tory of gonorrhea and fewer than 1% had a history of both. Eight percent of sexually active women had been treated for PID; 5% (approximately 60% of those with a history of PID) had been treated once, 2% had been treated 2–3 times and 1% had received treatment more than three times. Twenty-four percent of women diagnosed with PID had been hospitalized for the condition (not shown).

Thirteen percent of women whose first sexual experience occurred before age 15 reported a bacterial STD, compared with 3% of women who initiated intercourse after age 18 (Table 2). Women who had had more than five sexual partners were 10 times as likely as women who had had one partner to report a history of infection.

Women who had ever used a condom were more likely to have a history of bacterial STD infection than were those who had never used a condom (7% vs. 3%), and those who had ever used a condom to prevent disease transmission were more likely to report a history of infection than were those who had never done so. These findings may be explained by limitations in the data set that make it impossible to determine the order of events. Women with a history of STD infection were probably urged to take precautions, and therefore changed their behavior so as to prevent other infections. Furthermore, women who had been screened for an STD in the past year were more likely to have had a bacterial infection than were women who had not been screened (18% vs. 5%). Again, the inability to sequence these events makes interpretation difficult; the recent screening, for example, may have been associated with the reported STD.

Table 2 also indicates that the risk factors associated with a history of PID are similar to those associated with bacterial STD infection. Women who had first intercourse before age 15 were twice as likely to have had PID as were those who had first intercourse after age 18, and women with more than five partners were almost three times as likely as those with one partner to have had PID. In addition, black women were more likely to have had PID than were white women (10.6% vs. 7.2%, not shown).

Women who had ever used an IUD were more than twice as likely to have had PID as were women who had not done so, and women who douched were about twice as likely to have had the condition as were women who had never douché. PID was three times as common among women with a history of bacterial infection as among those with no such history.

**Multivariate Analyses**

In an initial set of regression analyses, lifetime condom use, frequency of intercourse and marital status were not significant predictors of bacterial STD infection and were therefore not included in the final analysis. (Presumably, condom use contributed little because the vast majority of women—82%—reported having used a condom at some time.)

The first panel of Table 3 (page 8) indicates that race and age contributed significantly to the likelihood of infection with a bacterial STD. Once the effects of all other variables are controlled, the estimated odds of a bacterial STD among black women were 1.7 times the odds among white women. Similarly, women aged 25–34 were nearly 1.3 times as likely as women aged 35–44 to report having a bacterial STD.

Age at first intercourse and lifetime number of sexual partners were highly significant predictor variables. Each year of age that women delayed first intercourse reduced the odds of a bacterial STD by 6%, and women with more than five partners were approximately nine times as likely to report a bacterial STD as were women with one partner.

To further examine the contribution of race to the risk for bacterial STDs, we estimated logistic regression models of bacterial STD infection separately for black and white participants (not shown). Both analyses included age, education, age at first sex and lifetime number of sexual partners.

For white females, only the lifetime number of partners achieved statistical significance: Women with more than five partners were nearly 10 times as likely to report a history of infection as were those with one partner, and those with 2–3 partners were twice as likely.

However, for black females, lifetime number of partners, age at first sex and educational attainment all had statistically significant effects. The odds ratios for number of sexual partners were similar to those observed in the model for white women, while each year of age that initiation of intercourse was delayed reduced the odds of bacterial STD infection about 10%. The effect of education on risk for bacterial STDs among black women is unclear: Black females with a high school diploma were about half as likely to report a bacterial STD as were those with a college degree, but black women with less than a high school education and those reporting some college education did not differ significantly.

The second panel of Table 3 indicates that the characteristics affecting the odds of PID differed from those influencing infection with bacterial STDs. Race, for example, had no significant effect on PID risk, while education had a linear and significant negative effect: Women who had not completed high school were 1.8 times as likely to report treatment for PID as were women who were college graduates, while those who had completed high school had a risk 1.4 times as great as that of college graduates. Women who had obtained some college education had a marginally higher risk than college graduates.

Age at first intercourse did not contribute significantly to the risk of PID, and lifetime number of partners had a limited effect: Women who had had more than five partners were 2.2 times as likely as...