, England)*, *350*(9090), 1500–1505. https://doi.org/10.1016/s0140-6736(97)07439-4

Klassen, B. J., Lachowsky, N. J., Lin, S. Y., Edward, J. B., Chown, S. A., Hogg, R. S., Moore, D. M., & Roth, E. A. (2017). Gay men's understanding and education of new HIV prevention technologies in Vancouver, Canada. *Qualitative Health Research*, *27*(12), 1775–1791. https://doi.org/10.1177/1049732317716419

Kramer, S. C., Schmidt, A. J., Berg, R. C., Furegato, M., Hospers, H., Folch, C., & Marcus, U., EMIS Network (2016). Factors associated with unprotected anal sex with multiple non-steady partners in the past 12 months: Results from the European men-who-have-sex-with-men internet survey (EMIS 2010). *BMC Public Health*, *16*(1), 47. https://doi.org/10.1186/s12889-016-2691-z

Leitinger, D., Ryan, K. E., Brown, G., Pedrana, A., Wilkinson, A. L., Ryan, C., Hellard, M., & Stoové, M. (2018). Acceptability and HIV prevention benefits of a peer-based model of rapid point of care HIV testing for Australian gay, bisexual and other men who have sex with men. *AIDS and Behavior*, *22*(1), 178–189. https://doi.org/10.1007/s10461-017-1888-1

MacQueen, K. M., McLellan, E., Kay, K., & Milstein, B. (1998). Codebook development for team-based qualitative analysis. *CAM Journal*, *10*(2), 31–36. https://doi.org/10.1177/1525822X980100020301

Marshall, Z., Dechman, M. K., Minichiello, A., Alcock, L., & Harris, G. E. (2015). Peering into the literature: A systematic review of the roles of people who inject drugs in harm reduction initiatives. *Drug and Alcohol Dependence*, *151*, 1–14. https://doi.org/10.1016/j.drugalcdep.2015.03.002

Medley, A., Kennedy, C., O'Reilly, K., & Sweat, M. (2009). Effectiveness of peer education interventions for HIV prevention in developing countries: A systematic review and meta-analysis. *AIDS Education and Prevention*, *21*(3), 181–206. https://doi.org/10.1521/aeap.2009.21.3.181

Meunier, É. (2014). No attitude, no standing around: the organization of social and sexual interaction at a gay male private sex party in New York city. *Arch Sex Behav*, *43*(4), 685–95. https://doi.org/10.1007/s10508-013-0182-1

Meunier, É., & Escoffier, J. (2021). The Triumph of Collective Intimacy—Gay Collective Sex in New York City from the Late 1800s to Today. In Christopher T. Conner & Daniel Okamura (Eds.), *The Gayborhood: From Sexual Liberation to Cosmopolitan Spectacle* (pp. 85–106). Lanham, MD: Rowman & Littlefield Publishers.

Meunier, É., Escoffier, J., & Siegel, K. (2019). Rethinking Risks and Interventions Beyond HIV: The Importance of Contextualizing Collective Sex. *Arch Sex Behav*, *48*(1), 51–56. https://doi.org/10.1007/s10508-018-1214-7

Meunier, É., & Siegel, K. (2019). Sex club/party attendance and STI among men who have sex with men: results from an online survey in New York City. *Sex Transm Infect*, *95*(8), 584–587. https://doi.org/10.1136/sextrans-2018-053816

Miller, R. L., Klotz, D., & Eckholdt, H. M. (1998). HIV prevention with male prostitutes and patrons of hustler bars: Replication of an HIV preventive intervention. *American Journal of Community Psychology*, *26*(1), 97–131. https://doi.org/10.1023/a:1021886208524

Mimiaga, M. J., Reisner, S. L., Bland, S., Cranston, K., Isenberg, D., Driscoll, M. A., VanDerwarker, R., & Mayer, K. H. (2010). It's a quick way to get what you want": A formative exploration of HIV risk among urban Massachusetts men who have sex with men who attend sex parties. *AIDS Patient Care & STDs*, *24*(10), 659–674. https://doi.org/10.1089/apc.2010.0071

Molina, J.-M., Capitant, C., Spire, B., Pialoux, G., Cotte, L., Charreau, I., Tremblay, C., Le Gall, J.-M., Cua, E., Pasquet, A., Raffi, F., Pintado, C., Chidiac, C., Chas, J., Charbonneau, P., Delaugerre, C., Suzan-Monti, M., Loze, B., & Fonsart, J., ANRS IPERGAY Study Group (2015). On-demand preexposure prophylaxis in men at high risk for HIV-1 infection. *New England Journal of Medicine*, *373*(23), 2237–2246. https://doi.org/10.1056/NEJMoa1506273

Molina, J.-M., Charreau, I., Chidiac, C., Pialoux, G., Cua, E., Delaugerre, C., Capitant, C., Rojas-Castro, D., Fonsart, J., Bercot, B., Bébéar, C., Cotte, L., Robineau, O., Raffi, F., Charbonneau, P., Aslan, A., Chas, J., Niedbalski, L., & Spire, B., ANRS IPERGAY Study Group (2018). Post-exposure prophylaxis with doxycycline to prevent sexually transmitted infections in men who have sex with men: An open-label randomised substudy of the ANRS IPERGAY trial. *The Lancet Infectious Diseases*, *18*(3), 308–317. https://doi.org/10.1016/S1473-3099(17)30725-9

Morgan, D. L. (1993). Qualitative content analysis: A guide to paths not taken. *Qualitative Health Research*, *3*(1), 112–121. https://doi.org/10.1177/104973239300300107

Morse, J. M. (2008). Confusing categories and themes. *Qualitative Health Research*, *18*(6), 727–728. https://doi.org/10.1177/1049732308314930

Mullens, A. B., Daken, K., Lemoire, J., Brownlow, C., Driver, G., & Gow, J. (2020). HIV Point of Care Testing (PoCT) at late-night Sex on Premises Venues (SOPV) for Gay and Bisexual Men and Other Men Who Have Sex with Men (GBMSM): A mixed methods analysis. *AIDS and Behavior*, *24*(2), 450–466. https://doi.org/10.1007/s10461-019-02500-0

Nyamathi, A. M., Wall, S. A., Yadav, K., Shin, S. S., Chang, A., Arce, N., Cuellar, H., Fernando, S., White, K., Gelberg, L., & Salem, B. E. (2021). Engaging the community in designing a hepatitis C virus treatment program for adults experiencing homelessness. *Qualitative Health Research*, *31*(11), 2069–2083. https://doi.org/10.1177/10497323211021782

Phillips, G., Grov, C., & Mustanski, B. (2015). Engagement in group sex among geosocial networking mobile application-using men who have sex with men. *Sex Health*, *12*(6), 495–500. https://doi.org/10.1071/SH15108

Phillips, G., Magnus, M., Kuo, I., Rawls, A., Peterson, J., West-Ojo, T., Jia, Y., Opoku, J., & Greenberg, A. E. (2014). Correlates of group sex among a community-based sample of men who have sex with men (MSM) in Washington, DC. *AIDS and Behavior*, *18*(8), 1413–1419. https://doi.org/10.1007/s10461-013-0527-8

Prestage, G., Down, I., Grulich, A., & Zablotska, I. (2011). Sex partying among gay men in Sydney, Melbourne and Brisbane, Australia. *AIDS and Behavior*, *15*(2), 298–304. https://doi.org/10.1007/s10461-010-9824-7

Reisner, S. L., Mimiaga, M. J., Skeer, M., VanDerwarker, R., Gaucher, M. J., O'Connor, C. A., Medeiros, M. S., & Safren, S. A. (2009). Differential HIV risk behavior among men who have sex with men seeking health-related mobile van services at diverse gay-specific venues. *AIDS and Behavior*, *13*(4), 822–831. https://doi.org/10.1007/s10461-008-9430-0

Rice, C. E., Lynch, C. D., Norris, A. H., Davis, J. A., Fields, K. S., Ervin, M., & Turner, A. N. (2016a). Group sex and prevalent sexually transmitted infections among men who have sex with men. *Archives of Sexual Behavior*, *45*(6), 1411–1419. https://doi.org/10.1007/s10508-015-0554-9

Rice, C. E., Maierhofer, C., Fields, K. S., Ervin, M., Lanza, S. T., & Turner, A. N. (2016b). Beyond anal sex: Sexual practices of men who have sex with men and associations with HIV and other sexually transmitted infections. *The Journal of Sexual Medicine*, *13*(3), 374–382. https://doi.org/10.1016/j.jsxm.2016.01.001

Rich, A. J., Lachowsky, N. J., Cui, Z., Sereda, P., Lal, A., Birch, R., Montaner, J., Moore, D., Hogg, R. S., & Roth, E. A. (2016). Substance use, sexual behaviour and prevention strategies of Vancouver gay and bisexual men who recently attended group sex events. *Culture, Health & Sexuality*, *18*(4), 361–376. https://doi.org/10.1080/13691058.2015.1084649

Safren, S. A., O'Cleirigh, C., Skeer, M. R., Driskell, J., Goshe, B. M., Covahey, C., & Mayer, K. H. (2011). Demonstration and evaluation of a peer-delivered, individually-tailored, HIV prevention intervention for HIV-infected MSM in their primary care setting. *AIDS and Behavior*, *15*(5), 949–958. https://doi.org/10.1007/s10461-010-9807-8

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing & Health*, *23*(4), 334–340. https://doi.org/10.1002/1098-240X(200008)23:4<334::AID-NUR9>3.0.CO;2-G

Shangani, S., Escudero, D., Kirwa, K., Harrison, A., Marshall, B., & Operario, D. (2017). Effectiveness of peer-led interventions to increase HIV testing among men who have sex with men: A systematic review and meta-analysis. *AIDS Care*, *29*(8), 1003–1013. https://doi.org/10.1080/09540121.2017.1282105

Simoni, J. M., Franks, J. C., Lehavot, K., & Yard, S. S. (2011a). Peer interventions to promote health: Conceptual considerations. *The American Journal of Orthopsychiatry*, *81*(3), 351–359. https://doi.org/10.1111/j.1939-0025.2011.01103.x

Simoni, J. M., Nelson, K. M., Franks, J. C., Yard, S. S., & Lehavot, K. (2011b). Are peer interventions for HIV efficacious? A systematic review. *AIDS and Behavior*, *15*(8), 1589–1595. https://doi.org/10.1007/s10461-011-9963-5

Smith, A. M. A., Grierson, J. W., & von Doussa, H. (2010a). Gay men's sex venues, the men who use them, and gay community perceptions: Insights from a convenience sample of gay men attending a community festival in Melbourne. *Sexual Health*, *7*(2), 177–181. https://doi.org/10.1071/SH09055

Smith, A. M. A., Grierson, J. W., & von Doussa, H. (2010b). Understanding gay men's sex venues as sites for sexual health promotion. *Sexual Health*, *7*(2), 182–185. https://doi.org/10.1071/SH09050

Solomon, T. M., Halkitis, P. N., Moeller, R. M., Siconolfi, D. E., Kiang, M. V., & Barton, S. C. (2011). Sex parties among young gay, bisexual, and other men who have sex with men in New York City: Attendance and behavior. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, *88*(6), 1063–1075. https://doi.org/10.1007/s11524-011-9590-5

Strömdahl, S., Hoijer, J., & Eriksen, J. (2019). Uptake of peer-led venue-based HIV testing sites in Sweden aimed at men who have sex with men (MSM) and trans persons: A cross-sectional survey. *Sexually Transmitted Infections*, *95*(8), 575–579. https://doi.org/10.1136/sextrans-2019-054007

Vines, B. (2020, March 17). Lessons of AIDS in mind as queer sex party industry reacts to coronavirus. *City Limits*. https://citylimits.org/2020/03/17/lessons-of-aids-in-mind-as-queer-sex-party-industry-reacts-to-coronavirus/.

Wohlfeiler, D. (2000). Structural and environmental HIV prevention for gay and bisexual men. *AIDS (London, England)*, *14*(Suppl 1), S52–S56. https://doi.org/10.1097/00002030-200006001-00008

Wohlfeiler, D., & Potterat, J. J. (2005). Using gay men's sexual networks to reduce sexually transmitted disease (STD)/human immunodeficiency virus (HIV) transmission. *Sexually Transmitted Diseases*, *32*(10 Suppl), S48–S52. https://doi.org/10.1097/01.olq.0000175394.81945.68

Woods, W. J., Erwin, K., Lazarus, M., Serice, H., Grinstead, O., & Binson, D. (2008). Building stakeholder partnerships for an on-site HIV testing programme. *Culture, Health & Sexuality*, *10*(3), 249–262. https://doi.org/10.1080/13691050701793806

Woods, W. J., Euren, J., Pollack, L. M., & Binson, D. (2010). HIV prevention in gay bathhouses and sex clubs across the United States. *Journal of Acquired Immune Deficiency Syndromes (1999)*, *55*(Suppl 2), S88–S90. https://doi.org/10.1097/QAI.0b013e3181fbca1b

Woods, W. J., Sabatino, J., Bauer, P. L., Adler, B., Dilley, J. W., & Binson, D. (2000). HIV testing in gay sex clubs.

International Journal of STD & AIDS, *11*(3), 173–175. https://doi.org/10.1258/0956462001915633

Woods, W. J., Sheon, N., Morris, J. A., & Binson, D. (2013). Gay bathhouse HIV prevention: The use of staff monitoring of patron sexual behavior. *Sexuality Research & Social Policy*, *10*(2), 77–86. https://doi.org/10.1007/s13178-013-0112-y

Ye, S., Yin, L., Amico, R., Simoni, J., Vermund, S., Ruan, Y., Shao, Y., & Qian, H.-Z. (2014). Efficacy of peer-led interventions to reduce unprotected anal intercourse among men who have sex with men: a meta-analysis. *Plos One*, *9*(3), Article e90788. https://doi.org/10.1371/journal.pone.0090788

Author biographies

Étienne Meunier, PhD, is a social scientist specializing in sexuality studies and LGBTQ+ health (emeunierphd@gmail.com).

Daniel Alohan, MPH, is a PhD student in the Department of Behavioral, Social, and Health Education Sciences at Emory University (daniel.alohan@emory.edu).

Stephen Tellone, MPH, is an Account Executive at IPG Health (stephentellonee@gmail.com).

Richard Silvera, MD, MPH, is an Infectious Diseases specialist at the Icahn School of Medicine at Mount Sinai (richard.silvera@mssm.edu).

Alwyn Cohall, MD, is a Professor in the Department of Sociomedical Sciences at Columbia University Mailman School of Public and in the Department of Pediatrics, Columbia University Irving Medical Center. He is the Director of Project STAY (atc1@cumc.columbia.edu).

Adam Baran is a filmmaker, writer, curator, and nightlife promoter (adambaran1@gmail.com).

Michael Wakefield has been a photographer, videographer, drag personality and sex party host in NYC since 1985 (wakefield8@aol.com).

Christian Grov, PhD, MPH, is Professor in the Department of Community Health and Social Sciences at City University of New York Graduate School of Public Health and Health Policy (cgrov@sph.cuny.edu).

Celia B. Fisher, PhD, is the Marie Ward Doty University Chair in Ethics at Fordham University, Professor of Psychology, and the director of the Center for Ethics Education and the HIV and Drug Abuse Prevention Research Ethics Training Institute (fisher@fordham.edu).