National Commission on Correctional Health Care
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POSITION STATEMENT

STI Testing for Adolescents and Adults Upon Admission to Correctional Facilities

Introduction

For many years, studies and surveillance projects have shown a high prevalence of sexually transmitted infections (STIs) in people entering jails, prisons, and juvenile facilities. These studies have identified risk factors for individual infections based on geographical location, age, and gender. Local health departments are an important resource for information on prevalence, antibiotic resistance, and treatment of these diseases in a specific area. Identification and treatment of STIs in jails and juvenile facilities offers a cost-effective opportunity to prevent complications of the diseases and reduce transmission of STIs in jails, juvenile facilities, prisons, and the community.

The Centers for Disease Control and Prevention (CDC) recommends universal screening for chlamydia and gonorrhea in women ≤ 35 and men < 30 years in correctional facilities. It also recommends that universal screening for syphilis be conducted on the basis of the local area and institutional prevalence of early (primary, secondary, and early latent) syphilis. The CDC further recommends that men who have sex with men (MSM) be tested for HIV, syphilis, and HBsAg for chronic HBV infection, in addition to screening from the relevant orifice for gonorrhea and chlamydia. There is no CDC recommendation for testing for trichomoniasis among asymptomatic adolescents and women in corrections.

Background

Nationwide rates of chlamydia, gonorrhea, and syphilis rose from 2013 to 2017, as shown in these CDC surveillance statistics (2017):

	Cases	Increase
Chlamydia	1.7 million	22%
Gonorrhea	555,608	67%
Primary and secondary syphilis	30,644	76%

Multiple studies have demonstrated that people entering correctional facilities have higher rates of STIs than their nonincarcerated counterparts in the community, and across many studies, rates have been consistently higher among incarcerated women than incarcerated men, particularly for gonorrhea and chlamydia.

Neisseria gonorrhoeae (GC) and *Chlamydia trachomatis* (CT) can lead to acute pelvic inflammatory disease, chronic pelvic pain, infertility, and ectopic pregnancy in women. These infections may be asymptomatic in women and men; they can also cause symptoms of discharge and urethral pain, and women may experience irregular vaginal bleeding with these STIs. Among infected pregnant women, GC and CT are associated with miscarriage, premature rupture of membranes, and preterm birth. Newborns born to infected mothers are at risk for conjunctivitis and, from chlamydial infection, pneumonia.

Syphilis causes a constellation of symptoms from rashes to neurologic disease, but can be asymptomatic for years. It can be especially serious in newborns, and for that reason prenatal care includes syphilis screening for all pregnant women. Syphilis differs in regional rates and epidemiology of occurrence, thus data and information from the local and regional area can be useful in other screening determinates.

Syphilis seroprevalence rates are considerably higher among adult men and women than in adolescents, consistent with the overall national syphilis trends.

Screening and treating people in correctional settings has an impact on the individual and can have an impact on community prevalence of these infections when people are released from correctional facilities. In 2011 correctional facilities accounted for up to 6% of reported syphilis cases in the United States. In at least one location, treatment of syphilis in a jail had a substantial impact on the prevalence in the local community.

Since most STIs may be asymptomatic, it is impossible to determine infection without direct laboratory testing. Those with symptoms or with risk factors for infection benefit from laboratory testing. Most testing for GC and CT is done together with one specimen collection test. Assays testing urine for these infections have high accuracy and samples are easy to collect. Among women, a vaginal swab is the preferred specimen; a first catch urine is also acceptable and may be more appropriate if a woman is not permitted or is unable to collect a vaginal self-swab, as vaginal exams may be traumatizing for many incarcerated females, who have high rates of prior sexual victimization. Collecting from other body sites such as oropharynx or rectum should be based on patients' reported sexual behavior and symptoms.

In short-term facilities, e.g., jails and some juvenile detention facilities, up to half of entrants are released back into the community within 48 hours. While results from GC/CT nucleic acid amplification testing (NAAT) can often be reported within 24 hours, results may not be available before release. As a result, treatment completion rates for those who are screened and receive STI diagnoses in short-term facilities might not be optimal. However, because of this population's mobility in and out of the community, the impact of screening in correctional facilities on the prevalence of infections among detainees and subsequent transmission in the community might be considerable. Moreover, treatment completion rates of > 95% for many STIs can be achieved by offering screening at or shortly after intake, which facilitates earlier receipt of test results; follow-up of untreated people can be conducted through public health outreach.

Screening at entry for asymptomatic GC and CT among incarcerated females ≤ 35 has been shown to be highly cost-effective and is recommended by the CDC. All pregnant women should be screened for GC and CT as well as syphilis in the first trimester or at their first prenatal visit, and again in the third trimester. Any female with signs or symptoms of GC or CT regardless of age should be tested. Although incarcerated females have a higher prevalence of trichomonas vaginalis, routine screening is not recommended; instead, women with symptoms of vaginal discharge should be evaluated and tested as appropriate.

Correctional facilities should make a determination of syphilis screening based on local prevalence.

Among males in corrections, recommendations are similar. Those ≤ 30 and all MSM should be screened appropriately, i.e., samples collected from relevant body sites.

STI screening should include HIV (with opt-out) testing, ideally done with rapid testing to ensure communication of results and rapid treatment initiation for those testing positive. Patients testing negative should be informed of preventive practices including condoms and availability of pre-exposure prophylaxis (PreP). (See NCCHC position statement on Administrative Management of People Living With HIV.)

CDC treatment recommendations for STIs, including dual drug treatment for CG, are available at www.cdc.gov/std/treatment.

Data suggest that cervical dysplasia, which is caused by human papilloma virus (HPV), is more prevalent among incarcerated females. Cervical cancer screening with Pap tests and HPV testing should occur among incarcerated females in accordance with national guidelines (see NCCHC position statement on Women's Health Care in Correctional Settings).

HIV screening should be discussed and offered to all adolescents. Repeat screening and the frequency of further screening should be based on risk. Among adolescents, rearrest represents a risk factor[1]. All pregnant women should be screened for HIV using opt-out. HIV screening should be offered to all adults upon entry based on U.S. Preventive Services Task Force recommendations for screening those age 15 to 65 and those at higher risk[2]. A risk-based approach for screening might be appropriate for adults not at risk who are rearrested, but this requires access to previous testing and systematic, confidential, non-judgmental assessment of risk factors. Women should be rescreened for repeat pregnancies[2]. (See links to screening recommendations below.)

Position Statement

NCCHC recognizes the ongoing constraints associated with providing additional STI screening and testing services upon entry to correctional facilities. NCCHC also recognizes that those services should prioritize men age 30 and under and women age 35 and under. NCCHC also acknowledges the availability of non-invasive laboratory test methods for ease in screening. Therefore, NCCHC recommends the following:

1. Local institutional administrators and medical staff are encouraged to develop and/or enhance their working relationships with their local health departments' communicable disease managers in an effort to determine the best use of resources available for the provision of STI laboratory testing and treatment.

2. Correctional facilities should review the yield of active syphilis screening in their institutions and local communities to determine whether laboratory screening is appropriate at intake. Universal screening should be conducted on the basis of the local area and institutional prevalence of early (primary, secondary, and early latent) infectious syphilis. Facilities should stay apprised of syphilis prevalence as it changes over time. All pregnant women should be screened for syphilis.

3. Women ≤ 35 and men < 30 years in correctional facilities should be screened for chlamydia and gonorrhea. This screening should be conducted at receiving or as soon as possible unless the person is transferred from a facility to where the testing is done. Pregnant women and MSM should be screened regardless of age from relevant body orifices.

4. If a facility does not have routine universal HIV screening, then at a minimum all people who desire screening and all who screen positive for any of the above STI infections should be screened for HIV infection. Patients testing positive for HIV should be offered immediate treatment. Those testing negative should be informed about PreP.

Adopted by the National Commission on Correctional Health Care Board of Directors: April 12, 2015
Reaffirmed with revision: May 3, 2020

Screening Recommendations

1 Centers for Disease Control and Prevention
2015 Sexually Transmitted Diseases Treatment Guidelines: Special Populations
https://www.cdc.gov/std/tg2015/specialpops.htm

2. U.S. Preventive Services Task Force
Human Immunodeficiency Virus (HIV) Infection: Screening
https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/human-immunodeficiency-virus-hiv-infection-screening#consider