Integrating Empowerment Strategies with ACT to Reduce HIV Stigma and Promote Collective Resilience

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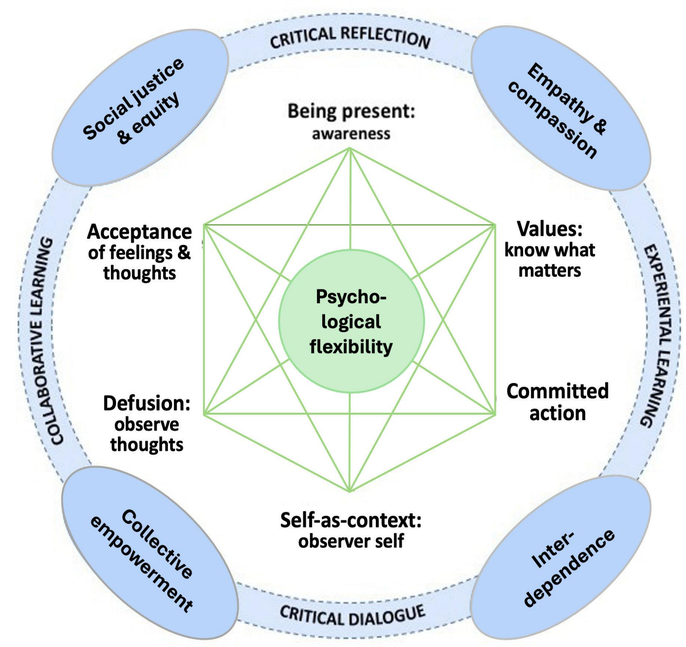
Introduction

Racialized, immigrant, and refugee communities are disproportionately impacted by HIV in Canada, accounting for nearly 70% of first-time diagnoses in 2022 despite representing only 26.6% of the population. The HIV disparities are driven by complex, intersecting structural barriers—including racism, gender inequities, homophobia, migration stress, and poverty—and are severely exacerbated by HIV-related stigma, which deters testing, delays care, and worsens health outcomes. Effective and sustainable stigma-reduction interventions are critically needed.

The ACE Intervention

The **Acceptance and Commitment to Empowerment (ACE)** intervention integrates 2 evidence-based models to reduce stigma at the individual and collective levels: (i) *Acceptance and Commitment Therapy (ACT)* that promotes psychological flexibility through mindful, experiential activities grounded in six processes of being present, defusion, acceptance, self-as-context, values, and committed action; and (ii) Freirean-informed Collective Empowerment (FCE) that honours the lived experiences and strengths of affected communities, promotes critical dialogue on self-compassion, praxis (reflection and action), interconnections/interdependence, and stigma in the context of power relations in society. ACE consists of six weekly online self-guided learning modules paired with six online group sessions.

Figure 1. ACE Model



Methodology

Project ACE consisted of three phases: ***(1) assessment of local contexts*** of stigma to inform ACE adaptation; ***(2) community capacity building*** through a train-the-trainer program with service providers and community leaders; and ***(3) community implementation of ACE training*** across six project sites (Calgary, Edmonton, London, Niagara, Ottawa, and the Greater Toronto Area). **Data collection**: (i) sociodemographic questionnaire; (ii) pre, immediate post-, 3-month post- intervention survey with validated scales; (iii) 3-month post-intervention focus groups; and (iv) monthly post-intervention activity logs.

Participants

The team engaged 141 participants; 126 completed the intervention: Phase 2 (n=38); and Phase 3 (n=88). This poster focuses on Phase 3 results.

Sociodemographic characteristics: Majority self-identified as new immigrants with **<5 years in Canada** (n=52; 59%); **female** (n=56; 64%); median age was **35-39** and mean age bracket was **38.5**. Participant **sexual orientation** included: heterosexual (n=62; 70%); bisexual (n=9; 10%); gay (n=5; 6%); lesbian (n=2; 2%); option not listed (n=9; 10%).

NOTE: Validated scales included: (i) the 12-item HIV Stigma Scale with 4 subscales on personalized stigma, disclosure concerns, concerns with public attitudes and negative self-image; (ii) the 4-item Perceived Discrimination from Service Providers Scale, (iii) the 12-item Cognitive and Affective Mindfulness Scale (CAMS-R) that assesses mindfulness; (iv) the 7-item Acceptance and Action Questionnaire Version II (AAQ-II) that measures experiential psychological inflexibility and cognitive fusion; (v) the 28-item BRIEF COPE that measures 14 different coping strategies; and (vi) the 12-item Self-Compassion Scale Short (SCS-S) that measures self-kindness, self-judgment, common humanity, isolation, mindfulness, and over-identification.

Results

The **ACE intervention** offers a powerful model to reduce stigma at multiple levels, moving psychological flexibility beyond an individual psychological trait into **collective empowerment** and social change.

Table 1: Descriptive Statistics and Repeated Measures ANOVA Results - Psychometric Outcomes Across Intervention Time Points

Psychometric-Scaled Variables	Pre-Intervention	Immediate post-int.	3-Months post-int.	Pairwise Comparison of Repeated Measures ANOVA			RM- ANOVA (M_1, M_2, M_3)
	N=88	N=86	N=73	Mean Diff (M_2-M_1)	Mean Diff (M_3-M_2)	Mean Diff (M_3-M_1)	
	M_1 (SD)	M_2 (SD)	M_3 (SD)				[a] F-Statistics
Stigma towards PLHIV (Scale=104, α =0.93)	44.3 (12.83)	41 (10.73)	42.75 (14.44)	**-3.3***	**1.75****	-1.55	[b]**13.33*****
Confidence to Fight Stigma (Scale=50, α=0.94)	38.84 (9.51)	41.77 (7.38)	41.73 (6.26)	2.93	-0.04	2.89	**4.28***
Self-Compassion (Scale =60, α=0.83)	40.86 (7.76)	41.41 (7.28)	42.82 (7.46)	0.55	**1.41***	1.96	**4.78***
Empowerment Readiness (Scale=36, α=0.85)	29.49 (6.5)	31.8 (5.34)	32.69 (4.6)	**2.31****	0.89	**3.2*****	**12.42*****
Mindfulness (Scale =48, α=0.81)	34.3 (6.22)	34.81 (6.31)	35.19 (5.42)	0.51	0.38	0.89	1.55
Acceptance and Action (Scale =49, α=0.91)	20.31 (10.46)	20.52 (8.92)	18.45 (7.76)	0.21	**-2.07****	-1.86	**4.71***
Use of Emotional Support, BRIEFCOPE 5, 15 (subscale=8, r=0.61)	5.53 (1.78)	6.05 (1.6)	6.06 (1.48)	0.52	0.01	0.53	**4.96***
Venting, BRIEFCOPE 9, 21 (subscale=8, r=0.28)	4.5 (1.69)	5.24 (1.41)	5.38 (1.4)	**0.74***	0.14	**0.88****	**11.18****
Planning, BRIEFCOPE 14, 25 (subscale=8, r=0.52)	6.15 (1.64)	6.63 (1.38)	6.73 (1.35)	**0.48***	0.1	**0.58***	**7.3****
Self-Blame, BRIEFCOPE 13, 26 (subscale=8, r=0.49)	4.46 (1.74)	4.38 (1.5)	3.95 (1.41)	-0.08	**-0.43***	**-0.51***	**6.73***

*<.05, **p<.01, ***p<.001; [a] F-Statistics measured the significance of within person change across the three intervention times.
[b] The quadratic trend, rather than the linear trend, of the Repeated Measures ANOVA was statistically significant for this variable.

Data Convergence and Divergence: Key Themes

THEME 1. PERSONAL TRANSFORMATION

Although the *mindfulness scores* did not reach statistical significance, participants' narratives diverged sharply. Many shared their use of **mindfulness** and **present-moment grounding** to connect to self-compassion and actively disrupt internalized oppression and stigma.

Mama K: *"For me, I like the fact that, the ACE, or what we learned, was, how to be mindful in everyday activities for the little things, even for, like, having a cup of tea. So, like, how to be mindful in all you do." (FG A)*

Tee: *"I learned to stop judging myself so harshly for things I couldn't control. Mindfulness was a truly transformative practice for me; when the anxiety or the stigma gets overwhelming, I use those grounding tools to bring myself back to the present moment."(FG A)*

Curry: *"I think mindfulness was the best. [..] There are many times we do things… in the subconscious. But this time, being mindful really helped bring them into my consciousness that, I'm actually doing this. I'm walking, and I want to listen to my steps… (FG C)*

THEME 2. INCREASED PSYCHOLOGICAL FLEXIBILITY

Survey scores showed a statistically significant increase in **psychological flexibility** and **self-compassion** among participants. Qualitative data converged, whereby participants reported a profound shift away from experiential avoidance toward defusion, emotional acceptance, self-compassion, and a broader sense of self-as-context.

Tee: "ACE helped me understand that disappointment is a normal emotion, not a failure… I learned how to sit with disappointment instead of fighting it, or blaming myself, or others." (FG A)

Amina: *"I used to think that venting or showing I was overwhelmed meant I was failing. But learning to just name the anxiety, to say 'I'm feeling completely stuck right now' out loud to someone else, stopped it from turning into that heavy self-blame. It's like I gave the feeling permission to just be there instead of trying to bury it." (Amina, FG A)*

Elena: *"Before the program, I kept everything locked inside and blamed myself. Learning to let it out—to vent, to lean on my support systems, and to actively plan for my future without shame—was like a weight being lifted off my shoulders." (FG B)*

THEME 3. STIGMA TRAJECTORY & PRAXIS

Data show an immediate reduction in stigma post-intervention (M2–M1=-3.30*), followed by partial attenuation at 3 months (M3–M2 = 1.75**), with stigma remaining below baseline overall. While this suggests a need for booster sessions or reflects scale limitations rather than individual failure, it is powerfully countered by a highly significant, continuous increase in **Empowerment Readiness** across the study (M3-M1=3.20***). Supported by this psychological readiness, participants (n=73) entered active Freirean ***praxis***, conducted **994 community activities, reaching >16,000 people**. Despite a hostile environment fluctuating their perceived stigma, their values-driven **Committed Action** remained uncompromised, as reflected in these entries in the Post-Intervention Activity Logs:

- *'Have gotten involved in a project to share my story on print media about stigma and how to overcome it."*
- *"During our 2SLGBTQIA+ get-together and games night, we created space for people to share their stories and experiences with stigma. Hearing each other's voices and strategies for coping was powerful; it reminded everyone that we are not alone and that stigma can be challenged through community and connection."*
- *"I challenged HIV misinformation gently and promoted inclusive, non-judgmental language in a group attended by 14 people"*
- *"I organized an online seminar with 10 students on HIV stigma and prevention, fostering empathy and informed discussions."*

Conclusion

This study demonstrates the powerful synergy achieved when expanding Acceptance and Commitment Therapy (ACT) beyond individual-level interventions into macro-level community health. While ACT promotes the essential psychological flexibility needed to navigate systemic stigma, pairing it with Freirean-informed Collective Empowerment (FCE) helps steer internal resilience toward collective action. By anchoring ACT processes in a structural framework like FCE, participants did not merely adapt to a stigmatizing environment—they actively mobilized to transform it. Ultimately, this integration encourages the ACT community to explore how intentional pairing of ACT core processes with macro-structural models can promote collective, values-driven committed action capable of transforming systemic health inequities.

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