DEVELOPMENT OF A SCREENING INSTRUMENT FOR HIV/AIDS SELF DISCLOSURE INTENTION (HIV-SDI-INDEX)

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ABSTRACT

Intention and actual behavior have been complexly linked, with the theory of reason action (RA). In this exploratory study, we developed an index that measures HIV disclosure intention (HIV-SDI-INDEX). Thirty-two items were extracted from Focus Group Discussions (FGD) themes produced by 47 PLWHA on the factors that underlay intention to disclose or not to disclose their HIV serostatus. These items were administered to a sample of 149 registered PLWHA in various hospitals. Their ages ranged between 21 and 53 years with Mean age of 34.30 and SD age of 3.072. Eighty-two (55%) of the participants were females, while sixty-seven (45%) were males. The HIV-SDI-Index has a significant Cronbach alpha of 0.92, indicating an acceptable level of reliability. Validity of HIV-SDI-Index was established through the construct (discriminant and convergent) validity. HIV-SDI-INDEX is recommended for use, when intention to disclose, rather than actual disclose of HIV/AIDS among individuals living with HIV/AIDS (PLWHA) is the focus of assessment.

INTRODUCTION

A major key for prevention of HIV/AIDS spread is when people living with HIV and Aids (PLWHA) disclose, and get treated of their sickness. Albeit, most patients do not want to disclose, and when they do, it is often inevitably done to very close family confidants, who may be part of the management (Olley et al 2016; Salami, Fadeyi, & Desalu, 2011). Evidence has also shown that some individuals living with HIV/AIDS may have the intention to disclose, but are afraid due to social devaluation projected by people around them (Chesney & Smith, 1999; Arrey, Bilsen , Lacor, & Deschepper, 2015; Adebiyi & Ajuwon, 2015), and lacking a sense of efficacy to do so (Amoran, 2012).

Sufficing is the anecdotal observations, which further showed that most PLWHA are selective and discreet about whom to disclose their serostatus to and moreso, whom to involve in their treatment: they are apt to disclose to blood relations, who share in their grief, and leaving out key persons such as spouse (field study, 2016). The reason for this selective disclosure may not be unconnected with the social feedbacks that often accompanied disclosure of positive serostatus, while effort to reduce stigma and discrimination towards PLWHA is receiving concerted attention, the projective intention of a typical patient living with HIV/AIDs to disclose his/her status needs to be explored, with a view of developing methods of intervention towards general and not selective disclosure.

Several management strategies have been proffered to aid disclosure in most treatment facilities world-wide (Bohle, Dilger & GroB, 2014). For example, the Treatment Support Specialist (TSS); where it is mandatory for a family member of the PLWHA to be involved in treatment, is been adopted in healthcare facilities in Nigeria (Olley, et al., 2016). Similarly, in Kenya, a patient-nominated treatment buddy (TBY), have been incorporated and adopted as a

strategy for disclosure to a close family member, who also assist in ensuring patient treatment compliance (Kibaara, Blat, Lewis-Kulzer, Shade, Mbullo, Cohen, & Bukusi, 2016).

Much attempt and resources have been dedicated to addressing the global menace of poor disclosure rate because of its associated problems (e.g. increasing rate of newly infected individuals with HIV, medication non-adherence; salami, et al., 2006). Disclosure among PLWHA had been a matter of cohesion i.e. force, and may not have be disconnected with the far below disclosure rate achieved in Nigeria (39.5% and 22%; Salami et al, 2006 & Olley, 2004 respectively) against the WHO (2004) recommended rate of 79% benchmark. on this basis, lack of this current scale implies that stakeholders saddled with counseling responsibilities to enhance disclosure are working immeasurably (i.e. quantifying disclosure intention level). Furthermore, westerners seem to perceived disclosure from generalized and bipolar stance (disclosure or non-disclosure) but African engaged in cost-benefit analysis (CBA) before disclosing HIV positive status, some disclose to their family members and maintain non-disclosure at workplace, vise-a-vise. it is however important to quantify disclosure from all social circle/angle in Nigeria, Africa.

Prior to this effort, there have been tools developed to measure disclosure of HIV (Sussan, Arinze-Onyia, Ifeoma Modebe, & Emmanuel, 2015; Dimie, Peter, Ikenna, Tubonye, Otonyo, & Ogechi, 2015), but not on disclosure intention. Most tools to measure disclosure of HIV status among PLWHA has been a one-item scale or a-one question scale, for instance, *Did you disclose your HIV status* {Yes or No} (e.g. Sussan, Arinze-Onyia, Ifeoma Modebe, & Emmanuel, 2015; Dimie, Peter, Ikenna, Tubonye, Otonyo, & Ogechi, 2015), which are not reliable and not recommended for use. Apart from being a one-item scale, it is often described as vague and defensive response pattern, leaving the respondents stalked up thinking about what direction is the question intended. There is also a need to include in the content of a scale, cultural relativity and contextual norms, which may be absent in contemporary, and foreign based HIV/AIDS disclosure scale (Sowell, Lowenstein, Moneyham, Demi, Mizuno, & Seals, 1997; Mburu Gitau, Ian, Sam, Choolwe, Fabian, Elizabeth, & David, 2014).

To the best of our knowledge, there has been no measure of HIV disclosure intention in Nigeria. Consequently, this study examines and developed a scale to assess HIV disclosure intention through explorative research process.

METHOD

Item generation: Item generation for the HIV-SDI-Index started firstly with, extensive search of the literature, reviewing existing scales that measured HIV/AIDS self disclosure and factors influencing it. The total of thirty-two (32) tentative items were generated and form the qualitative basis and guide for the explorative phase of the study. Explorative phase involved Focus group discussions (FGDs) and in-depth interviews (IDI) conducted among a purposive sample of PLWHAs on follow-up management to identify issues related to disclosure and its intention. Both the FGD and IDI were conducted by the authors. The demographic characteristics in each segment were not statistically different from one another. This approach enhanced content validity (Nunnally, 1978) as they were considered experts in their own right. The discussions in the FGD centered on both cognitive and cultural considerations that underlay

the intention of disclosing HIV to either spouse, parents, children, friends and colleagues. The interviews were recorded, translated and transcribed. From thematic analysis of the FGD, three basic contents emerged: (1) personal perception factor; (2) social perception factor, (3) perceived control factor. Items were generated with these factors resulting in 30 items/questions. The themes generated were then pre-tested.

Face validity: The generated content and items were subjected to face validity exercise, involving three Health Psychologists (two practicing health psychologist & one academics) and four doctoral level students specializing in clinical psychology. They are familiar with the culture of the setting in this context, because, they either have vast experience in research involving Nigerians living with HIV/AIDS or not less than 6 years practice experience in handling indigenous PLWHA. They were asked to evaluate the relevance, clarity and conciseness of the items included in the questionnaire. They were also asked to assess the items with a view to determine if the questionnaire contained relevant items for assessing HIV disclosure intention in the Nigerian context. There was a consensus agreement among the six respondents that the questions measured HIV/AIDS self disclosure intention. Based on this initial assessment, all 30 items were retained.

Pre-testing: One hundred and forty nine (149) PLWHAs, on treatment at both, State Specialist Hospital (SSH) Akure, and the Federal Medical Centre, Owo, Ondo State, were recruited for the pre-testing. They consisted of eighty-two (55%) females and sixty-seven (45%) males, with mean age of 34.30 SD 3.07 (range 21- 53years). They were excluded if unwilling and not in a position to give informed consent. Corrected filled questionnaire were scored and subjected to internal consistency (how well a set of items conceptually fit together), through Cronbach's alpha reliability value. Concurrent validity (the degree to which the construct being measured correlates with another measure of the similar and different constructs) was assessed by Pearson Product Moment correlations.

Basic Instruction

It is imperia to notify test-takers or respondent, that the index is strictly for clinical and academic purposes. Therefore, test-takers are encourage to read the instructions carefully and respond to each statement of the index truthfully as there are no wrong or right answers.

Statistical Analysis

Two major statistical techniques were used for analysis, which includes correlation analysis (Pearson Product Moment Correlation) and Cronbach's alpha reliability (for test of internal consistency).

RESULT

Item-Total Statistics: The number of valid cases for this set of variables is 149. None of the imputed items of HIV-SDI-INDEX is below the recommended 0.3 reliability, meaning that, no identified items load reduce the Cronbach value of the scale below the acceptable value. All items suggests strong relationship with the total scale strength, therefore, they are retained and subjected to further factor analysis (see table 13).

Step I: Reliability Report

Split half reliability: Split half reliability was determined by comparing responses to the HIV-SDI-Index among 149 participants who completed the questionnaire. The retrieved questionnaires were splitted into equal halves and were further correlated. The correlation coefficient for split half reliability as reported by Guttman Split-Half Coefficient of 0.824 (see table 6) indicated that the scale is internally reliable. This demonstrated an acceptable Guttman split-half coefficient value.

Internal Consistency: Internal consistency of the HIV/AIDS self disclosure Intention index (HIV-SDI-Index) was derived from the Cronbach alpha analysis revealing the overall alpha value of 0.92 (α = .92), indicated that the whole scale is strongly reliably (see table 1) and the dimensions or sub scales have meritorious reliability (Sub scale 1, α =.73, Sub scale 2, α =.65; Sub scale 3, α =.85 & Sub scale 4, α =.71, see table 2-5). (Anastasi, 1999).

Step II: Exploratory Factor Analysis

An exploratory factor analysis was applied to explore the underlying dimensions of factors disclosure intention scale. The Bartlett test of sphericity ($p <. 0.001$) and the Kaiser-Meyer measure of meritorious sampling adequacy suggest that the data matrix could be factorized (KMO = .838, $p <.001$). (see table 7).

Four factors with eigenvalues (> 1.0) were identified for the HIV disclosure Intention scale. The latent root criterion indicated that there were 4 components extracted. In other words, four subscales were noted in the HIV-SDI-INDEX. The four factors accounted for 86% of the total variance in the overall HIV/AIDS self disclosure Intention Index (see table 8 & 9). Varimax rotation revealed a four dimension factor**.** The factor loading for the items ranged from 0.52 to .86, which indicated that all the items loaded well on the factors precipitated. The factors include attitude towards disclosure, normative beliefs about disclosure, perceived behavioural control, and motivation to disclose (α = 0.73; 0.65; 0.85; & 0.71 respectively). The identified four HIV-SDI-Index subscales assesses;

- **Attitude**: a person's perception of his or her own disposition towards disclosing HIV status.
- **Normative Belief (social norm)**: a person's knowledge of societal or cultural disposition and perception towards disclosing HIV status.
- **Behavioural Control**: An individual perceived ease or difficulty of performing a particular behaviour i.e. HIV disclosure.
- **Motivation**: this assess the level of individual eagerness to disclose his/her HIV status.

Item(s) loading in more than one of the identified four components shall be removed. Two Items (10 and 12) were removed because they were considered as complex structure i.e. loaded on more than one component (see table 9). This indicates that they are complex item.

Items loading on component 1 are: item 1, 2, 3, 4, 5, 6, 7, 8, and 9

Items loading on component 2 are: item 13, 14, 15, 16, 17, 18 and 19

Items loading on component 3 are: item 20, 21, 22, 23, 24 and 25

Items loading on component 4 are: item 10, 11 and 12.

Step II: Validity Report

Construct Validity: Construct validity was accomplished through the convergent and discriminant validity. The overall scale was correlated with perceived stress scale by Cohen, Kamarck, and Mermelstein, (1983) and Sexual Disclosure Questionnaire by Byers and Demmons (2012) to established the discriminant and convergent validity respectively. The Pearson correlation analysis revealed that there was no significant relationship between overall HIV/AIDS self disclosure Intention index and perceived stress scale ($r = - 0.09$, $p > .05$), which established the scale discriminant validity. In other words, table 10 showed non-significant relationship between HIV-SDI-Index and PSS, thus, invariably indicating a strong discriminant validity (see table 10). Furthermore, the Pearson correlation analysis revealed a significant positive `relationship between overall HIV/AIDS self disclosure Intention Index and Sexual Disclosure Questionnaire, which established the scale convergent validity (see table 11). Table 11 showed a significant positive relationship between HIV-SDI-Index and SSDQ ($r = .83$, $p < .01$), thus showing a strong convergent validity.

Each dimensions (personal beliefs about disclosure, perceived social beliefs about disclosure, perceived behavioural control, and motivation to disclose) of the scale were correlated with the general scale i.e. HIV-SDI-Index (see table 12). The outcome revealed that personal beliefs ($r = .64$, $p < .01$), perceived social beliefs ($r = .47$, $p < .05$), perceived behavioural control ($r = .53$, $p < .05$) and motivation ($r = .66$, $p < .01$) have significant relationship with HIV disclosure intention scale (see table 12).

Psychometric Properties

Purpose of HIV-SDI-Index: HIV Self Disclosure Intention Scale (HIV-SDI-Index) was developed to measure the intention-behaviour of people living with HIV/AIDs to disclose their status to people around. The measure also may help in monitoring disclosure intention during intervention/treatment/counseling process. The test is a self-report assessment which takes approximately 10 to 20 minutes to administer.

Administrator: The test may be administered by psychologists, general medical practitioners, and an HIV/AIDs counselors. All parts of the test can be administered orally to persons with reading disability or visual impairment. The test taker is required to pick from options of 1 to 7 in response to the questions that ask the person how he/she feels.

Scoring Format

HIV-SDI-Index is a seven point Likert response scale (1 to 7) with items that are directly and reversely scored. Items to be directly scored are item 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 15, 16, 17, 18, 23, 24, and 25. Items to be reversely scored are item 14, 19, 20, 21, and 22.

Norm

Respondent's scores on HIV-SDI-Index can also be norm-referenced. The reported norms was derived from standardization of the scale among PLWHA. The overall sample achieved the mean score of 76.54 (Male = 75.69; Female = 76.74) and standard deviation of 06.34 (Male = 5.13; Female = 6.34).

Discussion

The purpose of this study was to develop and evaluate a culturally appropriate measure of HIV/AIDS self disclosure Intention Index (HIV-SDI-Index) among PLWHA in Nigeria, using the conventional systematic approach to tool development (Anastasi, 1999). The effort produced a 25-item scale index that provides a measure of HIV disclosure intention with proven reliability and validity. The Cronbach alpha was employed in evaluating the level of acceptability of the observed values of reliability coefficients. The alpha coefficient was strong for the overall and subscales items. The scale reported a considerable and acceptable level of internal consistency. There was an excellent split half reliability observed in this study and this supported the utility and reliability of HIV/AIDS self disclosure Intention index among HIV/AIDS patients. Furthermore, the selection of culturally appropriate items through qualitative research ensured that the items were appropriate to this context. Factor-analytic evidence suggested that the scale is multi-dimensional, indicating that it measured four constructs, namely, attitude towards disclosure, normative beliefs about disclosure, perceived behavioural control, and motivation to disclose. Summation of scores on the four subscales revealed the intention extent of the test taker to reveal his/her HIV status.

Few limitations to be considered in this paper include the highly selective participants for the study and the self reporting of item that may introduce response bias and under-reporting. Further studies that will consolidate the psychometric properties of the scale are needed.

Conclusions

This study has demonstrated that a measure to screen for intention to disclose sero status can be developed through a conventional systematic test construction process. The tool can help healthcare providers to screen for barriers against self disclosure, with the aim of instituting self disclosure management.

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APPENDIX

Table 1: Showing the internal consistency (Reliability) of HIV-SDI-Index using Cronbach's Alpha

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.920	.922	25

Table 2: Showing the internal consistency (Reliability) of Personal beliefs- HIV-SDI-Index using Cronbach's Alpha

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.730	.731	25

Table 3: Showing the internal consistency (Reliability) of social beliefs- HIV-SDI-Index using Cronbach's Alpha

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.650	.652	25

Table 4: Showing the internal consistency (Reliability) of perceived behavioural control- HIV-SDI-Index using Cronbach's Alpha

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.851	.855	25

Table 5: Showing the internal consistency (Reliability) of Motivation- HIV-SDI-Index using Cronbach's Alpha

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.71	.71	25

Table showing the Norms of HIV-SDI-Index

SEX	MEAN	SD
Male	75.69	05.13
Female	76.74	06.62
Total Sample	76.54	06.34

Table 6 Showing the Split half Reliability Statistics

Cronbach's Alpha	Part 1	Value	.793
		N of Items	13[a]
	Part 2	Value	.599
		N of Items	12[b]
	Total N of Items		25
Correlation Between Forms			.709
Spearman-Brown Coefficient	Equal Length		.830
	Unequal Length		.830
Guttman Split-Half Coefficient			.824

Table 7: KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.838
Bartlett's Test of Sphericity	Approx. Chi-Square	1534.035
	Df	86
	Sig.	.000

Table 8: Total Variance Explained

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	3.775	41.948	41.948	3.775	41.948	41.948
2	1.605	17.832	59.780	1.605	17.832	59.780
3	1.875	19.722	69.502	1.875	19.722	69.502
4	1.584	16.486	75.989	1.584	16.486	85.989
5	.488	5.426	81.415			
6	.473	5.254	86.668			
7	.446	4.961	91.629			
8	.397	4.412	96.041			
9	.356	3.959	80.000			
10	.473	5.254	86.668			
11	.446	4.961	91.629			
12	.397	4.412	96.041			
13	.473	5.254	86.668			
14	.446	4.961	91.629			
15	.397	4.412	96.041			
16	.356	3.959	85.755			
17	.473	5.254	86.668			
18	.446	4.961	91.629			
19	.397	4.412	96.041			
20	.473	5.254	86.668			
21	.446	4.961	91.629			
22	.397	4.412	96.041			
23	.356	3.959	80.875			
24	.473	5.254	86.668			
25	.446	4.961	91.629			
26	.397	4.412	96.041			
27	.473	5.254	86.668			
28	.446	4.961	91.629			
29	.397	4.412	96.041			
30	.356	3.959	86.651			
31	.473	5.254	86.668			
32	.446	4.961	100.000			

Extraction Method: Principal Component Analysis.

Table 9: Component Matrix

S/N	Initial S/N	Components			
		1	2	3	4
1	HDS1	**.713**	-.207	.313	302
2	HDS2	**.607**	-.318	.107	.298
3	HDS3	**.729**	-.076	.207	-.364
4	HDS4	**.764**	-.249	.229	-.205
5	HDS6	**.505**	-.216	.364	-.209
6	HDS7	**.719**	-.196	.207	.101
7	HDS8	**.705**	-.207	.229	.299
8	HDS9	**.719**	.313	.119	-.202
-	HDS10	~~**.572**~~	~~**.607**~~	~~**.572**~~	~~**.598**~~
9	HDS11	**.713**	.229	.113	.264
-	HDS12	~~**.705**~~	~~**.764**~~	~~**.607**~~	~~**.605**~~
10	HDS14	.119	**.705**	.229	.309
11	HDS15	.213	**.713**	.207	-.076
12	HDS16	.207	**.607**	.229	-.249
13	HDS17	.229	**.729**	.264	.264
14	HDS18	.264	**.764**	.207	.105
15	HDS20	.207	**.705**	.229	.398
16	HDS21	.229	**.713**	.333	.264
17	HDS22	.372	.207	**.607**	.105
18	HDS24	.113	.229	**.729**	-.209
19	HDS25	.207	.164	**.764**	.202
20	HDS26	.229	.105	**.705**	.198
21	HDS27	.264	.219	**.719**	.164
22	HDS28	.105	.372	**.572**	.205
23	HDS30	-.218	-.318	.313	.713
24	HDS31	-.276	-.076	.207	.607
25	HDS32	-.249	-.249	.229	.729

Extraction Method: Principal Component Analysis.

Table 10: Showing the Pearson Correlation of HIV-SDI-Index and Perceived Stress Scale Indicating the Divergent Validity

		HIV-SDI-Index	PSS
HIV-SDI-Index	Pearson Correlation	1	
	N	149	149
PSS	Pearson Correlation	-.091	1
	N	149	149

Note Abbr: **HIV-SDI-Index =** ***HIV Self-Disclosure Intention Index, PSS = perceived stress scale***

Table 11: Showing the Pearson Correlation of HIV-SDI-Index and Sexual Self-Disclosure Questionnaire indicating the Convergent Validity

		HIV-SDI-Index	SSDQ
HIV-SDI-Index	Pearson Correlation	1	
	N	149	149
SSDQ	Pearson Correlation	.830**	1
	N	149	149

Note abbr.:* HIV-SDI-Index = *HIV Self-Disclosure Intention Index, SSDQ = Sexual Self-Disclosure Questionnaire

Table 12: Correlation Matrix table showing the direction and significant relationship between Dimensions of HIV-SDI-Index and HIV-SDI-Index

	1	2	3	4	5	6	M	SD
1. Personal beliefs	1						37.91	10.10
2. Perceived Social beliefs	.113	1					31.38	0.49
3. Perceived behavioural Control	.282**	.436**	1				31.45	0.49
4. Motivation	.245**	.314**	.048	1			41.66	20.96
5. HIV-SDI-Index	.641**	.470*	.531*	.655**	1		41.63	08.16

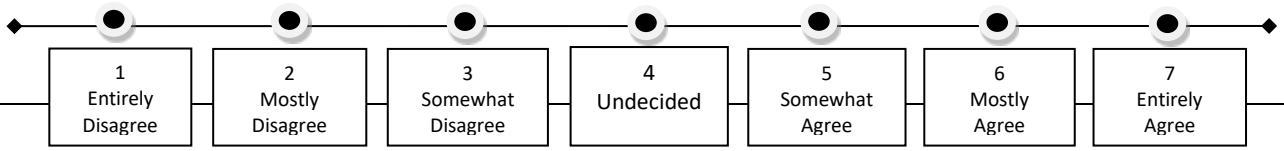
** correlation significant at 0.01 level of significant
* correlation significant at 0.05 level of significant

Table 13: Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
HDS1	28.76	77.575	.587	.424	.794
HDS2	27.97	82.167	.457	.374	.810
HDS3	29.10	77.741	.615	.409	.791
HDS4	28.68	79.048	.631	.520	.789
HDS5	28.18	81.171	.565	.416	.797
HDS6	28.48	80.563	.579	.457	.796
HDS7	28.30	84.172	.487	.324	.806
HDS8	28.62	84.577	.420	.393	.814
HDS9	28.64	85.298	.364	.405	.821
HDS10	28.68	79.048	.631	.520	.789
HDS11	28.18	81.171	.565	.416	.797
HDS12	28.48	80.563	.579	.457	.796
HDS13	28.30	84.172	.487	.324	.806
HDS14	28.62	84.577	.420	.393	.814
HDS15	29.10	77.741	.615	.409	.791
HDS16	28.68	79.048	.631	.520	.789
HDS17	28.18	81.171	.565	.416	.797
HDS18	28.48	80.563	.579	.457	.796
HDS19	28.30	84.172	.487	.324	.806
HDS20	28.62	84.577	.420	.393	.814
HDS21	29.10	77.741	.615	.409	.791
HDS22	28.68	79.048	.631	.520	.789
HDS23	28.18	81.171	.565	.416	.797
HDS24	28.48	80.563	.579	.457	.796
HDS25	28.30	84.172	.487	.324	.806
HDS26	28.62	84.577	.420	.393	.814
HDS27	29.10	77.741	.615	.409	.791
HDS28	28.68	79.048	.631	.520	.789
HDS29	28.18	81.171	.565	.416	.797
HDS30	28.48	80.563	.579	.457	.796
HDS31	28.30	84.172	.487	.324	.806
HDS32	28.62	84.577	.420	.393	.814

Table 14: HIV-SDI-INDEX

Instruction: Below are statements dealing with your general feelings about HIV disclosure. Participants are therefore encouraged to read the statements carefully and respond to each statement of the index truthfully as there are no wrong or right answers.



S/N	Items	Response Scale						
1	I often think of informing important family members about my HIV positive status	1	2	3	4	5	6	7
2	I constantly think of telling my intimate friends about my HIV positive status	1	2	3	4	5	6	7
3	I mostime think of informing my spouse/sex partners about my HIV positive status.	1	2	3	4	5	6	7
4	I often think informing my employers of my HIV positive status is the right thing to do.	1	2	3	4	5	6	7
5	Informing others of my HIV positive status willingly will aids better support from family members	1	2	3	4	5	6	7
6	Informing others of my HIV positive status will ensure better support from intimate friends	1	2	3	4	5	6	7
7	As for me, telling others of my HIV positive status is not a difficult task	1	2	3	4	5	6	7
8	I believe informing others of my HIV positive status will foster better support from spouse/sex partner	1	2	3	4	5	6	7
9	Informing others of my HIV positive status will ensure better support from my workplace.	1	2	3	4	5	6	7
10	I feel very uncomfortable disclosing my HIV/AIDS status in my environment	1	2	3	4	5	6	7
11	Most people around me would think I should inform others of my HIV/AIDS status	1	2	3	4	5	6	7
12	Most people around me will believe telling others my HIV/AIDS status is unnecessary	1	2	3	4	5	6	7
13	Informing people of HIV positive status in my environment is laudable.	1	2	3	4	5	6	7
14	*Some concerned individuals may think that I should disclose my HIV positive status	1	2	3	4	5	6	7
15	In my environment, people may think that I should attend HIV/AIDS counseling regularly but secretly.	1	2	3	4	5	6	7
16	Most people whose opinions I value would approve of not informing others my HIV positive status	1	2	3	4	5	6	7
17	Concern for workplace obligations may influence restrictions on my intention of informing them my HIV positive status	1	2	3	4	5	6	7
18	Friendship considerations may influence restrictions on my intention of informing my HIV status	1	2	3	4	5	6	7
19	*Consequences of informing others of my HIV positive status is less of concern to me.	1	2	3	4	5	6	7
20	*Concern for spouse relationship may influence restrictions on my intention to disclose my HIV positive status	1	2	3	4	5	6	7
21	*Concern for family obligations may influence restrictions on my intention to disclose my HIV status.	1	2	3	4	5	6	7
22	*I do not think my concern for any obligations may influence restrictions on my intention to disclose my HIV status.	1	2	3	4	5	6	7
23	I wish to inform my intimate friends & important family members of my HIV positive status	1	2	3	4	5	6	7
24	I intend to inform my spouse/sex partners of my HIV positive status	1	2	3	4	5	6	7
25	I intend to inform my employers of my HIV positive status	1	2	3	4	5	6	7

PSYCHOMETRIC SUMMARY OF INSTRUMENT FOR HIV/AIDS SELF DISCLOSURE INTENTION (HIV-SDI-INDEX)

Cronbach alpha:		***0.92***
Total no. of Items:		25
The Bartlett test of sphericity & KMO:		*(KMO = .838, p <. 0.001)*
Latent Root Criterion:		4
Total Variance Explained:		86%
Eigen-value*:*		*> 1.0*
Scale of Measurements:		*Interval (7 points Likert)*
Subscales:		*4*
	Attitude towards HIV Disclosure	• Sub scale 1, α = .73 • Item 1, 2, 3, 4, 5, 6, 7, 8 & 9.
	Social Perception	• Sub scale 2, α =.65) • Item 10, 11, 12, 13, 14,15, & 16
	Perceived Disclosure Control	• Sub scale 3, α =.85 • Item 17, 18, 19, 20, 21, & 22
	Motivation to disclose	• Sub scale 3, α =.71 • Item 23, 24 & 25