**STI Treatment Guidelines, 2021**

**Detection of STIs in Special Populations**

**Persons in Correctional Facilities**

Multiple studies have demonstrated that persons entering correctional facilities have a high prevalence of STIs, HIV, and viral hepatitis, especially those aged ≤35 years (*141*,*372*,*373*). Risk behaviors for acquiring STIs (e.g., having condomless sex, having multiple sex partners, substance misuse, and engaging in commercial, survival, or coerced sex) are common among incarcerated populations. Before their incarceration, many persons have had limited access to medical care. Other social determinants of health (e.g., insufficient social and economic support or living in communities with high local STI prevalence) are common. Addressing STIs in correctional settings is vital for addressing the overall STI impact among affected populations.

Growing evidence demonstrates the usefulness of expanded STI screening and treatment services in correctional settings, including short-term facilities (jails), long-term institutions (prisons), and juvenile detention centers. For example, in jurisdictions with comprehensive, targeted jail screening, more chlamydial infections among females (and males if screened) are detected and subsequently treated in the correctional setting than in any other single reporting source (*141*,*374*) and might represent the majority of reported cases in certain jurisdictions (*375*). Screening in the jail setting has the potential to reach substantially more persons at risk than screening among the prison population alone.

Both males and females aged ≤35 years in juvenile and adult detention facilities have been reported to have higher rates of chlamydia and gonorrhea than nonincarcerated persons in the community (*141*,*374*,*376*). Syphilis seroprevalence rates, which can indicate previously treated or current infection, are considerably higher among incarcerated adult men and women than among adolescents, which is consistent with the overall national syphilis trends (*141*,*374*). Detection and treatment of early syphilis in correctional facilities might affect rates of transmission among adults and prevention of congenital syphilis (*377*).

In jails, approximately half of entrants are released back into the community within 48 hours. As a result, treatment completion rates for those screened for STIs and who receive STI diagnoses in short-term facilities might not be optimal. However, because of the mobility of incarcerated populations 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 after release might be considerable (*378*). Moreover, treatment completion rates of ≥95% in short-term facilities can be achieved by offering screening at or shortly after intake, thus facilitating earlier receipt of test results and, if needed, follow-up of untreated persons can be conducted through public health outreach.

Universal, opt-out screening for chlamydia and gonorrhea among females aged ≤35 years entering juvenile and adult correctional facilities is recommended (*379*). Males aged <30 years entering juvenile and adult correctional facilities should also be screened for chlamydia and gonorrhea (*380*). Opt-out screening has the potential to substantially increase the number tested and the number of chlamydia and gonorrhea infections detected (*381*–*385*). Point-of-care (POC) NAAT might also be considered if the tests have demonstrated sufficient sensitivity and specificity. Studies have demonstrated high prevalence of trichomoniasis among incarcerated females (*386*–*392*).

**Screening Recommendations**

**Chlamydia and Gonorrhea**

Females aged ≤35 years and males aged <30 years housed in correctional facilities should be screened for chlamydia and gonorrhea. This screening should be conducted at intake and offered as opt-out screening.

**Trichomonas**

Females aged ≤35 years housed in correctional facilities should be screened for trichomonas. This screening should be conducted at intake and offered as opt-out screening.

**Syphilis**

Opt-out screening for incarcerated persons should be conducted on the basis of the local area and institutional prevalence of early (primary, secondary, or early latent) infectious syphilis. Correctional facilities should stay apprised of local syphilis prevalence. In short-term facilities, screening at entry might be indicated.

**Viral Hepatitis**

All persons housed in juvenile and adult correctional facilities should be screened at entry for hepatitis B and hepatitis C. All persons who are susceptible to HBV infection should be offered hepatitis B vaccine, per ACIP recommendations (<https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hepb.html>). During outbreaks in the facility or the surrounding community, all unvaccinated persons should be offered the hepatitis A vaccine; regardless of outbreak conditions, all persons who are at risk for HAV infection or severe disease should be offered hepatitis A vaccine, per ACIP recommendations ([https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hepa.html](https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hepa.html%29).

**Cervical Cancer**

Women and transgender men who are housed in correctional facilities should be screened for cervical cancer as for women who are not incarcerated (*393*,*394*) (see Cervical Cancer).

**HIV Infection**

All persons being housed in juvenile and adult correctional facilities should be screened at entry for HIV infection; screening should be offered as opt-out screening. For those identified as being at risk for HIV infection (e.g., with diagnosed gonorrhea or syphilis or persons who inject drugs) and being released into the community, starting HIV PrEP (or providing linkage to a community clinic for HIV PrEP) for HIV prevention should be considered (*395*,*396*). Persons are likely to engage in high-risk activities immediately after release from incarceration (*397*). For those identified with HIV infection, treatment should be initiated. Those persons receiving PrEP or HIV treatment should have linkage to care established before release. Correctional settings should consider implementing other STI prevention approaches, both during incarceration and upon release, which might include educational and behavioral counseling interventions (*398*–*401*), vaccination (e.g., for HPV) (*402*,*403*), condom distribution (*404*,*405*), EPT (*125*), and PrEP to prevent HIV infection (see Primary Prevention Methods).

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Source: [Division of STD Prevention](https://www.cdc.gov/std/dstdp), [National Center for HIV, Viral Hepatitis, STD, and TB Prevention](https://www.cdc.gov/nchhstp), [Centers for Disease Control and Prevention](https://www.cdc.gov/)