The Meharry Questionnaire was developed to measure the attitudes and behaviors of workers in health care facilities concerning AIDS-related issues. We were particularly concerned about attitudes which would be expected to compromise quality of care. Furthermore, we wished to identify differences in attitudes related to specific differences in demographics, specifically race, gender, education, and religious preference. In 1989, we used a convenience sample of 2,006 employees in the mental health and retardation residential facilities throughout the state of Tennessee. A follow-up questionnaire was administered in 1994 for the same population, using Items 4, 5, 6, and 8 from the original survey. The 1994 sample consisted of 857 respondents. Each administration of the survey achieved a fairly representative cross-section of socioeconomic strata by including respondents from all occupational categories at each of the facilities.

The combined 1989 and 1994 populations had a racial composition of 38% Blacks and 55% Whites; 68% of the sample were females. The highest levels of education completed by the respondents were as follows: 45% with high school or less, 33% with Bachelor’s degree or some college and 8% with Master’s or Doctorate degrees. The respondents who chose not to answer any of the demographics were not included in the statistics above.

Previous analyses from this data set revealed that Blacks were significantly more likely than Whites to affirm personal habit changes to prevent HIV infection and significantly more likely to reject the notion that AIDS is not a threat to rural areas of the United States (Ernst, Francis, Nevels, Collipp, & Lewis, 1991). Findings from the same questionnaire demonstrated that condemnation of homosexuality is stronger in the Black community deriving primarily from relatively less tolerant attitudes of Black females (Ernst, Francis, Nevels, & Lemeh, 1991).

Description

The Meharry Questionnaire consists of 13 statements to which subjects respond on a 6-point Likert scale of 0 (strongly disagree) to 5 (strongly agree). It was originally designed to assess attitudes of physicians and was later modified for general public comprehension.

Response Mode and Timing

The questionnaire requires approximately 5 to 10 minutes to complete, including the time in which respondents are providing cursory demographic information.

Scoring

Each of the 13 items was analyzed independently to compare differences in responses which might have been related to specific demographic characteristics. In unpublished work, a moral conservatism score was derived from responses to Items 2, 4, 6 (scored as a negative number), 9, 10, 11, and 13. The mean score on this measure of moral conservatism was 6.11, SD = .18 (range: –5 to 30).

Reliability

Reliability analyses yielded a Cronbach alpha of .70 with an average inter-item correlation of .16. Split-half reliability was .74. Test-retest correlation coefficients ranged from .24 to .72 for the 13 items.

Validity

Although no validity studies have been published to date, we have data supporting the validity of the questionnaire. For example, we have found that moral conservatism is strongly and inversely related to educational level (p < .000001). Religious preference is also predictable from scores on moral conservatism but this relationship is more complex because the more conservative religions (e.g., Church of God) tend to be over-represented by subjects with less formal education.

References


1 Address correspondence to Frederick A. Ernst, Department of Psychology and Anthropology, University of Texas–Pan American, 1201 West University Drive, Edinburg, TX 78541-2999; e-mail: fernst@utpa.edu
HIV/AIDS Knowledge and Attitudes Scales for Teachers

PATRICIA BARTHALOW KOCH¹ AND MAUREEN D. SINGER, The Pennsylvania State University

HIV is increasing among children and adolescents in the United States, with an estimate that at least one-half of all new infections occur in people younger than 25 years of age (Centers for Disease Control and Prevention, 2007). It is predicted that, in the near future, all school professionals will have contact with at least one student who is infected or affected by the disease (Landau, Pryor, & Haeftli, 1995). Education about prevention and how best to live with HIV-infected family members, friends, and co-workers, as well as how to deal with the disease if one is personally infected, is the key to disarming the devastating health effects of this disease and the stigma attached to it. Education at each school level (elementary, intermediate, and high school) has been recommended so that children can grow up knowing how to protect themselves. Yet researchers have indicated that children and adolescents continue to have many fears and questions about HIV/AIDS arising from a lack of education and from misunderstanding (Kistner et al., 1997; Steitz & Munn, 1993). Although the majority of states mandate HIV/AIDS education, and teachers indicate their support for it (Brucker & Hall, 1996), the implementation of HIV/AIDS education in the classroom is questionable (di Mauro, 1989–1990). Researchers have shown that teachers at various levels and from various backgrounds may lack basic factual knowledge of the cause, transmission, and prevalence of HIV/AIDS or lack sufficient comfort to teach about this topic (Boscarino & DiClemente, 1996; Dawson, Chunis, Smith, & Carboni, 2001).

Thus, the HIV/AIDS Knowledge and Attitudes Scales for Teachers were developed to serve as measurement instruments in determining teachers’ level of knowledge and attitudes toward HIV disease, in general, and specific educational issues. These scales can be and have been used with preservice education students, teachers in the field, and...