**Differences in Chlamydia Positivity—Asian and Native Hawaiian/Other Pacific Islander Women Age 15-24**

In Region IX and X Infertility Prevention Project (IPP) Family Planning Clinics

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### Results

Of the 19,643 test records in Region IX, 50.3% were among women age 15-19 and 49.7% among those age 20-24. About a quarter (26.4%) of the women in Region IX were Asian or Native Hawaiian/Other Pacific Islander, and nearly three-quarters (73.5%) were non-Hispanic White. Of the 58,902 test records in Region X, 42.7% were among women age 15-19 and 57.3% among those age 20-24. About 7% of the women in Region X were Asian or Native Hawaiian/Other Pacific Islander. The vast majority of cases (92.2%) were non-Hispanic White. Among women in Region X, there was not much variation in age and behavioral risks in the last 60 days by race/ethnicity. There was some variation in reason for visit; 37% of non-Hispanic White women had a non-routine reason for visit vs. about half of Asian (50.0%) and Native Hawaiian/Other Pacific Islander (52.0%) women. Table 1 shows characteristics of women in Regions IX and X, and Table 3 shows other characteristics of women in each region.

Unadjusted CT+ was highest among Native Hawaiian/Other Pacific Islander women in both Regions IX (12.0%) and X (10.2%). CT+ was lower among Asian women in both Regions IX and X (7.6% and 6.1%, respectively), but was still higher than among non-Hispanic White women (8.2% and 5.9%, respectively). Regardless of race/ethnicity, CT+ was higher among women age 15-19 than among those age 20-24. In Region IX, CT+ was elevated at each age category among Asian and Native Hawaiian/Other Pacific Islander women. In contrast, in Region X, CT+ was higher among non-Hispanic White women age 15-17 than among Asian and Native Hawaiian/Other Pacific Islander women. However, among women age 15-19 and age 20-24, CT+ was higher among Native Hawaiian/Other Pacific Islander women than among Asian and non-Hispanic White and Asian women. In addition, among women age 20 to 24, CT+ was higher for both Asian and Native Hawaiian/Other Pacific Islander women.

The logistic regression analysis, measures independently associated with CT+ included age, race/ethnicity, reason for visit (not routine visit, exposed to CT—last 60 days), behavioral risks in the last 60 days (multiple sex partners, new sex partner, symptomatic sex partner, no condom use at last sex), and one or more clinical findings. Consistent with data from 2000-2008, Native Hawaiian/Other Pacific Islander women in Region X were more likely—specifically, 1.5 times as likely—to test positive for CT than non-Hispanic White women. Reported reason for visit was also independently associated with positivity. Women who had a non-routine reason for visit were nearly 1.3 times as likely to test positive for CT as those who reported that their visits were routine, and women who reported that they were exposed to CT in the last 60 days were more than 4.5 times as likely as those who did not test positive for CT. In addition, women who reported behavioral risks in the last 60 days were more likely to test positive for CT than those who did not, and those with one or more clinical findings were nearly three times as likely as those with no clinical findings to test positive for CT. Table 4 shows additional multivariate results.

### Conclusions

Based on our analysis, Native Hawaiian/Other Pacific Islander women in Region IX and X IPP FP clinics had consistently higher levels of CT than Asian and non-Hispanic White women. In addition, there were significant differences in chlamydial infection between Asian and Native Hawaiian/Other Pacific Islander women.

Our analysis clearly supports the collection of data using the Census 2000 racial/ethnic categories and highlights the importance of exploring racial/ethnic disparities in chlamydia. It also suggests the importance of looking at disparities among racial/ethnic groups beyond White, Black or African American, and Hispanic or Latino and of disaggregating data within the Asian and Native Hawaiian/Other Pacific Islander populations.

In addition, we highlight the need for further assessment of community-level factors affecting CT+ among Asian and Native Hawaiian/Other Pacific Islander women. Our findings indicate that there may be factors other than the more traditional individual-level measures that explain the association between Asian and Native Hawaiian/Other Pacific Islander race and chlamydial infection, such as acculturation and generational issues, socioeconomic status and other behavioral risk factors. Finally, our findings support the current interest in the role of sexual network dynamics in STD transmission and the need for better information on female clients' sexual behaviors and practices, as well as sexual partners.