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Reaching Youth With Sexually Transmitted Disease Testing: Building on Successes, Challenges, and Lessons Learned From Local Get Yourself Tested Campaigns

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Abstract

Nine programs were funded across eight states in the United States to customize, implement, and evaluate local campaigns in support of the national *Get Yourself Tested* (*GYT*) campaign. Each program promoted chlamydia screening and treatment/referral to sexually active young women (aged 15–25 years) and their partners through accessible, free, or low-cost services. This article documents the strategies and outcomes of these local GYT campaigns, highlighting the diversity in which a national sexual health campaign is implemented at the local level and identifying challenges and successes. Nearly all ($n = 7$) programs involved target audience members in campaign development/implementation. Youth were linked to free or low-cost sexually transmitted disease testing through community centers, high schools and colleges, community and clinic events; online or text-based ordering of test kits; and community pickup locations. Sites used a combination of traditional and new media, on-the-ground activities, promotional products, and educational and social events to promote testing. With the exception of one site, all sites reported increases in the number of persons tested for chlamydia during campaign implementation, compared to baseline. Increases ranged from 0.5% to 128%. Successes included development of local partnerships, infrastructure, and capacity; use of peer leaders and involvement; and opportunities to explore new innovations. Challenges included use of social media/new technologies, timing constraints, limited organizational and evaluation capacity, and unforeseen delays/setbacks. Each of these issues is explored, along with lessons learned, with intent to inform future sexual health promotion efforts.

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Keywords

STD/HIV; STD testing; local adaptations; sexual health promotion; youth

Introduction

In an effort to promote chlamydia testing among young women and assess local social marketing efforts, the Centers for Disease Control and Prevention (CDC) funded nine geographically diverse community programs to develop, implement, and evaluate local campaigns in support of the national *Get Yourself Tested* (*GYT*) campaign. As part of this initiative, each program promoted chlamydia screening and treatment or referral to sexually active young women (aged 15–25 years) and their partners through accessible and free or low-cost services. The programs were funded from January 1, 2011, through September 30, 2011, with a minimum requirement to promote chlamydia (and other sexually transmitted disease [STD]) testing during the month of April (STD awareness month). Sites were encouraged to consider all aspects of the marketing mix in their efforts. Each site assessed campaign reach and engagement through media tracking and event attendance; measured uptake of screening, comparing chlamydia testing and positivity data during campaign implementation to the same time period in the previous year (2010); and tracked implementation barriers and successes through qualitative reports.

This article describes the settings, strategies, and outcomes of these nine local GYT campaigns, with the goals of identifying barriers to local implementation and evaluation of sexual health promotion efforts as well as lessons learned from on-the-ground successes and challenges.

Background

It is estimated that each year in the United States, there are approximately 20 million new STDs, half of which are among youth aged 15–24 years (Satterwhite et al., 2013). Many of these infections are asymptomatic, yet they can cause serious health consequences if left untreated. Chlamydia is a leading cause of preventable infertility and the most commonly reported STD in the United States (CDC, 2013). It affects an estimated 3 million people each year, with the heaviest burden on young women (Datta et al., 2007). CDC recommends annual chlamydia screening for all sexually active women aged 25 and younger. However, only about half of eligible women are screened each year, with lower screening rates among adolescents (National Committee for Quality Assurance, 2012). As a result, many young women are left undiagnosed and vulnerable to more serious health conditions, such as infertility.

Consumer research suggests that many young sexually active women are unaware of the recommendation for annual chlamydia testing, that chlamydia is often asymptomatic, and that it can cause infertility if left untreated (Friedman & Bloodgood, 2010). Access challenges as well as social and emotional costs—most notably stigma and fear—have been identified as barriers that prevent young women and their partners from getting tested for STDs (Hood & Friedman, 2011; Pavlin, Gunn, Parker, Fairley, & Hocking, 2006). Research

on young women's perceptions of chlamydia testing suggests that in order to promote this "product" or service, it needs to be normalized as a routine part of regular care, nonjudgmental, quick, easy, and free (Friedman & Bloodgood, 2010; Pavlin et al., 2006). Finally, message-testing research indicates that young women do not want to be the sole focus of STD testing efforts or campaigns, as they regard STD testing as both stigmatizing and a shared responsibility between men and women (CDC, 2008).

In response to consumer needs and high STD rates, the national GYT Campaign was launched in 2009 as an ongoing promotion under *It's Your (Sex) Life*, a long-standing public information partnership of MTV and the Kaiser Family Foundation. Other supporting partners of GYT include the American College Health Association, the National Coalition of STD Directors, and Planned Parenthood Federation of America (PPFA). Technical consultation is provided by CDC. GYT offers a youthful, empowering social movement that promotes STD testing and treatment among youth, aged 25 and under, through information, open communication with partners and providers, and links to STD testing services. It is a multimedia campaign that leverages product, place, pricing, and promotion strategies to minimize identified youth barriers to testing. It connects youth to testing through clinic locator tools and accessible, free, or low-cost, youth-friendly STD testing services at partner sites and makes testing cool and fun through events, promotions, and celebrity endorsements. It reaches intended audiences through television, online, and social media advertising and programming. GYT runs year round, with heightened promotions in April for National STD awareness month as well as at other points during the year (e.g., Valentine's Day, Back to School). The GYT website (www.gytnow.org) provides a tool kit of content and materials that can be used by national, state, and local partners to promote the campaign on the ground through their own media, marketing, and testing events, promotions, and outreach efforts (Friedman et al., 2014).

To address stigma and fear around STD testing, GYT increases visibility of the issue, uses normalizing messaging, and presents testing in a positive light (Hood & Friedman, 2011). Informed by consumer research (CDC, 2008), GYT messaging uses theoretically grounded messages that apply key constructs of the Health Belief Model (Rosenstock, Strecher, & Becker, 1988) and Theory of Planned Behavior (Ajzen, 1985). Specifically, it seeks to increase STD awareness and perceived risk; reduce STD testing-related fear; frame STD testing as a routine part of sexually active people's lives; and normalize testing for all youth as an act of pride rather than shame. The GYT acronym is intended to give youth an easy, comfortable way to talk about STD testing. The national campaign refreshes messaging each year, which is reflected in GYT promotional products and programming. It shifted from a focus on STD prevalence and ease of testing in 2009, to talking with partners and providers in 2010, and testing as a form of youth strength and empowerment in 2011. The GYT tagline, *Get Yourself Tested*, was expanded to *Get Yourself Talking* in 2010. Key messages included:

1 in 2 sexually active young people will get an STD by age 25. Most will not know it.

The only way to know for sure is to get tested.

Most STDs are curable; all are treatable.

Available evidence suggests that the national GYT campaign is associated with increases in chlamydia and other STD testing at participating clinics in the United States (Friedman et al., 2014). However, there have been limited efforts to document local campaign successes or challenges in implementing the campaign on the ground. CDC's current effort sought to promote and normalize chlamydia screening among women and their partners and to support local agencies in the implementation and evaluation of local GYT campaigns.

Method

Nine sites were selected to implement and evaluate local GYT campaigns based on a competitive award process coordinated by FHI 360. Each site was awarded a maximum of US$20,000 from January to September 2011. The sites represented diverse organization types, geographic regions, and urban/rural locations, each with demonstrated ability to reach at-risk target audiences. Each site was required to develop and execute a local social marketing campaign implementation and evaluation plan, with targeted campaign goals, audience, and behavioral objectives. They were also required to provide chlamydia screening and treatment/referral to 15- to 25-year-old females (or identified segments within that population) and measure uptake of testing services. At a minimum, sites were expected to implement local campaigns during STD awareness month (April 2011).

All sites were provided with CDC's chlamydia formative and message-testing research reports, which describe findings from national qualitative social marketing research on young women (CDC, 2008, 2010). Sites were encouraged to conduct their own consumer research, if feasible; to offer other STD testing/referrals to young women and their partners, as recommended by CDC; and to consider all "four Ps" of the marketing mix: product, place, price, and promotion strategies (Kotler & Andreasen, 1991). Due to government policies and regulations, sites were not required to conduct formative research and funding was restricted to campaign implementation and evaluation; it could not be used to support testing or health care service costs. Thus, sites were also encouraged to partner with service providers (if necessary) to offer accessible, free or low-cost, youth-friendly testing that responded to the needs of youth.

All 2009–2010 GYT promotional materials (i.e., posters, fact sheets, tip sheets, online video, text-messaging services, social networking resources, promotional products, and online quizzes), as well as chlamydia-specific materials (developed for girls and young women) were made available to sites. A 2011 GYT tool kit of promotional materials (posters, buttons, stickers, and information resources) was mailed to sites in February 2011 and made available to them online. Sites were able to customize GYT materials and resources with local contact information and event details or use them as a basis for developing their own promotional materials and resources (e.g., use logos/images to create new promotional materials, create a shorter document from an existing GYT brochure). Efforts were made to coordinate local activities with planned national campaign efforts whenever possible. The national campaign also supported local efforts in April through new public service announcements (PSAs) on MTV's television channels. Technical assistance from staff at FHI 360, CDC, and the GYT campaign partners was available upon request to all sites.

Local campaign reach and engagement were assessed through the tracking of events, material distribution, media coverage, web and social media metrics, and audience participation and event attendance. All sites submitted final reports at the conclusion of the grant period. Each site's final report included chlamydia (and in some cases, other STD) testing and positivity data collected during campaign implementation periods and comparable baseline data from the same time period in the previous year (2010). They also contained qualitative assessments of implementation barriers and successes.

This article draws on information from the sites' final reports and supplemental information (when available). Data analyses are descriptive for process, awareness, and testing measures. For STD testing, we focused on chlamydia, as this was the primary outcome of interest and the only testing data required of all sites. For chlamydia testing data, researchers also calculated the percentage change in number of persons tested from baseline (2010) to campaign implementation (2011) periods. Z tests were conducted to calculate the significance of these changes, under the assumption that catchment or service areas remained reasonably stable from 2010 to 2011 (Pocock, 2006).

Findings

A summary of grantee organizations, target audiences, methods of incorporating audience input into campaign planning, and key campaign strategies (product, place, price, and promotion) is included in Table 1.

Local Programs, Target Audiences, and Goals

Selected sites spanned eight states and included three clinics, three universities, two departments of health, and one community-based organization (CBO). The primary intended audience for local efforts was sexually active young women, although segmentation strategies varied by site. Most programs chose to target male partners of young women as secondary audiences. All sites aimed to increase STD testing and/or awareness of free/low-cost, youth-friendly testing services. Some sites also sought to promote secondary goals of STD prevention (condom use; $n = 3$) and open communication about STDs ($n = 1$). Local campaign implementation periods ranged from 2 to 8 months.

Audience Input

Of the nine sites, nearly all ($n = 7$) involved members from the target audience in campaign planning or customization. Two sites conducted focus group or survey research with youth to identify effective messages and channels; four sites established youth advisory groups or partnered with existing peer groups to solicit input from intended audiences; and two sites engaged youth through design contests, whose results yielded new promotional materials (e.g., posters and condom packages). Two sites did not involve youth directly in campaign planning. One of these sites had already conducted extensive formative research with intended audiences. The other site solicited message input from stakeholders (i.e., clinic/school staff) and used available CDC formative research reports to guide their effort.

Program Strategies

Product, place, and pricing.—Most sites modified the "product" by offering confidential, noninvasive chlamydia testing (urine-based rather than urethral or cervical swabs) for free or at reduced cost whenever possible. They linked youth to STD testing services through educational, health, and social events (e.g., athletic tournaments, concerts, fashion shows, health fairs, clinic open houses). These efforts aimed to reduce the social, physical, and time costs of testing. Testing was offered at community centers, high schools and colleges, school health centers, community pickup locations, and clinics with extended hours or promotions. In some cases, gift cards, raffle prizes, free food, extra school credit, or GYT-branded t-shirts, backpacks, and phone cases were offered in exchange for testing.

One site offered home-based, self-testing kits (genital and/or rectal swab tests), which allow consumers to test themselves privately and at their own convenience. Consumers order tests online and return them by mail. As part of its campaign, this site added a text-based ordering system and mobile app with a QR code to facilitate test ordering from mobile phones. It also distributed test kits at a GYT concert event.

Promotion.—Sites used a combination of on-the-ground, collateral materials (e.g., posters, brochures, flyers, palm cards); traditional media (e.g., radio, print, transit, outdoor, and movie theater ads/content); and new media (e.g., web, social media, short messaging service [SMS]) channels to promote their campaigns. A variety of approaches were used to customize GYT materials. The most common was adding local contact or event information to existing GYT materials. Some also added their own school/agency name before or after the GYT logo to create a localized brand. A few sites added the GYT logo to newly developed materials and messaging, or added GYT logos and messaging to existing campaign or program materials (cobranding). In some cases, the latter resulted in GYT messaging combined with HIV testing, sexual health, and/or STD prevention messaging. Many sites used a combination of these approaches to promote their campaigns. All sites retained the GYT logo and tagline (*get yourself tested or get yourself talking*) and maintained a positive, empowering tone in materials.

On-the-ground activities ranged from safer sex presentations to peer education workshops and mentoring sessions; GYT content integration into youth programming, retreats, school curricula, and student performances; and creative activities to engage youth, such as safer sex/STD games and GYT-themed events (e.g., campus parties, carnivals, basketball games, pub crawls, and game nights). Two sites were able to promote their efforts in coordination with the national GYT campaign's *Take Action Tour*, a 30-city concert series that held benefit concerts in their cities. Many sites offered promotional products (e.g., stickers and pins) and developed new GYT products, such as branded key chains, cell phone charms, packaged candy/snacks, and "safer sex kits" (GYT-branded information, promotional materials, and condoms) to raise campaign awareness, create buzz, and get youth talking about STD testing and prevention. All sites developed or enhanced existing organizational websites to provide locally relevant information, including events and resources. They also developed Facebook pages ($n = 5$), Twitter accounts ($n = 2$), interactive online games ($n =$

1), SMS programs/services ($n = 3$), and smartphone apps ($n = 2$) to link youth to sexual health information, STD testing, and/or condoms.

Partnerships.—All sites developed or expanded partnerships to broaden their reach through material distribution, event hosting, education, or testing services. Partners included universities, high schools, health departments, nonprofit organizations or clinics, local businesses, churches, and radio stations.

Process Evaluation

Table 2 highlights select process measures reported by site, including on-the-ground activities, material distribution, traditional media, and new and social media tracking. It reflects the broad scope and range of activities of local efforts. While some sites invested most of their efforts in advertising (e.g., University A), others invested in on-the-ground efforts (e.g., CBO) or a combination of both (e.g., Clinic B, Health Department B and University C). Taken together, local GYT events reached more than 13,209 individuals. Approximately 125 GYT educational presentations were given in colleges, middle schools, and residential programs; GYT content was integrated into three university and two high school courses; six sites trained peer educators (more than 40 were trained at one site) who helped disseminate information and engage youth through on-the-ground activities and social media. About 25,400 condoms or safer sex packets were distributed (among other materials), and over 2,400 STD test kits were ordered during campaign implementation periods.

Sites reported increases in web traffic (as much as 743% at one site) during the campaign implementation compared to baseline. Reported responses to social media activities were varied, with a range of 6 to 145 likes on local campaign Facebook pages; a range of 12 to 302 followers of campaign Twitter profiles; a range of 10 to 533 opt-ins for text-messaging programs, and 224 text requests for home-based self-testing kits. Only one site reported the number of new app downloads ($n = 55$).

Outcome Evaluation: Chlamydia Testing

Table 3 indicates the number of persons tested for chlamydia at the nine participating sites during baseline and implementation periods. Available data ranged by site, with most (5 of 9) sites reporting the number of youth and/or young females tested for chlamydia, and four sites only reporting data for all patients tested for chlamydia during baseline and campaign periods. With the exception of one site (Clinic B, which reported unrelated, unanticipated reductions in staff and organizational capacity that inhibited their ability to implement the campaign as intended), all sites reported increases in the number of persons tested for chlamydia during campaign implementation periods compared to baseline. Increases ranged from 0.5% to 128%, with a CBO and university health center reporting the largest increases in testing. Testing increases were significant for seven sites ($p < .01$).

Available data on chlamydia testing positivity at the nine local campaigns ranged from 6.7% to 21.1% at baseline, compared to a range of 6.3% to 15.5% during campaign implementation periods. Positivity rates increased at two sites but declined at four sites. The

largest declines in positivity rates occurred at the two sites with the largest increases in numbers of persons tested (CBO and University C), although the positivity rate among the "additional" tests at these two sites was 7.3% and 3.1%, respectively.

Reported Barriers and Successes

Key barriers and successes from local efforts are noted in Table 4. Several sites noted the advantages of using a social marketing approach to campaign development, specifically target audience involvement in helping to guide successful efforts. The use of focus groups, youth advisory groups, and peer educators was identified as instrumental in developing relevant strategies. Youth contests proved to be a low-cost and effective way of engaging youth and developing relevant, audience-centered campaign materials.

A number of challenges arose regarding the product, place, pricing, and promotions of GYT at the local level. One site reported limited uptake of services at the health department, despite promotional efforts, whereas another site reported challenges securing enough tests to meet student demand for free tests at school. The short duration and spring time frame of the campaign also proved challenging for some sites. This was true in clinic settings, where staffing and hours were gearing down for summer months. It was also true in school settings, where other events compete for school space and where students are busy with exams or preparing to leave for summer.

Two sites reported community hesitancy or resistance to the sexual topic of the campaign, which limited the settings in which testing could be offered and the ways in which testing events could be promoted. For example, barriers were encountered in marketing testing to minors in high school settings as well as in college settings in conservative (religious) communities. As a result, sites made adjustments, such as offering testing in nearby clinics rather than in schools. Adjustments were also made to planned campaign promotions, such as restrictions to the scope of themed events (e.g., from *sexual health to testing* fairs) and to material distribution (e.g., condoms). One site did not support GYT's normalizing messaging (which clinic staff felt would prompt unnecessary concern among the worried well), resulting in additional, unanticipated message development work.

Despite these barriers, most sites reported successes in their testing events and outreach to youth. All sites documented the development of new products, services, materials, themed events, and resources for future use. A few successfully integrated GYT content into existing curricula, which will be maintained for future use. Valuable lessons were learned regarding the influence of peers, with youth presenting for testing in pairs or groups and a strong youth presence noted as critical for recruiting others to testing at some sites. Practical lessons were noted regarding the importance of conducting school testing events in highly visible and trafficked areas with close proximity to bathrooms (for maximal convenience) and during lunch time or after 4 p.m. Incentives were noted as effective testing motivators at sites that offered them. Many sites also reported positive receptivity of GYT collateral materials for campaign branding and awareness raising. Youth were eager to take t-shirts, colorful stickers, pins, and key chains. At some sites, demand for materials exceeded supply. An exception was one site in the south, where youth were reportedly less willing to display stickers that associated them with STDs or testing.

Although some sites (n = 3) documented challenges with the use of social media or new technologies to promote GYT, others noted that it enabled them to reach hard-to-reach youth more effectively. Several sites noted the effectiveness of traditional marketing efforts, including on-the-ground (e.g., GYT tabling events, peer outreach), radio, and outdoor advertising or promotions in driving youth to campaign websites and testing events. Two sites reported that the majority of web traffic was driven by users directly typing in the campaign URL, compared to online advertisements, web searches, or social media pages.

Increases in organizational capacity were noted in the form of new/extended partnership efforts; the training of peer educators, advocates, and mentors; and enhanced evaluation capacity. However, organizational capacity remained a challenge at many sites. Some sites reported competing staff demands, inability to fill positions, difficulty keeping up with social media activities, challenges working with new partners, and capacity to collect and report data to CDC.

All sites encountered delays or setbacks due to unforeseen logistical, administrative, or weather-related factors. For example, two clinic sites faced political attacks and staffing shortages, which reduced the number of staff and local sites that could participate in the campaign. Many sites had not allotted the necessary time for school approvals and permissions for GYT promotions. Unanticipated logistical challenges also emerged regarding printing and distribution, social media efforts, GYT content integration, and on-the-ground promotions—including technical problems, fiscal policy conflicts, and permission requirements. Finally, inclement weather also resulted in event cancelation at several sites.

Discussion

This article documents the strategies and outcomes of nine local GYT campaigns and identifies challenges and successes implementing a national STD testing campaign on the ground. There was broad diversity in how local GYT campaigns were designed, packaged, and delivered at each site, including how GYT messaging was customized or adapted. Despite wide variations in campaign settings, messaging, strategies, and periods of implementation and evaluation, these data suggest that all sites increased the visibility of STD testing in their communities and generally yielded positive results on measures of exposure and STD testing. Other reviews have documented wide diversity in campaign implementation for delivering HIV prevention messages, with generally positive results on measured behavioral outcomes, such as HIV testing and condom use (e.g., Noar, Palmgreen, Chabot, Dobranksy, & Zimmerman, 2009; Snyder et al., 2004; Vidanapathirana, Abramson, Forbes, & Fairley, 2005).

Indeed, most local campaigns reported increased STD testing at participating sites compared to the same time period in the previous year, despite staffing and organizational challenges at some sites. Overall, nearly 7,000 individuals got tested for chlamydia through the nine funded local GYT campaigns, representing a 14.8% increase from the number of individuals tested at these sites during the previous year. The site offering home-based test kits saw a sixfold increase in test orders during the campaign’s peak promotion period compared to

baseline. Chlamydia testing positivity remained high enough overall to support the additional testing, even at the sites where positivity decreased from baseline.

This is consistent with findings from national GYT evaluations (Friedman et al., 2011, 2014) as well as previous research demonstrating that no or low-cost screening may be effective in facilitating testing among high-risk populations (Rietmeijer et al., 2005). It underscores the need for easy, convenient, private, and alternative (e.g., online ordering) testing options for youth (Friedman & Bloodgood, 2010; Pavlin et al., 2006). However, it also serves as a reminder that social marketing efforts must be strategically targeted in order to maximize scarce resources—reaching those at highest risk, without prompting demand for testing among the worried well. For a campaign such as GYT, with messaging that seeks to normalize testing for all sexually active youth, this may mean targeting testing events in higher risk settings.

Top performing campaigns (based on magnitude of testing increases) were programs that involved youth in strategic development; offered testing at convenient places and times (e.g., schools, communities, home); and were able to combine testing with social events that engaged youth. These sites also had existing staff capacity and partnerships with youth leaders and other community groups and had previous experience conducting youth-oriented campaigns. Experiences at many sites support and extend earlier research that the presence and normalizing effect of peers are powerful influencers of STD prevention (Caron, Godin, Otis, & Lambert, 2004; Davey-Rothwell, Tobin, Yang, Sun, & Latkin, 2011), including STD testing, among youth. Youth leadership and involvement appeared to be instrumental in encouraging other youth to engage in campaign activities and get tested, effectively breaking down the social stigma (cost) associated with STD testing. Findings that youth at some sites presented for testing in pairs or groups suggest that a “buddy system” could be an effective way to encourage testing in the future.

As evidenced by theory and practice, the extent of formative research and audience involvement, as well as quality of implementation, will impact campaign success (Hornik, 2002; Stead, Gordon, Angus, & McDermott, 2007). Most sites involved target audiences in campaign strategy development and GYT customization; however, the extent of audience involvement varied widely. Due to practical constraints, some sites made strategic decisions based on staff preferences or administrative/community requirements, rather than audience needs or preferences. This is illustrated in the customization of GYT promotions. Although the intent of customizing or adapting the national GYT campaign to local contexts was to increase cultural relevance, it is possible that in some cases efforts to localize campaign messages/materials or develop themed events may have compromised message integrity, clarity, quality, or effectiveness—particularly when efforts were not audience driven or theoretically based. Similarly, it is unclear what impact, if any, cobranded GYT efforts (with existing sexual health, HIV testing or other local programs) may have had on campaign delivery. Given that so many sites used a combination of promotional approaches that were not individually evaluated for receptivity or impact, it is impossible to assess the effectiveness of these local variations.

All sites used a combination of on-the-ground, traditional and nontraditional marketing and advertising efforts. Although the reported effectiveness of channels varied by site, most sites reported better responses to traditional outreach compared to social media activities and online promotions. A few sites even shifted their budgets from online advertising to more traditional advertising, indicating the importance of flexibility, continuous evaluation, and refinement.

Although reports indicate that GYT can be successfully implemented for diverse audiences across a range of settings, there are some settings and circumstances in which it may prove challenging. First, although April (STD Awareness Month) has traditionally been a key promotion period for the GYT campaign, this time frame may not be ideal for schools or clinics, whose ability to access youth may be compromised during spring months.

Second, reaching minors and students with GYT in both high school and college settings proved to be challenging in conservative communities. In such settings, accommodations had to be made to GYT products, messaging or planned events to enable programs to reach out to youth in acceptable ways, such as limiting promotion, product distribution, or message focus. Sites had to consider balancing the needs and interests of intended audiences against the social context of the setting (Kelly et al., 2010), including sensitivities and interests of community partners, which were sometimes at odds. Aligning the campaign with strategic partners and working under terms that are acceptable to those partners may pave the way for expanded programs in the future.

Third, despite youth and young adults' ubiquity in social networking spaces and their increasing use of mobile technologies for health information and management (Kachur et al., 2013), there was relatively limited campaign engagement on Facebook or Twitter and low uptake of newly developed GYT apps and SMS programs. Only two sites reported that new media technologies helped expand campaign reach to youth. One of these sites used an opt-in text messaging service and Twitter to broadcast social events (where testing took place) and the other created a QR code to facilitate access to STD test ordering via mobile phone. These resources offered useful information that met audiences' needs, simplified their experience getting services, and/or were not otherwise accessible through existing channels (Salt, 2012). Campaign social networking efforts should offer information that youth want and are genuinely interested in receiving, recognizing that the act of *friending* an organization's site or subscribing to its digital programs reflects "more than a superficial gesture" (Weeks & Holbert, 2013). It may be that the less popular GYT social media activities and apps were not sufficiently engaging for or marketed to youth or that the needs and desired experience of the target audience were not sufficiently considered at the outset (Salt, 2012).

It is also possible that, despite efforts to destigmatize STD testing, STDs remain too sensitive a topic for open youth engagement on social media sites, where the online connection can be seen by friends or parents (Friedman et al., 2014; Ralph, Berglas, Schwartz, & Brindis, 2011), or for downloading sexual health apps or receiving texts that others can see on their phone (Divecha, Divney, Ickovics, & Kershaw, 2012; Friedman & Bloodgood, 2013). Amid a long history of silence and STD-associated stigma (Hood &

Friedman, 2011), the process of normalizing STD communication and testing may indeed be gradual and slow. However, there is growing evidence of youth interest in online and mobile tools for sexual and reproductive health (e.g., Levine, 2011; PPFA, 2014), particularly when these tools respond directly and anonymously to youth questions, needs, and concerns. Broadening STD/ testing messaging and offerings to sexual or reproductive health topics (e.g., relationships, sex, pregnancy prevention) and integrating them more seamlessly into media and culture (e.g., relevant links to social interest stories and celebrity news) may better meet and sustain youth's interest. Local campaigns may also consider partnering with existing, popular social media tools or mobile apps to reach youth where they already are, rather than creating their own tools and building their own fan base. The question of how best to engage youth in sexual health promotion through new and social media warrants further exploration (Allison et al., 2012; Bull, Levine, Black, Schmiege, & Santelli, 2012). In the meantime, the sum of these many efforts, over time, may start to tip the balance toward normalizing the issue.

Finally, programmatic challenges related to staff capacity, resources, and time may have limited sites' ability to reach and test youth and to evaluate local efforts as intended. Barriers to real-world campaign evaluations have been noted elsewhere, including cost and design challenges and the need to rollout campaigns quickly (e.g., Hornik, 2002; Noar et al., 2009). The short funding period limited the extent to which local sites could plan for or sustain the effects of social marketing efforts. Logistical and material considerations often took longer than anticipated, and in several instances, well-planned events were canceled or delayed due to external factors. Additionally, many programs' ability to effectively reach youth depended on having youth partnerships or peer leaders, which takes time to develop or train (respectively) for programs that lack such relationships. Despite these challenges, these findings demonstrate that even a modest amount of funding can help organizations develop capacity and expand partnerships. It enabled the development of products and programs, which continue to be used locally and have been promoted through CDC and the national GYT campaign through websites and webinars for partners.

Moving forward, funding initiatives that support local STD testing social marketing efforts may want to consider longer funding periods in order to allow sufficient time for formative research, partnership development, recruitment or hiring of youth volunteers/staffing, and extended implementation periods that build in flexibility for community buy-in and unanticipated challenges. Funders should consider the range of flexibility offered to sites in localizing or adapting a national campaign. Although local customization or adaptation may add cultural relevance and increase effectiveness if social marketing principles are applied and strong design/creative resources are available, it may also dilute the message or compromise the integrity of the campaign brand if not. Sites may need more guidance on the "core campaign features" that should be retained, as well as communication and social marketing principles, to ensure fidelity and quality of implementation. This could be provided in the form of message briefs, webinars, and ongoing technical assistance (as needed).

To reach school-aged youth who are in greatest need of STD testing, GYT campaigns should prioritize communities with high STD prevalence among youth and consider shifting the

peak implementation periods to align with the school year, rallying around seasonal events, such as *Back to School* or Valentine's Day, for school settings. Organizations that have existing networks of peer leaders, can leverage normalizing traditional media (bus, radio PSAs) and community partnerships, and can offer easy, nonjudgmental testing services may hold the most promise of success. Pairing testing with social, musical, or athletic events and engaging coaches, mentors, or influential peer groups (e.g., athletic teams) may further help normalize testing. Finally, standard evaluation tools that assess specific implementation strategies, including control sites (to control for the effect of the national campaign), would be valuable for comparing local campaigns in the future.

Strengths and Limitations

This research marks the first published documentation of on-the-ground challenges and successes to implementing GYT, a national sexual health campaign targeting youth in the United States. Findings highlight facilitators and barriers to local sexual health promotion efforts in a diversity of settings, geographic regions, and youth populations of the United States. They offer practical considerations for program implementers in the United States and abroad, including the role of traditional and new media for reaching youth with sensitive health information and services.

There are several limitations to this research. First, although some sites aimed to increase STD awareness, knowledge, communication, and/or condom use, as well as STD testing; reported data focused only on materials tracking and chlamydia/STD testing. Thus, any changes in STD knowledge, communication, or condom use are not captured here. Second, although many individuals were tested during GYT events, available data do not specifically link chlamydia testing to campaign exposure. Moreover, several sites were unable to report patient demographic data so it is unclear what proportion of individuals tested during their implementation period represented intended audiences.

Third, the full extent of chlamydia testing associated with these local GYT campaigns may not be captured by this data. For many sites, the period of evaluation did not coincide exactly with the period of implementation. Some sites captured only a brief window of their full implementation periods, and other sites reported a full year of testing data as part of their implementation period, though their campaigns lasted only several months of the year. As a result, reported testing data may underestimate the actual changes in testing seen between baseline and campaign periods. Without comparable control groups, changes in testing during or after campaign implementation cannot be reliably attributed to these local campaign efforts.

Finally, funding constraints may have limited the extent to which sites were able to consider all Ps of the marketing mix (beyond promotion). Due to wide variations in program strategies, the myriad local activities and components at each site, and limitations in program evaluation, it is difficult to compare sites or assess the relative effectiveness of individual campaign components. However, the goal of this evaluation was to document successes and challenges at the local level, and it is acknowledged that the effectiveness of individual strategies may vary by audience and context.

Conclusion

Findings suggest an association between local GYT campaigns and increases in STD testing at participating sites. All programs also increased the visibility of STD testing in their communities through marketing and promotion efforts, serving to break the silence and help normalize STD testing. This program provided new opportunities for young people to hear the GYT message and engage with the campaign, demonstrating how grassroots efforts can lead to positive behavior changes among youth. It highlights the variations in which a national sexual health campaign is implemented at the local level, enabling the identification of challenges and facilitators, which can inform future efforts. The most successful local campaigns were those that considered all 4 Ps of the marketing mix. Based on this experience, future efforts to implement the GYT or other national STD testing campaigns at the local level may want to consider the following: allowing sufficient time for formative research and development of needed infrastructure and personnel prior to launch; securing testing services that can be conveniently, freely, and privately accessed by youth in nonjudgmental settings; anticipating challenges and building flexibility into campaign timelines; enlisting peer leaders for effective youth engagement; and identifying evaluation strategies that link to targeted outcomes during the development phase of campaigns.

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Figure 1.
Peer educators share the *Get Yourself Tested* (GYT) message at the local level.

Table 1.

Local GYT Campaign: Organization Type, Geographic Location, Target Audience, and Strategies.

Organization (Location)	Primary Target Audience	Target Audience Input	Strategies		
			Product and Place	**Price**	**Promotion (Select Highlights)**
County Health Department A (Illinois)	Women 15–25 years of age; largely African American, low-income students	Youth working group	GYT testing events and health fairs: • at 9 colleges/universities • in 2 communities Walk-in testing at: • health department • high school student health center Type of testing: urine-based chlamydia testing	Free testing Incentives: GYT t-shirts, backpacks, phone cases; free food, extra school credit	Testing promoted through press releases, table tents, small media dissemination, peer educator/mentor outreach, social media, community calendars, websites, e-mail, and text distribution lists Promo products: “safer sex” kits, GYT buttons and stickers, other
County Health Department B (California)	Sexually active women 18–25 years attending a state university/ community college campuses	Materials testing survey	On-campus STD screening events or referrals at: • student health centers • college and university campuses Monthly HIV testing at college campus	Free testing	Campaign promoted through: • outdoor, transit and print ads; local news coverage; FB page • events: GYT design contest (winning design used in ads); college health fairs, community events, *Take Action Tour* (concert) GYT texting service with STD and testing location info
CBO (Washington DC)	African American women 15–24 years of age	Focus groups	STD and HIV testing at: • 5 CBOs • sponsored community and university events	Free testing Incentives: free meal, raffle prizes	Testing promoted through street and social media outreach; campaign website; sponsored events (e.g., basketball tournament, fashion show, skating party)new texting program; and Twitter account GYT content integration into existing school and HIV prevention programming
Clinic A (Kentucky)	Women 15–25 years of age; primarily women of color, adolescents, and low-income individuals	Youth Task Force	STD testing days at: • clinics (extended hours) • university (on-campus) Free HIV/STD (and cholesterol, diabetes, and other) screening at: • clinic health fairs, block parties	Free or low-cost testing (US$15)	Testing promoted through 5 seasonally themed mini campaigns w/outreach and educational events (e.g., Valentine’s Day craft parties, GYT game nights, health fairs, block parties, pub crawls); traditional and social media Promo products: condom roses, gift bags, GYT jeopardy game; GYT chapstick, carabeener key chains, pens, tumblers

Organization (Location)	Primary Target Audience	Target Audience Input	Strategies		
			Product and Place	**Price**	**Promotion (Select Highlights)**
Clinic B (New Jersey)	Sexually active women 14–24 years of age	Materials development contests, college class, and peer group involvement	STD testing (chlamydia, gonorrhea, herpes, HIV) at network of clinics	Free testing	Promotional events at colleges, universities, student and women's centers: *Get Lei'd* event, *STI Game, GYT* poster contest, *GYT* skits (peer educators) Promo products: GYT cell phone charms, M&Ms GYT ads in movie theaters and on Facebook
Clinic C (South Dakota)	Women 15–24 years of age in two surrounding counties	Youth advisory group	STD screening offered at Clinic open houses every Monday (4 weeks) "Girls and Guys' Nights" STD screening events at 2 colleges STD presentation and screening event at residential youth program	Free or low-cost testing; Incentives: GYT branded t-shirts	Radio ads, Facebook page, website On the ground promos: GYT booths at events (e.g., Juneteenth, Gay Pride, concert); *Myth and Pee Pong* game (using urine cups and ping pong balls); educational sessions in high-risk settings Promo products: GYT bookmarks, flyers, key chains, condom compacts
University A (Baltimore, DC, Philadelphia)	Women 14–25 years of age	Previous formative research	Self-collection test kits for chlamydia, gonorrhea, and trichomoniasis (vaginal/penile/anal swabs) • ordered via web or mobile phone (text program or bar code app—new) • distributed at promotional events (GYT *Take Action Tour* concert)	Free testing Incentives: T-shirts to first 50 people who send in kits in April	Test-order web page promoted through: • social media ad campaigns (Facebook, OkCupid) • new smartphone bar code app and ad placements • small media distribution at high schools, colleges, clinics, health departments, events • news media outreach (radio and newspaper interviews and ads)
University B (California)	African American and Latino youth 15–24 years of age	Previous formative research	STD testing at: • community health centers • university clinic	Free/low-cost testing	Testing promoted through outdoor and transit ads, radio ads and programming, website, Youtube, swag, and presentations
University C (Missouri)	Women living on campus in residence halls	Student involvement, condom design contests	Outreach testing events at: • student health center • community organizations and events	Free testing	Campaign promoted through: • outdoor and campus transit ads, small media, Facebook page • new games for youth (*GYT jeopardy Game* and online interactive *Game of Risk*) • student contests: condom cover design contest and student videos New mobile app to provide real-time direction to on-campus condom dispensers and testing locations

Organization (Location)	Primary Target Audience	Target Audience Input	Strategies		
			Product and Place	Price	Promotion (Select Highlights)
					GYT content integrated into college curricula

Note. CBO = community-based organization; FB = Facebook; GYT = *Get Yourself Tested*; STD = sexually transmitted disease.

Table 2.

Campaign Reach and Exposure: Select Process Measures, Reported by Site.

Organization (Location)	On the Ground Activities	Material Distribution	Traditional Media	New and Social Media
County Health Department A (Illinois)	• 22 promotional events held, reaching an estimated 984 individuals • Educational presentations reached ~ 792 youth • 36 hr of donated time by peer educators for outreach, recruitment	• 3,800 safer sex kits with condoms distributed at events	• 2 community newspaper ads (20,000 impressions) • 22 press releases (227,350 impressions)	• 1,300 combined social media impressions; • 44 Facebook fans (estimated 70 FB users exposed to GYT posts each month) • 12 Twitter followers • 4 MySpace friends
County Health Department B (California)	• 5 college campuses hosted GYT events/health fairs, reaching 6,000 individuals • 30 presentations in middle schools	• 8,000 safer sex packs • 5,000 handbills, • 500 posters	• Print ads, earned local TV, and radio coverage • 8 ads ran in four college newspapers, reaching 35,000 students • 20 bus shelters and 20 bus backads (1 1,657,520 impressions/month) • Digital ads on campus screens (no # provided)	• Online advertising (website) • 6 likes on Facebook page (estimated 60–80 impressions/ Facebook post) • 10 people signed up for texting service
CBO (Washington DC)	• 34 presentations, reaching 384 youth; • Peer educators reached an estimated 10,817 youth • promotional events (basketball tournament, fashion show and skating party) reaching 432 youth • 5 community events, reaching 610 individuals • GYT content integration into school curricula, reaching 1,210 students; • GYT content integration into SISTA program, reaching 68 African American young women	• 2,000 safer sex packets distributed • small media disseminated through partners and events (not tracked)	• Traditional media not used	• Website traffic increased by 743% from baseline (average of 750 hits/month), majority of traffic came from users typing in URL directly • 533 texts received to sexual health texting service • 302 new Twitter followers (6 months)

Organization (Location)	On the Ground Activities	Material Distribution	Traditional Media	New and Social Media
Clinic A (Kentucky)	• 5 seasonal mini campaigns implemented; • 100+ attendees at Valentine's day craft party • 32 educational workshops • *GYT* jeopardy game reached 20 participants • 101 new patients served in clinic during implementation period; 19.8% reported their visit was prompted by a *GYT* program	• > 4,881 materials distributed (included 2,000 gift bags)	• 3 paid ads in newspapers • 4 ads and an interview on Spanish-language radio	• Clinic Facebook page updated with GYT messages (no tracking metrics provided)
Clinic B (New Jersey)	• *STI Game* at the *Get Lei-d event* reached 300 youth participants • Poster contest: 4 winning posters used to promote GYT online, at tabling events and in schools • 2 health fairs at teen events • GYT skits reached estimated 161 individuals	• 900 safer sex kits distributed • Posters, flyers, GYT pins, and palm cards also distributed (no # provided)	• Ads in movie theaters • 1 radio interview on sex talk show	• Facebook ads prompted 821 click through to clinic website
Clinic C (South Dakota)	• 30 presentations reached ~ 1,130 middle school students • GYT booth at district health fair reached 500 students • Residential program presentation reached 25 teens; • Four clinic open houses drew 66 participants	Material distribution at concert (3,500 attendees): • 352 GYT bookmarks • 554 GYT handouts; • 2,000 condom compacts • 100 t-shirts • >2,000 other materials	• 344 radio ads • 1 radio interview • 4 magazine ads	• Facebook ads and electronic billboard ads placed
University A (Baltimore, DC, Philadelphia)	• 2 GYT events (GYT concert, other), reaching 250 youth • 200 self-collection kits distributed at concert event	• # of brochures, business cards, and t-shirts distributed not tracked	• Print ads in 4 community papers • Weekend radio ads (2 stations)	• 2,430 kits requested via web and SMS requests (Jan–Sept) • 11,399 (65.7%) of web visits came from users entering the website directly. Other web referrals from: online media coverage (msnbc; 6%), Facebook (3.8%), OK Cupid (2.8%), google.com/url (3.8%), and google.com/search (3.2%);

Organization (Location)	On the Ground Activities	Material Distribution	Traditional Media	New and Social Media
				• 669 kit requests in April compared to 101 in January (precampaign); • 145 Facebook likes
University B (California)	• Presentation and outreach activities reaching 1,411 individuals	• 500 condom-shaped key chains distributed	• Outdoor/public transit ads reached ~ 1000+ individuals/day	• No tracking metrics provided
University C (Missouri)	• GYT Kickoff event with four nonprofit organizations • 30 educational presentations (average 20–30 attendees) • 4 events using the GYT jeopardy game; • 3 courses integrated GYT content during semester	Distributed: • 7,000 condom machine stickers/ quarter sheets • 150 flyers • 421 table tents • 240 t-shirts	• GYT campus banner received 90,000 impressions • Campus bus wraps and poster ads reached > 1,000 students/day	• 35 new Facebook friends (eventually shifted funds from Facebook ads to more popular channels with audience); • 55 downloads of mobile app; • New online game, GYT links, and online sexual health information

Note. CBO = community-based organization; FB = Facebook; GYT = Get Yourself Tested; SMS = short messaging service; TV = television

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Table 3.

Number of Persons Tested for Chlamydia by Site: Comparisons From Baseline to Implementation Period.

Implementation Site	Locations Reporting Testing and Positivity Data	Evaluation Period	Reported Population	Baseline Period 2010, # Persons tested for chlamydia (positivity rate)	Campaign Period 2011, # Persons tested for chlamydia (positivity rate)	% Change in # persons tested for Chlamydia (2010–2011)	Z
County Health Department A	1 Health Dpt/clinic 1 University health center	Varied by location within site[a]	All individuals tested	992 (N/A)	1,053 (N/A)	+6.1%	1.35
County Health Department B	3 Colleges/ university events and health centers	April to May	Young females tested, ages 18–24	39 (N/A)	67 (N/A)	+71.8%	2.72**
CBO	3+ Sites • 1 CBO • 1 university • community testing events	March 1 to September 1	All individuals tested	95 (21.1%)	217 (13.4%)	+128.4%	6.91**
Clinic A	5 Sites • 4 clinics/health centers • 1 university	Entire calendar year	Youth tested, ages 15–24 years	1,472 (N/A)	1,479 (N/A)	+0.5%	0.13
Clinic B	6 clinics	April to May	Youth tested, aged 14–24	1,428 (16.8%)	1,181 (15.5%)	−13.4%	4.83**
Clinic C	3 Sites • 1 clinic • 1 college • 1 residential center	April to May	Young females tested, ages 15–24	73 (11.0%)	115 (13.0%)	+57.5%	3.06**
University A	Virtual site (online and SMS ordering of STD test kits)	January to August	Young females tested, ages 14–25	169[b] (7.7%)	250[b] (8.8%)	+47.9%	4.06**
University B	1 University clinic	January to July	All individuals tested	1,500 (6.7%)	1,941 (6.3%)	+29.4%	7.52**
University C	3 Clinics and university health center	April	All individuals tested	299 (13.0%)	659 (7.6%)	+ 120.4%	11.63**
Total				6,067	6,962		7.84**

Note. CBO = community-based organization; N/A = not available; SMS = short messaging service; STD = sexually transmitted disease.

[a]Health department clinic location reported for entire calendar year, whereas university clinic location reported from January 1 to May 15.

[b]Reflects number of screening kits returned during reporting period.

** $p < .01$.

Table 4.

Key Successes and Challenges.

	Key Successes	Key Challenges
Audience input		• Focus groups with youth and/or discussions with existing youth groups (e.g., peer educators, advisory groups, task forces) provided essential input for making campaign relevant • Small, age-specific youth committees/task forces more effective in engaging youth and soliciting input than larger groups that combine high-school and college age youth • Not all sites were able to enlist audience input into campaign planning
Promotion	Grassroots events	• Capacity developed for future events and programming: – Products and tools can be repackaged for future use (e.g., STD games, prepackaged themed mini campaigns) – GYT content integrated into college and other courses • Effective elements: – Promotional events (e.g., table tents, flyers) were less costly/ more effective in drawing youth to screening events than print media – Peer mentors/ambassadors/outreach were helpful in engaging target audience – Design contests effectively engaged youth, helped produce new materials (by target audience) and promote GYT at no cost – Games engaged youth and extended GYT message – Events that are fun, cool, and link STD testing to youth interests drew considerable youth participation • Unanticipated policy barriers (e.g., school administration approvals, city permits/security) and inclement weather caused additional time, planning and rescheduling of planned testing and promotional/social events
	Small media and promotional materials	• Materials developed for future use • Noteworthy items: – Palm card template (valuable in bringing youth in for testing) – Event fliers and table tents (deemed *most useful* and *cost Effective* at some sites) – GYT t-shirts – Swag: multicolored GYT buttons, “1 Got Tested” stickers, pink heart shaped GYT cell phone charms • Development of material, including localization and additional artwork, required more time than anticipated • Some partners (e.g., schools) required permission by before distributing materials
	Traditional media	• Traditional and small media advertising/promos were more effective in directing consumers to campaign websites than online and social media advertising • Newspaper advertising expensive and less effective than other channels at some sites

	Key Successes	Key Challenges	
		• Cinema advertisements directed individuals to a campaign's website. • Free/extended coverage in select channels • Paid bus advertising earned free placement for additional 3–5 months because space had not purchased by other advertisers • Additional radio airtime earned on program segment on reproductive health and community issues due to high volume of listener call-ins	• Colorful GYT graphics are eye-catching but increase cost of advertising in print media • Some localized materials may have had too many messages or calls-to-action (e.g., phone, Facebook, text and health center info) and fonts too small for their intended application (e.g., bus shelter ads)
	New media	• Mobile app successful in increasing test kit orders • Mobile apps developed during campaigns will continue to be improved and marketed • Texting campaign effectively reached low-income youth without Internet access • Peer educator outreach on Twitter was a quick, low-cost way to reach youth	• Some sites had limited staff capacity to maintain relevant online presence (e.g., update new media posts, offer peer-to-peer communication) • Fiscal policies prevented some sites from purchasing social media • Social media activities and texting services were met with limited response: – Limited FB page fans and response to advertisements – Limited uptake of text-message (info/testing locator) service – Advertising (e.g., conflicts with Facebook payment policy) – Some sites shifted (or would do so in future) funds from social media advertising to peer outreach or traditional media
Product and place		• Best time to reach students with testing events: over lunch or after 4 p.m • Importance of verifying testing sites at schools in advance to ensure feasibility (e.g., proximity to bathroom) and visibility (high traffic area)	• Discussions with stakeholders (clinic staff) revealed that campaign messages were not embraced at one site • Campaign limited by short implementation period, which ran through summer months at some sites • Limited youth testing at health departments, despite promotions; • Challenges in school settings • Delays caused by required permissions for material distribution; • School/campus events in April conflicted with GYT events • Sexual topic of campaign proved challenging at some sites
Price		• Students were more open to testing when other students were present or engaged them through interactive presentations; • "Buddy system" effective in encouraging testing (youth often came for testing in pairs or small groups)	• Limited ability to offer free testing for large number of students

	Key Successes	Key Challenges	
		• Giveaways (t-shirts, free food, colorful GYT buttons/stickers) effective in incentivizing testing among youth	
Partnerships		• Strong connections with youth leaders (e.g., student health centers, peer mentors/educators, youth groups) critical for effective and relevant campaign • Diverse partnerships developed (e.g., middle and high schools, colleges, city health departments, local clinics and health care providers; faith-based, non-profit and community-based organizations; recreation centers, local busi-nesses {e.g., clothing stores), radio stations • Partnerships extended the reach of campaigns (e.g., to minors and minority populations) and can be leveraged for future efforts	• Some partners did not provide follow-up information, which hindered evaluation efforts • Relationship-building process can be time consuming • School resistance to certain elements of campaign in conservative/faith-based communities resulted in: – More limited focus of campaign/events (e.g., “testing” instead of “sexual health”) – More limited availability of testing (e.g., at nearby clinics instead of on school campuses) – Limited or no condom distribution – Delayed material distribution – More limited promotion channels (e.g., In clinics rather than all over schools)
Staffing		Capacity developed: • Training of existing staff, including evaluation and social media skills • Training of peer leaders • Development of resources for future health fairs, presentations, events	• Limited staffing capacity due to shortages, position vacancies and/or competing demands on staff time (incl. unforeseen political issues that arose) • Limited evaluation capacity, including ability to track and report all results

Note. FB = Facebook; GYT = Get Yourself Tested; STD = sexually transmitted disease.