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Adapting the *Get Yourself Tested* Campaign to Reach Black and Latino Sexual-Minority Youth

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Abstract

Background—Culturally appropriate efforts are needed to increase sexually transmitted disease (STD) testing and care among Black and Latino sexual-minority youth, who are at high risk for STDs. *Get Yourself Tested*, a national testing campaign, has demonstrated success among youth, but it has yet to be assessed for relevance or impact among this population.

Method—This effort included (1) formative and materials-testing research through focus groups; (2) adaptation of existing *Get Yourself Tested* campaign materials to be more inclusive of Black and Latino sexual-minority youth; (3) a 3-month campaign in four venues of New York City, promoting STD testing at events and through mobile testing and online and social media platforms; (4) process evaluation of outreach activities; and (5) an outcome evaluation of testing at select campaign venues, using a preexperimental design.

Results—During the 3-month campaign period, the number of STD tests conducted at select campaign venues increased from a comparable 3-month baseline period. Although testing uptake through mobile vans remained low in absolute numbers, the van drew a high-prevalence sample, with positivity rates of 26.9% for chlamydia and 11.5% for gonorrhea. This article documents the process and lessons learned from adapting and implementing a local campaign for Black and Latino sexual-minority youth.

Keywords

sexually transmitted diseases/prevention and control; social marketing/health communication; sexual health; health promotion; LGBT; minority health; focus groups

INTRODUCTION

The Centers for Disease Control and Prevention (CDC; 2015) estimates that there are about 20 million new sexually transmitted diseases (STDs) in the United States each year, costing the American health care system nearly \$16 billion in direct medical costs alone. Young people (ages 15–24 years) are disproportionately affected, accounting for 50% of all new STDs but representing only 25% of the sexually experienced population (Satterwhite et al., 2013). Youth also bear a disproportionate burden of HIV infections in the United States, which is particularly evident among Black and Latino youth and youth who identify as gay, lesbian, or bisexual (referred to hereafter as sexual-minority youth); face sociocultural barriers to STD/HIV prevention and testing (CDC, 2015; Mojola & Everett, 2012); have increased risk behaviors, and have higher rates of STD/HIV (Kann et al., 2011; Lindley, Walsemann, & Carter, 2013).

BACKGROUND/LITERATURE REVIEW

Because most STDs are treatable and frequently asymptomatic, increasing testing among young people is a public health priority (Workowski & Berman, 2007). Both CDC and the U.S. Preventive Services Task Force recommend routine testing for high-risk populations, including those age 25 and younger (Meyers et al., 2008; Workowski & Berman, 2007). Yet, despite the clinical and public health importance of STD and HIV testing, prevalence of testing among youth remains low (Inungu et al., 2011; OwusuEdusei, Nguyen, & Gift, 2011).

To address this deficiency, the national *GYT: Get Yourself Tested* campaign was launched in 2009 to promote and routinize STD testing and treatment among sexually active youth, ages 15 to 25 years. GYT was designed to be a youthful and empowering campaign relevant to all youth (without targeting specific subgroups) and promote STD information, open communication with partners and providers, and linkage to services (Friedman, Brookmeyer, et al., 2014). Evidence from national and local evaluations suggests that the GYT campaign is associated with increased STD testing during campaign promotion periods (Friedman, Bozniak, et al., 2014; Friedman, Brookmeyer, et al., 2014). However, these evaluations did not specifically assess impact on sexual-minority youth populations, and the GYT campaign has yet to be evaluated for relevance among sexual-minority youth.

A recent review of social marketing campaigns promoting STD/HIV testing among sexual-minority populations found evidence of impact for HIV testing campaigns but not for STD testing campaigns (Wei et al., 2011). Authors noted that rigorous evaluations are lacking, but community-wide campaigns may have the potential to reach and affect these vulnerable populations, calling for implementation research (among other research) to identify effective campaign elements in reaching these populations. This article describes the process through which elements of the national GYT campaign were tested, adapted, implemented, and evaluated for reach with Black and Latino sexual-minority youth, ages 25 and younger, in New York City. Given that few local campaigns are reported in the peer-reviewed literature (Friedman, Kachur, Noar, & McFarlane, 2015), this article offers a documented case study

on the development and implementation of inclusive health promotion campaigns for Black and Latino sexual-minority youth, with preexperimental evaluation of outcomes.

METHOD/STRATEGIES

Study Design and Setting

Project elements included (1) formative and materials testing research, (2) adaptation of existing GYT campaign materials based on formative research, (3) 3-month campaign implementation in four venues of New York City, (4) process evaluation of outreach activities, and (5) outcome evaluation using a preexperimental design. All research procedures and materials were reviewed and approved by the institutional review board at Public Health Solutions.

STD and HIV testing services were provided (without direct cost to the project) by the primary clinical and community partner for the campaign, Callen-Lorde Community Health Center. Callen-Lorde is a federally qualified health center serving lesbian, gay, bisexual, and transgender (LGBT) communities regardless of their ability to pay. The partnership leveraged Callen-Lorde's specialized program for teens and young adults (< 24 years), called Health Outreach to Teens (HOTT), which includes a designated youth-only medical suite in their clinical facilities with providers for teens/young adults, providing primary care, sexual and reproductive health, mental health, and social services. The HOTT program also operates a mobile van that is used to conduct outreach and provide direct medical services. While the HOTT program provided STD and HIV testing through the clinic and mobile van prior to this campaign, this partnership extended the locations and hours of operation of the mobile van and promoted these services through street outreach, printed materials, and online and social media marketing efforts.

Formative and Materials Testing Research

Two focus group discussions were conducted to gather first-person perspectives of Black and Latino sexual-minority youth in three research domains: (1) barriers to STD/HIV testing, (2) perceived effectiveness and reactions to existing STD/HIV testing campaigns and services serving intended audiences, and (3) reactions to 16 existing and revised versions of GYT images and messages. Adaptations to GYT messages were developed with input from an advisory board of stakeholders who serve LGBT youth populations prior to the focus groups. The images and messages tested included photographs and illustrations representing a variety of individuals and couples, including young Black males, male–male couples, and female–female couples.

Focus group participants were recruited using posters and flyers distributed at LGBT events and services through three community-based organizations (CBOs) serving sexual-minority communities in New York City, including the HOTT program. To be eligible for participation, youth had to be age 15 to 25 years, English-speaking, and able to give informed consent; sexual orientation was not included as an inclusion or exclusion criterion due to human subjects concerns of disclosing orientation prior to consent. Focus groups were guided by a semistructured discussion guide. The groups were audio-recorded and

transcribed verbatim. Grounded theory, which involves the process of collecting data, identifying categories or themes, and generating a theory that explains the process of a phenomenon, was used to identify themes in the transcripts (Strauss & Corbin, 1990). Manual coding was conducted independently by three investigators, with each investigator blinded to the coding of the other investigators. Discrepancies in coding were reviewed by each of the three investigators and resolved through consensus.

Process Evaluation of Outreach Activities

The tracking of campaign activities—including the number and types of materials disseminated, venues and events attended, and number of youth reached at each event—was documented and reported without identifiers by the outreach staff. Ongoing assessments of campaign implementation were made by collecting qualitative feedback during weekly meetings with campaign outreach staff. In these weekly debriefings, cumulative process measures were reviewed, and challenges and adaptations in the implementation of outreach activities were discussed.

Outcome Evaluation

The outcome evaluation used a preexperimental study design, using aggregated deidentified data exported from the electronic health record to test whether there was an increase in STD testing uptake at the mobile van and HOTT clinic testing sites (which serve only youth younger than 25 years) during the 3-month campaign period (June–September 2013), compared to a 3-month baseline period (March–May 2012). Data on the number of STD tests at both time points and positivity (by organism) for the postcampaign time period were exported from an existing clinical administrative database and reported by the clinical/community partner in aggregate. Demographic data on those tested were not reported due to concerns about confidentiality given the small sample size. Data on testing outcomes from the baseline period were not available. Follow-up treatment of any positive test result within 8 weeks of the end of the campaign was also reported.

RESULTS

Formative and Materials Testing Research Findings

A total of 25 youth (average age 18 years) participated in two focus groups (Table 1). Overall, 40% of participants were age 15 to 17 years, 80% were male, and 60% identified as gay or lesbian and 24% as bisexual. Most participants (84%) had been tested for STDs or HIV. Reflecting the recruitment settings, focus group participants in Group 2 were significantly older, exclusively male, and more likely to be African American or Black than participants in Group 1.

Barriers to STD and HIV Testing—Many youth cited health care providers as trusted sources of information; however, they expressed concerns about the confidentiality of testing services and the information they disclose to providers during the clinical encounter. Many of these participants were minors receiving health care services in the same clinic as parents/family members, or from providers who had known them for a long time. The consequences

of a confidentiality breach were particularly of concern when discussing same-sex partners with providers not trained (or settings not designed) to serve LGBT youth.

Perceptions of Existing STD/HIV Testing Efforts—Participants discussed local STD/HIV testing efforts in their communities, including campaigns, outreach through mobile vans, and testing events at house balls and school-based health centers. Two key themes emerged: a lack of privacy in nonclinical testing venues and messaging stigma and fatigue. Youth specifically cited reservations about seeking sexual health services at CBOs or clinical locations that serve sexual-minority communities, explaining that “everybody” in the LGBT community goes there and therefore there was no privacy (Table 2). Similarly, the lack of privacy or anonymity and fear of peer stigma precluded many youth from testing in community venues, such as house balls or schools.

Youth also expressed concerns about messages that target high-risk groups. Some youth felt that messages emphasizing high rates of infection among Black and Latino sexual minorities were “scare tactics” that can stigmatize and offend those they are trying to reach by implying that someone may be infected by virtue of their demographic characteristics or sexual orientation. Others argued that people need to know the “truth” rather than hide from (or be offended by) statistics. Some expressed fatigue with safe-sex and STD-testing messages targeting sexual-minority populations, which participants felt they were “flooded” with. Similarly, many participants expressed fatigue with the inclusion of sexual imagery in testing promotion materials, with one youth (male, Group 1) saying, “It doesn’t make me get tested, it’s like, whatever—I hear this everywhere.”

Two themes emerged from youth’s discussions of potential improvements to existing HIV/STD testing efforts: making testing more accessible and developing nonsexualized, inclusive and positive messaging about testing. Despite the concerns about privacy in community-based testing venues that many expressed, some supported the expanded availability of testing services, such as school-based programs that test everyone so no one feels singled out. To support privacy, many youth expressed interest in testing outside their communities, where they would not be seen. To ensure confidentiality, youth indicated a preference for providers who were not their family provider.

Participants indicated that materials should include positive images of people like them to be appealing. A small number of youth felt that “scare tactics” were needed to break through to teenagers, but no consensus was reached on this issue. While all participants supported the use of images that were inclusive of sexual-minority youth (without targeting or stigmatizing them), the use of sexual imagery was a subject of debate. Some youth expressed support for images that alluded to sex, reporting that “sex sells,” while others proposed that nonsexualized imagery may be more acceptable. The campaign therefore used a combination of materials, some text-only and some with images, including both sexual and nonsexual images to appeal to youth.

Reactions to Preliminary Adapted Materials and Messages—Youth were presented with a combination of original and adapted GYT materials and asked for their reactions regarding appeal, relevance, resonance, and effectiveness. In general, youth

expressed preferences for materials with bright colors and minimal text or statistics. Reflecting a general interest in messages that are “for them,” male youth in both groups identified a newly developed postcard with an image of an African American lesbian couple as being particularly compelling (Figure 1); it was perceived to be unique, attention getting, nonoffensive, and accepting of sexual-minority youth (“gay active”). Reflecting the broader discussion about the use of sexualized imagery in STD/HIV testing campaigns, a few youth expressed preference for adapted materials that did not include imagery, as they were more inclusive (Figure 1b, compared to Figure 1a). The campaign therefore used a combination of materials, some text-only and some with images.

INTERVENTION APPLICATIONS

GYT Campaign Materials Adaptation

In response to formative research, GYT materials were further revised and strategies were developed for reaching intended audiences with appropriate testing services and events (Table 2). The images and messages in the adapted materials were developed to be inclusive, promoting testing for sexual-minority youth while minimizing messaging stigma. Some images in the campaign materials contained only text and others included images alluding to sex (Figure 1a). Existing GYT campaign materials that were perceived as heteronormative were revised to be more inclusive by removing gendered silhouettes (Figure 1b) and new materials with new visual images but using existing messaging were developed (Figure 1c). Because of a lack of consensus on the effectiveness of “scare tactics,” and the voiced concerns about messaging stigma, fear-based messaging was not used in this campaign.

In total, five sets of adapted campaign materials were developed to promote testing and campaign events and reproduced in both postcard and poster format. Pins and stickers using two original GYT designs were also printed and disseminated. Other campaign tools included online and social media outreach, including a website with local listings of STD testing sites and other resources for sexual- and gender-minority youth.

Local GYT Campaign Implementation

Over the course of 3 months, the campaign conducted and promoted 37 testing events via mobile van. Mobile testing was offered by providers who were unknown to youth and trained to serve LGBT patients. Testing events were held three times a week, on weekdays and weekends in daytime and evening hours at select venues where street-involved, sexual-minority youth, including those who are homeless or who engage in sex trade, are known to gather. Examples of venues included the Christopher Street Piers and a shelter and food pantry serving sexual- and gender-minority homeless youth near Port Authority Bus Terminal.

It should be noted that many of the venues selected for mobile testing were already served by the HOTT mobile van and no changes were made to the frequency of testing through the mobile van from the baseline period. Rather, the project made significant structural adaptations to the locations and promotions of mobile van-based testing to advertise availability and address youth privacy concerns identified during the formative research

phase. Within the identified venues, the van was relocated to be easily accessible to the venues but not directly visible from them. Street outreach was conducted at identified venues prior to testing events to promote availability. To minimize STD/HIV testing stigma, promotions advertised the availability of a broad range of health care services including school health exams and general preventive health care (e.g., flu shots). In addition, the campaign website and print materials promoted the locations of several clinics offering testing to sexual- and gender-minority youth in New York City (including the HOTT clinic).

Direct project costs for outreach staff was \$15,000, and the direct cost for materials printing and supplies was \$5,697. Project support also covered staff time for two part-time evaluation staff. The project did not support the medical or staff costs of testing.

Process Evaluation of Outreach Activities

Campaign Tracking—Through street outreach, events, and 21 CBOs serving sexual- and gender-minority youth, the project distributed more than 13,700 campaign materials. These reached an estimated 2,500 youth at Pride events and 904 through general street outreach.

Continuous Feedback and Midcourse Corrections—Staff feedback revealed challenges, which prompted revisions to outreach strategies. For example, prior to the campaign, one of the neighborhood testing venues (Christopher Street Piers) was subjected to increased police presence and resident street patrols in response to mounting political pressure by residents, who objected to the congregation of sexual-minority youth in their neighborhood (Mananzala, 2011). This deterred youth from congregating there after dark, when testing events were originally scheduled. In response, the timing of GYT testing events was moved 1 hour earlier. A church-based program that provides meals to street-oriented youth (Swalec, 2012) was also added as a testing venue to reach youth who had been displaced from the Piers. New locations for testing event locations were identified by outreach staff through informal discussions with youth at the testing venues. To address low participation at some testing events, and in response to concerns about stigma voiced to outreach staff and in the focus groups, the availability of general preventive health services was promoted more visibly along with the testing.

Outcome Evaluation

During the course of the campaign, 33 youth were tested at the mobile testing events, and another 266 were tested at the HOTT youth-only clinic (Table 3). The number of youth tested on the van (unduplicated) increased 83% from the comparable 3-month baseline period (during which mobile testing was available at the same frequency but not promoted or coordinated with outreach events), while the number tested at the youth-only clinic increased 10% from baseline. Positivity rates for chlamydia and gonorrhea were higher among those tested through the mobile van (26.9% and 11.5%, respectively), compared to those tested in the clinic (5.3% and 8.5%, respectively) during the campaign period. On the other hand, rates of syphilis and HIV were higher among those who sought testing in the clinic during campaign implementation (6.3% and 1.7%, respectively), compared to those who tested in the mobile van, which yielded no HIV or syphilis cases. Given the small number of persons testing positive, these differences could be due to chance. The proportion

of youth testing positive who received treatment within 8 weeks of campaign completion was lower in the mobile van setting than the clinic: only 1 of 3 youth who tested positive for gonorrhea in the mobile van received treatment within 8 weeks of the campaign period, compared to 15 of 16 who tested positive in the clinic setting.

DISCUSSION

This project explored barriers to STD testing among Black and Latino sexual-minority youth and implemented an adapted GYT campaign to increase STD testing among these youth. Findings from formative research confirmed growing evidence that privacy and confidentiality are barriers to testing for youth and young adults (Blake, Kearney, Oakes, Druker, & Bibace, 2003; Dodge et al., 2012; Ginsburg et al., 2002; Tilson et al., 2004). Specifically, sexual-minority youth expressed reservations about seeking testing services at centers that specifically serve LGBT youth, because they are frequented by fellow members of the community and therefore are not “discreet.” Whereas numerous studies have identified the stigma of testing positive for an STD as a barrier to testing among youth (Duncan, Hart, Scoular, & Bigrigg, 2001; Fortenberry et al., 2002), this concern did not emerge among youth in our study. Contrary to expectations, common barriers to STD/HIV testing (identified in qualitative studies)—such as concerns about testing procedures (Lorimer, Reid, & Hart, 2009; Rose, Smith, & Lawton, 2008; Tilson et al., 2004) and low perceived risk (MacKellar et al., 2011; Peralta, Deeds, Hipszer, & Ghalib, 2007; Richardson et al., 2010)—were not mentioned by any of the youth in this research.

Rather, concerns about stigma centered on what youth perceived to be targeted and offensive public health messaging in many campaigns for sexual and racial/ethnic minority populations. Whereas the GYT campaign was not regarded in this light, some of its messages were seen as too heteronormative, and therefore not relevant or inclusive. To respond to youth needs for relevance and inclusion without stigma, this effort used both existing and adapted GYT materials to promote testing through clinic- or mobile van-based settings, offering LGBT-friendly providers and testing in the context of general health screenings.

Evaluation of testing data before and after the campaign pointed to an increase in testing at select campaign sites, yielding high STD positivity rates, which may have been driven by this campaign. More than a quarter of those who tested at GYT sites tested positive for chlamydia, compared to only 7.3% of youth in the national GYT evaluation; for gonorrhea, positivity was 11.5% in this setting, compared to 0.9% in the national evaluation (Friedman, Brookmeyer, et al., 2014). STD testing through a mobile unit has been found in other settings to be an effective way to reach youth who may be reluctant to access testing services in clinical settings (Ellen, Bonu, Arruda, Ward, & Vogel, 2003; Kahn, Moseley, Thilges, Johnson, & Farley, 2003).

This campaign implemented suggestions from youth that have also been proposed in other settings and populations (Balfe, Brugha, O’Connell, McGee, & O’Donovan, 2010; Prost et al., 2007; Tilson et al., 2004), including structural adaptations to mobile testing (i.e., relocating near but not directly visible from youth venues); advertising the availability of a

broad range of health care services, rather than emphasizing STD/HIV testing; and changing the hours at which testing services were offered to accommodate community pressure. Yet, despite these adaptations, testing uptake through the mobile van was low in terms of absolute numbers, though higher than the baseline period. Furthermore, of the 33 tested via the mobile van, 10 tested positive for at least one STD, indicating that the van drew a high-prevalence sample. The difference in youth testing numbers between the mobile van and the HOTT clinic may reflect youth's concerns about privacy in the mobile van setting, as uncovered in the focus groups. Moreover, differences in STD positivity and follow-up treatment rates confirm previously documented challenges in linking street-oriented youth to testing and care (Auerswald, Sugano, Ellen, & Klausner, 2006). These findings emphasize the challenges in reaching highest risk youth, even when they are met in their own communities. Although limited to a small community of youth, these findings may suggest the need for further exploration to identify new or innovative strategies to engage youth through future campaigns.

This study faced several limitations. During the formative research phase, the viewpoints of care-seeking youth may have been overrepresented, with a majority of participants reporting previous STD/HIV testing, whereas the opinions of other youth, particularly females, may have been underrepresented due to small numbers or a reluctance to speak in mixed-gender groups. The focus groups were not segmented by age within 15 to 25 age range, which may have obscured potential subgroup differences or communication preferences between minors and young adults. Moreover, the groups were conducted in English and did not include transgender participants so do not reflect the views of transgender or non-English-speaking racial/ethnic minority youth.

The process evaluation was also limited to materials distribution tracking and staff feedback; it did not include feedback from partnering CBOs regarding receptivity, uptake, or use of campaign materials. Nonetheless, it may be a helpful estimation of campaign reach and was useful in identifying needed mid-course corrections.

Finally, the deidentified outcome data did not include sociodemographic data on those tested (beyond age) nor did it allow us to link testing behaviors with campaign awareness, so it is unclear whether observed testing increases were indeed among intended youth audiences and related to the campaign. Whereas other explanations cannot be ruled out, there were no other local testing campaigns reaching this population at the time, to our knowledge. Finally, the full impact of this campaign is not captured in the current evaluation, which only collected testing data at two sites, although the campaign promoted availability of STD/HIV testing at numerous CBOs to accommodate youth's desire to seek testing outside of their communities. It also did not assess changes in STD testing attitudes or awareness, although the campaign reached an estimated 3,400 youth on the ground with campaign materials. Increasing the visibility of STDs in the community may help to break the silence and stigma around STDs, removing important barriers to STD testing and prevention (Hood & Friedman, 2011).

This evaluation, while not intended to be generalizable to other communities, offers a promising snapshot of the campaign's effects. During the campaign, STD testing at a mobile

van and youth clinic increased by 83% and 10%, respectively, compared to a comparable baseline period. The observed changes in testing uptake reflect the impact of promoting such testing services and adjusting the delivery of testing services, rather than the impact of introducing new testing services.

CONCLUSIONS

This study highlights how structural modifications to testing services and audience-centered promotional efforts were integrated into a campaign to reach Black and Latino sexual-minority youth in New York City. It responds to the urgent need for documented case studies on the development and implementation of inclusive health promotion campaigns for Black and Latino sexual-minority youth.

This project, reflecting recommendations from a recent systematic review of social marketing campaigns to promote STD and HIV testing in sexual-minority populations (Wei et al., 2011), involved the community in campaign development. Developers of health education campaigns seeking to reach Black and Latino sexual-minority youth should become aware of the cultural aspects of the youth they are trying to reach, maintaining sensitivity to the nuanced aspects of minority group membership and historical stigmatization (Mayer et al., 2008). Our focus group findings confirmed specific recommendations from an earlier mixed-method study among sexual-minority youth on what makes youth feel safe in a health care setting (Ginsburg et al., 2002): Sexual-minority youth value privacy, respect, and a nonjudgmental stance; conversely, youth are offended by STD/HIV campaigns that appear to equate their sexuality with HIV, which serves as a barriers to care. In developing health promotion campaigns and strategies, program developers should be sensitive to the intersecting needs of youth in general and of sexual- and gender-minority youth (Ginsburg et al., 2002; Peralta et al., 2007; Tylee, Haller, Graham, Churchill, & Sanci, 2007; Voisin, Bird, Shiu, & Krieger, 2013).

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FIGURE 1.

Campaign material images: (a) Existing national *Get Yourself Tested* (GYT) campaign image; (b) revised in response to focus group feedback to be more inclusive for use in the local campaign; (c) additional campaign image developed for local campaign

TABLE 1Sociodemographic Characteristics and Testing History of Focus Group Participants (*N* = 25)

Characteristic	Group 1 (<i>n</i> = 14), <i>n</i> (%)	Group 2 (<i>n</i> = 11), <i>n</i> (%)	Total (<i>N</i> = 25), <i>n</i> (%)
Age group (years)			
15–17	10 (71)	0 (0)	10 (40)
18–19	4 (29)	4 (36)	8 (32)
20–25	0 (0)	7 (64)	7 (28)
Gender identity ^a			
Male	9 (64)	11 (100)	20 (80)
Female	5 (36)	0 (0)	5 (20)
Race and ethnicity			
Black/African American, non-Hispanic	5 (36)	9 (82)	14 (56)
Hispanic/Latino, non-Black	7 (50)	0 (0)	7 (28)
Hispanic/Latino and Black	2 (14)	1 (9)	3 (12)
Other	0 (0)	1 (9)	1 (4)
Sexual orientation identity			
Gay or lesbian	8 (57)	7 (64)	15 (60)
Bisexual	5 (36)	1 (9)	6 (24)
Straight or heterosexual	1 (7)	3 (27)	4 (16)
Housing status			
Parent(s)/guardian(s)/foster care	13 (93)	7 (64)	20 (80)
Living on own (alone, roommate, dorm)	1 (7)	4 (36)	5 (20)
STD/HIV testing history			
Ever tested for STDs or HIV	12 (86)	9 (82)	21 (84)

NOTE: STD = sexually transmitted disease.

^aFisher's exact test, *p* = .046.

TABLE 2

Focus Group Themes of Barriers to STD and HIV Testing and Corresponding Adaptations Made to Campaign Materials and Activities

Barrier	Illustrative Quotes	Steps Taken by the Campaign to Ameliorate Barriers
Confidentiality	"I feel sharing your business with people you hardly know, it's like, it's really unsafe for your own well- being because you don't know them and you don't know what they're capable of if you tell them something." (Male, Group 1)	<ul style="list-style-type: none"> Partnered with clinical partner with extensive experience in serving sexual-minority youth
	"Like with the doctor, I won't tell the doctor, my sexual partners, who they are." (Male, Group 2)	<ul style="list-style-type: none"> Conducted trainings with project outreach staff on confidentiality to complement existing similar training for clinical staff
Privacy	"The hardest part is finding places to get tested. Places where you're not going to see nobody." (Male, Group 2)	<ul style="list-style-type: none"> Made testing more accessible while maintaining privacy
	"There are a lot of free places around, but ... everybody in the LGBTQ community frequents these places, so [people] want to be more discreet about it. That takes them away from actually going to see about their health." (Male, Group 2)	<ul style="list-style-type: none"> Mobile medical van offering STD testing relocated to location outside of view of congregating youth Campaign materials listed locations and hours for free STD testing at venues in all five boroughs so that youth could seek testing outside of their local communities
	"Everyone knows what you're going for." (Male, Group 1)	<ul style="list-style-type: none"> Visibly promoted availability of health services other than STD testing (e.g., flu shots, school health exams) to minimize stigma of seeking services from mobile van
Messaging stigma and fatigue	"You want people to have the sense that it is 'for them' —that there are people like them who need to get tested." (Male, Group 2)	<ul style="list-style-type: none"> Adapted campaign materials emphasized existing GYT tagline of "it's your sex life"— with equal emphasis (font size) on "your" rather than "sex" One set of adapted campaign materials included an African American lesbian couple
	"The epidemic of HIV is more like a scare tactic. Everybody kind of feels like, that the statistics around it, there's lots of stigma attached to it." (Male, Group 2) "There was a campaign that was put out, by the New York Health Department that was controversial about the scare tactics that they used, that was kind of offending the LGBTQ community. Basically saying, just because you're a man of color, you're automatically going to be positive anyway." (Male, Group 2)	<ul style="list-style-type: none"> Campaign materials adapted by the campaign did not refer to risk by sexual orientation, race, or ethnicity
	"I think [messaging] needs to be more generic—that is, reaching out to different crowds. We're obviously talking about sex, the words are talking about sex; the picture doesn't have to be about sex. You could have a video game controller, and someone who likes video games is going to look at that advertisement, but they're also going to get the message." (Male, Group 2) "But you always see two guys. We're flooded with [images of] the two men." (Male, Group 2)	<ul style="list-style-type: none"> Campaign materials included nonsexualized, inclusive images, including some with no imagery at all

NOTE: STD = sexually transmitted disease; GYT = *Get Yourself Tested*; LGBTQ = lesbian, gay, bisexual, transgender, queer.

STD/HIV Testing Uptake Before and During Adapted GYT Campaign by Participating Sites Serving Youth Ages 15 to 25 years, and Change in Testing Uptake, by Type of Test

TABLE 3

Testing Location	Type of Test	Baseline (March 1-May 31, 2012),		Campaign (June 21-Sept 22, 2013)				% Increase in Number Tested, Baseline to Postcampaign
		Tested (n)	Tested (n)	Tested (n)	Positive (n)	Positivity (%)	Treated (n)	
HOTT mobile unit	Syphilis	12	20	0	0	0	0	67
	Gonorrhea	16	26	3	11.5	11.5	1	63
	Chlamydia	16	26	7	26.9	26.9	6	63
	HIV	5	10	0	0	0	—	100
	Total nonduplicated testing clients	18	33	—	—	—	—	83
HOTT youth clinic	Syphilis	144	143	9	6.3	6.3	9	0
	Gonorrhea	170	189	16	8.5	8.5	15	11
	Chlamydia	170	189	10	5.3	5.3	10	11
	HIV	89	117	2	1.7	1.7	1	31
	Total nonduplicated testing clients	241	266	—	—	—	—	10

NOTE: STD = sexually transmitted disease; HOTT = Health Outreach to Teens. STD and HIV positivity data not collected at baseline. Number of youth tested (and entered into treatment) for each sexually transmitted infection are not unique because youth may have received more than one type of test and may have tested positive for more than one STD. Treated *n* refers only to those who were treated within 8 weeks of the end of the campaign.