

SHOW ME THE MONEY:

State
Investment
in STD Prevention,
FY2007

(Data updated May 2009)





American Social Health Association

PO Box 13827
Research Triangle Park, NC 27709
www.ashastd.org

This Report was supported by a Cooperative Agreement (5U50PS423253-05) from The Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention.



INTRODUCTION

Sexually transmitted diseases (STDs) continue to be a major public health challenge in the U.S. with an estimated 19 million new infections annually, half of which are among persons 15-24 years of age.¹ Chlamydia, among the most prevalent of STDs, remains largely undiagnosed, and several communities have experienced consecutive years of syphilis outbreaks. The cost to treat STDs in the U.S. has been estimated at \$14.7 billion annually.² The upward trend in STD infection rates and in prevention and treatment costs continues because, for years, public health and STD prevention efforts have been woefully underfunded while costs for new tests, treatments and vaccine technologies have soared.

While states have been the primary financier of public health services generally³, the conventional wisdom in STD prevention has held that the federal government, specifically the Centers for Disease Control and Prevention (CDC), provides the lion's share of the funding for STD prevention in states. This, however, remains unsubstantiated because little, if any, data have been collected to measure state financial contributions to STD prevention. As states enter a new era of fiscal austerity, and public health efforts are being cut back, it is important to examine how states are funding their own STD prevention efforts, so that these efforts can be safeguarded and enhanced. To do so, methods and measures must be developed to examine state funding and policy environments for STD prevention on an ongoing basis. Such an effort would also serve to strengthen nationwide efforts to improve STD prevention.

This report provides an overview of state funding for STD prevention in FY2007 and is based on a study that was funded by a grant from the Centers for Disease Control and Prevention to the American Social Health Association (#5U50PS423253-05). Special thanks to Dr. Beth Meyerson of the the Policy Resource Group, LLC for the development and implementation of this study. A national comparison of several state STD funding indicators is offered, as is information about how states are spending their STD investment, and what state policies support or prohibit effective STD prevention⁴. This report is a companion to a set of state STD funding and policy tools available on the American Social Health Association (ASHA) website. A searchable/interactive database contains state level funding, epidemiologic and policy information, and can be found at www.ashastd.org.



METHODS

State financial data from fiscal year 2007 were gathered from the state laboratory directors and the directors of state STD, Hepatitis and Immunization programs in all 50 states and the District of Columbia. Financial and policy questions were developed through a convenience sample of states and with the advice of a steering committee comprising members of the participating programs: state laboratories and state STD, Hepatitis and Immunization programs; national associations representing these public health programs (APHL, NCSN, NASTAD, AIM)⁵, and members of the ASHA board of directors.

Questions were pilot tested by representatives from the participating programs in California, Illinois and North Carolina in April. Based on input received, the four data collection tools were reformatted, revised, and launched on a survey website hosted by ASHA in May, 2008. The response rate was enhanced by numerous follow-up efforts with non-respondents by e-mail and telephone. For the purpose of this report, the term 'state' refers to all states and the District of Columbia.

States provided financial and policy data for state fiscal year 2007. As state data were gathered from multiple programs from the same state, care was taken not to duplicate questions regarding state funding for STD prevention. Each respondent program was asked only about state funding received directly for their STD prevention efforts (program and/or vaccine).

Secondary data were collected to allow for a variety of comparative analyses. Reported state funding was compared with federal grants to states for FY2007 in order to form an understanding of the proportion of state funding toward the total state STD prevention effort. We included STD prevention federal funding sent directly to counties and cities.

State public health funding information for 2006-2007 was gathered to help contextualize state STD prevention funding. Census data for 2006 were used to calculate per capita funding for national comparison, and STD surveillance data for 2006 were used to develop the funding and policy tools found on the ASHA website at www.ashastd.org. Federal grant data were provided by the Centers for Disease Control and Prevention. State public health funding data were gathered from the Healthier America Project of Trust for America's Health⁶, and state census data were provided by the U.S. Census Bureau for the year 2006.

STD 84%
LABORATORY 63%
IMMUNIZATION 59%
HEPATITIS 41%

All states and the District of Columbia responded to the survey, though only six jurisdictions (11.8%) returned surveys from all four programs⁷. STD programs responded most, with an 84% (43) response rate. Sixty-three percent (32 surveys) of the laboratory directors responded, 59% (30) of surveys among immunization managers were returned and 41% (21) of hepatitis directors returned surveys.



KEY INDICATORS OF STATE STD FUNDING

Several indicators of state STD funding were developed for this analysis to allow for national comparison and for the comparison of the state STD prevention funding with state public health funding.

- **Percentage of State Funding in STD Prevention Budget.** This indicates the state’s contribution toward its STD prevention effort. It is calculated as the percentage of state funding in the total state STD prevention budget for that state. The total STD prevention budget comprises federal and state funding for STD prevention. Federal funding for STD prevention includes the following FY 2007 CDC grants to states: Comprehensive STD Prevention Systems, extramural STD funding, and Adult Hepatitis B Vaccine funding.⁸
- **Per Capita State STD Prevention Funding and Per Capita State Public Health Funding.** Per capita state STD prevention funding was calculated by dividing the amount of reported state funding for STD prevention by the state population. Per capita state public health funding was calculated by dividing the reported state public health funding by the state population.
- **Percentage of State Public Health Funding Directed Toward STD Prevention.** The percentage of state public health funding directed toward STD prevention was calculated by dividing reported state funding for STD prevention by the reported state funding for public health and multiplying by 100.

THE NATIONAL PICTURE

The belief that the federal government carries the majority of the STD prevention burden for states was reinforced when calculating state contributions toward STD prevention for FY2007. As Table 1 indicates, the average state contributed 25.8% of the funding in its state STD prevention budgets. The average per capita STD prevention funding was \$0.23. As a point of reference, in 2007, the federal government contributed \$181,319,992 for STD prevention in states—a per capita amount of \$0.60. When comparing state STD prevention funding with state public health funding, it appears that states spent just over one half of one percent of their public health funding for STD prevention

Several states were above average STD prevention funders. Nine states (17.6%) reported sharing at least 50% of the financial responsibility for STD prevention in their jurisdictions. One state, Louisiana, reported funding 70% of the state STD prevention budget. In contrast, four states reported zero state funding for STD prevention. Three of these states, however, did not return surveys from a sufficient number of programs, and therefore, the result is not viewed as robust.⁹ Table 2 shows the distribution of states by their contributions to their STD prevention budgets. What is not shown here are the high rates of STDs in several states. Nevada, for example, funds only 1.2% of its state’s STD prevention budget; and yet among states it has the highest

Table 1: State STD Prevention Funding Indicators, FY2007 (N=51)

	Per capita State STD Prevention Funding	Per capita State Public Health Funding	% of State Public Health Funding Directed to STD Prevention	% of State Funding in STD Prevention Budget
Mean	\$0.23	\$43.14	0.61%	25.8%
Median	\$0.14	\$34.60	0.30%	21.2%
Minimum	\$0.00	\$3.51	0.00%	0.0%
Maximum	\$1.55	\$156.24	3.68%	70.2%
Standard deviation	\$0.31	\$34.89	0.71%	19.6%

reported case rate of congenital syphilis and the fifth highest rate of primary and secondary syphilis.¹⁰ In contrast, Louisiana, the state with the highest percentage of state dollars in the STD prevention effort, reflects the priority of STD prevention, as it has the second highest case rate of primary and secondary syphilis and the fourth highest case rate of gonorrhea.¹¹

Table 2: Distribution of States By Level of Contribution Toward the State STD Prevention Budget, 2007 (N=51)

State contribution of 0%*			
Georgia	0%	South Carolina	0%
Montana	0%	West Virginia	0%
State contribution from 1-9%			
Nevada	1.2%	Indiana	6.5%
Maine	2.0%	Vermont	7.6%
Missouri	3.0%	North Dakota	8.8%
Wisconsin	3.6%	Maryland	8.9%
Oklahoma	5.3%		
State contribution from 10-19%			
Alaska	10.3%	Pennsylvania	14.8%
Colorado	10.4%	Washington	17.3%
Illinois	10.4%	New Jersey	18.1%
Arizona	12.4%	North Carolina	19.0%
Iowa	13.8%	Ohio	19.9%
New York	13.6%		
State contribution from 20-34%			
Minnesota	20.7%	Oregon	26.9%
Delaware	21.2%	Wyoming	31.1%
District of Columbia	23.7%	Idaho	31.2%
Utah	24.1%	Mississippi	33.5%
South Dakota	28.6%	Virginia	34.8%
California	29.4%		
State contribution from 35-49%			
Texas	37.4%	Massachusetts	44.1%
Tennessee	38.0%	New Mexico	46.2%
Kentucky	38.2%	Kentucky	48.2%
Nebraska	44.0%		
State contribution from 50-75%			
Michigan	50.1%	Connecticut	55.9%
Florida	50.2%	Rhode Island	60.5%
New Hampshire	51.5%	Hawaii	62.5%
Alabama	53.7%	Louisiana	70.2%
Arkansas	54.0%		

*In South Carolina and West Virginia, only one program returned a survey. Additionally, the STD programs in South Carolina, West Virginia and Georgia did not return a survey.

A few states emerged as leaders in state funding for STD prevention when viewing their national ranking across key investment indicators. The top ten state STD prevention funders are found below. Five states (Louisiana, Rhode Island, Connecticut, Arkansas and Florida) were in the top ten for all three funding indicators. Three jurisdictions (District of Columbia, New Mexico and Hawaii) were in the top ten for per capita state funding in STD prevention and also, though not shown, for per capita funding for public health.

Top Ten State STD Prevention Funders, 2007 (N=51)

% of State Funding in STD Prevention Budget		Per capita State STD Funding	
1. Louisiana	70.2%	1. Louisiana	\$1.55
2. Hawaii	62.5%	2. District of Columbia	\$1.35
3. Rhode Island	60.5%	3. Rhode Island	\$0.72
4. Connecticut	55.9%	4. New Mexico	\$0.70
5. Arkansas	54.0%	5. Hawaii	\$0.63
6. Alabama	53.7%	6. Alabama	\$0.57
7. New Hampshire	51.5%	7. Arkansas	\$0.52
8. Florida	50.2%	8. Connecticut	\$0.47
9. Michigan	50.1%	9. Tennessee	\$0.34
10. New Mexico	46.2%	10. Florida	\$0.33

% of State Public Health Funding Directed to STD Prevention

1. Louisiana	3.68%
2. Connecticut	2.04%
3. Arkansas	1.96%
4. Mississippi	1.93%
5. Rhode Island	1.53%
6. Michigan	1.50%
7. Texas	1.37%
8. New Hampshire	1.36%
9. Kansas	1.25%
10. Florida	1.19%

HOW STATE FUNDING REACHES THE STD PREVENTION EFFORT

State funding reaches the STD prevention effort in a variety of ways. Some states direct funding to STD prevention through a line item in the state budget designated for STD prevention. In some cases, a state agency (e.g. state health department) is the recipient of the line item. In other cases, a specific program (such as STD or Immunization) is the designated recipient of the funding. State funding can also reach the STD prevention effort through state budget designations for public health generally or through a disease prevention or clinical services line item. In these cases, state funding is usually directed to a state agency and then distributed to the appropriate state program. In many cases, the state distributes funding through a combination of channels (see Table 3).

While a state budget line item for disease prevention, clinical services or similar category directed to the state agency was the most frequently listed means of receiving state funding for STD prevention (25.5%), those states receiving funding only via this mechanism were not generally among the top ten state STD prevention funders (see page 6) with the exception of Alabama, Louisiana and New Mexico. Rhode Island, Connecticut and Arkansas received state funding via a combination of an STD line item directed toward the STD program and a disease prevention and clinical services line item directed to the agency. Hawaii received state funding for STD prevention through an



STD line item directed toward the state agency. New Hampshire and Michigan received state funding through an STD line item in the state budget directed to the STD program. Finally, Florida received state funding for STD prevention through a disease prevention and clinical services line item directed to the STD program and also to the agency.

In each state, contributions for STD prevention were reported by at least one of the four public health programs participating in this study. STD programs most often reported state funding for STD prevention. Of the 43 STD programs responding to the survey, 88% (or 38) reported state funding for STD prevention. Of the 32 state laboratory directors responding to the survey, 65.7% (or 21) reported state contributions for STD prevention. Immunization managers reported state funding less frequently. Of the 30 Immunization programs responding to the survey,

Table 3: How States Distributed Funding for STD Prevention, FY2007 (N=51)

	# (%) of States
State budget line item for disease prevention, clinical services or similar category directed to the state agency (e.g., State Health Department)	13 (25.5)
State budget line item for STD directed to specific program (e.g., STD Program)	12 (23.5)
State budget line item for STD directed to state agency	8 (15.7)
No state funding received/No funding path specified	6 (11.8)
State budget line item for STD, AND a state budget line item for disease prevention, clinical services or similar category directed to the state agency	5 (9.8)
State budget line item for STD directed to a specific program, AND a state budget line item line for disease prevention, clinical services or similar category directed to the state agency	4 (7.8)
State budget line item line for disease prevention, clinical services or similar category directed to the state agency and also to a specific program	2 (3.9)
State budget line item for STD directed to a specific program and also to the state agency	1 (2.0)



Image courtesy of CDC/ Hsi Liu, Ph.D., MBA, James Gathany

23.3% (7) reported state funding for STD-related vaccines, while 6.7% (2) reported state funding for STD prevention activities and programming generally. Finally, of the 21 state hepatitis programs reporting, 14.3% (3) reported state funding for hepatitis B vaccine, and 9.5% (2) reported state funding for STD program related activities.

Seven states reported receiving state funding for STD prevention from another state program. The STD program was generally the recipient of such funding transfer; however, given the variable survey response rate among programs, this finding may not be entirely accurate. California's STD program reported receiving \$19,075 from the family planning program; Florida's Immunization program reported receiving \$2,100,000 from the state pharmacy, and the STD program reported receiving \$151,690 from the HIV program; Kentucky's STD program reported receiving \$100,000 from the Immunization program; Mississippi's STD program received \$750,000 from the HIV program; Missouri's Hepatitis program reported receiving \$50,000 from the Immunization program for perinatal hepatitis B; Nebraska's STD program received \$100,000 from a program called "Another Woman Matters;" North Carolina's STD program received \$218,000 from the state laboratory; and Wyoming's Hepatitis program reported receiving \$150,000 from the Immunization program.

WHERE DID THE MONEY GO? HOW STATES EXPENDED STATE FUNDING FOR STD PREVENTION

States reported how they expended state funding for STD prevention according to standard public health expenditure categories. These included program administration, clinical staff, laboratory and laboratory staff, surveillance and epidemiology, evaluation and quality assurance, medications, STD-related vaccines, health education and social marketing, screening and testing, evaluation and quality assurance; capacity building, technical assistance and training; supplies, such as test kits and condoms; and partner services, which for some states was not solely provided by those who were engaged in surveillance and field epidemiology (known as disease intervention specialists, or DIS). Data shown in Figure 1 represent a national picture of how states expended their state STD prevention funds in FY007.

Expenditure data should be viewed and interpreted with caution because the expenditure data presented in Figure 1 and in state profiles (on the ASHA website at www.ashastd.org) only represent the expenditure of state funding rather than a complete representation of a state STD program budget, which would contain both state and federal resources. As such, it is an incomplete picture of the revenues for STD prevention for a state program and their use.

When viewed on a national level (Figure 1), laboratory testing and laboratory staff together comprised the largest category of expenditures (28%), followed by disease surveillance and

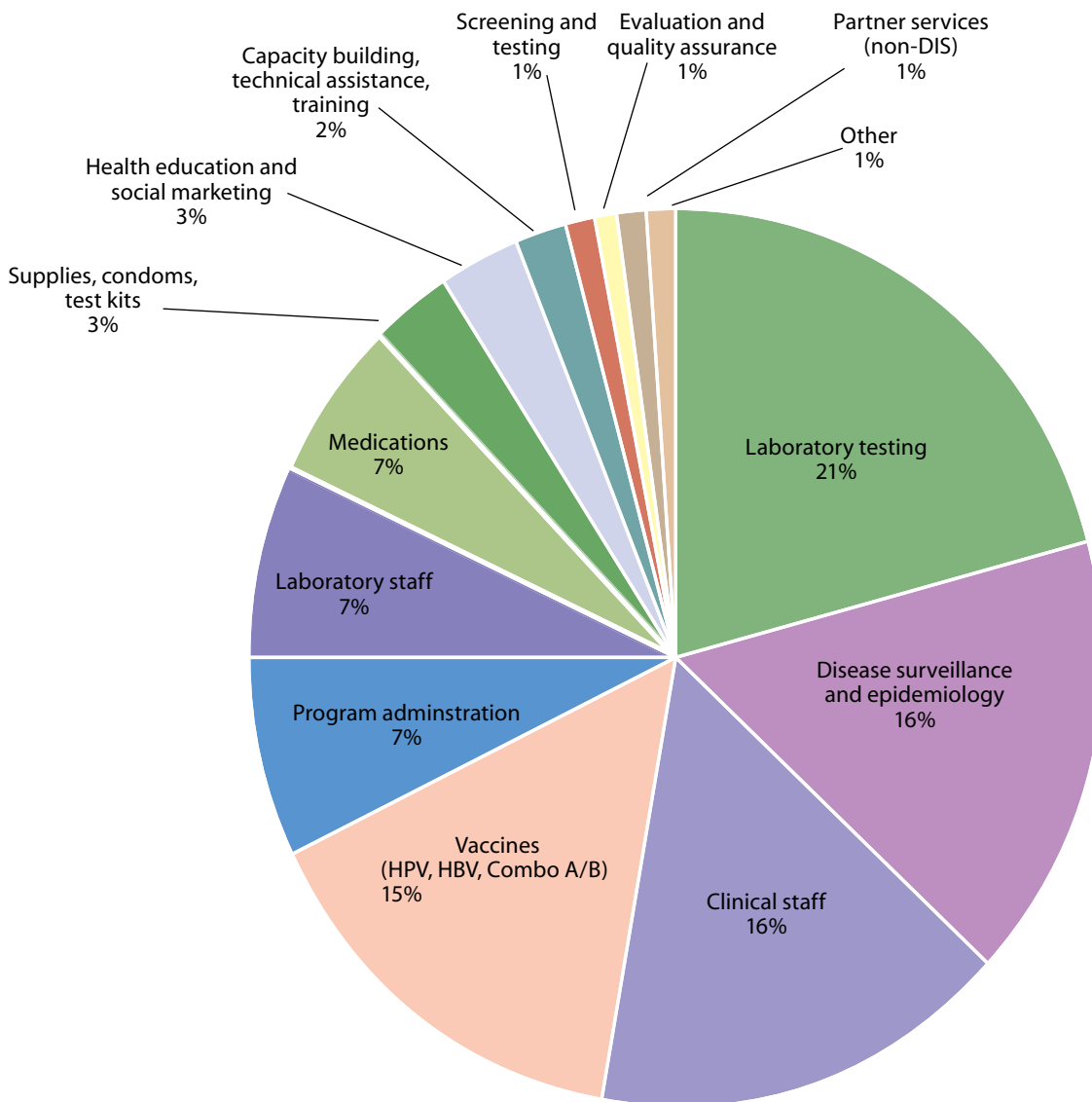


Figure 1: How States Directed State Funding for STD Prevention, FY 2007 (N=51)

epidemiology and clinical staff (both 16%). The category disease surveillance and epidemiology included field epidemiology conducted by staff such as DIS and other epidemiologists, and it included disease surveillance and monitoring activities such as disease reporting and analysis. Clinical staff included medical staff assigned to clinics or other STD treatment venues. STD-related vaccines included the purchase of hepatitis B, combination hepatitis A/B vaccines and vaccine for human papillomavirus. These vaccine purchases comprised 15% of the state expenditures in STD prevention and also include other related expenses such as vaccine administration.

There were several issues with the analysis of how states expended state funding for STD prevention. While every state detailed some of their expenditures, only 54.9% (or 28 jurisdictions), detailed the spending of all reported state funding for STD prevention. Less than half of the states (45% or 23 states) partially categorized the spending of reported funding. In some cases, this was due to the procurement of outcome-based contracts with local communities that did not specify how funding should be expended. Five states (or 9.8%) reported spending more than they received in state contributions. State profiles with expenditures and accompanying notes are found at the ASHA website at www.ashastd.org.

STD-RELATED VACCINES (HBV, COMBINATION HAV/HBV, HPV)



Photo courtesy of CDC/ Judy Schmidt

While several states purchased STD-related vaccines with state funding, only twelve states (23.5%) distributed funding specifically earmarked for STD prevention related vaccines. Five of these states reported such funding for the first time in the last two years. This perhaps reflects an emerging policy priority to finance the purchase of STD-related vaccines. In two states (North Dakota and Missouri), funding for vaccine purchase comprised over 80% of the reported state STD funding (see Table 4).

Most of the state funding earmarked for STD-related vaccines was directed to hepatitis B vaccination for adults and/or for children who were not eligible for the federal Vaccines for Children program.¹² Two states, Texas and Virginia, directed almost all of the earmarked funding toward the purchase of human papillomavirus vaccine.¹³

State	STD Program Vaccine Funding	Immunization Program Vaccine Funding	Hepatitis Program Vaccine Funding	Total State STD Prevention Budget	STD-Related Vaccine Funding as a % of Total State STD Funding
California	\$0	\$555,000	\$0	\$5,588,942	9.9%
Connecticut	\$0	\$306,000	\$0*	\$1,624,000	18.8%
Illinois	\$99,746	\$224,000	\$0*	\$766,849	42.4%
Louisiana	\$73,289	\$0*	\$0*	\$6,500,710	1.1%
Missouri	\$0	\$0	\$61,700	\$74,700	82.6%
New York	\$0	\$1,000,000	\$0*	\$1,761,000	56.8%
North Dakota	\$0	\$0	\$30,000	\$30,000	100%
Ohio	\$0	\$700,000	\$0*	\$900,000	77.8%
Oklahoma	\$0*	\$0	\$37,000	\$77,000	48.1%
Pennsylvania	\$56,800	\$0*	\$0*	\$1,026,800	5.5%
Texas	\$0	\$2,734,000	\$0*	\$4,674,214	58.5%
Virginia	\$0	\$1,300,000	\$0*	\$2,315,557	56.1%

*State did not return a survey for this program

Table 4: State Funding Earmarked for STD-Related Vaccines by Recipient Program, FY2007

THE STATE POLICY CLIMATE FOR STD PREVENTION

State investment in STD prevention can be measured in dollars as well as political will and policy climate. To help further clarify the policy climate for STD prevention, states were asked to identify current state policies (laws, mandates, rules or regulations) that enhance STD prevention and those that need to be eliminated because they were barriers to STD prevention. A list of recommended policies that enhanced STD prevention was developed based on literature review¹⁴ and included the following: age appropriate and comprehensive sex education, certification or specialized training for sexuality and health education instructors, electronic laboratory reporting for sexually transmitted diseases (STDs) and related conditions, expedited partner therapy,¹⁵ instruction about sexually transmitted diseases using a standardized curriculum approved by the state or jurisdiction, insurance coverage (public or private) for HIV and STD screening, policies allowing opt out for written consent for HIV testing in STD clinics, mandates for vaccine data storage in an immunization registry, prenatal screening for STDs, a requirement for comprehensive STD and/or HIV prevention education, and mandate(s) for specific STD-related vaccines.



Policy	# (%) States
Prenatal screening for STDs	25 (49.0)
Electronic laboratory reporting for STDs and related conditions	22 (43.1)
Opt out for written consent for HIV testing in STD clinics	14 (27.5)
Expedited partner therapy	10 (19.6)
Insurance coverage (public and private) for HIV and STD screening	10 (19.6)
Policy or mandate for vaccine data to be stored in state immunization registry	9 (17.6)
Mandate for specific vaccines	9 (17.6)
Age-appropriate comprehensive sex education for K-12	8 (15.7)
Requirement for comprehensive STD and/or HIV prevention education	6 (11.8)
Instruction about STDs using a standardized curriculum approved by the state health department	3 (5.9)
Certification and/or specialized training for all sexuality and health education classroom instructors	2 (3.9)

Table 5: Existing State Policies That Enhance STD Prevention, FY2007 (N=51)

States indicated that the policy climate for STD prevention is less than hospitable for the public health task. Fifteen states (29.4%) reported having none of the recommended policies to enhance STD Prevention.¹⁶ As noted in Table 5, while policies requiring prenatal screening for STDs and those requiring electronic laboratory reporting of STDs and related conditions were reported most often, less than half of states cited their existence. These relatively innocuous policies do not appear to be on the radar screen even for the survey participants, because only two states reported plans to initiate prenatal screening for STDs, and three states reported plans to initiate electronic laboratory reporting for STDs.

As HIV is increasingly understood as a sexually transmitted disease, states are initiating an opt out process for written consent to test for HIV in STD clinics. Fourteen states (27%) have this practice in place, and four other states are planning to initiate such a policy in the near future.

An emerging policy issue is the provision of therapy for the sex partners of those who test positive for STDs. This therapy is termed ‘expedited partner therapy,’ and appears to be on the policy radar of many states. While only ten states (19.6%) reported policies allowing partner therapy, 16 states (31.4%) reported plans to initiate policies allowing for expedited partner therapy.

States that reported specific mandates for vaccines tended to report mandates around hepatitis B vaccination. California requires hepatitis B vaccination for entry to child care, kindergarten and seventh grade, Hawaii requires hepatitis B vaccine for school entry; Illinois, Massachusetts, Minnesota, Missouri, Nebraska and Texas require hepatitis B vaccination but did not specify the audience or circumstance.

Seven states provide an STD policy leadership example and reported the existence of at least five of the recommended state policies for STD prevention. Policies most often cited include

insurance coverage for HIV and STD screening, prenatal screening for STDs, electronic lab reporting, mandates for specific vaccine, and mandates or policies requiring the storage of vaccine data in a state immunization registry (see Table 6.)

Several states listed additional policies, laws or mandates enhancing STD prevention beyond those recommended in this survey. California, Louisiana, Maryland, Missouri, and New Hampshire mandate that minors have access to STD diagnosis and treatment without parental consent. Maryland requires that such services be free of charge.

In California, medical providers must make a good faith effort to notify partners of those who test positive for an STD. They must also provide health education materials and report violations of “quarantine,” meaning that patients have not been treated within ten days after their diagnosis. Also, comprehensive sex education is optional, and human papillomavirus (HPV) vaccine is covered but not mandated. Florida has broadened the scope

Insurance coverage (public and private) for HIV and STD screening	California	Hawaii	Illinois		Minnesota	Alabama	Missouri
Prenatal screening for STDs	California	Hawaii	Illinois	Louisiana		Alabama	
Electronic laboratory reporting for STDs and related conditions		Hawaii	Illinois	Louisiana	Minnesota		Missouri
Mandate for specific vaccines	California	Hawaii	Illinois		Minnesota		Missouri
Policy or mandate for vaccine data to be stored in state immunization registry	California	Hawaii		Louisiana	Minnesota		Missouri
Opt out for written consent for HIV testing in STD clinics	California		Illinois	Louisiana			
Expedited partner therapy	California			Louisiana	Minnesota	Alabama	
Requirement for comprehensive STD and/or HIV prevention education		Hawaii			Minnesota	Alabama	
Age-appropriate comprehensive sex education for K-12	California						
Instruction about STDs using a standardized curriculum approved by the state health department		Hawaii	Illinois				
Certification and/or specialized training for all sexuality and health education classroom instructors				Louisiana			

Table 6: Policy Distribution for States Reporting at Least Five of the Recommended Policies to Enhance STD Prevention, FY2007

of reportable conditions to include HPV infection, recurrent respiratory papillomatosis in infants, neonatal herpes, abnormal cervical/genital cytology and histology and a broad range of STDs associated with child abuse. Indiana mandates that information about the HPV vaccine for girls be given to families of sixth graders.

Several states identified policies and policy emphases that need to be eliminated or changed in order to strengthen public health efforts in STD prevention. The policy most often referenced for elimination was an emphasis on abstinence when taught as part of sex education courses. Fourteen states (27.5%) indicated a desire to shift away from such emphasis. Eleven states (21.6%) identified the need to remove consent requirements for STD or HIV testing. Ten states (19.6%) identified policy barriers to expedited partner therapy (see Table 7).

Policy	# (%) States
Emphasis on abstinence when taught as part of sex education	14 (27.5)
Limits to expedited partner therapy (or prohibitions against)	10 (19.6)
Consent requirements for STD testing	6 (11.8)
Specific consent requirements for HIV testing	5 (9.8)
Limitations on partner notification	4 (7.8)
Parental consent requirements for school-aged children to participate in comprehensive STD and/or HIV education	3 (5.9)
Parental consent requirements for school aged access to STD prevention and treatment services	3 (5.9)
Policy or mandate that prohibits the purchase of STD-related vaccine	3 (5.9)
“Opt Out” clauses for school aged children to participate in sex education instruction	2 (3.9)
Parental consent for immunization records to be stored in a statewide registry	1 (2.0)

Table 7: Policy Elimination Recommendations, FY2007 (N=51)

CONCLUSIONS AND RECOMMENDATIONS

While it was found that the federal government was still carrying the majority of the STD prevention funding burden, states are in fact providing approximately one quarter of the total funding for their STD prevention efforts. There is room for improvement in terms of increasing the proportion of funding for their own STD prevention efforts, particularly when it is more efficient to prevent cases of STDs than to treat them. It is notable that most respondents did not have knowledge of what other participating programs within their own state received for STD prevention; so in addition to clarifying the national understanding of what states are doing to fund STD prevention, these study findings will help broaden state public health awareness of the overall STD prevention investment on a state by state basis. Credibility in the process of policy change and funding increases requires full knowledge of what is happening on a state level to fund STD prevention. Three key recommendations are offered:

- 1. Strengthen communication between and among state laboratories and state STD, Immunization, and Hepatitis Programs.** If state programs coordinate more closely on funding and policy, they might find opportunities to work together to improve the state funding and policy environment for STD prevention.
- 2. Strengthen state funding for STD prevention.** Efforts to increase state funding should be focused on establishing or enhancing an STD line item in the state budget because it is associated with stronger STD investment.
- 3. Strengthen state STD policy efforts.** States need to focus on those key policies that enhance STD prevention. Working on policies that have been established by most states or are being considered by most states will help facilitate legislative support. Examples include expedited partner therapy, prenatal screening for STDs and electronic laboratory reporting for STDs. Further, states can identify several ways to implement policy change. State laws are one way of making policy change. State rule, regulation, organizational practice and contract requirements are other means of strengthening the STD prevention effort without requiring change in state law.

STUDY LIMITATIONS

This study was the first of its kind to evaluate state funding for STD prevention. Four state public health programs provided state financial data for FY2007: state STD programs, state immunization programs, state Hepatitis programs and state laboratories. While all states and the District of Columbia participated in the study, program participation was far from complete. To more fully understand state contributions to STD prevention, it will be necessary to include expenditures for STD testing and treatment

by state correctional facilities and state Medicaid programs. Access to these utilization datasets (Medicaid and Correctional Health) will be particularly difficult, as several states outsource data management, and will charge for access to data reports of this kind. Despite the challenge, Medicaid and correctional health programs should be involved in future studies.

ACKNOWLEDGEMENTS

ASHA would like to thank the CDC for funding this important and timely project. Also, we'd like to thank many colleagues for their assistance with this project. Dr. Beth Meyerson of the Policy Resource Group, LLC served as the co-principal investigator along with ASHA's Dr. Lisa Gilbert. Four membership organizations were invaluable in endorsing and disseminating the data collection tools among their constituents: NCSd, APHL, AIM and NASTAD. We appreciate the time, expertise, and resources of the Steering Committee and CDC representatives: Mark Aubin, Gail Bolan, Don Clark, John Douglas, Evelyn Faust, Helen Fox Fields, Hunter Handsfield, Clare Hannon, Michael Herbert, Ned Hook, Cynthia Jorgenson, Dave Kern, Jeanne Marrazzo, Amy Pulver, Julie Scofield, Shannon Stokley, Brad Stoner, Craig Studer, Chris Taylor, Tony Tran, Katelyn Wells, Dan Wohlfeiler, and Kelly Wroblewski. Also, we are grateful to representatives from California, North Carolina, and Missouri State Health Departments who reviewed the data collection tool drafts and provided us with insightful feedback. Last and certainly not least, ASHA acknowledges and appreciates the financial support of the Centers for Disease Control and Prevention (CDC) and the assistance with access to federal data contributions from many CDC representatives.

NOTES

1. Centers for Disease Control and Prevention (2007). Trends in Reportable Sexually Transmitted Diseases in the United States, 2006. Online: <http://www.cdc.gov/std/stats/trends2006.htm>. Annual cost figure for treatment is in 2006 dollars.
2. Centers for Disease Control and Prevention (2007). Trends in Reportable Sexually Transmitted Diseases in the United States, 2006. Online: <http://www.cdc.gov/std/stats/trends2006.htm>. Annual cost figure for treatment is in 2006 dollars.
3. Trust for America's Health (2008). Shortchanging America's Health 2008: A State by State Look at How the Federal Public Health Dollars are Spent. Issue Report. (Washington, April 2008).
4. While HIV is a sexually transmitted disease, HIV programs and their financial data are not included in this study.
5. APHL: Association of Public Health Laboratories, NCSA: National Coalition of STD Directors, NASTAD: National Alliance of State and Territorial AIDS Directors which represented state hepatitis directors, and AIM: Association of Immunization Managers.
6. The Healthier America Project of Trust for America's Health supplied state contributions to public health for the fiscal year 2006/2007 via an online tool. See: <http://healthieramericans.org/healthieramerica/>. See also: Levi Jeffrey, Juliano Chrissie, Richardson, Maxwell (2007) Financing Public Health: Diminished Funding for Core Needs and State-by-State Variation in Support. *Journal of Public Health Management and Practice*, 13(2), 97-102. Public health funding is defined as all health spending except Medicaid, SCHIP or comparable health coverage programs, mental health funding and services related to developmental disabilities or severely disabled persons.
7. In this report, "states" will refer to all U.S. states and the District of Columbia.
8. Immunization federal grants (317 and Vaccines for Children) were not included in the calculation of the federal share of the STD investment for this study because it was not possible at this time to track whether and how they were directed toward STD prevention on a state by state basis. Both grants can be directed toward STD prevention, and some states probably are doing so. STD extramural funding was included in the federal grant calculation because it is directed toward the total STD effort in a state. Funding for STD Prevention Training Centers was not calculated as part of the federal grant contribution because it is distributed by region.
9. At this writing, three of the four states reporting zero state contribution to STD prevention did not return a survey from the STD program (Georgia, South Carolina, and West Virginia).
10. In 2006, the most recent year of reporting from the CDC, Nevada reported the highest case rate of congenital syphilis per 100,000 live births (4.26), and the fifth highest rate of primary and secondary syphilis per 100,000 population (5.7). See Centers for Disease Control and Prevention (2007). Sexually Transmitted Disease Surveillance 2006 Supplement: Syphilis Surveillance Report. Atlanta: CDC.
11. Centers for Disease Control and Prevention (2008). Sexually Transmitted Disease Surveillance 2006: Gonorrhea, Figure 14. Online: <http://www.cdc.gov/std/stats/figures/figure14.htm>
12. The Vaccines for Children Program is funded by the Centers for Disease Control and Prevention. This program provides vaccines for children through the age of 18 years with the following eligibility: Medicaid eligible or uninsured, or American Indian/Alaskan Native, or children who are underinsured (e.g. their health insurance does not provide for vaccine coverage). For more information, see: <http://www.cdc.gov/vaccines/programs/vfc/>
13. The Texas Immunization program reported directing 98% of their STD vaccine funding toward human papillomavirus vaccine. The remaining amount was directed to purchase hepatitis B vaccine for children who were not eligible for the Vaccines for Children program.
14. See Council of State Governments (2008). HIV and STD policy "pack" [online] www.healthystates.csg.org/NR/rdonlyres/A290E4D2-969A-4ACD-8C77-B18B02AE6B9F/0/HIVAIDSandSTDPrevention.pdf. Guttmacher Institute (2008). "State Policies in Brief" August 1, 2008. [online] http://www.guttmacher.org/statecenter/spibs/spib_SE.pdf; Gold R and Nash E (2001). State-level policies on sexuality, STD education. *The Guttmacher Report on Public Policy*, 4(4):4-7; Landry D et al. (2003). Factors associated with the content of sex education in U.S. public secondary schools, *Perspectives on Sexual and Reproductive Health*, 35(6):261-269; Meyer L, Greene BZ, Bogden JF; National HIV Prevention Conference (2003 : Atlanta, Ga.) Education Policies for Integrated HIV, STD, and Teen Pregnancy Prevention. Abstr Book 2003 Natl HIV Prev Conf July. abstract no. M3-E0401; Harriette B. Fox and Stephanie J. Limb for Incenter Strategies, Washington, DC. State Policies Affecting the Assurance of Confidential Care for Adolescents. Fact Sheet No. 5, April 2008: Online: <http://www.incenterstrategies.org/jan07/factsheet5.pdf>; National Women's Law Center Report Card: STD/HIV Education in Public Schools, 2007. online. See <http://hrc.nwlc.org/Policy-Indicators/Addressing-Wellness-and-Prevention/STDHIV-Education-in-Public-Schools.aspx>].
15. Expedited partner therapy (or EPT) refers to the provision of treatment to the sexual partners of persons with sexually transmitted diseases without a medical evaluation. Provision of therapy is usually through the patient to his/her partner(s). See: Centers for Disease Control and Prevention. Expedited partner therapy in the management of sexually transmitted diseases. Atlanta, GA: US Department of Health and Human Services, 2006; Golden, Matthew R., et al. (2005). Effects of Expedited Treatment of Sex Partners on Recurrent of Persistent Gonorrhea or Chlamydia Infection. *The New England Journal of Medicine*, 352:7, 676-85; Kissinger, Patricia, et al. (2005). Patient-Delivered Partner Treatment for Male Urethritis: A Randomized, Controlled Trial. *Clinical Infectious Diseases*, 41:623-9; Rein, D.; Kessler, W.; Irwin, K., et al. (2000). Direct medical cost of pelvic inflammatory disease and its sequelae: decreasing, but still substantial. *Obstetrics and Gynecology*, 95(3):397-402.
16. Seven of these states (Georgia, New Jersey, South Carolina, Tennessee, Utah, Vermont and West Virginia did not return a survey from the STD and/or the hepatitis programs).

