STDs in American Indians and Alaska Natives
DISTRICT OF COLUMBIA

District Population & AI/AN, 2000

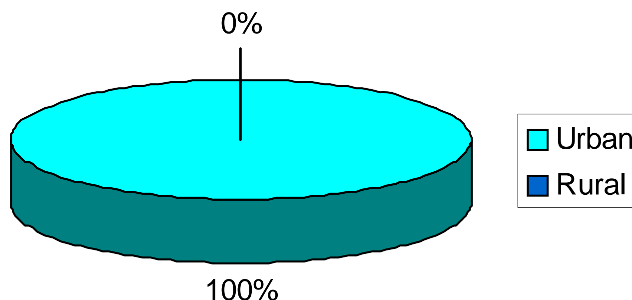
Population Group	Male	Female	Total	%
AI/AN	2,249	2,526	4,775	0.8
District	269,366	302,693	572,059	100.0

** American Indian population figures based on affiliation with American Indian alone and in combination with other races.*

District of Columbia STD Program Website: http://doh.dc.gov/doh/site/default.asp

CDC Project Area

District of Columbia Urban and Rural AI/AN Populations, 2000



AI/AN population data includes those with two or more races in combination with AI/AN.
Source: US Census Bureau

STDs in the AI/AN Population

National STD rates among AI/ANs are 2 to 6 times higher than rates for whites. In some states with AI/AN populations over 20,000, gonorrhea and syphilis rates are twice as high as among other ethnic groups. Below find District of Columbia- specific STD rates and percentages for the AI/AN population.

District of Columbia Chlamydia New Cases, 2005

Population Group	Male	Female	Total	%	Rate per 100,000
AI/AN	1	5	6	0.2	363.2
District	682	2,977	3,680‡	100.0	668.5

Source: District of Columbia Department of Health. Rate calculated on American Indian alone affiliation.

District of Columbia Gonorrhea New Cases, 2005

Population Group	Male	Female	Total	%	Rate per 100,000
AI/AN	4	5	9	0.4	544.8
District	1,113	1,029	2,146‡	100.0	389.8

Source: District of Columbia Department of Health. Rate calculated on American Indian alone affiliation.

District of Columbia P&S Syphilis New Cases, 2005

Population Group	Male	Female	Total	%	Rate per 100,000
AI/AN	0	0	0	0.0	0.0
District	103	11	114‡	100.0	20.7

Source: District of Columbia Department of Health. Rate calculated on American Indian alone affiliation.

‡ *"unknown" gender included*

**The term AI/AN is used in the text to refer to the American Indian and Alaska Native population*

This Fact Sheet was developed by JSI Research & Training Institute (303-262-4300, www.jsi.com) in conjunction with the Northern Plains Tribal Epidemiology Center (605-721-1922, www.aatchb.org/epi)

District of Columbia HIV New Cases

Data is not available at this time

District of Columbia AIDS New Cases, 2004

Population Group	Male	%	Female	%	Total	%	Rate per 100,000
AI/AN	1	0.1	1	0.4	2	0.2	41.9
District	705	100.0	285	100.0	990	100.0	22.0

Source: CDC HIV/AIDS Surveillance Supplemental Report, AIDS Cases by Geographical Area of Residence and Metropolitan Statistical Area of Residence 2004. Rate calculated on American Indian alone affiliation.

District of Columbia Hepatitis New Cases

Data is not available at this time

Select D.C. Demographics

Births

2004	Number of Births	%	% of Births to Mothers <19 (2002)	% w/ <12 yrs education (2002)	% Unmarried Mothers
AI/AN	9	0.1	0.0	11.1	11.1
District	7,933	100.0	7.2	19.5	55.9

Source: CDC National Vital Statistics System, CDC Wonder Search

Economics

2005	Median Household Income (USD)	% Below Poverty Level
AI/AN	63,450	n/a*
District	47,221	12.1

Source: US Census Bureau

Education

2004-2005	Enrollment % (K-12)	Actual Enrollment (K-12)	Dropout Rate %
AI/AN	<0.1	36	n/a
District	100.0	76,714	7.6

Source: National Center for Education Statistics

Resources/ Potential Partners/ Special Issues

District of Columbia Tribes: None available.
Tribal Health Programs: None available.
Urban Health Programs: None available.
IHS Health Programs: Indian Health Service (HQ), The Reyes Building, 801 Thompson Avenue, Ste. 400, Rockville, MD 20852-1627, 301-443-1083, http://www.ihs.gov/index.asp.
Inter-Tribal Health Programs: Not available.
Indian Health Boards: National Indian Health Board**,** 101 Constitution Ave. N.W., Suite 8-B02, Washington, DC 20001, (202) 742-4262, http://www.nihb.org.
IHS Tribal Epidemiology Centers: None available.
Tribal Colleges: None available.
State Health Native American Liaison: None available.

Special Issues:

—Tribal Health Departments are not required to report STDs, thus creating an undercount in the statistics.
—AI/ANs are often misclassified in race/ethnicity STD data. This misclassification increases with lower percentage of AI/AN ancestry.
—One needs to also consider the common mobility/migration of AI/ANs from reservation setting to other areas and back again.
—Like many other tight-knit communities, confidentiality can be difficult to maintain in AI/AN communities, especially in rural areas. This can be a barrier to testing, discussing sexual practices, obtaining treatment, or buying condoms in local stores.
—AI/AN prevention services are severely underfunded, and those that exist may not reach those at most risk.

** data not available at this time*