National guidance on commissioning sexual health and blood borne virus services in prisons 2011

Clinical Governance Committee
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Background

This document identifies priorities that commissioners and prisons need to address in partnership to achieve an improvement in services. The guidance highlights key issues that commissioners of sexual health services, clinicians and prison staff need to consider in order to improve sexual health and blood borne virus services in their local prisons. The guidance is in two sections and aims to highlight priority areas both for achieving a core level of service and identifying areas for future development. Priority areas may be more relevant to certain types of prisons than others. The guidance acknowledges the differences between prisons and the wider challenges facing prison health in terms of staffing, resource and capacity issues. Some of the priority areas identified, such as sex and relationships education, condom provision and prison staff training are areas where Primary Care Trust Commissioners do not have the lead responsibility. These areas are vital components of any programme to improve the sexual health of prisoners. It is therefore important that commissioners and Prison Partnerships work closely in these areas to ensure that the sexual health strategies of Commissioners are clearly linked and embedded within the Prisons Partnership processes. Prison Health Performance Indicators should be used to monitor and highlight areas of success and failure.

The health and social care needs of many offenders has been identified as deficient and possibly linked to their offending behaviour. There is an identified need for greater clarity and guidance, in Nov 2007 the Department of Health produced a consultation document ‘Improving health, supporting justice’ that has been followed in July 2008 with an Independent evaluation of the Offender Health Strategy. The clear purpose of this work was that services for inmates should be designed to meet their needs and to standards expected in the wider community. Services for inmates need to be well resourced and their effectiveness measured. The strategy recognised that health promotion and harm minimisation for blood borne diseases in prisons and the community had to be joined up by collaborative commissioning and interagency working. The strategy supports ‘aligned commissioning’ in which organisations share information about commissioning intentions, service and delivery plans.
In mid 2007 the Regional Sexual Health Task Group for the South West of England commissioned guidance to support the improvement of sexual health and blood-borne virus services in prisons. The guidance was produced by a steering group with membership drawn from a wide range of organizations with an interest in this area. The document was sent out for consultation to users, commissioners, public health specialists, health protection specialists and prison staff. Appropriate comments and suggestions received have been incorporated.

It was realised by BASHH that their document had applicability on a wider level and permission has been granted for their work to form the basis for this document. The authors of the original document are fully acknowledged in appendix 3, and the original document is available on the web at the following address: http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1231919480431.

**Standards for sexual health services**

The joint Department of Health and Prisons Service Note on *Prison Health: Transfer of Commissioning Responsibility to PCTs* (2003), states that:

"responsibilities are no different in this field than in any other commissioning or provision of health care, except in so far as they must be jointly agreed with the Governor so that they can be effectively provided within a custodial setting".

The *National Sexual Health and HIV Strategy* published in 2001 by the Department of Health had the following clear aims:

- Reduce the transmission of HIV and STIs;
- Reduce the prevalence of undiagnosed HIV and STIs;
- Reduce unintended pregnancy rates;
- Improve health and social care for people living with HIV; and
- Reduce the stigma associated with HIV and STIs.

In addition the national strategy contains the following standards:

- **Standard 1:** Sexual health service networks
- **Standard 2:** Promoting sexual health
- **Standard 3:** Empowering and involving people who use services
- **Standard 4:** Identifying sexual health needs
- **Standard 5:** Access to services
- **Standard 6:** Detecting and managing sexually transmitted infections (STIs)
- **Standard 7:** Contraceptive advice and provision
- **Standard 8:** Pregnancy testing and support
- **Standard 9:** Abortion service provision
- **Standard 10:** Protection and use of sexual health information
Effective Commissioning of Sexual Health and HIV Services (DH, 2003) defines the main elements of a modern, comprehensive sexual health service as providing:

- Contraceptive care and abortion
- Diagnosis and treatment of STIs and HIV
- Prevention of STIs and HIV
- Services that address psychological and sexual problems

**Key issues for prisons**

The prison population is likely to have different needs to the community in relation to sexual health and blood borne virus infection. Ref Appendix One Epidemiology. This variation should be reflected in local commissioning of services.

- Local and remand prisons are likely to have a high proportion of drug users and therefore a high prevalence of blood borne virus infections.
- Young Offender Institutions are likely to have a high prevalence of chlamydia and other sexually transmitted infection.
- Female prisons are likely to have a high proportion of drug users and commercial sex workers. This will result in a high prevalence of blood borne viruses and sexually transmitted infections. Pregnancy, contraception and abuse will also be key issues.

**Key performance indicators (KPIs)**

The KPIs for prison health jointly published by the Department of Health, Her Majesty’s Prisons Service and the National Offender Management Service in October 2007 include two indicators that relate to sexual health and blood borne virus services:

**KPI on sexual health:**

Prisoners:
1. Are aware of means of accessing condoms in prisons.
2. Have access to barrier protection and lubricants.
3. Access the social and life skills modules on sex and relationship education or similar
4. Have access to a Genitourinary Medicine (GUM) service in prison.
5. Have access to a chlamydia screening programme.

**KPI on Hepatitis B vaccination:**

All new receptions to prison, where there is no verifiable evidence of previous vaccination, are offered Hepatitis B vaccine OR where there is evidence of starting a course this is completed AND there is an uptake greater than 80%.
Summary of priorities to improve sexual health in prisons

The priorities that prisons and commissioners of health services will need to tackle to achieve the standards are summarised below. These priorities have been grouped under the following themes:

- Commissioning
- Access to services
- Reducing the risk of infection
- Information sharing
- Education and training

Commissioning:

1. A commissioning strategy linked to the local sexual health strategy and implemented by the local Prison Partnership Board must be in place.

Access to Services:

2. Every prisoner should have access to a doctor or nurse trained in sexual health. These ‘on site providers’ need clear and accessible pathways to the local specialist genitourinary medicine service. The model of service should ensure that access to appropriate levels of service (level 1, 2 and 3 as defined in the National Sexual Health Strategy) are available and accessible to all prisoners.

3. Every prisoner under 25 should have access to Chlamydia screening through the Chlamydia screening programme.

4. Consultations should be private and confidential.

5. Risk assessment for sexual health and blood borne viruses should be undertaken for all prisoners. Advice and screening should be available to all prisoners.

6. Access to treatment for blood borne viruses should be available to prisoners. Systems that ensure continuity of treatment should be in place, especially during transfer between prisons.

7. Abused women’s services should be available at all centres that accommodate female prisoners.

8. Contraceptive advice and support should be available to all female prisoners prior to release. Their chosen form of contraception should be functioning on release.
Information sharing:

9. The Staff providing sexual health care in prison should be part of a local sexual health network.

10. Arrangements for collection, collation and reporting of prison specific data on sexually transmitted infections and blood borne virus infections should be specified in commissioning.

11. Sharing of health care information on transfer and discharge should be improved possibly through a patient-held record.

Education and Training:

12. Nurses and general practitioners providing sexual health care in prisons should be adequately trained for this role utilizing the hub of local expertise.

13. Appropriate, timely and accessible sex and relationship education should be available to all prisoners.

14. Training and awareness programmes on sexual health and blood borne viruses should be provided to all prison staff to promote stigma reduction.

Reducing the risk of infection:

15. An accelerated course of Hepatitis B vaccination should be provided to all non-immune prisoners and its uptake should be monitored.

16. Effective means of preventing infection from injecting, piercing and tattoo practices should be available in all prisons.

17. Condoms and dental dams should be available and accessible to prisoners in order to prevent transmission of sexually transmitted infections.

18. Infection control plans and processes must be in place in prison healthcare facilities and should be linked to local infection control plans.

19. Post exposure prophylaxis for blood borne virus infections should be available to both prisoners and prison staff.
Priorities for improving sexual health and blood borne virus services in prisons, and how to achieve these standards

This section provides supporting evidence, relevant guidance and examples of implementation for each priority, where available. The examples of good practice are included from the South West where the original document was developed. Good examples from other parts of the UK could easily be included in future revisions.

**Theme: Commissioning**

**Priority: Commissioning strategy**

- A commissioning strategy should be in place for sexual health and blood borne virus services in prisons. This should be an integral part of the commissioning strategy of Primary Care Trust sexual health and blood borne virus services and should reflect the needs of each prison.
- Prison Partnership Boards should lead the implementation of the commissioning strategy which should be embedded in partnership processes.
- Key elements to be considered in a commissioning strategy (as identified in the national sexual health strategy toolkit) include:
  - Commissioner culture and expertise
  - Needs assessment
  - Strategic planning
  - User involvement
  - Communication
  - Primary care focus
  - Resources
  - Collaborative working
  - Education and training
  - Building relationships
  - Building local networks

**Supporting evidence and guidance:**
DH (2003a) *Effective Commissioning of Sexual Health and HIV Services: A sexual health and HIV commissioning toolkit for Primary Care Trusts and local authorities.*
NICE (2007a) Recommendation 4 in *Preventing Sexually Transmitted Infections and Reducing Under 18 Conceptions*
NICE (2007b) *Public health intervention guidance*
Theme: Access to services

Priority: Access to services and model of care

- Every prisoner should have timely access to a doctor or nurse who is trained to a minimum of level 2 in sexual health and linked (via clear referral pathways) to a genitourinary medicine specialist service (level 3).
- The model of service should ensure that access to appropriate levels of service (level 1, 2 and 3 as defined in the National Sexual Health Strategy) is available and accessible to all prisoners.
- Every prisoner under the age of 25 should have access to a chlamydia screening programme (level 1).

Supporting evidence and guidance:

- Prisoners attending GUM clinics have the same entitlement to privacy and confidentiality as non-prisoners. A risk assessment of the premises and the prisoner should be undertaken and if it is not practicable for the prison officers to remain outside the consulting and examination rooms in the GUM clinic, other arrangements should be made to see prisoners in privacy (e.g. in-reach clinics).

Supporting evidence and guidance:
Faculty of Family Planning and Reproductive Health Care of the Royal College of Obstetricians and Gynaecologists (FFPRHC) Faculty Standards on Confidentiality for Contraception & Sexual Health Services (March 2005)
BASHH/MEDFASH Jan 2010 ‘Standards for the Management of STI's’
Sexually Transmitted Infections in Correctional Settings, by Farah M Parvez, Alan L F Tang and Susan Blank.

Example of implementation from the South West:

Implementing a service model at HM YOI Portland and HMP The Verne
In response to a steady increase in GU referrals and waiting times, and difficulties with escort provision a nurse-led level 3 GUM in-reach clinics was commissioned at HM YOI Portland and HMP Verne (a resource for foreign nationals), supported by a consultant-led GUM clinic. In addition a prison nurse was identified and trained in GUM to act as a resource for the prison cluster and to provide level 2 care. One clinic a month is held at HMP Verne, and two at HM YOI Portland, staffed by a GUM nurse practitioner, (able to treat conditions under PGD), and a health adviser. Urgent problems, complex cases, and HIV patients are referred to the weekly consultant-led GUM clinic.

Challenges were faced in implementing practice. To tackle these challenges, a referral proforma for the in-reach GUM clinics was developed to facilitate triage of inmates and prevent inappropriate referrals. The clinics were called “sexual health” rather than “GUM” and the times & days of the clinics were optimised to facilitate access.

- All female prisoners should have access to a trained doctor or nurse (minimum level 2) for contraceptive advice and provision prior to release. Contraception use should be started in time to ensure that it is effective on release.
**Priority: Abused women, contraception & pregnancy**

- Abused women’s services should be available in female prisons.
- There is some evidence suggesting that one third to a half of all women prisoners in UK prisons have experienced some form of abuse.
- Providing abused women’s services is therefore a key part of the effective provision of sexual health services.
- Contraceptive advice and support should be available to all female prisoners, especially when being prepared for release. Their chosen form of contraception should be functioning on release.
- Pregnancy services should be available in female prisons.

**Supporting evidence and guidance:**
Social Exclusion Unit (2002) Reducing Re-offending by Ex-Prisoners

**Priority: Risk assessment, screening and advice**

- A risk assessment for sexual health and blood-borne virus infection should be undertaken for all prisoners by appropriately trained staff (level 1).
- All prisoners should be able to access advice and screening for sexually transmitted infections and blood borne viruses (level 1 or 2). It is important to maximize uptake, especially among those at highest risk. Providing more than one opportunity to do this, for instance at a second health screen after their reception screen, is likely to maximise uptake.

**Supporting evidence and guidance:**
*NICE Guidance* recommends that “health professionals identify individuals at high risk of STIs using their sexual history. Opportunities for risk assessment may arise during consultations on contraception, pregnancy or abortion, when carrying out a cervical smear test, offering an STI test or providing travel immunisation. Risk assessment can also be carried out during routine care or when a new patient registers.” Health professionals should have one to one structured discussions with individuals at high risk of STIs (if trained in sexual health), or arrange for these discussions to take place with a trained practitioner.
Department of Health and HM Prison Service (2007) *Prison Health Performance Indicators 18- General Health Assessment*
Faculty of Family Planning and Reproductive Health Care of the Royal College of Obstetricians and Gynaecologists (2006) *Service Standards for Sexual Health Services*
BASHH/MEDFASH Jan 2010 ‘Standards for the Management of STI’s’
Sexually Transmitted Infections in Correctional Settings, by Farah M Parvez, Alan L F Tang and Susan Blank.
Example of implementation in the South West:

Promoting testing for blood borne viruses at HMP Gloucester

Working closely with clinicians, Gloucester Care Services produced information leaflets on ‘getting tested for HIV and Hepatitis C’ they translated them into several languages. Prison staff have undergone training in counselling. Posters advertising the testing service were put up in each wing and the service is highlighted at prisoner induction.

Challenges included: ensuring all prisoners were aware of the service, maintaining confidentiality and ensuring appropriate referrals were made if they tested positive. To maintain confidentiality prisoners are notified of their blood results in the healthcare setting and not on the wings.

Example of implementation in the South West:

Chlamydia screening of all prisoners 25 years and under at HMP Gloucester

Working with the local chlamydia screening coordinator a care pathway was developed. Staff received training in testing, and nurses training in treating, using a PGD, those testing positive. Prior to receiving treatment, patients were educated on the use of condoms to protect themselves and their partners from STI’s on release. They were encouraged to share partner’s details so the chlamydia team could contact trace. Challenges faced included: promoting the service to prisoners; working out the best way of informing prisoners of the risks of untreated chlamydia; encouraging behaviour change with regard to safer sex; encouraging prisoners to take the test; collecting urine samples; transporting them to the local hospital.

To overcome these: Prisoner induction has proved to be an excellent opportunity to get the message across; as has the healthcare leaflet given to all prisoners who attend. Posters and leaflets promoting the service have been placed on every wing and in healthcare.

Example of implementation in the South West:

Chlamydia screening at HMP YOI Ashfield

At Ashfield, a sexual health risk assessment is carried out during reception week to determine whether the boy is sexually active and if he has any identifiable sexual health issues. Consent is gained for appropriate vaccinations and symptomatic boys are identified for appropriate management. On day 2 of induction week, sexual health is discussed together with identification of relevant vaccinations, each boy is encouraged to access relevant services. On day 4 of induction week, there is a designated time for all boys to attend healthcare to receive their first set of vaccinations and a self-taken chlamydia test. In order to complete the course subsequent vaccinations are administered using a diary system. Chlamydia results are given during a nurse delivered sexual health clinic, where a full sexual history is taken and appropriate blood tests or treatment administered. PGDs permit nursing staff to administer azithromycin.

Conducting a sexual health risk assessment during reception initially caused concern amongst nursing staff who did not feel it appropriate to use needles or take a full sexual history at this time. These boys had just been sentenced or had been in police custody for a prolonged time and needed to take a lot of other information in. The KPI on Hepatitis B vaccination were not being achieved and the staff needed to ensure that all opportunities for offering and delivering vaccinations were being met. A definite time slot was needed as the GP reception review for all boys had been discontinued. Previously, specimen jars were used to collect urine, and tests were done in the department, but a link established with the National Chlamydia Screening Programme means that now self taken samples are possible. The results go straight to the screening programme and are sent to us from their team.

Using the self-administered test prevents cross-contamination of NAATS, reduces the cost of gloves and staff time and means the boys take more responsibility for their sexual health. A very open, inclusive approach has developed a positive team who have driven and supported the change process. There have been problems in retrieving results through our EMIS system and work continues to improve this. Identifying time for clinics has been a challenge. The aim is to fit these clinics into the education regime, which is the most important daily achievement for each boy. After discussions with wing staff, times have been allocated and attendance at the sexual health clinic remains at 25-30 boys per week, not including induction boys.
**Priority: Access to treatment for blood borne viruses**

- Access to treatment for blood borne viruses should be available to prisoners, whether the infection is diagnosed within the prison or outside it.
- Systems and processes to ensure continuity of care must be in place when prisoners are transferred between prisons.

**Supporting evidence and guidance:**

MEDFASH (2003) *Recommended Standards for NHS HIV Services*


Sexually Transmitted Infections in Correctional Settings, by Farah M Parvez, Alan L F Tang and Susan Blank.

**Examples of implementation in the South West:**

**Continuity of treatment for HIV in Dorset**

To avoid unplanned treatment interruptions for prisoners receiving HIV treatment, it was agreed that the prison medical officers should prescribe ongoing antiretroviral therapy. This applied to treatment for prisoners on transfer to a Dorset prison or during their time spent in prison. Previously prison healthcare staff had needed to contact the GUM department to request a repeat prescription. This had resulted in unplanned treatment interruptions. HIV drugs are now ordered by the prison healthcare staff each week along with the usual pharmacy order. The HIV drugs are supplied by an external company, Healthcare at Home. The prescriptions (usually for 2 months) are completed by the prison medical officer, and the drugs sent to the hospital pharmacy. The main challenge was reaching agreement on the responsibility of care for prisoners prior to being seen in the GUM clinic. It was agreed that the GUM consultant could not be responsible for prescribing drugs for a patient they had not yet seen, but would be happy to provide support and advice to the prison medical officer. The local GMS contract for blood-borne viruses included targets for continuity of treatment and rapid referral to GUM.

**Managing Hepatitis C at HMP Shepton Mallet**

Patients undergoing treatment for Hep C are seen in the healthcare department at the prison, rather than at the local hospital (Royal United Hospital, Bath). The prison nurse does all blood tests and monitoring. The patient is seen weekly in the prison and a phone consultation with the hepatitis nurse at RUH is arranged as necessary. When staff were unavailable to escort prisoners their appointments had to be cancelled. By maintaining care within the prison inmate privacy and dignity is better preserved. The main challenge faced was changing work practice. It was addressed by good communication between, prison healthcare and hospital staff as well as patients.

**Care and referral pathways for blood-borne viruses in Dorset**

In Dorset, care pathways were developed by a BBV prison group to encourage routine assessment and screening for BBV. They were designed to support inexperienced staff to perform appropriate investigations, management and referral of those found to be infected. The GUM and hepatology service, as well as the prison healthcare staff were all involved in the development of the care pathways. The main challenge has been transferring the care pathways developed on paper, into a format that the local prison computerised systems could use. Paper and electronic copies of the guidelines are readily available within the prison healthcare settings but the pathways are not yet computerised.
**Priority: Sexual health networks**

- Prison staff providing sexual health care to prisoners should be part of local sexual health networks. They should be familiar with the local GUM team and should spend time with each member of the team in order to build links with the physicians, nurses and health advisors. Building these links will ensure that they benefit from opportunities to share good practice, identify areas that may be commissioned across areas (such as training) and have access to updates, communication and support.

**Supporting evidence and guidance:**
DH (2001) *National Sexual Health and HIV Strategy*
DH (2003b) *Effective Sexual Health Promotion: A toolkit for Primary Care Trusts and others working in the field of promoting good sexual health and HIV prevention.*
BASHH/MEDFASH Jan 2010 ‘Standards for the Management of STI's’

**Priority: Surveillance and data collection**

- Surveillance of sexually transmitted infections and blood borne virus infections in prisons should be improved. Arrangements for the collection, collation and reporting of prison-specific data on a regular basis should be commissioned. Use of specific prison site codes for prisoner samples to facilitate central laboratory data collection should be implemented.

**Supporting evidence and guidance:**
Sexually Transmitted Infections in Correctional Settings, by Farah M Parvez, Alan L F Tang and Susan Blank.

**Examples of implementation in the South West:**

**Minimum data set in Dorset**
The clinical governance agenda for the Dorset Prison Partnership Subgroup on BBV and STIs prioritised obtaining information about diagnoses of STIs and BBVs for each prison. Laboratory reports of tests requested for BBVs and positivity rates are produced regularly by the Dorset County Hospital laboratory. These are broken down by prison and those tests generated by prison healthcare and GUM in-reach. The GUM service specification for the in-reach service includes reporting of diagnoses of STIs and BBVs, and KC60 (GUM diagnostic and attendance) reports for each prison are also published.

The challenges included extraction of data from laboratory and GUM computer systems. Acknowledgement that laboratory reports of positive results do not accurately equate to diagnoses (e.g. most patients with epididymitis have a “non-specific” infection with negative culture results). Building firm links between GUM and microbiology, and employing a biomedical scientist with IT skills, has helped to overcome many of these challenges. The development of site-specific codes for each prison and GUM in-reach, enables data extraction directly from the pathology system. Other positive developments have been: instituting site-specific registration numbers for each GUM in-reach prison clinic; allowing production of individual KC60 reports for each site (eg VP07/0001, YP07/0003), and procurement of a GUM IT system with a user-friendly, flexible reporting facility.
**Priority: Healthcare information sharing**

- Sharing healthcare information on chronic medical conditions (such as HIV and Hepatitis C) on transfer between prisons and discharge, and between prisons and in-reach services should be a priority. This will facilitate achieving completion of hepatitis B immunisation.
- A single unified patient held record should be made available to facilitate healthcare information sharing within and between prisons.
- In facilitating information sharing, standards and guidance on confidentiality should be observed.

**Supporting evidence and guidance:**
FFPRHC Faculty Standards on Confidentiality for Contraception & Sexual Health Services (March 2005) 22

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**Theme: Training**

**Priority: Training**

- Prison nurses and doctors providing sexual health services in prisons should receive appropriate training to level 2 and develop and maintain clinical competence in sexual health and blood-borne viruses.
- The Sexually Transmitted Infections Foundation (STIF) course and RCN sexual health distance learning courses are examples of appropriate *level one* theoretical training courses. This will need to be consolidated through practical experience in a genitourinary medicine clinic to develop adequate competencies to level 2 (see ‘Standards for the Management of Sexually Transmitted Infections’ BASHH/MEDFASH Jan 2010, and ‘Competencies for Providing More Specialised Sexually Transmitted Infection Services in Primary Care’: DH, 2005).
- Commissioning of training at regional level may be a cost-effective and practical way of meeting this need.
- The nurses and doctors should also have close links and evidence of active engagement with local GUM clinic staff, with ready access to discuss cases and opportunities for attachments in GUM clinics to develop and maintain their skills.

**Supporting evidence and guidance:**
NICE (2007) Recommendation 4 in Preventing Sexually Transmitted Infections and Reducing Under 18 Conceptions
BASHH/MEDFASH Jan 2010 ‘Standards for the Management of STI’s’
**Priority: Sex and relationship education**

- Sex and relationship education courses should be available to all prisoners. The quality, timing and accessibility of existing courses were variable. Sex and relationship education courses should be clearly linked to rehabilitation and discharge programmes.

  **Supporting evidence and guidance:**

**Priority: Awareness and stigma reduction**

- Training and awareness on sexual health and blood borne viruses should be available to all prison staff, covering issues like stigma reduction.

  **Supporting evidence and guidance:**

**Theme: Reducing risk of infection**

**Priority: Provision of immunization against hepatitis B virus**

- Hepatitis B immunization should be offered to ALL prisoners who are not already immune and strategies to improve uptake should be in place.
- A super-accelerated schedule should be given to prisoners aged over 18 years (0, 7, 21 days) and to younger prisoners under a patient specific direction.
- A booster is required at one year.
- Prisons staff should have access to immunization against Hepatitis B through occupational health services.

  **Supporting evidence and guidance:**
  Department of Health (2006) *Immunisation against Infectious Disease*
  BASHH/MEDFASH Jan 2010 ‘Standards for the Management of STI’s’
Priority: Promotion of safer injecting, body piercing and tattooing

- To prevent transmission of blood-borne viruses to staff, prisoners and the wider population, all prisoners should have access to effective means of prevention.

Supporting evidence and guidance:

Priority: Provision of condoms and dental dams

- To prevent the transmission of STIs and BBVs, all prisoners should have access to condoms and dental dams in prisons and should know how to access them.
- Condoms should be provided to prisoners on weekend release.

Supporting evidence and guidance:
WHO/UNODC/UNAIDS (2007b) Effectiveness of Interventions to Manage HIV in Prisons: – Provision of condoms and other measures to decrease sexual transmission
There is evidence that provision of condoms is feasible in a wide range of prison settings. No prison system allowing condoms has reversed its policy, and none has reported security problems or any other major negative consequences. In particular, it has been found that condom access is unobtrusive to the prison routine, represents no threat to security or operations, does not lead to an increase in sexual activity or drug use, and is accepted by most prisoners and prison staff once it is introduced. At the same time, there is evidence that making condoms available to prisoners is not enough – they need to be easily accessible in various locations in the prison, so that prisoners do not have to ask for them and can pick them up without being seen by staff or fellow prisoners.
Sexually Transmitted Infections in Correctional Settings, by Farah M Parvez, Alan L F Tang and Susan Blank.

Examples of implementation in the South West:

Distribution of condoms and lubricants in HMP Gloucester.
In August 2007 Gloucester Prison developed a protocol for the distribution of condoms, which is being implemented. On reception all prisoners receive a healthcare leaflet that informs them of the availability of condoms and how to obtain them. Prisoners can approach a member of the nursing team or put in an application to request condoms. The prisoner will be referred to the nurses who are responsible for coordinating the provision of condoms. The prisoner will be offered sexual health information and advice and issued with an initial supply of condoms (maximum of 3) and lubricant. The prisoner is informed that any misuse of the condoms having potential implications for security, will be reported to the appropriate prison personnel. The staff are responsible for ensuring a supply of condoms and lubricant, which they can continue to supply to prisoners. A confidential numerical record will be kept of requests for condoms and of the numbers provided to prisoners. Each prisoner will be advised of the appropriate safe disposal method for used condoms to minimise risk to other prisoners or staff, i.e. small yellow clinical bag which can be disposed of appropriately.
Promotion of the service was achieved by distributing posters on to every wing with a guide on how to access condoms if required and by discussion during prisoner induction. The main challenge faced was the resistance inherent within staff (nursing and prison) and prisoners. It was addressed by education of the benefits in open discussions with officers on the wings; with prisoners during induction and with nursing staff in staff meetings.
Priority: Infection prevention and control in prison health care

- Infection control processes must be in place in prison health care facilities to prevent the transmission of blood borne viruses, linked with the wider Prison Partnership and Health Protection Unit infection control agenda.

Supporting evidence and guidance:
Medicines and Healthcare products Regulatory Agency (2005). *Guidance on Decontamination from the Microbiology Advisory Committee to the DH and MDA.*
Department of Health, HM Prison Service, National Offender Management Service (2007) *Prison Health Performance Indicators Number 30-Communicable Disease Control*

Priority: Provision of post-exposure prophylaxis

- Access to post exposure prophylaxis for blood borne virus infections should be available for prisoners and prisons staff in line with national guidelines. HIV post exposure prophylaxis should be given as soon as possible (ideally within 1-2 hours of exposure).

Supporting evidence and guidance:
BASHH/MEDFASH Jan 2010 ‘Standards for the Management of STI's’

Examples of implementation in the South West:
Informing prison officers about HIV PEP in Dorset Prisons
Posters were developed and displayed widely within the prison. These gave details about management of accidental injury and potential blood exposure, and information about post-exposure prophylaxis. The posters were based on adaptations of materials used in healthcare settings. The lead nurse in each prison was responsible for distribution.
The lack of occupational health provision for prison officers and the need to define the process and responsibility for testing the source (where status unknown) were two of the challenges faced. To overcome these, pathways were developed to transfer relevant clinical details enabling follow-up of prison staff at GP or GUM clinics. Guidelines were developed for prison healthcare managers to undertake source testing, including obtaining consent for results to be made available to the clinician caring for the recipient.
Conclusion

Improving sexual health and blood-borne virus services in prisons is an important challenge. This guidance document aims to support the process. Developing and producing the guidance is simply the first step. Translating the priorities identified in this document into practice is where the real challenge lies. The success of implementation will rely on the need for prisons healthcare staff, hospital staff, commissioners and prisons staff to work together in partnership to effect change, learning from examples in regions where improvements have been made.

Appendix 1:
Epidemiology

Data on the prevalence of sexually transmitted infections in prisons in the UK is limited. In many Western countries, prisoners have a higher prevalence of antibodies to HIV, hepatitis B (HBV), and hepatitis C (HCV) viruses than the general population. In these countries injecting drug use is the most commonly reported risk factor in prisoners. Outbreaks of HIV and HBV infection due to unsafe injecting in prison have occurred in Scotland and other parts of the United Kingdom. One study estimated prevalence of injecting drug use in a Liverpool prison at 16.4%

Findings from national surveys are summarized below:

- 3% of male prisoners had sex with another man within prison and over 6% of homosexual men in prison were infected with HIV.
- Among all those tested 0.4% (14/3930) were positive for anti-HIV, 8% (308/3930) for anti-HBc, and 7% (293/3930) for anti-HCV (the anti-HBc and anti-HCV prevalence were not adjusted for assay sensitivities of 82% and 80%, respectively).
- Twenty-four per cent (777/3176) of adult prisoners reported having injected drugs at least once, 30% of whom (224/747) reported having injected in prison.
- Three quarters of those who injected in prison (167/224) shared needles or syringes.
- Among adult injecting drug users, 0.5% (4/775) had anti-HIV, 31% (240/775) anti-HCV, and 20% (158/775) anti-HBc.

- Among users of an in-reach GUM service in a male prison, the most common infections were chlamydia (10.5%), warts (12.1%) and HCV (9%).
- Problems faced included lack of space and time, no flexibility in appointment system; unexpectedly high DNA rate. This was due to: rapid turnover of prisoners, court attendances, legal visits, some men choosing not to come when sent for, or mistaking the GUM clinic for the dentist. This is particularly a problem where English is not their first language. The attendance of prisoners at the GU medicine service is noted in their prison health record, with relevant information such as referral for management of hepatitis C.
Of 177 attendees at the GUM clinic in a YOI, 51.72% had an STI diagnosed on attendance.

Twenty-nine patients (16.38%) in the YOI had 2 or more sexual partners in the preceding three months.

Fourteen YOI patients (7.9%) had a previous history of STI vs. 25 (14.12%) in a similar GUM clinic population (P = 0.0618) in the community.

Thirty-five YOI patients (20.11%) gave a history of having injected drugs versus none amongst GUM clinic attendees.

Of the 35 patients with a history of intravenous drug use, four were hepatitis C-antibody positive.

Appendix two:

Effectiveness of Interventions to Manage HIV in Prisons: Needle and Syringe Programmes and Bleach and Decontamination Strategies (WHO/UNODC/UNAIDS, 2007a)

In 2007, the WHO, UNODC and UNAIDS published a series of Evidence for Action Technical Papers to ensure policy makers had access to the evidence for the effectiveness of intervention to manage HIV in prisons. One of these reviewed the effectiveness of 1) needle and syringe programmes and 2) bleach and decontamination strategies. The following is a summary of the results and recommendations:

1. Evidence for needle and syringe programmes (NSPs) in prisons

- There is evidence that NSPs are feasible in a wide range of prisons. This included male and female prisons of all security types and sizes, with individual cells or barrack-style accommodation, in well-resourced and less well resourced countries.
- Prison-based NSPs appear to be effective in reducing needle sharing and resulting HIV infection.
- Prison-based NSPs have additional and worthwhile benefits. These include reports of reduced risk of overdose, decrease in abscesses, facilitating referral to drug treatment programmes and increasing the numbers of prisoners accessing these programmes.
- There is no convincing evidence of any major, unintended negative consequences. They do not appear to result in increased drug use or injecting, use of injecting equipment as weapons or undermine abstinence-based programmes.
- For successful implementation:
  - Prisoners need to have easy, confidential access to NSPs.
  - Prisoners and staff need information and education about the programmes.
  - There is a mechanism for safe disposal.
  - Prisoners and staff should be involved in their design and implementation.

WHO Recommendation:

- Prison authorities in countries experiencing or threatened by an epidemic of HIV infection among IDUs should introduce NSPs urgently and expand implementation to scale as soon as possible.
- Based on the success of evaluated programmes and other evidence, NSPs may be beneficial in any prison where injecting drug use or sharing injecting equipment is a problem.
2. Evidence regarding bleach and decontamination strategies

- Disinfection and decontamination of needles and syringes in the community outside prison is not supported by evidence of effectiveness. In prison, effectiveness may be further reduced.
- Distribution of bleach or disinfectants is feasible and does not compromise security.
- Bleach programmes can only be regarded as a second-line strategy to NSPs.
- Public health practitioners should advocate introduction of NSPs.

Authors’ note
Although there is evidence that bleach may inactivate blood-borne viruses, effectiveness is dependent on a number of factors which are difficult to control in a prison setting. These factors include: effective cleaning prior to disinfection (including needle bores), correct concentration of disinfectant, correct exposure time. In addition bleach is corrosive to metals, which may also impair effectiveness and may be hazardous to health.

In the UK, disinfectants are not recommended in the community or hospital setting, for use with invasive devices such as needles, syringes or tattooing devices.

Appendix three:
References and links to key documents

British Association for Sexual Health and HIV (2005) Recommendations for Core Service Provision in Genitourinary Medicine

http://www.bashh.org/documents/58/58.pdf


http://www.cdc.gov/mmwr/PDF/rr/rr5201.pdf


Department of Health (2001) National Sexual Health and HIV Strategy

DH (2003a) Effective Commissioning of Sexual Health and HIV Services: A sexual health and HIV commissioning toolkit for Primary Care Trusts and local authorities.
Department of Health (2003b) *Effective Sexual Health Promotion: A toolkit for Primary Care Trusts and others working in the field of promoting good sexual health and HIV prevention*. London: DH

Department of Health (2006) *Immunisation Against Infectious Disease*


HM Prison Service Clinical Guidance Note: *Issuing Condoms to Prisoners 28th July 2006*


Appendix four:
South West Regional sexual health task group and prison guidance steering group

The South West sexual health task group has been established on behalf of the Regional Director of Public Health to bring together a range of health professionals, managers and representatives of service users in the South West Region to improve sexual health in the region and support professionals working in this area. It is chaired by Dr Hugh Annett, Director of Public Health, NHS Bristol and managed by Dr Isabel Oliver, consultant regional epidemiologist and regional policy lead for sexual health. The guidance was developed by a specially convened steering group with the following membership:

Ike Anya    Specialist Registrar Public Health Medicine
            Health Protection Agency South West (Convener)
Mike Bolton  Governor HMP Gloucester
Andrew de Burgh-Thomas  Consultant in Genitourinary Medicine, Gloucestershire
Lesley Dibben  Gloucestershire PCT
Howard Dunclaf  General Practitioner, HMP Exeter
Jane Easey  Healthcare Manager, HMP Erlestoke
Lucy Hornshaw  Healthcare Manager, HMP Shepton Mallet
Nikki Jeal  Consultant in Sexual and Reproductive Health, Bristol
Mike Jenkins  Prisons Health, Regional Public Health Group
Pam Mallalieu  Regional Lead for Prisons HPA South West
Janet McCuloch  Regional Health Protection Nurse, HPA South West (Convener)
Lorraine McMullan  Sexual Health Nurse, HMP YOI Ashford
Christine Miles  Blood Borne Virus Nurse, HMP Bristol
Janet Mountford  Modern Matron, HMP Eastwood Park
Angela Perrett  Prison Healthcare Service Improvement Manager, Bristol PCT
Cecilia Priestley  Consultant in Genitourinary Medicine, West Dorset
Jo Pring  Lead Nurse, HMP Exeter
Laurie Scott  Practice Manager, HMP Dorchester & HM/YOI Guys Marsh
Frances Stevens  Head of Primary Care Development, Deputy Director of Strategic Development Commissioning, Dorset PCT
Laura Williams  Acting Healthcare Manager, Bristol PCT

Appendix five:
List of Abbreviations

AIDS          Acquired Immune Deficiency Syndrome
BASHH         British Association for Sexual Health and HIV
BBV           Blood-borne virus
DNA           Did not attend
DH            Department of Health
GP            General Practice
GUM           Genitourinary Medicine
HBV           Hepatitis B virus
HCV           Hepatitis C virus
HIV           Human Immunodeficiency virus
HMP           Her Majesty’s Prison
IDU           Intravenous drug user
KC60          Statistical returns from GUM clinics in England, Wales and Northern Ireland
KPI           Key Performance Indicators
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<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>NAAT</td>
<td>Nucleic Acid Amplification Test</td>
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<tr>
<td>NSP</td>
<td>Needle and syringe programmes (needle-exchange schemes)</td>
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<tr>
<td>PCT</td>
<td>Primary Care Trust</td>
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<tr>
<td>PEP</td>
<td>Post-exposure prophylaxis</td>
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<tr>
<td>PGDs</td>
<td>Patient group directions</td>
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<tr>
<td>RAG</td>
<td>Red, amber, green rating</td>
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<tr>
<td>STI(s)</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>STIF</td>
<td>Sexually Transmitted Infection Foundation</td>
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<tr>
<td>YOI</td>
<td>Young Offenders Institution</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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