month follow-up (relative risk, 3.5; p=.03—not shown). At the one-year follow-up, the effect was no longer significant.

Testing and Safer-Sex at Follow-Up

There were no significant differences in sexual risk behavior between women who had been tested for HIV between baseline and the first follow-up and those who had not. About two-thirds of each group had reduced the proportion of times they had unprotected vaginal or anal sex, or reported no occasions of unprotected sex at either baseline or follow-up. At the one-month follow-up, there was no significant difference between women who had been tested and those who had not with regard to the median proportion of occasions on which condoms were used (65% and 75%, respectively), partner risk characteristics or lifetime STD history. Results were similar in subanalyses comparing intervention and control women.

At the one-month follow-up, women who had undergone mutual testing and those who had not were equally likely to say that they had decreased their proportion of unprotected sexual occasions or had no unprotected intercourse (70% and 66%, respectively). Results were similar at the six-month and one-year follow-up interviews.

DISCUSSION

This study provides important information to enhance HIV testing programs and to link HIV testing with traditional family planning services. Of our sample of clinic clients, 67% had been tested for HIV at baseline, which demonstrates that women who use clinic services are willing to undergo HIV testing. More than one-third of women who decided to get tested had done so as part of other health care services, suggesting that ease of access to testing was a factor in their decision. For these women, it appears that family planning clinics are an appropriate and efficient site for HIV testing and counseling, and that offering HIV testing as part of routine services can increase testing rates.

Some caution is needed in generalizing these results to all clients of family planning clinics, or even to all clients in urban settings. This sample was self-selected for a longitudinal HIV and STD prevention study, and thus cannot be considered representative of the general population of at-risk women living in regions of high HIV seroprevalence. In addition, we were unable to examine confidential HIV testing data in our random chart review of clinic clients; thus, we cannot infer that our testing rates are typical of the Planned Parenthood client population. Our sample, however, was similar in demographic characteristics and STD rates to this population. Therefore, it seems reasonable to conclude that our findings are generalizable to this particular clinic population.

In addition to accessibility, we identified other facilitators of testing. The vast majority of women who had been tested had done so because they felt at risk of acquiring HIV as a result of their own or their partner’s sexual behavior. These women felt that being tested was a way to decrease their anxiety about HIV. As compared with those who had not been tested, women who had been tested had a larger lifetime number of partners and were more likely to have a history of STD infection. Therefore, the decision to be tested for HIV appears to be motivated in part by an accurate assessment of some lifetime risk factors.

The predominant reason for avoiding HIV testing, cited by more than half of the women who had not been tested, was anxiety about a possible positive result. Nearly 20% also reported concerns about how their partner would react as a reason for not being tested. These findings highlight the importance of using pretest counseling to directly address anxiety about testing and concerns about partner reaction. Furthermore, more than one-fourth of women reported that concerns about confidentiality were a reason why they chose not to be tested; this finding supports results of previous studies. Facilities providing confidential testing may be able to address this issue by offering information on anonymous testing sites.

In spite of the high rates of individual testing, only about half of these women reported that their main partner had been tested for HIV. Nearly half did not know their partner’s HIV status, suggesting that many women had not explicitly discussed HIV with their partner. More important, only 12% of women had been tested with their partner.

This group-based, cognitive-behavioral intervention affected women’s attitudes toward HIV testing in several ways. Although individual testing was not explicitly promoted as a prevention strategy, women exposed to the intervention were more likely than those who were not to have undergone testing by the one-month follow-up. This result, however, was restricted to women who had already been