

‘Positive Talk for Positive Health’: Piloting a Telephone Support Service for People Living  
with HIV

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BPsych (Hons)

This thesis is submitted in partial fulfilment of the requirements for the degree of  
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## **Declarations**

### **Statement of Originality**

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. I give consent to this copy of my thesis, when deposited in the University Library\*\*, being made available for loan and photocopying, subject to the conditions of the Copyright Act 1968.

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### **Acknowledgement of Collaboration**

I hereby certify that the work embodied in this thesis has been done in collaboration with other researchers from the University of Newcastle (UON) The larger project design, and ethics application were conducted collaboratively by Professor Jenny Bowman (UON) and Karen Nairn (HNELHD), Todd Heard (HNELHD), and Glen Ferrero (ACON). I assisted the project team in survey and intervention manual development, support caller recruitment, project delivery, and data collection. I was primarily responsible for the review of literature, data analysis, and writing of the manuscript contained within this thesis. My work was forwarded to my supervisor Jenny Bowman for review, and amendments were made based on feedback received.

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Manuscript is formatted to comply with the Instructions for Authors from the Journal of  
AIDS Patient Care and STDs (see Appendix A).

‘Positive Talk for Positive Health’: Piloting a Telephone Support Service for People Living  
with HIV

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### ABSTRACT

The human immunodeficiency virus (HIV) has progressed from an acute illness to a chronic condition that requires ongoing care. Telephone based programs have shown potential for providing support to people living with HIV and have been described as an intervention modality that may overcome traditional barriers to care. The current study explored the acceptability and feasibility of a pilot telephone support program utilising a single group, pre-post design. Participants were invited to complete a baseline and follow-up survey, in addition to an exit survey providing feedback on program satisfaction and acceptability. The program consisted of six, monthly information support calls aimed at increasing treatment adherence, psychosocial wellbeing, and support service access of people living with HIV in two New South Wales (NSW, Australia) health districts. The sample included 24 participants who commenced the program and 21 participants who completed the full intervention, demonstrating an 88% retention rate. Almost all participants (94% (15/16)) rated the program information as very or fairly useful; and two-thirds (69% (11/16)) reported accessing support services as a result of information received during the program. This study provides the first preliminary support for the feasibility and acceptability of a HIV-specific telephone intervention within an Australian setting and provides directions for future research in HIV care.

Key words: HIV Treatment; Adherence; Telephone Support; Feasibility

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The human immunodeficiency virus (HIV) continues to contribute to the global burden of disease, with over 37.9 million people living with HIV worldwide at the end of 2018.<sup>1</sup> In Australia, 27,545 people were estimated to be living with HIV at the end of 2017.<sup>2</sup> This does not account for the estimated 10% of people living with HIV (PLWHIV) who are undiagnosed.<sup>2</sup> Addressing the morbidity and mortality of HIV and the acquired immunodeficiency syndrome (AIDS) remains an ongoing international health challenge.<sup>3</sup> Consequently, this requires increased and sustained efforts in treatment and management responses on a global scale.<sup>4</sup>

HIV is a blood-borne retrovirus that is typically acquired through sexual intercourse, exposure to infected blood, or perinatal transmission.<sup>5</sup> Retroviruses are Ribonucleic acid (RNA) viruses comprised of reverse transcriptase, a polymerase that synthesises pro-viral Deoxyribonucleic acid (DNA) from RNA. This DNA becomes integrated into an individual’s cellular genome and as a result, manifests as a persistent life-long infection.<sup>5</sup> HIV attacks the body’s immune system and causes the gradual destruction of CD4 T lymphocyte cells which assist the immune system to protect the body from infection.<sup>6</sup> As a result, HIV progressively makes an individual more susceptible to opportunistic infections or cancers.<sup>7</sup> AIDS is the result of chronic HIV infection and consequent depletion of CD4 cells. It is defined using a threshold cell count of less than 200 CD4 cells/microL or the presence of any AIDS defining conditions regardless of the CD4 count.<sup>7</sup>

Antiretroviral therapy (ART) has significantly improved the health and quality of life of PLWHIV, and considerably reduced HIV-related mortality.<sup>8</sup> Improvements in HIV treatment have substantially increased the life expectancy of PLWHIV to a level comparable to that of uninfected individuals.<sup>9</sup> Consequently, ART has significantly contributed to HIV



now being considered a chronic health condition that requires ongoing care.<sup>8</sup> Research has suggested that ART is the most important factor for predicting an individual's likelihood to achieve and maintain the suppression of HIV viral load.<sup>10</sup>

There is growing evidence that ART may also play a vital role as a preventative strategy that may reduce the transmission of HIV.<sup>11</sup> Viral load is the greatest risk factor for HIV transmission and ART operates by reducing viral load to undetectable levels, which may consequently interfere with HIV transmission, preventing further morbidity and mortality.<sup>11</sup> Systematic reviews have indicated that ART mediated virologic suppression may reduce sexual transmission and perinatal transmission of HIV.<sup>12,13</sup> Currently, in Australia HIV is primarily transmitted through sexual contact between men. In 2017, this accounted for 63% of new HIV diagnoses, followed by heterosexual contact (25%), and male-to-male sex and injecting drug use (6%) and injecting drug use only (3%).<sup>2</sup>

It is well established that strict adherence to ART (95% or greater) is a key determinant of managing the progression of HIV, and contributing to enhanced overall health and quality of life.<sup>14–16</sup> In contrast, low adherence to ART has been connected to drug resistance and treatment failure.<sup>17</sup> There has been a high rate of HIV treatment uptake across Australia, with recent research suggesting 87% of all PLWHIV are using ART.<sup>2</sup> PLWHIV in Australia are living longer and are becoming more experienced with various forms of ART.<sup>18</sup> However, ART treatment regimens are often complicated and may interfere with an individual's daily life due to the demanding medication schedule.<sup>19</sup> As a result, an individual's capacity to cope with their treatment regime varies broadly and may have considerable impact on their psychosocial wellbeing and disease progression.<sup>19</sup> Thus, supporting the uptake and treatment adherence of ART is widely accepted as a critical action for addressing the needs of PLWHIV and as a preventative measure to stop the transmission of HIV.<sup>11</sup>

HIV treatment adherence refers to the ability of an individual to be involved in selecting, commencing, managing, and maintaining a given medication and treatment regimen to control viral replication and improve immune function.<sup>20</sup> Research has reported mixed findings in regard to medication adherence for PLWHIV; adherence rates have been found to vary from 70% to 95%.<sup>19,21,22</sup> However, there is considerable disagreement in the literature in regard to identifying a gold standard treatment adherence measure for HIV.<sup>22,23</sup> Further evidence has noted that 10% of PLWHIV report missing one or more pills on any typical day, 30-50% indicate missing pills in the past two to four weeks, and as many as 50% report failing to take ART medication in accordance with dosage, time, and dietary instructions.<sup>24,25</sup>

Non-adherence to ART may be associated with a number of structural, behavioural, and psychosocial factors. These include alcohol and substance use, low health literacy, low levels of social support, stigma, non-disclosure of HIV status, and homelessness.<sup>26-28</sup> In addition, adherence to ART is closely associated with how prepared individuals are to manage the side-effects of these medications.<sup>29</sup> When PLWHIV are asked to describe reasons for missing doses and taking less ART medication than prescribed, four clusters of reasons have been shown to emerge. The four clusters include poor medication tolerability, regimen burden or complexity, conflicts with daily routines, and financial and access barriers to treatment.<sup>30</sup> Moreover, there are still negative perceptions associated with HIV treatment including doubts about the need to be on medication, concerns over harmful side-effects, and frustration regarding their inconvenience.<sup>31,32</sup> Further research has suggested that there is some community apprehension surrounding ART which may be a result of lack of knowledge and information surrounding HIV treatment.<sup>33</sup>

Many PLWHIV experience considerable psychological and existential issues that may impact their quality of life and psychological functioning.<sup>34</sup> Research has indicted that these

issues have continued since the advent of ART medication.<sup>34</sup> This suggests that while ART has greatly improved physical health and wellbeing, these improvements have not necessarily translated into improved psychological coping.<sup>34</sup> It is well documented that PLWHIV experience disproportionate rates of depression and anxiety and these disorders may be exacerbated by the physiological side effects of ART.<sup>35</sup> Research has suggested that an estimated 50% of PLWHIV have been diagnosed with a comorbid mental illness that may affect HIV treatment outcomes.<sup>36</sup> Depression and perceived stress have been strongly correlated with ART non-adherence.<sup>24</sup> Further research has indicated many PLWHIV experience increased anxiety related to the need for stringent levels of medication adherence.<sup>37</sup>

Substance use is also highly prevalent among PLWHIV, ranging from 40-74% reporting comorbid substance use or related disorders.<sup>38</sup> Substance use has been associated with the presence of other mental health problems for PLWHIV, such as depression and anxiety.<sup>36,39</sup> Furthermore, substance use may negatively impact medication adherence, CD4 T-Cell count, and suppression of viral load, leading to poorer medical outcomes.<sup>40-43</sup> Furthermore, rates of smoking tobacco have been shown to be two to three times higher for PLWHIV compared to the general population.<sup>44</sup> These health behaviours have been reported to place PLWHIV at an increased risk of non-AIDS related morbidity and mortality. While the relative impact of lifestyle factors compared to HIV-related factors is often debated, there appears to be an emerging trend that cardiovascular disease and non-AIDS malignancies are now a major cause of death for PLWHIV.<sup>44,45</sup>

In addition to health related behaviours, the psychosocial environment and wellbeing of PLWHIV are important aspects of coping with the disorder. These factors have not only been considered to have significant consequences on the behavioural management and treatment of HIV, but has also been suggested to impact the biological aspects of disease

progression.<sup>46</sup> Psychoneuroimmunology research has investigated the psychological factors relevant in the physical illness of HIV.<sup>47</sup> Research in this field is still emerging, however a number of studies have provided evidence that aspects of psychosocial functioning may influence the response of the immune system to HIV. Stress, depression, social support, and denial may influence the progression of HIV/AIDS.<sup>48</sup> Burack et al.<sup>48</sup> reported men with HIV who were depressed showed greater declines in numbers of CD4 lymphocyte cells over a subsequent five year period compared to a non-depressed control group. Markers of the importance of social connectedness have also been investigated with studies showing lower levels of social support are associated with a significantly faster progression in CD4 cell decline.<sup>49</sup> The death of an intimate partner due to AIDS may increase markers of disease progression and decrease effective lymphocyte cell function in bereaved partners.<sup>50</sup> These findings statistically controlled for demographic characteristics, health behaviours, sexual behaviours, ART, mental health problems and social support.

HIV has been shown to have significant effects on individuals' physical, psychological, and sociocultural determinants of health-related quality of life (QOL).<sup>51</sup> PLWHIV may find it difficult to attend to daily responsibilities and experience activity limitations as a result of progress of the disease or side effects of treatment.<sup>52</sup> The side effect profile of ART can be considerable and PLWHIV may need to manage adverse effects such as fatigue, muscle weakness, oedema, myalgia, nausea, and lipodystrophy.<sup>31</sup> As PLWHIV are living longer, they experience a wide array of physical and cognitive impairments such as wasting, neuropathies, blindness, and AIDS dementia complex.<sup>53</sup>

Research has outlined a number of psychological challenges of living with HIV, including fear of physical pain, debilitation, disfigurement and death, the prospect of real and anticipated losses, being abandoned by loved ones, and dealing with uncertainty.<sup>54,55</sup> Preserving a sense of hope is an ongoing psychological challenge that may impact the quality

of life for PLWHIV across illness progression. Depression is common among PLWHIV and may become severe, particularly for those who try to cope using avoidance strategies or believe their illness is punishment for past misdeeds.<sup>56</sup> Furthermore, PLWHIV may be rejected by friends or family following disclosure and this may exacerbate depression.<sup>55</sup> PLWHIV experience challenges unique to the condition in regard to the extent of stigma associated with it and the consequences of HIV being an infectious disease that may be potentially fatal to others.<sup>55</sup> Following a HIV positive diagnosis, individuals must integrate this new information into their sense of identity.

Across the progression of HIV, individuals are particularly vulnerable to acute distress, including when they receive their diagnosis, the initial onset of physical symptoms, abrupt deteriorations in CD4 cell count, the first opportunistic infection, or the first hospitalisation.<sup>55</sup> However, as HIV has transitioned from an acute to chronic condition the stages of illness have also been suggested to impact access and adherence to treatment. Research has suggested that stage of illness may be a barrier for uptake and retention in care, with non-symptomatic individuals being less inclined to seek help.<sup>57,58</sup>

Stigma and social isolation are significant factors impacting wellbeing for PLWHIV. HIV-related stigma has been shown to have a significant effect on the adjustment of PLWHIV and their families.<sup>59</sup> Stigma and discrimination have been said to occur for a variety of reasons for PLWHIV. Some of the most prominent reasons include the public fear of HIV/AIDS being considered a terminal illness, often misunderstood perceptions of how HIV is transmitted, an irrational fear of acquiring HIV from people infected with it, and the disease often being associated with homosexuality and drug abuse.<sup>60</sup> The result of these perceptions manifest in felt stigma (the fear of being discriminated against), enacted stigma (prejudicial attitudes and actual discriminatory behaviours), and courtesy stigma (prejudice and discrimination against individuals who are associated with stigmatised others).<sup>59</sup>

Consequently, both the individuals afflicted by the disease, and their family members, caregivers, friends, and romantic partners may be affected by stigma and discrimination and this may negatively impact their access to social support.<sup>61,62</sup> Stigma may be exhibited differentially depending on the status of other social groupings to which the person belongs. Consequently, men who have sex with men, injection drug users, and other minority groups may experience a compounded stigma burden.<sup>63</sup>

Despite efforts to reduce HIV related stigma since the beginning of the epidemic, it's impact continues to be a significant barrier for HIV prevention and optimal treatment.<sup>64</sup> Fear of stigma is a consistent barrier to engagement and retention in care and may discourage individuals from getting tested for HIV, accessing support, and attending HIV clinics.<sup>59,64,65</sup> Furthermore, stigma related barriers may provide even greater impact within rural communities.<sup>66,67</sup> HIV related stigma and discrimination is widely recognised as a barrier to both the delivery of quality services by health providers and their utilisation by PLWHIV.<sup>68</sup> Consequently, reducing HIV related stigma in health settings and promoting access to care has been described as a leading priority for health care managers.<sup>68</sup>

Research has highlighted the need for low-cost interventions that may support the uptake of medication, psychosocial wellbeing, and treatment adherence of PLWHIV to sustain better health outcomes and quality of life.<sup>69</sup> Telephone support options for HIV have been described as an intervention modality that may overcome traditional barriers such as transportation problems, lack of money, concerns about privacy, and the stigma sometimes associated with attending a clinic for HIV treatment.<sup>70</sup> These barriers have been identified in a number of qualitative and quantitative studies investigating access to and retention in care.<sup>71-75</sup> The use of mobile phones is widespread across countries which make them a viable method for the delivery of healthcare interventions.<sup>70</sup> There is considerable potential for telephone interventions to improve healthcare access and support across a wide-variety of

health issues, including HIV/AIDS.<sup>76</sup> Telephone support models have been shown to have some evidence for PLWHIV in delivering mental health interventions, providing test results, and supporting client contact with primary care settings.<sup>77–79</sup>

Current evidence is inconclusive regarding the feasibility and efficacy of telephone support interventions in relation to the medication adherence and psychosocial wellbeing of PLWHIV. Outcome trials have shown mixed findings in regard to the efficacy of telephone support for ART adherence with no data currently available in an Australian context.

Overseas studies have demonstrated mixed support to date, ranging from showing moderate effect sizes to no effect.<sup>70</sup> A meta-analysis conducted by Gentry et al.<sup>70</sup> in 2013 reviewed the findings of 11 eligible studies and concluded that while there is some evidence that telephone interventions may have a role in improving medication adherence and psychological wellbeing.

Studies to date have primarily addressed single focus interventions, as opposed to targeting multiple treatment adherence associated factors, such as attitudes to treatment, HIV medication information, general health behaviours, psychological wellbeing, and social and community participation. These are considered important for treatment uptake and adherence in Australia<sup>33</sup>. In regard to medication adherence, a 2019 meta-analysis has suggested telephone interventions may have limited impact on improving adherence.<sup>80</sup> However, outcomes are improved when interventions are combined with text message reminder systems and multiple targets associated with improved medication adherence are addressed.<sup>80</sup>

In Australia, the New South Wales HIV Strategy 2012-2015 encouraged Local Health Districts to implement initiatives which aim to promote the uptake and adherence to treatment for all people living with HIV.<sup>81</sup> The current study was initiated by the Hunter New England Local Health District (HNELHD) in collaboration with ACON, a national non-government organisation HIV support service. The initiative sought to contribute to the NSW

health directive and respond to the increasing demand on services in the area to provide information and support to PLWHIV. A goal of this support was to provide cost-free and accessible support that may benefit both consumers in rural and metropolitan areas; given the growing number of PLWHIV in rural areas where access to information and support is limited.<sup>2,33,81</sup> As a result, the current study aims to explore the feasibility and acceptability of a Pilot Telephone Support Program designed to support treatment adherence, psychosocial wellbeing, and support service access for PLWHIV in an Australian setting. The study will also explore pre versus post measures of treatment adherence and psychosocial wellbeing.

## **Method**

### **Design and Setting**

The present study was designed to evaluate the feasibility and acceptability of the ‘Positive Talk for Positive Health’ service, run in partnership by Hunter New England Population Health, ACON, and the University of Newcastle. The program was a telephone-delivered information support intervention aimed at facilitating better access to support services, encouraging the uptake of and adherence to ART treatment, and supporting the psychological and physical wellbeing. The program was available to PLWHIV in the HNE and Western NSW (WNSW) local health districts. HNELHD has a population of 920,370 people across a region of 131,785 square kilometres. The district consists of a major metropolitan centre, regional communities, and a small percentage of people living in remote communities.<sup>82</sup> WNSWLHD has a population of 270,775 people within approximately 250,000 square kilometres.<sup>83</sup> The district is diverse and is made up of cities, inner regional, outer regional, and remote communities. The study was conducted as a single group, pre-post design exploratory pilot study. Ethics approval was granted by the Hunter New England and



the University of Newcastle Human Research Ethics Committees (13/12/11/4.13) (See Appendix B).

### **Participants**

Participants were 27 PLWHIV (26 men and 1 woman) aged between 29 and 63. Participants were recruited through existing providers of HIV testing, treatment, and community support across the HNE and WNSW local health districts. Eligible participants were invited to participate in the program via convenience advertising at recruitment sites (See Appendix C). In addition to the provision of information about the project in routine correspondence from existing providers of HIV/AIDs care to potential participants. Eligible participants were English speaking, 18 years of age or older, had a current phone number, were not currently highly dependent on medical care (e.g. receiving inpatient care) and self-reported as being HIV positive. Potential participants were provided an outline of the study and informed consent was obtained electronically from all individual participants (See Appendix D). The study did not offer any external incentives for participation.

### **Procedure**

Potential participants entered the study by contacting the service through telephone or in person at ACON Newcastle. Potential participants completed an expression of interest, providing name and contact details (the option to use an Alias was also made available at their discretion). An initial registration call was scheduled which covered eligibility criteria, preferred day and time of support calls to be received (choosing between two weekday options within a 1-8pm timeframe). Recruitment was completed across a 6-month period. Participants were provided with a link to the online baseline survey. If participants were not able to complete the baseline survey online they were given the option to complete it in person at ACON or via telephone with a project supervisor who did not deliver any support call content.

Twenty-seven participants completed a baseline survey (online or over the telephone) before commencing the program (See Appendix E). The telephone support intervention was made up of six, monthly calls. Twenty-one participants completed the program and 17 participants completed a post-intervention follow-up survey online or via telephone interview. In addition to the follow-up survey, all participants (whether they completed the program or exited early) were invited to complete a telephone exit survey (See Appendix F). This survey gathered information regarding the acceptability and feasibility of the program and feedback concerning areas for improvement. Exit survey calls were completed by program supervisors independent of support callers. Fifteen participants completed an exit survey. Exit surveys and follow-up surveys were conducted as soon as possible following program termination.

### **Measures**

Where possible, survey questions were sourced from existing population based surveys including HIV Futures Seven Survey, Gay Community Periodical Survey, and the NSW Adult Population Health survey.<sup>84-86</sup> Survey questions included demographic information, HIV clinical characteristics (e.g., CD4 cell count and viral load), and smoking behaviours.<sup>84</sup>

Primary feasibility and process measures included length of support calls, call attempts, uptake and participant retention rates. Furthermore, all participants were offered the opportunity to answer questions pertaining to program acceptability and satisfaction which were adapted from a previous telephone support service evaluation project.<sup>87</sup> These items primarily required participants to choose from pre-determined answers or Likert response scales. An example item pertaining to uptake included asking participants ‘What were your reasons for deciding to participate in the service?’. Acceptability questions included items

such as ‘To what extent did the telephone support sessions address your needs?’ and ‘How would you described the average length of the telephone support sessions?’.

The Barriers to Care Scale (BACS) was included in the survey.<sup>88</sup> The BACS is a 12-item measure that enables PLWHIV to specify the severity of various barriers to care. The BACS includes four subscales assessing barriers related to: geography/location barriers, medical and psychological service barriers, community stigma barriers, and personal resource barriers. The BACS scale uses a four-point Likert scale (1 = ‘No problem at all’, 2 = ‘Very slight problem’, 3 = ‘Somewhat of a problem’, and 4 = ‘Major problem’).<sup>88</sup>

Pre versus post measures assessing treatment adherence included the HIV treatment and adherence self-efficacy scale (HIV-ASES) and the Perceived Self Competence scale.<sup>20,89</sup> The HIV-ASES has an 11-point Likert scale designed to measure self-efficacy for adherence to HIV treatment plans, including but not limited to taking ART.<sup>20</sup> Participants are asked 12 questions such as ‘In the past month, how confident have you been that you can: Integrate your treatment into your daily routine?’. The response scores range from 0 (‘cannot do at all’) to 10 (‘completely certain can do’). The scale has previously demonstrated robust internal consistency (Raykov’s coefficient  $\rho = .91$ ) and 3-month ( $r = .71$ ) and 15-month ( $r = .49$ ) test-retest reliability.<sup>21</sup> Additionally the Perceived Self-Efficacy Scale was also utilised which consisted of 4 items regarding management of HIV care such as ‘I feel confident in my ability to manage my HIV’, the scale consists of a 1 (‘Not at all true’) to 7 (‘Very true’) Likert Scale. Standardised psychosocial and general health secondary outcome measures included the Kessler K6 psychological distress scale, perceived stress scale, CDC Healthy Days Core Module, and Functional Assessment of HIV Infection Emotional and Social Wellbeing subscales.<sup>90–93</sup>

## **Intervention**

Calls were proactively delivered to participants by a volunteer support caller. Participants were not matched with a specific caller throughout the program. Each support call addressed topics that have been demonstrated to influence the uptake and adherence of HIV treatment. Call content was guided by an intervention manual developed by the project team which included members of the Hunter New England HIV Sexual Health team, ACON, and The University of Newcastle. The program was delivered in six standalone calls and covered material including introduction and orientation to program, HIV information and symptom management, physical and psychological wellbeing, social and community participation, and access to support services. Calls were designed to deliver information support material and self-management strategies within a 45-minute time frame. Support callers were volunteers who had recently graduated from a Bachelor of Psychology or who were currently enrolled in third or fourth year of undergraduate Psychology at the University of Newcastle. Volunteers completed a two day training workshop which was designed to introduce the intervention manual, develop callers' knowledge of HIV/AIDs aetiology and treatment, and build general competency motivational interviewing skills. Calls were conducted at ACON, under the supervision of an experienced HIV-counsellor who provided support call supervision.

### **Analysis**

Analyses were undertaken using SPSS version 23. Descriptive statistics were used to describe the participants' demographic information, and clinical characteristics; including pre and post rates of HIV treatment uptake and adherence. Furthermore, descriptive statistics were used to describe process data and measures of program feasibility and acceptability. Paired sample t-tests have been utilised to explore pre and post measures of HIV treatment adherence, and associated factors such as the Kessler K6 psychological distress scale,

Perceived Stress Scale 4, CDC Healthy Days Core Module, and the Functional Assessment of HIV Infection scale.

## **Results**

### **Demographics and Clinical Characteristics of the Sample**

Of the 27 participants who completed the baseline survey, 26 were male, 1 was female, and the large majority (96.3%) were Non Aboriginal or Torres Strait Islander. On average, participants were 48 years of age, reported a mean of 14 years since testing HIV positive, and over two thirds (70.4%) had an undetectable viral load. The majority of the sample were single (92.6%), on a social security pension (77.8%), and 11 (40.7%) participants identified as being a daily smoker. Demographic and clinical characteristics of the sample are shown in Table 1.

### **Reasons for participating**

Participants were asked to identify their reasons for participating in the service. Almost all participants answered ‘someone to talk to’ (91.76%), with the majority endorsing the items ‘convenience/no travel involved’ (83.33%), ‘it’s a free service’ (75%), ‘one to one support/privacy’ (75%) and ‘source of information (70.83%)’. Half of participants reported ‘like / prefer telephone based support (50%)’. Participant’s reasons for participating are outlined in Fig. 1.

### **Program implementation and feasibility**

The program commenced with 24 participants in total, 20 from HNE LHD and 4 from WNSW LHD. Based on the NSW HIV strategy 2012-2015 data report of people accessing ART therapy in NSW, this provided a recruitment rate of 5.35% (20/374) for HNE LHD and 5.97% (4/67) of WNSW LHD.<sup>81</sup> Of the 24 participants who completed call one, 21 went on to complete the program resulting in an 88% retention rate for program completion.<sup>17</sup>

participants completed follow-up data, providing a response rate of 71% (17/24). During the program a total of 131 support calls were made to program participants, with an average call length of 30 minutes across all calls made. Table 2 program implementation and feasibility provides an overview of participant attrition and support calls made during the program.

### **Acceptability and satisfaction**

Participants that accessed the service were generally very positive in regard to their experience and perceived benefits it brought them. Overall, 94% of participants (15/16) reported the program as very or fairly useful with one participant finding the program not very useful. Almost all participants (14/15) indicated that they would recommend the program to other people living with HIV if the program was to be run in the future. In regard to their evaluation of support caller competency, participants gave generally positive reviews with 93% rating callers as ‘very supportive’ or ‘quite supportive’, and 87% describing callers as ‘very able’ or ‘quite able’ to offer information or advice about the issues raised by participants. See Table 3 for participant acceptability and satisfaction.

Participants were asked to rate the extent to which certain aspects of their lives had been influenced as a result of participating in the program. Most participants reported that as a result of the program they felt better informed, less isolated, more confident, more able to make changes in their lives, and more able to take their medication as described. Perceived impact of program feedback is provided in Fig. 2.

The large majority of participants reported positive feedback across a number of acceptability and implementation measures, including ease of scheduling calls, and average call length. Participants reported preferring monthly calls, and the majority had no preference for telephone content to be delivered by the same caller. Implementation feedback is provided in Table 4.

### **Participant measures from Baseline to Follow-up**

The majority of participants (26/27) were using ART medication upon program commencement. Paired sample t-tests were conducted on baseline and follow-up measures. There were no significant findings in regard to primary medication uptake or treatment adherence. Paired sample t-tests suggested a significant decrease in the Functional Assessment of HIV Infection Emotional wellbeing subscale scores ( $t(16)=2.515, p=0.023$ ), suggesting an improvement in subjective HIV related emotional wellbeing scores of program participants from baseline ( $M=14.85, SD=8.17$ ) to follow-up ( $M=9.24, SD=7.33$ ). In addition, of participants who reported as current smokers at baseline and follow-up, cigarettes smoked per day decreased significantly ( $t(4)=2.956, p=0.042$ ) from baseline ( $M=20.42, SD=7.87$ ) to follow-up ( $M=13.17, SD=6.05$ ). Participant pre and post measures are presented in Table 5.

## Discussion

Due to advances in treatment, HIV has progressed to a chronic health condition that requires ongoing care to manage disease progression and promote quality of life for PLWHIV. The current exploratory study sought to evaluate the feasibility and acceptability of a telephone support intervention aimed at promoting the uptake of medication, treatment adherence, and psychosocial wellbeing for PLWHIV. This is the first study to the author's knowledge that has piloted a telephone support intervention for PLWHIV in an Australian setting and provides preliminary support for further investigation into the utilisation of proactive telephone support programs.

The current study demonstrated high retention rates for program participants. The findings suggested that once participants were engaged with callers and orientated to the program during call one, they were very likely to go on to complete the program. Retention is an ongoing priority in assessing the feasibility and acceptability of HIV interventions and a core component of feasibility studies. Previous randomised controlled trials have primarily

focused on single-focus interventions including medication adherence, psychosocial wellbeing, and smoking cessation interventions.<sup>94-96</sup> However, recent research investigating retention in HIV care has indicated a desire for holistic interventions by consumers of HIV services, and suggest that this may improve retention in services.<sup>58</sup> The current study implemented an accessible holistic information support service which may have contributed to the favourable retention rates demonstrated in the program.

While desired retention rates were achieved, the study did not recruit as many participants as anticipated by the project team. It is possible the avenues of recruitment and purpose of the intervention within overall HIV care was not defined clearly enough within HIV services, and thus acted as a barrier to increasing referrals at recruitment sites. It is likely that novel interventions such as the current program need adequate time and development to become known and accepted within communities and treatment facilities. Future interventions may need to further educate services on how telephone information services may fit within a stepped care model, in a way that may complement existing clinical or counselling services. Furthermore, relying on print posters in clinics may not be an optimal recruitment strategy, especially for hard-to-reach individuals who may not often attend care settings. Future interventions might benefit from the growing potential of including social media and internet based advertising, to assist in addressing the ongoing challenges of traditional recruitment methods.<sup>97,98</sup>

The current study design, purpose, and sample precluded outcome analysis and conclusions regarding the effect of the intervention on pre and post measures. Nevertheless, these were tentatively explored as a secondary component of the pilot study. These findings suggested minimal changes in pre-post measures for the majority of measures. However, there was a significant improvement on participants Functional Assessment of HIV Infection Emotional wellbeing scores. This may potentially correspond with the perceived benefit



reported in acceptability and satisfaction measures. No changes were found in regard to treatment adherence. This finding is consistent with a recent systematic review and meta-analysis by Shah<sup>80</sup> suggesting telephone support has limited ability to improve adherence as a stand-alone intervention. However, when implemented with text message reminders improvements in outcomes are strengthened. Furthermore, telephone support services that broadly address a range of factors related to medication adherence are more likely to be efficacious.<sup>80</sup> Future support programs may benefit by adding an additional text reminder component to increase the impact of the intervention on medication adherence outcomes.

Almost all participants were already using ART prior to commencing the program, and thus a ceiling effect for any changes to ART uptake was noted. However, the one participant who was not currently using ART at commencement of the program did begin using ART during the study, which may have been coincidental. The high rates of ART usage was not unexpected, with the majority of PLWHIV prescribed ART medication in accordance with HIV treatment guidelines.<sup>2</sup> Engaging the minority of PLWHIV who do not engage with treatment may be an ongoing challenge that needs novel solutions. Telephone support may be an option for accessing 'hard to reach' populations, however this was not achieved in the current study. This is likely a result of the convenience sampling of participants primarily through existing providers of HIV care and the relatively lower total population of PLWHIV in the HNE and WNSW health districts compared to larger health districts.<sup>81</sup>

The results of the participant feedback suggested that the intervention was well received by the majority of participants. Average call attempts remained low across the program, suggesting effective scheduling of support calls and positive receptivity from participants. Participant-reported subjective benefit and satisfaction with the program remained high over indicators of program satisfaction, acceptability, and implementation. A

minority of participants identified that the service ‘did not meet there needs or was not appropriate for their situation’, and this may be a result of the largely heterogeneous sample in regard to years since testing HIV positive, which may account for some difference in needs.

Participants provided positive feedback in regard to the usefulness of information received and ability of callers to deliver informational support. This suggests that the delivery of an information support service by callers with no previous HIV experience may be feasible and acceptable to participants. In addition, this provides some evidence that a brief (two day) training package in addition to a manualised support call program may be sufficient in providing informational support to PLWHIV. Interestingly, the majority of participants reported not having a strong preference to receive support calls from the same caller, which is contradictory to expectations given the well documented nature of therapeutic relationships.<sup>99</sup> However, this may provide some evidence that within an information and referral-based support service that independent callers is sufficient to deliver program content.

Given the relationship between mental health problems, HIV, and financial disadvantage, it is important to continue to develop low-cost interventions that can contribute to the support options available to PLWHIV. The current study suggests that non-clinical volunteers with undergraduate training in psychology were perceived as helpful and able to provide information support by the majority of participants. This may be a promising area for future research given the cost-saving potential of volunteers. Furthermore, the option of not pairing participants with a single caller may further increase intervention feasibility and logistical planning, while concurrently reducing costs.

Low-cost interventions may play a key role in facilitating preventative health care and early intervention. There is a growing importance for HIV and chronic health co-morbidity management, and this could be a target of future telephone supports. Given the suggestion

that PLWHIV who are asymptomatic may be less likely to access care, efforts are needed to engage this group.<sup>57,58</sup> Proactive telephone interventions may be able to reduce transport, financial and motivational barriers to increase the likelihood of providing early intervention through informational support and referral to further care as required. The majority of participants in the current study reported accessing external support services as a result of information received during the program. This finding suggests the utility of an information service that may link participants with relevant local support services to address needs that may be outside the scope of the current intervention. This approach is consistent with the Australasian Society for HIV guidelines outlining stepped care for PLWHIV in Australia and may promote early intervention and support.<sup>100,101</sup>

### **Limitations**

Results of the current study should be interpreted in light of its limitations. This study was an exploratory pilot study and these results should only be considered preliminary and may not be generalizable to larger sample sizes. The sample were already engaged to some extent with providers of HIV care and described moderate treatment adherence levels at baseline. It is unclear if the intervention would have offered different findings in regard to the feasibility and acceptability of the study to a less treatment adherent population, however previous research has suggested telephone interventions may be acceptable in non-adherent samples in the US.<sup>102</sup> Future research should aim to include PLWHIV who are not currently connected with HIV services. It is possible that non-response bias may have influenced some outcomes of participant feedback given the small sample size, however the response rate was considered sufficient. Some barriers were identified with participants having limited computer access and literacy. Future research could consider providing incentives for follow-up survey completion to increase completion rates.

### **Conclusion**

The current study provides the first preliminary support for the feasibility and acceptability of a telephone support service for PLWHIV in an Australian setting. The service aimed to address multiple information support needs in regard to treatment adherence, physical and psychological health and wellbeing, and access to additional support services. Consistent with research suggesting holistic interventions may promote retention in care for PLWHIV, the current study demonstrated that the majority of participants who commenced the program went on to complete the full intervention. Furthermore, the majority of participants reported subjective benefit and satisfaction with the program over indicators of program satisfaction, acceptability, and implementation. Utilising non-clinical staff in telephone support programs may show potential for providing cost-effective support within local health districts. Future research might aim to expand the uptake of future interventions, and further target rural and hard-to-reach populations who may benefit most from access to information support that does not require face to face clinical contact. Given the increasing number of PLWHIV and the associated demand for support services, expanding research into the role of telephone support models may be an important opportunity to address this need in Australia.

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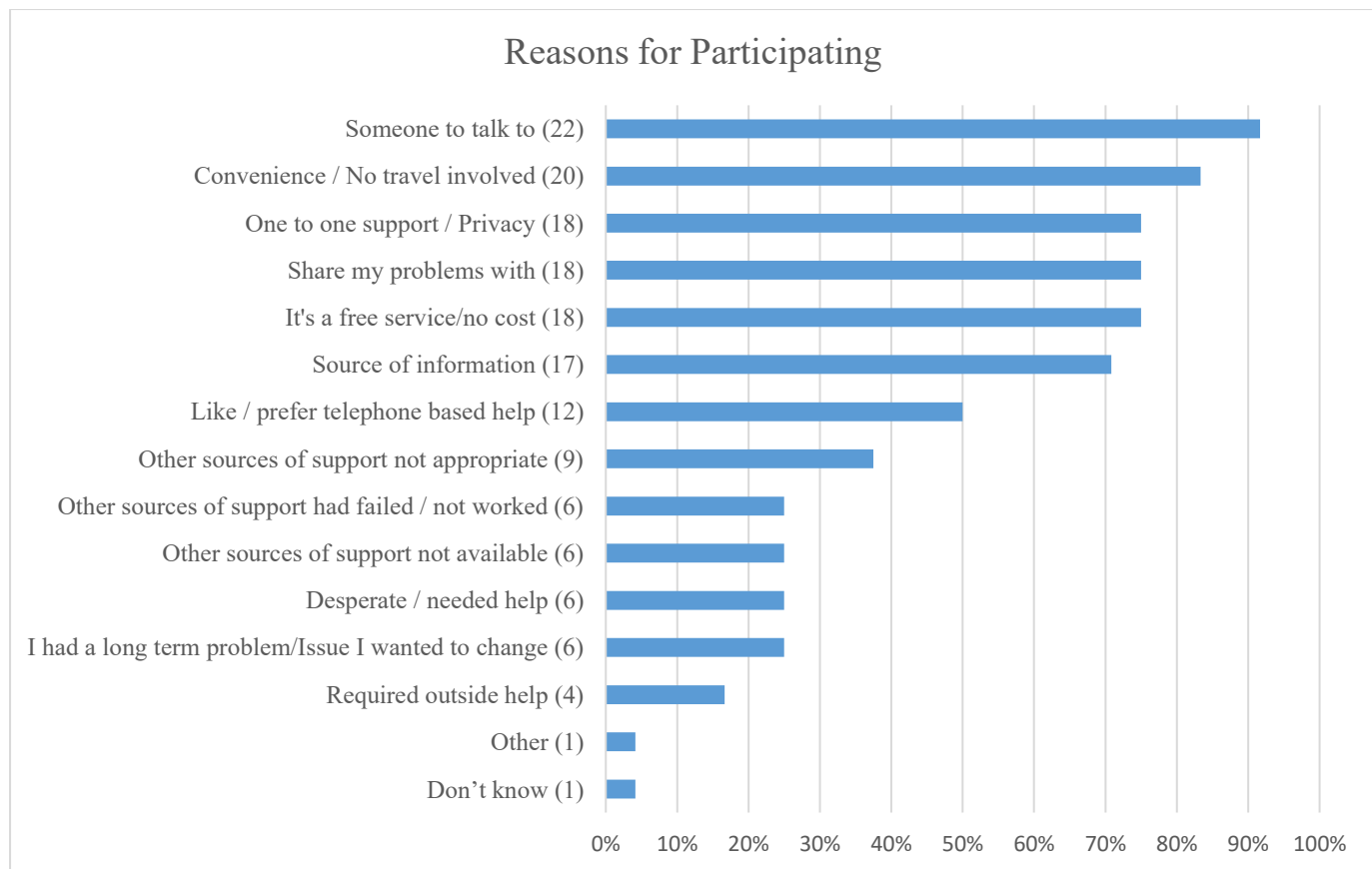
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*Table 1. Demographic and Clinical Characteristics at Baseline*

Characteristic	N= 27 (%)
<i>Age</i>	
<i>M</i> = 48.22, <i>SD</i> =9.40, <i>Range</i> = 29-63	
<i>Gender</i>	
Male	26 (96.3%)
Female	1 (3.7%)
<i>Relationship Status</i>	
Single	25 (92.6%)
Regular relationship/Married	2 (7.4%)
<i>Education level</i>	
Less than year 12	9 (18.5%)
Year 12 education	5 (18.5%)
Tertiary Diploma/Trade certificate/TAFE	9 (33.3%)
Undergraduate University degree or diploma	2 (7.4%)
Postgraduate University degree or diploma	2 (7.4%)
<i>Cultural Identity</i>	
Aboriginal or Torres Strait Islander	1 (3.7%)
Non Aboriginal or Torres Strait Islander	26 (96.3%)
<i>Employment status</i>	
On pension/social security	21 (77.8%)
Employed part-time	3 (37.1%)
Un-employed	1 (3.7%)
Student	1 (3.7%)
Other	1 (3.7%)
<i>Smoking Status</i>	
Daily smoker	11 (40.7%)
Occasional smoker	1 (3.7%)
Ex-smoker	8 (29.6%)
Non-smoker	7 (25.9%)
<i>Years since testing HIV+</i>	
<i>M</i> = 14.52, <i>SD</i> = 8.40, <i>Range</i> = 2-31	
<i>Most recent CD4 cell count</i>	
Greater than 500 cells/uL	19 (70.4%)
Between 500 and 350 cells/uL	5 (18.5%)
Less than 350 cells/uL	3 (11.1%)
<i>Viral Load</i>	
Undetectable	20 (74.1%)
Detectable	6 (22.2%)
Don't know	1 (3.7%)



*Figure 1. Participant reasons for participating*

*Table 2. Program implementation and feasibility*

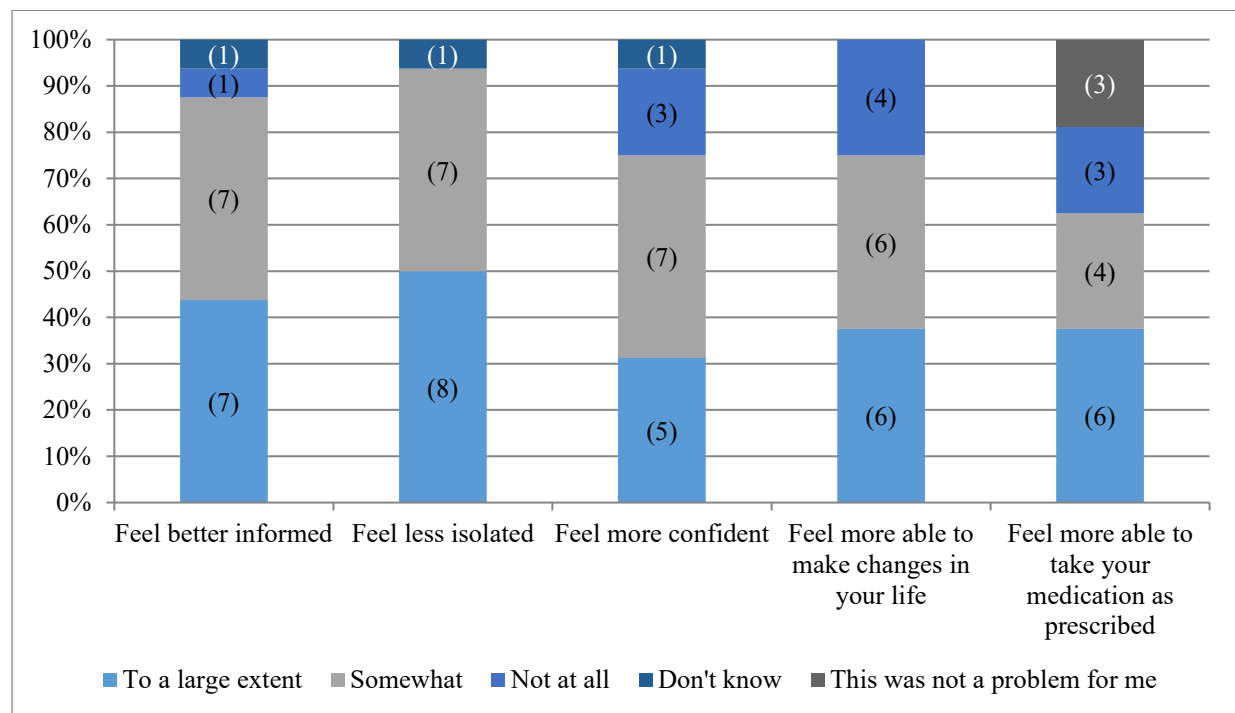
Call	Completed	Participant exits	Average Call length (min)	Average Call attempts
<i>Registration/Baseline Survey</i>	27	3 (prior to program commencement)	n/a	n/a
<i>One: Introduction + support services info</i>	24	-	25 ( <i>SD</i> = 8.9)	2.3 ( <i>SD</i> = 1.9)
<i>Two: Maintaining a healthy immune system</i>	24	-	31 ( <i>SD</i> = 13.5)	2.6 ( <i>SD</i> = 2.5)
<i>Three: Monitoring changes in body and mind</i>	21	1	34 ( <i>SD</i> = 13.2)	1.8 ( <i>SD</i> = 1.6)
<i>Four: Maintaining a healthy mind</i>	20	1	37 ( <i>SD</i> = 14.8)	1.8 ( <i>SD</i> = 1.3)
<i>Five: Maintaining a healthy body</i>	21	1	30 ( <i>SD</i> = 10.1)	2.6 ( <i>SD</i> = 2.1)
<i>Six: Developing a plan for maintenance</i>	21	-	28 ( <i>SD</i> = 16.0)	3 ( <i>SD</i> = 4.1)

*Table 3. Participant acceptability and satisfaction*

<b>Participant rated acceptability and satisfaction (N=17*)</b>		
<b><i>Response</i></b>	<b>N</b>	<b>%</b>
Overall how useful was the support or information you received?		
Very Useful	8	50.0
Fairly useful	7	43.8
Not very useful	1	6.2
Not at all useful	0	0
Don't know	0	0
To what extent did the telephone support sessions address your needs?		
To a great extent	8	47.1
To some extent	4	23.5
Not very much	4	23.5
Not at all	1	5.9
How appropriate do you feel the service was for your situation?		
Very appropriate	7	41.2
Fairly appropriate	5	29.4
Not very appropriate	3	17.6
Not at all appropriate	2	11.8
How supportive was your positive talk support caller?		
Very supportive	10	66.7
Quite supportive	4	26.7
A little supportive	1	6.7
Not at all supportive	0	0
How able were they to offer information or advice about issues you raised?		
Very able	7	50.0
Quite able	6	42.9
Somewhat able	1	7.1
Not at all able	0	0
Would you recommend the PTFPH support service to other PLWHIV?		
Yes	14	93.3
No	1	6.7

\*sample size varies due to missing data

**How has your participation in the Positive Talk for Positive Health support service changed things, to what extent do you?**



*Figure 2. Perceived impact of program*

*Table 4. Participant implementation feedback*

<b><i>Response</i></b>	<b>N</b>	<b>%</b>
Program calls completed:		
6 (entire program)	15	88.2
4	1	5.9
2	1	5.9
Preferred call frequency:		
One every week	0	0
One every fortnight	2	15.4
One every three weeks	0	0
One every month	11	84.6
Other	0	
How would you describe the average call length:		
About right	10	76.9
Too long	2	15.4
Too short	0	0
Other	1	7.70
How easy did you find scheduling calls at a time that suited you?		
Very easy	11	84.6
Usually easy	1	7.7
Not easy	1	7.7
Same vs different callers preference:		
Different callers is fine	11	64.7
Slight preference for same caller	3	17.6
Strong preference for same caller	3	17.6
Have you accessed support services as a result of information or advice received during the program:		
Yes	11	64.7%
No	4	23.5%
Did not require support services	2	11.8

\* sample size varies due to missing data

Measurement	Baseline (N=27)	Follow-up (N=17)
<i>Currently using ART medication</i>	26 (96.3%)	17 (100%)
<i>HIV treatment and adherence self-efficacy scale</i> ASES	$M=7.41$ , $SD=2.25$ , $Range = 3.92 - 10$	$M=7.78$ , $SD=2.09$ , $Range = 2.92 - 10$
<i>Perceived self-efficacy scale</i>	$M=5.76$ , $SD=1.22$ , $Range = 2.50 - 7$	$M=5.88$ , $SD=1.60$ , $Range = 1.75 - 7$
<i>Kessler-6 Distress scale</i>		
Low to Moderate	20 (74.1%)	13 (76.5%)
Severe Distress	7 (25.9%)	4 (23.5%)
<i>Barriers To Care Scale</i>	$M=2.53$ , $SD=0.67$ , $Range = 1.17-3.92$	$M=2.09$ , $SD=0.50$ , $Range = 1.00-3.08$
<i>Functional Assessment of HIV Infection: Emotional wellbeing*</i>	$M=14.85$ , $SD=8.17$ , $Range = 1-33$	$M=9.24$ , $SD=7.33$ , $Range = 1-27$
<i>Functional Assessment of HIV Infection: Social wellbeing</i>	$M=13.92$ , $SD=7.22$ , $Range = 0-27$	$M=17.00$ , $SD=8.43$ , $Range = 0-28$
<i>HRQOL – Healthy days</i>	$M=11.48$ , $SD=10.82$ , $Range = 0-30$	$M=16.29$ , $SD=9.79$ , $Range = 0-30$
<i>Current smokers* Cigarettes per day</i>	$M=20.42$ , $SD=7.87$ , $Range = 2-35$	$M=13.17$ , $SD=6.05$ , $Range = 7-20$
<i>Currently in contact with HIV/AIDS related organisations</i>		
Yes	22 (88.9%)	10 (81.5%)
No	3 (11.1%)	5 (18.5%)

Note: Sample size varies to missing data due to missing survey values

\* significant difference from baseline to follow-up on paired samples t-test

Table 5. Participant pre and post measures



**Appendix A: Journal Scope and Instructions for Authors**

# AIDS Patient Care and STDs

**Editor-in-Chief:** Jeffrey Laurence, MD

ISSN: 1087-2914 | Online ISSN: 1557-7449 | Published Monthly | Current Volume: 33

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Impact Factor:\* 3.742

\*2018 Journal Impact Factor, Journal Citation Reports (Web of Science Group, 2019)

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The premier peer-reviewed journal delivering critical peer-reviewed coverage of diagnostics and therapeutics for providing optimal care for HIV/AIDS patients.

[View Aims & Scope](#)

[Aims & Scope](#)

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*AIDS Patient Care and STDs* is the foremost journal providing the latest developments and research in diagnostics and therapeutics designed to prolong the lifespan and improve quality of life for HIV/AIDS patients. The Journal delivers cutting-edge clinical, basic science, sociologic, and behavior-based investigations in HIV/AIDS and other sexually transmitted infections. Clinical trials, quantitative and qualitative analyses of pilot studies, comprehensive reviews, and case reports are presented from leading experts and scientists around the world.

***AIDS Patient Care and STDs* coverage includes:**

- Prominent AIDS medications, therapies, and antiretroviral agents
- HIV/AIDS-related diseases, infections, and complications
- Challenges of medication adherence
- Current prevention techniques for HIV
- The latest news and developments on other STDs
- Treatment/prevention options, including pre- and post-exposure prophylaxis

*AIDS Patient Care and STDs* is under the editorial leadership of Editor-in-Chief **Jeffrey Laurence, MD**, Weill Cornell Medical College, Laboratory for AIDS Virus Research at New York Blood Center; Senior Consulting Editor **Robert C. Gallo, MD**, Institute of Human Virology, University of Maryland School of Medicine; and other leading investigators. View the entire [editorial board](#).

**Audience:** HIV/AIDS clinicians, nurses, and psychologists; behavioral and social scientists; infectious disease specialists; immunologists; pathologists; virologists; hospital and AIDS treatment facility staff; and municipal health department staff; among others.

## Information For Authors

### Mary Ann Liebert, Inc. Submission Benefits Package

Your submission to *AIDS Patient Care and STDs* provides you with robust tools and support to ensure maximum impact and readership for your work. By submitting your manuscript, you'll receive:

- **Rapid, rigorous peer-review** and editorial attention
- **Immediate deposit to PubMed** and other indexing services upon online publication
- **Exposure to thousands of thought-leaders** in your field, maximizing readers, citations, and downloads
- **Fast Track online-ahead-of-print publication**
- **Global availability in over 170 countries**
- **[Open Access](#) publication options**

## Submitting Your Manuscript

Submitting your manuscript to *AIDS Patient Care and STDs* delivers a comprehensive benefits program that ensures high-quality review of your research and maximum impact for your work. *AIDS Patient Care and STDs* carries a manuscript processing charge\* of \$50.00 USD upon submission of each new manuscript.

Upon payment, you will be provided a Manuscript Submission Code, and will be prompted to enter this information when uploading your files to our peer-review system. ***Please note:*** Securing a token does not automatically create an account in our peer-review system. If you do not already have an account, you will be asked to create one before you can begin your submission.

Submissions do not need to be completed at once. Submitting authors/agents may begin the submission process, save their work, and return to the site to complete the upload(s) at a later time. There is no limit on the number of times one can save their work and subsequently resume the submission. Doing so will not incur additional charges.

**[Click here](#) to submit your paper via our fast and user-friendly electronic submission system.**

## Manuscript Revisions

Processing charges and submission codes are NOT required for revisions to previously submitted papers. To upload a **revision** of a paper, the submitting author should log in to their Author Center at <http://mc.manuscriptcentral.com/aidspatientcare> and click on ***“Revised Manuscripts in Draft.”*** The paper will appear in this area, and the submitting author will be able to upload revised files without paying any charges or entering a submission code.

### **Please be sure to follow the Instructions for Authors below on Manuscript**

**Preparation.** Authors whose submissions do not comply with the Instructions for Authors will have their papers un-submitted so that the file(s) may be adjusted accordingly. Directions

regarding the necessary corrective actions will be provided in an email to the corresponding author at the time the paper is un-submitted. The submitting author/agent will then be provided the opportunity to re-upload the corrected file(s). If a paper is un-submitted, the paper will reside in the corresponding author's "Author Center" as a draft, and the submitting author/agent will be able to make the necessary adjustments and re-upload the paper without incurring another manuscript processing charge.

*\*The manuscript processing charge is independent of editorial decision and is non-refundable.*

### **Preparation of Manuscript**

Be sure these instructions are followed exactly.

We welcome Original Research and Review submissions on topics of major significance in biotherapy, radiopharmaceuticals, and related fields. Each coauthor accepts responsibility for the entire contents of the manuscript. Contributions to the journal are published at no charge to the author. Once a paper has been accepted for publication, it cannot be withdrawn. Authors will have the option to indicate one reviewer who should be excluded (non-preferred) from review of their manuscript. Authors will also have the option to suggest preferred reviewers during the submission process if they like.

**Note:** *AIDS Patient Care and STDs* does not publish Short Communications.

### **Abstracts**

ABSTRACT should be capitalized and centered on the page and have one space below. The text of the abstract is single spaced and should be limited to 250 words. This should appear on a separate page.

**Manuscript keywords (search terms):** On the title page of the manuscript, include a minimum of three (3), maximum of six (6), search terms that will aid in the discoverability of the article in indexing services and search engines. These terms may or may not be different from the terms you selected for the peer review process and areas of expertise. You will be asked to retype these search terms in the submission form when uploading your manuscript. These keywords will be included in the published article. If the search terms entered do not match the manuscript, the manuscript will serve as the default.

### **Keywords (Areas of Expertise)**

To facilitate the peer review process, select 4-6 keywords from the drop-down list of pre-selected terms when submitting your manuscript. These keywords will assist in the selection of skilled reviewers in the field for the purposes of peer review.

### **Tables and Figures**

Each table should be prepared in a separate file. Tables should be cited in the text (see Table 1). Tables should be submitted in Microsoft Word.

Each figure should be prepared in a separate file with the figure number visible. Each figure should be cited in text (Fig. 1). Legends should be on a separate page from the figures.

### **Please follow these guidelines for submitting figures:**

- Do **NOT** embed art files into a Word or PDF document.
- Line illustrations should be submitted at 1200 dpi.
- Halftones and color should be submitted at a minimum of 300 dpi.
- Save as either TIFF or EPS files.
- Color art must be saved as CMYK – **not RGB**.
- Black and White art must be submitted as grayscale – **not RGB**.
- Do **NOT** submit PowerPoint, PDF, Bitmap or Excel files.

Please name your artwork files with the submitting author's name i.e. SmithFig1.tif, SmithTable2.tif etc. Label figures and tables inside the files in addition to naming the file with the figure or table number. (ie: When figures or table files are opened, the figure or table number should appear inside the file.) **Authors who do not follow these guidelines may have their submission returned to them without being reviewed.**

You will be given directions on how to correct any files which do not pass.

### **ADDITIONAL INFORMATION ABOUT ART FILES**

**Converting Word or Excel files:** Perhaps the best and easiest way to **convert Word or Excel files** into a format which is suitable for print is to scan them using the guidelines below :

- All files should be scanned at 100% size.
- 300 dpi
- Final color mode: cmyk
- save file as: .tif or .eps

If you need directions on how to **convert a Power Point slide** to acceptable format go to <https://home.liebertpub.com/MEDIA/pdf/ppconvert.pdf>

**Footnotes**

Footnotes should be typed single spaced at the bottom of the appropriate page and separated from the text by a 3-inch line starting from the left margin with one space above and below it. Footnotes should be used only when essential.

**Acknowledgments**

Collaborations, sources of research funds, and other acknowledgments must be listed in a separate section at the end of the text ahead of the REFERENCES section.

**AUTHOR DISCLOSURE**

All authors are expected to disclose any institutional or commercial affiliations that might pose a conflict of interest regarding the publication of a manuscript. Institutional affiliations, as indicated on the title page, should include all corporate affiliations and any funding sources that support the work. Other types of affiliation, including consultantships, honoraria, stock ownership, equity interests, arrangements regarding patents, or other vested interests should be disclosed in the Acknowledgments section.

**References**

Use order-of-citation format for references. Cite references within the text by a superscripted Arabic number as in the following example: [. . .as described previously.<sup>1,4</sup>]. Provide a list of references, in numerical order, and in the order in which they appear in the text. Reference section should be double spaced.

For journal citations: (1) surname of author(s) and initials; (2) title of article; (3) journal; (4) year of publication; (5) volume number; (6) inclusive page range of citation.

For book citations: (1) surname of author(s) and initials; (2) title of book; (3) editor of book (if applicable); (4) edition of book (if applicable); (5) publisher; (6) city of publication; (7) year of publication (not in parentheses); and (8) page reference (if applicable).

For patents: (1) country of original registration; (2) patent number; and (3) month, day, and year of issuance. When data from an unpublished source are given, supply complete information (e.g., researcher's name and location). If work is in press, give journal in which it is to be published or publisher.

For book and journal references, if there are more than four authors, list only the first three, followed by et al.

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### **Correspondence**

Be sure to provide the complete name and address to which correspondence should be directed.

### **Disclosures**

Funding sources for research must be disclosed for all manuscripts accepted for publication.

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## Appendix B: Ethics Approval



21 January 2014

Dr Jenny Bowman  
School of Psychology  
University of Newcastle

Dear Dr Bowman,

**Re: HIV Telephone Support Program (13/12/11/4.13)**

**HNEHREC Reference No: 13/12/11/4.13**  
**NSW HREC Reference No: HREC/13/HNE/526**

Thank you for submitting the above application for single ethical review. This project was first considered by the Hunter New England Human Research Ethics Committee at its meeting held on **11 December 2013**. This Human Research Ethics Committee is constituted and operates in accordance with the National Health and Medical Research Council's *National Statement on Ethical Conduct in Human Research (2007)* (National Statement) and the *CPMP/ICH Note for Guidance on Good Clinical Practice*. Further, this Committee has been accredited by the NSW Department of Health as a lead HREC under the model for single ethical and scientific review. The Committee's Terms of Reference are available from the Hunter New England Local Health District website.

I am pleased to advise that following acceptance under delegated authority of the requested clarifications and revised Information Statement and Survey by Dr Nicole Gerrard Manager, Research Ethics & Governance, the Hunter New England Human Research Ethics Committee has granted ethical approval of the above project.

The following documentation has been reviewed and approved by the Hunter New England Human Research Ethics Committee:

- For the Participant Information Statement (Version 2 13 December 2013);
- For the Participant Consent Form (Version 2 dated 13 December 2013);
- For the Baseline Participant Survey (Version 2);
- For the Study Brochure; and
- For the Study Poster (Version 2)

For the study: **HIV Telephone Support Program**

Approval has been granted for this study to take place at the following site:

- **Hunter New England Population Health**

**Hunter New England Research Ethics & Governance Unit**

Locked Bag 1  
New Lambton NSW 2305  
Telephone: (02) 49214950 Facsimile: (02) 49214818  
Email: HNELHD-HREC@hnehealth.nsw.gov.au  
[http://www.hnehealth.nsw.gov.au/research\\_ethics\\_and\\_governance\\_unit](http://www.hnehealth.nsw.gov.au/research_ethics_and_governance_unit)

Approval from the Hunter New England Human Research Ethics Committee for the above protocol is given for a maximum of **3** years from the date of this letter, after which a renewal application will be required if the protocol has not been completed.

The *National Statement on Ethical Conduct in Human Research (2007)*, which the Committee is obliged to adhere to, include the requirement that the committee monitors the research protocols it has approved. In order for the Committee to fulfil this function, it requires:

- A report of the progress of the above protocol be submitted at 12 monthly intervals. Your review date is **January 2015**. A proforma for the annual report will be sent two weeks prior to the due date.
- A final report must be submitted at the completion of the above protocol, that is, after data analysis has been completed and a final report compiled. A proforma for the final report will be sent two weeks prior to the due date.
- All variations or amendments to this protocol, including amendments to the Information Sheet and Consent Form, must be forwarded to and approved by the Hunter New England Human Research Ethics Committee prior to their implementation.
- The Principal Investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including:
  - any serious or unexpected adverse events
    - Adverse events, however minor, must be recorded as observed by the Investigator or as volunteered by a participant in this protocol. Full details will be documented, whether or not the Investigator or his deputies considers the event to be related to the trial substance or procedure. These do not need to be reported to the Hunter New England Human Research Ethics Committee
    - Serious adverse events that occur during the study or within six months of completion of the trial at your site should be reported to the Manager, Research Ethics & Governance, of the Hunter New England Human Research Ethics Committee as soon as possible and at the latest within 72 hours.
    - All other safety reporting should be in accordance with the NHMRC's Safety Monitoring Position Statement – May 2009 available at [http://www.nhmrc.gov.au/health\\_ethics/hrecs/reference/files/090609\\_nhmrc\\_position\\_statement.pdf](http://www.nhmrc.gov.au/health_ethics/hrecs/reference/files/090609_nhmrc_position_statement.pdf)
    - Serious adverse events are defined as:
      - Causing death, life threatening or serious disability.
      - Cause or prolong hospitalisation.
      - Overdoses, cancers, congenital abnormalities whether judged to be caused by the investigational agent or new procedure or not.
  - Unforeseen events that might affect continued ethical acceptability of the project.
- If for some reason the above protocol does not commence (for example it does not receive funding); is suspended or discontinued, please inform Dr Nicole Gerrand, as soon as possible.

**Hunter New England Research Ethics & Governance Unit**

Locked Bag 1  
New Lambton NSW 2305  
Telephone: (02) 49214950 Facsimile: (02) 49214818  
Email: HNELHD-HREC@hnehealth.nsw.gov.au  
[http://www.hnehealth.nsw.gov.au/research\\_ethics\\_and\\_governance\\_unit](http://www.hnehealth.nsw.gov.au/research_ethics_and_governance_unit)



**You are reminded that this letter constitutes ethical approval only. You must not commence this research project at a site until separate authorisation from the Chief Executive or delegate of that site has been obtained.**

A copy of this letter must be forwarded to all site investigators for submission to the relevant Research Governance Officer.

Should you have any concerns or questions about your research, please contact Dr Gerrand as per the details at the bottom of the page. The Hunter New England Human Research Ethics Committee wishes you every success in your research.

Please quote **13/12/11/4.13** in all correspondence.

The Hunter New England Human Research Ethics Committee wishes you every success in your research.

Yours faithfully

For: Professor M Parsons  
Chair  
Hunter New England Human Research Ethics Committee

**Hunter New England Research Ethics & Governance Unit**  
Locked Bag 1  
New Lambton NSW 2305  
Telephone: (02) 49214950 Facsimile: (02) 49214818  
Email: HNELHD-HREC@hnehealth.nsw.gov.au  
[http://www.hnehealth.nsw.gov.au/research\\_ethics\\_and\\_governance\\_unit](http://www.hnehealth.nsw.gov.au/research_ethics_and_governance_unit)



**Health**  
Western NSW  
Local Health District

4 November 2014

Dr Jenny Bowman  
Associate Professor  
School of Psychology  
University of Newcastle  
CALLAGHAN NSW 2308

Dear Dr Bowman,

***Western NSW & Far West Local Health Districts  
HREC Project No. HREC/13/HNE/526  
SSA Application No. SSA/14/GWAHS/101***

***HIV Telephone Support Project***

***Site Specific Assessment Application***

Thank you for submitting a site specific assessment application to conduct research within the Western NSW & Far West Local Health Districts.

I am pleased to inform you that authorisation has been granted for this study to take place at the following sites within the Western NSW & Far West Local Health Districts:

- Western NSW LHD
  - Orange Sexual Health Clinic
  - Dubbo Sexual Health Clinic

The following conditions apply to this research project. These are additional to those conditions imposed by the Human Research Ethics Committee that granted ethical approval:

- 1 Proposed amendments to the research protocol or conduct of the research which may affect the ethical acceptability of the project, and which are submitted to the lead HREC for review, are copied to the Research Governance Officer; and
- 2 Proposed amendments to the research protocol or conduct of the research which may affect the ongoing site acceptability of the project, are to be submitted to the Research Governance Officer.

**Research Governance**

PO Box 143  
Level 1, 230 Howick Street  
BATHURST NSW 2795  
Tel: (02) 6330 5941 Fax: (02) 6332 3140

Should you have any queries regarding your project, please do not hesitate to contact the Western NSW & Far West Local Health Districts Research Governance Officer on (02) 6330 5941 or via email [WNSWLHD-EthicsCommittee@health.nsw.gov.au](mailto:WNSWLHD-EthicsCommittee@health.nsw.gov.au).

Please quote SSA Reference No. SSA/14/GWAHS/101 in all correspondence.

The Western NSW & Far West Local Health Districts wish you every success in your research.

Yours sincerely

Suzanne Degiorgio  
**Ethics & Research Governance Officer**  
**Western NSW & Far West Local Health Districts**

HUMAN RESEARCH ETHICS COMMITTEE

**Notification of Expedited Approval**

---

To Chief Investigator or Project Supervisor: **Associate Professor Jennifer Bowman**

Cc Co-investigators / Research Students: **Mr David Wilkinson**  
**Ms Karen Nairn**  
**Mr Todd Heard**

Re Protocol: **HIV Telephone Support Project**

Date: **06-Mar-2014**

HREC Reference No: **H-2014-0063**

External HREC Reference No: **13/12/11/4.13**

Date of Initial Approval: **04-Mar-2014**

---

Thank you for your **Initial Application** submission to the Human Research Ethics Committee (HREC) seeking approval in relation to the above protocol.

Your submission was considered under **Expedited Review of External Approval** review by the Chair/Deputy Chair.

I am pleased to advise that the decision on your submission is **External HREC Approval Noted** effective **04-Mar-2014**.

In approving this protocol, the Human Research Ethics Committee (HREC) is of the opinion that the project complies with the provisions contained in the *National Statement on Ethical Conduct in Human Research, 2007*, and the requirements within this University relating to human research.

As the approval of an External HREC has been "noted" the approval period is as determined by that HREC.

The full Committee will be asked to note this decision at its next scheduled meeting. A formal *Certificate of Approval* will be available upon request. Your approval number is **H-2014-0063**.

**PLEASE NOTE:**

As the HREC has "noted" the approval of an External HREC, progress reports and reports of adverse events are to be submitted to the External HREC only. In the case of Variations to the approved protocol, or a Renewal of approval, you will apply to the External HREC for approval in the first instance and then Register that approval with the University's HREC.

**Linkage of ethics approval to a new Grant**

HREC approvals cannot be assigned to a new grant or award (ie those that were not identified on the application for ethics approval) without confirmation of the approval from the Human Research Ethics Officer on behalf of the HREC.

Best wishes for a successful project.

Professor Allyson Holbrook

**Chair, Human Research Ethics Committee**

*For communications and enquiries:*

**Human Research Ethics Administration**

Research Services  
Research Integrity Unit  
The Chancellery  
The University of Newcastle  
Callaghan NSW 2308  
T +61 2 492 17894  
F +61 2 492 17164  
[Human-Ethics@newcastle.edu.au](mailto:Human-Ethics@newcastle.edu.au)

RIMS website - <https://RIMS.newcastle.edu.au/login.asp>

***Linked University of Newcastle administered funding:***

Funding body	Funding project title	First named investigator	Grant Ref
Hunter New England Population Health/Shared(**)	Investigation of Telephone Support for people living with HIV in the Hunter New England Region	Bowman Jennifer,	G1300875

**Appendix C: Recruitment Advertising**

Poster

The poster is divided into four horizontal color bands: green at the top, pink in the second, blue in the third, and dark blue at the bottom. The word 'Telephone' is faintly visible in the green band, and 'Health' is written vertically in pink in the pink band. The word 'Positive' is faintly visible in the blue band, and 'Wellbeing' is faintly visible at the bottom of the blue band. A thought bubble is in the top right, and a rotary telephone is in the bottom right of the blue band.


**“Positive Talk for  
Positive Health”**

**Confidential  
Information Support  
Service**

Program participants will be  
provided with six, monthly  
information and support calls.

For more information about participating in  
the free and confidential service please register  
your interest by calling:  
Phone: 02 49246373

## Brochure

HEALTHY BODIES 	POSITIVE TALK The service	HEALTHY MINDS How do I participate?
<p>The "Positive Talk for Positive Health" program is a free telephone based service for clients enrolled in the research project.</p> <p>Over the course of the program you will be supported to develop health and wellbeing goals that are relevant to your individual needs across the following areas:</p> <ol style="list-style-type: none"> <li>1. Maintaining your social &amp; emotional wellbeing;</li> <li>2. Living a healthy life;</li> <li>3. Discussing treatment decisions;</li> <li>4. Managing your symptoms; &amp;</li> <li>5. Planning for your health and support needs.</li> </ol>	<p><b>What the service offers ...</b></p> <ul style="list-style-type: none"> <li>• Access to trained telephone support staff.</li> <li>• Participation in six free confidential support calls over a period of six months.</li> <li>• The opportunity to discuss issues that are important to you.</li> <li>• Up-to-date information on issues that affect your health and wellbeing and support services available in your community.</li> <li>• Support to develop the skills &amp; motivation needed for self-management.</li> </ul> <p><b>The "Positive Talk for Positive Health" team is designed to support you to live healthy.</b></p>	<p>Participation in the information support service is easy:</p> <p><b>Step 1:</b> Call 02 49246373 to register your interest in participating.</p> <p><b>Step 2:</b> A member of the team will call you to learn about your individual needs.</p> <p><b>Step 3:</b> Commence participation in the information support service in 2014</p> <p><small>This service is part of a research project, being conducted by the Hunter New England Local Health District and the University of Newcastle. Participating in this research will contribute to improving treatment and quality of life outcomes for people living with HIV across the Hunter New England region.</small></p>

<p>Local HIV Support Services</p> <p>The Pacific Clinic Level 2, 670 Hunter Street, Newcastle Phone: (02) 4016 4536</p> <p>HIV Support Services John Hunter Hospital Phone: (02) 4922 3444</p> <p>Clinic 468 468 Peel Street, Tamworth Phone: (02) 6764 8080</p> <p>Manning Clinic Taree Community Health Centre 64 Pultney Street, Taree Phone: (02) 4016 4536</p> <p>ACON Health Hunter 129 Maitland Road, Islington, Phone: (02) 4962 7700</p> <p>Karumah Positive Living Centre Phone: (02) 4940 8393</p> <p><u>Emergency Contacts:</u></p> <p>Lifeline 24 hour service 13 11 14</p> <p>Medical emergency call 000</p>	<p>TAKE THE FIRST STEP!</p>  <p>For more information about participating in the free and confidential service please register your interest by calling:</p> <p>Phone: 02 49246373 Available Monday - Friday (9am-5pm), you can leave a message out of hours.</p>	<p><i>"Positive Talk for Positive Health"</i></p>  <p><b>Confidential Information Support Service</b></p> <p>Positive</p> <p>Positive Talk Healthy Minds Healthy Bodies Positive Health</p>
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## Appendix D: Participant Information Statement and Consent Form



### Participant Information Statement for the HIV Telephone Support project "Positive Talk for Positive Health"

You are invited to participate in the "Positive Talk for Positive Health" project. The "Positive Talk for Positive Health" is a project for people living with HIV in the Hunter New England Area. The project is being conducted by a research team from the *Hunter New England Local Health District (HNELHD)* and the *University of Newcastle* and led by Principal Investigators, Dr Jenny Bowman and Ms Karen Nairn.

#### *Why is the research being done?*

The HNELHD and the University of Newcastle are committed to providing information and support to people living with HIV across the HNELHD. The 'Positive Talk for Positive Health' project will investigate whether a telephone delivered information and support service will contribute to improving treatment and quality of life outcomes for people living with HIV.

#### *What does the research involve?*

The 'Positive Talk for Positive Health' pilot project will provide information and support for people living with HIV via telephone. The telephone support will be delivered by trained support callers over six, monthly calls. To measure the project's effectiveness, information will be collected from project participants by surveys at the commencement of the project, the completion of the project and four months following the project.

#### *Who can participate in the research?*

People 18 years of age or over living with HIV across the HNELHD will be invited to participate in the project. Participants must also be fluent in English and be able to give consent to take part.

#### *What choice do you have?*

Participation in this research is entirely your choice. Your decision to participate, or not, will not influence in any way the health care provided to you by any existing HNELHD health care services or providers. If you do decide to participate, you may withdraw at any time without giving a reason, and any information you have provided relating to you will be destroyed.

#### *What would you be asked to do?*

If the project is suitable for you and you decide to participate, you will be asked to indicate your consent and complete the first survey; which you will have the option of completing online or by telephone and will take about 20 minutes. The survey will ask questions about your age, background, sexual orientation, HIV diagnosis and progress, health related behaviours, psychological and general quality of life, health service use and barriers to care and support.

After completing the baseline survey, you will be contacted by a member of the research team who will schedule a time for your first support call. During that first support call, we will discuss what would suit you with regards to arranging for further calls (5 calls at approximately 1 month intervals). On two further occasions following your completion of the "Positive Talk for Positive Health" program you will be asked to complete a follow up survey: immediately after completing the program and then again four months later. These surveys will ask similar questions to the first survey and also seek your feedback on the project.

*How will your privacy be protected?*

If you agree to participate, your name and contact details will be recorded. Your survey will have been allocated a randomly generated I.D. number. Your name and contact details with the associated I.D. number will be stored securely and separately from your answers to the survey questions. When analysing survey responses, your name and any identifying information will not be included. You may request a summary report of your own survey responses be provided to yourself, but complete confidentiality of your responses will otherwise be maintained.

*What are the risks and benefits of participating?*

It is expected that the benefits will include an increased level of information and support that may assist participants to make decisions that contribute to improved treatment and quality of life outcomes. There is the possibility that answering questions about your personal circumstances may sometimes be upsetting. Should you feel in any way upset by participating, we recommend you discuss this with one of the Principal Investigators, your ongoing provider of HIV information support, your GP or your local mental health service (Mental Health Hotline phone no. 1800011511). The "Positive Talk for Positive Health" project will provide contact details for sources of mental health support in your local area as a standard part of the information provided.

*How will the information collected be used?*

All data collected in the project will be analysed on a group basis only, with no individual identifying information. Any reports or publications regarding the project will discuss results on a group basis only. Information collected as part of the project will be stored securely in electronic files and paper copies will be stored in a locked filing cabinet. Access to data will be restricted to members of the research team. Data that is non-identifying will be kept for a period of 15 years to allow for ongoing analyses. Identifying information (e.g. the list of names, contact details and I.D. numbers) will be destroyed at the completion of the project.

*What do you need to do to participate?*

Please read this information statement carefully. If you think you might like to take part, or have further questions about the project, please contact Todd Heard by phone on 0249246373 or email [todd.heard@hnehealth.nsw.gov.au](mailto:todd.heard@hnehealth.nsw.gov.au). Your enquiry will be treated in strictest confidence.

Thank you for considering this invitation.

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Dr. Jenny Bowman  
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School of Psychology  
University of Newcastle  
ph 02 49215958  
email [jenny.bowman@newcastle.edu.au](mailto:jenny.bowman@newcastle.edu.au)

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Ms Karen Nairn  
Director, HIV and Related Programs  
Hunter New England Population Health  
Hunter New England Local Health District  
ph 02 49246022  
email [Karen.nairn@hnehealth.nsw.gov.au](mailto:Karen.nairn@hnehealth.nsw.gov.au)

**Complaints:** This project has been approved by the Hunter New England Human Research Ethics Committee of Hunter New England Health, Reference **13/12/11/4.13**. Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is being conducted, it may be given to the researcher, or, if an independent person is preferred, to Dr Nicole Gerrand, Manager, Research Ethics and Governance, Hunter New England Health, Locked Bag 1, New Lambton NSW 2305. Telephone (02) 4921 4950. Email [Nicole.Gerrand@hnehealth.nsw.gov.au](mailto:Nicole.Gerrand@hnehealth.nsw.gov.au)



**Health**  
Hunter New England  
Local Health District

**Consent Form for the HIV Telephone Support project  
"Positive Talk for Positive Health"**

People living with HIV in the Hunter New England Area, are invited to participate in the "Positive Talk – Positive Health" pilot project, which is being conducted by a research team from the *Hunter New England Local Health District (HNELHD) and the University of Newcastle* and led by Primary Investigators, Dr Jenny Bowman and Ms Karen Nairn.

**Please refer to the Participant Information Statement before completing this form, for detailed information regarding the project and participation.**

I agree to participate in the above research project and give my consent freely.

I understand that the project will be conducted as described in the Participant Information Statement, a copy of which I have retained.

I understand I can withdraw from the project at any time and do not have to give any reason for withdrawing.

I understand that my personal information will remain confidential to the researchers, except in the situation where I have provided my consent to my answers being shared with my ongoing provider of HIV treatment and support.

I have the opportunity to have questions answered to my satisfaction.

I consent to;

- Being contacted on the number provided for the purpose of participation in this project  
☐ Yes
- Completing a baseline survey prior to participating in the project (online or by phone)  
☐ Yes
- Completing a survey at the completion of the project (online or by phone)  
☐ Yes
- Completing a further follow up survey at approximately 4 months (online or by phone)  
☐ Yes

## Appendix E: Baseline/Follow-up Survey

### Positive Talk for Positive Health: Follow-up survey

Variation Key:

- Questions previously approved for use in baseline survey
- Additional follow-up Questions

<b>Survey Question:</b>
<b>Q1.</b> Please enter your survey ID which is six characters long, made up of: The first two letters of your first name, the first two letters of your mother's name, and the numerical form of the month you were born in. E.g. Participant: John Smith Participant's mother: Melinda Smith Month Participant born: February Participant ID = JOME02  Survey ID _____
<b>Q2.</b> In what year were you born?
<b>Q3.</b> What is the postcode or suburb/town where you live? <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> / _____
<b>Q4.</b> Are you: <ul style="list-style-type: none"> <li>- Employed full-time (1)</li> <li>- Employed part-time (2)</li> <li>- On pension/social security (3)</li> <li>- A student (4)</li> <li>- Unemployed (5)</li> <li>- Other (6)</li> </ul>
<b>Q5.</b> Where do you currently live? <ul style="list-style-type: none"> <li>- Own or purchasing house or flat (1)</li> <li>- Private rental accommodation (2)</li> <li>- Public rental accommodation (government owned) (3)</li> <li>- Rent-free (e.g. provided by friends, family, etc.) (4)</li> <li>- Community housing/housing co-operative (5)</li> <li>- Other (please describe) (6)</li> </ul>
<b>Q6.</b> Who do you live with? (tick as many as apply to you) <ul style="list-style-type: none"> <li>- No-one (1)</li> <li>- Partner/spouse (2)</li> <li>- Dependent children (3)</li> <li>- Other family members (4)</li> <li>- Friend(s)/Flatmate(s) (5)</li> <li>- Other (please specify) (6)</li> </ul>
<b>Q7.</b> Are you now in a regular relationship/married? <ul style="list-style-type: none"> <li>- Yes (1)</li> <li>- No (2)</li> </ul>
<b>Q8.</b> What is your partner's HIV status?

<ul style="list-style-type: none"> <li>- HIV positive (1)</li> <li>- HIV negative (2)</li> <li>- Don't know (3)</li> </ul>					
<b>Q9.</b> In what year did you first test positive for HIV?					
<b>Q10a.</b> Have you had a T-cell (CD4) test in the last 12 months?					
<ul style="list-style-type: none"> <li>- Yes (1)</li> <li>- No - why not? _____ (2)</li> <li>- Don't know (3)</li> </ul>					
<b>Q10b.</b> What was the result of your most recent T-cell (CD4) test?					
<ul style="list-style-type: none"> <li>- Greater than 500 cells/<math>\mu</math>L (1)</li> <li>- Between 500 and 350 cells/<math>\mu</math>L (2)</li> <li>- Less than 350 cells/<math>\mu</math>L (3)</li> </ul>					
OR					
<ul style="list-style-type: none"> <li>- _____ cells/<math>\mu</math>L (4)</li> </ul>					
<b>Q10c.</b> When was your most recent T-cell (CD4) test?					
<ul style="list-style-type: none"> <li>- Month _____ year _____</li> </ul>					
<b>Q11a.</b> Have you had a viral load test in the last 12 months?					
<ul style="list-style-type: none"> <li>- Yes (1)</li> <li>- No - why not? _____ (skip to Q25) (2)</li> <li>- Don't know (skip to Q25) (3)</li> </ul>					
<b>Q11b.</b> What was the result of your most recent viral load test?					
<ul style="list-style-type: none"> <li>- Undetectable (1)</li> <li>- Don't know (2)</li> <li>- Detectable, specify test result (if known): _____ copies/mL (3)</li> </ul>					
<b>Q12.</b> How many viral load tests have you had in the past 12 months?					
<b>Q13.</b> What is your experience of HIV treatments?					
<ul style="list-style-type: none"> <li>- Currently taking antiretroviral drugs for HIV (1)</li> <li>- Have taken antiretroviral drugs for HIV in the past, but not currently taking them (2)</li> <li>- Never taken antiretroviral drugs for HIV (3)</li> </ul>					
<b>Q14.</b>					
Please indicate how you feel about the following statements:					
	<b>Strongly agree</b> (1)	<b>Agree</b> (2)	<b>Disagree</b> (3)	<b>Strongly disagree</b> (4)	<b>Don't know</b> (5)
14.1 I am healthy now and don't need to use combination antiretroviral drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.2 Combination antiretroviral drugs are harmful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.3 Combination antiretroviral drugs are ineffective.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14.4 New treatments will be developed in time for me to gain benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.5 HIV treatments will stop me dying from AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.6 My doctor knows a lot more about the treatment of HIV than I do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.7 My doctor and I work together to find the best treatment for me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.8 The side-effects of antiretroviral drugs outweigh the benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.9 Medical treatments for HIV/AIDS make safe sex less important than it was	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.10 Undetectable viral load means HIV is unlikely to be transmitted to a sexual partner even if I have sex without a condom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Q15.** Do you believe that combination antiretroviral drugs mean better prospects for most people with HIV?

- Yes (1)
- No (2)
- It's too soon to tell (3)
- Don't know (4)

**Q16.** Which of the following best describes your smoking status? This includes cigarettes, cigars and pipes.

- I smoke daily (1)
- I smoke occasionally (2)
- I don't smoke now, but I used to (Skip to Q27) (3)
- I've tried it a few times but never smoked regularly (Skip to Q27) (4)
- I've never smoked (Skip to Q27) (5)

**Q17a.** How soon after you wake up do you smoke your first cigarette?

- Within 5 minutes (3)
- 6-30 minutes (2)
- 31-60 minutes (1)
- After 60 minutes (0)

**Q17b.** How many cigarettes per day do you smoke?

- 10 or less (0)
- 11-20 (1)
- 21-30 (2)
- 31 or more (3)

**Q17c.** Number of cigarettes you smoke per day:

<p><b>Q18.</b> Have you ever tried to quit smoking? And if so, how many times?</p> <ul style="list-style-type: none"> <li>- Yes – Once (1)</li> <li>- Yes – 2 to 3 times (2)</li> <li>- Yes – More than 3 times (3)</li> <li>- Never tried to quit (4)</li> </ul>
<p><b>Q19</b> In the last year, have you made any quit attempts where you did not smoke for at least 24 hours?</p> <ul style="list-style-type: none"> <li>- No (1)</li> <li>- Yes (2)</li> </ul>
<p><b>Q20.</b> In the last 6 months, have you made any quit attempts where you did not smoke for at least 24 hours?</p> <ul style="list-style-type: none"> <li>- No (1)</li> <li>- Yes (2)</li> </ul>
<p><b>Q21.</b> Are you seriously thinking of cutting down the number of cigarettes you smoke?</p> <ul style="list-style-type: none"> <li>- No (1)</li> <li>- Yes (2)</li> </ul>
<p><b>Q22.</b> Are you seriously thinking about quitting smoking?</p> <ul style="list-style-type: none"> <li>- No (1)</li> <li>- Yes (2)</li> </ul>
<p><b>Q23.</b> Do you plan to quit smoking?</p> <ul style="list-style-type: none"> <li>- No (1)</li> <li>- Yes (2)</li> </ul>
<p><b>Q24.</b> If you plan to quit smoking, by when do you plan to quit?</p> <ul style="list-style-type: none"> <li>- 1 month (1)</li> <li>- 3 months (2)</li> <li>- 6 months (3)</li> <li>- More than 6 months (4)</li> </ul>
<p><b>Q25.</b> Since your HIV positive diagnosis, has any health care provider ever advised you to quit smoking?</p> <ul style="list-style-type: none"> <li>- No (1)</li> <li>- Yes (2)</li> </ul>
<p><b>Q26.</b> If there were a free or low-cost smoking cessation program to help you quit, how likely would you be to use it?</p> <ul style="list-style-type: none"> <li>- Not at all likely to use the program (1)</li> <li>- Maybe would use the program (2)</li> <li>- Would definitely use the program (3)</li> </ul>
<p><b>Q27.</b> How many serves of vegetables do you usually eat each day? [1 serve = 1/2 cup cooked or 1 cup of salad vegetables]</p> <p>- _____ serves per day</p>
<p><b>Q28.</b> How many serves of fruit do you usually eat each day? [1 serve = 1 medium piece or 2 small pieces of fruit or 1 cup of diced pieces]</p> <p>- _____ serves per day</p>
<p><b>Q29.</b> In the last month how many days a week did you usually do 30 minutes or more of physical activity?</p> <ul style="list-style-type: none"> <li>- No days (1)</li> <li>- One (2)</li> </ul>

-	Two	(3)
-	Three	(4)
-	Four	(5)
-	Five or more	(6)
-	Don't know	(7)
-	Can't for health or treatment reasons	(8)

**Q30a.** How often did you have a drink containing alcohol in the past year?

-	Never	(1)
-	Monthly or less	(2)
-	2 to 4 times a month	(3)
-	2 to 3 times per week	(4)
-	4 or more times a week	(5)

**Q30b.** How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?

-	1 or 2	(1)
-	3 or 4	(2)
-	5 or 6	(3)
-	7 to 9	(4)
-	10 or more	(5)

**Q30c.** How often did you have six or more drinks on one occasion in the past year?

-	Never	(1)
-	Monthly or less	(2)
-	2 to 4 times a month	(3)
-	2 to 3 times per week	(4)
-	4 or more times a week	(5)

**Q31.** Which of the following have you used in the last 12 months? (Please tick as many as apply)

<input type="checkbox"/> Crystal Meth	<input type="checkbox"/> Heroin (injected)	<input type="checkbox"/> Steroids (injected)
<input type="checkbox"/> Speed (injected)	<input type="checkbox"/> Cocaine (not injected)	<input type="checkbox"/> GHB/GBH/Fantasy
<input type="checkbox"/> Speed (not injected)	<input type="checkbox"/> Ecstasy	<input type="checkbox"/> Viagra or similar
<input type="checkbox"/> LSD/trips	<input type="checkbox"/> Amyl	<input type="checkbox"/> Methadone (prescribed)
<input type="checkbox"/> None	<input type="checkbox"/> Marijuana	<input type="checkbox"/> Other (please specify)

**Q32a.** Would you say that in general your health is?

-	Excellent	(1)
-	Very good	(2)
-	Good	(3)
-	Fair	(4)
-	Poor	(5)

**Q32b.** Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?

- Number of days \_\_\_\_\_

**Q32c.** Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

- Number of days \_\_\_\_\_



**Q32d.** During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?  
 - Number of days

**Q33.** Have you been diagnosed with a sexually transmissible infection in the last 12 months?

- No (1)

- Yes (2)

**Q34.** Below is a list of statements that other people with your illness have said are important.

- Please mark one box per line to indicate your response as it applies to the past 7 days

	Not at all	A little bit	Some-what	Quite a bit	Very much
	(1)	(2)	(3)	(4)	(5)
34.1 I feel sad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34.2 I feel nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34.3 I worry about dying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34.4 I worry that my condition will get worse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34.5 I am unhappy with my appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34.6 It is hard to tell other people about my infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34.7 I worry about spreading my infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34.8 I am concerned about what the future holds for me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34.9 I am embarrassed by my illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Q35.** Below is a list of statements that other people with your illness have said are important.

- Please mark one box per line to indicate your response as it applies to the past 7 days

	Not at all	A little bit	Some-what	Quite a bit	Very much
	(1)	(2)	(3)	(4)	(5)
35.1 I feel close to my friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

35.2 I get emotional support from my family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35.3 I get support from my friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35.4 My family has accepted my illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35.5 I am satisfied with family communication about my illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35.6 I feel close to my partner (or the person who is my main support)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35.7 I have people to help me if I need it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Regardless of your current level of sexual activity, please answer the following question. If you prefer not to answer it, please mark this box <input type="checkbox"/> and go to the next section</i>					
35.8 I am satisfied with my sex life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Q36.</b> The following questions ask about how you have been feeling during the <b>past 30 days</b> . For each question, please mark the box that best describes how often you had this feeling.					
	<b>All of the time</b>	<b>Most of the time</b>	<b>Some of the time</b>	<b>A little of the time</b>	<b>None of the time</b>
	(5)	(4)	(3)	(2)	(1)
<b>During the past 30 days, about how often did you feel...</b>					
36.1 ...nervous?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36.2 ...hopeless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36.3 ...restless or fidgety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36.4 ...so depressed that nothing could cheer you up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36.5 ...that everything was an effort?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36.6 ...worthless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Q37.** The questions in this scale ask you about your feelings and thoughts during the last month. In each case, please indicate how often you felt or thought a certain way.

	<b>Never (0)</b>	<b>Almost Never (1)</b>	<b>Sometimes (2)</b>	<b>Fairly often (3)</b>	<b>Very often (4)</b>
<b>In the last month...</b>					
37.1 How often have you felt that you cannot control the important things in your life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37.2 How often have you felt confident to handle your personal problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37.3 How often have you felt that things were going your way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37.4 How often have you felt that difficulties were piling up so high that you could not overcome them?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Q38.** Please indicate to what extent each of the following circumstances makes it difficult for you to receive the care, services or opportunities you wish to obtain

	<b>No problem at all (1)</b>	<b>Very slight problem (2)</b>	<b>Some- what of a problem (3)</b>	<b>Major problem (4)</b>
38. a) Long distances to medical facilities and personnel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. b) Medical personnel (e.g. physicians, nurses), who decline to provide direct care to persons with HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. c) The lack of health care professionals who are adequately trained and competent in AIDS care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. d) The lack of transportation to access the services I need	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. e) The shortage of psychologists, social workers and mental health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

counsellors who can help address mental health issues				
38. f) The lack of psychological support groups for persons with HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. g) The level of knowledge about HIV/AIDS among residents in the community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. h) Community residents' stigma against persons living with HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. i) The lack of employment opportunities for people living with HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. j) The lack of supportive and understanding work environments for people living with HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. k) My personal financial resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. l) Lack of adequate and affordable housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Q39.</b> Many people find it difficult to take all their HIV medications exactly as prescribed. How many doses of your HIV medication did you miss in the last 7 days?  (Number of doses)				
<b>Q40.</b> What percentage would be your best guess for how much of your prescribed HIV medication you have taken in the last month? We would be surprised if this were 100% for most people ____ (%)  Examples: - 0% means you have taken no medication - 50% means you have taken half your medication - 100% means you have taken every single dose of your medication				

**Q41.** The following questions ask about situations that could occur during your treatment for HIV. Treatment can involve different things for different people. Sometimes this might refer to taking medications, and other times it could refer to other things that you do to deal with HIV such as diet and exercise or taking vitamins. So, when these questions ask about your ‘treatment’ or your ‘treatment plan’, we are talking not only about any medications that you might be taking for your HIV, but also other things that make up your self care. For the following questions, please answer for the last month, including today, how confident you have been that you can do the following things. Use a response scale ranging from 0 (‘cannot do at all’) to 5 (‘moderately certain can do’) to 10 (‘completely certain I can do’).

- a. Stick to your treatment plan even when side effects begin to interfere with daily activities
- b. Integrate your treatment into your daily routine
- c. Integrate your treatment into your daily routine even if it means taking medications or doing other things in front of people who don’t know you are HIV-infected
- d. Stick to your treatment schedule even when your daily routine is disrupted
- e. Stick to your treatment schedule when you aren’t feeling well
- f. Stick to your treatment schedule when it means changing your eating habits
- g. Continue with your treatment even if doing so interferes with your daily activities
- h. Continue with the treatment plan your physician prescribed even if your t-cells drop significantly in the next 3 months
- i. Continue with your treatment even when you are feeling discouraged about your health
- j. Continue with your treatment even when getting to your clinic appointments is a major hassle
- k. Continue with your treatment even when people close to you tell you that they don’t think that it is doing you any good
- l. Getting something positive out of your participation in treatment, even if the medication you are taking does not improve your health

**Q42.** Please respond to each of the following items in terms of how true it is for you with respect to dealing with your HIV

Use a response scale ranging from 1 to 7 (1 = not at all true, 4 = somewhat true, 7 = very true)

- a) I feel confident in my ability to manage my HIV
- b) I am capable of handling my HIV now
- c) I am able to do my own routine HIV care now
- d) I feel able to meet the challenge of controlling my HIV

**Q43.** Overall how useful was the support or information you received during the positive talk for positive health telephone sessions?

- Very useful (1)
- Fairly useful (2)
- Not very useful (3)
- Not at all useful (4)
- Don't know (5)

**Q44.** How has your participation in the positive talk for positive health support service changed things, to what extent do you?

	To a large extent	Somewhat	Not at all	Don't know	This was not a problem for me (N/A)
a) Feel better informed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Feel less isolated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Feel more confident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Feel more able to make changes in my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Feel more able to take my medication as prescribed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Q45.** If this service were to be available in the future, would you recommend the positive talk for positive health support service to other people living with HIV?

- Yes (1)
- No (2)
- Unsure (3)

**Q46a.** How would you rate the positive talk support caller who conducted your sessions on the following issues?

How supportive was your positive talk support caller?

- Very supportive (1)
- Quite supportive (2)
- A little supportive (3)
- Not at all supportive (4)

**Q47b.** How able were they to offer information or advice about the issues you raised?

- Very able (1)
- Quite able (2)
- Somewhat able (3)
- Not at all able (4)

**Q48.** In the past month have you had contact with any HIV/AIDS-related organisations?

- Yes (1)
- No (2)

**Q49.** What is your involvement in these organisations? (tick as many as apply)

- I am an employee
- I am a member
- I am a client/use their services
- I receive newsletters and mail-outs
- Access information on their websites
- I am a volunteer                      hours per week

**Q50.** Which HIV/AIDS organisation(s) do you have contact with?

\_\_\_\_\_

**Q51.** Please indicate which of the following services you have used through HIV/AIDS-related organisations in the last month

- Treatments advice
- Counselling
- Financial assistance
- Financial advice
- Legal advice
- Peer support
- Social contact with other PLHIV
- Pharmacy services
- Other (please specify)

**Appendix F: Exit Survey****Positive Talk for Positive Health – Exit Survey**

ID \_\_\_\_\_ Name \_\_\_\_\_ Number \_\_\_\_\_ Finish Date \_\_\_\_\_

	Attempt			Call Length	Code *	Comment
	Date & Day	Time of call	Finish time			
1						
2						
3						

**Qu1.** (CHCE) If this program was to be run in the future, how often do you think support calls should be made to be the most helpful for people?

- One every week (1)
- One every fortnight (2)
- One every three weeks (3)
- One every month (4)
- Other (Please specify) (5)

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**Qu2.** (CHCE) How would you describe the average length of the telephone support sessions?

- Too long (1)
- Too short (2)
- About right (3)
- Other (Please specify) (4)

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**Qu3.** (CHCE) How easy did you find scheduling calls at a time that suited you?

- Very easy
- Usually easy
- Not easy

**Qu4.** (OPEN) Are there any particular topics or information that you would have liked to be included in the program?

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**Qu5a.** (CHCE) To what extent did the telephone support sessions address your needs?

- To a great extent (1)
- To some extent (2)
- Not very much (3)
- Not at all (4)

**Qu5b.** (OPEN) Are there any needs in particular that the sessions did address well?

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**Qu5c.** (OPEN) Were there any needs in particular that were not addressed well?

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**Qu6a.** (CHCE) How appropriate do you feel the positive talk support service was for your situation?

- Very appropriate (1)
- Fairly appropriate (2)
- Not very appropriate (3)
- Not at all appropriate (4)

\* If Qu6a = 1 go to Qu7

\* If Qu6a = 2, 3, or 4 go to Qu6b

**Qu6b.** (OPEN) Why do you think the service was not really appropriate to your situation?

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**Qu7.** (OPEN) Is there anything that you would identify about the telephone service that was positive?

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**Qu8.** (CHCE) Most people talk to more than one support caller during the program, do you believe this is ok or would you have preferred to have had the same caller to be speaking with each time?

- Different callers is fine (1)
- Slight preference for same caller (2)
- Strong preference for same caller (3)

**Qu9.** (OPEN) Is there anything you would identify about the caller(s) you spoke to that was positive?

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**Qu10.** (OPEN) Is there anything that you would identify about the telephone service that was not so good?

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**Qu11.** (OPEN) Is there anything that you would identify about the caller(s) you spoke to that was not so good?

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**Qu12.** (OPEN) How could the service be improved?

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**Qu13.** (CHCE) Have you accessed any support services as a result of information or advice you received during the positive talk for positive health program?

- Yes (1)
- No (2)
- Did not require any support services (3)

**Qu14.** (CHCE) In the past month have you had contact with any HIV/AIDS-related organisations?

- Yes (1)
- No (2)

*\* if Qu14. = 1 go to Qu15.*

*if Qu14. = 2 Survey end.*

**Qu14.** (OPEN) Which HIV/AIDS organisation(s) did you have contact with and was there anything useful that came out of that for you?

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**End survey**

**Appendix G: Follow-up Survey Participant Program Comments**

<i>'Thank you for taking the time to see how I am travelling.'</i>
<i>'Please could there be more programs in the rural for social isolation and stigma.'</i>
<i>'Enjoyed talking to callers as they were friendly and supportive.'</i>
<i>'Thanks guys. Doing a great job. Much appreciated.'</i>
<i>'It was a beneficial course to do. Even though I felt already informed it updated the information I had regarding HIV/AIDS treatments in the Newcastle area.'</i>
<i>'I enjoyed receiving the calls as the information helped me with ways I could help myself in my life. Very useful service and convenient'</i>
<i>'I would do it again, I hope it will continue'</i>
<i>'Service was good but a consistent referral service with HIV would be good around meds, doctors, nutrition.'</i>
<i>'It was a fantastic program and I would participate in it again.'</i>
<i>'Great program'</i>
<i>'I think this was a program that should be continued as many people don't share this sort of information with others and it's good for learning. The calls were just great and I commend all the staff working in the program.'</i>