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Construction and Standardization of Scale for Measuring Attitude towards Voluntary HIV/AIDS Testing

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Abstract : *For measuring public attitude towards voluntary HIV / AIDS testing, the present task was undertaken to construct and standardize an attitude scale. For this, the data were collected from individuals (above 18 years of age) belonging to different professions by adopting the procedure of multi-stage systematic sampling technique. An item pool was developed initially by consulting various sources and theoretical and empirical literature available in the concerned area. This item pool was put to evaluation and criticism by technical as well as language experts. The preliminary draft of attitude scale was further subjected to item analysis to select highly discriminating items only for the scale. The reliability of scale was ascertained with the help of test-retest and split-half method which were found to be appreciably high. The validity of attitude scale was also ascertained and norms were established for interpretation of obtained scores on the scale. In the last, conclusions have been presented and implications in the shape of the applicability and usefulness of attitude scale have been discussed.*

Keywords: *Construction, Standardization, Multiple Anxiety, Inventory.*

Introduction

India is facing today the epidemic of HIV/AIDS just like other developing countries of world. Among one billion inhabitants living in India, around 2.4 million people are currently living with HIV (Human immunodeficiency virus). It is the virus that causes AIDS. The severity of the HIV/AIDS epidemic in the early 1980s captured more political and scientific mobilization than any other disease. The latest data from WHO reveal that 33.4 million people live with HIV virus worldwide with almost 90% of the infected living in developing countries. India's first case of HIV was diagnosed among commercial sex workers in Chennai in 1986. Soon after, the Government of India established the National AIDS Committee within the Ministry of Health and Family Welfare. Across India, HIV prevalence appears to be low among the general population, but disproportionately high among high risk groups such as injecting drug users (IDUs 7.2%), female sex workers (5.1%), men who have sex with men (MSM 7.4%), STD clinic attendees (3.6%) as well as truck drivers and migrant workers. The diseases HIV

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and AIDS are becoming more common in society yet, sadly some people are undereducated and misinformed about the illnesses. Unfortunately, there are people who are narrow minded, have a negative attitude to patients and act in irresponsible ways. Because of lack of awareness among individuals; talking about such issues is considered a taboo, even the parents do not talk about HIV/AIDS openly to their children. In reality, the fear of being infected has led to irrational and discriminatory treatment of people living with HIV/AIDS. Individuals infected with HIV/AIDS are not accessing proper care, treatment and support. As a result, they are shunned by family, peers and community. AIDS orphans encountered hostility from their families and communities rejected and denied access to schooling and healthcare. In India, where young people in the age group 15-24 years comprise almost 25% of the country population, accounts for 31% of the AIDS burden. In the conservative society where sex-related issues constitute a taboo for discussion, young people are hindered from actively seeking counseling regarding sexual health. Social ostracism and disease - associated stigma have created an attitude of negativity and shame in the minds of especially young people. Hence, the emerging pandemic of HIV/AIDS has an adverse impact on the country's economy. This has also been supported by research evidences not only in India but also across the globe. A brief of such empirical evidences is provided here.

Review of Research Studies

It was reported by Bharat (1996) that although a majority of those who had shared their HIV status with their families received care and support, it was largely men rather than women who qualified for such care. Forms of discrimination against women with HIV included being refused shelter; being denied a share of household property, being denied access to treatment and care; and being blamed for a husband's HIV diagnosis especially when diagnosis was made soon after marriage. Similarly, Anand, Pandav and Nath (1999) in their study projected that an estimated 2.5 billion HIV-infected people in India would be likely to lead to an annual cost of 20.16 billion rupees (US \$ 386 870 407). This emerging pandemic in the young, who comprise the most productive age group, will certainly have an adverse impact on the country's economy. Lal et. al. (2000) reported that among college students in the state of Kerala, those from urban areas demonstrated a more favourable attitude towards AIDS. Massawe et. al. (2001) determined the acceptability of counseling and testing and participation in a mother-to-child HIV-1 transmission intervention study using antiretroviral therapy. It was found that out of 68%, only 16.7% of enrolled women disclosed their positive HIV serostatus to their sexual partners. The main reasons for not disclosing the HIV serostatus were fear of stigma and divorce. Roth, Krishnan & Bunch (2001) revealed that the lack of privacy in stores and the social stigma associated with condom use comprise the most significant barriers to condom usage. Kumari (2004) reported severely discriminatory attitude of Indian youth, from a group of students from the State of Jharkhand where 95.8% said that they would prefer not to have medical treatment in a hospital where HIV/AIDS patients are treated, while 76.4% said that they would like to terminate a friendship with a person found to be HIV positive. Mahajan and Sharma (2005) indicated that urban adolescent girls have comparatively better knowledge regarding HIV/AIDS than rural adolescent girls. The rural adolescent girls of Jammu were found almost ignorant regarding HIV/AIDS. In the National Family Health Survey (2005-06), it was concluded that as a result of a stigma associated with HIV/AIDS, there are unfavourable attitudes towards HIV testing. Only 3% of Indian Youth reported to have ever undergone HIV testing. In a study of NACO (2006), 92% of the youth indicated that there was easy availability of condoms in their respective areas, but once again, the low usage rate was attributed to lack of privacy in acquiring condoms. Sexual activity was found to be very high in homeless street children, putting them at risk of

HIV/AIDS. Sood and Nambiar (2006) found that the key to HIV/AIDS control among youth lies in health education, behavioural change and communication (BCC) and ensuring safe sex services. Mass media was reported to be especially important for imparting HIV/AIDS education through TV programmes. Reality shows and dramas have been found to be most cost effective in bringing about desired behavioural change. The study conducted by CEDPA (2007) pointed that non-governmental organizations are playing an increasingly important role in spreading AIDS awareness. The Centre for Education Development and Population Activities (CEDPA) runs programme known as 'UDAAN: Towards a Better Future' which strengthens AIDS education in the state of Jharkhand by providing technical assistance and training for master trainers and teachers and adding comprehensive life-skills curriculum to the existing AIDS education programme for school children. Bhavani, Asha & Rangaswami (2009) studied the psychological aspects of children affected with HIV. Majority of the children have no knowledge that they were affected with HIV. 19% of children exhibited behavioural problem such as disobedience, anger, temper outbursts and 80% had emotional problems like restlessness, clinging behavior, depression and unhappiness. Adekeye (2011) studied the attitude of counselors towards undergoing HIV voluntary counseling and testing in Nigeria. It was reported that participants possessed negative attitude towards undergoing voluntary testing though they acknowledged the importance of HIV/AIDS testing. The participants identified fear of being HIV/AIDS positive, lack of confidentiality and knowledge of HIV/AIDS barriers to their undergoing HIV/AIDS test. Similarly, NACO (2007) suggested that peer education should be given due importance. Some on-campus programmes supported by the State AIDS Control Societies under NACO, 'YUVA-Youth Unite for Victory on AIDS' and Red Ribbon Club are welcoming step in this respect. Nath (2009) explored the possible strategies that could be effective in combating the spread of this disease. She asserted that even though condom awareness is fairly high, condom usage is low. Indian youth appear to hold negative attitudes towards HIV testing. Although, a number of preventive and control programmes and policies exist, they need further strengthening and evaluation. Sasaki et. al. (2010) recommended that in order to achieve greater acceptance of HIV testing, counseling on HIV prevention and treatment must be provided not only to mothers but also to their partners.

In this context, voluntary HIV/AIDS testing can play an effective and successful role. Voluntary HIV/AIDS testing is the people's own free will to opt for HIV/AIDS testing. It has been found to be the most important approach towards the control of the HIV/AIDS. Test results can help people make choices about pregnancy and helps them to protect their partners, baby and themselves. Hence, voluntary HIV/AIDS testing can increase the acceptance of HIV as a community issue, can reduce denial, stigma, discrimination and increase the uptake of antiretroviral treatment and prevention. Hence, keeping this into consideration, it was decided to construct and standardize a scale to measure the attitude of people towards voluntary HIV/AIDS testing.

Objectives

1. To prepare the preliminary draft of a scale for measuring public attitude towards voluntary HIV/AIDS testing.
2. To carry out item analysis of preliminary draft of scale for attitude towards voluntary HIV/AIDS testing.
3. To estimate reliability of scale for attitude towards voluntary HIV/AIDS testing through test-retest method and internal consistency method.

4. To ascertain the validity of scale for attitude towards voluntary HIV/AIDS testing.
5. To establish norms for interpretation of scores obtained on scale for attitude towards voluntary HIV/AIDS testing.

Research Method

For construction and standardization of scale for measuring public attitude towards voluntary HIV/AIDS testing, survey technique under descriptive method of research was employed by the investigators.

Sampling

Multistage sampling technique in combination with systematic sampling technique was employed in this investigation. The sample for the present investigation was taken from Mandi, Kullu and Kangra districts of Himachal Pradesh. Firstly, a sample of 120 individuals was selected for carrying out item analysis of preliminary draft of attitude scale towards voluntary HIV/AIDS testing. At the second stage, a sample of 50 individuals was taken for estimating test-retest reliability of attitude scale. At the third stage, a sample of 55 individuals was selected to compute split-half reliability of the attitude scale. At the last stage, a sample of 310 individuals (above 18 years of age) was selected for establishing norms for interpretation of scores obtained on scale for attitude towards voluntary HIV/AIDS testing.

Technique Employed for Developing Scale for Measuring Attitude towards Voluntary HIV/AIDS Testing

For development of attitude scale, the method of summated ratings as given Likert (1932) was employed. Each item of the scale was rated on five consecutive points i.e., strongly agree, agree, undecided, disagree and strongly disagree. An individual's total attitude score towards voluntary HIV/AIDS testing is calculated by adding the scores on all items. The items are scored in such a manner that, if the answer to a positive item is 'strongly agree', a score of '5' is given, for 'agree', a score of '4', for 'undecided', a score of '3', for 'disagree', a score of '2' and for 'strongly disagree', a score of '1' is given. On the other hand, in case of negative items, the above scoring procedure was reversed completely. The sum of scores on all statements is considered as respondent's total attitude score towards voluntary HIV/AIDS testing. The total attitude score on the scale can range from 48 to 240. The higher score on the scale indicates favourable attitude towards voluntary HIV/AIDS testing.

Preparation of Initial Draft of Attitude Scale

Items were initially prepared in Hindi language in order to improve their usefulness by bringing better understanding among the individuals for whom it is mainly intended for. After preparing initial draft of attitude scale towards voluntary HIV/AIDS testing, the items were reviewed by seeking the experts' opinion. The initial list of 62 items was given to 25 experts for rating each item on a scale i.e. '0' for item/statement 'not acceptable', '1' for 'doubtful' item and '2' for 'acceptable' item. The experts were researchers, medical officers, psychologists, counselors, doctors, mass education and information officers and health workers. They were explained the evaluation criterion and requested to evaluate each item in terms of its technical and logical accuracy as well as relevance to the object under consideration i.e. attitude towards voluntary HIV/AIDS testing. On the basis of criticisms and comments offered by experts, only those items which received atleast 90% approval of the experts were retained for try-out form of attitude scale towards voluntary HIV/AIDS testing. In the light of this, 3 items were rejected from the initial draft. Thus, try-out form of attitude scale towards voluntary HIV/AIDS testing was comprised of 59 items. In addition to this, the help of language experts was also sought in order to remove any sort of linguistic ambiguity contained in the items. For this, the copies of attitude

scale towards voluntary HIV/AIDS testing were given to experienced language teachers teaching in schools and colleges. Their suggestions were taken into consideration and necessary changes were made. Out of 59 items in try-out form of attitude scale, 47 items were of positive type and rest 12 items were of negative type.

Data Analysis and Results

Item Analysis of Preliminary Draft (Try-Out Form) of Attitude Scale

The technique of item analysis was employed for the selection/rejection of statements for preparing final draft of attitude scale towards voluntary HIV/AIDS testing. For this, the try-out form of attitude scale was administered on 120 individuals. Afterwards, 27% of individuals with lowest total scores and 27% of individuals with highest total scores on attitude scale were taken into consideration. The middle 46% individuals were weeded out and not considered for future analysis. Then, the mean and standard deviation for each item/statement separately for high scoring group as well as low scoring group were calculated and then onwards, 't' values were computed to find out the significance of mean difference among two groups separately for each item of the scale. The value of 't' is a measure of the extent to which a given item/statement differentiates between high and low scoring groups of individuals. According to Edwards (1957), 't' value equal to or greater than 1.75 indicates that the average response of high and low scoring groups to item/statement differs significantly. Thus, 't' values for all 59 items of try-out form of attitude scale towards voluntary HIV/AIDS testing were computed and the statements having 't' value equal to or greater than 1.75 were selected for final draft of attitude scale towards voluntary HIV/AIDS testing and rest of the statements having 't' values less than 1.75 were rejected. The 't' values in respect of each item of try-out form of attitude scale towards voluntary HIV/AIDS testing are given in Table 1.

Table 1: 't' Values In Respect Of Various Items Of Try-Out Form Of Attitude Scale Towards Voluntary HIV/Aids Testing

Item Number	't' Value	Item Number	't' Value
1	1.98	31	1.82
2	0.66 *	32	1.94
3	2.08	33	2.38
4	0.56 *	34	2.27
5	3.15	35	4.84
6	4.89	36	1.58 *
7	2.75	37	1.80
8	0.58 *	38	0.92 *
9	2.32	39	4.06
10	1.00 *	40	5.16
11	2.93	41	3.62
12	3.33	42	1.93
13	3.3	43	2.5
14	4.42	44	2.16
15	3.36	45	2.07
16	3.36	46	2.0

17	5.58	47	3.43
18	2.5	48	2.81
19	4.06	49	2.86
20	0.86 *	50	1.85
21	2.93	51	3.57
22	2.20	52	1.25 *
23	4.41	53	3.54
24	2.30	54	2.01
25	4.60	55	0.38 *
26	0.65 *	56	1.75
27	0.6 *	57	3.36
28	4.41	58	3.69
29	2.65	59	3.29
30	3.66	--	--

Note: * indicates rejected items ($t < 1.75$).

After carrying out item analysis procedure, eleven items with serial number 2, 4, 8, 10, 20, 26, 27, 36, 38, 52 and 55 in the try-out form of attitude scale were rejected and remaining forty eight items were selected for final draft of attitude scale towards voluntary HIV/AIDS testing. In the final draft of attitude scale comprising of 48 items, 26 were of positive type and remaining 22 items (with serial no. 2, 3, 5, 11, 12, 13, 14, 16, 17, 19, 23, 28, 29, 30, 34, 35, 37, 39, 40, 41, 45 and 48) were of negative type. A copy of final draft of attitude scale is given in Annexure-I.

Reliability of Attitude Scale

In the present study, the reliability of attitude scale was established by following methods:

i) Test-Retest Reliability

The test-retest reliability of attitude scale was estimated by administered the final draft of the scale twice on 50 individuals after a time gap of 15 days. Then, the correlation coefficient was calculated between the two set of scores by applying "Pearson's Product Moment Correlation Method". On applying this method, the correlation coefficient 'r' i.e. reliability index came out to be 0.71. This value of reliability index i.e. 0.71 can be considered to be appreciably satisfactory index of reliability.

ii) Split-Half Reliability

For estimating the reliability of attitude scale by split-half method, the statements of final form of attitude scale were divided into two halves by following odd-even procedure. The two halves of attitude scale were administered on 55 individuals and scoring was done separately for two halves of the scale. Then, the value of correlation coefficient was computed between the scores of two halves by using Karl Pearson's 'Product Moment Correlation Method'. On applying product moment correlation method, the correlation coefficient for only one half of the attitude scale was computed which came out to be 0.59. The reliability of the whole or complete attitude scale was obtained with the help of 'Spearman-Brown Prophecy Formula'. Thus, the split-half reliability of full attitude scale came out to be 0.742 which was higher than the table value ($r = 0.362$) at 0.01 level of significance, for df 53 and can be termed as highly significant. This was indicative of the fact that the present attitude scale was internally consistent to measure the attitude towards voluntary HIV/AIDS testing.

Validity of Attitude Scale

The validity of attitude scale was ascertained in terms of item validity, content validity, intrinsic validity and cross validity. Attitude scale was considered valid enough in terms of item validity because only those items were retained in the final draft of the scale which were having t-values equal to or greater than 1.75 (highly discriminating items). The content validity of attitude scale was established by carrying out critical discussions with field experts at the time of development of preliminary draft of the scale. The experts were of the opinion that the statements in the attitude scale were fully adequate and relevant to measure the public attitude towards voluntary HIV/AIDS testing. In addition to this, only those items were retained in the preliminary draft of attitude scale for which there has been at least 90 % agreement amongst experts. Thus, the attitude scale was found to possess adequate content validity. Furthermore, the attitude scale can be considered to have adequate intrinsic validity because split-half reliability of the scale was found to be 0.742 which is a fairly high correlation index. The cross validity of attitude scale was ensured by taking entirely different samples of individuals (above 18 years of age) belonging to various professions in order to carry out item analysis, establishing reliability, internal consistency and for developing norms.

Norms for Interpreting Attitude Scores

Before establishing the norms for interpretation of attitude scores obtained by individuals on the scale, the obtained data were verified for possessing normality. This was done by computing the values of skewness and kurtosis for overall scores of sampled individuals (N = 310) on the inventory. The value of skewness came out to be -0.179 showing the distribution of total attitude scores as somewhat negatively skewed. In addition to this, the value of kurtosis was calculated to be 0.323 indicating that the distribution of attitude scores is platykurtic in nature. These values indicated that the selected sample of individuals for establishing norms does not diverge much from normality. Further, on the basis of collected data, the mean and standard deviation for total attitude scores of all sampled individuals was calculated which came out to be 172.02 and 20.15 respectively. Then, the raw attitude scores were converted into Z-scores by taking into consideration the values of mean and standard deviation in order to establish norms for interpretation of obtained attitude scores. The following range of z-scores on a continuum can be used as suggestive norms for interpreting scores obtained on scale for measuring attitude towards voluntary HIV/AIDS testing.

Table 2 : Norms for Interpretation of Attitude Scores

Z-score Range	Attitude Scores	Interpretation
+2.01 and above	213 and above	Extremely Highly Favourable
+1.26 to +2.00	198 to 212	Highly Favourable
+0.51 to +1.25	183 to 197	Above Average Favourable
-0.50 to +0.50	162 to 182	Average / Moderate
-0.51 to -1.25	147 to 161	Below Average Favourable
-1.26 to -2.00	132 to 146	Less Favourable
-2.01 and below	131 and below	Extremely Less Favourable

Conclusions

Following conclusions may be drawn with respect to construction and standardization of scale for measuring attitude towards voluntary HIV/AIDS testing: .

1. The present attitude scale can be used for any type of Indian or non-Indian social and demographic situations.
2. The initial draft of attitude scale was comprised of 62 statements which was put to strict and rigorous examination in terms of expert opinions. After such critical examination and taking into consideration the suggestions of field experts, three statements were rejected and certain items were modified/revised. The preliminary draft of scale was thus comprised of 59 items. After carrying out item analysis, eleven statements with t-values less than 1.75 (least discriminating items) were rejected and final form of the scale has 48 items. Out of these, 26 items were positive in nature and 22 items were of negative type.
3. The reliability coefficients computed through test-retest and split half method were found to be 0.71 and 0.742 which were highly significant and thus attitude scale possessed appreciably high stability and internal consistency respectively.
4. The validity of attitude scale has also been ascertained in terms of item validity, content validity, intrinsic validity and cross validity which have been found to be satisfactory.
5. The suggestive norms for interpretation of obtained scores on the attitude scale have been developed on the basis of which, the level of attitude can be ascertained.

Applicability and Implications

The present research work was undertaken to construct and standardize a tool (attitude scale) to measure the attitude of general public towards voluntary HIV/AIDS testing. The present scale can be used with any type of diverse group of population differentiated on the basis of any social, geographic or demographic conditions. The scale is fairly reliable and valid to measure individuals' attitude towards voluntary HIV/AIDS testing. The present attitude scale can be administered easily, scored and interpreted conveniently. The scale can be used both in individual and group situations. The responses obtained on this scale are objective in nature, conveniently interpretable and can be used for bringing modification in attitude of individuals towards different aspects of voluntary HIV/AIDS testing. The findings revealed on the basis of this attitude scale may help in designing various awareness and intervention programmes in order to curb the menace of HIV/AIDS stigma in current social scenario.

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See Next Page for Annexure - 1

ANNEXURE - 1

Scale for Attitude towards Voluntary HIV/AIDS Testing

S. No.	Statement	SA	A	U	D	SD
1	Complete knowledge and understanding should be given to the individual before testing him/her voluntarily for HIV/AIDS.					
2*	Most of the people avoid HIV/AIDS testing because of shame and arrogance.					
3*	I do not wish to go for HIV/AIDS testing because of fear of needles.					
4	If I will be found positive in HIV/AIDS testing then I have to take care that it must not spread to others from me.					
5*	I am afraid of going for HIV/AIDS testing because of fear of getting infected with terrible HIV/AIDS disease.					
6	The terrible disease like AIDS can be stopped by voluntary HIV/AIDS testing.					
7	Testing for HIV/AIDS before marriage should be made compulsory under laws and legal provisions.					
8	It is necessary to seek advice of counselor before going for voluntary HIV/AIDS testing.					
9	I possess positive outlook towards voluntary HIV/AIDS testing.					
10	The next generation of children can be provided with a safe and better future by promoting voluntary HIV/AIDS testing.					
11*	Due to my busy schedule, I will not be able to go for HIV/AIDS testing.					
12*	There is no benefit of voluntary HIV/AIDS testing.					
13*	Till date, no one has explained me about the advantages of HIV/AIDS testing.					
14*	I do not wish to go for HIV/AIDS testing because if I will be found HIV positive then what people will think about me.					
15	Voluntary HIV/AIDS testing will prove to be effective and successful in reducing the danger of this epidemic among HIV sensitive and high risk behaviour people like truck drivers, sex workers etc.					
16*	I do not wish to go for HIV/AIDS testing because it is an unnecessary interference in my personal life.					
17*	There is no question of going for HIV/AIDS testing because I am not highly active in sexual relations and activities.					
18	An HIV infected mother can protect her child from HIV/AIDS infection by going for its voluntary testing.					
19*	I do not wish to go for HIV/AIDS testing because of fear of losing my status in the society.					
20	Voluntary HIV/AIDS testing encourages people to make use of uninfected (HIV free) blood.					
21	In order to promote voluntary HIV/AIDS testing, the government should make provision of some incentives apart from free HIV testing.					
22	HIV/AIDS testing is not a violation of human rights.					
23*	I do not wish to go for HIV/AIDS testing because if I will be found HIV positive then my friends and colleagues will not accept me.					
24	Voluntary HIV/AIDS testing inspires to remain loyal with the life partner.					
25	Unsafe sexual practices prevailing in the society can be stopped by going for voluntary HIV/AIDS testing.					
26	Our traditions and religious beliefs do not create any hindrances in voluntary HIV/AIDS testing.					
27	Voluntary HIV/AIDS testing helps us in leading a happier and prosperous life.					
28*	I do not wish to go for HIV/AIDS testing because I am afraid of being socially rejected if I am found HIV positive.					
29*	It is an intolerable social disgrace to be found as HIV positive (AIDS infected).					
30*	I do not wish to go for HIV/AIDS testing because my family members do not allow for it.					
31	HIV/AIDS testing should be made compulsory before appointing any person on a job.					
32	I wish to go for HIV/AIDS testing because it is mandatory under current laws and legal provisions.					
33	It is possible that some person is HIV positive and he is unaware of it.					
34*	The people who go for voluntary HIV/AIDS testing are considered as inferior in the society.					
35*	I do not wish to go for HIV/AIDS testing because I am worried that my test results will not be kept confidential.					
36	I am satisfied with the government efforts carried out for promotion of voluntary HIV/AIDS testing.					

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37*	Most of the people do not go for HIV/AIDS testing because of fear of getting HIV infected.					
38	I can be at risk of HIV infection if I will not go for HIV/AIDS testing.					
39*	I am not sure that voluntary HIV/AIDS testing can be done.					
40*	I will not go for HIV/AIDS testing because there may be conflicts in my relations with my life partner if I am found HIV positive.					
41*	I am not willing for HIV/AIDS testing even if there is the facility of free HIV/AIDS testing at testing and counseling centres.					
42	Testing for HIV/AIDS should be done with the agreement of the concerned individual.					
43	Voluntary HIV/AIDS testing helps the HIV infected person to make safe sexual relations.					
44	I do not know that what should be my expectations if I will go for HIV/AIDS testing.					
45*	People do not wish to go for HIV/AIDS testing because of fear of being discriminated in the society.					
46	A positive attitude towards AIDS infected persons can be developed through voluntary HIV/AIDS testing.					
47	People should not forcibly be involved in HIV/AIDS testing.					
48*	I am unaware of current legal provisions regarding voluntary HIV/AIDS testing.					

SA: Strongly Agreed, A: Agreed, U: Undecided, D: Disagreed, SD : Strongly Disagreed

*Note: Items marked as * indicate negative items.*

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