HHS Public Access

Author manuscript

AIDS Care. Author manuscript; available in PMC 2024 November 01.

Published in final edited form as:

AIDS Care. 2024 November ; 36(11): 1570–1579. doi:10.1080/09540121.2024.2372722.

Perceptions of a community-based HIV/STI testing program among Black gay, bisexual, and other MSM in Baltimore: a qualitative analysis

Rashida Hassan[a], **Nicole Thornton**[b], **Hope King**[a], **Gabrielle Aufderheide**[b], **Bradley Silberzahn**[c], **Steven Huettner**[b], **Jacky M. Jennings**[b], **Kimberly N. Evans**[a], **Errol L. Fields**[b]

[a]Division of HIV Prevention, Centers for Disease Control and Prevention, Atlanta, GA, USA

[b]Johns Hopkins School of Medicine, Baltimore, MD, USA

[c]Department of Sociology, University of Texas at Austin, Austin, TX, USA

Abstract

Black gay, bisexual, and other men who have sex with men (GBM) are disproportionately affected by HIV and STIs. Safe Spaces 4 Sexual Health (SS4SH), a community-informed, status-neutral HIV/STI testing intervention combines online outreach via geo-social networking apps and social media with mobile van testing. During 2018–2019, we recruited 25 participants for interviews about their perceptions of SS4SH compared to clinic-based testing. Participants were aged 21–65 years (mean 35); 22 (88%) identified as Black/African American; 20 (80%) identified as gay; and 10 (40%) were living with HIV. Interviews were transcribed, coded, and analyzed using a modified thematic constant comparative approach. Five themes emerged; two related to perceptions of online outreach materials (participants were drawn to eye-catching and to-the-point messages and desired more diversity and representation in messages), and three related to preference for the mobile van (participants found SS4SH provided more comfort, more privacy/confidentiality, and increased accessibility and efficiency). GBM is increasingly using geo-social networking apps to meet sexual partners, and tailored online outreach has the potential to reach historically underserved populations. SS4SH is a barrier-reducing strategy that may serve as an entry to a status-neutral approach to services and help reduce stigma and normalize accessing HIV services.

Keywords

HIV; sexually transmitted infections; black sexual minority men; health disparities; qualitative analysis; SDG3 good health and well-being; SDG 10 reduced inequalities

CONTACT Rashida Hassan rhassan1@cdc.gov.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Introduction

Gay, bisexual, and other men who have sex with men (GBM) accounted for 69% of new HIV diagnoses in 2019 (Centers for Disease Control and Prevention, 2021a). One in five Black GBM with HIV do not know they have HIV, and Black GBM have lower rates of engagement in HIV care and viral suppression compared to all people with HIV (Centers for Disease Control and Prevention, 2019, 2021a, 2021b). Black GBM are also disproportionately affected by sexually transmitted infections (STIs). In 2019, non-Hispanic Blacks accounted for 30.6% of all chlamydia, gonorrhea, and syphilis cases in the U.S.A., despite accounting for only 12.5% of the U.S. population (United States Census Bureau; Centers for Disease Control and Prevention, 2021c). Rates of STIs also remain higher for GBM than for men who have sex with women only (MSW) and women. (Centers for Disease Control and Prevention, 2021c) Reducing these health disparities is critical to reducing disease burden, improving health outcomes, and Ending the HIV Epidemic (EHE) in the U.S.A. (U.S. Department of Health and Human Services, 2021)

An estimated 80% of HIV transmission in the U.S.A. is due to people who do not know they have HIV or are not receiving routine HIV treatment; therefore, CDC recommends that all sexually active GBM get tested for HIV and STIs at least once a year, and that those who engage in behaviors that may increase their chances of getting HIV may benefit from more frequent testing (DiNenno et al., 2017; Li et al., 2019; U.S. Department of Health and Human Services, 2021; Workowski & Bolan, 2015). Unfortunately, Black GBM continues to face structural barriers to accessing testing and care services, such as stigma and discrimination, structural racism in the healthcare system, a lack of adequate culturally tailored services, limited services where Black GBM live, and a deficiency of services in correctional institutions (Bailey et al., 2021; Levy et al., 2014; Matthews et al., 2019; Mays et al., 2004; Tempalski et al., 2020). Black GBM are less likely than GBM of other races to have health insurance or a primary healthcare physician, are less likely to feel comfortable disclosing sexual behaviors to their healthcare providers, and are more likely to live in areas with the lowest density of HIV prevention services (Bernstein et al., 2008; Dorell et al., 2011; Levy et al., 2014; Magnus et al., 2010; Millett et al., 2012; Petroll & Mosack, 2011; Pierce et al., 2007; Qiao et al., 2018).

The Anderson behavior model of healthcare utilization, initially developed in the 1960s, is a useful lens to help understand factors impacting the utilization of health services (Andersen & Newman, 2005; Andersen, 1995). The model posits that domains of environment (physical environment and the health care system), population characteristics (predisposing characteristics, enabling resources, and perceived need), and health behavior (motivation, use of services) all influence and impact health outcomes. (Andersen & Newman, 2005; Andersen, 1995) In general, alternatives to traditional clinic-based testing, such as tailored community-based strategies, self-testing, and expedited testing events can increase testing rates among Black GBM (Campbell et al., 2018; Drumhiller et al., 2018; Frye et al., 2018; Sharma et al., 2014). These approaches may increase the percentage of people with HIV who are aware of their status, linked to care and virally suppressed, and reduce the rate of new HIV infections among this population.

Among the >1.7 million CDC-funded HIV tests conducted in 2021, 74% were conducted in healthcare settings, such as community health centers and STI clinics (Centers for Disease Control and Prevention, 2021d), likely most often reaching people already engaged in healthcare. Community-based non-healthcare testing sites can increase reach to minority populations by reducing structural barriers such as confidentiality concerns and stigma (Holliday et al., 2017; Mathews et al., 2020; Mdodo et al., 2014; Weidle et al., 2014). To address this need, our team developed a community-based testing strategy tailored to Black GBM in Baltimore City, Maryland – Safe Spaces 4 Sexual Health (SS4SH). In this analysis, we explore SS4SH participants' perceptions of online outreach messages for recruitment and experiences with this testing program as compared to their prior clinic-based testing experiences.

Materials and methods

Safe Spaces 4 Sexual Health (SS4SH) is a community-informed, status-neutral HIV/STI testing intervention combining online outreach with mobile van testing (Fields et al., 2022; Safe Spaces & Places). GBM were recruited for testing through direct online messaging, online ads in social and sexual networking apps (e.g., Grindr, Facebook), and participant referrals. Images, text and messaging for advertisements and all other recruiting materials were community-informed using findings from our team's prior work (Fields et al., 2020a, 2020b) and feedback from a community advisory board (CAB) of Black GBM. The CAB voiced the following recommendations which we incorporated in the development of recruiting materials: (1) images that show the local urban setting, (2) images of Black gay couples, (3) sexually enticing images or messages– especially for ads to be placed on "hook-up" sites, (4) messaging that communicated linkage to sexual health services, and (5) prioritizing images of Black men. A sample of the images used is shown in Figure 1.

Participants were eligible for SS4SH if they were at least 18 years old, identified as cisgender male, and reported oral or anal sex with another man within the past 12 months. The mobile van operated in 4-hour shifts, 4 times weekly rotating across 15 locations from February 2018 to April 2019. In total, 151 participants were recruited for SS4SH. Participants completed a 20–30 minute ACASI (Audio Computer-Assisted Self-Interviewing) survey on provided tablets. Questions were adapted from the National HIV Behavioral Surveillance survey and included demographics, sexual behaviors, and behaviors associated with HIV transmission (Gallagher et al., 2007). Participants had the option to receive rapid HIV tests, as well as syphilis and gonorrhea/chlamydia testing on the van and were provided incentives for completing the survey ($50) and HIV/STI testing ($10 per test type). A trained HIV counselor provided HIV rapid test results, and those with a reactive test were referred to HIV care. Participants completed an intake form, and their demographic, contact, other information was sent with their biological specimens to the Baltimore City Health Department (BCHD). BCHD processed the confirmatory HIV and STI tests and contacted participants with test results using routine procedures. The study team received de-identified results linked to participants' ACASI forms using a unique study identifier. Results were manually matched to qualitative interview data using interview dates and reported demographic information.

Between October 2018 and January 2019, we recruited 25 GBM following their participation in SS4SH. Participants completed 60-minute semi-structured qualitative interviews. Interviews were conducted by research staff with prior experience in conducting qualitative interviews, and participants received a $50 incentive. All interviews were completed in a private office, were audio recorded, and transcribed verbatim. The interview guide focused on the following domains: (1) Participants' reasons for accessing SS4SH for HIV/STI testing services, (2) Their experiences accessing these services, (3) How their experience compared to other HIV/STI testing services they had accessed previously, and (4) The acceptability of offering these services long-term. This study was reviewed and approved by the institutional review board at the Johns Hopkins University School of Medicine.

Data analysis

ACASI data were analyzed in Stata 17.0 to generate descriptive statistics. Qualitative interviews were transcribed, de-identified, and uploaded to NVivo 12 for coding and analysis using a modified thematic constant comparative approach, and thematic codes were compared within and across interviews. We conducted coding using a 3-stage analytic approach: open coding (examining transcripts for relevant codes), axial coding (identifying associations between codes), and selective coding (identifying a core category integrating axial codes) (Ritchie et al., 2013). Transcripts were separated into segments, sorted into categories, and coded, allowing for a comparative examination across participants on pertinent topics. Codes were identified through open coding and data immersion.

A three-tiered coding hierarchy was developed based on categories that emerged during open coding performed by authors GA and EF. GA and EF used this hierarchy to develop a codebook and trained another staff member on the completed codebook (BS). We used stepwise replication to improve the dependability of the coding process. GA and BS double-coded 20% of the transcripts to establish inter-rater reliability based on the categories that emerged from the analysis. Differences in coding were discussed between GA and BS until a consensus was reached. After establishing an agreement, GA and BS completed coding the remaining transcripts.

For the final stage of coding (selective coding), we identified a core category that related to all previously identified codes and was relevant to the research domains by writing memos while coding, which included descriptions of recurring themes, possible relationships among major categories, and variations in responses to questions or expressions of themes relevant to the research question.

Results

Participant characteristics

Participants ranged in age from 21 to 65 years (mean 35) (Table 1). Twenty-two (88%) identified as Black/African American, and 20 (80%) identified as gay. Ten participants (40%) were living with HIV, including one participant (4%) with a new HIV diagnosis. Four (16%) participants had laboratory evidence of syphilis antibodies and had been previously

treated, and three (12%) tested positive for a new syphilis infection. Three (12%) tested positive for chlamydia, and none of the participants tested positive for gonorrhea. Ten (40%) reported seeing online recruitment ads for the SS4SH mobile testing van. There were no statistically significant differences among the interview participants and the SS4SH study participants across these characteristics.

Qualitative results

Five main themes related to their perceptions of the online outreach materials (two themes) and their preference for the SS4SH mobile van (three themes) emerged from the interviews. Illustrative quotes by theme are presented in Table 2.

> **Theme 1: Drawn to eye-catching and to-the-point, online outreach messages:** "*Just being blunt, especially for Baltimore City, just being blunt*."

Forty percent of the qualitative interview participants reported seeing the online outreach messages posted on geo-social networking apps or social media platforms. Participants preferred messages that were clear and easy to understand, especially in the short amount of time messages would pop up on their phones while using apps.

Participants liked seeing messages with images of people participants described as attractive and found these ads eye-catching and appealing. Many described being drawn to click on ads if there were enticing images. However, participants were also drawn to pictures that felt relatable, rather than seeing only images of men who looked like models.

Participants enjoyed seeing messages that incorporated humor or illustrated a casual experience, which seemed to dispel some of the stress around seeking testing or medical services. Overall, participants preferred direct, easy-to-understand messages that included a mixture of images, both of enticing and relatable people.

> **Theme 2: Desire to see more diversity and representation in online messages:** "*Do a variety of races because gay is not only for black men*."

Participants appreciated seeing Black GBM in the images, but many wanted to see more diversity. They preferred images that encompassed the totality of the diverse GBM experience. Similarly, participants wanted to see more racial, gender, and sexual identity diversity in the messages. Many felt that including only Black GBM might imply that others are not impacted by HIV and STIs. They preferred messages that made it clear that anyone can get HIV or an STI, and so everyone should get tested.

The last three themes that emerged from the qualitative interviews related to participants' experiences with and preference for the SS4SH mobile van over other venues for HIV and STI testing:

> **Theme 3: Greater sense of comfort with staff and testing environment:** "It was like a different environment than being in a hospital. And everybody was real kind and polite."

Participants described both positive and negative past experiences getting tested at clinic-based venues. Some had prior experiences with staff being rude, unpleasant, or distracted;

they felt staff were not personable or did not care about their needs. Other participants described past testing experiences where they've seen friendly staff, which encouraged them to return to these sites for care.

Overall, participants said that SS4SH staff were friendly and welcoming, and they took the time needed to explain everything to them in detail. They appreciated the care staff took in their interactions. Participants felt that staff at SS4SH were caring and didn't rush through the process. Participants also appreciated the casual and friendly atmosphere at SS4SH, which created a relaxed and comforting environment.

Participants had positive and negative experiences getting tested at clinics previously. Overall, participants said the SS4SH van provided an environment where they felt comfortable opening up and talking about their sexual history. They appreciated the accepting language and comfortable environment provided in the van.

> **Theme 4: Provided more privacy/confidentiality:** "I felt like the van is much more discrete and private … When you're in the [STI clinic], you're out there with a bunch of people … it's just really crowded."

Participants were fearful of seeing people they know at a testing location and described that as a barrier to accessing testing services at traditional clinic locations. Participants preferred a more discreet testing environment, where it would not be obvious that clients were there for STI or HIV testing. Participants preferred the privacy of the van compared to past testing experiences, where clinics were often crowded, and it was easy for their conversations to be overheard. Participants thought keeping the van available long term was a good idea, because it offered more privacy than other testing venues.

Participants appreciated that the van appeared inconspicuous; it was not easy for people passing by to know what was happening inside the van, so participants felt an added sense of privacy and confidentiality seeking testing. Participants felt this would attract folks to the van who may avoid getting tested at traditional clinics.

Participants felt the van provided an extra layer of privacy and confidentiality to their testing experiences, that they often do not have when going to a clinic for testing.

> **Theme 5: Increased accessibility and efficiency:** "I did really like the van being in the evening hours, being offered multiple days per week so that I could fit it in my schedule. I like that it shows up in different places in the community."

Participants described that most traditional testing sites offered limited hours, usually during regular business hours, creating a barrier for accessing these services. Participants had busy work schedules that did not align with these traditional hours, limiting their access to these services. Participants really appreciated that the van offered evening hours and was open several days a week, making it easier to schedule appointments around their busy schedules.

Participants also saw benefits in the mobility of the van, because it was able to provide testing throughout the community to areas that may not have many testing sites, eliminating transportation barriers. Participants also wanted an efficient and quick testing experience.

Some participants had waited for long times at other testing sites, especially crowded and busy locations. They appreciated that the testing process at SS4SH was quick and timely.

Participants described the flexible and extended hours, the mobility of the van itself, and the efficiency of the visits as benefits to the van over traditional clinic-based testing venues.

Discussion

Participants were recruited via a novel method, which involved tailored online outreach messages on geo-social networking apps and social media platforms. Participants preferred recruitment messages that were direct and included diverse persons in the images; some participants preferred images that were enticing or eye-catching, while others preferred seeing people who were more relatable. Participants generally preferred SS4SH because it mitigated barriers to HIV/STI testing they encountered in typical clinical settings. Participants felt a greater sense of comfort with SS4SH, more privacy/confidentiality, and increased accessibility. SS4SH is an innovative recruitment and testing strategy with the potential to help reduce health disparities for STIs and HIV among Black GBM and further EHE goals by increasing the number of people who are aware of their HIV status.

GBM are increasingly using geo-social networking apps to meet sexual partners. Online platforms may increase exposure to sexual networks which are more dense, homogenous, and sometimes include those with untreated or unsuppressed HIV and STI infections, which may facilitate increased transmission of these infections, although this was not something we were able to measure within the scope of this study (Brantley et al., 2017; Jennings et al., 2015; Lewnard & Berrang-Ford, 2014). Tailored online outreach for testing and other care services has the potential to reach historically underserved segments of the population disproportionately impacted by HIV, especially Black GBM (Centers for Disease Control and Prevention, 2019, 2021a, 2021b). Previous studies have shown that different types of recruitment strategies (both online and offline) reach different subsets of the GBM population, and a variety of strategies are needed to recruit a diverse and representative sample of GBM (Iott et al., 2018). Future approaches should use diverse and representative images on population-specific recruitment platforms, which reflect the local population.

SS4SH is a barrier-reducing strategy and can serve as an entry point to a status-neutral approach to HIV care and prevention services, where every HIV test result (negative or positive) leads to an engagement in care (Myers et al., 2018; U.S. Department of Health and Human Services, 2021). While SS4SH did not include a linkage to care component, future iterations of this approach could include immediate linkage to HIV care and treatment, for those persons living with HIV, and immediate linkage to HIV prevention services, such as pre-exposure prophylaxis (PrEP), for those who test negative (Myers et al., 2018; U.S. Department of Health and Human Services, 2021). Creating a low threshold entry to these two pathways will help to further reduce health disparities in rates of viral suppression and PrEP utilization.

Participants appreciated the non-traditional hours offered by the mobile testing van and found it more convenient to go for testing in the evenings or on the weekends. Mobile

testing units have the potential to further reduce barriers to accessing testing services, by reducing transportation and time barriers and meeting people where they are. Different testing strategies have been shown to reach different segments of the population (Baytop et al., 2014; Ellen et al., 2003), highlighting the importance of offering a variety of testing options to ensure access for all. This will help achieve the CDC-recommended annual STI and HIV testing for all sexually active GBM and reduce racial disparities in HIV testing rates (DiNenno et al., 2017; U.S. Department of Health and Human Services, 2021; Workowski & Bolan, 2015).

When designing tailored service models for Black GBM, it is important to consider the domains as outlined in the Anderson behavior model, which are specific to the population (Doshi et al., 2013; Elopre et al., 2021). For example, SS4SH creates a welcoming environment for Black GBM (creates a trusted provider-patient relationship, maintains privacy and confidentiality), tailors messages and services for the population characteristics (provides mobile testing in the community where people are, with accessible hours and location), and appeals to health behavior practices/beliefs of this population (online testing messages that appeal to and motivate Black GBM to access services).

This analysis has several limitations. First, there is the potential for social desirability bias, as the interviewer was a frequent staff member on the van so participants may have been inclined to express more favorable responses (Bergen & Labonté, 2020). While this limitation could not be eliminated, we attempted to mitigate the impact by ensuring interviewers were trained and experienced in in-depth interview techniques, including strategies to build rapport and trust with participants. Second, this study only looked at one modality of non-clinic-based testing and did not compare the acceptability and feasibility of alternative strategies. Other approaches, such as venue-based strategies and self-testing, may be preferred by some over the SS4SH modality. Third, the results of this analysis may not be representative of the Black GBM population outside of Baltimore. Finally, these data were collected prior to the COVID-19 pandemic, and do not reflect subsequent changes in HIV testing strategies. Further plans include tailoring this strategy for younger men, expanding it to include linkage to HIV prevention and care services, and evaluating the effectiveness of this model compared to standard public health mobile van testing and alternate strategies implemented as a result of the pandemic.

In conclusion, innovative and population-specific strategies can reduce barriers to HIV testing for Black GBM. Further analyses of population-specific and culturally competent approaches will help to identify an optimal suite of modalities to deliver testing services to Black GBM who may not access traditional testing venues. Additionally, implementation science research will help elucidate the most effective ways to implement such strategies given real-world constraints. Identifying and implementing approaches to reduce barriers for Black GBM to access HIV testing, prevention, and care services will reduce the burden of HIV among this population and further EHE progress toward reducing new HIV infections and racial HIV disparities in the U.S.

Funding

This work was supported, in part, by the Centers for Disease Control and Prevention, U.S. Department of Health and Human Services (HHS) award U01PS005115.

Disclaimer

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

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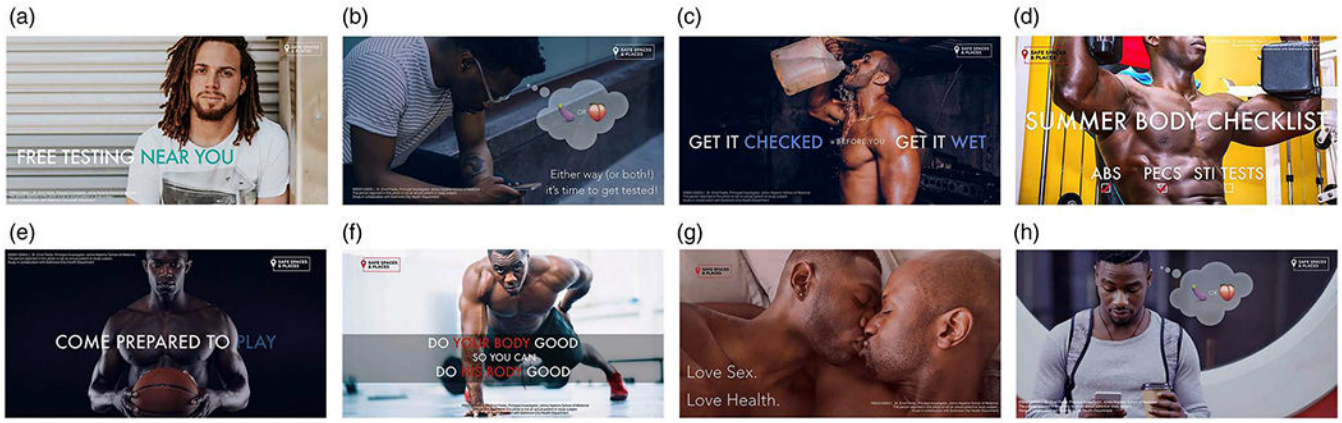

Figure 1.
Sample SS4SH online advertisements.

Table 1.

Characteristics of safe spaces and places (SS4SH) mobile testing van qualitative interview participants (*N* = 24) compared to all SS4SH participants (*N* = 127), for whom ACASI and HIV/STI testing data are available.

Characteristic	Qualitative interview participants *N* = 24 *N* (%)	All other SS4SH participants *N* = 127 *N* (%)	*P*-value
age (years)	**Mean = 34.8, SD = 11.4**	**Mean = 34.0, SD = 9.9**	**0.713**
Race			
Black/African American	20 (83.3)	92 (72.4)	0.844
White	3 (12.5)	25 (19.7)	
Hispanic	1 (4.2)	8 (6.3)	
Non-Hispanic, Other	0 (0)	2 (1.6)	
Sexuality			
Gay	20 (83.3)	96 (75.6)	0.510
Bisexual	3 (12.5)	27 (21.3)	
Heterosexual	0 (0)	2 (1.6)	
Unknown	1 (4.2)	2 (1.6)	
HIV Result			
Previous Positive	8 (33.3)	39 (30.7)	1.000
New Positive	1 (4.2)	9 (7.1)	
Negative	14 (58.3)	70 (55.1)	
Unknown	1 (4.2)	6 (4.7)	
Not Tested	0 (0)	3 (2.4)	
Syphilis result			
Positive	3 (12.5)	10 (7.9)	0.870
Previously Treated	4 (16.7)	20 (12.8)	
Negative	13 (54.2)	75 (59.1)	
Unknown	1 (4.2)	4 (3.2)	
Not Tested	3 (12.5)	18 (14.2)	
Gonorrhea result			
Positive	0 (0)	4 (3.2)	0.420
Negative	24 (100)	110 (86.6)	
Unknown	0 (0)	1 (<1)	
Not Tested	0 (0)	12 (9.5)	
Chlamydia result			
Positive	3 (12.5)	9 (7.1)	0.375
Negative	21 (87.5)	105 (82.7)	
Unknown	0 (0)	1 (<1)	
Not Tested	0 (0)	12 (9.5)	

Note: Data are missing for 24 SS4SH participants and one qualitative interview participant.

Table 2.

Selected illustrative participant quotes by theme.

Theme 1: Drawn to eye-catching and to-the-point, online outreach messages	You want to keep it direct … And especially because a lot of times when they're on the apps with the – looking at the ads of the app, it shows up when they open it up. So, it literally is "I see it, now I don't". And so, keeping it to where they see the words "get tested," "free testing," and stuff like that … because you have ten seconds for them to see that and to grab their attention. (*32-year-old Black gay male, person living with HIV – previous positive, syphilis and chlamydia positive*) Well, they're beautiful men with beautiful bodies, I mean, you know … so that kind of grabs my attention. (*56-year-old Black gay male, person living with HIV – previous positive, STI negative*) Like when you see it, you can kind of see yourself when it's just a regular person in the ad. (*25-year old Black gay male, HIV negative, STI negative*) I thought they were tongue-in-cheek. I thought it was a – there's a way it grabs attention, but also it kind of does deliver the message … They were just like puns … just light-hearted, I guess. It kind of takes away some of the like nervousness of just any medical situation … with a more casual understanding atmosphere in the ads that helps with taking away the … seriousness … *(26-year old White gay male, HIV negative, STI negative)*
Theme 2: Desire to see more diversity and representation in online messages	And looking at some of the ads, I like the diversity, but it's also looking for like more diversity as well. So, it's not even just using Asian models. Using bears. Not just muscle guys. Use twinks, use bears, guys with different body types because what's going to happen is psychologically, they'll look at an ad and they'll be like, "Oh, I see a bear on there. He looks like me." And so, psychologically, they'll actually look at the ad longer if they see a body type that matches theirs. (*32-year-old Black gay male, person living with HIV – previous positive, syphilis and chlamydia positive*) So I think I always have an issue with stuff that [targets] especially toward MSMs … I feel like this is just saying a one message, that it's only for men … So I feel like messages need to be carefully catered, because I understand that this study involves MSM, but for somebody who doesn't know that the study just involves MSM … Somebody looking at this is just going to think, okay, well, PrEP is just for MSM. (*38-year-old Black bi-sexual male, HIV negative, STI negative*)
Theme 3: Greater sense of comfort with staff and testing environment	[The public health clinic staff] don't care as much. They just see the patient. They treat you. I feel like they not worried about you per say. They just worried about how many partners you have. (*33-year-old Black gay male, HIV negative, STI negative*) I always have a good experience with [the academic hospital] that's why I always usually go there for the emergency treatment rather than any hospital in Baltimore, so they're always very nice and try to make me feel comfortable, crack a little joke every now and then so it's always helpful. And they know I'm a little uncomfortable with needles so they always try to joke about, "Put on your big boy drawers," and stuff like that, so yeah, they made me feel comfortable. (*35-year-old Black male, HIV negative*) It was like a different environment than being in a hospital. And everybody was real kind and polite so it didn't it, you know, it just it didn't seem as if you was you know how usually when you go into a hospital and like a lot of people, they hate the hospital. It didn't give that type of feeling. It was like a little bit more casual, you know … the staff that was in the van they're a lot younger than the staff that's at the [public hospital] is … I guess it was like I was having the test done by my peers versus like my parents. (*30-year old Black gay male, person living with HIV – previous positive, STI negative*)
Theme 4: Provided more privacy/ confidentiality	[At the public health clinic] I kept thinking like what if I see somebody I know, but then I had to think uncomfortable like, okay, it's a free clinic, I'm pretty sure everyone comes here when they don't have insurance. But now I have insurance now, so … .Because all I could think about was, oh, my God, somebody's going to think I've got an STD or something like that. (*27-year-old Black gay male, HIV negative, STI negative*) So I think the van is more private, I can sneak in and sneak out and especially it's at night now too, I can get in and get out and ain't got to worry … Nobody's going to know that I'm at the clinic. I go to [a specific clinic] … everybody knows. I think the van is a great idea. (*49-year-old Black gay male, person living with HIV – previous positive, previously treated for syphilis*) I think that it appeals to usually the Black gay man just because like I said, it's more discrete and a lot of people don't want everyone to know their business and HIV is so big in our community so it's just like I think it does appeal more to a Black gay man. (*35-year-old Black male, HIV negative*)
Theme 5: Increased accessibility and efficiency	So a lot of times, one thing I've noticed across anywhere in the country is that when there's STI testing and there's a brick and mortar, they only do testing from a certain time to a certain time so it's quote unquote normal business hours … like I love the fact that you guys do a mobile unit, that you guys have night shifts because a lot of people if they want to get tested, if they have jobs, they're not off until five and your last test is at six … it's hard to get in for them to be an actual working adult to, "I have to call off work just to go get tested," and everything else, and it should be available a lot easier … because then more people will get tested, the more people feel comfortable to be tested because it's convenience. (*32-year-old Black gay male, person living with HIV – previous positive, syphilis and chlamydia positive*) [The van] gives people a chance that don't have a chance to go to the doctor's office, they can find the location where you guys are going to be and make it easy for them to get to. (*53-year-old Black gay male, person living with HIV – previous positive, STI negative*) To me the mobile health van is faster. They do the same tests and it's quicker. It's like done, you're in and out. (*34-year-old Black gay male, HIV negative, STI negative*)