



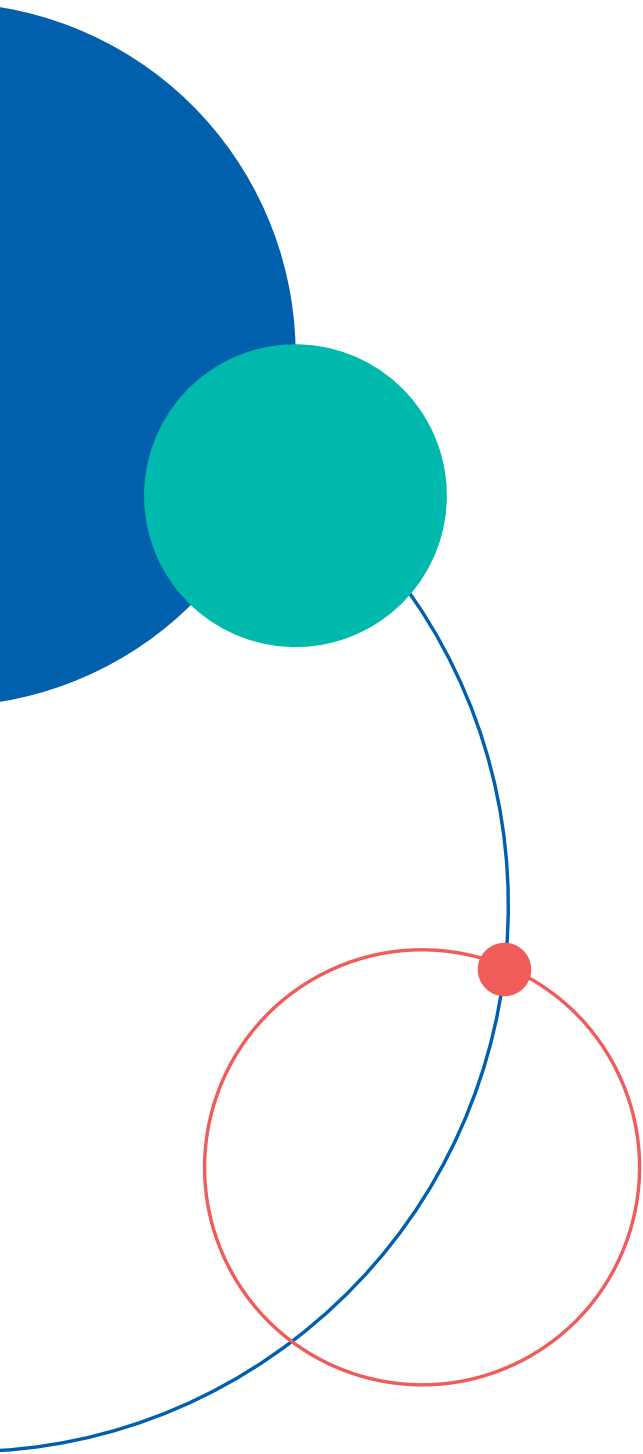
ashm

napwha national association of
people with HIV australia

Discussing HIV viral load and U=U in clinical settings

ASHM / NAPWHA Workshop Report

October 2026



Discussing HIV viral load and U=U in clinical settings

ASHM / NAPWHA Workshop Report
October 2026

This report summarises discussion at a workshop convened by ASHM and NAPWHA. It is not clinical guidance. *U=U: ASHM guidance for healthcare professionals* can be found separately.



ASHM, formerly the Australasian Society for HIV, Viral Hepatitis, and Sexual Health Medicine, is a peak organisation for health workers and medical professionals who work in HIV, blood borne viruses (BBVs), and sexual and reproductive health (SRH). ASHM draws on its experience and expertise to support the health workforce and to contribute to the sector, domestically and internationally. ASHM is a professional, not-for-profit, member-based organisation. It supports its members, sector partners and collaborators to generate knowledge and action in clinical management and research, education, policy and advocacy in Australasia.



A handwritten signature in black ink, appearing to be 'JH'.



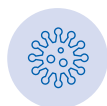
The National Association of People with HIV Australia (NAPWHA) is Australia's peak non-government organisation representing community-based groups of people with HIV. Through leadership in policy, health promotion, representation, education, and prevention, NAPWHA strives to minimise the adverse personal and social effects of HIV. By championing the participation of people living with HIV at all levels of the national response, we aim to build a positive future for all in our communities.



A handwritten signature in black ink, appearing to be 'Scarlett'.

Contents

Introduction	4
Background	4
The workshop	5
Key themes and recommendations	6
Challenges in reinforcing the U=U message	6
Supporting clinical conversations about U=U	7
Appendix A: Summary of discussion	8
Reviewing the evidence	8
What do clinical conversations about viral load and transmissibility currently look like?	9
What does an ideal clinical conversation about viral load and transmissibility look like?	10
How can we have more complex conversations about viral load and transmissibility?	11
Appendix B: Workshop attendees	12



Introduction

In June 2025, ASHM and NAPWHA convened a workshop bringing together clinicians and people living with HIV to consider strategies for discussing HIV viral load and U=U in clinical settings. U=U, or “undetectable equals untransmittable”, refers to the fact that people who take antiretroviral therapy (ART) for HIV as prescribed, and who achieve and maintain a viral load of less than 200 copies/mL (HIV RNA <200 copies/mL), cannot sexually transmit the virus to an HIV-negative partner.

The workshop focused specifically on the challenges of discussing transmissibility in situations where a person living with HIV does not have an undetectable viral load but may still fall below the threshold for U=U of <200 copies/mL, for example, due to low-level viraemia. This report provides a summary of the discussions at that workshop.



Background

The discussions that led to this workshop began in July 2023, when the WHO published *The role of HIV viral suppression in improving individual health and reducing transmission*¹, a policy brief providing guidance on how viral load monitoring could guide decision making about transmissibility for people living with HIV in a range of resource settings. The brief outlined a different paradigm from U=U, establishing a traffic-light system of “three key categories for HIV viral load measurements”²:

- Undetectable (viral load not detected by test used, “Zero risk of transmission to sexual partner(s)”)
- Suppressed (detected but ≤ 1000 copies/mL, “Almost zero or negligible risk of transmission to sexual partner(s)”)
- Unsuppressed (> 1000 copies/mL, “Increased risk of falling ill and/ or passing virus on to sexual partner(s)”)

The primary benefit of these re-framed categories was that, in resource-limited settings with less consistent access to sensitive viral load testing, people living with HIV would still be able to benefit from the knowledge that, even in the “suppressed” category, there was “almost zero or negligible risk” of sexual transmission. The publication of the WHO brief was a significant achievement, and ASHM received multiple enquiries about whether it would be incorporated into ASHM U=U guidance for healthcare professionals.

1. World Health Organization (2023), *The role of HIV viral suppression in improving individual health and reducing transmission*, Policy brief, Accessed online 23/02/2026: <https://www.who.int/publications/i/item/9789240055179>

2. WHO (2023), p. 5

However, in Australia, as the success of U=U has been linked to the use of unequivocal language in relation to viral load and transmissibility, there are concerns that the WHO brief could contribute to uncertainty. Adapting the brief for the Australian context could pose a particular problem for people living with HIV who received viral load test results of >0 and <200 copies/mL. These results clearly fall within the “undetectable” range of U=U, but in the WHO brief would be described as “suppressed”. Discussing this issue with HIV clinicians and people living with HIV, ASHM and NAPWHA both received reports that HIV viral load test results falling within this range were already leading to challenging discussions about transmissibility in clinical settings. People living with HIV reported that test results indicating low levels of detectable viral load were sometimes leading clinicians to tell them they should not be having sex due to (non-existent) transmission risks. For example, as available testing assays in Australia became more sensitive, some people living with HIV had received detectable viral load test results below 200 copies/mL, despite no actual change to their viral load.

Others said that U=U’s emphasis on “undetectable” was leading to confusion among people living with HIV about what these sorts of viral load test results meant for them. For example, as available testing assays in Australia became more sensitive, some people living with HIV had received detectable viral load test results despite no actual change to their viral load. This in turn necessitated complex clinical discussions about transmissibility that those involved were not always equipped to have.

ASHM and NAPWHA agreed that the WHO policy brief wasn’t appropriate to adapt for Australian settings, but these conversations had raised a range of other important questions about how clinicians and people living with HIV talk about HIV viral load test results, particularly in instances of low-level viraemia (detectable HIV RNA level <200 copies/mL)³. These conversations were also timely, as ASHM was preparing to review the existing resource, *U=U: ASHM guidance for healthcare professionals*⁴.



The workshop

On 24 June 2025 in Sydney, ASHM and NAPWHA brought together a group of HIV clinicians and people living with HIV for a national workshop to discuss two key questions:

How is U=U currently being discussed with people living with HIV in clinical settings, in situations where HIV viral load test results indicate viral blips or low-level viraemia?

How can clinicians and people living with HIV be better supported to discuss HIV viral load and transmissibility, in situations where HIV viral load test results indicate viral blips or low-level viraemia?

The group attending the workshop included clinicians (one sexual health and HIV physician, three GP s100 prescribers, one nurse practitioner s100 prescriber and one clinical pharmacist), people living with HIV community leaders (including those working with community organisations), and ASHM and NAPWHA staff.

3. ASHM (2020), *U=U: ASHM guidance for healthcare professionals*, Clinical guidance, Accessed online 24/02/2026 <https://ashm.org.au/resources/uu-ashm-guidance-for-healthcare-professionals/>

4. ASHM (2020), *U=U: ASHM guidance for healthcare professionals*, Clinical guidance, Accessed online 24/02/2026: <https://ashm.org.au/resources/uu-ashm-guidance-for-healthcare-professionals/>



Key themes and recommendations

The workshop sought to answer key questions related to discussing HIV viral load and transmission risk in clinical settings, where viral load test results indicate viral blips or low-level viraemia (LLV). Key themes and recommendations arising from the discussion fell into two areas.

Challenges in reinforcing the U=U message

1. Increased sensitivity in HIV viral load testing and inconsistencies in clinical and pathology processes may be contributing to confusion among people living with HIV and clinicians about whether a person's viral load meets U=U's definition of "undetectable".
.....
2. U=U's focus on "undetectability" may be undermining its own message (specifically, the <200 copies/mL definition) in cases where a person living with HIV has a viral load of between 0 and 200 copies/mL.
.....
3. While Australia is not ready to adopt the WHO definition of a "suppressed" viral load, more complex conversations about HIV viral load and transmissibility may be possible for people whose viral load is between 200 and 1000 copies/mL. However, it's important that these conversations do not undermine clinical and community consensus about zero risk of sexual transmission at a viral load of <200 copies/mL.
.....
4. Future updates to ASHM's U=U clinical guidance should emphasise the <200 copies/mL definition, rather than focus on undetectability.
.....
5. Future updates to ASHM's U=U clinical guidance should support more complex conversations about transmissibility, but without undermining the core message that an HIV viral load of <200 copies/mL means zero risk of sexual transmission.
.....
6. Maintaining unequivocal language in relation to U=U and sexual transmission risk is critical, e.g. "zero risk".
.....
7. ASHM and NAPWHA should work with public and private pathology providers to include clear and consistent U=U messaging on HIV viral load results. This would help clinicians and people living with HIV understand that a detectable viral load maintained below 200 copies/mL on treatment still means zero risk of sexual transmission.

Supporting clinical conversations about U=U

8. Staying up to date with the current evidence about HIV viral load and transmissibility will help clinicians to have more supportive conversations about U=U.
.....
9. Clinicians can support people living with HIV to feel more comfortable about transmission risk by explicitly discussing transmissibility in the context of viral blips and low-level viraemia.
.....
10. Viral load continues to be a site of perceived or actual judgement from clinicians, particularly in relation to how people living with HIV take their medication. Conversations about medication should be supportive and avoid judgement.
.....
11. It can be challenging for clinicians to explain the potential clinical implications of viral blips and low-level viraemia, while also reassuring people living with HIV about transmissibility. Clinicians should balance their own clinical priorities with the priorities of their patient.
.....
12. Different people will have different priorities when it comes to talking about HIV viral load: some may want to talk about it in detail, while others may only want to understand its impact on transmissibility. Clinicians should seek to understand their patients' priorities as part of a conversation about viral load.
.....
13. Complex conversations about HIV viral load and transmissibility can be supported by an ongoing relationship between a clinician and a person living with HIV.
.....
14. Conversations about HIV viral load and transmissibility should clearly distinguish between different modes of transmission, for example, sexual, pregnancy, breast and chest-feeding, or sharing injecting equipment.
.....
15. Peer navigators can be a vital resource for supporting complex conversations about HIV viral load and transmissibility.



Appendix A: Summary of discussion

Reviewing the evidence

After introductions from ASHM and NAPWHA framing the objectives and background to the day, a presentation was given by a general practitioner and HIV s100 prescriber, outlining the evidence underpinning U=U and clinical management of low-level viraemia. While it can take one to three months of ART for a person with HIV to become undetectable⁵, viral rebound can occur within days of stopping treatment⁶.

“Viral blips” occur when a person who had been undetectable then receives a detectable viral load test result, which then returns to virological suppression³. Viral blips on their own are not evidence of treatment resistance and can be caused by several factors: immune stress caused by another infection, missed doses of medication, or even issues with how samples are handled in pathology labs. It was stressed that the important thing to do following a viral blip is to test again, review treatment adherence, and provide reassurance to the person living with HIV.

In contrast to viral blips, low-level viraemia (LLV) is a persistently detectable viral load of around 50 to 200 copies/mL³. It is associated with several factors including a higher baseline (pre-ART) viral load, a possible larger viral reservoir, and persistent immune dysfunction.

Reviewing the evidence on LLV and sexual transmission, across eight studies there were no recorded transmissions where a person’s viral load was between 200 and 600 copies/mL, and only two recorded transmissions in the 600 to 1000 copies/mL range⁷. The evidence supporting the <200 copies/mL definition for U=U comes from four pivotal studies out of this group, where follow-up was able to determine the likelihood of a person’s viral load at the time of transmission⁴.

It was highlighted that U=U’s definition of “undetectable” has been very connected to the strength of HIV viral load testing assays. As assays have become more sensitive, viral load test results that fall within the 0 to 200 copies/mL range, which would have previously come back as “undetectable,” may now come back with a detectable viral load that still meets U=U’s definition of undetectable.

5. Kassutto, S. et al. (2006), ‘Longitudinal analysis of clinical markers following antiretroviral therapy initiated during acute or early HIV type 1 infection’, *Clinical Infectious Diseases*, 42(7), pp. 1024–31, Journal article
6. Gunst, JD. et al. (2025), ‘Time to HIV viral rebound and frequency of post-treatment control after analytical interruption of antiretroviral therapy: an individual data-based meta-analysis of 24 prospective studies’, *Nature Communications*, 16(1), p. 906, Journal article
7. Broyles, LN. et al. (2023), ‘The risk of sexual transmission of HIV in individuals with low-level HIV viraemia: a systematic review’, *The Lancet*, 402(10400), pp. 464–471, Journal article

What do clinical conversations about viral load and transmissibility currently look like?

Both clinicians and community members discussed that inconsistencies in clinical conversations and processes related to U=U might reflect out-of-date clinician knowledge and education, potentially based on old evidence. A GP with a low caseload of people living with HIV might be operating based on guidelines from 5 to 10 years ago and may not have the time to stay up to date with developments in evidence relating to the clinical management of HIV. Moreover, some clinicians might assume that everyone already knows about HIV, including U=U. One community member said that while that may be true for men who have sex with men, it is less true for women living with HIV and their families.

Community members described inconsistencies in processes across settings, one person giving the example of a woman refused a water birth despite a viral load well below the U=U threshold. It was unclear where this policy had come from, given U=U's focus on <200 copies/mL.

These inconsistencies are further complicated by differences between the ways pathology labs and clinicians might describe a viral load test result. One community member said that the way they had been told about a detectable viral load result had been informed by how it appeared on the pathology slip: as "virus detected" rather than "undetectable" for a result of <200 copies/mL. ASHM shared that in Western Australia, public pathology labs included messaging about U=U on pathology slips for a viral load test result of <200 copies/mL, and that this approach was being investigated for other states and territories.

Several community members gave examples of both positive and negative experiences in clinical consults. One community member gave a positive example of how a clinician had discussed transmission risk in the context of a viral blip. When they had been worried about what it would mean for their HIV-negative partner, the clinician explained to them explicitly that because their viral load was still below 200 copies/mL, they could still have condomless sex with zero risk of transmission.

Community members also said that the threat of criminalisation informed how people living with HIV thought about viral load and transmissibility. Legal risk was impossible to separate from transmission risk in a legal environment where many felt U=U afforded uncertain legal protections. On the clinician's side, there are legal obligations in some Australian jurisdictions to discuss U=U as a means of minimising transmission risk. While a detailed discussion of the legal implications of U=U was beyond the scope of the workshop, the group agreed that these questions may need to be revisited as part of the update to ASHM's U=U guidance.

Both clinicians and community members said that clinical consults sometimes remained a site of moral judgement, and that viral load could be a focal point for those judgements. One clinician said that they had heard multiple reports from people living with HIV of feeling blamed for viral load test results of over 200 copies/mL. While the way someone takes their medication could be a factor in LLV, many other things could be as well. Even the language of medication "adherence" implied judgement to some clinicians and community members, who agreed that we need better language for talking about taking medication.

Clinicians stressed that it is difficult to draw conclusions based on a single viral load test result. They noted a detectable viral load might just be a blip, so it is important to situate results over time and observe trends in viral load results. However, clinicians also emphasised that a detectable viral load might have clinical implications for the person living with HIV and drug resistance. It was made clear that the framing of these conversations can be challenging.

What does an ideal clinical conversation about viral load and transmissibility look like?

A major focus for the discussion was that clinicians and people living with HIV might have different priorities when it comes to talking about viral load. Community members acknowledged that not every person living with HIV will want to talk about viral load results in the same way. One attendee said they didn't want their clinician to tell them they have a viral load of "23", and would rather the clinician focused on transmissibility. In contrast, a clinician described some patients who were very "data-focused" and found comfort in being walked through the detail of their test results. There's no one-size-fits-all approach to any clinical conversation, so one solution might be for clinicians to take a more proactive approach to asking the person in front of them how they would like to discuss viral load test results.

Clinicians discussed that while for some people transmissibility might be the most relevant takeaway from a conversation about viral load, test results indicating LLV can have other clinical implications. The question was asked, "how do we reconcile what is important to the person living with HIV with what might be clinically relevant, if those things don't always align"? The group didn't have a clear answer, but community members stressed that conversations about adherence, for example, needed to be non-judgemental, and centre the autonomy of the person living with HIV. Many clinicians might not realise how common it is for people living with HIV to miss a dose, so asking questions like: "Have you had any challenges in taking your pills?" could be a more neutral approach that avoids judgement.

Reflecting on the changes in the WHO policy brief, the group agreed that unequivocal language around viral load and transmissibility was critical: zero risk. If a situation arose where a higher viral load might indicate the potential for transmission, quantifying the specific risk (for example, in percentages) rather than simply saying something like "low risk" might help mitigate moral judgements from clinicians. The group emphasised that updated guidelines should reflect the fact that U=U is, first and foremost, a stigma-reduction strategy. As much as possible, the guidelines should reduce the opportunity for clinicians to use their moral judgements to influence how they talk about U=U.

Both community members and clinicians discussed how the possible scope of conversation in a clinical consult varies widely depending on the setting. A GP might have a years-long relationship with a patient, while a clinician in a sexual health clinic might be seeing someone for the first time, or vice versa.

While simple messaging that can be adapted for a variety of settings is a laudable goal, everyone acknowledged that these are complicated topics that aren't necessarily going to be comprehensively addressed in a single consult. Complex conversations about viral load and transmissibility may need to be scaffolded over time, underpinned by a supportive relationship between a clinician and a person living with HIV.

Given the disparities across clinical relationships, peer navigators were extensively discussed as an ideal support for these complex conversations. Some people living with HIV may not want to say everything to a clinician, for cultural or social reasons for example, but will talk to a peer navigator. Peer navigators may also have more time and be better equipped to have complex conversations than some clinicians who do not regularly see patients living with HIV.

How can we have more complex conversations about viral load and transmissibility?

Much of the discussion focused on the <200 copies/mL viral load threshold that defines U=U. While everyone acknowledged the WHO's assessment of "Almost zero or negligible risk of transmission to sexual partner(s)" up to 1000 copies/mL, scientific and community consensus for "zero risk" supported the <200 copies/mL definition of undetectable. Consensus is extremely important as a foundation for consistent and supportive clinical conversations about viral load and transmissibility, so many attendees were very reluctant to do anything that might jeopardise that consensus.

One community member pointed out that being able to point to the science to support a position on transmissibility was insufficient: this was also about establishing social and cultural norms when it comes to talking about the certainty of U=U.

While some clinicians said they felt comfortable saying that even a viral load of up to 600 copies/mL meant zero risk of transmission, some community members were sceptical that a shift like that would make a difference to how those conversations played out in the clinic. As one community member said, "if someone isn't believing the science behind U=U at <200 copies/mL, why would they believe it at <600 copies/mL?"

The group agreed that not enough was being done to reinforce the message that <200 copies/mL is the viral load cutoff for transmissibility, according to the definition of U=U. While the day's discussion had highlighted some of the complexities of transmission risk when it came to LLV, the fact remained that even people with LLV who clearly met the definition of U=U were facing judgement and inconsistencies in clinical settings. There was a range of views on the utility of the term "undetectable", but many in the group argued that saying "undetectable" to actually mean "<200 copies/mL" was the cause of much of the confusion.

Discussing how these insights might inform upcoming changes to ASHM's U=U clinical guidance, the group suggested that the guidance should focus on reinforcing the <200 copies/mL definition, rather than focusing on undetectability. They acknowledged the need for more complex conversations about sexual transmissibility >200 copies/mL but said this could be the focus of a separate section, to avoid undermining the core message. Some community members also stressed the importance of clearly distinguishing between different modes of transmission, for example, pregnancy, breast and chest-feeding, or sharing injecting equipment.



Appendix B: Workshop attendees

- Akumu Deborah Leticia
- Fiona Bisshop
- Jane Costello
- Adam Finch
- Scott Harlum
- Richard Keane
- Mark O'Reilly
- Arron Sparkes
- Michelle Tobin
- Arthur Wong
- Shannon Woodward
- Erainia Wu
- Bo Justin Xiao

ASHM Staff

- Benjamin Riley
- Joel Paparello

NAPWHA Staff

- Brent Clifton
- Aaron Cogle
- James Holland

Contributions summarised in Appendix A are not attributed to individuals.

Special thanks to Edwina Wright, Rick Varma and Andrew Grulich, who provided feedback on initial ideas for this workshop.



ashm

napwha national association of
people with HIV australia

ashm.org.au