

Prisons and HIV

A call to action to support
the goals of the HIV Action
Plan for England

February 2026



Background

This paper is from the HIV Health Equity and Justice Partnership (a collaboration between Sophia Forum, Ci2 Bureau, Terence Higgins Trust, and National AIDS Trust). Its purpose is to make clear to policy makers the current gaps and challenges in providing appropriate HIV-related care and treatment for people in prisons and places of detention, and to secure commitments towards ending HIV-related stigma and discrimination.

The content of this paper is based on the experiences and insights shared at a roundtable discussion on 11 November 2025, prior to the publication of the HIV Action Plan for England, attended by stakeholders from government departments, the voluntary sector, health commissioners, and representatives from public health, and clinical providers. The recommendations, views and conclusions presented here are solely those of the HIV Health Equity and Justice Partnership.

The healthcare needs and wellbeing of people in prison and places of detention who are living with HIV are not currently sufficiently met, nor are their experiences recognised and responded to and prioritised.

People in prisons generally have poorer physical and mental health than the general population, as well as higher rates of sexually transmitted infections (STIs), substance misuse, and mental health diagnoses (such as PTSD, depression, and personality disorders). These outcomes are often linked to deprivation, trauma, and the experience of difficult prison conditions.

Although efforts exist to provide healthcare in prisons that is comparable to that received in the community, persistent barriers and systemic issues continue to affect access to and adherence to antiretroviral therapy, the provision of post-diagnosis peer support, and individuals' ability to continue care upon release.

Prisons are unique settings which demand dedicated focus and specific action in relation to the diagnosis, treatment, and prevention of HIV, as well as interventions that respond to the harmful challenge of stigma and discrimination.

The UK Government has committed to achieving the UNAIDS goal of ending new transmissions of HIV and AIDS-related deaths by 2030 and in December 2026 published a new [HIV Action Plan for England 2025-30](#).

While commitments in the Action Plan include widening access to PrEP and PEP, and a specific action to *'complete and review BBV (blood-borne viruses) and STI prisons audit to understand provision of HIV prevention and care in prisons from primary care and sexual health services'*, we believe that without further substantive action, the needs of people living with HIV in prisons will continue to go unmet.

We welcome the BBV and STI prisons audit and believe that it provides an opportunity for gathering key data that is currently missing. But an audit alone can only go so far – there must be commitment and appropriate funding to act on its findings. Data on levels of stigma in prison, the up-take and coverage of appropriate opt-out testing, and access to prevention tools are needed, but assurances and action must follow to fix the treatment gaps and to provide a pathway for appropriate rollout of injectable HIV medication and PrEP.

Since the goal to end new transmissions by 2030 was committed to in 2019, a coordinated and comprehensive approach that fully responds to the challenges related to HIV in prisons has been lacking. Without this we believe the 2030 goal will not be reached, and people living with HIV will continue to experience sub-standard care and fall behind in the care continuum.

This must change, and it must change now.



Without further substantive action, the needs of people living with HIV in prisons will continue to go unmet.



The HIV Action Plan for England 2025-2030 must now be complemented with a dedicated set of concrete actions that meet the challenges of HIV care in prisons.

Delivering these actions will require joint responsibility and partnership, particularly between DHSC, HMPPS, the NHS, local authorities, and the third sector.

The actions must respond to the pressing challenges that we see as being fundamental:

Poor quality data, including lack of estimates of numbers of people living with HIV in prison, incidence rate and number of diagnoses from opt-out testing

Insufficient offer and uptake of opt-out testing – with lack of consistent reporting

High levels of HIV stigma

Unlawful discrimination and data breaches

Lack of consistent access to HIV medication and care for people while in prison

Lack of peer support provision to people living with HIV

Lack of awareness of HIV – amongst people in prison, healthcare staff and other staff

Lack of awareness of HIV transmission, U=U, and treatment - amongst people in prison, healthcare staff and other staff

Lack of consistency in prisons having sufficient arrangements in place with local community sexual health services to provide in-reach services for the assessment and treatment of HIV

Persistent systemic issues that result in people leaving prison without their antiretroviral medication or without being linked to an HIV clinic or HIV community service

Inconsistent and insufficient implementation of BASHH quality standards for the management of sexual health in UK prisons and the BHIVA HIV standards of care

Unless these issues are understood properly, and responded to fully, people in prison will continue to experience poor health outcomes, stigmatising experiences and unmet mental health needs. In wider policy terms – identifying the right solutions that must be implemented in prisons has to be a fundamental part of public policy **to reach the UK Government’s goal of ending new HIV transmissions by 2030.**

To make progress, better data is urgently needed

Data on HIV testing, prevention, and treatment in prisons is severely lacking compared to the general population.

This is despite the UK having some of the best, and most granular, HIV surveillance and monitoring data in the world enabling us to track progress, identify key populations with highest need, and inform decision-making on the right interventions needed for the HIV response.

It is a failing of the system right now that we do not have sufficient evidence and knowledge of HIV in prisons – a setting where people are often most vulnerable and are more likely to have high levels of unmet need in relation to their HIV care and wellbeing.

Underpinning many of the policy areas that we believe must be responded to is the necessity of having more and better data. While UKHSA are currently undertaking work on better data collection, often their hands are tied due to the shortcomings of a fragmented system.

We believe that urgent investment and priority must be given so that it can be possible to answer the following questions and ensure that the right policies and interventions can follow:

Key to improving access to and quality of services for people in prison is having the right data. Currently, data is fragmented, incomplete, and inconsistent. We believe that all partners need to work together so that we can get data and evidence to be able to answer the following questions:

How many people are living with HIV in prison?

How many HIV transmissions take place in prison?

What levels of testing are taking place (both opt-out, and general offer?)

What improvements do prisons intend to implement to increase offer and uptake of testing?

What role can community organisations take to help with this?

How many prisons provide HIV care in their prison?

Why are operational staff using restraints and staying in HIV consultations when Home Office policy recommends against this where possible?

In how many prisons is PrEP and PEP available?

How many people in prison use PrEP and PEP?

Which prisons, if any, offer peer support for people living with HIV?

However, the steps towards more comprehensive data can take time. So while data improvement must be a priority, we cannot allow its absence to hold back progress on responding to the challenges that are well-known and recognised by stakeholders, partners across sectors, and people with lived experience.

Prison and HIV: where we are in 2025

Intersecting risk factors, including poverty, housing insecurity, involvement in sex work, and a history of injecting drug use, increase the likelihood that people in prison are more susceptible to acquiring HIV than the general population.

Incarceration and confinement are known to have a negative impact on a person's physical and mental health, due to isolation, limited access to healthcare and the higher risk of violence within a closed setting.

Access to health care is reduced due to the complexities and constraints of the prison service regime and services do not mirror those available to people in the community. Our understanding of the HIV and healthcare related needs of prison populations is restricted by a lack of data around prevalence amongst people in prisons. Most research into the risk factors and facilitators for HIV prevention interventions is not recent or UK-specific, prohibiting development of effective services tailored to the health needs of people in prison. For context, the estimated global HIV prevalence amongst people in prisons is 3% according to the UN Office on Drugs and Crime, 2020.

HIV testing in prisons

Opt-out BBV testing should be in place in all prisons. Before 2010, fewer than 4% of the English prisons' population had been tested for BBVs.¹ To improve this, a partnership agreement between the relevant organisations in place at the time - Public Health England (PHE), NHS England and the National Offender Management System (NOMS) - introduced a national 'opt-out' testing policy in adult prisons in 2014. The importance of testing all people in prison was underlined in the 2016 NICE guidelines on the Physical Health of People in Prisons.

Willingness to test is linked to an individual's perception, identification, and self-assessment of their risk. Therefore, despite engaging in behaviours that carry a risk of BBV acquisition, individuals may not present for testing in prison. Healthcare providers (HCP) to vulnerable populations must provide HCP-led risk identification and support education on risk perception for people in prisons.

Real and perceived stigma represent the biggest barrier to HIV testing in prisons. Some people prefer not to know their HIV status for fear of being treated differently if they are known to be living with HIV. Added to HIV stigma are intersecting challenges - including homophobia and racism - which reinforce the need to have confidential access to PrEP or treatment.



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1. https://assets.publishing.service.gov.uk/media/5afc1b0540f0b622d4e981db/Event_Report_FINAL.pdf

The consistency of the implementation of opt-out testing across prisons remains unclear, leading to concerns that people are not being tested at the right time, if at all, on entry to and transfer between prisons.

Following data presented in the Chief Medical Officer's report [The health of people in prison, on probation and in the secure NHS estate in England - GOV.UK](#) which suggests that many women entering prisons were more likely than men to be living with HIV, a gendered approach to sexual health should be explored.

Guidance to develop and maintain a care pathway model would benefit prisons and staff, especially with overcrowding, staff shortages and people on remand who might be only there for a short-term stay. There are anecdotal examples of prisons that have implemented opt-out BBV testing without an established protocol for linking people who are diagnosed into care.

HIV prevention in prisons

There are long-standing barriers that prevent people who are in prison from engaging with prevention methods and harm-reduction measures that address higher-risk behaviours. These behaviours include tattooing without sufficiently sterilised equipment, sharing needles to inject drugs, and condomless sex without PrEP or access to PEP.

The lack of targeted interventions to address these barriers may be linked to limited reliable data on these behaviours, as rates of sexual activity, sexual assault, tattooing, and injecting drug use may be higher than reported. In addition, harm-reduction approaches are sometimes contested on the grounds that they may be perceived as encouraging risky behaviours.

The HIV Action Plan for England includes actions to improve awareness of PrEP; however, specific measures to improve knowledge of and access to HIV prevention tools within prisons are needed. The recent Chief Medical Officer's report makes clear that further action is required to widen access to both PrEP and PEP. NHS England Health and Justice should act on the recommendations set out in the CMO's report. In addition, long-acting injectable HIV prevention options should be prioritised in prison settings to go towards addressing practical challenges of continual access to PrEP.



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Overall, a consistent health promotion and harm reduction approach to HIV prevention is needed in prisons that addresses the reality of the behaviours that take place in prison settings. For example, People in prisons have reported instances of being refused condoms, demonstrating that policies, protocols, and behaviours of prison staff are barriers to reducing HIV transmission. While having sex in prison is prohibited, the availability and access to prevention tools must be improved for people who disclose involvement in sexual activity.

There is also a higher representation of people who inject drugs in prison than the general population. Harm reduction strategies, such as needle and syringe programmes, remain unavailable in most prison environments. Many prisons prohibit the distribution of injecting equipment on the grounds of the criminalisation of drug use and the security threat posed by needles, even though this does not reduce injecting drug use within prisons.

Health promotion should be shaped with insight from people in prison and people who previously were in prison. Resources and education should reflect the intersecting identities of people in prisons and their dynamics with each other and the operational staff. The prevalence of coercive and consensual sex should be explored further to shape interventions as it might suggest need for a greater focus on sexual violence prevention, condom distribution and further training for staff.

HIV treatment

Treatment interruptions occur frequently in prison settings. This is driven by inconsistent access to secondary healthcare (often linked to prison officer shortages), stigma, and concerns about breaches of confidentiality. These concerns may arise from the need to attend healthcare daily to receive medication or from holding medication personally and the risk of it being discovered. Both issues could be substantially mitigated by making long-acting injectable treatments available across the prison estate and prioritising prison populations in their future rollout. This approach should not, however, undermine or limit patient choice.

Ensuring swift starting of treatment, and continuation of treatment, must always be a priority. Experiences have been shared of delays of availability of medication, particularly when people arrive or are transferred between prisons and other settings. Without adequate planning and support, people leaving prison may disengage from care and experience difficulties adhering to treatment.

People previously in prison can find it hard to reintegrate back into society. Appropriate support – provided by multiple agencies – is often needed on housing, poverty, the experience of estrangement from loved ones, and – for people adjusting to a new diagnosis – living for the first time outside of a prison or detention setting with HIV. Stigma and self-stigma will further exacerbate the challenges experienced by some people.



Resources and education should reflect the intersecting identities of people in prisons and their dynamics with each other and the operational staff.



BHIVA's Standards of Care 2018 <https://bhiva.org/wp-content/uploads/2024/10/BHIVA-Standards-of-Care-2018.pdf> state that 'When leaving prison, people should be provided with at least 1 month's supply of medication to allow continued adherence while making their own arrangements for a further supply and a booked follow-up appointment with an HIV provider.'

Mental ill health, and lack of access to sufficient mental health care, in prisons undermines engagement with HIV care and adherence to treatment. People in prison have a high prevalence of mental ill health. This is linked to multiple factors such as pre-existing mental health conditions, trauma, substance misuse, homelessness, violence, immigration and the psychological trauma associated with detention.

People living with HIV in prisons have to navigate the compounding impacts of enforced isolation due to incarceration, high levels of stigma (and for some, self-stigma), as well as the lack of confidential space and privacy. These factors can and do affect adherence to HIV treatment while in prison.

Stigma and discrimination in prisons

HIV is not well understood by the general population, and evidence shows that in prisons the levels of knowledge of HIV and how it is transmitted are even worse, among both the prison population and staff.

HIV-related stigma from people in prison and staff including healthcare workers impacts trust and safety. It limits opportunities for conversations, engagement in HIV related care and peer support. Staff members and people in prison can lack HIV knowledge which leads to perpetuation of stigma, breaches in confidentiality, poor adherence to medication and a further enforced isolation.

As well as being stigmatising experiences that impact an individual's wellbeing and mental health, these instances also indicate that there are regular breaches of law taking place – in particular relating to privacy rights under the Data Protection Act, and unlawful discrimination under the Equality Act.

Data from research carried out by the Terrence Higgins Trust, Sophia Forum, and Ci2 Bureau involving people in prison and prison staff show pervasive perceptions and stigma:

- over half (57%) of participants believed HIV could be transmitted via sharing a toothbrush, compared to just 17% of the general public
- only 20% felt people living with HIV are treated fairly in prison.
- 38% were unsure about – and 35% were opposed to – sharing a cell with someone who is living with HIV

(These figures are based on responses from 653 pre-session and 269 post-session surveys.)

The provision of appropriate training to the workforce in prisons (including but not limited to those who are delivering healthcare) must be a priority. Reviewing and updating protocols and processes (such as confidentiality) are also crucial steps in addressing these systemic barriers.

Annexe 1:

Published actions and recommendations relating to HIV and prisons

The information included below present the relevant contextual reports and guidance that relate to HIV care and prisons.

HIV Action Plan

<https://www.gov.uk/government/publications/hiv-action-plan-for-england-2025-to-2030/hiv-action-plan-for-england-2025-to-2030>

- Access to prevention strategies including PEP and PrEP must align to BASHH standards for the management of sexual health in UK prisons and monitored at local, regional and national level
- DHSC support local/regional partners to complete and review the BBV and STI prisons audit to understand provision of HIV prevention and care in prisons from primary care and sexual health services.

Chief Medical Officer's report on health of people in prison

<https://www.gov.uk/government/publications/the-health-of-people-in-prison-on-probation-and-in-the-secure-nhs-estate-in-england>

- ICBs, commissioners, directors of public health and local probations services should establish formal relationships with regular engagement (through HWBBs or Community Safety Partnerships) to understand health needs of people under probation and design local pathways
- ICBs, commissioners and DPHs trial and evaluate specialist prison staff training or peer health champion training for health promotion
- Healthcare commissioners and providers with justice services should establish consistent and complete data recording across the secure estate on risk factors and prevalence of chronic diseases
- ICBs should support continuity of care for patients who are referred to or receiving specialist care if they are required to move areas as part of their journey through the justice system.
- DHSC should ensure that health-related data from prisons is included in wider screening and surveillance programmes such as local federated data platforms, General Practice Extraction Service and UKHSA surveillance platforms that are currently available from community general practices
- DHSC should develop a cross-departmental team with permission to explore possibility of using a unique identifier (potentially the NHS number) and oversee data governance, linkage and analysis to support information-sharing between community and prisons to support individuals' care
- NHS RECONNECT to work in partnership with both prison and health partners to ensure a comprehensive plan for continuity of care for prison leavers
- ICBs should support continuity of care for patients who are referred to or receiving specialist care if they are required to move areas as part of their journey through the justice system
- NHS England and DHSC should update guidance on the implementation and reporting of physical health checks in prison and ensure the target of screening is met

BASSH guidance on testing

https://www.bashh.org/_userfiles/pages/files/resources/3079_prison_standards_bashh_1_final.pdf

UKHSA: Understanding HIV testing in England: 2025 report

<https://www.gov.uk/government/publications/understanding-hiv-testing-in-england/understanding-hiv-testing-in-england-2025-report>

- In March 2018, opt-out testing of BBVs, including HIV, was implemented in all adult prisons in England. New arrivals and people transferring between prisons should now be offered HIV tests, unless they have been tested within the last year and are not at risk, or they have a known HIV positive status.

Positive Perspectives Report – EPIC Consultants 2021

EPIC Consultants were commissioned by NHS England Health & Justice to undertake a piece of research to capture the lived experiences of people living with HIV in UK prisons. The research was carried out in 2021 during the COVID-19 pandemic and found:

- Testing on reception is reported to be inconsistent with less than half of survey respondents reporting they were offered a test on reception.
- Literacy levels of prisons were seen to impact on testing uptake
- HIV appears to be less of a priority than Hep C which has received notable investment.
- Feelings of isolation, desolation and loneliness were commonplace when trying to manage a new diagnosis
- Patients forced to travel to external clinics or hospitals are forced to disclose private health issues with escorting officers and can be stigmatised by community patients
- There is little to no peer support for people living with HIV in prison
- Sexual health professionals are rarely part of formal release or resettlement conversations, despite working hard to ensure continuity of care.
- Everyone we spoke to living with HIV had experienced discrimination in prison

A full copy of the report is available on request from donna@epicconsultants.co.uk

About us

Sophia Forum

Sophia Forum exists to advance the rights of all women including transgender women living with and affected by HIV and we challenge unequal access to services and opportunities based on gender. We have been driving change since 2009 through our policy, research and peer led advocacy work.

Ci2 Bureau

The Ci2 Bureau is a pioneering organisation harnessing the power of collective intelligence to address the complex and deeply rooted issue of HIV stigma. By bringing together diverse voices, lived experiences, and cross-sector expertise, we co-create innovative, context-specific solutions that challenge stigma where it thrives—particularly within prison systems. Our work is grounded in collaboration, equity, and the belief that the most effective answers come from those closest to the problem. Through partnerships, research, and community-led insight, the Ci2 Bureau is redefining how we confront HIV stigma, one system at a time.

Terrence Higgins Trust

Terrence Higgins Trust is the UK's leading HIV charity. Our work across the UK focuses on ending new cases of HIV, supporting people to live well with HIV and fighting HIV stigma. For more than four decades, we have offered trusted information, emotional support and practical services to help people live well with HIV, alongside playing a central role in the national effort to end new HIV transmissions. Our work is rooted in compassion, expertise and lived experience, ensuring that anyone affected by HIV can access the support they need.

National AIDS Trust

We're the UK's HIV rights charity. We work to stop HIV from standing in the way of health, dignity and equality, and to end new HIV transmissions. Our expertise, research and advocacy secure lasting change to the lives of people living with and at risk of HIV. Learn more about our work at www.nat.org.uk

