STAYING ALIVE

Evaluation of the Keep it Alive! HIV Awareness and Prevention campaign for African, Caribbean and Black Communities in Ontario

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ACCHO worked with Top Drawer Creative to develop and implement the "Keep it alive!" campaign.

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EXECUTIVE SUMMARY

This report discusses the findings from the research study, *Staying Alive: Evaluation of the "Keep it Alive!" HIV Awareness and Prevention Campaign for African, Caribbean, and Black Communities in Ontario.*

Keep it alive! (KIA) was a community-based social marketing campaign developed and implemented by the African and Caribbean Council on HIV/AIDS in Ontario (ACCHO) from 2006-2009. KIA was designed to increase awareness of HIV and reduce HIV-related stigma in African, Caribbean and Black (ACB) communities, promote safer sex and HIV-testing, and to raise ACCHO's profile among ACB communities. The first phase of the campaign consisted of images and messages urging an informed, practical and compassionate interest in HIV within the context of caring for one's self, one's family and ACB communities. The images and messages were disseminated through advertisements in public transit systems and community newspapers, as well as on posters, postcards, t-shirts, and condom packs. The campaign also included one public service announcement (PSA) for radio. The second phase included the continued dissemination of the images from the previous phase, in addition to nine PSAs for TV that featured ACB community members speaking about issues regarding HIV and AIDS.

From 2009 to 2010, a team developed under the auspices of ACCHO implemented the KIA evaluation study to examine how the campaign was received and understood by ACB communities, and to assess community knowledge, attitudes, and behaviours in relation to HIV.

The evaluation comprised focus groups and a survey among ACB communities in London, Ottawa and Toronto. A total of 48 individuals participated in seven focus groups in Toronto, London and, Ottawa. Overall, focus group participants felt that the KIA images were visually attractive and empowering with positive portrayals of Black people. However, they also suggested that the quality of the images may have overshadowed the messaging, and that 'HIV' and 'AIDS' were not displayed prominently enough. The campaign messaging was very subtle and a bolder HIV prevention message was needed. Conversely, because of the stigma associated with HIV, others preferred the more subtle approach. There were mixed reviews about a campaign that targeted ACB populations. Some participants were wary of HIV being perceived as a Black or African disease. Others held that it was encouraging to see a campaign implemented for and by Black people. Some participants distanced themselves from HIV and expressed a degree of skepticism as to whether HIV is a real issue for ACB communities in Canada.

Focus group participants who were themselves living with HIV were more aware of the HIV landscape in ACB communities in Ontario and offered more nuanced perspectives on the campaign. The images were interpreted as demonstrating that people living with HIV can look vibrant, healthy and beautiful and the models were perceived as individuals who could be people living with HIV (PHAs) or family and friends. Participants in this particular focus group identified strongly with the 'Keep It Alive!' slogan and aligned the campaign values with attainable goals that could be achieved regardless of a positive diagnosis. Unlike other focus groups, participants did not mention the need for including PHA testimonies in future campaigns.

The self-administered survey yielded a sample of 243 participants in Toronto, London, and, Ottawa. Of the two-thirds (66.3%) who reported seeing KIA campaign images, 68.9% indicated that they found them to be appealing. More than half (53.2%) of all participants who saw the KIA images reported that the images increased their awareness of HIV/AIDS. Participants born in Africa and the Caribbean, and participants older than 30 years were more likely to report an increase of HIV/AIDS awareness. The local public transit system was the most common location participants reported having seen the campaign images. The TV PSA messages reported to be the most important included 'always use a condom when you have sex (13.5%)', and 'preventing the spread of HIV is everyone's business' (13.5%). Among the participants who recognized the images and TV PSAs, 90.8% described the campaign as "very important" or "important" for ACB people in Ontario.

The survey also measured HIV-related stigma using a scale developed by Visser et al (2008). The median score among participants was 1, indicative of low stigma levels. However, higher levels of stigma were seen in regards to items of a personal or intimate nature. For example, around half of participants (51.7%) agreed with the statement, "I would not drink from a cup if a person with HIV had just drunk from it". Participants who were older, possessed higher levels of education, reported having tested for HIV in the past and found the KIA images appealing demonstrated lower levels of HIV-related stigma.

The HIV knowledge scale measured participants' level of knowledge about HIV. It was adopted from the CDC (1988) and modified by Leake (1997). The overall median was a score of 15 with 40% of participants scoring 16 or higher. This demonstrates relatively high levels of HIV knowledge. Participants who demonstrated higher levels of stigma also demonstrated a lesser knowledge about HIV. Participants who were older, had higher levels of education, reported having tested for HIV in the past and having seen KIA images demonstrated higher averages of HIV knowledge.

Focus group participants made a number of recommendations for effective HIV campaigns among ACB communities. In regards to messaging, a call to action, a clear and visible HIV prevention message, information for newly diagnosed individuals and factual information about the HIV landscape in Canada were proposed. PHA testimonies, involvement of community or popular leaders, an HIV education component, and multi-sectoral participation were proposed as delivery strategies for future campaigns. Other considerations included giving attention to cultural, linguistic and religious diversity within ACB communities, addressing stigma associated with HIV as a Black/African disease, and considering campaign ideas that may be too subtle or extreme.

Although the Keep It Alive! social campaign was successful in its reach and impact, the evaluation highlighted several issues. For example, ACB people who were born in Africa or the Caribbean often do not interpret HIV as an issue of concern for their communities in Canada (as opposed to the situation "back home"). Also, the tensions expressed in the focus groups around executing an effective HIV prevention campaign signified the need for creative and refined strategies for addressing the complexities associated with HIV. Developing and implementing HIV education and stigma reduction initiatives for younger ACB people can be of great value. Our findings also suggest a need for culturally sensitive interventions to address HIV disclosure.

1. INTRODUCTION

1.1 HIV, "Keep It Alive!", and African, Caribbean and Black communities in Ontario

HIV/AIDS disproportionately affects African, Caribbean and Black (ACB) communities in Canada. ACB people represented 2.5% of the Canadian population in the 2006 Census, but accounted for an estimated 12.2% of HIV infections in Canada (PHAC, 2009).

In 2008, ACB people accounted for 3.9% of Ontario's population, but represented an estimated 18.3% of the 26,627 people living with HIV in the province (Remis et al., 2010). Furthermore, it is estimated that only 55.7% of ACB people living with HIV in Ontario have been diagnosed (Remis et al., 2010). Men represent 60% of ACB people in Ontario estimated to be infected with HIV through heterosexual transmission (Remis et al., 2010).

The "Keep it Alive!" (KIA) campaign was a community-based HIV/AIDS education and awareness social marketing campaign for ACB communities in Ontario, Canada. The campaign was developed and implemented by the African and Caribbean Council on HIV/AIDS in Ontario (ACCHO) between 2006 and 2009.

The objectives of the KIA campaign were to:

1. Raise awareness about HIV among ACB communities in Ontario
2. Promote safer sex and HIV testing
3. Reduce HIV-related stigma within ACB communities
4. Raise the profile of ACCHO, a newly formed organization at the time

The KIA campaign targeted ACB communities in Ontario, specifically in Toronto, Ottawa, London, Windsor, Peel Region, Hamilton and Thunder Bay. The campaign was designed around universal values of family, self-respect, friendship, love, potential, and pride. Its materials (particularly the posters and postcards) encouraged individuals to adopt various action-oriented responses to HIV, such as getting tested for HIV, speaking with their children about HIV and health, and using condoms. In addition, the materials encouraged people to get more information about ACCHO and HIV by visiting the ACCHO and Keep It Alive! websites.

The KIA campaign was developed in two phases. The first phase, officially launched in the spring of 2006, was the creative development, which began with the formation of the campaign committee consisting of ACCHO members. Subsequently, the campaign committee worked with a communications company, a public relations firm and a campaign coordinator to develop the campaign theme, content, messages, materials and dissemination strategy. The campaign featured advertisements on bus shelters, in public transit systems, in community newspapers, and on radio. It was also featured on posters, postcards, t-shirts, and condom packs. The campaign also included community engagement activities at popular community events where ACCHO members distributed campaign materials and exchanged information about the campaign and HIV with ACB community people.

The second phase of the campaign, which was a team effort like the first phase, was launched in January 2007. In addition to the post cards and posters from phase 1, it included 9 TV public service announcements (PSAs) that featured ACB community members speaking about HIV and AIDS to their significant others and/or communities. The PSAs aired from February to March 2007 and were re-run in the summer of 2007. The advertisements addressed HIV prevention and stigma, and sought to mobilize support, treatment and care. All stages of the development of the KIA campaign were community-driven and featured members of the ACB communities.

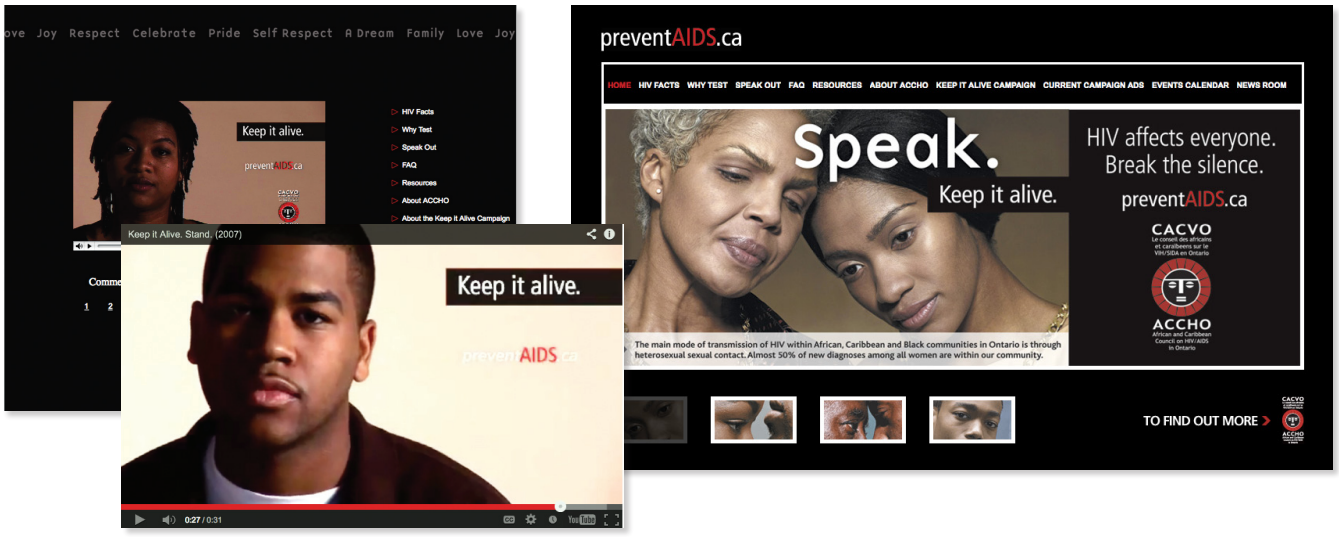
1.2 Media campaigns in perspective

Since the beginning of the global HIV/AIDS movement in the mid 1980s, organizations, activists, and government institutions have utilized mass media campaigns to generate awareness of HIV and promote HIV prevention (Noar et al., 2009; Myrhe and Flora, 2000; Spieldenner and Castro, 2010). In Canada, the Federal Initiative to Address HIV/AIDS identified social marketing initiatives as key components to increasing public awareness about HIV/AIDS and encouraging greater access to HIV/AIDS services among those who are part of "hidden populations" (PHAC, 2004). While the earliest HIV prevention campaigns emerged from an environment of public health urgency (Myrhe and Flora, 2000) and focused on raising awareness of the disease, recent campaigns have shifted focus towards promoting behaviour change within specific vulnerable communities (Noar et al., 2009).

Mass media campaigns vary in scale, scope, tools, reach, and financial resources (Myrhe and Flora, 2000). HIV/AIDS social marketing campaigns are generally educational, in that they provide information about HIV and encourage people to practice safer sex, get tested for HIV, or access appropriate services (Spieldenner and Castro, 2010). However, some campaigns are (or aim to be) more controversial than others. Moreover, some campaigns appear to inspire fear as a motivation for behaviour change, while others are more inspirational.

AIDS service organizations (ASOs) in Canada have launched several social marketing campaigns that have targeted various communities such as the national "Think Again" (Trussler and Marchand, 2005) and provincial (Ontario) "Be Real" (Ross and Rynard, 2007) campaigns for men who have sex with men (MSM), and the "Wrap it Right" campaign for South Asian gay men in Toronto. In recent years, specific campaigns catering to ACB communities in Toronto have also been created by the Black Coalition for AIDS Prevention. These campaigns include "One Night, Your Choice" for young, sexually diverse Black women, and the "Think" campaign for young Black MSM.

In the early 1990s, the World Health Organization (WHO) identified mass media campaigns as important to reducing the spread of HIV/AIDS (WHO, 1992). Although social marketing campaigns have continued to evolve, there is a dearth of systematic research examining their impact (Myrhe and Flora, 2000). At a minimum, ongoing assessments of previous campaigns should inform new ones (Myrhe and Flora, 2000; Noar et al., 2009).



1.3 The Evaluation

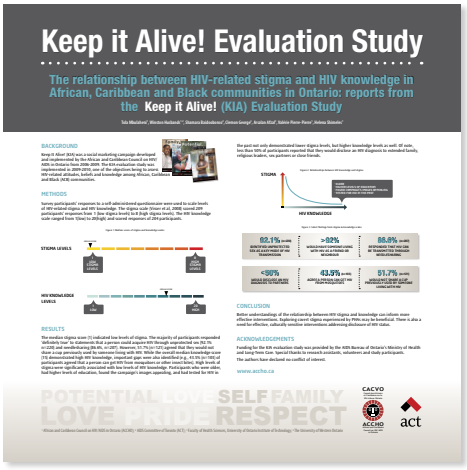
The KIA evaluation study was implemented in 2009-2010 in order to assess how the KIA campaign was received and understood by ACB communities and to assess community knowledge, attitudes, and behaviours related to HIV. The study involved a survey and focus groups among ACB communities in Toronto, Ottawa and London.

The specific objectives of the evaluation were to:

1. Determine the level of exposure to the KIA campaign in ACB communities;
2. Examine the correlates of exposure to the KIA campaign;
3. Examine the association of the level and type of exposure to the KIA education campaign with individuals': (a) awareness of HIV/AIDS as an issue for ACB communities; (b) willingness to discuss HIV/AIDS; and (c) HIV testing;
4. Assess the perceived importance of education messages received from the KIA campaign;
5. Identify individual and community reactions to and assessments of the KIA campaign.

The evaluation protocol received ethics approval from the Research Ethics Board at the University of Ontario Institute of Technology. The evaluation consisted of a survey and focus groups among ACB communities, and a focus group with HIV service providers from agencies that work with ACB communities in Toronto. In London and Ottawa, the Regional HIV/AIDS Connection (formerly known as the AIDS Committee of London) and AIDS Committee of Ottawa (ACO), respectively, assisted the KIA research team with hiring and providing offices for research assistants and facilitated data collection. The Toronto segment of the evaluation was implemented entirely through ACCHO. In all three cities, research assistants played an important role in outreach, recruitment of survey and focus group participants, and supporting data collection.

Survey and focus group participants were recruited from a variety of sites and events frequented by ACB communities, including barbershops/salons, universities, cafés, community events, agencies, community organizations, churches, and restaurants. Participants in the focus group for service providers in Toronto were recruited through ACCHO's membership networks. Survey and focus group participants were African, Caribbean or Black, except for a few participants in the focus group for service providers.



Survey questionnaire

Overall, 243 self-administered questionnaires (197 in English and 46 in French) were completed in Toronto (n=94), London (n=75), and Ottawa (n=74) between September 2009 and March 2010. Participants received an honorarium for their involvement in the study. Survey data were analyzed using SPSS (version 18) and SAS statistical software (version 9.2).

The questionnaire was designed to assess:

- Socio-demographic characteristics (i.e., age, gender, HIV testing, etc.)
- Visibility of the KIA campaign images and TV PSAs
- Impact and appeal of KIA campaign images and TV PSAs
- HIV-related stigma
- Knowledge of HIV transmission
- Willingness to disclose HIV status

Furthermore, poster images and screenshots of the TV advertisements from the KIA campaign were provided in the questionnaire to aid participants in recalling or assessing:

- Whether participants saw the campaign and how often
- Where they saw the campaign and in what format (e.g., TV ad, print media, radio, etc.)
- Whether they had conversations with anyone about the campaign
- Whether they found the campaign appealing
- Whether the campaign increased awareness that ACB communities in Ontario are affected by HIV/AIDS
- What key messages were drawn from the KIA TV PSAs
- How important the KIA campaign was/is for ACB communities in Ontario

The HIV-related stigma scale (Visser et al 2008) was included to measure attitudes and beliefs about HIV/AIDS. The HIV-related knowledge scale assessed participants' understanding of HIV transmission; the scale was adopted from the Centers for Disease Control National Health Interview questionnaires (1988) and modified by Leake et al (1997). Lastly, we measured participants' willingness to disclose HIV-positive status by posing a hypothetical question – If you found out that you were HIV positive, who would you tell?

Focus groups

We conducted seven focus groups with 48 participants as follows:

- Toronto (two focus groups): youth aged 16-24 (n=11), service providers who work with ACB communities (n=8);
- London (two focus groups): men (n=7), women (n=5);
- Ottawa (two focus groups): men (n=7), women (n=6 Francophone/French-speaking women);
- Four people living with HIV/AIDS (PHAs) participated in a separate focus group. All four were affiliated with ACCHO. We did not ascertain the serostatus of participants in the other focus groups.

In the focus groups, we were interested in learning from participants:

- Whether they saw the campaign materials
- Their impressions of the campaign
- Whether the campaign affected how they thought about HIV/AIDS in ACB communities in their city
- Whether they understood the messages
- Whether the campaign made the issue seem important
- Whether the campaign appealed to them and to ACB people in their city
- Their advice for an organization wishing to do a similar campaign.

All focus group discussions were audio-recorded and transcribed, and the transcriptions were coded thematically using NVivo 8 software.

1.4 Limitations

Study participants were recruited through convenience (or opportunity) sampling since it was impossible to establish a sampling frame from which to draw a representative sample. Participants were recruited from sites and events frequented by ACB people. As such, it should be noted that the results from our study cannot be generalized as representative of the entire ACB population in Ontario or the three cities where the research was implemented.

While the survey questionnaire explored a range of questions about whether participants had seen the campaign, we did not include a question about participants' opportunity to see or access the campaign at various sites through various media. For example, people who do not watch television or listen to a particular radio station on a regular basis would have little opportunity to encounter the campaign through those media. This way of filtering the data might have improved our understanding of whether the campaign achieved its intended reach. Additionally, the survey questionnaire did not include a question about sexual orientation or HIV status (although there was a question about whether participants had ever been tested for HIV).

Another limitation worth mentioning is that focus group participants were only invited to comment mainly on the KIA images (visual and print PSAs). Hence, feedback about the KIA TV PSAs is not reflected in the focus group discussion findings. In the survey design, screenshots of the KIA TV PSAs were printed in the questionnaire which may not have adequately helped participants recall whether they saw the TV advertisements.

2. KEEP IT ALIVE! EVALUATION FOCUS GROUPS

Table 1 presents a profile of focus group participants except for the eight service providers who participated in a separate focus group.

Most of the eight service providers who participated in the Toronto service providers' focus group came from community-based health agencies (e.g., ASOs, community health centres, etc.), except for one participant who worked in a program at a large hospital. All of the agencies had a record of service to ACB communities.

We have organized the focus group findings as follows:

- How KIA was received and understood
- Perceptions and beliefs related to HIV
- How PHAs responded in comparison to other focus group participants
- Informing future campaigns
- Identified factors associated with implementing effective HIV campaigns for ACB communities
- Barriers to implementing effective HIV campaigns
- Parallels with previous studies conducted by ACCHO and its partners

Regarding the last category, relevant findings from other studies conducted by ACCHO and partners are also incorporated in this section to assist with contextualizing what we learned in this evaluation. The two studies that will be referenced are MaBwana: Health, Community and Vulnerability to HIV among African, Caribbean and Black Gay and Bisexual Men in Toronto (Husbands et al., 2010) and HIV/AIDS Stigma, Denial, Fear and Discrimination: Experiences and Responses of People From African and Caribbean Communities in Ontario (Gardezi et al., 2008). In the MaBwana Study, participants were also asked to provide feedback about the Keep it Alive! campaign materials. Additionally, the Stigma Study, in part, explored the systemic and societal challenges that ACB people experience in accessing appropriate sexual health services and HIV-related information, particularly for people living with HIV/AIDS.

2.1 How KIA was received and understood

Captivating, distracting, conflicting

"[Our agency] was stunned at how beautiful they were. They were actually really lovely pictures, really polished. We were like 'wow this is very beautiful'." (Toronto service provider)

The KIA campaign committee wanted to portray ACB people as self-aware, confident and capable, in opposition to the general trend in media portrayals that fixates on sadness, helplessness and confusion. KIA presented an opportunity for ACB people to portray and represent themselves to their own communities.

Overall, focus group participants were impressed with the quality of the KIA campaign posters and they complimented the attractiveness of the images. Several participants felt that the visual attractiveness of the campaign materials may have overshadowed the HIV prevention messages.

"…You can't get past the image so I'm thinking like the images for the ads are powerful but I guess they're a bit too powerful if people are not actually getting to the message…." (Ottawa male participant)

For some participants, the images of apparently healthy people in the posters contradicted traditionally held notions of HIV as an illness.

"…Usually when I hear AIDS or people who are HIV-positive …we immediately think of the negative things like death and hurt. Then Keep It Alive!…it's like they don't match with each other [they conflict]." (Toronto youth participant)

While it is necessary to acknowledge that people who are HIV positive may not show any obvious signs of their serostatus, focus group participants suggested that it is also necessary to raise awareness of the harmful realities associated with living with HIV. For some people, HIV should have been visible through obvious signs of ill health and the challenges associated with drug therapies.

Table 1. Socio-demographic profile of ACB focus group participants*

	Ottawa		Toronto**		London		PHAs***		Total	
Sex	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Men	7.0	53.9	5.0	55.5	7.0	58.3	1.0	25.0	20.0	52.6
Women	6.0	46.1	4.0	44.4	5.0	41.7	3.0	75.0	18.0	47.4
Total	13.0	100.0	9.0	100.0**	12.0	100.0	4.0	100.0	38.0	100.0
Age	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
16-19	0.0	0.0	1.0	11.1	1.0	14.3	0.0	0.0	2.0	5.6
20-29	5.0	38.5	8.0	88.9	1.0	14.3	0.0	0.0	14.0	38.9
30-39	5.0	38.5	0.0	0.0	0.0	0.0	3.0	75.0	8.0	22.2
40-49	1.0	7.7	0.0	0.0	2.0	28.6	1.0	25.0	4.0	11.1
50 +	2.0	15.4	0.0	0.0	6.0	42.9	0.0	0.0	8.0	22.2
Total	13.0	100.0	9.0	100.0	10.0	100.0	4.0	100.0	36.0	100.0
Place of Birth	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Africa	6.0	46.1	1.0	11.1	8.0	66.6	2.0	50.0	17.0	44.7
Caribbean	2.0	15.4	1.0	11.1	2.0	16.7	2.0	50.0	7.0	18.4
Canada	5.0	38.5	6.0	66.7	1.0	8.3	0.0	0.0	12.0	31.6
Other	0.0	0.0	1.0	11.1	1.0	8.3	0.0	0.0	2.0	5.3
Total	13.0	100.0	9.0	100.0	12.0	100.0	4.0	100.0	38.0	100.0
Time in Canada (If foreign born)	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
2 years or less	3.0	37.5	0.0	0.0	1.0	14.3	0.0	0.0	4.0	14.8
3-5 years	0.0	0.0	0.0	0.0	4.0	28.6	3.0	75.0	7.0	25.9
More than 5 years	5.0	62.5	3.0	100.0	7.0	57.1	1.0	25.0	16.0	59.3
Total	8.0	100.0	3.0	100.0	12.0	100.0	4.0	100.0	27.0	100.0

*This table does not include the service providers who participated in a separate focus group. The service providers came from a range of agencies that work with ACB people in Toronto. Percentages may not add up to 100% due to rounding.

**There were 11 participants in the youth focus group, but two participants did not provide socio-demographic information.

***This column refers to a separate focus group that was held for PHAs exclusively. We did not collect data on the serostatus of participants in the other focus groups.

"…The individual comment I heard … was 'this isn't real, for someone coming from Africa it's not real'. They [KIA campaign] are using people who are healthy to advertise but … where do they find people who are sick to advertise who want to talk about it? [She said] 'this doesn't really make impact, for me, it doesn't really make impact because they don't know what it is. These people are healthy.' That's what she said…." (Toronto service provider)

Subtle, empowering, values-based

The campaign materials all mentioned HIV and AIDS, and were also designed to draw viewers to the ACCHO and KIA websites. However, the words "HIV" and "AIDS" did not dominate the text of the posters. Several participants indicated that it wasn't immediately obvious to them that the KIA images were connected to HIV prevention. Participants gravitated towards the values ascribed to each poster (love, pride, self-respect, potential, etc.) and often interpreted KIA as being an empowerment campaign.

"…I do not associate these words with HIV, like pride… [or] potential. So it is linked to prevention, yes, but I am not able to see the link but I understand that the words are important. But I do not make the link with prevention." (Ottawa female participant)

"…I was like 'okay she's telling girls to respect themselves and make sure all people respect them too'. It didn't really capture my attention that it's for AIDS…." (Ottawa male participant [See Appendix 1a for "Self-Respect" KIA poster])

Some participants perceived the prevention messages as being too subtle. They suggested that more risks should have been taken in delivering prevention messages that explicitly use the words HIV and AIDS. Often, participants compared prevention campaigns taking place in Canada with bolder campaigns that they recalled from "back home".

"You have to mention the word HIV/AIDS, period. Without mentioning it, it doesn't look like a campaign for HIV/AIDS." (London male participant)

"…In Africa, they can allow to put condoms, in bold the word HIV, protection. Why here …do they hide behind words?" (Ottawa female participant)

Not all participants felt this way. A few participants described a subtle approach to delivering campaign messages as being more "intriguing" for audiences, which may lead them to proactively seek out further information to learn more. Participants also felt that, due to the stigma associated with HIV, the explicit use of the words HIV and AIDS could deter people from recognizing the benefits of the campaign.

"I think the most common, the most successful campaigns are the ones that are subtle, the ones that detour to the subject." (Toronto youth participant)

"I think the whole message was just to capture a person's attention because AIDS or HIV was too big or they would probably breeze over it and not even look 'okay you know it's not really talking to me there's a black figure on this poster but....'" (Toronto service provider)

"I think rebranding of it because AIDS has a negative stigma and if we take out AIDS and just put prevent.ca people wouldn't know, but when they go to the website they will be revealed to it." (Ottawa male participant)

Participants often described the campaign as a refreshing Black empowerment campaign, portraying Black people in a positive light. Often, the perspectives shared by PHA participants extended beyond perceiving KIA as just a "feel good campaign," to recognize that the KIA messages were invaluable to newly diagnosed PHAs.

"…It does encourage people to get tested and it touches on all the points that you know someone who maybe have just been diagnosed, the things that they worry about…am I going to lose my friends? How will my family react? Am I going to be loved? And what about my life? Do I still have potential you know, and of course your pride, your dignity - everything is attached. So I think the posters touched on everything that someone might be afraid of when it comes to getting tested and stuff like that to show, you know what, all those points that you're afraid of, it can be okay…." (PHA participant)

"…It gives hope to people to say life can go on, you're still alive…you can still have your normal life, have friends, have family, have love, all that is possible…." (PHA participant)

The values ascribed to the campaign posters (i.e., love, family, self-respect, pride and potential), were described by some participants as those that are easily identifiable to members of the ACB communities and to the "Black experience." Participants identified that the campaign effectively utilized these values to appeal to ACB communities:

"Sometimes there's a tendency to allow the mainstream to determine campaigns. But, I think it was a good thing that Keep it Alive! stuck to the interests and values of the community…." (Toronto service provider)

Targeting African, Caribbean and Black people: Necessary but challenging

Some focus group participants voiced reservations about a campaign that directly targeted ACB people. Often, participants were concerned that HIV would be perceived as a Black or African disease.

"I would want it to not to be thought in the big community that only Black people have AIDS…." (London female participant)

"…This attracts my attention because in Ottawa we do not really see images of Black people. So, I was intrigued. But also when you begin to think a bit further and you see that why it is only images of Black people that you see, you start to ask the question. Then you begin to consider the look of others and to say yes well…." (Ottawa female participant)

"I don't want it to center us out." (London female participant)

"… Someone from my community… [said] I don't really like that…we hear that HIV/AIDS is rampant in the African, Caribbean, Black communities and those pictures are just confirming that and further fuelling stigma so I just said to them you know we have to tell it as it is. It's a big problem. So there is that issues that I heard from some people." (Toronto service provider participant)

At the same time, KIA focus group participants often expressed feeling comforted by the fact that the campaign was created and implemented by ACB people.

"The reason why I like ACCHO is because you know, Black people for Black people and it makes me personally feel comfortable because these are people who understand where I am coming from who are like me versus somebody who's not like me trying to cater to me…." (PHA participant)

2.2 Perceptions and beliefs related to HIV

Impact of HIV/AIDS in Canada: uncertainty and detachment

Some focus group participants tended to distance themselves from being associated with HIV/AIDS. The underlying message found in these responses was "if HIV is not in my circle, why should I be concerned?" There was also a sense of skepticism about whether HIV is really a problem for ACB communities in Canada.

"…It affects Black people and I know that there must be Black people that have AIDS… but, I don't personally know Black people that have AIDS…." (London female participant)

"…Where's the motivation coming from, you know? If it's not really affecting me, do I really need to know more about it?" (Ottawa male participant)

Participants expressed uncertainty and curiosity about the experiences of people living with HIV. With the exception of participants in the PHA and service provider focus groups, participants expressed a lack of understanding and awareness about life after an HIV diagnosis.

"…Where…[is]…the information to say okay this is what you should do or could do once you're tested and find out you're positive …it's not just 'wear a condom so you don't get infected' and leave it at that…." (Toronto service provider)

"I don't see myself being in a physical relationship with someone who is HIV positive…ohh, it is so bad to think this way, but what if the condom breaks?... Why would I put myself in that situation if I can save myself, right?" (Toronto youth participant)

2.3 How People Living with HIV responded

In the focus group for PHAs, several themes emerged that were aligned with what was raised in other focus groups. However, there were also very distinct responses to the KIA campaign that were not heard elsewhere. These similarities and differences are summarized in Figure 1.

Overall, PHA focus group participants demonstrated a more nuanced understanding of HIV/AIDS and its impact on members of ACB communities. Similar to other focus group participants, PHAs found the campaign posters to be quite attractive; however, unlike the other participants, most PHA focus group participants interpreted the models in the campaign posters as people living with or affected by HIV.

"...Like the family one, just a regular family that maybe they have a brother who's not in the picture who is affected [by HIV] but, it still kept the family together. Maybe one of them is infected but we don't know which one." (PHA participant [See Appendix 1b for "Family" KIA poster])

"...They have this image of HIV and what people with HIV are supposed to look like and I think these pictures will break that. It's also supposed to get them to say "oh okay" these people could have It...people still go around trying to figure out with their eyes what HIV looks like and they don't protect themselves because they think they can see it...but it's changed, it's changed like me the way I look nobody would tell from seeing me." (PHA participant)

PHA focus group participants identified strongly with the Keep it Alive! slogan and the messages of its values (e.g., love, family, pride, etc.). As mentioned, these values were often associated with desirable life goals that can be attained despite an HIV positive diagnosis. PHA participants also attested to the need for stronger and more explicit HIV prevention messaging which was echoed by other focus group participants.

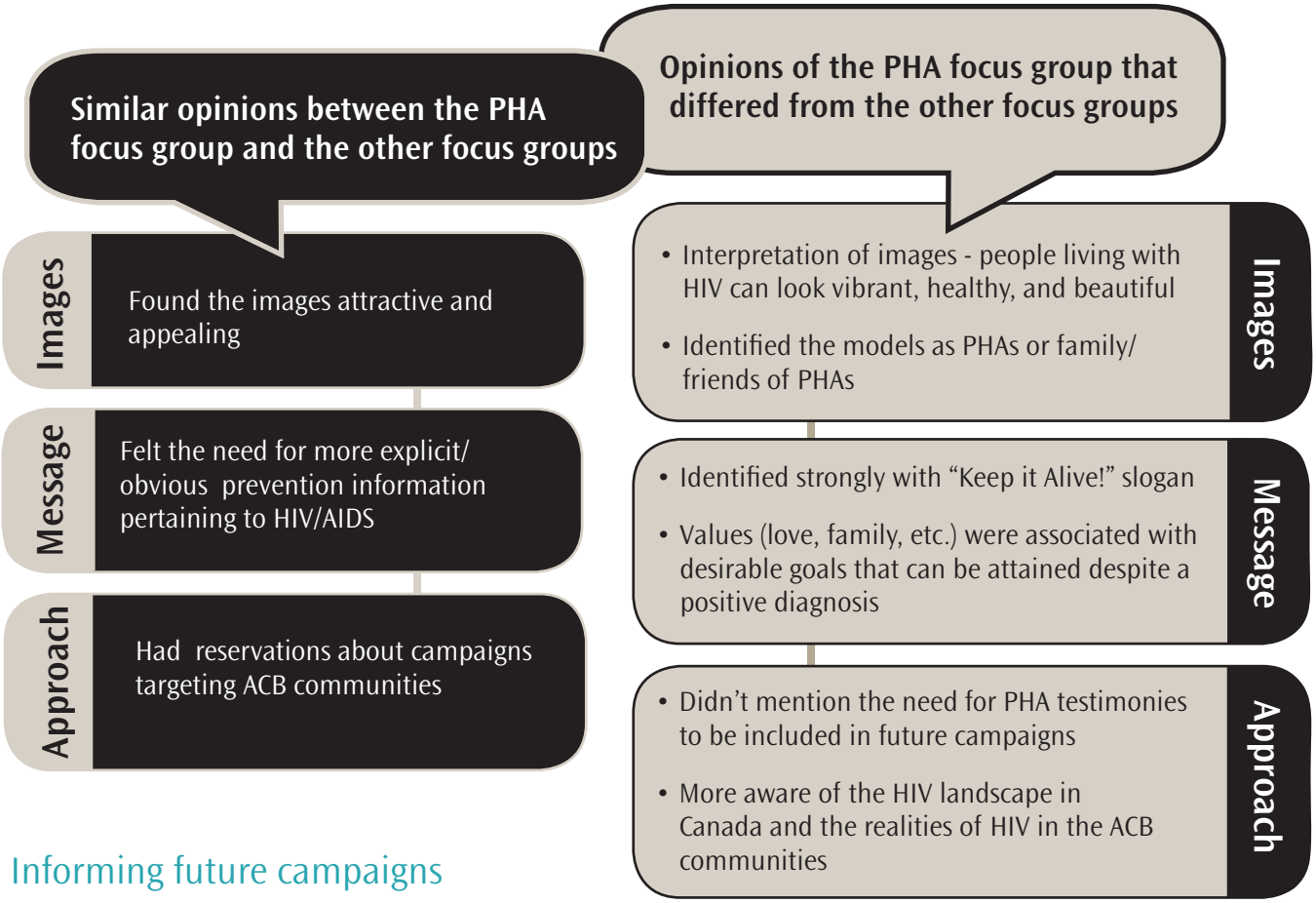
Interestingly, there was also contention among PHA focus group participants about whether a campaign that targets ACB communities is an effective prevention strategy. Concerns regarding perpetuating HIV-related stigma among ACB communities were raised.

"...Sometimes African people see it as are they saying only Black people have AIDS now…so there is a negative impact also…but I'm not sure how we deal with that." (PHA participant)

"…We need to target the Black community. We need to help ourselves because if it is affecting us and people are not talking about it no one is going to help us if we don't help ourselves." (PHA participant)

While other participants, particularly youth focus group participants, described the need to hear the testimonies of people living with HIV, this was not raised by PHA focus group members. In fact, PHA focus group participants emphasized that the experiences of people living with HIV *should* be conveyed in future campaigns as an effective educational strategy. This distinction – between hearing the testimonies of PHAs, and conveying the experiences of PHAs – may prompt some consideration among ACCHO members about how or whether PHAs may publicly disclose their status in a social marketing campaign.

Figure 1. Summary of how PHAs responded similarly and differently from other focus group participants



2.4 Informing future campaigns

Providing facts, evoking "buzz", managing stigma

Participants were clearly interested in learning more about the landscape of HIV/AIDS in Canada and how ACB communities are affected. Participants recommended incorporating numerical data on HIV as a necessary way to conceptualize how HIV disproportionately impacts ACB communities in Canada.

"…Sometimes people are intrigued by numbers… Prevention but also awareness…." (Ottawa female participant)

"...If there was a fact you would be able to connect the image and the numbers...it would actually make me want to stop and read the poster again maybe once or twice so then I would do my own research after to get more information about what's going on." (Ottawa male participant)

Participants also recommended incorporating bolder images and messaging to capture people's attention in a media saturated environment. Some participants were wary of this idea, cautious about the potentially stigmatizing backlash that could result from this approach.

"…An image that's more controversial really catches your eye it's like 'oh my god what's that?'" (Ottawa male participant)

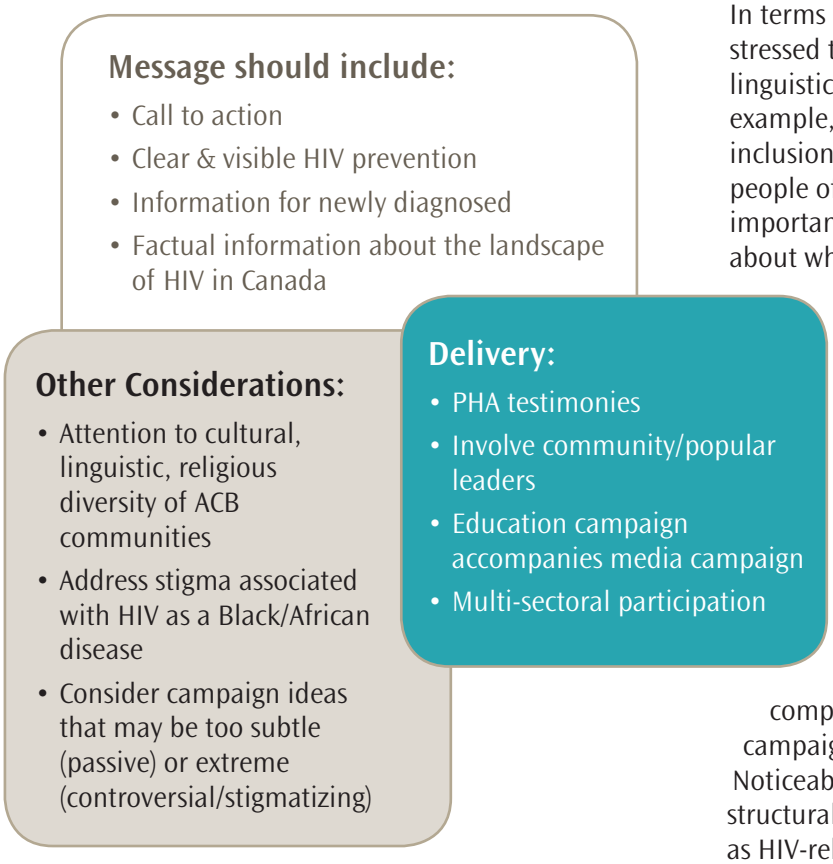
"The last thing you wanna do is scare people…because you have to be careful with your words…so I think we have to be very, very delicate in this because it's such a touchy subject…." (Ottawa male participant)

Factors identified with effective HIV campaigns for ACB communities

Overall, focus group participants generously provided numerous recommendations for future prevention campaigns serving ACB communities (Fig. 2).

With regards to messaging, participants suggested that the messaging in future campaigns should include a clear call to action or motivation to act, such as "know your status." While a straightforward HIV prevention message was cited as important, participants also indicated that including information for newly diagnosed PHAs is essential for a campaign such as "Keep it Alive!". Participants described the need to include more factual and local (i.e., Canadian) information regarding the impact of HIV/AIDS within ACB communities.

Figure 2. Recommendations for effective HIV campaigns for ACB communities



In terms of the delivery of future campaigns, participants (except those in the PHA focus group) often described the need for testimonies from PHAs to be included to shed light on the lived experiences of people living with HIV. It was also suggested that popular leaders be involved in delivering prevention messages in order to attract more attention to future campaigns. Participants also recommended that future campaigns should include HIV education at community events (though community engagement had been a key strategy for disseminating KIA campaign materials and generating dialogue with ACB people about HIV/AIDS, ACCHO and the campaign). Lastly, participants described the need for multiple organizations and community partners outside of AIDS service organizations to be involved in outreach and dissemination activities in future campaigns. ACB communities access multiple sites and services outside of ASOs such as community centres, clinics, cultural centres, and faith-based institutions that present opportunities for meaningful community engagement.

In terms of other considerations, focus group participants stressed the need for greater attention to the cultural, linguistic and religious diversity of ACB communities. For example, a key issue which was raised was the lack of inclusion of diverse Caribbean communities (e.g., Caribbean people of South or South East Asian heritage). It is also important to take into consideration and think critically about whether campaign materials may be perceived as stigmatizing to ACB community members. When developing prevention campaigns, organizations should strive to achieve a balance between campaign messages that may appear to be too passive or even too subtle, and those that may be too aggressive and potentially stigmatizing.

Barriers to implementing effective HIV campaigns for ACB communities

Focus group participants outlined numerous competing variables and barriers preventing effective campaign outreach and implementation (Table 2). Noticeably, many of the identified barriers are systemic or structural in nature and take into consideration issues such as HIV-related stigma, social isolation, institutional barriers, and media focus on HIV in Africa while concurrently

rendering HIV invisible in Canada. Participants felt that campaigns may be ineffective if sufficient people do not have access to the Internet. Also, participants described that people are often in a hurry and might miss the campaign.

Table 2. Identified barriers to implementing effective HIV campaigns

HIV-related stigma	"...It seems to be a problem....where to go to get tested and how...again culturally it's all about privacy it's all about shame, blame, judgment ...because the community seems so small [that] people are nervous because they're gonna go somewhere where they know somebody..." (Toronto service provider)
Social isolation	"...There are [HIV positive] people that are hiding." (Ottawa female participant)
Institutional barriers	"...There are some schools where you go you are not allowed to talk about condoms. And if you give your speech or whatever, it is so guided on what you should say but then you know these kids they will say 'what about condoms?'...." (Toronto service provider)
Media focus on HIV in Africa	"...The media discredits us. At every moment when they talk about HIV, it is Africa, it is Africa...." (Ottawa female participant)
HIV is hidden in Canada	"...I noticed it right away from being in Canada ...I don't see it on TV, I don't see billboards, I don't. It's not talked about. It's like its only talked about within our own communities, our own agencies...I know the information is out there for those who want to go get it but...I feel like there should be more of it, everywhere." (PHA participant)
People are in a hurry	"...There are so many other things that are competing for my attention that if they don't get me right away something else will." (Ottawa male participant)
Limited Internet access	"...You need something to call, if they don't have a computer at home to go search for information on HIV and AIDS...." (Toronto service provider)

2.5 Parallels with the MaBwana and Stigma studies

The Stigma Study (Gardezi et al., 2008) and the MaBwana Study (Husbands et al., 2009) presented similar narratives regarding perceptions and beliefs related to HIV and how the KIA campaign was received and understood. In the MaBwana Study, participants were invited to provide their interpretations of a particular campaign image addressed to Black gay men. The Stigma Study aimed to explore HIV-related stigma, fear, discrimination and their impact in the lives of ACB people living with HIV and their communities. Although the Stigma Study was released before the KIA campaign was launched, there are several parallels found between the Stigma Study and our evaluation study.

MaBwana Study

Similar to the findings in this evaluation and the Stigma Study, MaBwana study participants felt that the visibility of HIV campaigns in Canada paled in comparison to prevention campaigns in their countries of origin, which were thought to be much bolder:

"…Like from my country it was always so in your face, always so pronounced." (MaBwana Study participant [Husbands et al. 2009, 'p. 66])

Also similar to both studies, concerns related to the KIA campaign perpetuating HIV-related stigma and its connection to Black communities were raised in the MaBwana Study:

"I almost felt like it [KIA] was propaganda from the white community…I always just assumed it was the white community trying to push away and say [HIV is] like a Black thing again, or it's Black people, they just don't know any better…." (MaBwana Study participant [Husbands et al. 2009, p. 67])

The idea of refusing to have a sexual relationship with someone who is HIV-positive (which was voiced by youth participants in the KIA evaluation), was also raised by a MaBwana participant:

"...If I know somebody is positive, I wouldn't want to have sex with them and I'm not discriminating, but prevention is better than cure and you can go have sex with them and the condom break and then you get infected. So fi prevent that now me personally prevent that; mi just don't go in there. I mean mi no scorn them, mi no scorn people who HIV positive mi no scorn them; me deal with them normally just like people, it depends but fi mi dae tighter with somebody if me have a partner and then mi find out say him positive it different it different inna that case...." (MaBwana Study participant [Husbands et al., 2009, p. 53])

Similar to KIA focus group participants, some MaBwana participants could not reconcile what they regard as the facts about HIV (i.e., HIV is a debilitating condition), with the reference to love, potential and similar values portrayed in KIA:

" …When I have to sit in a room and hear about, you know, the resources that are available and, and the real stuff, not the nice, but the hardcore facts, and when I heard someone talk about, you know, the problems they have to bear and all the medication, and what it is doing to their system 'Woah' you know." (MaBwana Study participant [Husbands et al., 2009, p. 65])

Stigma Study

For Stigma Study participants (Gardezi et al, 2008), the impact of HIV/AIDS in Canada was not always understood or felt. Participants echoed the sentiment that not personally knowing someone who was HIV-positive contributed to their level of skepticism and detachment from the issue. This also contributed to the belief that certain cultures or communities are inherently less vulnerable to HIV:

"… I haven't seen a Somali person who's HIV positive. That creates something of a myth. Like, everybody's talking about HIV, but practically, I haven't seen anyone who's HIV positive. So what are they talking about? Anybody in the community who gets this [positive HIV] test would go underground. That is their right to be that way, but that creates a problem of no practicality, just theory. So that is why a lot of people in the community believe it doesn't happen to Somalis…" (Stigma Study focus group participant [Gardezi et al. 2008, p. 20])

Participants from the Stigma Study also maintained that the lack of visibility of HIV/AIDS as an issue in Canada, in comparison to "back home", contributes to assumptions that HIV is not an issue in Canada.

"[In Ethiopia] every day the radio, the TV, they talk about it and people [are] dying every day. But here they think there is not HIV because they never talk about it. … The TV, the mass media is more powerful here. If they talk about HIV maybe people [will say] 'oh, still here in Canada.' But when they come from Ethiopia they think there is not HIV here. That fools a lot of young people." (Stigma Study interviewee [Gardezi et al. 2008, p. 21])

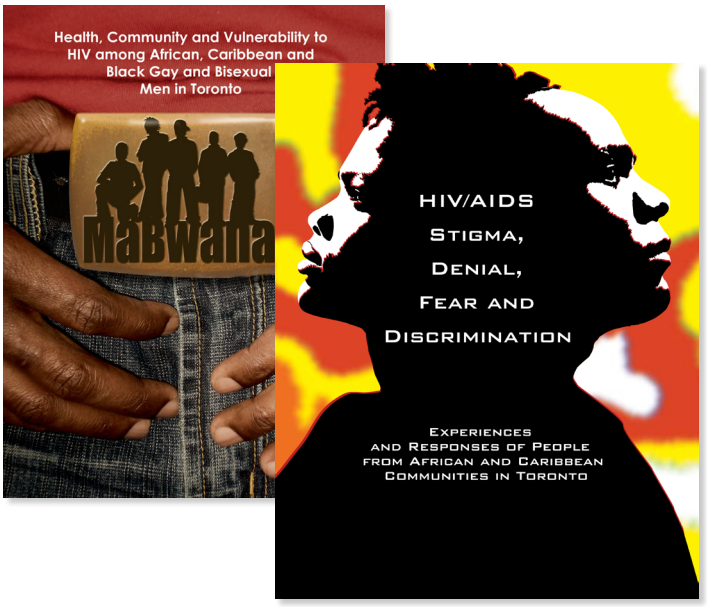
Concerns about HIV/AIDS being perpetuated as an African/Black disease were also raised in the Stigma Study:

"I think part of the denial around HIV, the reason why the mainstream Black community doesn't want to deal with it, is because AIDS has been portrayed as something from Africa. And like, well, they don't want the community, the mainstream world, the European white world, to pin this on Black people. So there's a sort of [view that] it's homosexual and it's from sin. It's not from Africa." (Stigma Study focus group participant [Gardezi et al. 2008, p. 28])

One of the barriers to seeking health and support services for PHAs mentioned in the Stigma Study was fear of being seen and having one's HIV status revealed. As a result, PHAs who participated in the Stigma Study cited that they often cut themselves off from others in their community, thereby isolating themselves. In the KIA evaluation study, isolation also emerged as a barrier that hindered people from accessing HIV prevention campaigns.

"I'm scared to go places that people don't really know me because then sometimes I'm thinking, they're looking at me, they probably know that I am [HIV positive]. I just don't want to think because of the way I've been treated. Like, it scares me. So I don't tend to go anywhere really." (Stigma Study interviewee [Gardezi et al. 2008, p. 32])

Another finding from the Stigma Study that parallels our findings is the lack of knowledge about what it is like to live with HIV and how to avoid the practice of stigmatizing HIV positive people. While the participants from the KIA evaluation study noted that this lack of knowledge prevented them from judging the importance of the issue, Stigma Study participants had expressed how the lack of knowledge about HIV and PHAs may exacerbate stigma and community silence.



Appendix 2 provides a socio-demographic profile of the 243 survey participants. We note that:

- 58.9% indicated that they were female, 41.1% were male;
- Most (52.0%) were young (i.e. 29 yrs or younger), and 48.0% were 30 and older;
- Half of all participants (50.6%) were born in Africa, and slightly more than one-quarter (25.6%) were born in the Caribbean;
- Most (59.8%) had previously tested for HIV;
- Of those who were born abroad, most (57.8%) had lived in Canada for more than 5 years;
- More than one-third (35.0%) rated their health as excellent, and a roughly similar percentage (36.6%) as very good (i.e., close to three-quarters of survey participants rated their health as excellent or very good); only 1.2% rated their health as poor ; and
- One-third (33.8%) had completed college or university, and a further 25.7% had some college or university.

3.1 Visibility, appeal, awareness, and importance

Visibility

Overall, two-thirds (66.3%, n=157) of the survey participants indicated that they saw the KIA campaign images (Table 3), though the images were more likely to have been seen in London and Toronto.

Table 3. Visibility of KIA images, by city

Did you see the KIA campaign images?	Ottawa		London		Toronto		All Participants	
	N	%	N	%	N	%	N	%
Yes	36.0	50.0	55.0	77.5	66.0	70.2	157.0	66.3
No/not sure	36.0	50.0	16.0	22.5	28.0	29.8	80.0	33.7
Total	72.0	100.0	71.0	100.0	94.0	100.0	237.0	100.0

χ^2(2 d.f.[1]) =13.15, p=0.0014

[1] d.f.-degrees of freedom

Appeal of KIA Images

Among participants who saw the KIA images, more than two-thirds (68.9%) reported that the images were appealing, although there were significant differences between cities (Table 4). Participants from London and Ottawa were more likely to report finding the campaign images appealing than participants from Toronto.

Table 4. Appeal of KIA images by city

Did you find the KIA images appealing?	Ottawa		London		Toronto		All Participants	
	N	%	N	%	N	%	N	%
Yes	29.0	80.6	43.0	81.1	30.0	50.9	10.02	68.9
No/not sure	7.0	19.4	10.0	18.9	29.0	49.2	46.0	31.1
Total	36.0	100.0	53.0	100.0	59.0	100.0	148.0	100.0

χ^2(2 d.f.) =14.96, p=0.006

Awareness of HIV/AIDS by place of birth

More than half of all participants who saw the KIA images also reported that the campaign images increased their awareness of HIV/AIDS (Table 5). Participants born in Africa or the Caribbean seemed more likely to report that the KIA images increased their awareness of HIV/AIDS compared to participants who were born in Canada or elsewhere.

Table 5. KIA images increased awareness of HIV/AIDS, by place of birth

	Africa		Caribbean		Canada		Elsewhere		All Participants	
	N	%	N	%	N	%	N	%	N	%
Yes	38.0	53.5	20.0	69.0	23.0	50.0	2.0	20.0	83.0	53.2
No/DK	33.0	46.5	9.0	31.0	23.0	50.0	8.0	80.0	73.0	46.8
Total	71.0	100.0	29.0	100.0	46.0	100.0	10.0	100.0	156.0	100.0

χ^2(3 d.f.) =7.5144, p=0.0572 DK: Don't know

Awareness of HIV/AIDS, by age

Table 6 summarizes the results for the relationship between age and awareness of HIV/AIDS among those exposed to the KIA images Even though there is no significant relationship between age and awareness of HIV/AIDS, the data indicates that individuals who were older than 30 were more inclined to say that the campaign increased their awareness of HIV among ACB populations in Ontario.

Table 6. Whether KIA images increased awareness of HIV/AIDS, by age

	<20		20-29		30-39		40+		All Participants	
	N	%	N	%	N	%	N	%	N	%
Yes	20.0	45.45	27.0	47.37	13.0	76.47	23.0	60.53	83.0	53.0
No/DK	24.0	54.55	30.0	52.63	4.0	23.53	15.0	39.47	73.0	47.0
Total	44.0	100.0	57.0	100.0	17.0	100.0	38.0	100.0	156.0	100.0

χ^2(3 d.f.) =6.3555, p=0.0955 DK: Don't know

Where KIA campaign images were recognized

Participants who reported that they saw the KIA campaign images were also asked where or in what format they saw the campaign. Participants could indicate multiple responses. Responses indicate that the local public transit system was the number one site where they recalled having seen the KIA campaign images (Table 7). Participants also reported seeing the KIA images at an organization/agency (35.0%), in a poster (29.3%), at an event (19.1%), and as a postcard (14.0%).

Table 7. Where KIA images were recognized

Location	# of Respondents	% of Responses (N=291)	% of Respondents* (N=157)
Bus/ public transit	76.0	26.1	48.4
Organization/ agency	55.0	18.9	35.0
Poster	46.0	15.8	29.3
Event	30.0	10.3	19.1
Postcard	22.0	7.6	14.0
Billboard	17.0	5.8	10.8
Print ad	15.0	5.2	9.6
Can't remember	12.0	4.1	7.64
Other	18.0	6.2	11.5

*participants could choose multiple locations and/or formats

Important messages conveyed by KIA TV PSAs

We asked participants who reported seeing the KIA TV PSAs what they perceived to be the key messages conveyed. Participants could indicate multiple responses. Out of the 61 participants who saw the TV PSAs, 63.9% named "always use a condom when you have sex" and "preventing the spread of HIV/AIDS is everyone's business" as the top messages received from the KIA campaign TV PSAs (Table 8). Participants also named "HIV/AIDS is a growing problem for African, Caribbean, or Black people in Ontario" (60.7%) as the second most important message received from the KIA TV PSAs. Furthermore, "we should talk to our family and friends about HIV/AIDS" (49.2%) and "young people can get HIV too" (47.5%) were other key takeaway messages acknowledged by participants.

Table 8. Respondents' perceptions of key messages delivered by KIA TV PSAs

Message	# of Respondents	% of Responses (N=288)	% of Respondents (N=61)
Always use a condom when you have sex	39.0	13.5	63.9
Preventing the spread of HIV is everyone's business	39.0	13.5	63.9
HIV/AIDS is a growing problem for African, Caribbean or Black people in Ontario	37.0	12.8	60.7
We should talk to our family and friends about HIV/AIDS	30.0	10.4	49.2
Young people can get HIV too	29.0	10.1	47.5
People who are infected with HIV deserve care and support	27.0	9.4	44.3
Our African, Caribbean and Black communities in Ontario need to talk about HIV	27.0	9.4	44.3
There are services available to help people who are infected with HIV	24.0	8.3	39.3
Not only gay men get HIV	20.0	6.9	32.8
African, Caribbean and Black gay men should practice safer sex	16.0	5.6	26.2

Importance of KIA campaign

We asked survey participants, "In your opinion, how important was the Keep it Alive! campaign for African, Caribbean, and Black people in Ontario?" We excluded participants who indicated that they did not see the campaign images or TV advertisements. The importance of the KIA campaign was analyzed in relation to how participants responded to a separate question about whether they recognized the KIA images or TV PSAs. As shown in Table 9, 67.4% (n=118) of participants who were exposed to the campaign described the KIA campaign (images and TV PSAs) as being "very important" for ACB people in Ontario. However, participants who

recognized the images and PSAs were more likely to report that the campaign was "very important" for ACB people. Among the participants who recognized the images and PSAs 90.8% described the campaign as "very important" or "important" for ACB people in Ontario.

Table 9. Perceived importance of the KIA campaign, by exposure to KIA

	Recalled print images or TV PSAs		Could not recall print images or TV PSAs		Total	
	N	%	N	%	N	%
Very important	100.0	70.4	18.0	54.6	118.0	67.4
Important	29.0	20.4	3.0	9.1	32.0	18.3
Not important	3.0	2.1	0.0	0.0	3.0	1.7
DK	10.0	7.0	12.0	36.4	22.0	12.6
Total	142.0	100.0	33.0	100.0	175.0	100.0

χ^2 (3 d.f.) =21.8911, p<0.001

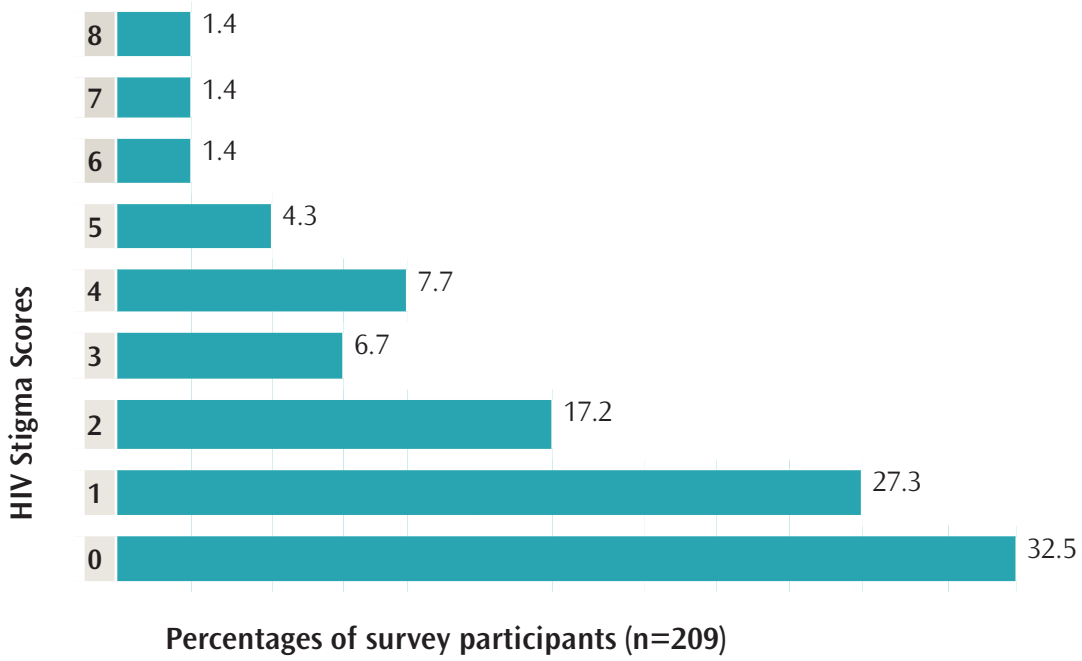
3.2 HIV-related stigma scale

HIV-related stigma scale items (Visser et al 2008) and the frequency of responses are shown in Table 10. HIV-related stigma was scored from 0 (low level of stigma) to 8 (high level of stigma). Overall, 209 participants completed all items in the stigma scale. The overall median score for the sample was 1 which indicates a low level of stigma. This is further illustrated in Figure 3. However, as demonstrated in the distribution of stigma scale responses by items in Table 10, there were some items where participants demonstrated higher rates of HIV-related stigma. These items in the HIV stigma scale presented issues that were more intimate or personal in nature in comparison to the other items. For example, over half of participants (51.7%) agreed with the statement "I would not drink from a cup if a person with HIV had just drunk from it", and over one-fifth (21.9%) indicated that they would feel "uncomfortable around people with HIV".

Table 10. Distribution of HIV-related stigma scale responses by item

	Item	Agree		Disagree		Total
		N	%	N	%	N
a.	I think getting HIV is a punishment	38.0	16.0	200.0	84.0	238.0
b.	If I was in public or private transport, I would not like to sit next to someone with HIV	22.0	9.2	217.0	90.8	239.0
c.	I think less of someone because they have HIV	16.0	6.8	220.0	93.2	236.0
d.	I would not like someone with HIV to be living next door	12.0	5.0	227.0	95.0	239.0
e.	I would not like to be friends with someone with HIV	17.0	7.1	221.0	92.9	238.0
f.	I feel afraid to be around people with HIV	34.0	14.4	202.0	85.6	236.0
g.	People with HIV/AIDS have only themselves to blame	22.0	9.4	212.0	90.6	234.0
h.	I would not employ someone with HIV	22.0	9.4	212.0	90.6	234.0
i.	I would not drink from a cup if a person with HIV had just drunk from it	121.0	51.7	113.0	48.3	234.0
j.	If you have HIV you must have done something wrong to deserve it	17.0	7.2	220.0	92.8	237.0
k.	People with HIV should be ashamed of themselves	16.0	6.7	223.0	93.3	239.0
l.	I feel uncomfortable around people with HIV	52.0	21.9	185.0	78.1	237.0

Figure 3. Distribution of HIV stigma scores



HIV-related stigma and educational attainment

Participants who did not complete high school demonstrated higher levels of stigma compared to participants with higher levels of education (Table 11). Pairwise comparison of educational group means revealed statistically significant differences in average stigma scores between participants with "some high school education or less" versus "college/university education" as well as between participants with "some high school education or less" versus "some college or university education".

Table 11. Average HIV-related stigma score, by level of education

Education Level	N	%	Avg. Stigma Score
Some high school or less	59.0	28.9	2.3
High school	21.0	10.3	1.1
Some college or university	52.0	25.5	1.7
College or university	72.0	35.3	1.2
Total	204.0	100.0	

F =3.89, p=0.0022

HIV-related stigma and age group

As shown in Table 12, older participants demonstrated lower levels of HIV-related stigma than younger participants. With each one year increase in age, stigma score decreased by 0.032 points (p=0.0007). When age was categorized into groups, statistically significant differences in average stigma scores were found in the following pairwise comparisons: <20 vs. 40+, <20 vs. 30-39.

Table 12. Average HIV-related stigma score, by age group

Age Group	N	%	Avg. Stigma Score
<20	61.0	29.2	2.4
20-29	76.0	36.4	1.7
30-39	21.0	10.0	0.8
40+	51.0	24.4	1.1
Total	209.0	100.0	

F=7.32; p < 0.0001

HIV-related stigma and HIV testing

Participants who reported having a past HIV test had a lower average HIV-related stigma score (i.e., demonstrated a significantly lower level of stigma) in comparison to participants who reported not having been tested for HIV (Table 13).

Table 13. Average HIV-related stigma score, by HIV testing

HIV test	N	%	Avg. Stigma Score
Yes	123.0	59.1	1.4
No	85.0	40.9	2.0
Total	208.0	100.0	

t=-2.63, d.f.=206, p=0.0091

HIV-related stigma and appeal of KIA images

As shown in Table 14, participants who reported that the KIA images were appealing demonstrated a lower average HIV-related stigma score than participants who did not.

Table 14. Average HIV-related stigma score, by KIA appeal

Images Appealing	N	%	Avg. Stigma Score
Yes	86.0	68.8	1.4
No/ NS	39.0	31.2	2.2
Total	125.0	100.0	

t =-2.23, d.f.=123, p=0.0274
NS = Not Sure

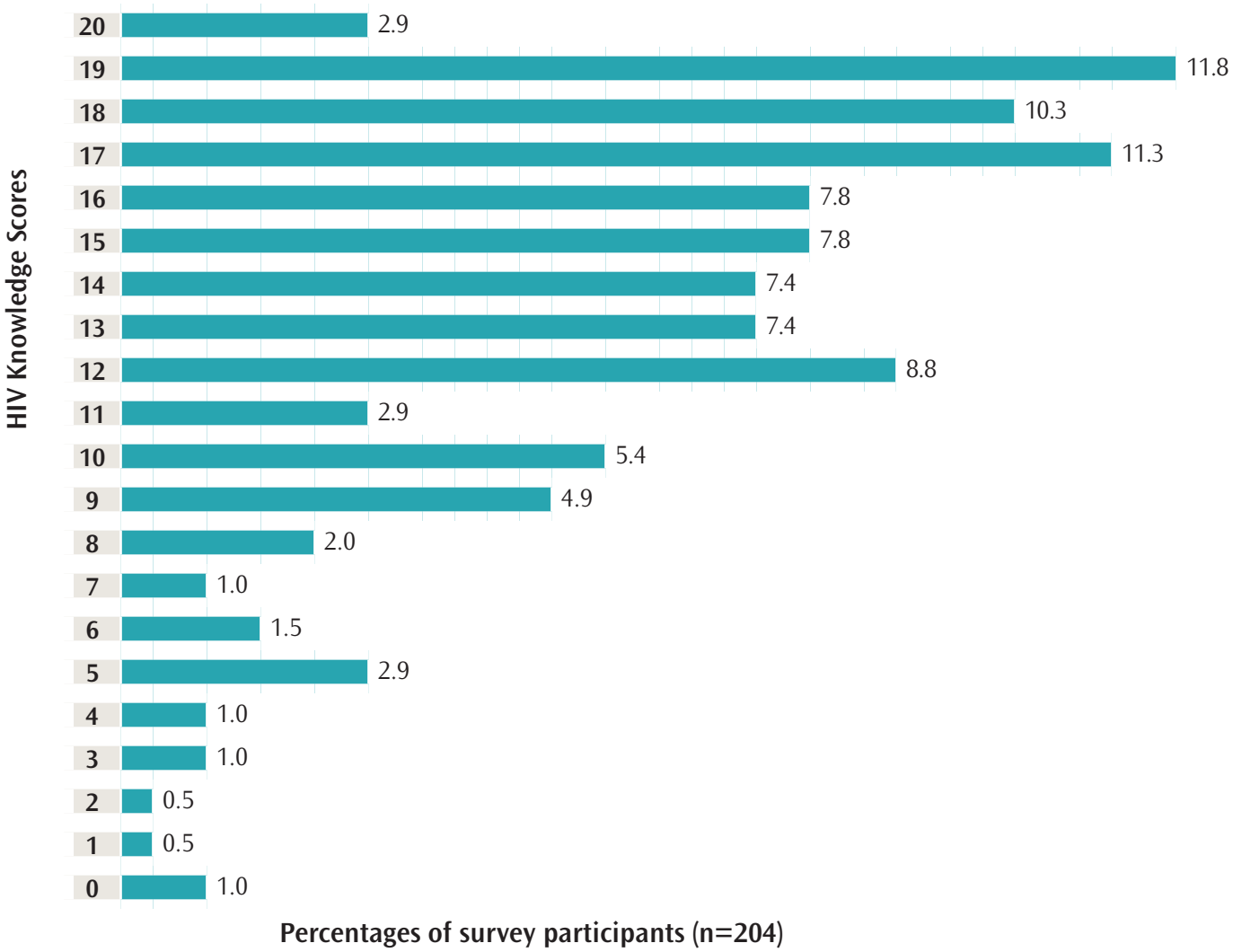
3.3 HIV knowledge scale

The HIV knowledge scale items and frequency of responses are shown in Appendix 2. HIV knowledge was scored from 0-20 where a low HIV knowledge score indicates low HIV knowledge and a high score indicates high HIV knowledge.

The overwhelming majority of participants correctly identified needle sharing and unprotected sex as key modes of HIV transmission (Appendix 2). Most participants also generally understood that perinatal transmission was possible. However, the distribution of knowledge scale responses also highlights key HIV knowledge gaps. For example, 39.6% of participants responded “definitely true”, “probably true”, or “I don’t

know" in response to "there is a vaccine available to the public that protects a person from getting HIV" (item i). Furthermore, 43.5% of participants responded "definitely true", "true", or "I don't know" in response to item "a person can get HIV from mosquitoes or other insect bites" (item s). Overall, the median score for the 204 participants who completed all items of the knowledge scale was 15, which demonstrates a relatively high level of HIV knowledge among participants (Fig. 4). Over 40% of survey participants recorded a score of 16 or higher.

Figure 4. Distribution of HIV knowledge scores:



HIV-related stigma and HIV knowledge

Survey participants who were less knowledgeable about HIV showed higher levels of stigma. For every one point increase in stigma score, knowledge score decreased by 0.7246 points ($p<0.0001$).

HIV knowledge and educational attainment

HIV knowledge varied by level of education. As shown in Table 15, as participants' level of education increased, so too did their knowledge of HIV transmission.

Table 15. Average HIV knowledge score, by level of education

Education Level	N	%	Avg. Knowledge Score
Some high school or less	53.0	26.8	12.7
High school	22.0	11.1	13.2
Some college or university	52.0	26.3	14.2
College or university	71.0	35.9	15.2
Total	198.0	100.0	

F=3.81, p=0.011

HIV knowledge and age

As demonstrated in Table 16, older participants demonstrated higher levels of HIV knowledge than younger participants. As age increased by one year, HIV knowledge score increased by 0.089 points (p=0.0002). Statistically significant pairwise differences between age group and average knowledge score existed for the following age groups: 30-39 vs. <20 and 40+ vs. <20.

Table 16. Average HIV-related knowledge score, by age group

Age Group	N	%	Avg. Knowledge Score
<20	53.0	26.0	11.9
20-29	82.0	40.2	13.8
30-39	19.0	9.3	15.6
40+	50.0	24.5	15.5
Total	204.0	100.0	

F=7.17, p<0.0001

HIV knowledge and HIV testing

There was a statistically significant difference in HIV knowledge scores between participants who reported having been tested for HIV and those who reported not having been tested (Table 17). Participants who reported having been tested for HIV were more knowledgeable about HIV transmission than those who reported not having been tested for HIV.

Table 17. Average HIV knowledge score, by HIV testing

HIV test	N	%	Avg. Knowledge Score
Yes	124.0	61.4	15.0
No	78.0	38.6	12.4
Total	202.0	100.0	

t=4.24, d.f.=200, p=<0.0001

3.4 Willingness to disclose HIV status

We posed a hypothetical question to survey participants: "Suppose you recently found out that you were HIV positive, who would you tell?" Participants could indicate more than one response. The response frequencies are described in Table 18.

The highest and lowest responses indicate that participants would be much more inclined to disclose to a doctor, spouse or parents than to a religious leader. Less than half of survey participants reported that they would disclose an HIV diagnosis to their children, other family members (i.e., not including spouses, children and parents), or to their religious leader (e.g., pastor, priest or imam). In addition, less than 60% reported that they would disclose an HIV diagnosis to sex partners or close friends.

Among those who responded, participants who had previously tested for HIV were more willing to disclose a positive test to their spouse (Table 19) or to their religious leader (Table 20) than participants that had never been tested for HIV.

Table 18. People to whom participants would and would not disclose if they were HIV-positive

Item		Yes		No		Not Sure		No Answer		Total
		n	%	n	%	n	%	n	%	N
a.	My spouse	153.0	65.7	12.0	5.2	12.0	5.2	56.0	24.0	233.0
b.	My boyfriend or girlfriend	139.0	61.0	17.0	7.5	35.0	15.4	37.0	16.2	228.0
c.	Other sex partners	123.0	56.2	15.0	6.9	38.0	17.4	43.0	19.6	219.0
d.	A close friend	128.0	57.1	33.0	14.7	58.0	25.9	5.0	2.2	224.0
e.	My children	104.0	47.1	25.0	11.3	36.0	16.3	56.0	25.3	221.0
f.	My parents	155.0	68.3	26.0	11.5	38.0	16.7	8.0	3.5	227.0
g.	Other family members	92.0	41.1	48.0	21.4	72.0	32.1	12.0	5.4	224.0
h.	My doctor (if he/she did not test you)	215.0	92.7	8.0	3.5	5.0	2.2	4.0	1.7	232.0
i.	My religious leader (pastor, priest or imam)	86.0	38.2	56.0	25.9	54.0	24.0	29.0	12.9	225.0

Table 19. Willingness to disclose HIV status to one's spouse, by HIV testing history

Willingness to disclose	Tested		Not Tested		All Participants	
	N	%	N	%	N	%
Yes	97.0	90.7	54.0	79.4	151.0	86.3
No/ NS	10.0	9.4	14.0	20.6	24.0	13.7
Total	107.0	100.0	68.0	100.0	175.0	100.0
Missing	7.0		3.0		10.0	

χ^2 (1 d.f.) = 4.4408, p=0.0351 NS = not sure

Table 20. Willingness to disclose HIV status to one's religious leader, by HIV testing history

Willingness to disclose	Tested		Not Tested		All Participants	
	N	%	N	%	N	%
Yes	59.0	50.0	27.0	34.6	86.0	43.9
No/ NS	59.0	50.0	51.0	65.4	110.0	56.1
Total	118.0	100.0	78.0	100.0	196.0	100.0
Missing	10.0		7.0		17.0	

χ^2 (1 d.f.) =4.5135, p=0.0366 NS = not sure

Table 21 suggests that, among those who responded, males expressed greater willingness than females to disclose a positive HIV test to other family members, though the relationship is not statistically significant.

Table 21. Willingness to disclose HIV status to other family members by gender

	Male		Female		All Participants	
	N	%	N	%	N	%
Yes	44.0	51.2	47.0	37.9	91.0	43.3
No/ NS	42.0	48.8	77.0	62.1	119.0	56.7
Total	86.0	100.0	124.0	100.0	210.0	100.0
Missing	5.0		14.0		19.0	

χ^2 (1 d.f.) =3.6359, p=0.0565 NS = not sure

4.1 What we learned and some things we should feel good about

We learned that, for many focus group participants in our study, HIV/AIDS prevention campaigns were perceived to be more visible "back home" than they are in Canada. Prevention campaigns that are too subtle may be doing a disservice to African, Caribbean, and Black (ACB) communities who may be more familiar with bolder campaigns.

Also, the invisibility of HIV/AIDS as an important health issue in Canada may contribute to the misconception that HIV/AIDS does not exist in Canada. In our study, some focus group participants expressed that HIV did not feel relevant; they needed to be convinced that HIV is a public health concern. As a result, participants often described the need for factual information about the HIV/AIDS epidemic in Canada and its impact on ACB communities to be highlighted in future campaigns. We know that HIV is an issue for ACB communities; however, the people to whom we spoke had the impression that HIV is not a Canadian issue. It is important then, for ACCHO, its member agencies and partners to address this misconception.

Participants also grappled with feelings of discomfort due to the way that many Canadians link HIV with African or Black people. Learning that the KIA campaign was led by ACB community members helped participants reconcile feelings of discomfort about an HIV prevention campaign that targets ACB communities.

The focus group discussions about how to represent people living with HIV in campaigns centred on the observation that the models in the campaign images did not appear to be ill. Such judgements about the outward appearance of people living with HIV have implications for people's assumptions about HIV and those who are infected and, ultimately, for prevention efforts. However, more than three-quarters of survey participants acknowledged that how a person looks is not an indicator of that person's HIV status.

The tensions around implementing effective HIV prevention campaigns for ACB communities demonstrates a need for innovative and sophisticated HIV prevention campaign strategies that challenge and address these complex and seemingly contradictory notions (Table 22). In addition, it is important to continue to stress that prevailing stigma at the individual and community levels intersects with multiple forms of inequality, such as racism, sexism, and homophobia, and continues to be a barrier to HIV/AIDS prevention efforts.

Table 22. Key tensions about HIV prevention campaigns among focus group participants

HIV/AIDS is a health concern among ACB people	
Disproportionate impact of HIV/AIDS on ACB communities in Ontario	HIV is not particular to Black/African people
Messaging related to HIV/AIDS	
Bold HIV prevention campaigns are needed	We must be careful not to further stigmatize
If I contract HIV, can I live a relatively healthy life?	We don't want to promote risk-taking behaviour
Campaigns should not gloss over or diminish the stressful realities of living with HIV	Showing that one can live with HIV and maintain reasonably good health is important
Visibility of People Living with HIV/AIDS	
Voices of PHAs must be included in prevention campaigns	Should PHAs be publicly (visibly) associated with prevention campaigns?

We also learned that survey participants who demonstrated lower reported HIV-related stigma were more likely to be older, more educated, have tested for HIV in the past, and have found the KIA campaign images appealing. Similarly, survey participants who demonstrated higher HIV knowledge were more likely to be older, to be more educated, to have had an HIV test, to have seen the KIA images, and to have reported finding the KIA images

appealing. Based on these trends, it is not surprising that participants who were more knowledgeable about HIV also demonstrated lower levels of stigma. People who have been tested for HIV were more knowledgeable about HIV transmission, demonstrated lower stigma, and demonstrated a greater willingness to disclose a positive HIV test to significant others.

Roughly two thirds of the survey participants overall indicated that they saw the KIA campaign images, demonstrating the successful impact and reach of the campaign. Furthermore, nearly 90% of survey participants who were exposed to the KIA campaign indicated that the campaign was "very important" or "important" for ACB people in Ontario. The most likely site where the KIA campaign images were recognized was on the bus or other parts of the public transit system. This indicates to us that public transit was an effective marketing site for the KIA prevention campaign and for potential future campaigns. The survey results also indicate that participants were also favourably disposed to the campaign images and messages. The importance of consistent condom use and preventing the spread of HIV/AIDS were most commonly referred to as the key messages drawn from the KIA TV PSAs by survey participants.

4.2 What do we need to work on?

Participants from London and Toronto were more likely to have seen the campaign, which indicates that the roll out and promotion of the campaign may have been less effective in Ottawa (a city with a large Francophone ACB population). On the other hand, participants from Ottawa and London found the KIA campaign more appealing than participants from Toronto.

Overall, only 26.4% (n=63) of survey participants indicated that they saw the KIA TV PSAs and the responses did not differ significantly by city. We did not have access to any data to indicate whether this figure is low or high. However, we note that the screenshots of the TV PSAs which were provided in the questionnaire may not have been sufficient in assisting participants with recalling whether they saw the TV PSAs. Secondly, we did not ask about frequency of use or access to media sources such as television to help contextualize the response outcomes. Lastly, focus group participants did not have access to any materials from the TV PSAs to aid their recall.

Overall, there were low reported rates of HIV-related stigma. However, we found that questions presented in the HIV stigma scale that were more intimate in nature e.g., "I would not drink from a cup if a person with HIV had just drunk from it" appeared to elicit slightly higher rates of HIV-related stigma. It would be helpful to capture the ways in which stigma continues to emerge, not just through individual actions, but also through various systems, institutions, and structures that PHAs encounter on a daily basis.

The HIV knowledge score overall was relatively high, indicating high knowledge about HIV transmission. However, several knowledge gaps described in Appendix 2 demonstrated a degree of uncertainty regarding HIV transmission through insect bites and the availability of an HIV vaccine. It is possible that the HIV/AIDS knowledge scale used in our study may be limited in terms of capturing the depth of knowledge of HIV/AIDS transmission. Our survey results indicated that younger participants were less knowledgeable about HIV/AIDS and demonstrated higher stigma in comparison to older participants. Moving forward, it may be worthwhile to implement future HIV education and stigma reduction efforts that focus on younger ACB people.

Lastly, we learned that, if participants found out that they were HIV positive, only 56.5% would disclose their HIV status to their sex partners. This finding is disturbing, given the fact that the question was presented in the context of knowing one's HIV status. This is also troubling considering the criminalization of HIV non-disclosure in Canada. Our findings suggest a need for effective and culturally sensitive interventions to address disclosure to reduce the spread of HIV/AIDS.

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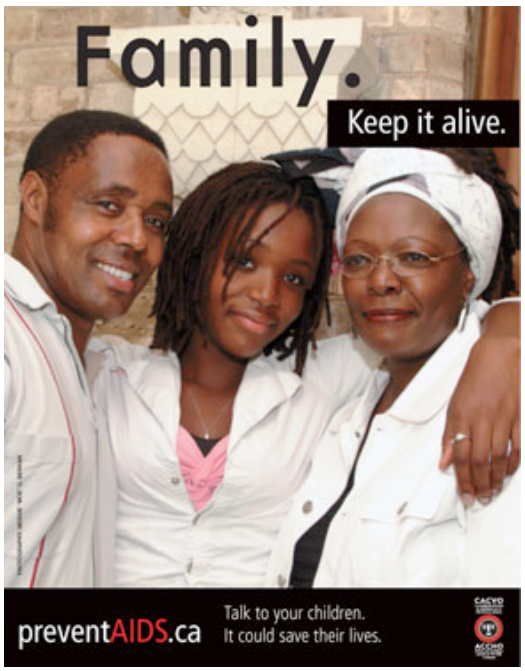
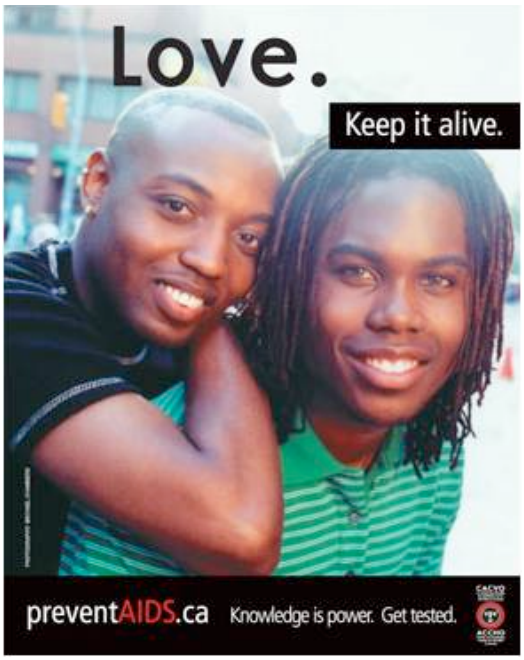
Appendix 1: Selected Campaign Images

a)

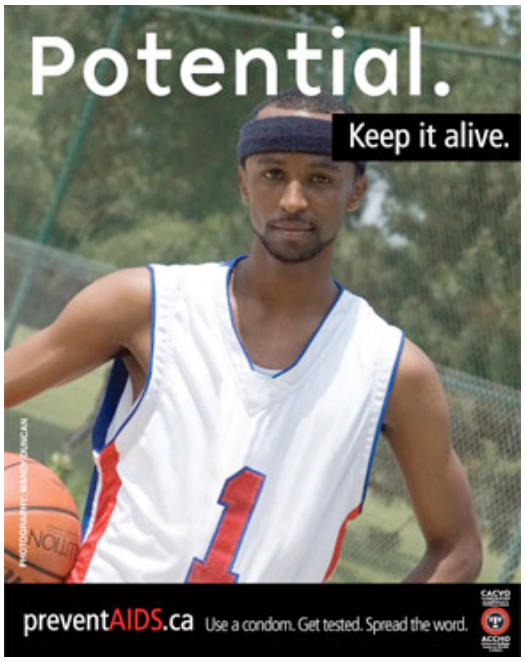
b)



c)



d)



Appendix 2: Distribution of HIV knowledge scale responses by item

Item		Definitely True		Probably True		Probably False		Definitely False		Don't know		Total	Missing
		N	%	N	%	N	%	N	%	N	%	N	%
a.	HIV/AIDS can reduce the body's natural protection against disease	156.0	65.8	40.0	16.9	9.0	3.8	12.0	5.1	20.0	8.4	237.0	6.0
b.	HIV/AIDS can damage the brain	49.0	20.9	58.0	24.7	46.0	19.6	41.0	17.5	41.0	17.5	235.0	8.0
c.	HIV/AIDS is caused by an infectious virus	168.0	71.5	41.0	17.5	8.0	3.4	6.0	2.6	12.0	5.1	235.0	8.0
d.	Teenagers cannot get HIV	12.0	5.0	3.0	1.3	20.0	4.2	210.0	88.2	3.0	1.3	238.0	5.0
e.	A person can be infected with HIV and not have the disease AIDS	150.0	63.0	38.0	16.0	12.0	5.0	20.0	8.4	18.0	7.6	238.0	5.0
f.	Looking at a person is enough to tell if he or she has HIV	11.0	4.7	8.0	3.4	25.0	10.6	182.0	77.1	10.0	4.2	236.0	7.0
g.	A person who has HIV can look and feel well	165.0	69.9	51.0	21.6	7.0	3.0	7.0	3.0	6.0	2.5	236.0	7.0
h.	A pregnant woman who has HIV can give the virus to her baby	146.0	60.8	60.0	25.0	9.0	3.8	10.0	4.2	15.0	6.3	240.0	3.0
i.	There is a vaccine available to the public that protects a person from getting HIV	16.0	6.7	29.0	12.1	26.0	10.8	119.0	49.6	50.0	20.8	240.0	3.0
j.	There is no cure for AIDS at present	154.0	65.0	28.0	11.8	13.0	5.5	27.0	11.4	15.0	6.3	237.0	6.0
k.	A person can get HIV from living near the home of someone with AIDS	5.0	2.1	8.0	3.3	20.0	8.3	194.0	80.8	13.0	5.4	240.0	3.0
l.	A person can get HIV from working near someone with HIV/AIDS	4.0	1.7	9.0	3.8	19.0	8.02	199.0	84.0	6.0	2.5	237.0	6.0

Appendix 2: cont'd

Item		Definitely True		Probably True		Probably False		Definitely False		Don't know		Total	Missing
		N	%	N	%	N	%	N	%	N	%	N	%
m.	A person can get HIV from shaking hands, touching, or kissing on the cheek someone who has HIV	5.0	2.1	16.0	6.7	21.0	8.8	190.0	79.8	6.0	2.5	238.0	5.0
n.	A person can get HIV from sharing plates, forks, glasses with someone with HIV/AIDS	9.0	3.8	38.0	16.0	35.0	14.8	138.0	58.2	17.0	7.2	237.0	6.0
o.	A person can get HIV from using public toilets	5.0	2.1	32.0	13.5	40.0	16.9	138.0	58.2	22.0	9.3	237.0	6.0
p.	A person can get HIV from injecting with the same needle used by someone with HIV/AIDS	207.0	86.6	23.0	9.6	2.0	0.8	6.0	2.5	1.0	0.4	239.0	4.0
q.	A person can get HIV from being near someone who coughs or sneezes and has HIV	10.0	4.2	31.0	13.2	40.0	17.0	128.0	54.5	26.0	11.1	235.0	8.0
r.	A person can get HIV from attending school with a child who has HIV	4.0	1.7	3.0	1.3	33.0	14.0	186.0	78.8	10.0	4.2	236.0	7.0
s.	A person can get HIV from mosquitoes or other insect bites	17.0	7.1	49.0	20.6	33.0	13.9	102.0	42.9	37.0	15.6	238.0	5.0
t.	A person can get HIV from having unprotected sex (not using a condom) with someone who has HIV/AIDS	220.0	92.1	13.0	5.4	4.0	1.7	1.0	0.4	1.0	0.4	239.0	4.0

Appendix 3. KIA survey socio-demographic profile

	London		Toronto		Ottawa		Total	
	N	%	N	%	N	%	N	%
Total	**75**	**30.9**	**94**	**39**	**74**	**30**	**243**	**100**
Age	**n=69**		**n=92**		**n=67**		**n=228**	
<20	12	17.4	25	27.2	20	29.9	57	25.0
20-29	19	27.5	26	28.3	17	25.4	62	27.2
30-39	12	17.4	25	27.2	15	22.4	52	22.8
40+	26	37.7	16	17.4	15	22.4	57	25.0
Gender	**n=73**		**n=94**		**n=73**		**n=240**	
Female	39	53.4	66	70.2	36	48.6	141	58.9
Male	34	46.6	28	29.8	37	50.0	99	41.1
Other	0	0.0	0	0.0	0	0.0	0	0.0
Education	**n=73**		**n=91**		**n=72**		**n=236**	
< Elementary or primary	3	4.1	1	1.1	0	0.0	4	1.7
Elementary or primary	3	4.1	1	1.1	2	2.8	6	2.5
Some high school	12	16.4	24	26.4	25	34.7	61	25.8
High School diploma	6	8.2	7	7.7	12	16.7	25	10.6
Some college/University	18	24.7	30	33.0	13	18.1	61	25.8
College/University	31	42.5	28	30.8	20	27.8	79	33.5
Background/Heritage *								
African	45	59.2	39	39.4	44	57.1	128	50.8
Caribbean	17	22.4	39	39.4	10	13.0	66	26.2
Black/African Canadian	11	14.5	19	19.2	17	22.1	47	18.7
Other	3	3.9	2	2.0	6	7.8	11	4.4
Time in Canada**	**n=62**		**n=52**		**n=51**		**n=165**	
Less than 1 year	1	1.6	2	3.8	5	9.8	8	4.8
1-2 Years	8	12.9	11	21.2	5	9.8	24	14.5
3-5 years	20	32.3	7	13.5	10	19.6	37	22.4
More than 5 years	33	53.2	32	61.5	31	60.8	96	58.2

Appendix 3. cont'd

	London		Toronto		Ottawa		Total	
	N	%	N	%	N	%	N	%
Place of Birth	**n=75**		**n=94**		**n=73**		**n=242**	
Africa	44	58.7	29	30.9	38	52.1	111	45.9
Caribbean	14	18.7	20	21.3	9	12.3	43	17.8
Canada	13	17.3	40	42.6	21	28.8	74	30.6
Elsewhere	4	5.3	5	5.3	5	6.8	14	5.8
Tested for HIV	**n=74**		**n=93**		**n=73**		**n=240**	
Yes	54	73.0	51	54.8	38	52.1	143	59.6
No	18	24.3	39	41.9	34	46.6	91	37.9
Can't remember/I don't know	2	2.7	3	3.2	1	1.4	6	2.5
Language Spoken at Home*								
English	63	61.2	70	57.9	48	44.4	181	54.4
French	5	4.9	32	26.4	34	31.5	72	21.6
Arabic	5	4.9	2	1.7	4	3.7	11	3.3
Other	30	29.1	17	14.0	22	20.4	69	20.7
Self-Rated General Health	**n=75**		**n=94**		**n=73**		**n=242**	
Excellent	35	46.7	27	28.7	22	30.1	84	34.7
Very good	21	28.0	44	46.8	24	32.9	89	36.8
Good	15	20.0	18	19.1	21	28.8	54	22.3
Fair	3	4.0	3	3.2	5	6.8	11	4.5
Poor	1	1.3	1	1.1	1	1.4	3	1.2
I don't know	0	0.0	1	1.1	0	0.0	1	0.4

*For questions regarding heritage and language, participants had the option of selecting multiple responses

** Time in Canada refers only to participants who were not born in Canada