DATA AND METHODS
We collected data from the charts of clients who received care at an urban Midwestern prenatal clinic. The study was approved by the University of Minnesota’s institutional review board.

Sample Selection
Using a matched retrospective cohort design, we selected participants from an automated clinical database containing data for all 1,865 women who received care at the clinic and delivered at an affiliated hospital between 1991 and 1996. This database included demographic and clinical information, as well as documentation of abuse status as reported by the client to a clinic social worker.

We identified all clients who had experienced physical or sexual abuse and had delivered a live-born singleton, and selected this group of 304 women for chart review. (We excluded women who had a fetal death because of incomplete documentation.) For each abused woman, we randomly selected two women who did not report any abuse and who delivered live-born singletons to serve as a comparison group. These women were matched to the abused women by maternal age-group (younger than 20 vs. 20 and older)* and year of infant’s birth.

Thus, 912 women (49% of those who received services) were selected for chart abstraction. Of this sample, 149 were excluded because their charts lacked documentation of abuse status† (i.e., no social worker’s form), and two because the database had duplicate entries. Thirteen women had had more than one delivery during the study period; for each of these, we randomly selected one pregnancy for study inclusion. Prior to analysis, four women were excluded because their charts lacked documentation of STD testing during the study pregnancy. The remaining sample consisted of 744 women who had chart documentation of abuse status and of STD testing during the study pregnancy, and who delivered live-born singletons.

Data Collection
Medical and demographic data were originally charted on standardized prenatal care forms and were abstracted for the study via retrospective chart review by two medical records technicians who were unaware of the study hypotheses. The outcome measures were documented STD history (as reported by the women) and incident STD (as determined by a laboratory test during the study pregnancy). Clinic protocol required routine testing for gonorrhea, syphilis and chlamydia at 16 weeks’ gestation or at the first prenatal care visit if that visit occurred after 16 weeks; testing for gonorrhea and chlamydia was repeated at 36 weeks. Screening for HIV, human papillomavirus, herpes, trichomoniasis and other infections was conducted as indicated for symptomatic or at-risk patients; the designation of at-risk was subjectively defined by clinicians on the basis of social or demographic risk factors for STD. If a woman tested positive for a viral STD (e.g., herpes or human papillomavirus), we cross-checked her medical history to verify that the infection was new.

Abuse data were originally collected and documented in the medical record by one of the clinic’s two social workers. According to clinic protocol, a social worker conducted a psychosocial interview with each client during her first prenatal visit. The interview included a standard list of topics, all of which were to be discussed in an open-ended format; there were no standardized questions. The social work-

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*For analysis, however, we examined women younger than 18 or 18 or older because of differential STD risk.
†These women were all from the comparison group.