

REPORT BY THE NGO REPRESENTATIVE

**Undetectable = Untransmittable =
Universal Access (U=U=U):**

**A foundational, community-led global
HIV health equity strategy**

Additional documents for this item: *None*

Action required at this meeting—the Programme Coordinating Board is invited to:

92. *take note* of the Report by the NGO Representative;
93. *call upon* Member States, UNAIDS and Cosponsors to:
- embed Undetectable = Untransmittable (U=U) in global, regional, national and subnational health and/or HIV strategic plans;
 - promote anti-stigma interventions, through updated comprehensive sexuality education curricula and across the HIV combination prevention, testing, treatment and care cascade, where community-led U=U initiatives and U=U research are well resourced; and
 - ensure that U=U is leveraged to support expanded health equity efforts to improve the health and well-being of people living with and affected by HIV, especially members of key populations and other vulnerable groups, such as women and girls, adolescents and young people, Indigenous Peoples, and migrants;
 - *accelerate* progress to get the global HIV response back on-track to meet the SDGs by fast-tracking equitable access to HIV combination prevention, testing, treatment, care and support through the planning, costing, implementation, scaling up, and the monitoring and evaluation of rights- and evidence-based community-led U=U programming, service delivery and monitoring, including the accelerated expansion of viral load diagnostics and viral load testing strategies without sacrificing other planned prevention and treatment initiatives;
94. *call upon* UNAIDS to:
- utilize the growing body of evidence on the multimodal use of U=U, ensuring that U=U is incorporated as a key health equity strategy and policy instrument to complement and enhance the attainment of 2021–2026 Global AIDS Strategy targets (95–95–95, 10–10–10, 30–80–60), including by:
 - meeting HIV prevention and treatment targets;
 - promoting initiatives to support health and allied professionals, law enforcement, decision-makers, and members of key populations and other vulnerable groups;
 - leveraging U=U for greater access to effective treatment, diagnostics and testing;
 - promoting enabling and supportive environments at global, regional, national and subnational levels; and
 - supporting improved health outcomes, well-being and quality of life for people living with HIV;
 - convene a multi-stakeholder U=U working group co-led by WHO to support the development of harmonized definition(s) of U=U as a health-equity strategy that is designed to accelerate equitable, barrier-free access to affordable HIV treatments, health commodities and health technology innovations within the HIV response. The multi-stakeholder working group should advise on the following parameters:
 - common policy definition(s) accompanied by evaluation metrics to support and encourage consistency across policy, programming and technical guidance;
 - common clinical standard(s) on viral load suppression, including the updating of such definition(s) when new evidence becomes available;
 - recommendations on appropriate multimodal strategies to be incorporated into technical support to Member States and Co-sponsors on the integration and implementation of U=U; and
 - appropriate U=U targets and metrics to be included into routine Global AIDS Monitoring and UBRAF reporting.

Cost implications for the implementation of the decisions: *none*

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Acronyms and abbreviations

AIDS	acquired immunodeficiency syndrome
ARV	antiretroviral
ART	antiretroviral therapy
CDC	Centers for Disease Control
CSE	comprehensive sexuality education
Global Fund	Global Fund to Fight AIDS, TB and Malaria
HIV	human immunodeficiency virus
NGO	nongovernmental organization
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
SDG	Sustainable Development Goal
SRH	sexual and reproductive health
STI	sexually transmitted infection
U=U	Undetectable = Untransmittable
UHC	universal health coverage
WHO	World Health Organization

Executive summary

1. The latest UNAIDS data show that the pace of progress in preventing new HIV infections continues to slow. Alarming numbers of new infections still occur each year and far too many people living with or at risk of HIV remain without access to life-saving treatment and prevention services.¹
2. Despite the many evidence-based strategies that chart paths to “a world free from poverty, hunger, disease and want, and where all life can thrive”,² too many global reports continue to show that we are not moving fast enough to end the social and structural drivers of current pandemics. In some cases, entrenched inequities are reversing hard-won gains.^{3 4 5} Widening inequalities within and between countries are a primary driver of HIV and other pandemics, including but not limited to tuberculosis, malaria, cholera, Ebola, Monkeypox and COVID-19.⁶
3. Undetectable = Untransmittable (U=U) is a concept that has been endorsed by governments and diverse communities around the world. It has transformed the lives of millions of people living with and affected by HIV, and HIV prevention, testing, treatment, care and support generally. Robust evidence shows that U=U is a highly effective approach for eliminating HIV stigma and discrimination through access to information, knowledge (education) and advocacy that is tailored to local contexts and communities. U=U has been described as “one of the most effective and historic counter-narratives to HIV stigma”.⁷
4. This annual report by the NGO Delegation to the UNAIDS's Programme Coordinating Board focuses on the untapped potential of U=U as a vital community-led, global HIV health equity strategy. It describes how U=U can improve the health and quality of life of people living with HIV, key populations and other vulnerable groups,ⁱ and it underscores the fundamental role U=U can play in achieving the 95–95–95 treatment targets and in ending AIDS by 2030.
5. In preparing this report, it was clear that U=U means many things to many people. For the purpose of this report, U=U refers to a multimodal concept that is:
 - based on biomedical evidence that a person with a suppressed viral load cannot sexually transmit HIV;
 - centred on the experiences and treatment needs of people living with HIV, while supporting evidence-based combination prevention efforts for seronegative people and those who still need to learn about their status;
 - an advocacy campaign that arose from the collaborative efforts of people living with HIV and leading scientists to ensure that people living with HIV have access to the latest scientific evidence that can have a direct impact on their health, well-being and quality of life;
 - an expansion beyond the normative description of U=U as a biomedical and anti-stigma intervention to a global movement led by people living with HIV to help support people in attaining and maintaining optimal health, while also improving outcomes in HIV prevention, diagnosis, care and treatment; and
 - to be recognized as a new community-led health equity policy instrument following the inclusion of U=U in the [2021 High-Level Political Declaration on HIV and AIDS](#).
6. Ending AIDS by 2030 requires ending inequality and inequity. It requires strengthening the health and community systems that can better prepare the world to prevent, identify

ⁱ Key populations and other vulnerable groups such as, women and girls, adolescents and young people, and migrants who are disproportionately affected by HIV.

https://www.unaids.org/sites/default/files/media_asset/PCB49_Decisions_EN_.pdf

and respond to future pandemics and health challenges.^{8 9} Achieving the UNAIDS global treatment targets means making good on commitments to global solidarity and ensuring universal access to quality HIV combination prevention, testing, treatment, care and support for all.

7. The report has six sections:
 - an introduction to the topic of U=U, along with key terminology and a review of the methodology used in developing the report;
 - a review of the landscape to provide context for discussion of U=U as a global, community-led HIV health equity strategy that harmonizes with the UNAIDS global treatment targets of 95–95–95 and the Global AIDS Strategy (2021–2026);
 - a discussion of critical issues related to U=U and specific areas of alignment with the Global AIDS Strategy;
 - a summary of key challenges and facilitators for U=U, including stigma and discrimination; ensuring enabling environments to support marginalized communities that are not yet engaged in U=U and the HIV treatment cascade; investments in community systems, leadership and responses, including within global pandemic prevention, preparedness and responses; and access to technology and innovation;
 - proposed decision points for consideration by members of the PCB; and
 - 14 illustrative case studies from government and nongovernmental partners implementing U=U in regions across the world.

Key points

8. Limited and inequitable access to HIV combination prevention and testing services means that not enough people know their HIV status and receiving life-saving HIV treatment. This threatens their health and well-being and contributes to the ongoing cycle of HIV transmission.¹⁰
9. U=U represents a grassroots, rights-based, community-led public health paradigm shift that repositions the understanding of what it means to be living full and healthy lives with HIV without stigma, shame or the fear of transmitting HIV on to others.
10. The scientific evidence shows that effective antiretroviral therapy reduces viral loads to such low levels that a person cannot transmit HIV to others. Yet, limited research has been conducted on the applicability of U=U for all key populations and vulnerable groups. This gap in research undermines the pursuit of health equity and the potentially powerful role of universal access to ART, diagnostics and sustained (health) care in reducing new HIV infections.
11. The transformative and untapped potential of U=U is optimized when services are designed and delivered in strategic and supportive partnership with facility-based and community-led health providers, communities living with and affected by HIV, and government programmes.¹¹ They:
 - improve the well-being of people living with HIV by incorporating U=U in comprehensive sexuality education, transforming the social, sexual, and reproductive lives and legal rights of people living with HIV by freeing them from the shame and fear of sexual transmission to their partners;
 - challenge and dismantle deep-seated HIV-related stigma and discrimination and public perception about HIV transmissibility;

- support HIV combination prevention and treatment goals by reducing the structural barriers and anxiety connected with testing and treatment; and
- advance an evidence-based public health and health equity argument for universal access to HIV testing, diagnostics, treatment, and care that will support improved health outcomes, save lives and prevent new HIV infections.¹²

Introduction

“I as person living with HIV, who personally benefits from U=U because U=U is about making sure I have access to optimal diagnostics, optimal treatment regimens, affordable medicines, must adhere to my meds and be virally suppressed in order to maximize benefits. However, there is also the collective responsibility to create enabling ecosystems where being HIV+ or loving who we want to love is not a criminalized offence. U=U will not be achieved where health services are not available, viral load not accessible, medicines not affordable. Then the failure to achieve U=U is a government failure not mine.”

– **Dr. Vuyiseka Dubula-Majola**, Centre for Civil Society, University of KwaZulu-Natal, South Africa

“We can win the fight to end pandemics, but only if we are bold enough to end the inequalities which drive them.”

– **Helen Clark**, Co-chair of the Independent Panel for Pandemic Preparedness and Response

12. The NGO Delegation to the UNAIDS Programme Coordinating Board (PCB) produces an annual NGO report that is presented during one of the biannual PCB meetings. The Delegation selects the topic of the report. The highest priority is given to a topic that is timely, critically important to communities and civil society, and seen to require urgent action at global and national levels in order to end AIDS by 2030.
13. This year’s NGO report focuses on the untapped potential of U=U as a vital community-led, global HIV health equity strategy to improve the health and quality of life of people living with HIV and contribute to the global treatment targets of 95–95–95 by advancing universal access to antiretroviral therapy (ART), diagnostics and sustained care, while reducing HIV transmission.
14. The NGO Delegation acknowledges the [2021 United Nations High-Level Political Declaration on HIV and AIDS: Ending inequalities and getting on-track to end AIDS by 2030](#), the Global AIDS Strategy 2021–2026, and the WHO Global Health Sector Strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections (STIs) and the recognition of Undetectable = Untransmittable (U=U) as a highly effective tool for eliminating HIV-related stigma and discrimination, and its significant HIV prevention benefits.¹³
15. The report recalls UNAIDS’s support for the U=U concept in the 2018 UNAIDS document [Undetectable = Untransmittable: Public health and HIV viral load suppression](#) and the renewed call to action in the [Global AIDS Strategy \(2021–2026\)](#) to end inequities. The Global AIDS Strategy 2021–2026 states the ambition to “fulfill the potential of treatment as prevention” and to prioritize the “urgent implementation and scale-up of evidence-based tools, strategies and approaches that will turn incremental gains into transformative results ... while importantly avoiding the artificial dichotomies between treatment and prevention, focusing instead on fully leveraging the synergies between combination prevention and treatment”.¹⁴

16. The NGO Delegation recognizes the transformative potential of U=U as an evidence and rights-based global response that is driven by communities living with and affected by HIV and their allies, as an embodiment of the principles the Greater Involvement of People Living with HIV (the [GIPA Principles](#)) and the meaningful engagement of all communities who are vulnerable to HIV.
17. This NGO report builds on a series of previous reports from the Delegation to the UNAIDS Programme Coordinating Board, including but not limited to:
- Left out: the HIV community and societal enablers in the HIV response (UNAIDS/PCB (49/21.24.rev1));
 - If it is to be truly universal: Why universal health coverage will not succeed without people living with HIV and other key populations, women and young people (UNAIDS/PCB (45)/19.23);
 - People on the move—key to ending AIDS (UNAIDS/PCB (43)/18.20);
 - An unlikely ending: ending AIDS by 2030 without sustainable funding for the community-led response (UNAIDS/PCB (39)/16.23);
 - Sexual and reproductive health and rights of people most affected by HIV: the right to development (UNAIDS/PCB (38)/16.4);
 - When rights cause wrongs: addressing intellectual property barriers to ensure access to treatment for all people living with HIV (UNAIDS/PCB (35)/14.19); and
 - The equity deficit: unequal and unfair access to HIV treatment, care and support for key and affected communities (UNAIDS/PCB (33)/13.16).
18. In developing this report, the Delegation collected community experiences and reflections on key considerations about U=U, its current and potential benefits, and important lessons learned from the COVID-19 pandemic. Key messages and recommendations were developed in consultation with community and civil society experts. They are presented here with a set of illustrative case studies of community leadership and good practice research, policy and practice from around the world.
19. The NGO Delegation urges Member States and UNAIDS to take immediate and accelerated action to tackle the challenges that continue to slow progress towards the UNAIDS global targets and to act on the “untapped potential”¹⁵ of U=U by taking to scale this foundational, community-led, global HIV health equity strategy.

Methodology

20. Between July-September 2022, a mixed methods approach was used in preparing this report, including:
- a **literature review** of more than 90 articles and publications, including UNAIDS and other UN publications, peer-reviewed journal articles, reports, policy briefs, and resources prepared by community-led groups and civil society partners.
 - **key informant interviews** with 18 individuals, using a semi-structured question set. Interviews done via zoom sought the perspectives, reflections and recommendations of community and civil society activists, community-led service providers, and representatives from governments and leading multilateral organizations and UN partner agencies. Interviews were conducted across all regions represented on the Delegation: Africa, Asia-Pacific, Europe, Latin America and the Caribbean, and North America.
 - **case studies** that were collected via an open call for submissions. Twenty case studies were submitted by government and nongovernmental partners. They feature examples of good practices and community recommendations at country,

regional and global levels. They show how community-led U=U has contributed to increased and more equitable access and improved uptake of testing, treatment and care services across diverse communities in low-, middle-, and high-income settings.

- a **peer review process** that entailed draft iterations of the report being reviewed by serving members of the NGO Delegation, 13 community and civil society experts, representatives of key population across all regions, and members of the UNAIDS Secretariat.

21. The methods used were not intended to provide quantitative data or to produce measurements, numerical data or statistical analysis. The report therefore does not provide a quantification of knowledge, attitudes, behaviours or practices in relation to U=U. The intention is to provide a literature review and qualitative data, including community and expert opinions, by using a range of methods.



Defining the terminology

22. **Undetectable = Untransmittable (U=U)** refers to the scientifically proven fact that a person living with HIV who is on effective ART that lowers the amount of virus in their body to undetectable levels cannot sexually transmit HIV to another person. The low level of virus in the blood is referred to as an undetectable viral load. This means that the viral level is too low to be detected by viral load test or they are below an agreed threshold (such as 50 copies/ml¹⁶ or 200 copies/ml for undetectable viral load).^{17 ii}
23. An undetectable viral load is the first goal of ART.¹⁸ When people living with HIV are on treatment and have undetectable viral loads, they protect their own health and cannot transmit HIV to their sexual partners.¹⁹ U=U is achieved by knowing one's status and by having equitable access to effective HIV diagnostics, testing, treatment, care and support to maintain viral suppression.
24. U=U is a crucial biomedical tool in a comprehensive HIV prevention toolkit, but it is also much more than an instrument for successfully reaching the global 95–95–95 treatment targets. It represents a rights-based, community-led public health paradigm shift that reshapes understandings of what it can mean to live full and healthy lives with HIV without stigma, shame or the fear of transmitting HIV to others.

ⁱⁱ The UNAIDS Indicator Registry describes viral suppression as: "Individual-level viral load is the recommended measure of antiretroviral therapy efficacy and indicates treatment adherence and the risk of transmitting HIV. A viral load threshold of <1000 copies/mL defines treatment success according to the 2016 World Health Organization's Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. People with viral load test result below the threshold should be considered as having suppressed viral loads ... Viral suppression among people living with HIV provides a benchmark for monitoring global targets over time and a standardized indicator of HIV treatment and prevention success, critical to ending the AIDS epidemic. When considered as a proportion of the number of people on treatment (the numerator of Indicator 2.2), this indicator monitors the third 95 of the UNAIDS 95–95–95 targets: that 95% of the people receiving antiretroviral therapy will have suppressed viral loads by 2025" (<https://indicatorregistry.unaids.org/indicator/people-living-hiv-who-have-suppressed-viral-loads#:~:text=Viral%20suppression%20is%20defined%20as,95%2D95%2D95%20target>).

25. The term U=U was pioneered by the Prevention Access Campaign (PAC) in 2016 as part of an anti-stigma communication campaign that evolved into a global, community-led movement of people living with HIV, HIV advocates, activists, researchers, governments and other community and private sector partners who are committed to end the AIDS epidemic. U=U has been integrated into local contexts and communities in over 105 countries. For instance, communities in Viet Nam refer to U=U as K=K. In Russian, it is referred to as N=N, in French and Spanish it is known as I=I, and in Chinese, it is known as 測不到=不傳染.
26. **Treatment as prevention** is a biomedical HIV prevention approach that refers to any HIV prevention method that uses ART to decrease the risk of HIV transmission through sexual, blood-borne or through vertical transmission (pregnancy, childbirth and breast/chest-feeding). The preventive effect stems from lowered community viral load as a result of ART within a population. ART reduces the HIV viral load in blood, semen, vaginal fluid, breastmilk and rectal fluid to very low levels, and as a result reduces HIV transmission. Historically, many people living with HIV had concerns with the term "treatment as prevention" because of its singular focus on prevention. U=U is centered on both combination prevention and treatment.ⁱⁱⁱ By combining the tools of U=U, pre-exposure (PrEP) and post-exposure prophylaxis (PEP) supports a "status neutral approach", which supports people to reach and maintain their optimal health, while also improving outcomes in HIV prevention, diagnosis, care and treatment.²⁰
27. **PrEP** is defined in the [WHO 2021 Consolidated HIV guidelines](#) as the use of antiretroviral (ARV) drugs by HIV-negative people to reduce the risk of acquiring HIV infection. Based on evidence from randomized trials, open-label extension studies and demonstration projects, WHO recommended daily oral PrEP containing tenofovir in 2015 as an additional prevention choice for people at substantial risk of HIV infection.
28. The updated [Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations](#) (July 2022) present important new recommendations and guidance. This includes the use of long-acting, injectable cabotegravir as an additional HIV prevention choice in combination prevention approaches for people at substantial risk of HIV infection, including sex workers, gay men and other men who have sex with men, people who inject drugs,^{iv} people in prisons and other closed settings, and transgender and gender-diverse people.²¹ U=U, PrEP and PEP, and other prevention technologies such as "post-exposure prophylaxis-in-pocket",^v the Dapivirine vaginal ring and long-acting injectable ARVs are crucial tools for effective combination HIV prevention and treatment strategies. In 2021, WHO released a conditional recommendation for the Dapivirine ring as an additional prevention choice for women who are at substantial risk of HIV infection, as part of combination prevention approaches.²²

ⁱⁱⁱ For a history of the evolution of U=U, please see: U=U taking off in 2017. *Lancet HIV*. 2017;4(1):e475 ([www.thelancet.com/journals/lanhiv/article/PIIS2352-3018\(17\)30183-2/fulltext](http://www.thelancet.com/journals/lanhiv/article/PIIS2352-3018(17)30183-2/fulltext)).

^{iv} "PrEP services for people who inject drugs and their sexual partners can provide benefits both in the prevention of sexual transmission, and likely in the prevention of HIV, acquired through unsafe injection practices. PrEP services should not replace needle and syringe exchange programs (NSPs). NSPs have the greatest impact in preventing the transmission of HIV and other bloodborne infections, including hepatitis C (HCV) associated with injecting drug use." WHO Consolidated Guidelines, p. 50.

^v PIP refers to "post-exposure prophylaxis-in-pocket" and is used by individuals with low-frequency, high-risk, HIV exposures. The approach involves providing selected patients with a 28-day prescription for PEP before exposure occurs. See: [https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667\(19\)30152-5/fulltext](https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(19)30152-5/fulltext).

29. **Post-exposure prophylaxis** is the use of ARVs in emergency situations by people who possibly have been exposed to HIV. PEP must be taken within 72 hours of exposure if it is to be effective.²³
30. **Community-led responses**^{vi} are actions and strategies that seek to improve the health and human rights of their constituencies, and that are specifically informed and implemented by and for communities.²⁴ U=U is a prime example of an effective community-led response that has evolved into a grassroots-led global movement to improve the health, well-being and quality of life of people living with HIV, while contributing to HIV prevention efforts when people know their HIV status, are on effective HIV treatment and are supported in maintaining an undetectable viral load.

“End AIDS by ending inequalities, and because inequalities affect access to testing, diagnostics, treatment and care, it also affects U=U”.

– **Community member, Latin America and Caribbean region**

31. **Community-led organizations**^{vii} are groups and networks in which the majority of leadership, staff, spokespeople, membership and volunteers represent the experiences, perspectives and voices of their constituencies and which have transparent mechanisms of accountability. Community-led organizations, groups and networks are self-determining and autonomous, and are not influenced by government, commercial or donor agendas. Not all community-based organizations are community-led.²⁵
32. **Community-based responses** are delivered in settings or locations outside formal health facilities and are run by civil society organizations.²⁶
33. **Community systems strengthening** refers to the development and fortification of informed, capable and coordinated communities that work to achieve improved health through their involvement in the design, delivery, monitoring and evaluation of health-care services and programmes, including for HIV, COVID-19 and other ongoing pandemics. Resilient health and community systems are the essential building blocks for progressing towards universal health coverage (UHC), and all the Sustainable Development Goals (SDGs). They are foundational for effective, efficient and sustainable responses to HIV and other health-related threats.^{27 28}

Never before has it been more clear that increasing access to treatment, including addressing ARV stock-outs, ending criminalization and removing barriers to U=U not only saves the lives of people living with HIV, but also prevents new transmissions, reduces health-care costs and burden, contributes to economic growth, and accelerates progress toward ending the epidemic.

– **The Win-Win agenda, Prevention Access Campaign, 2022**

The current landscape

34. In 2021, the world marked 40 years since the first cases of AIDS were reported. In settings where investments have matched ambitions, we have had four decades of progress in tackling one of the deadliest and most complex pandemics of modern

^{vi} Discussions about the definitions of community-led organizations and community-led responses are ongoing in the context of the work of a MultiStakeholder Task Team on Community-Led AIDS Responses, at the request of the UNAIDS Programme Coordinating Board. The definitions were conceived as umbrella terms, inclusive of the leadership of people living with HIV, key populations, women and youth in all their diversity. The definitions under discussion can be accessed [here](#).

^{vii} *Ibid*

times.²⁹ Yet, despite the sophisticated knowledge about HIV and an extensive evidence base of effective approaches to prevention, treatment, care and support, the world is not on-track to meet the global commitment to end AIDS as a global public health threat by 2030.³⁰ HIV remains an urgent global health crisis.³¹

35. The COVID-19 pandemic continues to wreak havoc on health and social systems, plunging the economies of households, communities and entire nations into crisis. COVID-19 continues to lay bare the underinvestment in public health systems and social protection,³² ongoing inequalities, glaring fissures in the social fabric, and the

“In this time of COVID-19, there is a significant risk that political attention to and financing for HIV will drift. If we do not take the steps needed to tackle the inequalities driving HIV today, not only will we fail to end the AIDS pandemic, we also will leave our world dangerously unprepared for future pandemics”.

– **Helen Clark**, Co-chair of the Independent Panel for Pandemic Preparedness and Response

impact of social and structural barriers on efforts to achieve the 2030 Agenda for Sustainable Development.³³

36. Status reports by UNAIDS and other global entities continue to show that HIV infections and AIDS-related deaths are not decreasing quickly enough to reach the 2030 targets.³⁴ Globally, more than 13 000 deaths a week are attributed to HIV³⁵ and an estimated 7.7 million AIDS-related deaths will occur in the current decade if the international community fails to build on the gains and meet the commitments made in the [2021 Political Declaration on HIV and AIDS](#).³⁶
37. The global scale-up of and access to life-saving ART is widely recognized as one of the greatest achievements of the global HIV response to date.³⁷ However, while some countries have succeeded in drastically reducing HIV morbidity and mortality, progress has been uneven within and between countries.³⁸ HIV continues to affect millions of people and communities around the world.³⁹
38. The UNAIDS Global AIDS Strategy targets for 2030 require that countries provide effective HIV combination prevention options to at least 95% of all people at risk of HIV; ensure that at least 95% of people living with HIV are aware of their HIV status; ensure that at least 95% of people who know their status are on effective HIV treatments; and, that at least 95% of all people on HIV treatment achieve viral suppression.⁴⁰
39. In 2021, approximately 85% of all people living with HIV knew their HIV status. That meant that about 6 million people did not know they were living with HIV.⁴¹ Approximately 88% of people who knew their HIV status were accessing treatment and 92% of those on treatment were virally suppressed.⁴²
40. Of the estimated 38.4 million people living with HIV, approximately 10 million are not receiving the quality information, testing, treatment, and care that is necessary to reach U=U and protect their health, while being relieved from stigma and anxiety around onward transmission.⁴³ For many people living with HIV who have access to quality treatment and services, the virus is a manageable, lifelong condition. With appropriate support, people can manage their health in ways that fit their daily lives and can be empowered to achieve undetectable viral load levels.⁴⁴
41. U=U harmonizes well with the UNAIDS global treatment targets because it envisions a world where, in the absence of an HIV vaccine, or cure, people living with HIV can improve the quality of their lives and halt the sexual transmission of HIV. This can be

achieved by knowing one's HIV status and having equitable access to effective treatment, testing and the supports necessary to achieve and maintain viral suppression.

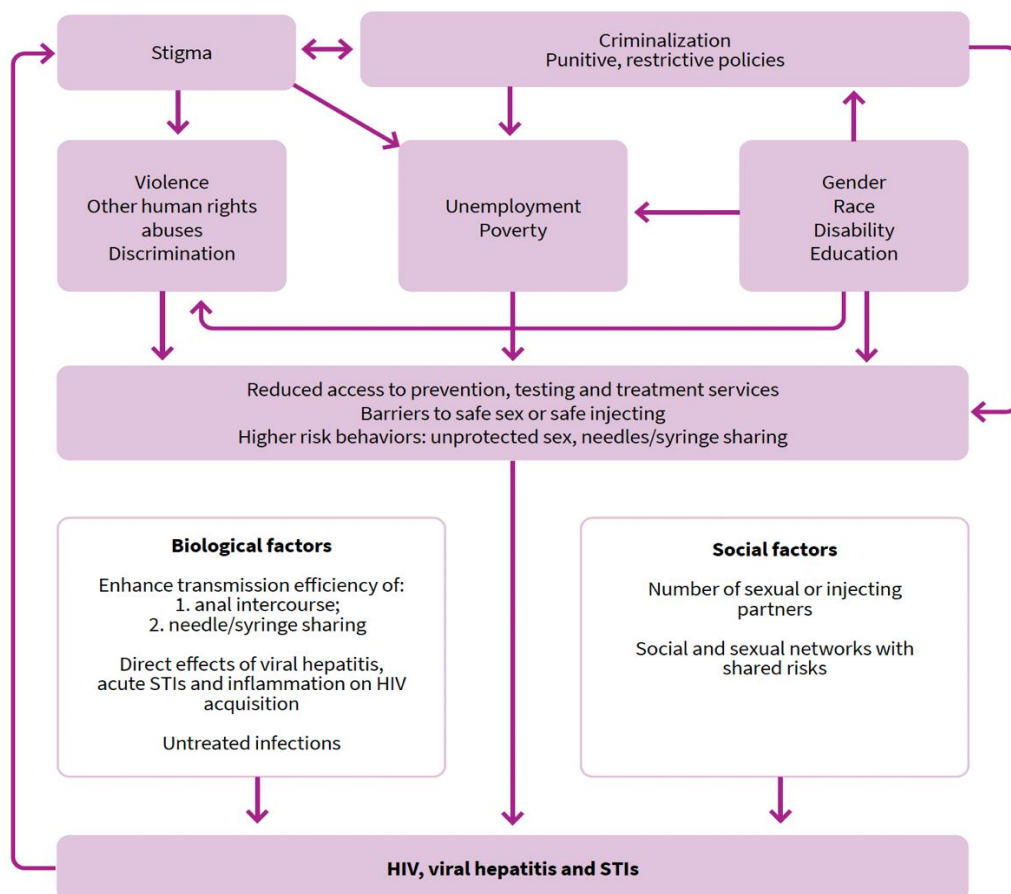
42. Common clinical standard(s) on viral load suppression and policy definition(s) of U=U are crucial to leverage U=U as a policy tool to advance health equity, with appropriate monitoring and evaluation metrics. Making U=U a reality for all people living with HIV improves individual and population health, transforms the lives of people living with HIV, and is essential for accelerating progress towards ending the pandemic.⁴⁵
43. HIV is both a cause and a consequence of poverty and inequity.^{46 47} In all HIV settings, barriers to combination prevention, treatment, care and support occur at the individual, interpersonal, community and societal level.⁴⁸ Stigma, discrimination, criminalization, gender-based violence, poverty and a range of social, racial, age and gender inequalities and social and structural determinants of health continue to fuel HIV epidemics. They often exact the heaviest toll on populations that experience higher disease mortality and morbidity and that have lower access to life-saving prevention, treatment, care and support programmes and services.⁴⁹
44. Key and vulnerable populations^{viii} face multiple and intersecting inequities that expose them to higher risks of HIV and other life-threatening infections and that subject them to social exclusion and marginalization in society (Figure 1).^{50 51 52} Key and vulnerable populations include sex workers, people who inject drugs, people in closed settings such as prisoners, transgender people, gay and bisexual men and other men who have sex with men, adolescent girls and women, Indigenous peoples and mobile populations.
45. Gender inequality and gender-based violence continue to drive the heightened risk of HIV infection experienced by women and adolescent girls. Approximately 5,000 young women worldwide aged 15–24 years become infected with HIV weekly. In sub-Saharan Africa, women and girls accounted for 63% of all new HIV infections in 2021.⁵³ Combination prevention approaches that include U=U, PrEP, PEP, and the Dapivirine vaginal ring must be integrated into comprehensive sexuality education (CSE) for improved sexual and reproductive health (SRH) and rights of women and girls, boys and men, trans and gender diverse people. If the underlying inequities are addressed, prevention and treatment outcomes will improve (Figure 1).
46. The NGO Delegation sees health inequity as a normative concept that describes systematic differences in health between population sub-groups that are unjust, unfair, and avoidable or remediable.⁵⁴
47. An equity-oriented approach recognizes that systemic and structural inequality, rather than solely individual behaviours and practices, are the root causes of health disparities that drive the disproportionate impact of HIV on key and vulnerable populations. An equity-oriented approach entails targeting population groups that have greater exposure and vulnerability to risk of infection and lesser access to a continuum of quality, right-based services that promote better health, well-being and quality of life.⁵⁵ This approach embodies the SDG principle of leaving no one behind, and it applies to the vision of

^{viii} “Key populations or key populations at higher risk, are groups of people who are more likely to be exposed to HIV or to transmit it and whose engagement is critical to a successful HIV response. In all countries, key populations include people living with HIV, in most settings, gay men and other men who have sex with men, transgender people, people who inject drugs and sex workers and their clients are at higher risk of exposure to HIV than other groups. However, each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context.” Global AIDS Strategy, footnote 9, p8.

ending HIV as much as it does to pandemic prevention, preparedness and response, and other global goals such as UHC and the SDGs more broadly.

In the case of HIV, tackling the inequities that create the fault lines in the HIV care continuum is needed to ensure that everyone with HIV knows their status and receives the quality treatment, support and care they need to achieve viral suppression. Outcomes of U=U will improve the health and well-being of all people living with HIV, improve their quality of life, drive down rates of new HIV infections, reduce health-care costs, and lead to a healthier society, which will contribute to economic growth.

Figure 1: Factors contributing to HIV, STIs and viral hepatitis in key populations



Source: WHO, 2022⁵⁶

48. The Global AIDS Strategy (2021–2026) uses an equity-oriented approach that prioritizes actions to first reach key and underserved populations and to close the gaps in access to prevention, treatment and care that undermine the benefits of ART. The Strategy calls for “substantially greater prioritization of tailored, combination HIV prevention packages, including scaling up underutilized prevention approaches and community-led responses, such as comprehensive sexuality education, harm reduction services, PrEP and U=U.”⁵⁷
49. A U.S.-based study conducted by Quan and others (2021) provides a strong cost-effectiveness argument for equity-oriented HIV combination implementation strategies in reducing long-term health care costs, as well as reductions to incidence-related disparities and health inequity measures in racialized communities.⁵⁸

50. **Case study 1** (United States) provides a best practice example of how equity-focused HIV combination prevention intervention strategies⁵⁹ within community-based care settings can use U=U to address persistent disparities in viral load suppression and barriers to care for highly vulnerable populations living with HIV. This work has led to institutional policy changes and the use of the U=U health equity intervention by seven additional service providers in 20 locations in the New York City region.⁶⁰

Investing for impact: U=U=U, a foundational health equity strategy

51. Despite the proven benefits of U=U, its application to other modes of transmission, including breast- or chest-feeding and blood-borne transmission, is under-researched and requires more attention, investment and policy/clinical guidance.⁶¹ The need for further research to address the current gaps in the U=U evidence base was noted in the 2021 Political Declaration on HIV and AIDS.⁶²
52. Clinical recommendations and guidelines on HIV and infant feeding are not unequivocal. In resource-constrained parts of the world, the standard of care calls for parents living with HIV to breast-feed their infants while on ART, but in high-income countries public health guidelines call for replacement feeding.⁶³ Noted by public health experts, civil society and community members, the complexity and confusion around feeding guidelines in the era of U=U is challenging, particularly in contexts where HIV is criminalized.⁶⁴ Existing studies demonstrate an extremely low to zero risk of HIV transmission when the breast-feeding parent has sustained viral suppression.^{65 66 67 68}
53. Viral load tests are a key marker of treatment success. However, only 38% of people living with HIV who receive ART currently have access to viral load tests. Access is even more limited in some parts of the world, especially in countries with low HIV prevalence and weak health systems. There is a need to invest in viral load technology for U=U in low- and middle-income countries.⁶⁹
54. Pregnant people and parents living with HIV must have easy access to the information, resources and structures to support their autonomy and informed decision-making when considering their infant feeding options. **Case study 2** (Argentina) presents research findings from community-led research on the experiences and perspectives of cisgender women living with HIV in Argentina, as well as recommendations for research, policy and practice.
55. Similarly, there remains a dearth of research on the applicability of U=U for people who use drugs. Evidence shows that people who inject drugs will not transmit HIV through sexual activity if they have a suppressed viral load. Although earlier research (2013) suggested that an undetectable viral load may also reduce the risk of HIV transmission through needle-sharing, research findings remain inconclusive on this matter.⁷⁰
56. Also needed is research into the applicability of U=U for younger populations,⁷¹ as well as on how U=U could affect policy and clinical guidance for blood donations.
57. Given the scientifically proven benefits of effective ART that reduce viral loads to undetectable levels in the blood, the limited research on the applicability of U=U for all key populations and other vulnerable groups compounds health inequities and undermines HIV prevention efforts.

58. In 2019, Dr. Anthony Fauci, Director of the National Institute of Allergy and Infectious Diseases in the United States, called the U=U campaign “the foundation of being able to end the epidemic”, along with the use of PrEP for HIV prevention.⁷² A wealth of research has arrived at similar conclusions, underscoring the enormous opportunity for clear, positive and evidence-based communication about the value of U=U for ending HIV-related discrimination, advancing health equity for people living with HIV, and ending AIDS.⁷³ To harness this opportunity, all HIV partners must ensure U=U is consistently integrated and implemented.

“U=U, it’s not about looking at you as a vector of disease, but taking that burden away, placing that burden completely outside of the individual and giving you back your dignity and empowerment to know that I have the option. It’s in my hands, I can design this, but also the peace of mind in knowing that we are part of a solution to ending AIDS.”

– **Community representative, Europe**

“[U=U] really highlights the structural issues, but it also gives us hope. U=U is a tool of hope: that we can end the AIDS pandemic and new HIV infections and destroy internalized stigma.”

– **Community representative, Asia-Pacific**

“First of all, there’s a lot of misconception. But secondly, it’s not a thing about privilege—it’s about right, it’s about access, it’s about having quality health care and a quality of life that is attainable by anyone. It doesn’t matter where you are. It doesn’t necessarily mean you need to have 40 options of treatment. A country can have six options and still ensure that the [viral loads of the] population can be undetectable. It’s just how those options are managed.”

– **Community Representative, Global Key Population Network**

59. U=U threads across the three interlinked strategic priorities of the Global AIDS Strategy and potentially contributes to each of its 10 result areas. This transformative but untapped potential of U=U can be realized if services are designed and delivered in strategic and supportive partnerships with facility-based and community-led health providers, communities living with and affected by HIV, and government programmes.⁷⁴ The services would:

- improve the well-being of people living with HIV by incorporating U=U in CSE, transforming the social, sexual and reproductive lives and legal rights of people living with HIV by freeing them from the shame and fear of sexual transmission to their partners;
- challenge and dismantle deep-seated HIV-related stigma and discrimination and public perception about HIV transmissibility;
- support HIV combination prevention and treatment goals by reducing the structural barriers and anxiety connected with testing and treatment; and
- advance an evidence-based public health and health equity argument for universal access to HIV testing, diagnostics, treatment and care that can support improved health outcomes, save lives and prevent new HIV infections.⁷⁵

60. The transformative impact of U=U can be unleashed if Member States and UN Cosponsors integrate U=U into national HIV and health strategies and guidelines. **Case study 3** offers examples from the Asia-Pacific region of the importance of early government endorsement of U=U. The experience shows that when used strategically, U=U will dismantle stigma and discrimination, increase demand for ART, address

barriers to accessing life-saving ART and decrease loss to follow-up by promoting adherence.

61. **Case study 4** provides insight from a 2022 global survey conducted among civil society and community partners to better understand the critical components of being able to achieve and sustain an undetectable HIV viral load and to better understand the experiences of people living with HIV when U=U is promoted.
62. Key informant interviewees highlighted some of the positive lessons learned from the COVID-19 experience that should be maintained beyond the COVID-19 era to propel forward the U=U movement and the HIV response more broadly. These include:
 - the *power of digital technologies* to mobilize communities and to design and deliver complex programmes, services and advocacy efforts by using virtual platforms, including ensuring equitable internet access for remote or key and vulnerable populations;
 - the *power of digital online platforms* as a dissemination channel for teaching, providing training and accessing wider audiences through the internet;
 - the role of *heightened public awareness of health, treatment and vaccine equity* to elevate debates and public pressure around the barriers which intellectual property rights pose to effective public health emergency responses;
 - increased awareness about the *importance of treatment literacy* in the general public, and literacy about pandemics more generally, including awareness about how pandemics evolve and cross geographic borders;
 - *heightened public awareness about the need for strong public health systems* to manage and overcome the COVID-19 pandemic, which offers a chance to renew attention on the HIV pandemic. The COVID-19 experience has reinforced the understanding that, in order to overcome pandemics, people must have equal access to testing, treatment and care;
 - evidence that *multi-month dispensing of ART and point-of-care viral load testing* helped reduce the impact of service disruptions on treatment access and adherence;⁷⁶ and
 - evidence that *swift, systemic change is possible* when there is political will, investment, public pressure and motivation to act appropriately.
63. Moving forward, it is important that these and other lessons and innovations drawn from the COVID-19 experience are integrated into the scale-up of U=U across all settings, particularly in resource-constrained and conflict areas, to mitigate HIV service disruptions and treatment access.
64. Since the emergence of U=U in 2016, significant momentum has been achieved to institutionalize the campaign. Public and actionable endorsements have been made by HIV researchers and activists, community and civil society organizations, bilateral and multilateral partners (e.g. PEPFAR, UNAIDS, US CDC and WHO) and national governments (e.g. Canada, Thailand, the USA,^{ix} Viet Nam and many others), as well as eminent academic journals such as *Lancet*, the *Journal of the International AIDS Society* and the *Journal of the American Medical Association*.⁷⁷
65. In Viet Nam, for instance, U=U is at the heart of the country's response to their HIV epidemic. The country was the first PEPFAR country to achieve viral suppression in

^{ix} U=U is endorsed and has been made actionable in policy and programming as outlined in the US National HIV/AIDS Strategy (2022–2025). <https://www.whitehouse.gov/wp-content/uploads/2021/11/National-HIV-AIDS-Strategy.pdf>

over 95% of people on ART (**Case study 5**).⁷⁸ PEPFAR's updated (2022) country guidance emphasizes the need to integrate U=U along the HIV care continuum.

66. U=U has become widely known in the global HIV sector as a powerful, scientifically proven communication tool that brings together biomedical progress with contemporary knowledge in behavioural and social science.⁷⁹ Yet, myths and misinformation about U=U and HIV transmission abound. **Case study 6** (Botswana) offers a good practice example of the crucial roles of community-led, peer-based U=U communication and treatment literacy strategies to improve the quality of life and treatment outcomes of people living with HIV, while addressing internalized stigma and popular misconceptions about HIV testing and treatment.
67. **Case study 7** (Canada) showcases an online public education and communication campaign led by the Canadian government in partnership with community partners. It was aimed at dispelling incorrect HIV-related information in the general population, while reducing the social stigma and discrimination associated with an HIV diagnosis. Another Canadian online educational video titled "Strong medicine", has been developed in partnership with Communities, Alliances & Networks (formerly the Canadian Aboriginal AIDS Network) and CATIE, with and for Indigenous people living with HIV. The video shares accurate information about HIV testing and treatment by weaving Indigenous knowledge of culture and wellness with western knowledge of HIV testing and treatment. It encourages people to get tested and to start, resume or stay on HIV treatment for their own health and wellness.⁸⁰
68. **Case study 8** (Ukraine) presents the experiences of a Government-funded national care and support programme aimed at supporting viral suppression among people living with HIV. Activities include support for treatment adherence and access to viral load testing to help people achieve and maintain viral suppression.
69. **Case study 9** presents a multicountry, youth-led intervention involving young people between 15–29 years in 11 sub-Saharan African countries. The initiative was developed in response to an identified gap in the provision of practical and tailored materials to facilitate productive U=U dialogues with adolescents and youth living with HIV. The case study provides further evidence for integrating U=U and other combination prevention tools into CSE.
70. Respondents' reflections on the most critical issues and considerations around U=U included:
 - emphasizing and advancing U=U as an advocacy tool and health equity policy instrument to improve equitable access to testing, diagnosis, quality treatment and care, including equitable access to medical advancements such as long-acting injectables;
 - unlocking data generated by U=U to change harmful laws and policies that criminalize people living with and at risk of HIV; and
 - dispelling common concerns that U=U will result in surging rates of STIs if it encourages people to have more condomless sex. Some studies have shown people living with HIV, with regular access to healthcare, tend to have better overall health than the general population. From a biomedical standpoint, U=U encourages regular/more frequent health visits, as well as viral load and STI testing for the individual.

U=U: facilitators and challenges

71. Structural and systemic inequities continue to affect the ability of key populations and other vulnerable groups to experience the benefits of effective HIV treatment. They include poverty, inequitable access to treatment and viral load testing, stigma and HIV criminalization. This section summarizes key barriers to achieving the goal of ending AIDS by 2030. They include stigma and discrimination; a lack of enabling environments to support marginalized communities who are not yet engaged in U=U and the HIV treatment cascade; insufficient investments in community systems, leadership and responses; and a lack of access to technologies and innovations.

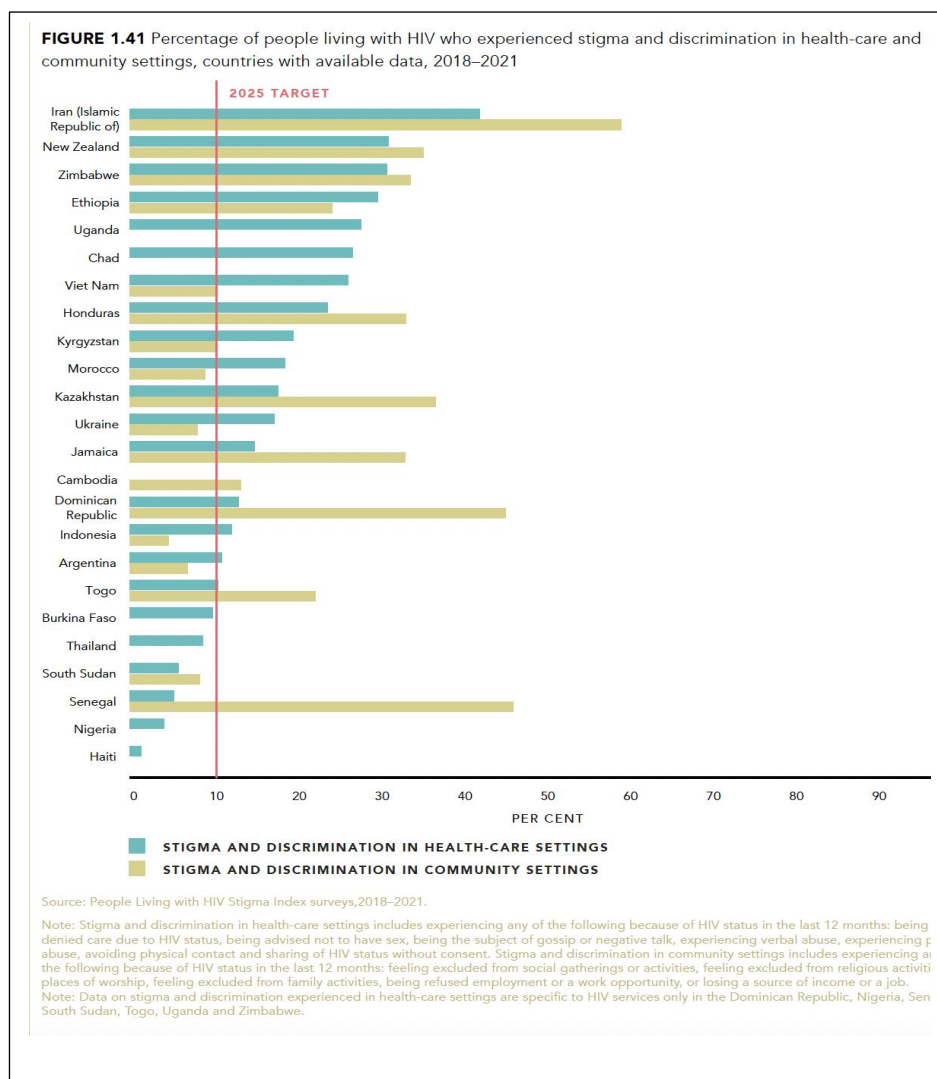
Stigma and discrimination

"I think it would be great to like to have something like universal, let's say a guideline, or let's say, some kind of instruction for health-care providers [on] how to discuss U=U with patients or with other people. Because it's still, like, questionable concepts for many of them."

– Medical professional, Eastern Europe

72. Numerous studies have identified the quintessential role of health-care providers in raising awareness and improving knowledge about U=U, in addition to their role in achieving positive health outcomes. Despite progress in the past six years by the U=U campaign, research has shown that limited awareness about U=U among people living with and at risk of HIV remains a significant barrier across population groups and country income status. A robust body of research shows that, while learning about U=U from non-health-care providers is beneficial, patient discussions with health-care workers:
- is associated with favourable mental, sexual and general health outcomes, medication adherence and rates of viral suppression;
 - can constitute an effective primary prevention tool; and
 - is in line with health workers' ethical obligation to do no harm, provide optimal care and support patients in accessing accurate information and health education.⁸¹
- As such, U=U must be considered a standard of care in medical education and clinical guidelines.^{82 83 84}
73. This body of evidence points to the value of training health-care providers and allied professionals on U=U and sexual health assessments. Furthermore, U=U should become a mandatory component of the standard of care for primary health care and HIV specialty care visits.

Figure 2. Percentage of people living with HIV who experienced stigma and discrimination in health-care and community settings, countries with available data, 2018–2021



Source: *Global AIDS update 2022*. Geneva: UNAIDS; 2022

74. Stigma and discrimination remain among the major barriers blocking key and vulnerable populations from accessing quality and timely health care, including HIV combination prevention, testing, treatment, care and support services. The 2021 Political Declaration on HIV and AIDS commits countries to ensure that less than 10% of people living with and at-risk of HIV experience stigma and discrimination by 2025. The current Global AIDS Strategy has added a sub-target to track experienced stigma and discrimination within formal health care settings. The 2022 *Global AIDS update* confirms the continued pervasiveness of this barrier to care despite decades of education and advocacy. Figure 2 shows that countries are off-track in meeting the target of ensuring less than 10% of people living with HIV report experiencing stigma and discrimination in health and community settings by 2025.⁸⁵
75. **Case study 11** (Canada) presents results from two Canadian studies. The first focuses on barriers in the uptake of U=U among sexual minority men, while the second offers insights on communicating U=U messaging in everyday practice. **Case study 12** (Australia) presents good practice media guidelines on HIV and U=U to improve the quality of HIV information reported by journalists. **Case study 13** (Germany) offers a snapshot of the #DoubleKnowledge (#wissenverdoppeln) anti-stigma media campaign.

It was aimed at improving the low levels of public awareness and knowledge about U=U by using multiple media platforms to publicize accurate information about effective, rights-based HIV prevention and treatment.

Enabling environments: reaching the 5–5–5

"There's, I think, a false dichotomy in treatment and prevention as opposing forces when actually they're the yin and yang. Because if you see people that are not getting proper treatment and care, yeah, then why disclose, why if they're being discriminated against, it puts people underground, or people are being criminalized, and it makes people not want to go out, and they don't even want to mention HIV is the bad thing in the closet. And when you get people living with HIV standing up and saying, I got tested, I got treatment, I'm gonna live forever, I can't pass on HIV... well, those are extremely strong messages, to know that, that we have tools, it's a way to open up a conversation and show them all new tools, we have. It's a huge thing."

– **Community representative**, North America

76. The "5–5–5" concept refers to those population groups who are not being reached by efforts to achieve the UNAIDS global 95–95–95 treatment targets. Population groups within the 5–5–5 are often the most marginalized and hardest to reach with facility-based HIV programmes and services.
77. "Reaching the last mile first means that health-care models that work for the minority will also work for the majority"—this was a critical contribution made by the Global Network of People Living with HIV (GNP+) to the High-Level Meeting on UHC. Placing the needs of the poorest and most marginalized members of society at the centre of programmes and services is crucial for the HIV response. Within the context of the 95–95–95 targets, reaching the last mile first means first reaching those communities that fall within the 5–5–5 in ways that support their ability to enjoy the health and quality of life benefits of U=U, while also accelerating progress towards ending AIDS.
78. Enabling environments are key for reaching and engaging the poorest and most marginalized communities in the 5–5–5. Those environments protect people's rights, facilitate the elimination of stigma and discrimination, and remove or reduce obstacles such as criminalization and punitive legal frameworks, gender and racial discrimination, gender-based violence, unemployment and poverty, poor access to education and social protection. Partners and advocates of U=U emphasize its positive implications in legal environments that criminalize people living with HIV and members of key and vulnerable populations.⁸⁶
79. As noted by Stefan Baral and others, HIV treatment implementation strategies that are directed at the most marginalized communities will have important differences compared with programs focused only on treatment numbers.⁸⁷ In this new era of U=U, crucial considerations include ensuring that shifts in legal environments do not further victimize or threaten individuals who are not virally suppressed, reinforce disparities, or stoke HIV-related stigma and discrimination.⁸⁸

Investing in community systems, leadership and responses

"The reality is that from theory and evidence to practice in many cases there is a wide gap. The shortages of ARVs in middle- and low-income countries were significant during COVID-19 and showed us that PrEP and other approaches that science has given us, can be lost or heavily affected in a pandemic."

– **Community representative**, Latin America and the Caribbean

80. Community-led responses provide vital lifelines to communities who are cut off from formal health and social services. Irrespective of the public health challenge, community-led responses help ensure that no one is left behind. Lessons learned from the ongoing COVID-19 pandemic show that resilient community-led responses play central roles in keeping people healthy and protecting vulnerable communities.^{89 90 91}
81. Organizations and services that are led and delivered by communities living with and affected by HIV play a particularly crucial role in national HIV responses and boost the effectiveness of prevention, treatment, care and support programmes.^{92 93} As a grassroots community-led global movement with close to 1,100 community partners, on every continent and across 105 countries, U=U is a shining example of the transformative power of community leadership in the HIV and global health landscape improving the health and quality of life for people living with HIV, eliminating stigma and accelerating progress to end the HIV epidemic.
82. Community-led systems and responses have measurable impact, the potential to reach people at scale, and serve populations who are not accessing formal health services.⁹⁴ Yet, the essential role of community systems and responses, including community-led monitoring remains severely underfunded and under-acknowledged. They generally are not prioritized and/or integrated into national plans or domestic health budgets.⁹⁵ Without adequate resources, civic space and autonomy, the potential of community systems and responses to make a lasting impact in addressing the health disparities affecting the poorest and most marginalized members of society, will continue to be an "untapped potential" of the global HIV response.

Access to technology and innovation

83. Barrier-free access to quality, rights-based combination prevention, testing, treatment, care and support services includes equitable access to technology and innovation. Scaling up access to treatment and affordable medicines requires that countries are empowered to make full use of flexibilities regarding intellectual property rights in current international trade agreements (including but not limited to compulsory licensing). It also requires pursuing alternative initiatives to stimulate both the development of, and equitable access to, affordable medicines and other innovative health technologies in response to public health needs.
84. Access to routine viral load testing and ARV stock-outs resulting from disruptions in procurement and supply chain systems are significant health systems barriers.⁹⁷ A wealth of research indicates that achievement of the global 95–95–95 targets, particularly the final "95", is at risk in many low- and middle-income countries due to gaps in viral load coverage, poor follow-up on viral load results, weak supply chains (e.g. cold chains, especially in remote areas) and treatment stock-outs.^{98 99}
85. An extensive systematic review published in June 2022 by Pham et al. identified several critical gaps. They included insufficient access to viral load testing; a lack of appropriate

follow-up on viral load results (patient management); and a lack of access to second- and third-line ARV regimens.¹⁰⁰ That review raises vital questions on how to best provide viral load services in weak health system settings. Its findings suggest that community-based models of care, implemented with local health authorities, can deliver high viral load coverage. However, common clinical standards and policy guidance are needed. **Case study 10** (Nepal) speaks to the need for common clinical standards that can support consistency in U=U messaging and in national policy documents.

86. Decentralized models of HIV treatment and care such as “hub-and-spoke” approaches, differentiated care, adherence clubs”, new point-of-care viral load technologies, and research clinics with free HIV services (including free viral load testing) support better health, improved quality of care, reduced treatment failure and the scale-up of effective treatment in low- and middle-income settings.¹⁰¹ Importantly, while resource constraints may be slowing the expansion of viral load testing, they should not impede the integration of U=U as a health equity policy instrument while global health bodies, decision-makers and civil society address the ongoing inequity of global resources. Resource limitations have real-life implications for people living with HIV, especially on issues of criminalization, which remain a key barrier to reaching the 10–10–10 targets of the UNAIDS Global AIDS Strategy.
87. **Case study 14** (Cameroon) presents the experience of a U.S.-funded community-based project led by Humanity First Cameroon Plus that focused on strengthening the capacities of community health workers to collect blood samples and deliver them to laboratories as a way to increase access to HIV viral load testing.

Conclusion

88. Global health institutions recognize that overcoming the widening inequities that constitute key social determinants of health is the top priority for reaching our global 2030 SDG goals and targets, including ending AIDS as a public health threat, accelerating the pace of UHC and of pandemic prevention, preparedness and response.
89. U=U as a health equity strategy is a critical facilitator to meet the global commitments which Member States endorsed at the 2021 High-Level Meeting on HIV (and in the 2021 Political Declaration on HIV and AIDS). However, formidable challenges stand in the way of realizing the full potential of U=U. They call for:
- reducing stigma and discrimination (individual, systemic and structural discrimination, such as systemic racism and punitive legal frameworks that criminalize key and vulnerable populations);
 - ensuring enabling environments to support key and vulnerable populations that are not yet engaged in U=U and the HIV treatment cascade;
 - investing in community systems, leadership and responses;
 - increasing access to medicines, health technologies and innovations; and
 - relieving the fiscal constraints and economic realities that hinder programmes and services in many of the countries hardest hit by HIV.
90. The UNAIDS PCB is uniquely placed to drive action at the global and national levels and to accelerate the roll-out and uptake of U=U as a means to everyone enjoying individual and public health, personal well-being and improved quality of life.
91. With this report and the recommendations presented, the NGO Delegation urges Member States to take immediate and accelerated action to tackle the challenges that

are slowing progress towards the global targets and to act on the “untapped potential”¹⁰² by taking to scale U=U as a foundational, community-led, global HIV health equity strategy to get us back on-track to end AIDS by 2030.

Proposed decision points

The Programme Coordinating Board is invited to:

92. *take note* of the Report by the NGO Representative;
93. *call upon* Member States, UNAIDS and Cosponsors to:
 - embed Undetectable = Untransmittable (U=U) in global, regional, national and subnational health and/or HIV strategic plans;
 - promote anti-stigma interventions, through updated comprehensive sexuality education curricula and across the HIV combination prevention, testing, treatment and care cascade, where community-led U=U initiatives and U=U research are well resourced; and
 - ensure that U=U is leveraged to support expanded health equity efforts to improve the health and well-being of people living with and affected by HIV, especially members of key populations and other vulnerable groups, such as women and girls, adolescents and young people, Indigenous Peoples, and migrants;
 - *accelerate* progress to get the global HIV response back on-track to meet the SDGs by fast-tracking equitable access to HIV combination prevention, testing, treatment, care and support through the planning, costing, implementation, scaling up, and the monitoring and evaluation of rights- and evidence-based community-led U=U programming, service delivery and monitoring, including the accelerated expansion of viral load diagnostics and viral load testing strategies without sacrificing other planned prevention and treatment initiatives;
94. *call upon* UNAIDS to:
 - utilize the growing body of evidence on the multimodal use of U=U, ensuring that U=U is incorporated as a key health equity strategy and policy instrument to complement and enhance the attainment of 2021–2026 Global AIDS Strategy targets (95–95–95, 10–10–10, 30–80–60), including by:
 - meeting HIV prevention and treatment targets;
 - promoting initiatives to support health and allied professionals, law enforcement, decision-makers, and members of key populations and other vulnerable groups;
 - leveraging U=U for greater access to effective treatment, diagnostics and testing;
 - promoting enabling and supportive environments at global, regional, national and subnational levels; and
 - supporting improved health outcomes, well-being and quality of life for people living with HIV;
 - convene a multistakeholder U=U working group co-led by WHO to support the development of harmonized definition(s) of U=U as a health-equity strategy that is designed to accelerate equitable, barrier-free access to affordable HIV treatments, health commodities and health technology innovations within the HIV response. The multistakeholder working group should advise on the following parameters:
 - common policy definition(s) accompanied by evaluation metrics to support and encourage consistency across policy, programming and technical guidance;

- common clinical standard(s) on viral load suppression, including the updating of such definition(s) when new evidence becomes available;
- recommendations on appropriate multimodal strategies to be incorporated into technical support to Member States and Co-sponsors on the integration and implementation of U=U; and
- appropriate U=U targets and metrics to be included into routine Global AIDS Monitoring and UBRAF reporting.

[Annexes follow]

Annexes

Case study 1

The undetectable viral load suppression programme(UND) for highly vulnerable people living with HIV; Housing Works, USA

United States of America

Objectives

To advance the transformative fact that Undetectable = Untransmittable (U=U), via: (1) organizational change to elevate viral load suppression as a key goal across our multiservice community-based organization that is critical to our commitment to ending the epidemic; (2) a broad superhero themed anti-stigma social marketing campaign that acknowledges viral load suppression as a heroic act that protects individual and community health to end the epidemic; and (3) a tool kit of evidence-based adherence strategies, including financial incentives, designed to advance HIV health equity by supporting people living with HIV to overcome social and structural barriers to achieving and sustaining viral load suppression.

Outcomes

Sustained viral load suppression among people living with HIV who face barriers to care; reduction of inequities in rates of viral load suppression; an organizational culture free of fear and stigma that is centered on ending the AIDS epidemic; celebrating people living with HIV as heroes for keeping themselves and their communities healthy.

Populations

People with HIV who face demonstrated social and structural barriers to treatment adherence and sustained viral suppression; among demonstration project participants (n=502), 50% had a mental health diagnosis, 63% used unregulated drugs and 60% experienced homelessness during the 24-month study period; 71% identified as Black, 20% Hispanic/Latino, 27% female and 2% transgender.

Stakeholders

Communities living with HIV; health professionals; civil society organizations; government officials (local, national, global); HIV case coordinators/case managers.

Abstract

To share the ground-breaking U=U message, address persistent viral load suppression disparities, and advance ending the epidemic, in 2014, New York City service provider Housing Works collaborated with the University of Pennsylvania to develop, implement and evaluate The Undetectables Viral Load Suppression Program (UND) (liveundetectable.org). This client-centered model employs innovative superhero-themed, antistigma social marketing, agency cultural change and a tool kit of evidence-based ART adherence strategies (including quarterly US\$ 100 financial incentives) to support people living with HIV to achieve and sustain viral load suppression (<200 copies/ml).

Many people living with HIV face social, structural and behavioural health barriers to viral load suppression, including poverty, homelessness, mental health issues, racism and/or marginalization due to substance use, gender identity, sex work or other factors. The UND programme adds individualized ART adherence planning to integrated medical, behavioural, and care management services, via case conferences for people living with HIV and care team members to consider barriers and the toolkit of adherence supports. A broad social marketing campaign features superheroes known as "The Undetectables". They combat

stigma and apathy, and emphasize elements of the U=U message to demonstrate how being undetectable improves individual and community health, making the individual a hero in combating the HIV epidemic. Published evaluation results of a 24-month demonstration (n=502) showed significant positive impacts, with a 15% increase in the mean proportion of suppressed time-points for each participant (from 67% to 82% in the 24 months pre- to post-enrollment, $p < 0.0001$) and a 23% increase in the proportion of participants virally suppressed at all time-points (from 39% to 62% pre- to post-enrollment, $p < 0.0001$). Significant social/racial disparities in viral suppression found at baseline disappeared post-enrollment.

Beginning in 2016, the New York City Department of Health and Mental Hygiene scaled the intervention to seven additional providers offering the UND programme in 20 locations, and the intervention is now included in IAPAC's Best Practices Repository.

Further reading: <https://liveundetectable.org/assets/images/Ghose-et-al-2019-Undetectables-evaluation.pdf>

Case study 2

ICW Argentina

Argentina

Objectives

Breast-feeding for people with lactating capacities is a topic that is often relegated in the context of U=U. In low- and middle-income countries with high infant mortality rates, breast-feeding can be heavily promoted as a harm reduction practice. In other parts of the world, it is prohibited, while some regions are already applying the first recommendations on breastfeeding with undetectable viral load being allowed for "at least 12 months and up to 24 months or longer, similar to the general population". However, there is no clear consensus on the topic.

This study sought to investigate perceptions of this situation, with the understanding that reproductive rights are human rights. Women of reproductive age who are living with HIV and are members of ICW Argentina were asked about the options that are presented in the case of the impossibility of breast-feeding, how they experience this, and possible relevant intervention in order to address the problem.

Outcomes

The interviews highlighted that providing updated information on breast-feeding to women living with HIV requires taking into account the social, economic, and geographical conditions that mark their lives and affording them access to information that is essential for their lives and the lives of their babies.

Women with HIV of reproductive age in Argentina are discouraged from breast-feeding, but do not have access to updated information regarding to the choices and possibilities they have, as well as the reasoning behind all them. They tend to seek the information from health authorities, but often find that the authorities do not offer the information or manage the enquiries in a satisfactory manner. This constitutes a violation of their right to information, to health, to breast-feed, and to make decisions about their bodies.

Stigmatization weighs on the women: that of the "bad" mother, mainly associated with not breast-feeding. "If you don't breast-feed, you're a bad mother", according to one of the interviewees.

Populations served

Women with HIV of reproductive age from Argentina.

Stakeholders engaged

Communities living with HIV; health professionals; civil society organizations; government officials (local, national, global)

Abstract

I=I (Spanish for U=U) is a transformative movement for people living with HIV. Several studies document how women in all of their diversity are more exposed to expressions of violence and discrimination. Breast-feeding is not an exception to this, with research not having deepened significantly on the impact of viral load suppression on transmission via lactation since the adoption of U=U. This has generated a lack of consensus regarding if and how people with gestational capacity can breast-feed their babies should they have an undetectable viral load. Different countries have different, even contradictory guidelines.

Description

27 cisgender women living with HIV from different provinces of Argentina were interviewed. They were asked about their experiences of lactation, the importance of this practice in their lives, and knowledge management of current public policies regarding breast-feeding in people with HIV.

Lessons learned

The interviews showcased the harm caused by not having access to up-to-date information, which has repercussions in the intimate-political space, the affective field, the physical health, the exercise of the sovereignty of bodies and the political-collective space. Access to knowledge should not be a privilege for a few people and information should not be filtered by prejudice or opinion nor should it be provided in a biased manner. Above all, it should not be offered without empathy or be at the service of biocontrol.

Next steps

This study aims to enrich the conversation regarding a wider framework of choice for women and all people with lactating capacities and to provide recommendations to those who hold institutional authority in the field of health, who perform research on the subject or who in the field of symbolic production and activism.

Case study 3

Building common understanding and tailoring key messaging on Undetectable = Untransmittable in Asia-Pacific

Asia-Pacific

Implementer

APCOM, Asia-Pacific region (Indonesia, Japan, Malaysia, Nepal, the Philippines, South Korea, Taiwan, Thailand and Viet Nam).

Background

PARTNERS2's finding that "undetectable equals untransmittable (U=U)"—i.e. that people living with HIV who are virally suppressed *cannot* pass on the virus through sexual transmission—was a landmark scientific finding. However, awareness about U=U among

people living with HIV in the Asia-Pacific region remains low. Their access to routine viral load testing is limited and viral load tests are often not available in HIV clinics.

Misinformation about U=U also persists among health-care providers in the region. This is one of the reasons why HIV-related stigma and discrimination against key populations persist in health-care settings.

Objectives

Translate the scientific findings of PARTNERS2 into sets of understandable messages that are tailored around the HIV contexts of countries in the region, and share strategies and key messages for those that have rolled out U=U campaigns.

Specifically, this initiative:

- establishes a common understanding about U=U among community-based organizations and key populations at regional and country level;
- serves as technical assistance to partner community-based organizations at the country level in developing messages around U=U in their respective contexts. These are relevant to access to ART and viral load testing for people living with HIV, stigma and discrimination, and mental health;
- strengthens the communication strategies of partner community-based organizations to tailor and adapt the stages and key messages to guide active engagements with communities, health providers and national HIV programmes; and
- serves as a knowledge-sharing platform for community-based organizations around U=U.

Approach

APCOM facilitated a regional consultation on U=U to map out existing initiatives about U=U at the country level. Several sessions were also organized to determine the applicability in Asia of examples of good practices from other countries. The consultations allowed communities to share their perspectives about integrating U=U in national HIV programmes, especially in relation to challenges in integrating U=U in national guidelines and identifying the role(s) of PEPFAR or the Global Fund in integrating U=U in national policies.

APCOM provided support in developing U=U fact sheets that were tailored to HIV stakeholders. Fact sheets increased the awareness of U=U among people living with HIV. Fact sheets for health-care providers addressed stigma and discrimination in health-care settings and helped reduced discontinuation of ART.

Lessons learned

Examples of good practices around U=U demonstrated that early government endorsement are key for successfully integrating U=U in HIV responses. However, in some countries in Asia, high levels of stigma and discrimination blocks the integration of U=U and undermines access to ART. Hence, it is vital to bring the science of U=U to both health practitioners and people living with HIV.

U=U often does not appear in national HIV guidelines. When used strategically, U=U can reduce stigma and discrimination, increase demand for ART, address barriers to access to life-saving ART, and decrease loss-to-follow-up by promoting adherence.

More information

https://www.apcom.org/wp-content/uploads/2021/12/Factsheets-APCOM_UNAIDS-HIV-treatment_v3.pdf

<https://www.apcom.org/contextualizing-uu-at-countries-in-asia/>

<https://www.apcom.org/experiences-of-uu-campaign-in-tokyo/>

<https://www.apcom.org/uu-in-taiwan-no-track/>

<https://www.apcom.org/uu-in-korea-the-repeal-article-19-movement-and-beyond/>
<https://www.apcom.org/getting-to-zero-leveraging-uu-for-community-empowerment-eliminating-stigma/>
<https://www.apcom.org/no-time-for-excuses-uu-in-asia-pacific-at-rrrap-con-2020/>

Case study 4

ICASO Global Community Survey 2022: what drives U=U?

Global

Aims

To improve understandings of the critical factors for achieving and sustaining an undetectable HIV viral load and of the experiences of people living with HIV as a result of the promotion of U=U.

Methods

During two weeks in April 2022, ICASO sought feedback through an online survey from over 50 community leaders in 16 countries with regard to the research questions (aims) of the project. The responses offered a range of perspectives, opinions and insights which the researchers distilled into 10 categories based on each of the two research questions. A global survey targeting people living with HIV was translated and provided in three languages (English, French and Spanish). The survey was promoted via social media and emails. It made use of three unique QR codes for each of the different languages. Over the period of five weeks (mid-April to mid-May 2022), 549 people living with HIV from 56 countries responded to the survey (n=295 Spanish language survey; n=229 English language survey; n=19 French language survey). Respondents were aged between 19 and 80 years, with a median age of 41 years. Men comprised 60%, women 35%, and trans- and gender-non-conforming people 5% of the sample.

Results

The tables below show the rankings and scores in relation to the two research questions.

Outcome	Score	Rank
Empowerment of people living with HIV	6.58	1
Less fear of HIV transmission	6.50	2
Reduced HIV stigma	6.10	3
Improved adherence to HIV medications	6.06	4
Improved sexual and reproductive wellbeing	5.79	5
Higher quality of life	5.77	6
Longer life expectancy	5.67	7
Improved social connectedness	5.57	8
Better engagement in healthcare	4.97	9
Improved resilience	4.96	10

Contributing Factor	Score	Rank
Consistent access to HIV medication	7.33	1
Adherence to HIV medication	6.94	2
High-quality public healthcare services	6.08	3
Consistent access to viral load tests	6.04	4
Affordable HIV medication	5.78	5
A good quality of life	5.76	6
Freedom from stigma and discrimination	5.74	7
Accessible counselling support	5.36	8
Support from peers	4.95	9
A hopeful outlook on the future	4.88	10

Conclusions

Consistent access and adherence to affordable HIV treatment, diagnostics and health-care services are seen and both critical and vital to being able to achieve and sustain an undetectable viral load. The U=U message can be seen to have significant effects on the empowerment of people living with HIV, improved sexual health, improved adherence and as having a significant impact on HIV stigma and fear of onward transmission of HIV to sexual partners.

Case study 5

United States Centers for Disease Control and Prevention, on behalf of the Viet Nam Authority for AIDS Control and the Viet Nam Network of People Living with HIV, and other community partners

Viet Nam

Objectives

To foster an all-of-programme commitment within policy, collaboration, coordination across government and community to make U=U foundational to the HIV response in Vietnam.

Outcomes

1. Political commitment and policy is critical for centering U=U in HIV programmes and responses.
2. Impactful public messaging on U=U can change stigmatizing perceptions of HIV and empower HIV-affected communities.
3. To deliver comprehensive U=U messaging in health settings, health providers must be equipped, confident and empowered by U=U science.
4. Community advocacy, demand and dissemination created a positive environment to tailor U=U messaging to key populations.

Populations

Government officials; community leaders, organizations and members; health providers; influencers and thought leaders; and the general public.

Stakeholders

Communities living with HIV; health professionals; civil society organizations; government officials (local, national and global); international agencies and donors (including PEPFAR); an LGBTQ-led media firms.

Abstract

In Viet Nam, the Ministry of Health, National Network of People Living with HIV, and community leaders rapidly and comprehensively leveraged U=U (K=K in Vietnamese) as a programme catalyst and driver for eliminating HIV stigma and meeting epidemic control goals. K=K is a versatile concept beyond reducing stigma that drives Viet Nam's programme priorities for case finding and ART initiation, especially among gay men and other men who have sex with men.

Since its 2017 inception, the K=K movement ushered policies to document viral load suppression <200 ml/copies as treatment success and mandated integration of K=K messaging into health practice. Three successful public campaigns (first in Hanoi and Ho Chi Minh City, and then nationally) confronted public perceptions around HIV. Grants to community-based organizations ensured widespread dissemination of K=K to key population and people living with HIV networks, especially young urban gay men and other men who have sex with men.

Lessons

Coordinated Ministry of Health and community commitment is critical to place K=K at the centre of HIV programme strategy. Despite global endorsements, health-care providers were initially reluctant to inform patients of the benefits of K=K. Simple, visually powerful materials clarified K=K messaging and addressed concerns around the prevention of mother-to-child transmission, blood transfusion transmission, and the prevention of other sexually transmitted infections. Initial campaigns were conducted in cities where success could influence broader commitment and leverage Viet Nam's impressive viral suppression rates. In response, the Ministry of Health officially endorsed K=K and issued national implementation guidelines. Community forums confirmed regionally nuanced messaging and preferred platforms for effective dissemination, as well as the design of a national campaign.

K=K revolutionized the national HIV response. In September 2019, Viet Nam became the first PEPFAR country to disseminate official U=U/K=K guidance and document 95% viral load suppression <200 copies/ml among ART patients. In 2021, it reached 97% <50 copies/ml. In 2021, Viet Nam combined messaging around effective ART for people living with HIV and PrEP for people at substantial risk of HIV so that the preventive use of ARVs offers a clear path to HIV epidemic control.

Case study 6

Centre for youth of hope

Botswana

What were the objectives of your work described in your case study?

To train 15 peer educators living with HIV in basic HIV treatment literacy. Training focused mainly on the HIV viral cycle and actions of different classes of ARVs in the viral cycle. This training provided our peer educators with basic understanding of viral suppression in the context of U=U. Basic research literacy sessions formed part of this training. Studies confirming that U=U were used for the training. HPTN052, the Opposite Attract study, and the PARTNER 1/2 studies were included in the training curriculum.

To train 15 peer educators living with HIV in basic U=U patient communication strategy. Educators were trained in health messaging and communication focusing on, audience analysis, setting goals/objectives and crafting tailored U=U messages. HIV basic treatment literacy helped the educators to build confidence and capacities to accurately communicate

the U=U message to 2,000 clients living with HIV in Gaborone in 12 months (April 2021 – March 2022). Global U=U consensus and U=U statements from the US Centers for Disease Control and PEPFAR were used.

What key outcomes does your case study address?

Value of people living with HIV on the ground who have been contributing their community's members.

What population groups were engaged in your case study?

People living with HIV.

What stakeholders were engaged in the work described by your case study?

Communities living with HIV; health professionals; civil society organizations.

Abstract

We used a qualitative evaluation approach to evaluate outcomes of U=U messaging to clients living with HIV in Gaborone health catchment ARV clinics. We compared baseline data and current 12 months' data. The following were the level results:

- quality of life for people living with HIV (social, sexual and reproductive lives): 89% of the 2,000 clients reported a reduction in HIV anxiety associated with HIV and their sexual and reproductive life;
- HIV stigma: Internalized stigma fell by 89% among participants; and
- treatment goals (U=U added an incentive to remain on treatment and in care). There was 99% retention (n= 2000) in care during the 12-month study.

Conclusion

U=U messaging can be used as an incentive to fast-track the achievements of 95–95–95 global targets, which Botswana has achieved. Messages can be integrated into existing testing and care programmes.

Case study 7

A U=U public education and communication campaign

Canada, Public Health Agency of Canada

Objectives

Undetectable = Untransmittable (U=U) video testimonials were used to share the perspectives of people living with HIV in a positive, uplifting, compassionate and meaningful manner, with a focus on reducing HIV stigma and raising awareness of the impact of U=U.

The videos explore how HIV stigma has affected people, and how their lives have been and can be transformed, including their relationships, romances and partner-seeking. They seek to represent diverse perspectives, including those of members of key populations and across age groups, in a non-stereotypical manner. The videos provide a case study of a U=U education and communication campaign aimed at reducing the stigma and discrimination that is often associated with an HIV diagnosis.

Outcomes

The primary outcomes of the video testimonials were increased awareness of the U=U concept and reduced HIV stigma.

The videos served to increase public understanding of the following key messages:

- by sticking with their treatment plans, people living with HIV have taken control of their health. U=U means life can be lived to the fullest;
- U=U challenges the stigma that people living with HIV are less sexual or are dangerous, to be avoided and stigmatized;
- prevention tools such as PrEP and PEP help prevent HIV from being passed on to a sexual partner;
- U=U means that treatment can serve as prevention;
- with treatment, HIV becomes an invisible manageable condition—it is invisible yet real with episodic physical, psychological, social and spiritual manifestations (good and bad);
- dating with HIV, finding partners and romance with HIV is possible. U=U means sexual relationships are possible without the risk of passing on HIV; and
- What U=U means to long term survivors.

The goal of the video testimonials was to have representation from all of the key populations most affected by HIV, as well as others participants. Including a broad cross-section of participants helped avoid stigmatization, reinforced the fact that anyone can get HIV, and provided more opportunities for viewers to find a perspective they could identify with. The U=U video testimonials had in 43 684 YouTube views (English and French versions).

Population groups

- People born with HIV (youth),
- Indigenous peoples,
- older persons and long-term survivors,
- LGBTQ2S+ community members,
- people who uses or used drugs,
- heterosexual females, and
- Black Canadians.

Stakeholders

Communities living with HIV; civil society organizations; government officials (local, national, global).

Abstract

In 2019, the Public Health Agency of Canada produced a series of testimonial videos highlighting the impact that U=U had on the lives of people living with HIV. The project was aimed at reducing HIV stigma by demystifying and addressing misconceptions. The inspiring stories raised awareness about the potential of U=U and supported the changing of societal attitudes.

The direction of these videos, from conceptualization to implementation, was led by a steering committee composed of people living with HIV and community-based stakeholders. They identified priority themes/stories to be profiled, identified individuals to be interviewed, and developed interview questions. The committee also provided feedback on the format and approach of each video. They suggested that the focus should be on the impact of social determinants, as well as why certain populations are disproportionately affected by HIV, in order to avoid stigmatization. The collaboration allowed for a tailored dissemination

strategy to reach people who were not already engaged. Their guidance and insight ensured that the videos resonated with audiences and demonstrated sensitivity and compassion for people living with HIV.

An introductory compilation video presented a wide variety of people living with HIV and introduced key facts about the HIV epidemic in Canada. The testimonial videos explored five people's experiences of living with HIV.

The videos were posted on the Government of Canada website and YouTube, and video snippets were produced to promote the series via the Government of Canada's various social media accounts. The videos were also promoted through community partners, including Canada's knowledge broker for HIV/STBBI information, CATIE, and other HIV community-based organizations and provincial/territorial partners. The videos have been showcased at conferences and on social media on an ongoing basis.

Case study 8

Public Health Center of the Ministry of Health of Ukraine

Ukraine

What were the objectives of the work described in your case study?

Care and support services for people living with HIV funded by state budget.

What key outcomes does your case study address?

The number of people living with HIV who received care and support services in 2021 at the expense of the state budget through NGOs.

What population groups were engaged in your case study?

People living with HIV.

What stakeholders were engaged in the work described by your case study?

Civil society organizations; government Officials (local, national, global).

Abstract

According to the national assessment of the HIV/AIDS situation in Ukraine in 2021, there about 174 000 people living with HIV in government-controlled areas (<https://npsi.phc.org.ua/Wiki/717>). Since 2019, the Public Health Center has been implementing a state programme for the care and support of people living with HIV. Activities are implemented through NGOs with experience in working with people living with HIV. The cost of providing these services is covered by the state budget. Public Health Center monitors the indicators of the work performed by NGOs, provides recommendations to improve the quality of services and programme effectiveness. Thus, during 2021, 32 720 people were covered by care and support services, 98% of whom regularly visited a doctor and received ART without interruption.

The state programme of care and support has two directions of work: "formation of adherence to HIV treatment and maintenance under medical supervision" and "involvement of people who inject drugs in the provision of medical care in connection with HIV and formation of adherence to ART". Clients are included in the programme for six months. The

basis of the programme is consultations that are aimed at motivating clients to start HIV treatment and acquire the skills to regular take the medicines. Service providers refer clients to medical facilities and develop their skills to take care of their own health. The results of medical examinations, in particular viral load testing, are recorded in clients' laboratory card.

One of the consultation sessions of the programme is devoted to the topic of reproductive health. Service providers also work with clients on safe behaviour skills, discuss readiness to disclose HIV status to relatives, and inform them about reducing the risk of partner infection. Those activities are aimed at increasing adherence to treatment and reducing viral loads to undetectable levels.

Case study 9

Elizabeth Glaser Pediatric AIDS Foundation

Multicountry, sub-Saharan Africa

What were the objectives of the work described in your case study?

The overall aim is the development of a practical tool that provides direction in initiating discussions around U=U with adolescents and youth navigating different scenarios for use by health-care workers and young peers in various psychosocial support settings. It was important that this tool's development be youth-led to ensure that the stories were authentic and represented youths' lives and experiences realistically. It also needed to be responsive to the gaps in messaging and present solutions to the difficulties faced by youth.

What key outcomes does your case study address?

Increased comprehension and understanding of the concept of U=U, as well as relating it to people's lives, including:

- deeper insight into effective means for messaging U=U for adolescent and young people living with HIV, key populations, and adolescents and youth generally, as well as the means to increase the capacity and awareness of U=U among providers and adolescent and youth facilitators working with all adolescents and youth living with HIV; and
- adding to the evidence on meaningful adolescent and youth engagement and leadership in the development of relevant and practical tools for the adolescent and youth population.

Initial reactions from young people while gathering additional inputs:

“The tool explains very well about U=U and adolescent appealing to young people”;

“The tool is good and awesome and directly responded to most of young people's needs”.

What population groups were engaged in your case study?

Young people between 15–29 years in the Elizabeth Glaser Pediatric AIDS Foundation's Committee of African Youth Advisors were engaged as partners in the development of the tool. The Committee sought additional insights from adolescents and youth aged 15–24 years.

Stakeholders

Communities living with HIV, adolescents and youth.

Abstract

In response to a recognized gap in the provision of practical and tailored materials to facilitate productive U=U dialogues with adolescents and youth living with HIV, the Elizabeth Glaser Pediatric AIDS Foundation's Committee of African Youth Advisors (CAYA), with support from the University of Cape Town, proceeded with a youth-designed tool. CAYA members are young leaders aged 15–29 years from 11 sub-Saharan African countries. A gap analysis was conducted to avoid redundancy among existing U=U tools focused on adolescent and youth living with HIV.

Virtual discussions with CAYA members identified areas of focus and determined the particular form the delivery of the messaging should take. Through an iterative process, a short graphic-based story collection was drafted. CAYA members developed character profiles, story lines and dialogues. With support from the Urithi design team based in Uganda, CAYA members then led initial validation discussions with adolescents and youth in their networks (including in psychosocial support groups and networks of young people living with HIV) using a standardized questionnaire to gather additional insights. Almost 190 adolescents and youth living with HIV in Kenya, Malawi and Uganda shared insights. Highlighted was the need for simpler, everyday language, designing characters with more youthful looks and ensuring conversations take place in confidential settings in the stories. The final stories are in development.

Case study 10

Blue Diamond Society

Nepal

Objectives

To communicate proper messaging of U=U; initiate comprehensive intervention for viral load suppression; and incorporate and proper implementation of U=U in a policy document.

Outcomes

Proper messaging and implementation of U=U in policy document.

Populations

All key populations.

Stakeholders

Communities living with HIV; health professionals; civil society organizations; government officials (local, national, global).

Abstract

During consultations to develop the national guidelines on HIV testing and treatment (2021–2026), many local NGOs (including Blue Diamond Society, Nepal's leading LGBTIQ+ organization) advocated strongly for the inclusion of U=U and an emphasis on its implementation in local HIV/AIDS programming. This led to inclusion of U=U in the national guidelines (<http://www.ncasc.gov.np/uploaded/publication/NHSP-2021-2026/NHSP-2021-2026-English.pdf>), which notes the need to “increase the focus on effective HIV awareness messaging for all key populations such as treatment leads to better health outcomes including survival, U=U, etc.”.

While the Government of Nepal swiftly integrated U=U in its policy document, the wording is brief and is based on the clinical definitions (e.g. in the guidelines, an undetectable viral load is set at less than 200 copies/mL, whereas viral suppression is set at less 1000 copies/mL). Nepal is following the WHO 2016 Consolidated guidelines on the use of ARV drugs for treating and preventing HIV infection. Community members appreciate the inclusion of U=U in the policy document. However, they are confused by the fact that viral suppression is defined as having less than 200 copies/mL of HIV as per the US CDC.

Proper implementation of U=U as a national guidelines strategic action is needed. Successful, holistic integration of U=U (e.g. accurate messaging and quality services, and promotion of U=U for treatment adherence and as part of comprehensive prevention interventions along with PrEP) require community-led monitoring. At a systems level, U=U should be leveraged as evidence-informed rationale for uninterrupted dispensing of ART as well as for expanded and more equitable access to well-maintained viral load testing technology, diagnostic tools, regular viral load testing.

Case study 11

Two Canadian studies working with community partners doing community-based research related to U=U and HIV undetectability.

Canada

What were the objectives of the work described in your case study?

British Columbia: The objective was to inductively learn from diverse sexual minority men with different HIV serostatuses to understand what HIV undetectability means to them, including its sexual significance and contested interpretations amid an evolving and uneven landscape of biomedical HIV prevention strategies

(<https://www.tandfonline.com/doi/full/10.1080/13691058.2020.1776397#:~:text=We%20describe%20this%20as%20a,who%20have%20sex%20with%20men>).

Ontario: The objective was to better understand how various HIV/STI service providers (e.g. nurses, public health workers, physicians, frontline providers, and sexual health educators) communicate the U=U message to sexual health service users in Ontario, Canada. We were specifically interested in understanding the communication of the U=U message in everyday practice, including barriers experienced by service providers to consistently convey this HIV prevention message

(<https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0271607>).

What key outcomes does your case study address?

Barriers to health communication for service users and health-care providers.

What population groups were engaged in your case study?

Gay, bisexual, and other men who have sex with men; HIV/STI service providers (e.g. nurses, public health workers, physicians, frontline providers, and sexual health educators).

What stakeholders were engaged in the work described by your case study?

Communities living with HIV; health professionals; civil society organizations.

Abstract

U=U is a public health message that is designed to reduce HIV stigma and help communicate the scientific consensus that HIV cannot be sexually transmitted when a person living with HIV has an undetectable viral load. Between October 2020 and February 2021, we conducted 11 in-depth interviews and 3 focus groups with diverse HIV/STI service providers (nurses, public health workers, physicians, frontline providers, and sexual health educators) in Ontario, Canada (n=18). The objective was to understand how U=U was communicated to sexual health service users in health-care interactions. Interview questions were embedded in a larger study focused on improving access to HIV/STI testing.

Most providers emphasized the significance of U=U as a biomedical advance in HIV prevention, but experienced some challenges communicating U=U in everyday practice. We discovered 4 interrelated barriers when communicating the U=U message: (1) provider-perceived challenges with “zero risk” messaging (e.g. wanting to “leave a margin” of HIV risk); (2) service users not interested in receiving sexual health information (e.g. in order to provide “client-centered care” some providers do not share U=U messages if service users are only interested in HIV/STI testing or if other discussions must be prioritized); (3) skepticism and HIV stigma from service users (e.g. providers explained how the hesitancy of some service users to accept the U=U message was shaped by a legacy of HIV prevention messages and persistent HIV stigma); and (4) need for more culturally appropriate resources (e.g. communities other than sexual and gender minority men, non-English speaking service users). We discuss ways to overcome barriers to communicating the U=U message, as well as limitations and potential unintended consequences of U=U framings in the context of unequal access to HIV prevention and treatment.

Case study 12

Media guidelines for reporting on U=U: working with journalists to reduce stigma *Australia*

Objectives

To develop a set of media guidelines to assist journalists reporting on HIV to encourage the inclusion of factual and appropriate information about U=U in order to:

- reduce the HIV-related stigma that continues to be present within Australian news reporting on HIV, particularly in relation to exaggerated reporting of HIV transmission risk; and
- reduce HIV-related stigma associated with sensationalized and negative news reporting on HIV, and people living with HIV.

Outcomes

The media guidelines were developed and published in consultation with people living with HIV, and journalists working in Australian news media. They were distributed among networks of Australian journalists and have been cited in Australian news reporting on HIV.

Groups involved

People living with HIV.

Stakeholders

Communities living with HIV; representatives from a wide range of Australian community organizations representing people living with HIV; journalists in the Australian news media

reporting on HIV; broader networks of Australian news journalists; journalists attending 2022 International AIDS Conference in Montreal.

Background/purpose

Research has shown a link between low HIV knowledge and stigmatizing attitudes. Journalists who are unfamiliar with the evidence behind U=U may be skeptical about the principle and minimize its validity, contributing to stigmatizing depictions of HIV in their reporting.

Media guidelines are information packs for journalists to guide reporting on specialist subjects and have been used to inform reporting on topics such as suicide. The development of U=U media guidelines aims to support more factual reporting on HIV transmission and to reduce stigmatizing depictions of people living with HIV.

Approach

A thorough review of existing media guidelines and their use in Australian media identified best practice for development and implementation. Interviews were conducted with journalists to determine their knowledge of HIV and U=U. Journalists were asked what barriers might prevent them from using available media guidelines. In interviews, people living with HIV shared their views about the depictions of HIV in news media they found stigmatizing, and how this might be addressed. Based on this research, a set of media guidelines was developed to improve journalists' understanding of HIV transmission risk in relation to U=U. The guidelines were promoted to media contacts.

Outcomes/impact

Interviewees said omissions of information about U=U in news media contributed to false and stigmatizing views that presented a risk to them and others. Journalists said that a lack of easy access to clear, authoritative information and time pressures were barriers to increasing their understanding of U=U.

The guidelines developed accounted for pressured work environments of Australian journalists and provided clear, concise information. Examples of stigmatizing HIV reporting were used to show how the inclusion of U=U messages could reduce stigmatizing depictions of people living with HIV .

The guidelines were adapted for an international audience and provided to journalists at AIDS 2022 and have been shared with multiple news media organizations in Australia, including the Science Journalists Association of Australia. The guidelines are being used by journalists reporting on HIV in Australia.

Innovation and significance

These are the first such guidelines to be produced globally. They provide an innovative example of a stigma-reducing activity that connects media practice to clinical and community experience and expertise.

Case study 13

#DoubleKnowledge

Deutsche Aidshilfe, Germany

What population groups were engaged in your case study?

People living with HIV, key audiences of Deutsche Aidshilfe, the general public.

What stakeholders were engaged in the work described by your case study?

Communities living with HIV; health professionals; civil society organizations; parliamentarians.

What were the objectives of the work described in your case study?

Generating outreach, spreading knowledge of U=U.

What key outcomes does your case study address?

Raised awareness for the U=U fact among general public and key audiences.

Abstract

#wissenverdoppeln (which translates as #DoubleKnowledge) is a cross-media campaign which Deutsche Aidshilfe conducted in 2018–2020. The overall objective was to publicize the U=U message in the wider public and to reduce HIV-related stigma and discrimination. A request to spread the knowledge (by sharing it on social media or telling friends and colleagues) was the campaign's central "call to action". The campaign generated strong outreach and press coverage.

Background

The objective of doubling the knowledge of U=U until everyone knows relates to a survey in 2017, which showed that only 10% of the general public in Germany knew that HIV cannot be transmitted sexually by a person who is virally suppressed. The campaign was financed by Bundeszentrale für gesundheitliche Aufklärung/Federal Centre for Health Education (BZgA) in the context of the annual campaigns around World-Aids-Day on December 1.

Campaign elements

The campaign featured a campaign website (www.wissen-verdoppeln.hiv, in German), videos with role models, digital and print advertisements and giveaways.

The campaign was also supported by many local member organizations of Deutsche Aidshilfe and self-organized communities of people living with HIV, who both were provided with information material and assistance in publicizing the message.

Outcomes

The campaign generated very high outreach. Many prominent people shared the information in social media profiles (e.g. artists and politicians) and there was broad media coverage (including on the public broadcaster). The campaign videos had more than 1 million views on social media. A follow-up survey in 2020 showed that knowledge of U=U had increased significantly in the general public (up by 18%) and some discriminatory beliefs regarding people living with HIV had been reduced.

Case study 14

The use of U=U to promote equal access to viral load testing: experience of community workers with gay men and other men who have sex with men in Yaoundé, Cameroon

Humanity First Cameroon Plus, Cameroon

What were the objectives of the work described in your case study?

Use the U=U approach to enhance access to viral load testing for key populations, and train community workers to perform blood sample collection and safe transportation to laboratories for testing.

What key outcomes does your case study address?

Key populations know their viral load testing and can live without fear of transmitting HIV to others. Understanding that U=U is a reality, not just a slogan.

What population groups were engaged in your case study?

Gay men and other men who have sex with men.

Stakeholders

Communities living with HIV; health professionals; civil society organizations.

Background

Achieving an undetectable viral load for successful HIV treatment is often fraught with challenges. In low- and middle-income countries, although many efforts are being made to test and link to treatment people living with HIV, access to viral load testing remains difficult, with very few laboratories performing these tests. Furthermore, discrimination encountered in health facilities prevents key populations at high risk of HIV from accessing the services. Humanity First Cameroon Plus (HFC+), through implementation of the CHAMP project (continuum of prevention, care and treatment with most at-risk populations in Cameroon), put in place a programme to strengthen the capacity of community workers to collect blood samples and transport them to laboratories. The CHAMP project aims to limit the incidence of HIV by starting key populations living with HIV on treatment so they can achieve and maintain an undetectable viral load.

Description

The CHAMP programme has been implemented in Cameroon since 2014 and is supported by the US Government. HFC+ is a community-based organization which benefits from that programme and works with gay men and other men who have sex with men in Yaoundé. To facilitate access to viral load testing, 15 men were trained to collect and transport blood samples for testing in laboratories.

Lesson learned

In fiscal year 2021, during the COVID-19 crisis, we collected 960 blood samples and transported them to laboratories, 912 of which had an undetectable viral load, (95%). Through this work, we have understood that it is important to include most affected communities if we are to make U=U a reality.

Next steps

We will advocate to perform viral load testing directly at the community level by using less sophisticated equipment.

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Regions represented in key informant interviews

Region	Number of interviews
Africa	4
Asia-Pacific and Middle East and North Africa	3
Eastern Europe and central Asia	2
Europe	3
Latin America and the Caribbean	2
North America	4
Total	18

Civil society experts for peer review of the NGO report

Name	Organization	Country and region
Brent Allan	ICASO	Global
Solange Baptiste Simon	International Treatment Preparedness Coalition	South Africa (Africa)
Javier Hourcade-Bellocq	Plataforma VIH 2025	Argentina (Latin American and the Caribbean)
Laurie Edmiston	CATIE	Canada (North America)
Sandra Ka Hon Chu	HIV Legal Network	Canada (North America)
Erika Castellanos	GATE	Netherlands (Europe)
Lucy Wanjiku Njenga	Positive Young Women Voices	Kenya (Africa)
Mat Southwell	International Drug Policy Consortium	United Kingdom (Europe)
Kaythi Wynn	Asia Pacific Network of Sex Workers	Thailand (Asia-Pacific)

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