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UMI

**AN EXPLORATION OF THE HIV/AIDS HEALTH PROMOTION ACTIVITIES OF
PUBLIC HEALTH NURSES WITH FEMALE CLIENTS**

by

Susan J. Kocela

**A Thesis
Submitted to the Faculty of Graduate Studies and Research
through the School of Nursing
in Partial Fulfilment of the Requirements for
The Degree of Master of Science at the
University of Windsor**

Windsor, Ontario, Canada

1997

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ABSTRACT

Because women are experiencing the largest HIV rate increase in North America, a qualitative study using interactive interviews was conducted with 17 public health nurse (PHN) volunteers at four health units in Central/Southwestern Ontario in order to explore the health promotion/illness prevention activities of PHNs with Canadian women. Data analysis focused on the following topics: impact of the virus, populations at greatest risk, risk factors for women, nurses' HIV/AIDS activities, factors promoting or inhibiting activities, and nurse-identified missed opportunities for HIV health promotion. Although many themes emerged from the data, the theme of 'variability' was paramount. Using Lalonde's Health Field Concept as a framework, recommendations were made regarding nursing education (i.e. need for more emphasis on biology, women's health, and human sexuality), nursing research (i.e. need for studies to evaluate activities used to improve self-esteem and sexual health), and the need to advocate for an expanded role in public health nursing practice.

DEDICATION

This work is dedicated to my husband and children whose unending encouragement and patience made it possible for me to complete this project.

ACKNOWLEDGEMENTS

I would like to thank all of the public health nurses who participated in this study, as well as the four health units which provided staff time and assistance in recruiting volunteers. I would like to thank my husband, Ron, who printed all of the coded data onto over 2700 file cards and provided unlimited computer support and assistance. I am grateful to my faculty advisor, Dr. Barbara Thomas, for her enthusiasm, guidance, and encouragement, and to my committee members, Dr. Laurie Carty and Dr. Alan Sears, for their participation and support.

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CHAPTER ONE

Introduction

“The HIV/AIDS epidemic is a new global phenomenon, still highly dynamic and unstable, whose major impacts are yet to come, and whose current shape and future depend exclusively on individual and collective behavior” (Mann, Tarantola, & Netter, 1992, p. 16). Although global in its impact, the effects of the pandemic have been unequal throughout the world. Since its discovery in the early 1980’s, HIV/AIDS has afflicted both men and women in similar proportions throughout sub-Saharan Africa and the Caribbean, while its impact in North America has been absorbed, until recently, by a predominantly male population (Mann et al.). Not surprisingly, the viral momentum has shifted and currently women comprise the North American population with the largest HIV rate increase (Massachusetts Medical Society, 1995). From an epidemiologic perspective, there is clear indication for the need to mobilize the ‘individual and collective’ efforts of the nursing profession with respect to health promotion and HIV/AIDS in women. As “the professional group most often involved in implementing public health strategies” (Hayward et al., 1993, p. 23), public health nurses (PHNs) have a major role to play in this endeavour. It is essential, therefore, to determine the degree to which these nurses are meeting, or are prepared to meet this need. Such an assessment of the status quo is required to enable nurses in health promotion/illness prevention to develop and focus effective strategies to combat the HIV epidemic.

Statement of the Problem

Because the HIV/AIDS epidemic has not yet reached the same proportions in Canada as it has in the United States (US), there is a significant window of opportunity for nurses in health promotion to reduce the impact of HIV/AIDS on Canadian women. There are, however, strong reasons to suspect that health care professionals may not view the spread of HIV as a priority concern with this population and may be providing insufficient education and counselling. This suspicion is supported by a consideration of the following factors: social attitudes toward the disease, the general neglect of AIDS as a women's health issue by the health care community, the possible influence of the American media on Canadian perceptions of HIV/AIDS epidemiology, the probable lack of personal educational opportunities for nurses regarding HIV/AIDS, and the current high incidence in women of another sexually transmitted disease, chlamydia--used here as an indicator for unprotected sexual activity.

In the early days of the HIV/AIDS pandemic, North America was classified as a Pattern I Area wherein the primary modes of transmission were identified as injection drug use or homosexual/bisexual behaviours in men (Mann et al., 1992). The social condemnation of these lifestyles has resulted in attitudes of homophobia, blame and stigmatization toward individuals who have AIDS or who are seropositive for the HIV virus. In addition, this focus has resulted in decreased public recognition of the risks inherent in other sexual activities, including heterosexual sex (Mann et al.) and in other populations, such as women.

Many authors support the argument that women's health concerns have been overlooked and under-researched (Achilles, 1987; Auerbach & Figert, 1995; Duffy,

1985; Phillips, 1995; Simkin, 1995). HIV/AIDS is no exception. The vast majority of AIDS research has focused on risk factors and disease manifestations in men (Berer, 1993). The paucity of attention given to AIDS and women in medical literature may also be a factor in many physicians' failure (Fletcher, 1990) to assess or counsel women regarding risk factors for HIV/AIDS when they present for gynecological problems. Although the majority of the opportunistic infections experienced by men also affect women, the presenting symptoms in women are often very different (i.e. increased incidence of yeast and/or herpes infections) and not readily associated with HIV by physicians (Clark, Hankins, Hein, Mitchell, & Williams, 1993). Invasive cervical cancer was not added to the criteria diagnostic of AIDS until 1993 (Stine, 1995).

The epidemiology of AIDS in Canadian women is different from that of American women. Figure 1 utilizes available data up to October 1995 from the Laboratory Centre for Disease Control (LCDC) as well as data from the Massachusetts

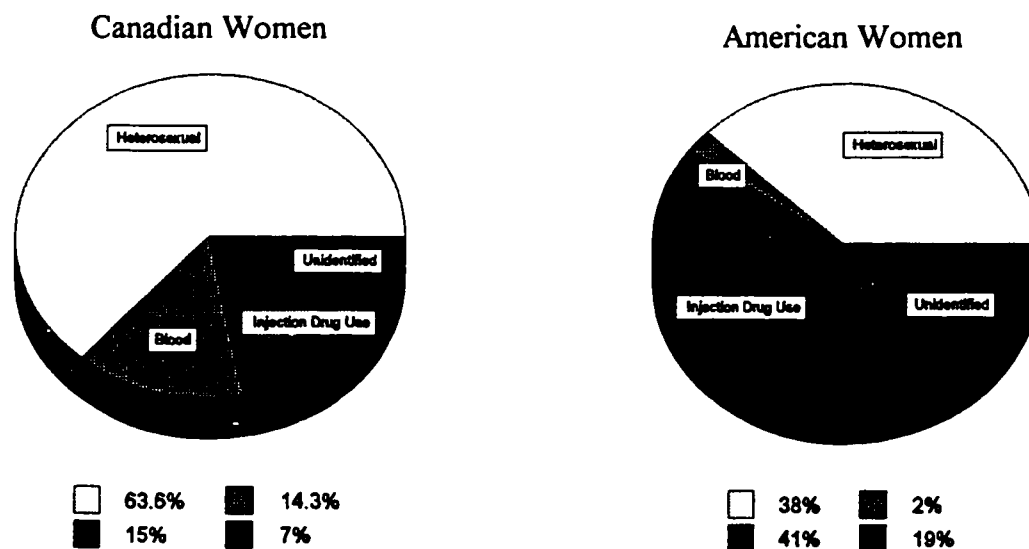


Figure 1.

Medical Society (1995) to identify and compare the modes of HIV/AIDS transmission in Canadian and American women. In the United States 77% of females with AIDS are Black or Hispanic (Massachusetts Medical Society, 1995). In Canada, approximately 60% of infected females are Caucasian (Health & Welfare Canada, 1992). Because most of the Canadian population lives near the American border and because the American media exerts such a strong influence throughout North America, there is potential for American reports to mislead Canadians about the risks for women in this country.

Data provided by the Statistics and Research Section of the Registration Department of the College of Nurses in Ontario (CNO) (personal communication, March 12, 1996) (see Figure 2) indicated that 67% of the public health nurses practising in 1994, graduated in or before 1981. That was the year that the first AIDS cases were identified in Los Angeles (Stine, 1997). Seventy-three percent were educated prior to the discovery

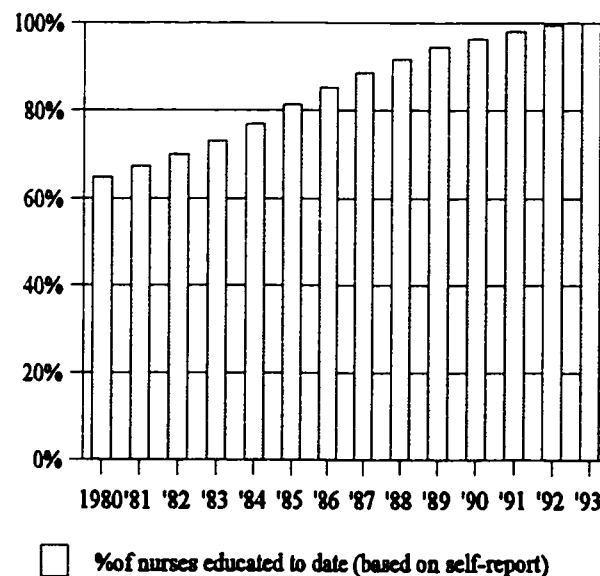


Figure 2. Number of public health nurses educated by 1994.

of HIV-1 in 1983, and 85% were educated prior to the discovery of HIV-2 in 1986.

Clearly the majority of public health nurses graduated before HIV/AIDS education was included in the nursing curriculum. Furthermore, Marilyn S. Wang, Director of Registration at CNO (personal communication, March 12, 1996), reported that although infection control is a required component of nursing education, HIV/AIDS is not specifically identified. While it is safe to assume that all schools of nursing have stressed the need for universal precautions over the past several years, one can make no assumptions about the degree to which even recent graduates have learned about the many other issues associated with HIV/AIDS.

The 'safer sex' practices recommended to prevent transmission of the HIV virus are also preventative for other sexually transmitted diseases (STDs). The Ministry of Health in Ontario (1994) reports that the incidence of chlamydia has increased dramatically from 1985 to 1993 (5,187 cases to 14,381 cases). The highest rates of infection occurred in females 15 to 19 years of age, with a rate of infection seven times that of men the same age. Women in the 20 to 24 year age range suffered three times the incidence of chlamydia as men. Not only does chlamydia act as a cofactor in HIV transmission (Stine, 1995), its high rate of occurrence serves as an indicator for the same unsafe sexual practices which permit transmission of the human immunodeficiency virus.

This research study was designed to explore the status of public health nurses' HIV/AIDS health promotion/disease prevention activities with women. It was important to determine to what degree public health nurses were knowledgeable about HIV/AIDS disease factors and transmission as they related to women. Did these nurses view HIV/AIDS as a significant women's health issue? Were they actively engaged in

HIV/AIDS health promotion/disease prevention strategies with that population? Had their professional activities, vis-à-vis women and AIDS, been influenced by the Canadian or the American epidemiology? A related concern which was likely to impact on a nurse's decision to initiate or participate in HIV/AIDS health promotion/illness prevention activities was her/his comfort discussing sexuality and sexual practices. The study required not only an examination of current activities, but also an exploration of those occasions when nurses could have conducted HIV/AIDS health promotion activities, but for some reason, did not do so. It required an understanding of forces which motivated nurses to initiate activities, as well as forces which inhibited this motivation. Such knowledge is crucial in assisting the nursing profession to develop an effective public health campaign to combat HIV/AIDS.

Research Questions

An exploratory study was designed to answer the following broad research question: What is the current status of HIV/AIDS health promotion/disease prevention by public health nurses with female clients?

To answer this primary question, the following three sub-questions were developed:

1. When and where do PHNs counsel women regarding HIV/AIDS?
2. What type of health promotion/disease prevention activities are being conducted?
3. What factors promote/inhibit this activity?

Conceptual Framework

This research study utilized the Health Field Concept (Lalonde, 1974) as a framework (see Figure 3) for exploring the topic of women and HIV and the related health promotion/illness prevention activities of public health nurses. In his landmark and now classic document, entitled A New Perspective on the Health of Canadians, Lalonde introduced the Health Field Concept, “a sort of map of the health territory” (p. 31), wherein he subdivided the health field into four components: human biology, environment, lifestyle, and health care organization. These components or determinants of health, as they have come to be known, have been broadened to “incorporate psychosocial factors such as gender and ethnicity” (Shah, 1994, p. 9) under the heading of environment. Utilization of this framework permitted a comprehensive exploration of women’s health issues without superimposing a rigid structure which might have masked the discovery of the theories or guiding principles used by nurses in their professional practice. Moreover, an exploration of the health field, vis-à-vis women and HIV/AIDS, highlights both the significance of the topic as a women’s health issue as well as the

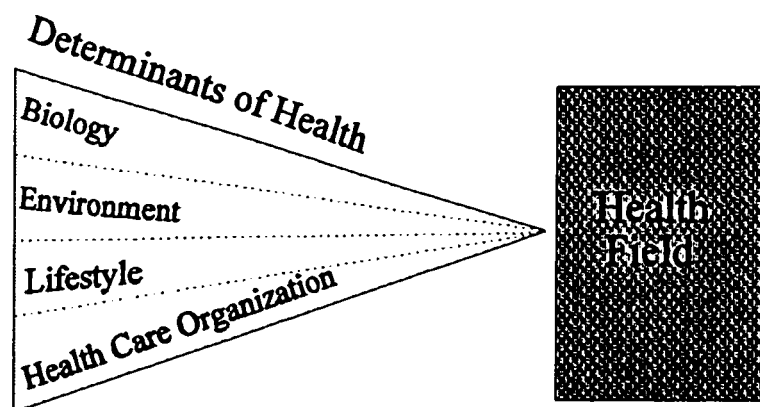


Figure 3. Lalonde’s Health Field Concept

challenges presented to those involved in health promotion and illness prevention activities.

Human Biology

The task of tailoring HIV/AIDS health promotion and illness prevention activities to females is especially significant and challenging because many of the determinants of health and disease are different for women than they are for men. Although human biology is not modifiable, it is an especially significant focus for health care providers. Women at both extremes of the age spectrum have increased biologic risk factors for HIV transmission. Immaturity of the cervix and decreased production of vaginal mucus are significant factors for young females (Hankins, 1995). Postmenopausal and older women are at increased risk related to vaginal wall thinning and age-related decrease in immune system response (Tichy & Talashek, 1992). Nevertheless, Health and Welfare Canada (1992) confirms risk for all ages of women by stating that AIDS cases occurred equally in three age categories: 15 to 29 years, 30 to 39 years, and 40 years or older. Heterosexual intercourse poses a significantly greater risk for women than for men (Berer, 1993; Centers for Disease Control, 1990; Hankins, 1995). This is because the viral loading of semen is greater than that of vaginal fluids (Clark et al., 1993) and because there is an increased exposure of mucosal surface area in the female vagina or rectum compared to the male urethra (Church & Gill, 1994). These risks are further increased in women who are menstruating, using an intrauterine device, or suffering from a gynecological infection (Berer, 1993). Additionally, an HIV positive woman has a 25% to 35% risk of infecting her infant prenatally or by breastfeeding (AIDS Education and

Prevention Unit, 1994).

Environment

From the environmental perspective, more women live in poverty than men (Health & Welfare Canada, 1992). This reduces their access “to the educational, social and health resources they need to protect themselves from HIV infection and to receive effective care and support if they become infected” (Health & Welfare Canada, p. 7). The struggle to survive poverty and social isolation may place HIV prevention in a low priority category. Power imbalances, common in male-female relations, prevent many women from negotiating condom use with their partners even in consensual sex acts (Cohen, 1995). Non-consensual intercourse carries increased risk related to lack of lubrication and probable non-use of condoms (Hankins, 1995). Because more men than women are infected with HIV, women have an increased statistical risk of exposure from a heterosexual relationship (Bezemer, 1992). Recommendations to elicit a partner’s sexual history before having intercourse may be based on unrealistic social expectations regarding honesty (Fletcher, 1990) and imply that individual risk is calculable. In fact, “people cannot really compute their ‘real’ risk levels because the calculations are too complex” (Sobo, 1995, p. 21). Women with bisexual or unfaithful partners may assume they are in a stable monogamous relationship and see no need to adopt ‘safer’ sexual practices. Older women entering into new relationships, may have been inattentive to recent “safer sex” campaigns during the course of a previous long-term relationship (Sipes, 1995). Exposure to immigrant populations from Pattern II countries may also place some women at risk. Remis and Sutherland (1993) speculate that the heavy incidence of AIDS among women in Quebec is due to the high rate of influx of

immigrants who acquired AIDS heterosexually.

Lifestyle

Research indicates that many Canadian women may be unaware of the lifestyle risks for HIV/AIDS. In a recent study of HIV positive women in Ontario, Calzavara and Jackson (1995) reported that 78% of the infected women had been unaware of their personal risk status. According to Health and Welfare Canada (1992), unprotected vaginal and/or anal intercourse are the primary behavioural factors in disease transmission in women. Although no comprehensive studies have been conducted, there are both quantitative and qualitative data to support the belief that many or most women do not practice safer sex (Bowd & Loos, 1995; Gahagan, 1995; Ramsum, Marion, & Mathias, 1993). Nineteen percent of Canadian women are presumed to engage in anal intercourse (Health & Welfare Canada, 1992). Anal intercourse may be practised for pleasure, contraception, to preserve virginity before marriage, or in situations where vaginal intercourse is precluded by infibulation (Berer, 1993). Unprotected, this activity increases the risk of disease transmission since the tissue of the rectum is more easily torn than that of the vagina (Stine, 1995). Although many women are unaware of it, lesbian sex practices (i.e. the sharing of insertive devices) may also put women at risk (Stevens, 1994). The sexual history of a lesbian partner and each of her previous partners (male or female) poses the same unknown risks as in heterosexual activity. Increasing numbers of Canadian women are contracting AIDS by sharing needles for injection drug use (LCDC, December, 1995). In addition to other behavioural risks, alcohol and drug use can lead to a loss of personal control which also increases the chance of infection (Health & Welfare Canada, 1990).

Health Care Organization

With respect to the health service sector, benefits such as universal health care coverage have been offset by other factors. Although anonymous or confidential HIV/AIDS testing and treatment are available, these services are of little value to a population which does not consider itself seriously at risk. One author states: "Because many women are unaware of their risk even when questioned, risk-based screening may miss 50-60% of infected women" (Bush, 1995, p. 331). In practice, many physicians are reluctant to ask personal questions about lifestyle issues related to disease transmission (Sipes, 1995). Because little research has focused on AIDS symptomatology in women, many doctors have been slow to diagnose the disease and begin treatment. This is the presumed cause for the increased morbidity and mortality experienced by women suffering from AIDS (Health & Welfare Canada, 1992).

As conceptualized by Lalonde, the Health Field is comprised of four components (human biology, the environment, lifestyle, and health care organization), each of which provides a framework for examining a complex subset of factors (determinants) which impact on the health of the population--in this case, Canadian women. The breadth and simplicity of Lalonde's framework provided a non-restrictive structure which enabled the researcher to interpret data results and identify implications for nursing practice.

Significance of the Problem

As described, this research study is significant from the broad perspective of women's health. It is even more significant from the perspectives of nursing science and the potential for nursing to influence the impact of the HIV virus on the health of

Canadian women. An assessment such as that provided by this study, is an essential component of the nursing process and provides information which may enable nurses to develop and focus health promotion/illness prevention strategies which can be used throughout the broad spectrum of public health nursing practice: at the level of individuals, families, groups, communities, and populations. Moreover, the results of this study have the potential to guide changes in nursing education related to course content in schools of nursing, employers' responsibilities for professional in-service, and nurses' responsibilities for continuing education. Furthermore, data arising from this study may inspire future nursing research efforts.

The nursing activities which arise from this study could have a profound effect on the epidemiology of HIV/AIDS in Canada. Although there are only 397.7 cases of AIDS per million in Canada as compared to 1542.3 cases per million in the United States (LCDC, December 1995), the epidemic is growing. By the beginning of 1995, approximately 15,893 adult AIDS cases (number of cases adjusted for reporting delay and under-reporting) had been diagnosed in Canada (LCDC). It took eleven years for the first 1/3 of the cases to develop, three years for the second 1/3 to evolve, and only two years for the final third of cases to be identified (LCDC). All age groups, geographic regions, and races have been affected. The demographic trends (LCDC, 1996) are also significant (see Figure 4). From 1988 to 1995 there were decreases in the proportion of AIDS cases diagnosed in men who have sex with men (MSM) and in the proportion of AIDS cases contracted from blood. In contrast, heterosexual contact and injection drug use (IDU), alone or in conjunction with male homosexual behaviour, are related to a higher incidence of AIDS than in the past. The proportion of AIDS cases in women has

been rising steadily (LCDC, 1997) (see Figure 5). Well designed nursing interventions may significantly alter these trends.

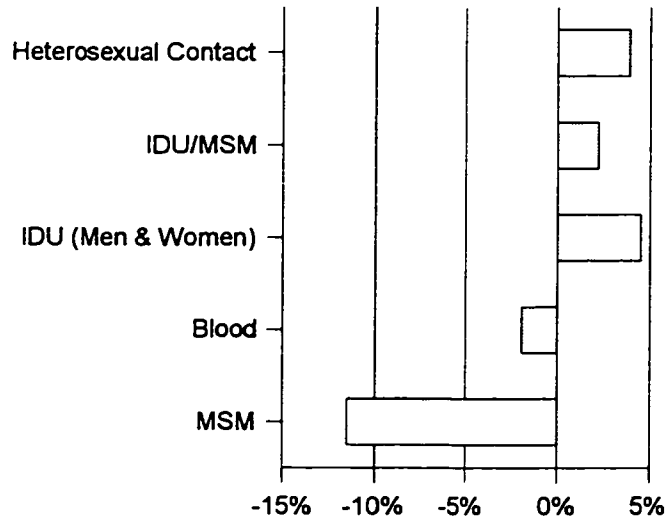


Figure 4. The change in rates of incidence from 1988 to 1995.

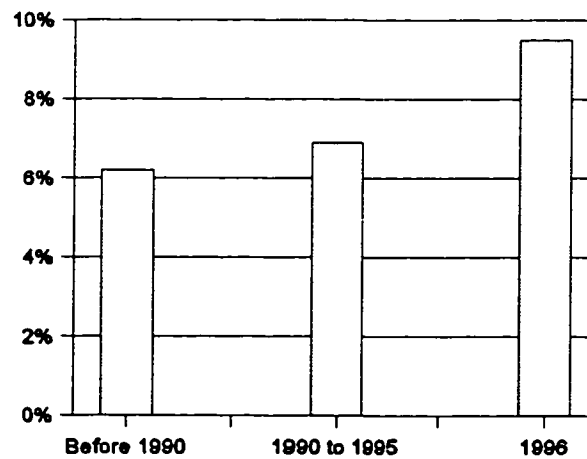


Figure 5. The proportion of AIDS cases in women in Canada.

Assumptions

1. All public health nurses engage in health promotion/illness prevention activities.
2. The minimum educational requirement for a public health nurse is a Diploma in Public Health Nursing (DPHN) or a Bachelor of Science in Nursing Degree (BScN).
3. Although the expertise of nurses will vary with employment responsibilities, each nurse will have a sound knowledge base relating to the health issues of the population she/he serves.
4. Health promotion is a broad concept which may not be defined the same way by all nurses; however, all nurses will agree that it “subsumes health education within its boundaries” (Glanz, Lewis & Rimer, 1990, p. 8).

CHAPTER TWO

Review of Literature

A review of professional literature supports the view the need for increased health promotion and prevention efforts to address HIV/AIDS issues specific to women in Canada (Church & Gill, 1994; Sourdif, 1993), in the United States (Clark et al, 1993; Cohen, 1995; Miramontes, Tom & Gillen, 1994; Sipes, 1995), and internationally (Araujo & Diniz, 1994; Berer, 1993; Fletcher, 1990; Hankins, 1995; Lucke & Raphael, 1995; Sabo & Carwein, 1994; Smeltzer, 1992).

Canadian author Isabelle Sourdif (1993) has voiced strong concerns that the majority of women believe they will never be affected by the epidemic and that many health care professionals are not sufficiently alerted to this problem. A review of the Cumulative Index to Nursing and Allied Health Literature (CINAHL) from 1982 to date, has identified innumerable studies which explore the general knowledge and attitudes of nurses with respect to HIV/AIDS.

One commonly identified theme is fear of accidental disease transmission related to caring for HIV positive patients (Armstrong-Esther & Hewitt, 1989; Laschinger, Goldenberg, & Dal Bello, 1995; van Wissen & Woodman, 1994). Nevertheless, despite fear of cross infection between patient and nurse, most of the nurses in one study “agreed that universal precautions should be followed but admitted that they were not necessarily taking these measures” (van Wissen & Woodman, p. 1144).

Another focus of nursing research has been nurses’ attitudes toward HIV positive patients. Some nurses believed that they should be able to choose whether or not HIV

positive patients were assigned to their caseload (van Wissen & Woodman, 1994). Gignac and Oermann (1991) reported that increased knowledge levels were related to increased willingness to care for HIV/AIDS patients. The statistical relationship of increased education levels resulting in increased knowledge levels and more positive attitudes was supported by the findings of three studies (Gignac & Oermann, 1990; Highriter, Tessaro, Randall-David, & Quade, 1995; Lawrence & Lawrence, 1989).

Canadian nurse researchers, Armstrong-Esther and Hewitt (1989), identified a knowledge deficit regarding HIV/AIDS symptoms and disease transmission in both general baccalaureate nursing students and in post-RN baccalaureate students. Other researchers, Gignac and Oermann (1990), surveyed Canadian nursing students and faculty and identified a similar gap in knowledge. Although the margin of difference was small, nurses ranked third in Passannante, French and Louria's study (1993) of the AIDS knowledge levels of doctors, dentists, and nurses in New Jersey. In that study, doctors identified 71% of the correct answers; dentists identified 66%; and nurses identified 65%. British researchers, Lewis and Bor (1994), reported that despite enormous changes in cultural attitudes toward sexual matters and heightened awareness of sexuality resulting from the identification of HIV/AIDS, nurses' knowledge about sexuality had not increased in 20 years. Fifty-four percent of nurses reported being embarrassed discussing sexuality, although 78.5% believed they had been adequately trained in sexual matters. Sixty-five percent admitted that they rarely asked questions about sexuality even though many believed they should. Several of the researchers (Armstrong-Esther & Hewitt, 1989; Demirbag & Ridenour, 1995; Laschinger et al., 1995; Passannante et al.; van Wissen & Woodman, 1994) and significant numbers of surveyed nurses (Armstrong-

Esther & Hewitt; Highriter et al., 1995; van Wissen & Woodman) identified a need for increased education of health professionals relative to HIV/AIDS.

There is international agreement regarding the necessity for nurses to be knowledgeable about HIV/AIDS. British nurse researcher Tierney (1995) comments that “the long-term future really does depend on the willingness of nurses and other health-care workers to use every available opportunity for health education” (p. 14). Canadian nurses Laschinger, Goldenberg, and Dal Bello (1995) note that community nurses will play a critical role in the AIDS epidemic since all home care agencies will eventually have AIDS patients on their caseload. Likewise, American authors endorse this role in community health nursing (Demirbag & Ridenour, 1995) and also comment on the importance of public health nurses in HIV/AIDS health promotion and disease prevention. According to Tessaro and Highriter (1995):

Control of HIV is dependent on prevention through education and risk reduction.

The practice of public health nursing provides many opportunities to educate individuals about behavioral risk reduction and to evaluate the need for HIV antibody screening. Public health nurses are thus a valuable resource for helping individuals reduce their risk of HIV transmission. (p. 30)

There is, however, little information available regarding public health nurses' HIV/AIDS health promotion/illness prevention practices with women. Stinson (1993), Corkum and Ruf (1993) and Wagman (1993) utilized a case study approach to describe macro level AIDS health promotion programs targeted at large Canadian populations in Winnipeg, Toronto and Vancouver respectively. Although women were the target of the Vancouver initiative, the article focused on the development and implementation of the

social marketing campaign which utilized hired consultants, focus groups and peer educators. Public health nurses were not mentioned. The authors of the three macro level programs did recommend the following actions: using focus groups and telephone surveys, acting as a catalyst among community agencies, facilitating collaboration among agencies, employing peer education strategies, and using “fun activities” to promote comfort with condom use. Nelson (1993) provided a similar case study approach to describe nurse-initiated interventions in a rural area of Ontario. The author provided community-specific approaches and indicated success with the following strategies: linking personally with community agencies, employing different educational strategies for each segment of the population, and utilizing resources from the National AIDS Clearinghouse in Ottawa. She did note one specifically female-focused activity: the distribution of pink condoms and AIDS literature at hairdressing salons during AIDS Awareness Week.

Demirbag and Ridenour (1995) included public health nurses in their study of community and home health nurses in Texas. Although the respondents reported high levels of interest in primary prevention, they identified low to medium areas of expertise in “legal/ethical issues, epidemiology/transmission, and HIV testing/counselling” (p. 131). A significant survey of 311 public health nurses in 41 health departments in high and low AIDS prevalence areas in North Carolina was examined in two journal articles (Highriter et al., 1995; Tessaro and Highriter, 1995). Highriter et al. found that the nurses had generally high levels of knowledge about HIV/AIDS although many expressed the need for help in HIV prevention and counselling skills. Despite the fact that high proportions of the nurses identified favourable attitudes regarding working with

HIV positive clients, many of the nurses revealed “attitude problems” (p. 331) associated with their discomfort around intravenous drug users, their moral condemnation of homosexual lifestyles, and their discomfort in discussing sex with homosexuals. There was also a concern that the rights of HIV positive individuals overshadowed the attention given to the health of the general public. Tessaro and Highriter (1995) evaluated the sample’s general HIV education and risk-assessment practices. Of the 244 nurses employed in settings where such practices were appropriate, only 60% reported conducting these activities with their clients. This behaviour was more strongly correlated with current employment specific to HIV-prevention counselling, increased knowledge about HIV, and high levels of self-efficacy regarding HIV-prevention counselling than it was to their perception of client risk.

In their study on postmenopausal women, funded by the AIDS Bureau of the Ontario Ministry of Health, Dyson and Farkas have identified ambiguous reports regarding the counselling of older women by public health nurses in Ontario (Farkas, personal communication, March 7, 1996). While departments of public health have informed the researchers that the nurses did counselling and were aware of older women’s psychosocial, behavioural, and clinical risks, few of the responding health units provided the requested details regarding the content and context of the counselling.

An examination of publications and announcements from the federal government confirms the research deficit. In 1992, as part of the National AIDS Strategy Part I, Health and Welfare Canada published a document entitled Women and AIDS: A Challenge for Canada in the Nineties. It stated, “This paper is intended to be a first step in developing approaches and initiatives which meet the needs of women, as part of

Canada's overall response to the AIDS epidemic" (p. 2). The document made specific references to determinants of health impacting on women's risk for HIV/AIDS and noted that there had been little research done to determine the personal and social characteristics of Canadian women infected with HIV. However, in a federal review of the highlighted achievements of the Phase I initiative, the only noted initiative regarding women concerned research on prenatal mother-to-child transmission of the AIDS virus (Health & Welfare Canada, 1993). Phase II of the National AIDS Strategy identified Aboriginal people, injection drug users and their sexual partners, people in correctional facilities, street-involved youth, and gay/bisexual men as targets for interventions (Health & Welfare Canada). No specific references were made to women. Despite the previously identified concern, the Health Minister has announced that Phase III of the National AIDS Strategy, which was to commence in 1998, has been cancelled (Ditchburn, 1995). It appears now, that a national focus on HIV/AIDS prevention in women is not forthcoming.

A review of the literature has identified several issues. To date, there are no published reports which provide an in-depth exploration of the current practices or attitudes of Canadian public health nurses with respect to HIV/AIDS health promotion/illness prevention activities with women. Although the above-noted articles support the suspicion that such activity may be inadequate, most of those studies were conducted outside Canada and did not focus on nursing interactions with women. Two of these studies were limited by low participant response rates (Demirbag & Ridenour, 1995; Passannante et al., 1993). Most studies used a quantitative methodology which restricted the findings to issues previously identified by the researchers. Although van

Wissen and Woodman (1994) utilized focus groups for a broad exploration of nurses' attitudes and concerns, they concluded by recommending that further research employ a one-on-one interview technique "to supplement the data base further" (p. 1146). All of these factors support the need for a new nursing research initiative to explore this pressing concern in a more comprehensive manner.

CHAPTER THREE

Methodology

Since this topic had not been studied previously, an exploratory design was chosen to increase nursing knowledge about the current status of HIV/AIDS health promotion/illness prevention activities conducted by public health nurses with female clients. A qualitative inductive approach was used to explore these phenomena from the emic perspective (cultural context) of public health nurses and to discover the themes and patterns of behaviour associated with these activities. Such a process of discovery would not have been possible using a quantitative design. The “interactive interview” (Morse, 1991, p. 18) format was used wherein “the researcher uses probes and explores concepts, tape records the interview, and then transcribes the tape verbatim” (Morse, p. 18). Morse acknowledges this methodology as “legitimate qualitative research for which, as yet, there is no name” (p. 18).

The Setting

Data gathering took place in four health units in Central/Southwestern Ontario. These agencies serviced both rural and small to moderate sized urban communities. Interviews were conducted privately, in office space provided by the health unit.

Gaining Access

The researcher contacted a director of nursing at each health unit to ascertain that agency’s protocol for processing requests to conduct nursing research. In some instances

the Medical Officer of Health (MOH) gave approval; in other instances the decision was made by a health unit research committee. In negotiating approval, the researcher offered to present the research findings to each health unit at the conclusion of the study.

Subsequent to application for and receipt of official agency approval for the study, the researcher collaborated with a director of nursing (or delegate) at each site to establish research dates, space for interviews, and access to nursing staff. Individual letters of intent (see Appendix A) from the researcher were distributed to the nurses via their personal mailboxes in order to enlist their support. (In one health unit, the director of nursing recruited volunteers through an announcement at a general staff meeting after approval for the letters was delayed due to a postal error.) Prior to arrival, the researcher wrote the local Ontario Nurses Association (ONA) president at each health unit to request her endorsement of the study with nursing staff. The researcher, herself, was an ONA member at another health unit and familiar with that nursing 'sub-culture'. It was anticipated that a collegial bond would facilitate her acceptance within the health units.

Sample

Key informants were identified as those nurses who planned and delivered the agency's HIV/AIDS programs; however, it was also the intent of the researcher to collect data from nurses working in a broad range of other areas in order to determine under what circumstances and how often, the opportunity for HIV/AIDS health promotion/illness prevention activities arose in those areas. The researcher's goal of interviewing 15 to 20 nurses was met when 17 nurses volunteered to participate in the study. (The employment responsibilities of informants are summarized in Table 1.) Job

descriptions varied from health unit to health unit within a specified area of focus. Some of the nurses working with HIV also worked with STDs. Most of the nurses also taught prenatal classes. Most PHNs had experience working in other areas of the public health, and all of the nurses had a BScN degree. All of the nurses were female. Two of the nurses were in the 25 to 35 year age range; twelve were in the 35 to 44 year age range; and three were in the 45 to 54 year age range. Thirteen were married; one was single; two were separated; and one was divorced.

Table 1

Informants: Focus of Practice

Focus of Practice	Number
HIV/AIDS program	4
Child/adolescent program	4
Sexual health program	2
Reproductive health program	1
Children 0-5 years program	3
Healthy elderly program	1
Health promotion	2

Time Frame

The research was conducted in the Fall of 1996. The researcher spent two days at each of the health units and interviewed one to three nurses per day. While most interviews lasted approximately one hour, the length of the interviews ranged from 45

minutes to almost two hours.

Ethical Considerations

Prior to its initiation, the study received ethical approval from the Research Committee of the School of Nursing at the University of Windsor. Formal ethical review processes were conducted at two of the health units. At the other two agencies, the Medical Officer of Health provided agency approval for the study.

Informed consent (see Appendix B) was obtained in duplicate from each informant. One copy was retained by the nurse; the other was kept by the researcher. This consent included permission for audio taping the interview and guaranteed the confidentiality of data collected. Informants were informed of the following: that their consent could be withdrawn at any time during the research process; that audiotapes of interviews would be labelled by number, not by name; that the researcher would be the only person to associate individuals with the data they provided; that all tapes would be erased once the data was transcribed; that transcripts would be retained, without identifying information, in a secure location; that transcripts would be destroyed once the necessary analysis had been completed; and that the researcher would destroy the list of informants' names at the conclusion of the research. The researcher assured each PHN that no single individual would be identifiable in the final research report.

Data Collection

Primary data collection occurred via open-ended interviews with the public health nurses who volunteered for the study. (See Appendix C: Tentative Schedule of

Questions.) Each interview began with general personal introductions and the collection of demographic data regarding the nurse's age group, marital status, focus of practice, length of time practising in that area, number of years since graduation, and level of education. A relaxed setting was provided so that the nurses could feel comfortable enough to speak freely. Each PHN was asked to speak to the interviewer as if she were not a nurse in order to avoid the presumption of a shared body of knowledge. During the taping process, one or two nurses asked that the tape be turned off while she briefly discussed a sensitive area which she wanted excluded from the interview. Such requests were consistent with the previously noted nurse-interviewer consent agreement. Where possible, the researcher attempted to validate reports by obtaining more than one nurse's perception of a service or health promotion event. The foci of the interviews varied as different themes emerged and were pursued by the interviewer. All nurses provided their home phone numbers so that the interviewer could contact them for further information or clarification as needed, although such contact was never required. Whenever possible, the researcher inquired about supplementary data sources (i.e. teaching kits, policies and procedures, relevant newspaper articles relating to agency health promotion events, etc.).

The interviews were tape-recorded and numbered sequentially. At the end of each interview, the researcher made field notes regarding the nurse's non-verbal behaviour during the conversation. Audio taped notes were made regarding any supplementary data sources which were examined. Notations derived from the researcher's thoughts, feelings, or conjecture were kept separate from observations and recordings of conversations (Morse, 1994a).

Data Analysis

All interviews were transcribed verbatim by the researcher. Observations regarding occurrences such as laughter, intrusive noises, changes in the nurse's volume or rate of speech, etc., were noted parenthetically.

Analysis followed the four cognitive processes which Morse (1994a) identifies as integral to all qualitative methods: comprehending, synthesizing, theorizing, and recontextualizing. Comprehension was based on interviews, observations (of nurses' responses), and use of other documents. The researcher made every effort to collect the data from the perspective of the informants and to absorb it with a nonjudgemental attitude. The process of comprehension was facilitated by adopting a "stance of active inquiry" (Morse, p. 28) and learning to distinguish the norm from the exception. Using "intraparticipant microanalysis" (Morse, p. 29) the researcher analysed the interview transcripts line-by-line (or word-by-word). Excerpts of text were coded and compiled into categories of common themes. Each transcribed interview was first coded by hand with coloured markers and then coded by computer onto 'cards' sorted into 12 theme 'folders' using the Martin v. 2.0 data processing package. This number of folders was consistent with recommendations made by Morse and Field (1995): "The categories are initially broad so that a large amount of data may be sorted into a few groups, usually between 10 and 15 categories per study" (p. 140). This two-step process of both hand and computer coding provided a means of double checking and verifying the data codification. Whenever data was relevant to more than one category, duplicate or triplicate cards were made for insertion into each theme folder.

Synthesizing began when the researcher developed the ability to describe the

norms and variations in behaviour of the informants, to discriminate between significant and insignificant data, and to account for the variation in the data. Cards, ordered by folder, were printed onto 4 inch by 6 inch unlined index cards. The 17 data sets for each category (folder) were then grouped together to facilitate content analysis. New groupings by sub-category or themes arose as the data analysis continued. The researcher's comments were handwritten onto the cards. During the process of analysis, cards were moved from one grouping to another as necessary. The hand-coded transcripts were bound and used as a cross-reference to ensure that quotes were used within the correct context.

During the theorizing phase, the data were manipulated and constructed into alternative explanations until “the best theoretical scheme [was] developed” (Morse & Field, 1995, p. 128) to explain the data. During the recontextualization phase, “theory-based generalizations” (Morse, 1994a, p. 35) were made in an attempt to advance nursing science.

Rigour

Following Morse's guidelines (1994b) to ensure the rigour of the study, the researcher obtained an appropriate sample of PHNs with experience in a wide range of activities involving female clients; collected data to the point of saturation (i.e. no new data were being collected from the interviews); and incorporated an audit trail into the data analysis of the research report.

CHAPTER FOUR

Results

The interviews with the public health nurses yielded a large amount of data covering a wide range of topics. In order to answer the research questions, a focused analysis was made of the information provided by nurses on the following topics: (a) The impact of the HIV virus, (b) populations at greatest risk for the virus, (c) risk factors for women, (d) HIV/AIDS health promotion/illness prevention activities, (e) factors promoting or inhibiting HIV/AIDS health promotion/illness prevention activities, and (f) nurse-identified missed opportunities for HIV health promotion.

The Impact of the HIV Virus

Information was gathered about the nurses' views on the impact of the HIV virus in order to gain insight into their knowledge of the topic and the degree to which they viewed it as a health priority. General comments will be noted and relevant themes explored. The nurses' views on the comparative Canadian and American demographics will also be noted since it was speculated that the American media may have unduly influenced the nurses' perceptions of risk for Canadian women.

Some nurses appeared not to have thought about this issue before and were formulating their opinions as they spoke. One nurse from the children 0-5 years program began talking about the viral impact as "traumatic", but concluded by labelling it "quite serious." Another sexual health nurse explored her thoughts:

I don't know that it has had an enormous impact on Canadian health just yet....It

just doesn't seem like it is around in this area. You don't hear anything about it. It doesn't mean it's not here; it just means we don't hear about it. It is still fairly quiet as far as what is happening. It's hard to gauge how much it is affecting because, you know, I think we tend to focus on what's in our community.

Another nurse was very matter-of-fact:

The impact of the HIV virus is just that there is another disease the people can contract and unfortunately there is no cure for this disease...so it's like living with a terminal illness. You just treat them as well as you can and provide counselling for them.

When asked about the morbidity and mortality of the virus, two of the nurses, women working in HIV programs, offered accurate statistics. Generally, nurses volunteered that they did not know any statistics and made statements such as the following: "I don't know a lot of stats", "I don't know off hand now but I used to know that information", "I don't know any numbers", and "I don't really keep up with that."

Wide-ranging general comments were offered regarding the magnitude of the impact: "small", "significant", "large", small numbers with "huge" impact, "devastating", and "totally different world now."

As the nurses expressed their views, two predominant themes arose: 1) the issue of loss and personal suffering and 2) the potential of the virus to affect behavioural change.

The issue of loss and personal suffering.

From one perspective, the viral impact was identified as most significant for HIV positive individuals and their families. "I think for those who have contracted HIV, and

their families, it's been devastating. It's a terrible disease to get." Another individual noted that the impact extended to the sexual health of the entire population. "It's a huge impact...well obviously people are dying and other people are looking after them. Families are impacted. That affects their health. I think it affects sexual health of everyone." A third perspective incorporated health care organization and economic effects.

Well overall, I think it has certainly impacted us all--whether it be by the loss of some very valuable people or whether it be by the redirection of some very valuable health care dollars. I think all of those things have a very big impact.

The potential of the virus to affect behavioural change.

Many nurses addressed the issue of impact by commenting on the virus' potential to affect behaviour. Negative, neutral and positive effects were noted. One nurse believed the fear generated by the virus had a crippling effect: "I think people are terrified of it...to the point where they're forgetting about other diseases that can be prevented too; and they don't do anything about them because they're so worried about HIV." Other nurses stated that people were being stigmatized as a result of the virus, and one placed blame on the media:

I think, however, the media has, I guess, raised such a focus to the topic of AIDS that there is a lot of fear, a large anxiety. There's also the continued focus that AIDS, in fact, could be a gay disease. So there's stigma.

Some believed that fear of HIV had resulted in little behavioural change. "I think it has a general fear aspect to it; but I don't know. If you take the general population, I don't think it has changed, on a global basis, their behaviour much--unfortunately."

Many nurses expressed concern over adolescents' resistance to change. "I think it's frightened a lot of people. I think, with the adolescents, I think they're still suffering from the four 'I's. I get the impression that they think they're immortal, infertile, invincible, and...immune."

Several nurses identified positive behavioural effects of the virus, with the most common being that "it's allowed us to talk more openly about sexuality issues." One nurse indicated that the virus had provided a new impetus for education about sexual health. "I think it's been a door that's opened questions about education regarding sexuality and relationships and it's given us an opportunity to get out there with our health promotion in these areas." These new activities had the potential to improve overall sexual health. "As a result we are beginning to look at strategies that will reduce the risk of sexually transmitted diseases including HIV." One AIDS educator noted that some people are starting to "communicate with a partner about what they like sexually, what they want, what they're willing to do, what they're not willing to do. You know, I think that's a good thing." This same nurse made the following comment regarding sexual orientation:

We're having to talk about sexual orientation...and for all the gay and lesbian and bisexual youth that are out there, at least they don't have the isolation that those youths had even ten years ago before AIDS. Because of the association of the gay community--even though it's not just gay people who get it--that association is still there; but at least people who are gay know that they are not alone. We get a lot of calls, you know, people who have questions about their own sexual orientation. AIDS agencies seem to be safe places to call and ask those questions.

In direct contrast to a comment noted earlier by another nurse, one AIDS educator believed that addressing homosexuality had resulted in “quite a dramatic amount of acceptance...of people who are different, not just sexually, either...but people who are different races, people who are different genders...disabled perhaps--all the different special groups.”

When asked to compare the Canadian and American demographics for HIV, nurses working in HIV or STDs provided informed answers; however, they frequently used words like “I think” or “I guess” and focused their answers on one or two of the following populations, noting that their risks are greater in the US than in Canada: Haitians, blacks, the poor, immigrants, women, infants, and injection drug users. One nurse spoke of the confusion which sometimes results from differing Canadian and American recommendations. Regarding the per capita difference between the two countries, one AIDS educator stated, “I don’t know. I stay away from stats....It’s only the people who’ve been diagnosed--so it’s not the real picture anyway. AIDS is seven to ten years along in the disease. You don’t really have good stats.”

Another nurse stressed,

I think our absolute numbers are considerably less than in the US. I think that’s something that we need to be stressing to people--not to minimize the risks, not to minimize the trend--but population-based, we’re not as badly off.

Most other nurses indicated that they were guessing when trying to answer this question.

Some guessed correctly: “My guess is that American is probably larger than the Canadian numbers.” Some guessed incorrectly: “I’m going to really admit ignorance here

because I have no idea. My thought would be that just percentage wise, they would probably be somewhat similar.” One nurse spoke confidently about the differences, but was not accurate. “I know that’s a different kind of HIV than we largely have in Canada.” The majority of nurses denied experiencing more exposure to US media than to Canadian.

Populations at Greatest Risk for the Virus

To gain further information about the nurses’ knowledge of HIV/AIDS, all of the nurses were asked what populations they thought were at greatest risk for contracting the virus. Their answers varied greatly. Many gave answers which reflected the national statistics and stated that gay men and IV drug abusers were at greatest risk. Almost as many nurses specified teens as the population most at risk. Several acknowledged women’s risks as increasing; and a couple of nurses, one of whom was an AIDS educator, included women in the “at greatest risk” category. One nurse emphasized the impact of low socioeconomic status in identifying risk, but included other groups as she continued to think about the matter. “Low socioeconomic. I feel that they’re not aware of what the impact is on their life. [long pause] Homosexuals, drug users, IV drug users, [long pause] the younger population.” Another nurse emphasized the universality of risk:

I think everyone is at risk at this point. Anybody that has sexual activity or risky behaviours with shared needles or the body piercing, tattooing, any utensils that aren’t cleansed properly and are used with other people. I think anybody is at risk at this point.

Risk Factors for Women

To gain information about the nurses' knowledge specific to women, informants were asked about factors which put women at risk for contracting HIV. Two important themes emerged which were not specific to women, but which had serious impact on their behaviour. The first was denial or a sense of invincibility. All nurses identified this theme and many associated it primarily with the teen population. "[They think] that they're invincible and they don't need to take precautions because it won't happen to them." The second global factor was the "new morality", and the fact that "the monogamous relationship is almost falling by the wayside." This was also noted to be a risk factor impacting on all heterosexual relationships, family life, and individuals' sense of security and personal worth.

A very broad range of other factors surfaced in the discussion of specific risks for women, although most nurses focused their discussion on just a few issues. These included, but were not limited to the following: unsafe sexual practices, injection drug use, promiscuity, prostitution, multiple partners, being boy crazy, bisexual or unfaithful partner, the power imbalance in male/female relationships, the influence of alcohol, lesbians sharing sex toys, lesbian history of sex with an infected male partner, and misplaced trust. One PHN noted that older women re-entering the dating scene after the loss of a partner were at somewhat greater risk because they had not been exposed to AIDS education in the school system:

The kids know how you get it and don't get it. The kids know about condoms and all the details about condoms: latex, the lube kit....The older people don't know the specific details. They know it's dangerous, but to handle a condom properly

and all those things, [they don't know].

Another nurse believed homemakers were at higher risk. "You know, they tend to be very focused on their home life and what's happening around the family, not focusing on women's issues in a broad sense." With respect to women of low socioeconomic status, one nurse noted:

Maybe they're the ones that need more information because maybe they don't have access to some of the information that other people would--like they don't read things--they can't read for one thing. So maybe they do need a little more information there.

Nevertheless, the most frequently noted themes which emerged as factors specific to women were low self-esteem and societal attitudes towards sex.

Low self-esteem.

Low self-esteem was identified as a significant risk factor by virtually every nurse in the study. One nurse stated:

I think women are very vulnerable. I think, dealing with the population I do, self-esteem is such an issue that sometimes they just don't feel they can ask their partner to protect themselves. They don't feel they have that right. If the partner chooses not to use the condom, then it's OK.

Another nurse theorized on the influence of peers, the media and society on young women's self-perceptions and behaviours:

I think young girls are under a lot of pressure from the media and from society and from peers to behave a certain way, to look a certain way, to belong to a certain group and part of that is a message I think that they think they hear that

everybody's doing it, and so, if they're not doing it, well heck then 'What's wrong with me?'I think that...affects their self-esteem...or affects their perception of themselves and so they may make unhealthy choices, unhealthy decisions--thinking that that's going to make them feel better, make them more accepted, make them more like they're supposed to be....And that may put them at risk of contracting, not just AIDS, but other diseases.

Societal attitudes towards sex.

Several nurses noted that women were victimized by societal attitudes towards sex. One nurse stated, "Many females feel uncomfortable talking about sex. That's tied back to the old sexual mores or myths that if women know too much about sex, they're considered sleazy." A couple of nurses spoke of the "Cinderella" myth which persists in our society. "They're started right from when they're young girls that a boyfriend and marriage is important...They don't feel empowered to be individuals...Be beautiful, be perfect. It comes from the media and it comes from everything around." Because of sexual mores, nurses stated that many women were not comfortable with condoms or seeking information about STDs. Social attitudes towards HIV and the gay population were postulated to make some women believe they were not at risk.

HIV/AIDS Health Promotion/Illness Prevention Activities

Nurses were asked about their involvement in any health promotion/illness prevention activities which directly or indirectly addressed the issue of AIDS--preferably AIDS and women. Their answers were not restricted to current job activities, but applied to any recent relevant activities. One nurse, working in health promotion, commented,

“You never get off duty. I probably do more general public health nursing counselling with my family and friends than I do in my work at the moment that would touch on sexuality and AIDS and things like that.” With the obvious exception of PHNs working in AIDS, most nurses were unaccustomed to analysing their activities from the perspective of HIV/AIDS health promotion/illness prevention. The inclusion of a gender analysis made the process even more difficult; so nurses were asked to discuss any and all AIDS related activities. This analysis will focus on those activities related to women and HIV/AIDS.

The nurses indicated that HIV/AIDS was addressed directly or indirectly within six broad areas of public health nursing practice: within the school setting, via community presentations/liaisons, in prenatal classes, in the activities of the children 0-5 years team, in birth control clinics, and in HIV or STD clinics. Activities within those areas will be discussed prior to exploring the themes which arose as nurses described their activities.

Within the school setting.

Within the school setting, nurses addressed HIV/AIDS directly through AIDS presentations and as a component of sexually transmitted disease, birth control, and sex education classes. Both mixed and single gender groups were addressed. Sometimes the child/adolescent nurse (also known as the ‘school nurse’) conducted all the classes herself. Sometimes, nurses working in HIV/AIDS or sexual health conducted these classes. Factors such as teacher preference, health unit protocol, staff availability, and the school nurse’s comfort with HIV/AIDS influenced the nurse’s role.

The HIV/AIDS emphasis in birth control, sexuality and STD classes varied

greatly. “I do go into the schools and I do talk about HIV, but I only talk about it for about 5 minutes. The rest of the time I talk about sexuality because that’s the message that they need.” Although one nurse denied mentioning AIDS separate from other STDs, another nurse reported that, in her birth control classes, she always showed a video clip of a teenage girl who had unprotected sex with a boy whose previous partner’s partner died of AIDS. “It just gives me the goose bumps; the impact is just unbelievable. It’s only like a five minute clip, but it’s really good; so I always show that.”

The school boards and/or principals also placed restrictions on the nurses’ activities. Although some Public School Boards permitted nurses to distribute condoms in the school, Roman Catholic School Boards and some fundamentalist Christian Schools did not. Although the official policy of the Catholic Schools prevented nurses from introducing condoms as a topic for discussion, student introduction of the topic was acceptable. (This topic is addressed further under the sub-topic of “Religion” in the section on “Factors Promoting or Inhibiting Health Promotion/Illness Prevention Activities.”)

School nurses, especially those in the high schools, were usually available for private counselling a few hours each week. That counselling focused on the expressed needs of the clients, the majority of whom were female. “I would say 95% female-- probably 95 to 98%--and 2% male.” Birth control was one of the most frequently requested topics of individual discussion. Yet again, the inclusion of HIV/AIDS varied greatly during those counselling sessions. Few students sought counselling for the purpose of discussing HIV/AIDS. “I can think of two instances this year where they came in specifically with that concern--out of all the kids I see.”

Programs varied greatly from health unit to health unit and some school nurses did note special activities designed for females which included AIDS as a topic. One HIV/STD clinic nurse collaborated with the school nurse to work with single moms groups in local high schools. She said:

These are high risk moms and sometimes it helps just seeing a face they might need to connect with again....We talked about all kinds of things. And we take a condom teaching model around and elicit the giggles then and get it over with and let them talk about it. It's interesting to hear how many--especially the young parents--may not ever have used condoms or may not have used them well.

Another nurse spoke of a new series of classes for grade 6 girls and their mothers:

We are going to mention HIV; but it's going to be sort of mentioned along with the STDs. The whole point of the series is to sort of promote better negotiation skills for these girls, not only with their boyfriends and with their parents....Just make more secure...girls that are going to become women, more sure of themselves, more assertive, more self-confident...so they don't see boys as the be-all, end-all in life.

Community presentations/liasons.

Community outreach presentations or liaisons regarding HIV/AIDS were conducted primarily by nurses whose focus of practice was HIV. Three of the four HIV nurses noted activities specifically involving women. These included discussing sexuality and risks with battered women in second stage housing, and special presentations for lesbians, women's church groups, and women at a YMCA residence. As a component of AIDS Awareness Week, one nurse held a panel discussion with HIV positive women. It

was “for women to learn about AIDS and it was also women who have AIDS sharing their experience--what it’s like.” Another nurse spoke of the challenges of trying to talk to ethnic women about AIDS:

I talked to some women at...community health centre with various ethnic backgrounds. That can be challenging...Condoms were a very big taboo. First of all, it is not even a woman’s choice; but second of all it’s against their religion to try and contracept at all--let alone disease prevention. That link wasn’t there. It was interesting to hear their questions and be culturally sensitive; but you don’t always know what cultures you’re walking into in a group like that.

A few nurses noted varying degrees of involvement with local AIDS committees. One nurse noted working with a local AIDS Committee on a funded project targeting heterosexual women. “Although I was quite pleased because of the language in it...women who have sex with women wouldn’t be turned off.” The group produced a poster, pamphlet and magnet which they were marketing to women’s agencies and committees in the region. Another nurse spoke of conducting very basic AIDS education with a predominantly female group at a geared-to-income senior citizen’s apartment centre where residents were “terrified” of the AIDS patients who had been placed there.

I said to the group very openly, ‘Do you want a condom demonstration?’ One little dear put up her hand and said, ‘I’ve never seen one’. So we did that, did a condom demonstration, tried to explain the basics. And I had a little pile of them left at the end. Always at the end, people come up with their individual questions. Out of the corner of my eye I was watching this little lady grab my condoms and shove them down her bra. I could hardly keep a straight face. This is what I see in

high school. It was interesting.

Another nurse spoke of targeting service clubs as a means of educating the community and eliminating the “fear, the misconceptions, the stigma that the National Enquirer tends to perpetuate.” She found female groups to be more supportive than men and stated that one particular group had:

Marketed the group as mothers....As women they tend to be nurturing and certainly very supportive in that way. Some of the male service clubs tend to be, as part of the rural setting, somewhat homophobic and may in fact still perceive HIV as a gay disease. They really don't want to get involved.

Prenatal classes.

Most of the nurses who were interviewed taught prenatal classes in addition to their other responsibilities. Again, reports of HIV related activities varied widely. One nurse stated, “In prenatal here, AIDS does not get mentioned.” A nurse from another health unit reiterated, “I don't think anybody really brings it up.” Some maintained that HIV was not addressed because the prenatal clients were in stable relationships and presumed to be not at risk. “The topic of AIDS is not addressed directly. At that point they're in a monogamous relationship.” Upon questioning, however, these nurses did acknowledge that many of the prenatal class clients were not in stable relationships. Other nurses did mention AIDS briefly in prenatal class: “Not in depth though--just when we're talking about birth control and mention sexually transmitted diseases and AIDS at the same time.” At the other end of the spectrum, the HIV educator at one health unit specifically asked prenatal teachers to discuss the Ministry's “recommendation that pregnant women get tested for HIV.” One of the prenatal teachers in that health unit

maintained that local doctors were testing all pregnant women for HIV and “we mention it in the respect that their blood is tested for it.” It was noted that HIV was more likely to be addressed in prenatal classes which were held for single moms. Nevertheless, even that emphasis varied from, “There would be information given specifically about AIDS and how AIDS is communicated from one person to another....They described why you used condoms” to “Prenatal classes--it comes up, especially with the single moms. It doesn’t come up a lot.”

Activities of the children 0-5 years team.

The HIV/AIDS health promotion activities reported by nurses working in this area, arose primarily within the context of birth control discussions at home visits. Although birth control was a potential topic of discussion identified by all nurses with experience in this area, it was not always addressed.

Well, we talk about STDs in general. That varies with every public health nurse too. Like some--I don’t think, will spend much time on it at all; but when I personally go out and do a home visit, will try and to ask them if they’ve thought about birth control--mainly because these are young moms, to prevent another pregnancy from coming. And then also what type of method they want to use and like the pill won’t prevent an STD.

HIV was usually addressed briefly as one of the STDs or addressed very indirectly through the recommendation that condoms be used for birth control while breastfeeding or before going on the pill.

And even with the young clients that we visit, we do talk a bit about birth control and we’ll mention sexually transmitted diseases. We don’t really mention AIDS

specifically. By using a type of birth control that will help prevent STDs and further pregnancies, that might be the only...

Birth control, STDs, and HIV were much more likely to be discussed if the young mother had no current partner or a history of multiple partners. "Probably the more high risk people. It might come up when you're talking about birth control." As for low risk moms, "We don't usually talk about AIDS. I know I don't." No nurse identified HIV as a topic included in breastfeeding discussions. Regarding this topic, one nurse stated: "I don't remember it [HIV] ever coming up. You know I don't know a lot about that. I don't. So I would certainly have to brush up on it before I intended to teach it."

Birth control clinics.

Most of the clients at birth control clinics were female since the birth control pill was always a primary clinic focus. One-on-one birth control counselling took place in the school nurses' offices as well as at the health units' birth control clinics. In some agencies, the same nurses worked in both areas and actually initiated the client work-up at the school by filling out the clinic assessment form. This assessment form usually contained a question about what the client had done to prevent STDs or a question asking if the client had ever thought about how AIDS or Hepatitis B could affect their lives. In some instances, a 'yes' response to the latter question resulted in no further mention of HIV. All nurses working in these areas counselled clients to use condoms, even when they were on the pill, in order to protect against STDs. Most nurses reported thorough instruction on condom use as well as condom negotiation. Again, the degree to which nurses included HIV/AIDS varied greatly. One stated, "I find I include it a lot--which I don't know is right or wrong. I think they're thinking HIV is the worst"; while another

reported, “I usually bring it up just as general conversation...but not great detail unless they’re really: ‘OK. Where would I go for testing?’ and then we go into it.” At this point that nurse always referred interested clients to the HIV clinic.

Condoms were available free of charge at all of the clinics. Any client requesting HIV testing was sent to the HIV clinic.

STD/HIV clinics.

Because some of the nurses reported overlapping duties related to STDs or HIV, these two clinical areas have been combined for this discussion. Not all health units had STD clinics, although all of the health units did conduct HIV testing. Three kinds of testing were offered--anonymous, non-nominal, and nominal--although anonymous testing was not available at all sites. Nurses working in these areas provided one-on-one counselling to male and female clients. Most of them reported having seen approximately equal numbers of both genders. Nurses reported thorough counselling and risk assessment practices in the HIV clinics. One nurse commented specifically on the challenges of counselling older women:

When we interview some of the older women, it is really important, as a counselling process, to make the older women feel comfortable because nobody ever talked to them about sexual issues...I always...give them permission by saying ‘Many people I know have practised anal sex’....Then they open up and disclose within a comfortable, trusting setting. If you don’t do that as part of your process, the women feel very self conscious even talking about sex and sexuality issues.

The nurses working in these clinics faced an unusual dilemma which impacted on

women's risks for HIV. They counselled men who had been unfaithful to their wives, wished to conceal their infidelity, and had contracted an STD or were afraid they might have contracted the AIDS virus. One nurse stated, "You walk a fine line between being supportive to the client and yet recognizing the risks to other parties." Nurses reported using several approaches to deal with these situations. One approach included a matter-of-fact delivery of options:

We, as we always do, provide them with options. If you want to tell your spouse and bring them in, that's fine. If you want us to call your spouse, we will do that. That's fine. Your name is not used. But the bottom line--we know you have a spouse. We have an obligation. This is where the health protection act becomes a bit of a threat. We don't give people the pills sight unseen for a spouse.

Another strategy involved persuasion:

I'll go to 'Turn it around. How would you feel if this were you?' 'You have a right to know.' 'You're saying that this could damage the relationship. I challenge you that your relationship is already damaged. Very few spouses have no idea that there's something going on.'

A third strategy, in which the end justified the means, involved scheming with the client:

I help them problem solve. One thing we have used is for a man to say that he has a urinary tract infection and for that reason he has to use a condom so that he doesn't pass it on.

This action was recommended until the window period had passed and accurate HIV testing could be completed.

These clinic nurses, as well as a few others, had experience with STD follow-up

related to public health laboratory reports on clients from an STD clinic, birth control clinic or a doctor's office. Nurses were asked if they advised clients who tested positive for an STD that they were also at risk for HIV. Again, there was wide variation in their answers. One HIV nurse reported that circumstances affected her actions:

If the person doesn't seem to be very receptive or doesn't seem to know a lot about AIDS, often we'll say 'You know this could have been more serious. If you don't change your behaviour in the future, it could be AIDS'. So we go over prevention information about in the future what are you going to do to prevent catching another STD.

The clinical diagnosis also affected the likelihood of that nurse introducing the topic of HIV. "Chlamydia doesn't jump out at me as one of the infections--although it certainly can go hand in hand--that would indicate that there is an HIV infection." A nurse working in a birth control clinic believed, incorrectly, that chlamydia was not a reportable disease and was very evasive about answering this question. Ultimately she acknowledged that she did not counsel clients with chlamydia about their risks for HIV, but hinted at frustration with nurse-doctor relations as a factor:

No I think generally it would be considered not appropriate because I think what they believe is that is the doctor's role. In fact we have sometimes said that the client is saying she wants an HIV test; then when she goes to see the doctor, it's not done.

A third nurse identified the diagnosis of chlamydia as a real concern:

And I'll say to them 'now we can easily take care of the chlamydia issue. That's not a problem for us; but have you thought that this is a risk indication? An STD

means something's gone on somewhere. Either it's unprotected sex or a partner's had previous partners. Would you consider HIV testing?' Almost 50%, I would say--you blow them away the moment you mention that.

In the description of HIV/AIDS related activities, several themes arose: heterosexual focus, AIDS as a gender-neutral issue, encouraging condom use, building self-esteem and empowering women, increasing client comfort, and reducing risk from drug and alcohol use.

Heterosexual focus.

Despite the media attention on AIDS as a homosexual disease, the focus of most of the health education conducted by PHNs outside HIV clinics was on heterosexual rather than homosexual activity. "The curriculum, the talk about risk reduction, is heterosexual. They will have role models that show a male/female relationship." The teens are shown videos with a heterosexual focus. "I showed a video today which was called 'Teens and AIDS in Focus'. The focus was that anybody can get it." One AIDS educator noted their teaching kits were too focused on heterosexual sex:

Very much heterosexual sex. And we are trying to...change that to include other groups. When I rounded up all our old kits and I tried to review them, you really see how the focus is on the heterosexual all the time.

AIDS as a gender-neutral issue.

None of the nurses identified AIDS as a gender or sexual orientation issue. A nurse on the sexual health team stated, "I haven't focused so much on females, I just make it a general thing that everyone is at risk." A nurse on the children 0-5 years team

stated, "I wasn't focusing on anyone. I was pretty well saying anyone who is sexually active can [get it]." AIDS educators reiterated the same theme:

By and large it has been sort of non-gender related. OK? So it's general information; but it deals with issues within each program. So, within school-age, we will talk about issues for females because some of the classes are female.

Some of the classes are male. Some of them are co-ed. So we build those into our program.

Females were identified as one of the many groups for whom nurses sometimes modified their presentations. Nurses also noted creating focused presentations for the following groups: those with learning disabilities, firemen, law enforcement officers, male homosexuals, lesbians, health support workers, etc.

Because the PHNs conducted a broad range of health promotion activities which addressed general HIV risk and transmission issues, females had many opportunities to experience general AIDS education. Examples of this gender-neutral or dual-gender education conducted by the nurses in this study included the following: elementary and high school classes, school bulletin boards, school assemblies, sexual health fairs, an AIDS program with an interactive theatre group, parent education nights, AIDS Week initiatives, presentations to drug rehabilitation centres, risk-reduction workshops for drug awareness week, presentations for mixed groups of adolescents serving time on the weekends, programs for high risk adolescents who are out of school, workplace health programs, print and video media, bar campaigns, and other assorted community presentations.

Encouraging condom use.

Although the literature includes the promotion of condom use as a component of the 'safer sex' message, only nurses working in HIV regularly used the phrase "safer sex." One school nurse even spoke of "safe sex." Nevertheless, all of the nurses identified the need to promote condom use with female clients. "If we feel they're a little hesitant, we would roll on a condom and I'll go over the whole procedure about how to use a condom--the steps." Nurses reported using frozen bananas, wooden penises, carrots and their fists as models for condom use instruction--demonstrations by the nurse and return demonstrations by the clients. One nurse even described a "condom suit" demonstration in which a condom-like costume is put on a volunteer and cue cards containing relevant information are used to stimulate discussion.

First of all, I have them bend over and I ask them if they mind if I touch their back. I touch them and I stroke them and they become erect. Then I have the stretch terry cloth. It has a hole for the face; but it's got the reservoir tip and I roll it over them and I have little cards like 'pinch an inch' and 'expiry date'--some of the points to keep in mind when using condoms.

Nurses used various means to encourage clients to negotiate condom use. One nurse gave the girls direct instructions. "Well, if he doesn't like the condom, then you don't have sex! And that's just the bottom end. If he doesn't like condoms, you keep holding out." Another nurse tried to teach the girls to interject humour into the situation. "We give them funny little things to say. Like sometimes the guy will say 'I'll just stay in for a minute' and I'll tell them, 'You can say: I'm not a microwave oven'." A common theme was that the girl should carry and apply the condoms herself in order to ensure use.

I really stress with the condom use that it's almost better that she be the one that carries them because they kind of still put them in their back pocket wallet and it goes like this (*rubbing sound*) and it wears down [and]...that she be the one to carry it and put it on; so it's put on properly all the way down to the base of the penis and that she hold onto the base of the penis and the condom when he pulls out, so she knows that it's there all in one piece. We had an incident where a girl about 19 was coming in for her annual pap smear and the doctor and I are in the room and he put the speculum in and I saw this white blob at the bottom of the cervix....He looked in and it was a condom; so he pulled it out and...he looked again and there was a second condom there. I was so angry.

One nurse suggested using condoms as part of sex play. "The other things we've talked about and have supplies of are coloured condoms and extra lube and maybe flavoured condoms and trying to make it into a novelty approach or erotic approach." Another stressed the need for girls to keep the light on while having sex in order to inspect her partner's penis.

We say flashlight, candle or something; but just so they can see what it is they're having sex with and if they see some discharge and it's green and frothy and foamy, and smells like a fish--you don't go near it. Make an excuse to get out.

Wake up!

Some nurses avoided making suggestions themselves, but conducted brainstorming sessions with the girl or girls (they often bring female friends to the birth control clinic with them) about how they would plan to negotiate condom use.

Building self-esteem and empowering women.

Although building self-esteem and empowering women are separate topics, they arose as combined themes from the interviews with these nurses. Over and over again the nurses spoke of the need for women or girls to feel better about themselves so that they would exert more control in their lives and reduce their risks for pregnancy, STDs, etc. It was interesting that, although nurses were quick to note these factors vis-à-vis women's risks for HIV/AIDS, and they were quick to note actions taken to address those issues, many of the nurses had never viewed their actions from the perspective of HIV health promotion/illness prevention.

Although nursing actions directed at building self-esteem and empowering women occurred in a variety of contexts, most arose within the context of condom use and condom use negotiation. Other instances in which nurses attempted to enhance self-esteem and empower women related to choosing abstinence, promoting healthy body image, or caring for herself by getting a pap test. All of these activities had the potential to reduce risk. One nurse talked to the girls about identifying their own feelings and using "I" messages to express them. Another stated, "You go into their self-esteem and how they feel about themselves and make them start thinking." Similar activities were reported in both group and individual counselling sessions. Again and again nurses encouraged the young women:

You could get the sense when you were talking to the girls that when you said 'Well you have the right to say NO', they would sort of say 'Well why?'. And you'd say, 'It's your body and you have to take care of it. This goes one step beyond, because when you sleep with someone, you sleep with someone with a

past history.’

Role playing was used to develop strategies and assertiveness skills. “We try to give them opportunities to do that role playing in a safe situation so that when their health is depending on it, they’ve done it once before.” “We talk about how to...say ‘no’ to things without losing face.” Nurses also addressed the social issues underlying female behaviour: “Showing them how society, through the media...portrays men and women in a way that makes them both fill a certain role which they may not be comfortable with-- or why they’re not comfortable with those roles.”

Not all nurses found satisfaction in their efforts to empower clients. The words of one nurse revealed a clear sense of frustration and less commitment than her peers when she spoke of the empowerment process:

Yea, you try to, but it’s such a quick thing and...sometimes they don’t have the maturity level. You don’t know if you can get through, but it’s our responsibility to inform the client, I think, that there’s a danger out there. And this is what you can do. And now it’s your decision.

Increasing client comfort.

Many nurses identified the need to increase client comfort prior to establishing a therapeutic relationship or discussing sexual behaviour. This was true with both group activities--“Well for one thing making a safe environment where they can come and talk, but within limits of language and respecting other people’s confidentiality and privacy”-- and with one-on-one sessions:

I think we need to be able to talk plain language....We need to get away from clinical jargon. We also need to get away from any sort of power: I’m up here,

I'm the professional. We need to have equal partnership in relationship and we need to be able to sort of give permission for people to talk.

Some nurses used humour as an ice-breaker:

I try to use a lot of humour when I'm talking with women...to kind of settle things down. A little cartoon is probably several years old. It shows two women having coffee and they look to be fairly old. 'Things are sure different today, Alice. In our day safe sex consisted of stopping the car first.' To start with something like that and get into it a little bit more.

Other nurses used self-disclosure:

I guess what I say now to people is that I had a cousin, first cousin, who died of AIDS and even though you think it will not affect you, if you don't get it, you will know someone very close to you who may get it and die from it. So it is real, very real out there.

Some nurses were more indirect. They reported beginning with a discussion of relationships as a prelude to discussing birth control. "Sometimes the girls are embarrassed. Sometimes they don't want to talk about it. So...I incorporate it into the whole discussion that's going on...talking about relationships."

Reducing risk from drug and alcohol use.

The use of drugs and alcohol were identified as likely to increase risk taking behaviour. Although this was a less common theme, counselling on drug and alcohol use was identified by several nurses as an overall risk reduction strategy:

With the drug and alcohol use, you're looking at safety as far as making good decisions for themselves. And you know we've heard some real disaster cases

where the girl has blacked out because of the drug they're drinking and rolls this guy off her in the morning and God only knows what has happened.

It is interesting to note that the family planning nurse in the aforementioned quotation, was not identifying drug and alcohol counselling as an HIV health promotion strategy, but giving an example of the many activities which consumed her time and prevented her from addressing HIV more thoroughly.

Factors Promoting or Inhibiting HIV/AIDS Health Promotion/Illness Prevention

Activities

Nurses were asked to identify factors which promoted or inhibited their HIV/AIDS activities with women. As stated previously, most nurses were not accustomed to viewing their professional practice from the perspective of activities relating to women and HIV. Several broad themes emerged as nurses spoke in general terms of factors which promoted or inhibited their HIV activities: employment responsibilities, the role of the health unit, client/community requests, nurse and client comfort levels, HIV priority status, religion, and the research interview.

Employment responsibilities.

Although none of the health units shared an identical structure, all organized their staff into specialized functional groups. Such employment responsibilities were the key factor in predicting the degree to which a nurse identified her involvement in HIV/AIDS activities. When asked about factors promoting or inhibiting HIV/AIDS health promotion/illness prevention activities, one nurse summed up the thoughts expressed by many: "Well I don't have any direct job responsibilities. That would probably be the

most obvious answer there.”

One nurse in the children 0-5 years program stated that other than if a known HIV positive client was considering breastfeeding, “[HIV] wouldn’t really affect our area.” She also admitted that the topic of HIV would “probably not” be introduced into a breastfeeding class. She denied ever hearing clients express any attitudes or thoughts regarding the topic of AIDS and women. A nurse working in the same program at another health unit stated, “I’m not in the AIDS program right now. I don’t really have a lot to do with it.”

As noted previously, one nurse working in family planning acknowledged that she did not address HIV as an issue with clients diagnosed with chlamydia because “I think what we believe is that this is the doctor’s role.”

When asked to reflect on whether or not there was a place for HIV education in prenatal classes, most nurses deferred to the written curriculum for delineation of their responsibilities. One of the factors inhibiting the introduction of HIV/AIDS was the fact that “it’s [not] in the curriculum to bring it up.” A few nurses shared this perspective. “I don’t know, I guess it’s just not in the outline. We have our class outlines and the content and teaching kit and we just go through that. I don’t think it’s ever mentioned.” Another nurse remembered conducting prenatal classes differently at another health unit, but had not questioned the current curriculum she was using. “We talk about intimacy and keeping communication open and that’s interesting. Not here--in other places where I worked--we did discuss sexual activity during pregnancy a lot more. And we don’t here.” She could not explain its omission because she “wasn’t in on writing the prenatal class.” Again and again nurses reiterated a common theme: “I think the fact that we have an

AIDS program, the thought is, if it should be done, they would be directing us to do it.”

The delineation of job responsibilities affected nurses' knowledge regarding HIV. “Personally, I think I've got a fairly good level [of knowledge]. Professionally, it's probably somewhat lacking....It doesn't impact on my job description right now.” A nurse from a different health unit expressed the same attitude toward her self-identified knowledge deficit. “It's what I need at the moment I suppose; but, I mean, as soon as I've got a technical question, I have to be getting some information from somebody else. I'm not up.” Another nurse admitted she restricted her teaching based on her lack of knowledge:

I probably don't keep up to date enough....I restrict what I say because I don't want to say the wrong thing. OK? I probably don't have the time or am able to spend the time to read up on it. I think to myself, we have an AIDS co-ordinator, I'll refer them to that person who knows more. That's probably where I get stuck.

Some nurses expressed frustration about their situation. One nurse made the following comment when asked about the HIV testing her health unit offered: “I'm not up on this. I feel very badly. You know, we've asked again and again, ‘Couldn't we just go down there and work sometimes?’ But, no we can't.” Nurses from two other health units expressed similar concerns about inter-departmental communications, or lack thereof. One nurse stated that the effectiveness of the AIDS educator in disseminating information within the health unit depended on “the communications between divisions in the...health department....It's something that [the health unit] is addressing at this point. Trying to make people aware of what's going on in other programs. They haven't got a clue.”

A variety of opinions were expressed regarding nurses' opportunities to expand their knowledge regarding HIV/AIDS. A nurse in a family planning clinic complained: "There's not a lot of quiet time....I don't tend to find I get a lot of time to read." Yet a nurse from the same health unit noted that the AIDS program conducted annual in-services with staff "to up-date them on stats and risk categories and ideas for teaching: new resources, new referral systems." At another health unit, none of the nurses had received any kind of in-service from the AIDS educator. "I haven't seen her actually doing anything with our team. That's all I can say." As for the AIDS component of teaching kits at that health unit, another nurse stated, "She's just updating it now. It was out-of-date for a long time." While an AIDS educator from a third health unit acknowledged she had not conducted any in-servicing in a couple of years, "and that was more on homophobia and heterosexism", a school nurse from the same health unit applauded her agency for keeping staff abreast of new issues.

Nevertheless, many of the nurses supported the focused practice roles and identified the HIV staff or AIDS educator as 'promoting factors' in terms of HIV health promotion. "The fact that we have an AIDS co-ordinator is one positive avenue. She does pre-test counselling. She does the post-counselling. She can refer to other places. That's her job. That's her specialty." Another nurse identified the value of having one specific individual to whom she could refer clients.

If you give a person five people to contact, they're not going to call. If you give them one, there's a good chance that they're going to call. You need a liaison.

You definitely need a liaison. You can't just have a department.

Similarly, many nurses spoke of the AIDS educator as a valuable professional resource to

the rest of the staff, both as a source of information and as a person to whom they could refer clients for further information. “She has certain forms that she fills in and stuff and certainly questions she would ask—more specific questions than I would ask. She goes into anal sex, the oral sex and all that stuff more so.”

However, other nurses identified the AIDS educator role as an inhibitive factor. “I think having an AIDS educator is inhibitive because the ones that aren’t the AIDS educators don’t feel empowered to talk about it that much. That’s the 100% paid position that does all that.” A nurse from another health unit commented on what would happen if other nurses got involved in HIV health promotion activities: “Well, you’re going to step on people’s toes. You’re going to get into turf war there if you start.” A staff member from yet another health unit reiterated, “This insular approach to health care has got to go!”

Nevertheless, another nurse expressed a third perspective on this issue. While she acknowledged that the focused approach tended to result in others not assuming responsibility for specialized knowledge, she qualified that response. “It’s up to the individual whether they choose to do that. There’s no kind of onus on them that they must. It’s up to them if that’s an area that they feel is important.”

Time constraints related to job responsibilities, were also identified as inhibiting factors. A couple of nurses noted heavy client loads during STD clinic hours. “It’s a lot of people and...we really feel we are not giving quality service to that many people; but you also look at they’re there and you try and deal with them.” A couple of nurses suggested that time might be a factor in not discussing HIV in prenatal classes: “I know we are crunched for time. Maybe that might be one reason.” The lengthy assessment tool

used in the family planning clinics was identified as an inhibiting factor for some nurses working in that area. A school nurse identified time limitations in her ability to counsel students since she was unable to spend more than a few hours at her schools each week. Classroom time was also problematic: "Things that would inhibit in the classroom is always time because...invariably you run out of it." Nurses on the children 0-5 years team frequently expressed the concern that it took time to meet the clients' most immediate needs and to build the rapport needed before discussing sexuality issues.

And with us, we don't do a lot of long term follow-up....And sometimes it takes a few visits or calls to develop that relationship and it's not something you just want to jump into on the first visit... You want to keep the doors open.

The role of the health unit.

Some nurses identified the health unit's mandated role as a primary promoting force behind their HIV/AIDS activities. "It's a broad goal to reduce morbidity and mortality from AIDS and HIV. Our objectives do include a lot of education right from the primary grades through to teaching the nurses over at the college." One nurse from the children 0-5 years program saw no health unit-related inhibiting factors. "I think public health...[is] pretty well open to doing HIV teaching and counselling and I don't see that there are any barriers. I might be wrong but...." An AIDS educator, who reported exceptionally wide-ranging initiatives, identified working for a very progressive health unit: "Certainly the health unit has been very supportive. They're the ones that have been very proactive and I think you have to have all of those factors in place to have a good program." She noted the existence of accessible satellite services which enabled nurses to reach clients who might otherwise be isolated and the responsive actions of a Medical

Officer of Health whose investigation of local HIV incidence spurred activity on within the children 0-5 years team.

In contrast, a nurse from a different health unit identified her MOH as a prohibiting factor with regard to HIV/AIDS health promotion activities:

The community itself is relatively conservative, and our Medical Officer of Health tends to go conservative as well. And I think he is very much into not upsetting the public and not making big issues out of things he feels shouldn't get blown out of proportion--which is understandable, I think. It's his job....But I just think we need more education in this area...as nurses and as the public.

Some nurses identified adequate funding as a promoting factor. "I think there's a lot of funding in public health units given for HIV teaching programs." Others held the opposite view:

Inhibit it? The cutbacks, funding. You have to look at the programs and cut back everywhere. So, maybe it's not getting the amount of time it should get. Funding cutbacks definitely inhibit it, but we have all these other things we have to promote too.

Staff shortages were identified as a result of inadequate funding and broad Ministry expectations. "You know we're all spreading ourselves rather thin these days with all the mandated programs we are required to do. And you know--funding--we are only funded for one fulltime AIDS person." Another nurse identified staffing problems related to requests for presentations outside the regular hours of work.

Well an inhibiting factor for us is staffing. That's a critical one. A lot of community groups prefer evening presentations. Staff are reluctant, especially in

a case like mine where I'm already working two evenings a week most times, to commit to after-hour presentations. We do what we can.

Several nurses identified health unit re-organization or recent Ministry initiatives as interfering with HIV/AIDS health promotion initiatives. "There's not a lot being done right now. We're sort of in limbo." School nurses from a couple of health units noted that some requests for HIV education had to be turned down because of the Ministry's special measles and Hepatitis B initiatives:

We were very heavily booked with the Hepatitis B vaccinations, the measles campaign last year. There were times when we had to turn it [teaching request] down because of other responsibilities. Every nurse was on board for those vaccinations, so you had to schedule yourself.

Client/community requests.

Regardless of their job description, all of the nurses indicated that they responded to requests for information on HIV/AIDS. Requests for information or services came from individual clients, teachers, student groups, relatives, friends, community agencies, etc. Nurses' responses varied from providing the service personally, to obtaining information for a client, to making a referral to a more knowledgeable resource. The latter was usually the health unit AIDS educator or HIV clinic, but also included the community's local AIDS Committee. Nurses were quick to note limitations in personal knowledge about HIV and to ensure that clients received accurate information.

Nurses also hypothesized about what triggered those requests. They stated that the media had a considerable impact. "We know when there has been something on TV, like Oprah Winfrey or one of those talk shows on AIDS, because then the next day we get

boards of calls.” Other media activities which prompted requests included promotion of AIDS Week, newspaper articles, innovative posters, and classroom video presentations. Nurses noted the effectiveness of messages which caused clients to personalize the risk of HIV. “Advertising. I think identifying a risk--that they might have a risk--is one thing [which promotes inquiries].” Risk identification prompted requests not only from individuals, but also community organizations and workplaces.

The Ontario Ministry of Education requirement that AIDS education be included in the curriculum was identified as a major stimulus behind school requests for HIV/AIDS health promotion/illness prevention activities. The nurses noted that some teachers requested their assistance because they were not prepared to discuss this topic themselves.

Since some nurses stated that HIV education occurred “totally on request”, failure to receive requests was an inhibiting factor. Several nurses speculated on why this might occur: “I think people have heard a lot about it and it’s not one of the big issues right now.” One AIDS educator said:

They’ve heard about it for what? Ten years now?....They think they know everything; so why would they go to a talk on it? I think that that’s maybe one of the biggest barriers: that it doesn’t apply to them or they know everything they need to know.

Another nurse stated that clients did not seem especially interested in the topic of women and AIDS. A third nurse speculated that ignorance and isolation prevented women from inquiring about services:

I think there are some factors that affect women in particular from accessing

services. Number one might be their cognitive level as to what's available...in which case you have to address marketing issues....Secondly, there also are...women that maybe lack funding to travel to services.

Many of the nurses identified societal discomfort with sexuality as a key factor inhibiting requests for information. "First of all, we're a sex negative society" stated one nurse. Another made this comment about Canadians: "I think we have an abysmal record on teaching people about human sexuality and enjoying our own human sexuality. We're at the bottom of the list for our ability to have any kind of acceptance of ourselves." Another nurse identified a public concern that discussing sex was promoting sexual behaviour:

Oh I think that some...are concerned that the message of safer sex is a promotion of sex message. I think some truly believe if you don't discuss it, it won't happen. And to some degree--the 'abstinence only' message--I see there is some value in that; but kids do have choices. People do have choices. And presenting the choices as options shouldn't be seen as a bad thing.

A related factor identified as an inhibition to seeking HIV testing, was the social stigma which surrounds socially transmitted diseases.

I think one of the prevailing problems for women is a concept around sexuality, the stigma that if you go for an HIV test that maybe you've been sleeping around, though it's a self-imposed thing based on societal attitudes.

Nurse and client comfort levels.

Nurses identified that both their own comfort as well as their client's comfort influenced the likelihood or the degree to which HIV/AIDS activities would be initiated.

Some nurses also noted reciprocal relationships between the comfort levels of themselves and their clients. An uncomfortable or distraught client sometimes created an unfavourable environment.

My security with my environment will influence my counselling. I mean I can remember doing an HIV contact tracing once where the fellow was obviously quite disturbed and kept making reference to the knives he had...I don't think my counselling was the best in that situation. My anxiety level was too high for my own safety. I just wanted to get out.

Other nurses also noted the influence the environment had on their behaviour. Some nurses from the children 0-5 years team were inhibited from introducing the topic of birth control at a home visit when the client had guests present. "The confidentiality thing. A lot of these clients do have other people around. There are people just floating in and out of the apartment you know." For one school nurse, enjoyment of classroom teaching promoted a personal response to teaching requests rather than referral to another nurse. "I do as much as is requested. I like teaching." Some nurses covered more material in one-on-one interventions. "Usually when there's one-on-one counselling, I will go through condom use."

Some nurses, especially those in HIV or STD areas, indicated that a client's indifference to the topic of HIV was a trigger for the nurse to delve more deeply into the topic. Nurses in other areas were more likely to curtail their teaching if the client showed indifference or reluctance to talk. Nurses, especially nurses on home visits for new babies, were concerned about damaging the nurse-patient relationship by introducing sex-related topics too soon in their relationship. "Well, I think I'd feel uncomfortable,

that they might feel I was intruding in an area that they didn't want me to talk about....It might close the door to further intervention with them.”

Information overload was also a consideration for nurses. One nurse on the children 0-5 years team stated, “Maybe they're really concerned about this baby and they're not going to hear anything else you say. If their issue is breastfeeding and you're bringing up condoms, I don't think you're going to get anywhere. Sometimes it's information overload.” A nurse in STDs and HIV stated, “If someone is absolutely in shock, I'll step back and think ‘I'm not doing a lot in depth here because it's not going in’. So it might be piecemeal and little bits.”

Similar to the way societal attitudes towards sexuality were identified as inhibiting factors in client/community requests for HIV information, PHNs also identified client discomfort regarding discussions of sexuality as inhibitors to nurse-patient interactions. One nurse commented on the difficulty she had getting girls to do a return demonstration on condom use. “So we go over that if they haven't started to leave the door once they've got the condoms because they're so nervous about being there.”

Another nurse identified a similar problem:

So we took that opportunity to talk about condoms and how to put a condom on, how to safely store them, and it was just amazing--the reaction that you get--it was just like a wall went right up. They didn't want to talk about it.

Although the nurses in this study stated that they were “pretty comfortable” or “very comfortable” providing sex education, some admitted that it had taken time and experience to achieve a comfort level with this topic. One school nurse stated, “At first I was scared to death. When I started here, I said ‘I can't ever do that! Never! Never!’...and

I was so scared, but I love it! I really like it.” A couple of nurses expressed discomfort in specific situations such as when comments were personalized toward the nurse (“What does sex feel like?”) or when student behaviour interfered with classroom teaching. Also, a few nurses who were not involved in HIV or STD areas and who were not experienced in counselling homosexual clients, thought they might be a little uncomfortable working with them. Some nurses identified that their peers were not comfortable dealing with this topic. “[What would inhibit them] would be their lack of knowledge, their discomfort in talking about sexuality. I mean public health nurses are no different than other people.” These nurses also indicated that PHNs should not be expected to function in that role if they are not comfortable with it.

I think that talking about sexuality takes some time to develop that comfort. It may not be the choice of all people. I think if it’s not their choice, they will not do a good job....I think that’s fair and we should respect that individual’s choice.

Just as nurses identified their own comfort levels as influencing the degree to which they addressed topics of sexuality or HIV, they also identified that their clients’ comfort and willingness to talk were influenced by the nurses themselves. “I think that depends on how comfortable they are in talking to you and how they see you, how they perceive you, how you wear your nursing hat, in whatever context you choose to wear it.” One nurse noted that some people view “public health as the enforcer” and may be disinclined to interact for that reason. “If there’s negative connotation can you get people to come and say ‘OK I’m going to get tested?’”

Nurses identified that some clients had specific preferences for either group or one-on-one settings for this kind of health education.

Some kids can be fairly explicit, not so much in the classroom, but in just one-on-one or with a friend or two talking in my office at school. They'll pretty much tell you anything. But in the classroom, it's not like that.

Other nurses thought students were less intimidated in the group setting. One nurse stated: "In my office, kids are so uncomfortable on a one-on-one....In a group presentation, they're protected by the desks and everything." In a group setting, such as prenatal or classroom teaching, group dynamics were reported to have an effect on the topics which the informants introduced. One prenatal nurse reported such variation in the degree to which HIV was discussed. "Once in a while it will come up. It depends on the group."

HIV priority status.

To some extent, health promotion activities appeared to be influenced by the degree to which nurses held HIV as a priority issue. A couple of PHNs stated that they did not view HIV/AIDS as the priority health issue for women and noted more immediate concerns which were affecting broader segments of the population. One nurse believed that an HIV breakthrough had been achieved.

Now they're finding people are building immunity to HIV and who are living a lot longer without any sign of AIDS, so they've made that breakthrough and I think it's just a matter of time--where other things like breast cancer are still a long ways.

She also believed that AIDS was not a 'majority' issue. "I think sometimes a lot of emphasis is put on AIDS when there are so many other things affecting women that for the majority of women is more important." A nurse working in the family planning clinic

knew her clients were at serious risk for STDs, and was very concerned for their reproductive health, but did not see HIV as a serious threat despite the fact that she knew her clients lacked knowledge about HIV.

Personally I feel these clients of mine will get another STD besides HIV....In a couple of months we had about eight abnormal paps with HPV, papilloma virus...It's quite prevalent out there; so we have to be really aware, especially for their reproductive health....They've heard HIV. It's mandatory education in grade 7, so they've pretty well heard it. They maybe still don't understand exactly how to get it. There are some misconceptions there. But I would say I focus more on the common STDs that they are probably definitely going to run into before HIV. I know, 10 years down the road they may pick up HIV from the relationship they just had 10 years before, but I tend to focus more on the STDs.

Religion.

Several of the nurses expressed concerns about the restrictions that the Separate School Boards placed on sexual health education teaching.

There are some conservative attitudes and some religious differences because of their belief systems. You know, not believing in premarital sex, not believing in birth control methods. We are not allowed to bring up the issue of condoms in... separate secondary schools. We are not allowed to put any materials up in the schools that address the issue of condoms. So many materials now come with information about condoms or posters or pamphlets that it really reduces the number of materials that we can use in separate high schools.

While there were variations from school to school depending on the principal, most

nurses felt constrained in that setting. “It’s so strange because they say with AIDS you have to talk about condoms; but then we’re really not supposed to tell them about condoms. It’s just very tricky what you say. You feel like you’re walking on eggshells.” Despite the limitations on topics the nurse could initiate herself, she was free to answer any questions the students asked. “If they bring up the question, I can answer them, but I can’t bring it up. I cannot bring up the word condom. They bring it up.” Hence the degree to which the nurse could discuss HIV was somewhat dependent on the knowledge the students already had. A few nurses also noted restricted activities in fundamentalist Christian schools.

The research interview.

A few of the nurses indicated that this interview would act as a stimulus to increase their HIV activities in the future. At the end of the interview one nurse volunteered: “It comes up in prenatal and it comes up on home visits occasionally, but not like something I spend a lot of time on. It made me think maybe I should spend a little more.” Another nurse commented several times during the interview that conversation was “heightening [her] awareness.” She concluded by saying, “I think I will probably talk about it more.” Subsequent to our conversation, one of the prenatal nurses indicated that she could foresee using AIDS posters as a “silent teacher” for prenatal classes.

Nurse-Identified Missed Opportunities for HIV Health Promotion

In order to determine how the nurses assessed their own HIV health promotion practices, they were asked to reflect on whether or not there had been instances when

they could/should have discussed HIV/AIDS, but for some reason did not. The nurses' responses fell into four broad categories: no missed opportunities, opportunities missed for good reason, possible missed opportunities, and probable missed opportunities.

No missed opportunities.

AIDS educators stated either that the question was "irrelevant" or that they had not missed any opportunities. One nurse from the family planning clinic stated that the potential for missed opportunities had been solved in the early '90s when the AIDS program received full funding. Prior to that, she was not sure if it was even necessary since she didn't know if any of their clients had since contracted the virus. This nurse clearly viewed HIV education as the primary responsibility of the AIDS educators.

Opportunities missed for good reason.

A few nurses readily acknowledged that there were occasions when HIV information could have been offered or offered in greater detail. Because the rationales for their behaviour were outlined in the section entitled 'Factors Promoting or Inhibiting HIV/AIDS Health Promotion/Illness Prevention Activities', they will receive brief mention at this point. The most commonly cited reason for not doing so was shortage of time. One nurse began her response by identifying lack of time as the key factor, but as she continued to explain her activities, it became clear that HIV was not a priority for her. "If I don't mention it, it is a time factor. It's always mentioned when I'm talking about birth control unless I'm busy and we don't get to that point or whatever."

In the school setting, sometimes HIV or STDs were introduced briefly because a different focus, such as birth control, had been specified by the teacher. In some instances the teacher requested a brief review of HIV/STDs because she felt she had already

covered some of that topic with the class.

One STD clinic nurse withheld further education if she felt the client could not cope with more information. She stated, “By and large, I think I’m fairly comfortable with confronting the facts; however I won’t push the person past what I feel is their limit for the day.” Another reason for not introducing the topic of AIDS was the presence of a parent at the counselling session.

Possible missed opportunities.

Our interview left some nurses uncertain and questioning whether or not they should have addressed HIV in various situations.

I’m not sure. I’m really not sure. It’s not that I don’t think it’s important information, but when it comes to prenatal classes, they’re so focused that I’m not sure it has a place there....I guess I’m not sure.

Another stated, “There may have been one or two visits where I could have brought it up and didn’t.” She went on to say, “Like HIV just isn’t something that I really bring up on my home visits and I’m not sure if...it’s something that we should be doing on our home visits...I don’t know the answer to that question.” She explained that they “don’t do a lot of long term follow-up” and it takes time to develop a relationship. “Well, I think I’d feel uncomfortable, that they might feel I was intruding in an area that they didn’t want to talk about in their life.”

Probable missed opportunities.

Upon reflection, several other nurses identified occasions when they probably should have conducted HIV/AIDS illness prevention/health promotion activities. One nurse decided that she probably should have discussed HIV/AIDS with some of the new,

high risk moms that she visited. “I think it’s my own awareness. I wouldn’t use the word negligence, but now I’m thinking maybe I should have in lots of cases.” With respect to recent activities with mental health clients, another nurse expressed regret. “Yea I would say I probably should have fit more time in...discussing AIDS and AIDS transfer and transmission...and didn’t based on the time factor.” She went on to say, “Not that I couldn’t have changed it. I could have.” Despite the fact that she believed that some high risk moms might have “just sloughed it off” if she had introduced the topic of AIDS, one nurse indicated that she would do things differently if she had the opportunity. “Oh I would have done it anyway. You never know, even if they get something little from it, it’s worthwhile.” Another nurse stated she had “missed the boat” with respect to HIV/AIDS. Although she acknowledged limited opportunities for home visits and the need to address the immediacy of client concerns as priorities, she believed her activities offered an “ideal opportunity” to conduct HIV health promotion activities. The therapeutic relationship would not be damaged if the right approach was used. “I think you could approach it from the point of talking to the person about their self-help, talking about what they think of themselves, their self-esteem.”

Although a variety of themes arose from five of the six topics explored in this analysis (see Table 2), the single most pervasive theme which emerged from the interviews, was the theme of variability. As noted previously, the nurses varied in their views regarding the impact of the HIV/AIDS virus on the health of Canadians. They varied in their assessment of population at greatest risk for the virus. Their self-reported

Table 2

Themes Which Emerged From Interview Topics

<u>Topics</u>	<u>Themes</u>
Impact of HIV Virus	Loss and personal suffering Potential of virus to affect behavioural change
Populations at Greatest Risk for HIV Virus	Variability
Risk factors for Women	Denial New morality Low self-esteem Societal attitudes towards sex
HIV/AIDS Health Promotion/ Illness Prevention Activities	Heterosexual focus AIDS as a gender-neutral issue Encouraging condom use Building self-esteem and empowering women Increasing client comfort Reducing risk from drug and alcohol use
Factors Promoting or Inhibiting Activities	Employment responsibilities Role of the health unit Client/community requests Nurse and client comfort levels HIV priority status Religion The research interview
Missed Opportunities: Nurse Identified	No missed opportunities Opportunities missed for good reason Possible missed opportunities Probable missed opportunities

HIV health promotion activities varied broadly within similar settings. The factors which promoted or inhibited their activities varied from health unit to health unit and from nurse to nurse. And finally, the interpretation of missed opportunities varied among PHNs. While this variability was most pronounced in the comments made by nurses working outside the area of HIV/AIDS, there were reports of variability within this group of nurses as well. The professional responsibilities of the informants working in HIV differed somewhat in each health unit. Three of the four women had clinical responsibilities related to HIV, although the type of testing offered varied among health units. In three of the health units, the person identified as AIDS educator had regular or back-up responsibilities in STDs. One of these three nurses reported having pursued in-depth education in health promotion and was very involved in community development and advocacy. The fourth nurse had a non-clinical practice which focused on AIDS education in the community. (One of the health units visited by this researcher also employed an AIDS educator who was not classified as a Public Health Nurse. As such, she was not a member of the target population and was not interviewed for this study.)

CHAPTER FIVE

Discussion

The purpose of this study was to explore the status of public health nurses' HIV/AIDS health promotion/illness prevention activities with women. Lalonde's Health Field Concept was used to highlight both the significance of the topic as a women's health issue as well as the challenges facing those involved in health promotion. This conceptual framework will also be used to structure a discussion of the research findings prior to discussions on implications for nursing practice and study limitations.

Determinants of Health

Human biology.

As stated previously, females have specific gender and age-related risks related to HIV transmission. Some nurses noted that an HIV positive woman could transmit the disease to her infant in utero or through breast milk. One nurse noted with wavering certainty--"well I think that they say"--that women picked up STDs more easily than men and that it was more difficult for a man to contract HIV than for a woman. No other biologic risks specific to women were noted or discussed. As stated previously, most health promotion activities were gender-neutral. When nurses did identify female-focused activities, no references were made to issues of human biology as a component of that special focus.

Insofar as the interviews were open-ended and interactive, identical questions were not used in each interview. Consistent with the nursing activity context of the study, most of the responses had a behavioural focus. Although this focus may have distracted

some nurses from addressing the topics of human anatomy and physiology, some of the researcher's questions did invite answers with that focus. Examples included the following questions: "Do you think there are ways by which being female puts us at greater risk?"; "Can you think of any risk factors which women have that men don't have?"; "Can you think of some of the reasons why women are at risk for HIV?" The informants did not discuss human biology in this context, suggesting that issues of human biology were not their usual or familiar focus.

The themes of HIV as a heterosexual focus and a gender-neutral issue, coupled with the non-emphasis on female biology, suggest that the public health nurses in this study did not view HIV/AIDS as a 'women's health issue'. Most of the clients seen by public health nurses are female. Based on the nurses' reports, they see approximately equal numbers of men and women in the HIV and STD clinics; they interact with more girls than boys in the school setting; and they see many more women than men in the family planning clinics and on home visits. Clearly, the nurses have many opportunities to address women's health. Without including HIV/AIDS in that focus, nurses may be overlooking important strategies and health promotion opportunities which could impact on the health of Canadian women.

Environment.

Shah (1994) defines the environment as "a mosaic composed of our cultural, social, technical, psychological, political, economic, occupational and physical environments" (p. 26). This very broad category was a major focus during the interviews. Taken as a whole, the nurses identified many of the environmental factors which the literature has associated with women's risk for contracting HIV: poor education, poverty,

power imbalances, domestic violence, re-entering the dating scene later in life, partner infidelity, etc. Although female gender-focused interventions were limited in number, nurses (primarily those working in an HIV program) did relay accounts of interventions targeted at some of these high risk groups: i.e. women who left school early, older women, and women in second stage housing. Community liaisons such as that formed by one AIDS educator with a local women's service club, typify the community capacity building role which the nursing literature supports for public health nurses in health promotion (Kang, 1995).

In their individual responses, the risk factors over which nurses expressed the greatest concern were the following: low self-esteem, societal attitudes towards sex, and denial of risk. As noted previously, nurses spoke of one-on-one encounters in which nurses attempted to verbally empower female clients, and of a couple of innovative group activities recently initiated to address a variety of psychosocial issues including self-esteem, gender role, communication, etc. The group process had been introduced, not to deal with HIV, but as an overall risk reduction strategy. When such programs existed, they targeted girls in grade 6 or high school. One AIDS educator voiced strong concerns that self-esteem issues and risk reduction strategies needed to be addressed earlier in the school system:

I've talked to so many teachers who really believe that they can identify problems....If there was an umbrella of options to deal with the behaviours at a grade 3, 4, 5 level rather than letting them all occur and dealing with them at a secondary level of health care, our costs would be [much less]. You can change behaviour at grade 3, 4 fairly quickly; but to change behaviour in kids who are 17,

18, 19, they're pretty well [set].

Societal attitude toward sex and gender roles fell into a similar category where nurses attempted, individually and in group settings, to help girls identify and discuss media influences regarding issues such as unrealistic body image and women's roles in society. Sexual mores were even more difficult to deal with. Nurses' comments identified a dichotomous situation where young women were experiencing strong media and peer influences to be sexually active while at the same time they were living in the same "sex neutral" society where sex is not discussed and prenatal nurses were reluctant to discuss sexuality during pregnancy because "when you bring it up, everybody sitting there turns red....It's almost like we've made it asexual."

Denial of risk was viewed as a universal problem, not just an issue for women. Opinions varied as to whether or not health education measures could make a difference. While some ascribed this "sense of immortality" to teens, others viewed it as an integral part of human nature beyond the known scope of nursing interventions.

Nurses also identified many other environmental factors which inhibited or promoted HIV/AIDS health promotion activities: e.g. client/community requests, nurse and client comfort levels, HIV priority status, and religion. Regarding nurse comfort levels, nurses' comments about personal experiences and the attitudes of their peers, indicated that nursing practice may be subject to the same cultural sexual mores which influence clients. As for HIV priority status, this study raises the concern that some nurses, such as those who did not associate chlamydia with risk for HIV, were experiencing the same 'denial of risk' phenomenon which the nurses associated with clients who practised unsafe sex.

Lifestyle.

The nurses were quick to note the lifestyle factors commonly associated with risk for HIV: unsafe sex, injection drug use, tattooing, body piercing, and transfusion of blood products (noted as a past risk factor). Shah (1994), who writes from the perspective of medicine and public health, states that “the term lifestyle diseases should be exchanged for lifestyle consequences, a lifestyle consequence being something that could have been avoided by choosing an alternative lifestyle that was realistically available” (p. 40-41). Unlike Shah, but consistent with the “holistic and complex view of disease causation” (Lowenberg, 1995, p. 319) typically espoused by public health nursing, many of the nurses in this study spoke of lifestyle issues from the perspective of the ‘environmental’ factors (low self-esteem, gender role, denial of risk, etc.) which needed to be addressed before women could be empowered to make wiser decisions. Some of the nurses did attribute lifestyle risks to lack of education, but noted that often environmental factors such as lack of transportation, no child care, social attitudes about sex, etc. prevented the message from being disseminated.

Nevertheless, the nurses did address those lifestyle factors usually associated with HIV. Nurses reported discussing the risks associated with tattooing and drug and alcohol use. They focused intensive efforts on promoting condom use to prevent STDs. Concurrent with instruction on the mechanics of condom use, many nurses, as discussed previously, incorporated their understanding of environmental issues to assist women in learning to negotiate condom use with their partners. Although AIDS educators used the phrase ‘safer sex’, most others did not. This may have reflected their lack of familiarity with the ‘safer sex’ literature and AIDS prevention campaigns.

Health care organization.

The major health care organization factors identified in this study were addressed under the topics of HIV/AIDS health promotion/illness prevention activities, employment responsibilities, and role of the health unit. From the public health perspective of preventing the spread of a communicable disease to women (the population with the highest HIV rate increase in North America), concern arises from the preeminent position which the theme of 'variability' occupied within descriptions of this determinant of health. While this study cannot presume to evaluate the effectiveness of focused practice roles in public health, it certainly supports the need for organizational review of such roles from multiple perspectives: client/community outcomes, impact on the knowledge and functional capacity of related roles, and employers' responsibility for staff in-servicing. Many of the nurses, such as those on the children 0-5 years team or those teaching prenatal classes, used rationales which were consistent with Knowles' adult education theory (Decker & Knight, 1988) to explain why they did not address birth control, STDs or HIV during their client interventions. Two of those rationales were the following: adult learners "help to identify what they wish to learn and the sequence of learning" (Decker & Knight, p. 339) and "adult education is a process for defining problems and solving them for the present" (Decker & Knight, p. 339). The concern identified in this study is that because of their focused practice roles, some of the nurses had not really thought about how their activities impacted their clients' risks for contracting HIV/AIDS. Some appeared to have not thought about the association of unplanned pregnancies, unstable relationships, etc., with a risk for the virus. The nurses were very honest about knowledge deficits related to HIV statistics, demographics, etc.

and they reported taking care to practise within the limits of their knowledge by seeking out correct answers or referring clients to experts. The concern that arises is that nurses who do not experience regular HIV updates, may not be able to accurately identify the limits of their knowledge. As noted previously, the nurses did not appear to experience confusion regarding Canadian and American epidemiologies; they identified an imprecise knowledge of HIV epidemiology in general. Nurses who are unaware of changing epidemiologies are unable to alter their practices to reflect that change.

Implications for Nursing

Utilization of the Health Field Concept has helped to identify numerous implications for nursing education, nursing research and professional practice. From the perspective of nursing education, the findings of this study support the need for an increased focus on human biology, human sexuality, and women's health. While the informants spoke often of determinants of health relating to the environmental and lifestyle components of the Health Field, the human biology component was weakly addressed. A sound knowledge of human biology is essential to the nursing process. Although some nurses expressed the opinion that peers who are uncomfortable discussing sexuality or sexual behaviours, should not have to address that topic, the testimony of others indicated that comfort discussing sexuality can be acquired. Indeed, since holistic nursing practice encompasses sexuality, that comfort must be acquired. There was little evidence from this study to indicate that nurses generally placed HIV under the umbrella of 'women's health issues'. Until such time as the health care 'establishment' studies and addresses women's health to the same degree as men's health, 'women's health' should

be a compulsory component of nursing education so that nurses will be more likely to look beyond the gender-neutral (i.e. male) standard of health care and more readily address the necessary issues important to women's health. Inclusion of HIV/AIDS as a women's health issue may also assist nurses (a predominantly female profession) to internalize and personalize the issues surrounding the disease, and increase the likelihood of their addressing those issues.

As an exploratory study, one of the purposes of this research was to identify issues requiring further investigation. Nurses identified a wide variety of health promotion interventions which directly or indirectly addressed the topic of HIV/AIDS. When asked about the success of their interventions, again and again nurses expressed frustration with poor, non-existent, or invalid outcome indicators. Nursing interventions need to be evaluated. As indicated by recent articles published in PHERO (Public Health Epidemiology Review in Ontario) exhorting public health facilities to incorporate an evaluation component into their planning process (Ottawa-Carleton Teaching Health Unit, 1997; Program Evaluation Work Group, 1996), the political health care climate may be ready to support nurse researchers in this area. By the same token, if nurses fail to act soon, the opportunity and responsibility for evaluating nursing programs may be assumed by another profession, health unit epidemiologists.

Two particular recommendations for research will be addressed at this point. One area is that of self-esteem, specifically the degree to which nursing interventions are correlated with enhanced self-esteem and reduction in client risk-taking behaviour. The other area is the promotion of sexual health. Many nurses identified low self-esteem as an especially serious risk factor for women and AIDS. In a 1993 paper published in the

Issues in Health Promotion Series by the Centre for Health Promotion at the University of Toronto, Dr. Dennis Raphael questions the common presumption of correlations among self-esteem, health status and health-enhancing behaviour. He concludes his extensive review of the literature by stating:

Whatever the level or type of health promotion intervention or activity implemented, the emphasis should not be upon improving individuals' self-esteem, but rather on enhancing health and health-related behaviours. In some cases, this will involve enhancing environmental opportunities, in other cases, developing individual's means of coping with diversity. (p. 24)

To the degree that the reported practice-based nursing knowledge of these PHNs is in disagreement with Dr. Raphael's conclusions, further research is necessary.

Another area in need of research and clarification, is the effectiveness of nursing interventions employed to promote sexual health. Nurses in this study described numerous factors which promoted or inhibited these activities, but consistently worked under the assumption that such activities were beneficial. According to Irwin (1997), a nurse working in HIV and sexual health, little research has been conducted in this area. He acknowledges that "the promotion of sexual health may indeed be a legitimate role for health care professionals and an essential nursing function" (p. 174); but states that while practitioner knowledge deficit may be problematic, there are graver concerns due to the potential for 'victim blaming' which arises from "incognizance of the social, cultural, political, and economic determinants of sexual behaviour" (p. 174) and due to "the close relationship of nursing to medicine in the medicalization of sexuality and sexual activity" (p. 174). He maintains that some clients may be harmed during the

counselling process and that:

Greater rigour is required in the evaluation of interventions designed as sexual health promotion, and more attention is required to the contextual constraints which impinge on the promotion of sexual health. (p. 174)

Irwin's concerns support those of the nurses who identified environmental and psychosocial barriers to discussing sexuality and risky sexual behaviour, and also reinforce the need for nursing research in this area.

From the perspective of professional practice, the concerns expressed by nurses in this study underline the need for public health nurses, as a professional collective, to formulate and express their views on the future of public health nursing. For maximum effectiveness, these voices must be grounded in theory and research. Periodically, the Ministry of Health develops mandatory program guidelines to direct the functioning of public health units. These programs are based on statistically determined public health priorities, not the principles of holistic health care which guide nursing practice. Herein lies a major dilemma. The Ministry of Health has not expressed the concern that nurses address every health care issue of breast feeding mothers; but the nursing profession has identified the delivery of holistic health care as a professional responsibility. This discrepancy needs to be addressed. Options include, but are not limited to the following: periodic development of professional guidelines for self-education, lobbying for better staff education, and lobbying for a greater voice in the public health sector.

Consistent with nursing literature which promotes the role of public health nurses in community development (Chalmers & Bramadat, 1996; Kang, 1995), the nurses in this study often focused on the social and environmental factors impacting on clients' health;

yet, few of the nurses identified employment roles with the potential to effect social or environmental change. During this time of health care restructuring (or upheaval), as responsibility for public health is about to be transferred to municipalities (January 1998), public health nursing may best serve the public by enhancing community capacity for health promotion “through facilitating community participation, enhancing community health services, and coordinating public policy to achieve core public health responsibilities of assessment, policy, and assurance” (Kang, p. 312). Widespread incorporation of such a role into the practice of public health nursing may hold the greatest potential for impacting on AIDS and many other women’s health issues; but such a change will not be achieved without concerted effort of nurses advocating for an expanded role within the public health sector.

Limitations

As in any research endeavour, this study had limitations. Each nurse was interviewed only once. Some health units had placed limits on the number of nurses and the number of hours which they were prepared to donate to this research effort. Since most of the nurses were not accustomed to viewing their practice from the perspective of women and AIDS, such an analysis was difficult for them. Had they had the opportunity to consider these issues in advance, their prepared responses may have included isolated activities which they forgot to mention in the interview; but those responses may also have presented a less candid reflection of their attitudes, knowledge, and practices. Had repeat interviews been permitted, they also may have interjected that bias.

It is most likely that the researcher’s experience as a public health nurse and as an

ONA member facilitated her acceptance within the health units. That collegial relationship may also have had an effect on the interview process. PHNs were asked to talk to the researcher as if she were not a nurse and to describe their activities with the same detail they would use in talking to someone unfamiliar with public health nursing. Although the nurses did comply with this request, the professional distancing or the objective, analytic tone inherent in many of their responses, may have reflected their awareness of the nursing sub-culture that they shared with the interviewer and their desire to present an accurate accounting of their professional practice rather than a more personal reflection on their activities. Such professional distancing could have masked the personal discomfort a nurse might have felt regarding the topic of AIDS. Although it is logical to assume that some of the nurses' comments may have been guarded for fear of professional criticism, the honesty and openness displayed by nurses pondering issues such as potential for missed opportunities for health promotion or their reactions to providing sex education are indications that such 'guarding' was not a serious limitation.

With one exception, there were fewer informants from each health unit than requested. This did not affect the overall numbers of nurses interviewed since an additional health unit had been enlisted to compensate for such an occurrence. Those who volunteered may have been more knowledgeable or more interested in HIV/AIDS than the norm.

As requested, nurse informants came from a variety of nursing programs within each health unit. One or two nurses from health units with lower participation commented that a superior had suggested they might like to volunteer for this study; however, the fact that most health units yielded fewer nurses than requested, indicates

that undue pressure to participate was not exerted.

As requested, several PHNs came from areas of practice which the researcher presumed would afford little opportunity to address the AIDS issue; however, several of these nurses had personal or previous work-related opportunities to deal with HIV. They may have been more knowledgeable than their peers on this topic.

While the nurses interviewed in this study may have been more knowledgeable or interested in HIV than their peers, such a consideration lends support to the study's recommendations since the nurses interviewed may have presented a 'best-case' rather than a 'worst-case' scenario regarding HIV/AIDS health promotion/illness prevention activities with women.

Conclusion

An exploratory study such as this, does not yield definitive answers. Instead it produces food for thought: thought about women and HIV, thought about nursing practice in public health, thought about nursing education, and thought about nursing research. Nursing is both an art and a science. Critical nursing judgement, a complex interaction of that art and science, is required in all professional interactions. It was not the purpose of this study to evaluate the nursing interventions described by the informants in this study, but to use those descriptions as a springboard for thoughtful consideration of the many issues raised in this research. It is clear that HIV/AIDS does not hold the same statistical risk for women as it does for gay men; however, there are unique biologic, environmental, lifestyle and health care-related determinants of health with enormous potential to impact Canadian women should the disease burden of HIV

reach a 'critical mass' in Canada. If safer sex is broadly recommended for everyone (with specific exceptions) because it is impossible to accurately assess the potential risk of a sexual partner, should nurses target HIV/AIDS health promotion interventions to all women, since they cannot accurately assess every woman's risk? How should nurses deal with the concept of relative risk? Dr. Robert Remis, researcher at the University of Toronto, states that there has been "an incomplete appreciation of the problem to date" (personal communication, August 7, 1997). Based on the results of a new, unpublished study, he recommends routine HIV screening for all pregnant women as a means of reducing neonatal infection, despite his opinion that 97% of women of childbearing age are at low risk. Such a recommendation, if heeded by the Ministry of Health, will have implications for nursing practice in public health and elsewhere.

While there are no easy answers to this complex issue, the educational, research and professional recommendations arising from this study have the potential to expand nursing knowledge in health promotion and safeguard the health of Canadian women.

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Appendix A

Sample Letter to Be Distributed to All Public Health Nurses:

Dear Colleague,

My name is Susan Kocela and I am a candidate in the Master of Science Program in Nursing at the University of Windsor. Having received ethical approval from the Nursing Research Committee at the University of Windsor, I will be conducting a qualitative research study with Public Health Nurses at several Health Units in Southwestern Ontario. Your agency has given me permission to interview _____ [insert number] nurses during work hours. As a Public Health Nurse myself, I am writing to request your participation in this study.

Each volunteer will spend one to two hours, engaged in a private, audio-taped, open-ended interview with myself. The general topic of discussion will be HIV/AIDS; and although I am hoping to interview a nurse (or nurses) whose practice focuses on this area, I would also like to obtain the broad perspective of nurses working in other areas such as reproductive health, sexual health, STDs, the maternal/child program, the adolescent health program, etc. All information will be held in strictest confidence. Audio-tapes will be labelled by code, not by name, and will be destroyed upon completion of the study. Transcripts will be retained, without identifying information, in a secure location. They will be destroyed once the necessary analysis has been completed. No individual will be identifiable in the final research report, and individual health units will not be mentioned by name. I feel that this study has the potential to advance nursing knowledge in health promotion and to make recommendations which could benefit program planning and impact on the epidemiology of HIV/AIDS in Canada.

I will be visiting your health unit on _____ [insert date(s)] and would very much appreciate your participation in this study. If you are available to assist with this research project, please submit your name, phone extension, and information regarding the best time to reach you to _____ [to be negotiated with the health unit].

If you have further questions please do not hesitate to contact me at (519) 258-2146, EXT 229 (during work hours) or at (519) 734-1999. My faculty advisor, Dr. Barbara Thomas, and the Chair of the Nursing Research Committee, University of Windsor, are also available to discuss questions or concerns related to this study. They may be contacted through the School of Nursing at (519) 253-4232, EXT 2258.

Looking forward to meeting you,

Sue Kocela, RN, BScN

Appendix B

Informed Consent Form

PROJECT TITLE: An Exploration of the HIV/AIDS Health Promotion Activities of Public Health Nurses with Female Clients

INVESTIGATOR: Susan Kocela, RN, BScN, Candidate: Master of Science in Nursing
Phone: (519) 734-1999 OR (519) 258-2146 Ext. 229 (during work hours)

ETHICAL APPROVAL: from the Nursing Research Committee, University of Windsor

ADDITIONAL CONTACTS: Faculty advisor, Dr. Barbara Thomas and the Chair of the Nursing Research Committee, University of Windsor
Phone: (519) 253-4232 EXT 2258

The purpose of this research is to explore the status of HIV/AIDS health promotion/disease prevention activities of public health nurses with female clients. Open-ended interviews, lasting one to two hours, will be conducted with public health nurses at several Public Health Units. During these interviews, questions will be asked about HIV/AIDS and any opportunities you may have to conduct HIV/AIDS related health promotion/illness prevention activities. Demographic data will also be collected. Our interviews will be tape-recorded and labelled by code, not by name. All tapes will be destroyed upon completion of the study. Transcripts will be retained, without identifying information, in a secure location. They will be destroyed once the necessary analysis has been completed. Neither the tapes, nor the transcriptions will be shared with anyone from your agency; but the final report, containing anonymous quotations, will be available to all at the end of the study.

Your participation is valuable in advancing nursing knowledge regarding this public health issue.

.....

THIS IS TO CERTIFY THAT I, _____ (print name)
HEREBY agree to participate as a volunteer in the above-named project.

I hereby give permission to be interviewed and for these interviews to be tape-recorded. I understand that, upon completion of the research, the tapes will be erased. I understand that the information will be published, but my name will not be associated with the research.

I understand that I am free to refuse to answer any question during the interview. I also understand that I am free to withdraw my consent and terminate my participation at any time.

I have been given the opportunity to ask whatever questions I desire, and all such questions have been answered to my satisfaction.

OPTIONAL: I consent to the possibility of a follow-up telephone contact, at my convenience, if the researcher requires further information.

YES _____ : my home phone number is _____ NO _____

Participant _____ Researcher _____

Date: _____

Appendix C

Tentative Schedule of Questions

After obtaining informed consent and answering any questions posed by the informant, the researcher will obtain the following demographic data: age group, marital status, focus of practice, length of time practising in that area, number of years since graduation, and level of education.

The following are potential questions and sub-questions to be used during the interview process:

- What do you think has been the impact of the HIV virus on the health of Canadians?

How serious a problem is it?

Which populations do you think are a greatest risk? Why?

- To what degree do you think HIV/AIDS is a health risk for Canadian women?

How did you come to this conclusion?

What attitudes or thoughts have your colleagues expressed regarding the topic of AIDS and women?

What attitudes or thoughts have your clients expressed regarding the topic of AIDS and women?

- As a public health nurse, to what degree have you ever been involved in health promotion/illness prevention activities which focused on or related to the topic of HIV or AIDS?

Under what circumstances (what, when, where) did these activities take place?

- To what degree have these activities focused on women and AIDS?

Under what circumstances (what, when, where) did these activities take place?

What promoted or inhibited these activities?

How would you describe the success of these activities?

- How would you describe your comfort level discussing issues of sexuality or sexual behaviours relating to transmission of the HIV virus?

What factors do you think influence your comfort level?

- How would you describe the clients' comfort levels during these interactions?

What factors do you think influence these comfort levels?

- Reflecting on your own professional activities, are there any occasions when it would have been appropriate to discuss HIV/AIDS with clients, and yet for some reason, you did not?

Can you describe these circumstances?

- To what degree do you think public health nurses should be involved in conducting HIV/AIDS health promotion/illness prevention activities with women?

What factors promote or inhibit this activity?

- From what sources (i.e. formal education, individuals, media) have you learned about HIV/AIDS?

How satisfied are you with this knowledge level?

- How would you advise a couple who wanted to know when they could safely engage in unprotected sex?

Would your answer vary with the sexual orientation of the couple (i.e.

heterosexual, homosexual, bisexual)?

Describe the degree to which your comfort level might be affected by the sexual orientation of the clients?

VITA AUCTORIS

NAME: Susan J. Kocela (nee Mason)

PLACE OF BIRTH: Windsor, Ontario

EDUCATION: Vincent Massey Collegiate Institute, Windsor
1961-1966

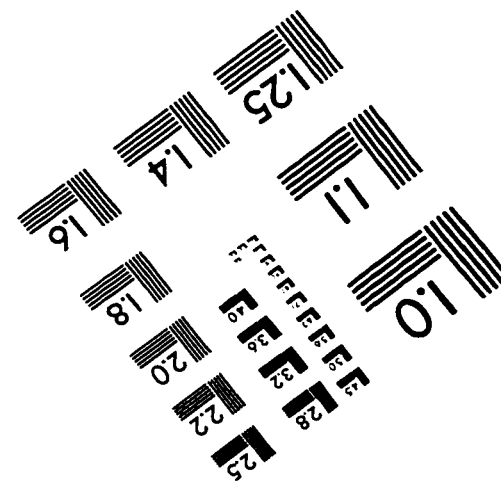
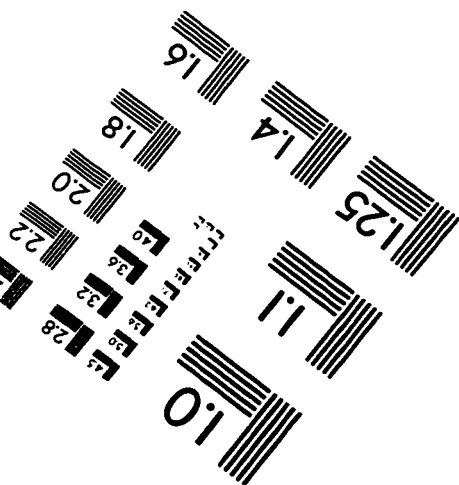
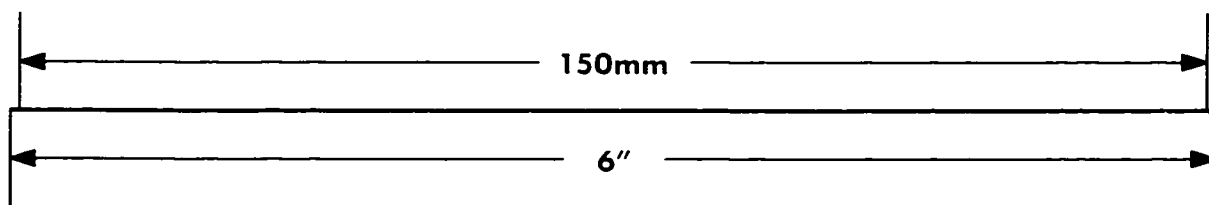
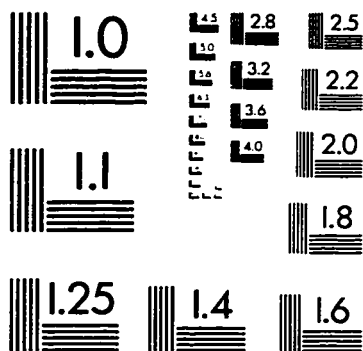
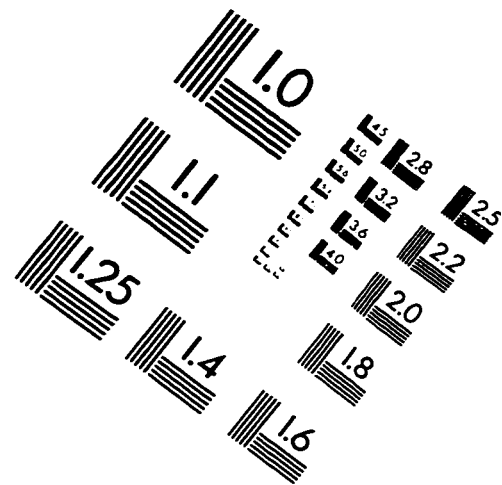
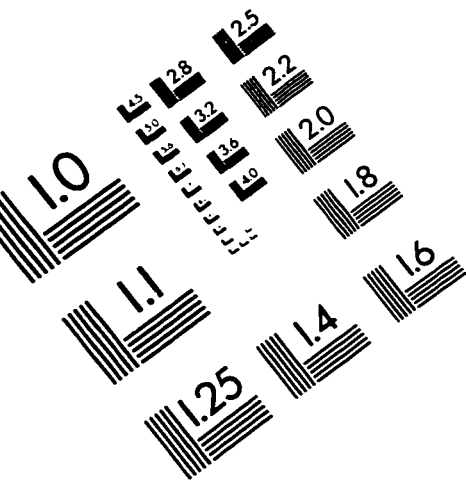
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