



**ON BECOMING CULTURALLY
COMPETENT: HIV NURSING
IN THE 21ST CENTURY**

Best practices for nursing care of HIV-infected patients

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ABSTRACT

Tampereen ammattikorkeakoulu
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UUSI-TARKKA, HANNA & WINCH, PAULA:
On Becoming Culturally Competent: HIV Nursing in the 21st Century
Best Practices for Nursing Care of HIV-Infected Patients

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The goal of this study was to illuminate the current state of knowledge about culturally competent nursing care of Human Immunodeficiency Virus (HIV) focusing on the Current Care Guidelines, culture, cultural competence, stigma, education, medication adherence, and patient experience.

This thesis presents and reviews the most up-to-date methods for nurses to provide culturally competent care to their HIV-infected patients. The literature review in this thesis demonstrates how culturally competent nursing care can help nurses provide optimal care for their culturally diverse HIV-infected patients.

The thesis also provides evidence-based recommendations for culturally competent nursing strategies for nurses' culturally diverse HIV-infected patients. This analysis was formulated through a rigorous review of the relevant literature in the field and is based on the recognized, current, and culturally competent best practices of nursing for HIV-infected patients. The synthesis and analysis of this research revealed unquestionably that culturally-competent nursing care improves the quality of life of HIV-infected individuals.

It would be valuable for further research to explore and develop an understanding of if, and how, gender roles impact a patient's management of his/her HIV-infected status. In addition, further research on the effect of stigma experienced in Finland by culturally diverse HIV-infected patients could improve nursing care practices as well as the patient's medication adherence and self-care.

Key words: hiv, multicultural patient, cultural competence, culturally competent nursing care, stigma.

TIIVISTELMÄ

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Opinnäytetyön tarkoituksena oli tuoda esiin nykytietämys kulttuurienvälisen hoitotyön merkityksestä immuunikatovirusta (HIV) sairastavan potilaan hoitotyössä. Opinnäytetyössä käsitellään HIV-infektoituneen potilaan hoitoon liittyviä suosituksia, kulttuuria, kulttuurista pätevyyttä, stigmaa, potilaan ohjausta, lääkehoitoon sitoutumista sekä potilaiden kokemuksia.

Tämä opinnäytetyö esittelee ajan tasalla olevia metodeja siitä kuinka sairaanhoitajat voivat tarjota kulttuurisesti pätevää hoitotyötä HIV-potilaille. Työ esittelee myös kuinka kulttuurisesti pätevä hoitotyö voi auttaa sairaanhoitajia antamaan optimaalista hoitoa eri kulttuureista tuleville potilaille. Opinnäytetyö tarjoaa tutkittuun tietoon perustuvia suosituksia kulttuurisen pätevyyden toteuttamiseen eri kulttuuritaustaisten HIV-infektoituneiden potilaiden hoitotyössä.

Opinnäytetyö toteutettiin narratiivisena kirjallisuuskatsauksena, jossa analysoitiin kahdeksan vertaisarvioitua tieteellistä artikkelia. Kirjallisuuskatsauksen tulokset esittävät, että kulttuurisesti pätevä hoitotyö parantaa HIV-infektoituneiden potilaiden elämänlaatua.

Lisätutkimusta suositellaan siitä kuinka sukupuoli ja sukupuoliroolit mahdollisesti vaikuttavat HIV-infektoituneen potilaan omahoitoon ja infektion ymmärrykseen sekä hyväksymiseen. Lisätutkimusta suositellaan myös siitä kuinka ulkomaalaiset Suomeen muuttaneet kokevat stigman suomalaisessa ympäristössä. Kyseiset seikat saattavat parantaa HIV-infektoituneen potilaan hoitotyötä sekä edistää potilaan omahoitoa ja lääkehoitoon sitoutumista.

Asiasanat: hiv, monikulttuurinen potilas, kulttuurinen pätevyys, kulttuurienvälinen hoitotyö, stigma.

CONTENTS

1	INTRODUCTION	6
2	PURPOSE, PROBLEMS AND OBJECTIVE	8
3	THEORETICAL STARTING POINTS	9
3.1	HIV	9
3.2	HIV medication.....	14
3.3	Adherence to HIV medication and treatment plans	15
3.4	HIV care in Finland	16
3.5	HIV/AIDS education	17
3.6	Stigma	18
3.7	Patient experience	19
3.8	Culture	20
3.9	Cultural competence	20
3.10	Culturally competent nursing care for HIV-infected patients.....	23
4	METHODOLOGY	25
4.1	Literature review	25
4.2	Literature search	26
4.3	Data analysis	33
5	FINDINGS	34
5.1	How can nurses provide HIV nursing care best practices?.....	34
5.1.1	Factors that impact HIV-infected patients' disease management	37
5.1.2	Stigmatized patient.....	38
5.2	What factors influence the care of an HIV-infected patient?	38
5.3	Why is culturally competent nursing care necessary for HIV-infected.....	40
	patients?.....	40
6	DISCUSSION	42
6.1	Applying the findings	42
6.2	Validity	43
6.3	Evaluation of literature review	44
6.4	Limitations	45
7	RECOMMENDATIONS FOR FURTHER RESEARCH	46
8	CONCLUSION	47
	REFERENCES.....	48
	APPENDICES	54
	Appendix 1. Research matrix.....	54

ABBREVIATIONS AND TERMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARVO	Antiretroviraalisen hoidon ohjeistus
CINAHL	Cumulative Index to Nursing and Allied Health
ECDC	European Centre for Disease Prevention and Control
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
MEDLINE	Medical Literature On-Line
NHS	National Health Service, United Kingdom
NIH	National Institute of Health, the United States
THL	National Institute for Health and Welfare, Finland
WHO	World Health Organization

1 INTRODUCTION

The goal of this study was to illuminate the current state of knowledge about culturally competent nursing care of Human Immunodeficiency Virus (HIV). This thesis sought to determine how culturally competent nursing care can help nurses provide optimal care for their culturally diverse HIV-infected patients. The aim was to provide recommendations for culturally competent nursing strategies for nurses' culturally diverse HIV-infected patients (National Minority Aids Council 2003). This analysis was formulated through a rigorous review of the relevant literature in the field and based on the recognized, current, and culturally competent best practices of nursing for HIV-infected patients (Purnell & Paulanka 1998; National Minority Aids Council 2003).

Culturally competent nursing is a cornerstone of best practices for nursing culturally diverse patients (Flowers 2004, 48). Based on the premise that a patient's health beliefs are influenced by his/her cultural identification, this thesis sought to identify culturally competent best practices so that nurses working with HIV-infected patients are able to provide their patients with the best available nursing care (Flowers 2004, 48). In fact, research has shown that when healthcare providers do not provide culturally competent care, patient outcomes are likely to suffer (Flowers 2004, 49; Long 2012, 102). It follows, therefore, that culturally diverse HIV-infected patients will receive better nursing care if nurses provide culturally competent care (National Minority Aids Council 2003).

The number of immigrants and refugees living in Finland is increasing all the time (Tanner 2011). In 2002, according to the Finnish Ministry of the Interior, there were 103,682 natives of other countries living in Finland, and by 2012, that number had increased to 195,511, making it 3.6% of the population. The largest foreign-born minority residing in Finland is from Estonia (approximately 40,000 people), followed by Russia, Sweden, Somalia, China, Thailand, Iraq, Turkey, India, and Germany. (Ministry of the Interior 2013, 3-4.)

As Finland's "Professional Nursing Competencies" state, nurses need to recognize the significance of culture in health promotion and nurses need to be able to work with individuals, families and communities from different cultures (Ammattikorkeakoulusta terveydenhuoltoon 2006, 63, 67). Finland's commitment to equal rights through this

commitment to immigrants, as well as diversity projects such as Joint Promotion of Anti-discrimination (JOIN), Finland Forward Without Discrimination (SEIS), the European Refugee Fund in Finland (ERF), and Finland's social, economic and foreign policy, have attempted to continually uphold human rights. The combination of forward-looking Finnish governmental policies and the high value placed by Finnish society on equality, integrity and well-being, has placed Finland in a unique position to model meaningful integration not only for its immigrants but for its HIV-infected immigrants (Tanner 2011; European Centre for Disease Prevention and Control 2013).

There are annually over 150 new HIV diagnoses in Finland. By October 13th 2013, there were 3,174 HIV cases and 614 AIDS cases reported in Finland (National Institute for Health and Welfare 2013a). Late diagnosis (CD4 count <350) is high, especially on individuals of non-Finnish origin (62%), and their proportion of all HIV cases has also increased. It is timely that Finland is poised to effectively address the nursing care needs of its culturally diverse HIV-infected patients (National Institute for Health and Welfare 2012a). The National Institute of Health and Welfare explains that the key populations at risk for HIV infections are men who have sex with men, persons who inject drugs, and persons with migrant backgrounds (Anttila 2010; Liitsola, Kauppinen, Pahlman, Pasanen, Brummer-Korvenkontio, Anttila & Salminen 2012, 4; National Institute for Health and Welfare 2012a; Jaakola, Lyytikäinen, Rimhanen-Finne, Salmenlinna, Vuopio, Roivainen, Nohynek, Löflund, Kuusi & Ruutu 2013). Moreover, a deep stigma against HIV exists in Finland (Clarke 2009, 25).

The cooperating partner for this thesis was an infectious disease ward in the Pirkanmaa Hospital District of Finland. Due to Finland's increasingly multicultural demographics, nurses require new skills to effectively care for culturally diverse HIV-infected patients. The working life connection allowed us to share knowledge about culturally competent nursing care for multicultural HIV-infected patients.

2 PURPOSE, PROBLEMS AND OBJECTIVE

It has been recognized that there is a lack of nursing training in cultural competence for HIV-infected individuals and their families in Finland (Clarke 2009, 25; Flowers 2004; Suominen Koponen, Mockiene, Raid, Istomina, Vänskä, Blek-Vehkaluoto & Välimäki 2010, 145). Therefore, the purpose of this thesis was to provide a thorough literature review that defines culturally competent care for HIV-infected patients and illustrates its significance.

Although the number of HIV-infected individuals who are not of Finnish descent is increasing, the nursing care provided to them has only begun to be researched. The Finnish State does however assert that all HIV-infected individuals residing in Finland have a right to quality nursing care in Finland (National Institute for Health and Welfare 2012a).

The thesis objective was to provide nurses with relevant recommendations of culturally-competent best practices that can help them provide more effective nursing care for their HIV-infected patients.

The research questions were:

1. How can nurses provide HIV nursing care best practices?
2. What factors influence the care of an HIV-infected patient?
3. Why is culturally competent nursing care necessary for HIV-infected patients?

3 THEORETICAL STARTING POINTS

In order to discuss HIV, culture, cultural competence, and culturally competent HIV nursing care, it is necessary to define these concepts clearly for the purposes of this thesis analysis. The following section provides a thorough explanation of the HIV disease as well as definitions of key terms used in the thesis so that the reader has a clear understanding of the thesis' fundamental concepts.

3.1 HIV

HIV is a virus that infects cells of the immune system, destroying or impairing their function (World Health Organization 2013a). Due to the effectiveness of the medication known as Highly Active Antiretroviral Therapy (HAART), HIV is currently considered a chronic disease. Progression of the infection can be slowed with proper medication, treating the opportunistic infections and preventing other diseases appearing. (Syrjänen & Ristola 2005, 4981-4982; Bradley-Springer, Stevens & Webb 2010, 32-33.) Good management of the disease, including effective nursing care, can also dramatically improve one's quality of life (National Minority Aids Council 2003).

The HI-virus is present in all bodily fluids, including saliva, tear fluid, perspiration, urine, feces and vomit. However, the virus amounts in these contaminants are very low. As a result, the infection is not likely to spread unless some blood content is also present. Higher doses of the virus are present in blood, semen, vaginal fluids, and breast milk. (HIV/AIDS Basics 2013.) The HI-virus is transmitted from contaminated blood or through unprotected sexual intercourse (vaginal, anal or oral) with an infected person. Sexually transmitted infections, inflammation, or ulcers on mucous membranes increase the risks of transmission. The virus can also be transmitted from mother to child during pregnancy, childbirth or breastfeeding (Aho & Hiltunen-Back 2007; WHO 2013a; WHO 2013b.) HIV cannot be transmitted by ordinary social contact, such as shaking hands, hugging, kissing, sharing food, or going to sauna (Finnish AIDS council 2013; WHO 2013a).

HIV transmission can be prevented and reduced in several ways. Risky behavior such as unprotected sex, having several sexual partners or using shared needles when injecting drugs should be avoided. The proper use of a proper type of condom with an appropriate lubricant during all forms of all sexual contact can reduce the risk of transmission. (HIV/AIDS Basics 2013; HIV-potilaan ohje 2013.) In the event that both sexual partners are HIV positive, the couple should continue to practice safe sex. This is not only due to the fact that the virus transforms, but also because the virus types may not be identical. Safe sex should also be practiced even when the HIV-infected individual is on HAART. (HIV-potilaan ohje 2013, 3.) Testing for HIV is always advisable, especially for individuals who practice risky behaviors. (Bradley-Springer et al. 2010, 35.)

Due to the fact that HIV undermines the immune system by attacking and then destroying T-lymphocytes (CD4 cells, CD4 being the white blood cell type essential to immune system functioning), a patient's CD4 count and viral load are important indicators of the progression of the disease (Bradley-Springer et al. 2010, 33; Barry, Powell, Renner, Bonney, Prin, Ampofo, Kusah, Goka, Sagoe, Shabanova & Paintsil 2013).

The progression of HIV varies based on the patient's age, individual characteristics, economic situation, and social context. In addition, HIV has distinct stages. Each stage necessitates unique nursing care and different types of psychosocial support. Nurses have a key role to play in helping HIV-infected patients manage their disease so as to increase the likelihood of extending the patient's longevity, preserving and/or restoring their immune functions, and improving their quality of life (Bradley-Springer et al. 2010, 33). HIV-infected patients require compassionate nursing care, continuity of care, and high quality hospital and home care at every stage of the disease (Bradley-Springer et al. 2010, 37).

The progression of the HIV infection can be divided into four stages (table 1). The infected individual can spread the HI-virus during any and all stages. The acute stage takes place between one to eight weeks after the initial infection (Hannuksela 2013). The infected person may be asymptomatic (about half to two thirds do not experience symptoms) or have influenza or mononucleosis-like symptoms, such as fever, pharyngitis, headache, swollen lymph nodes, rash, diarrhea, pain in the joints, or sore mouth ulcers. The symptoms usually last between one to four weeks. During this stage, multiple viruses inhabit the infected person's organs, and these viruses are highly contagious. At

this point, the immune system may produce the antibodies against HIV. However, due to their low levels in this early stage, it is not possible to diagnose the antibodies from blood draws (Aho & Hiltunen-Back 2007; Hannuksela 2013; National Institute for Health and Welfare 2013b; WHO 2013a).

The HIV antibodies may be tested from blood draws between two to four weeks after the symptoms have started (Hannuksela 2013), or at the latest within three months of the initial infection (Aho & Hiltunen-Back 2007; Hannuksela 2013). However, the HI-virus test may detect the infection earlier (Bradley-Springer et al. 2010, 34; Hannuksela 2013). The test should only be taken with the patient's consent. A positive test result is confirmed with a confirmation test. (Bradley-Springer et al. 2010, 35.)

After the acute stage, the infected person can be asymptomatic for up to 15 years, the average being ten years (Syrjänen 2013). At this stage, the CD4 count can still be relatively normal and the immune system can fight against the HI-virus (Aho & Hiltunen-Back 2007). Gradually over the years, the immune system weakens due to the increased viral load and the decrease in CD4 cells. The HIV-infection also progresses into the symptomatic stage. The HIV-infected individual does not yet suffer from opportunistic infections, but can have general symptoms or skin infections (Aho-Hiltunen-Back 2007; Rintala 2007, 9).

The final stage of the HIV infection is Acquired Immune Deficiency Syndrome (AIDS). During this phase, the immune system is badly damaged and the person becomes vulnerable to opportunistic infections. (Leinikki 2009.) AIDS is not defined by the CD4 count but by the presence of at least one of the 28 opportunistic infections or illnesses (Rintala 2007, 10) as presented in table 1. AIDS typically leads to death within three years (Leinikki 2009).

Common complications of HIV include diabetes, hyperlipidemia, pancreatitis, lactic acidosis, and poor distribution of amino acids. The most common negative side effects of HIV include depression, muscle aches, weakness and painful joints, headache, rash, insomnia, shortness of breath, and for women, vaginal itching. (Bradley-Springer et al. 2010, 37.)

Patients must attempt to maintain their health as much as possible once HIV-infected. In order to work to slow the disease's advancement, patients must rigorously adhere to their HIV medication, the medication for comorbid conditions, monitor their symptoms, maintain healthy eating habits and excellent hygiene, be as physically active as possible, and prevent transmission. Smoking cessation is also extremely important. (Webel & Higgins 2012, 27; HIV-potilaan ohje 2013, 4).

TABLE 1. Stages and symptoms of HIV and AIDS (Syrjänen & Ristola 2005; Aho-Hiltunen Back 2007; Leinikki 2009; Rintala 2009; Hannuksela 2013; National Institute for Health and Welfare 2013c; Syrjänen 2013, modified)

stage	acute stage / primary HIV infection	asymptomatic stage	symptomatic stage	AIDS
duration	1 to 8 weeks after the initial infection, the symptoms last 1 to 4 weeks	2-15 years, average 10 years	1,5-2 years	typically leads to death within 1,5-3 years
symptoms	-no symptoms or -fever -headache -pharyngitis -swollen lymph nodes -rash -diarrhea -pain in the joints -sore mouth ulcers	-no symptoms or -swollen lymph nodes -bacterial skin infections	-fever -prolonged diarrhea -weight loss -fatigue -night sweats -herpes zoster -oral candidiasis -anemia -leukocytopenia -thrombocytopenia	Diagnosis is made when at least one of the following is present: -Pneumocystis carinii pneumonia -Candidiasis of bronchi, esophagus, trachea or lungs -Herpes simplex infection (chronic ulcers lasting more than a month or bronchitis, pneumonitis or esophagitis) -Cytomegalovirus retinitis -Cytomegalovirus disease outside of the liver, spleen or lymph nodes -Mycobacterium tuberculosis in or outside the lungs -Mycobacterium avium complex or infection caused by mycobacterium kansasii -Other species of mycobacterium that has spread -Salmonella septicemia that is recurrent -Toxoplasmosis of the brain -Pneumonia that is recurrent -Progressive multifocal leukoencephalopathy -Cryptococcosis, outside the lungs -Cryptosporidiosis, in the intestines and lasting more than a month -Coccidioidomycosis that has spread -Histoplasmosis that has spread -Isosporiasis, in the intestines and lasting more than a month -Multiple myeloma or bacterial infection, that is recurrent and on under 13 years olds -Kaposi's sarcoma -Lymphoma that is primary and affects the brain -Immunoblastic lymphoma -Burkitt's lymphoma -Encephalopathy that is HIV-related -Cervical cancer that is invasive -Lymfoid Interstitial pneumonia, on under 13 years olds -Wasting syndrome caused by HIV infection

3.2 HIV medication

There are a variety of medications that are prescribed at different stages of HIV infection, and each works in different ways (Bradley-Springer et al. 2010, 38). As noted, the medication used to treat HIV is known as “Highly Active Antiretroviral Therapy (HAART). It is a combination of at least three different active antiretroviral (ART) medicines which stop the HI-virus from multiplying. In so doing, the CD4 count is increased. HAART does not cure HIV, however, it is the best way to treat the infection when carried out accurately. With the HAART medication, one’s quality of life and life expectancy improve. (Bradley-Springer et al. 2010, 34; HIV-potilaan ohje 2013, 5.)

A patient’s unique characteristics are taken into account when considering the specific HIV treatment regimen. HAART is not always begun immediately following HIV diagnosis. The initiation of HAART is discussed with the patient when the CD4 count is $0,35 \times 10^9/l$. HAART is started when the HIV-infected patient experiences HIV-related symptoms, or when the CD4 count is no more than $0,20 \times 10^9/l$. The patient’s viral count, other medical problems, rapidity of the HIV progression, and the patient’s age are all factors that are taken into consideration (Arvo 2013, HIV-potilaan ohje 2013, 5). It is important to note that HAART also decreases the possible transmission of the HI-virus from mother to child (Bradley-Springer et al. 2010, 34; HIV-potilaan ohje 2013, 6). It is essential that care providers thoroughly discuss HAART with the patient prior to beginning the intervention, as well as help motivate the patient to adhere to his or her treatment protocol (Arvo 2013).

As is the case with medication generally, each medication may affect and interact with other medical and herbal products. Negative side-effects are also possible (Bradley-Springer et al. 2010, 38; HIV-potilaan ohje 2013, 5) ranging from mild to severe and further to life-threatening. The effects that are considered only “mild” include feelings of nausea, fatigue, headache, peripheral neuropathy, diarrhea, vomiting, asthenia, and rash. (Bradley-Springer et al. 2010, 38.) These adverse effects can severely affect a person’s ability to function in the community, one’s motivation to care for oneself, as well as strain one’s family relations. These effects often improve with good continuity of care and effective clinical management of the disease. (MacNeil 2002, 256; Bradley-Springer et al. 2010, 38.) Therefore, the effects, including the side-effects of HAART, and state of the HIV-infection are controlled by blood tests which are taken every two to

three months, or according to the patient's individual needs. The patients who are on HAART should maintain a viral load below 50 copies/ml of plasma, meaning it is not measurable. (Syrjälä & Ristola 2005, 4984.) In addition to the routine bloodwork, additional routine control visits at the infection polyclinic are needed. (Syrjänen & Ristola 2005, 4982.)

3.3 Adherence to HIV medication and treatment plans

The United States National Institute of Health (NIH) asserts that HIV-infected patient adherence to HIV medication involves taking the accurate dosage of medication every day, at the proper time, and only as prescribed. Adherence helps decrease the amount of HI-virus in the individual's body. It also helps prevent drug resistance in the patient's body. The NIH emphasizes that adherence from the beginning of treatment is paramount to effective treatment over the long term. (Panel on Antiretroviral Guidelines for Adults and Adolescents 2012.)

The NIH notes that common barriers to effective medication adherence include, but are not limited to, difficulty swallowing, having to take multiple pills a day at different times, side effects such as nausea and diarrhea, illness, depression, alcohol or drug use, and work or travel schedules. If the HIV-infected individual's mental and physical condition improves, it is not unusual for patients to become less compliant with their medication adherence. The NIH also notes that patient support and counseling to help manage depression, alcohol abuse and stigma related to HIV also enhances medication adherence. (Panel on Antiretroviral Guidelines for Adults and Adolescents 2012.)

According to Bradley-Springer et al. (2010), patients must strictly stick to their HAART regimen. If they fail to do so, they run a significant risk that their bodies will develop resistance to the HAART medications (Bradley-Springer et al. 2010, 37). This can of course be dire. Due to this critical fact, every effort to maintain patient medication adherence are of utmost importance.

3.4 HIV care in Finland

According to Finland's Criminal Code (39/1889), chapter 21 "Homicide and bodily injury (578/1995)", HIV-infected individuals have responsibilities. If an HIV-infected individual is cognizant of their HIV-positive status and is practicing unprotected sex without informing about the HIV-infection, the individual can be charged. The person can also be charged criminally if they are performing other activities which can spread the HI-virus, such as sharing used injection needles. (Criminal Code of Finland 39/1889; HIV-potilaan ohje 2013, 3.)

Finland's Ministry of Social Affairs and Health Act on the Status and Rights of Patients (785/1992) states that all patients have the right to good quality healthcare and medical care. All HIV-infected individuals residing in Finland have a right to quality nursing care in Finland as well as access to free HIV-related health care and treatment. These include taking into account the patient's mother tongue, individual needs and culture when considering and carrying out the patient's care and treatment (Act on the Status and Rights of Patients 785/1992). However, the Finnish State acknowledges that it is struggling to provide the same level of care to all HIV-infected patients living in Finland regardless of immigrant or refugee status (Finnish National Institute for Health and Welfare 2012b).

According to the National Institute of Health and Welfare, Finnish hospitals offer specialized medical care for HIV-infected patients on outpatient infectious disease clinics of regional or university hospitals. The country's municipal health services handle the diagnosis and primary care for HIV-infected individuals, including ongoing education, counseling, and examinations. (Syrjänen & Ristola 2005, 4982; European Center for Disease Prevention and Control 2012, 2, 11.)

Additionally, the Finnish AIDS Council, run by the Finnish HIV Foundation, is dedicated to HIV/AIDS prevention, training, and advocacy work. There is one organization in Finland that focuses exclusively on providing support for HIV-infected individuals: Positiiviset Ry/HivFinland. The organization's mission is to support the well-being of HIV-infected individuals and their families, and help people infected with HIV to improve their quality of life (European Center for Disease Prevention and Control 2012, 2).

Under the Communicable Diseases Decree (583/1986), it is stipulated that the HIV infection is a notifiable communicable disease. The physician shall make a communicable disease notification B to The National Institute for Health and Welfare. The notification needs to be made for all new HIV cases, as well as when the disease progresses into AIDS, and also when the person dies. The notification shall be made within seven days of the diagnosis. (Communicable Diseases Decree 583/1986.)

3.5 HIV/AIDS education

Education about HIV and how to cope with the disease varies dramatically, especially in countries where many people have little or no access to formal education or adequate health care (WHO 2013c). Therefore, it is safe to assume that the less formal sex education a community has received, the less information they are likely to have about HIV. As noted by Tung Hu, Efir, Yu and Su (2012) in their study of college students in China, the lack of sex education in schools or clinics is likely to result in poor awareness about HIV and AIDS. This lack of knowledge in turn increases the risk of HIV infection (Tung et al. 2012, 607). This important reminder tells us that if nurses are going to be able to provide the best possible care to their HIV-infected patients, they need to meet their patients with an open mind. In order to explore the patient's understanding of the disease, nurses need to first approach their patient in such a way that they do not make assumptions about how they understand the disease in relation to themselves (Hossein-zadeh, Hossain and Niknami 2012, 124).

In the Limpopo province of South Africa, an extensive research project identified that although there had been a "massive awareness campaign by the government and non-governmental organizations and the inclusion of information on HIV and AIDS in the schools curricula in South Africa" (Melaw & Oduntan 2012, 193), there was still a general lack of knowledge on the basics of HIV/AIDS (Melaw & Oduntan 2012, 193). In other words, some amount of awareness and exposure to education about the disease do not necessarily mean that individuals understand HIV, let alone how to begin to manage it in their own lives.

3.6 Stigma

According to the Oxford Dictionary, stigma is defined as “a mark of disgrace associated with a particular circumstance, quality, or person” (Oxford Dictionaries 2013). As noted, stigma, and therefore shame, are not uncommon experiences faced by HIV-infected patients (Clarke 2009, 25). With regard to women, special attention should be paid to the need for patient empowerment around the illness as a result of the sense of shame associated with the disease. As noted by MacNeil (2002, 255-256), young women especially have been found to respond more positively to treatment when nursing attitudes toward them do not humiliate them but rather respect and honor them and their privacy.

In another recent study on HIV education, the stigma around HIV/AIDS is found to be a significant barrier to prevention and care awareness. As reported from Iranian communities living in Sydney, Australia, the respondents said they would avoid patronizing the local market whose owner had AIDS. Additionally, the respondents reported that they would avoid having their children attend school with children who had been diagnosed with AIDS. (Hosseinzadeh et al. 2012, 120.)

The researchers of this study found that among people with lower income and less education, more stigmatized attitudes about HIV and AIDS prevailed. For nurses, this is an important reminder of not only the importance of educating their patients about the disease, but perhaps more importantly that their patients may have attitudes that challenge their ability to internalize and apply the care they are trying to provide (Hosseinzadeh et al. 2012, 124).

As the abovementioned study reveals, there are many and varying attitudes and degrees of education around HIV all over the world. These beliefs and diversity of information illuminate how important it is that nurses have at least a basic awareness of the fact that patients have varying degrees of understanding about the disease. Patients also present a huge range of attitudes about HIV (Flowers 2004, 52; Hosseinzadeh et al 2012, 24). As a starting point, it is therefore essential that nurses are proactive about having a receptive attitude toward patients. Nurses need to adapt their communication styles so that they can more effectively interact with patients of a wide variety of cultures and backgrounds, and therefore provide improved nursing care. (Flowers 2004, 52.)

3.7 Patient experience

Patient experience is the “sum of all interactions, shaped by an organization’s culture, that influence patient perceptions across the continuum of care” (National Health Service 2012). This includes all the ways in which patients interface with health professionals (National Health Service 2012). As the World Health Organization asserts, patients are the only ones actually living with their disease. Medical professionals, although they have expert knowledge on the disease, are not experiencing it personally (Bleich, Özaltın & Murray 2009). The WHO emphasizes that the patients’ “autonomy, choice, communication, confidentiality, dignity, prompt attention, quality of basic amenities and support” are of central importance to their experience (WHO 2013). Bleich et al. (2009) also highlight the importance of family and community support networks to the quality of patient experience.

The United Kingdom’s National Health Service (NHS) asserts that it is essential to understand that patient experience is as critical as patient safety and clinical expertise (Youngson 2008). According to NHS research, the key factors influencing patients’ improved experience include, but are not limited to, 1) patients feeling informed and being given options; 2) a staff who listen and spend time with the patient; 3) being treated as a person, not a number; patients’ involvement in their care and being able to ask questions; 4) value of support services (such as support groups); and 5) efficient processes that provide the patient with a sense of continuity of care (Robert & Cornwell 2011). The NHS found that central to patient experience is the quality of the relationships between staff and patients. According to the NHS, empathy, dignity and emotional support are not less important to patients than concerns such as food, noise, access, and clinic waiting time (Youngson 2008).

The above findings are consistent with Hekkink et al.’s research (2003, 190) with HIV-infected patients. Their findings indicate that it is of significant importance to HIV-infected patients that they are taken seriously by their providers, that their providers have special knowledge about HIV, that they not have to wait for extended periods of time for their appointments, and that they are given the time they need with their provider. Hekkink et al. (2003, 192) also found that it was of particular importance to HIV-infected patients that they be informed about the possible side effects of medications,

how to use the medications, the pros and cons of specific treatments, and that they be provided care consistently by the same medical personnel.

3.8 Culture

Culture is more than race, ethnicity, gender, and sexual orientation. It includes thoughts, language, customs, behaviors, life roles, family structures, and institutions. (Kodjo 2009, 57; Richter et al. 2009; Hayward & Charrette 2012, 79; Long 2012, 103.) Leininger (2006) defines culture as “learned, shared, and transmitted values, beliefs, norms, and lifeways of a specific culture that guides thinking, decisions, actions, and patterned ways of living” (Leininger 2006, 13). Culture is an important factor that influences every level of the nursing process (Mahoney, Carlson & Engebretson 2006; Kodjo 2009; Berlin, Nilsson & Törnkvist 2010; Flowers 2012; Long 2012).

There are myriad ways in which culture influences how patients interact with nursing care (Flowers 2004, 49). Some of the key elements include education, patient help-seeking behavior and motivation, presentations of illnesses, coping styles, social stigma, trust and mistrust of the healthcare system, definitions of illness, health beliefs and practices, community/family support, how emotions are expressed, interpretation of symptoms, and last but not least, how pain is manifested (Mahoney et al. 2006, 228; Flowers 2004, 49).

3.9 Cultural competence

Cultural competence is a special skill and a nursing skill that respects human dignity and values diversity (Wellman 2009). It is a core nursing competency founded in empathy and curiosity. (Mahoney et al. 2006; Kodjo 2009, 58; Carey 2011; Flowers 2004, 48; Long 2012;). According to O’Hagan (2001), it is not that nurses need to be highly knowledgeable about diverse cultures, “but must approach culturally different people with openness and respect” (Papadopoulos, Tilki & Lees 2004). Although this may take nurses far outside their comfort zone, part of this openness is being willing to ask patients questions and truly engage with them (Kodjo 2009, 58).

Becoming culturally competent is always a process, not an endpoint, which involves engaging in self-reflection as a nurse in order to become more self-aware about one's attitudes and behaviors (Mahoney et al. 2006; Kodjo 2009, 58; Adamson, Warfa & Bhui 2011; Hayward & Charrette 2012). According to Campinha-Bacote (2002, 182-183) cultural competence includes five components which are defined in table 2.

TABLE 2. Components of cultural competence (Campinha-Bacote 2002, 182-183, modified)

Cultural Awareness: Thoughtful reflection on one's own professional and cultural reference points; the awareness of personal opinions and understandings in relation to client populations.

Cultural Knowledge: The process of developing knowledge about a variety of cultural and ethnic communities, as well as tolerating clients' world views, which help explain how clients understand their own health conditions, and how their cultural identity influences how they are, and how they think, act, and react.

Cultural Skill: The tools to gather significant cultural information about clients' concerns and to be able to carry out culturally specific appraisals; includes how to do cultural evaluations and physical appraisals that are culturally framed.

Cultural Encounter: The process that galvanizes nurses to participate actively in cross-cultural situations with clients from different cultures; directly engaging with these clients allows nurses to improve and reframe their notions about different cultural groups and help them avoid making assumptions about people from different cultural backgrounds.

Cultural Desire: The enthusiasm to develop cultural awareness, increase knowledge, become more adept at and be open to diverse cultural interactions, instead of participating in such situations only out of obligation; involves a sincere eagerness to be receptive to others, welcome and appreciate difference, and be open to what others with different cultural expertise have to share.

When providing culturally competent nursing care, nurses must recognize that the patient's family may play a central role in the patient's relationship with his/her illness, his/her response to nursing care, and many other aspects of his/her care. It is in nurses' best interest to expose themselves to cross-cultural experiences and relationships, have the motivation and desire to engage in the process of becoming aware, skillful and willing to deepen and expand their engagement with diverse cultures (Campinha-Bacote 2002; Kodjo 2009, 57; Adamson et al. 2011; Hayward & Charrette 2012).

Part of the process of becoming more culturally competent involves deepening one's understanding of cultural differences, cultural dynamics and social contexts in society. (Mahoney et al. 2006; Kodjo 2009, 58; Adamson et al. 2011; Flowers 2004, 52; Hayward & Charrette 2012.) This includes an expansion and improvement of one's cultural knowledge, sensitivity, and cultural awareness (Campinha-Bacote 2002; Kodjo 2009, 59; Suominen et al. 2010; Adamson et al. 2011; Flowers 2004, 52; Hayward & Charrette 2012; Long 2012).

One of the key dimensions of becoming more culturally competent is engaging in a process of self-reflection as a nurse (Mahoney et al. 2006; Campinha-Bacote 2002; Kodjo 2009, 58; Adamson et al. 2011; Long 2012). As nurses become more self-reflective in their approach to nursing, they are able to begin to change their attitudes about cultural difference, including their ability to avoid stereotyping cultural groups. This is a fundamental step in nurses' ability to begin to reach their patients with more cultural competence (Mahoney et al. 2006; Suominen et al. 2010; Adamson et al. 2011; Hayward & Charrette 2012).

In addition, health care institutions have a critical role to play in helping nurses become increasingly culturally competent. Standards, policies, practices, and the general adaptation of health care services need to be reconfigured to reflect the needs of the culturally diverse populations they serve (Campinha-Bacote 2002; Adamson et al. 2011). Recruitment policies that require more rigorous efforts to employ diverse staff from the communities served is another way in which health care institutions can become more culturally competent (Adamson et al. 2011).

Nurse visits to patient homes are one important way in which health care provision can become more culturally competent (Richter et al. 2009). Nurses can that way not only get a glimpse into patients' lives but also perhaps connect more thoughtfully with patients. Education and training to become more culturally competent are also critical ways in which nurses can improve their care of their culturally diverse patients (Adamson et al. 2011; Carey 2011, Long 2012).

The concept of a "Nursing Learning Community" is one of the more promising and innovative ways in which nurses can continually work to become more culturally competent. Nurses can gather around a shared learning goal and discussing nursing issues re-

lated to that goal. Nurses can therefore readily learn about specific topics of interest and share their experiences of working with culturally diverse patients. (Hayward & Charrette 2012, 85.)

Research shows that providing culturally competent nursing care optimizes patient recovery (Adamson et al. 2011; Flowers 2012; Hayward & Charrette 2012), improves the quality of care throughout the care process (Mahoney et al. 2006; Adamson et al. 2011; Flowers 2012; Hayward & Charrette 2012; Long 2012), helps patients manage their disease more effectively (Hayward & Charrette 2012), and improves health care providers' ability to respond to the range of needs in the communities they serve (Adamson et al. 2011).

3.10 Culturally competent nursing care for HIV-infected patients

It is in nurses' best interest to meet their patients with an open mind. Ideally, nurses would be willing to, and prepared to, learn something about their patients' understanding of and attitude toward HIV. Subsequently, nurses can better begin to bridge the gap and potentially provide care that helps their patients manage their disease effectively (National Minority Aids Council 2003; Flowers 2004, 49).

As noted by MacNeil (2002, 254), a country's sociopolitical atmosphere, as well as one's immediate community and work environment, all significantly impact on the care and support HIV-infected individuals and their families receive. Not only is cultural diversity a relatively new phenomenon in Finland, but the nation also continues to struggle with a significant stigma against HIV (Clarke 2009, 25). This adds up to a potentially double stigma for culturally diverse HIV-infected individuals and their families when meeting the health care system.

Research shows that in Finland some healthcare providers continue to stigmatize HIV-infected patients (Clarke 2009, 25). This can lead to, among other things, patients being treated disrespectfully by healthcare providers, not providing needed health care services, providing poor care, betraying patient privacy, and generally avoiding HIV-infected patients (Chen et al. 2010, 262). Due to nurses' roles as primary caregivers, it is

of utmost importance that nurses are well-trained in helping HIV-infected patients and their families know how to manage the disease.

In addition to living in a culture that is not one's own, living with HIV carries with it anxieties and uncertainties of its own. These include, but are not limited to, how one is accepted by one's family and friends, how stigmatization affects one's daily life and social roles, how one will be able to be a productive member of society, the physical aspects of the HIV infection, as well as how to carry on the basics of daily life. (MacNeil 2002, 256; Webel & Higgins 2012, 27.) As the disease progresses all of these dynamics also change in unpredictable ways. (MacNeil 2002, 256.)

Finland has a steadily growing population of individuals and families from outside Finland, and outside Europe (Clarke 2009, 25; Ministry of the Interior 2013). These changing demographics must be recognized as relevant in the nursing setting due to the fact that culture is an important factor influencing every level of nursing process (Mahoney et al. 2006; Kodjo 2009; Berlin et al. 2010; Flowers 2012; Long 2012). A review of the relevant literature illuminates that patient adherence to treatment protocol improves when the nurse respects and works with the patients' distinct cultural needs in relation to their disease (Mahoney et al. 2006).

4 METHODOLOGY

4.1 Literature review

As defined by Polit and Beck (2010), a literature review summarizes a specific topic using a critical lens. As was the case with this thesis, the literature review was carried out so as to contextualize the research topic, synthesize the selected evidence-based material, and provide a thorough analysis of the peer-reviewed articles (Polit & Beck 2010, 558). The purpose of identifying, selecting and analyzing peer-reviewed literature is to increase the understanding of certain aspects of a topic (Parahoo 2006, 127). In order to write a literature review, previous research about the topic needs to exist (Johansson, Axelin, Stolt & Ääri 2007, 2).

According to Salminen (2011), a literature review is divided into three basic types. These include a traditional literature review, systematic literature review, and meta-analysis. A traditional literature review is among the most used, and it is divided into two subtypes: narrative review and integrative literature review. (Salminen 2011, 6-8.) This thesis employed a traditional narrative literature review. A systematic approach was used in the data collection.

The phases of this literature review included the research plan, in which the research questions were formed, and which guided the research process. This was followed by a literature search that located and identified the most relevant and current material (Parahoo 2006, 127), selecting the studies for review, completing a critical reading of the selected literature, carrying out an analysis of the selected literature, and finally, drawing general conclusions about the topic (Parahoo 2006, 127, 133; Johansson et al. 2007, 47).

4.2 Literature search

Parahoo (2006, 126) emphasizes that researchers must look for information which is up-to-date, relevant and credible, meaning that information should be found in academic journals and books, research reports, and theses. The data for this thesis were collected from such sources. The peer-reviewed articles were gathered systematically so that the research would have credible sources, be replicable, and be reliable.

The data were gathered from several sources. For nursing research, the most useful electronic bibliographic databases are CINAHL (Cumulative Index to Nursing and Allied Health) offered through EBSCOhost, and MEDLINE (Medical Literature On-Line) offered through PubMed (Polit & Beck 2012, 100-101). For articles published in Finland, the Finnish health science electronic database, Medic, was used. An additional ancestry approach, which allows for the use of earlier studies cited in the article reference lists, was also used (Polit & Beck 2012, 98).

In the data collection, the Boolean operator “AND” to receive articles which have both search terms was used. “OR” was employed to obtain articles which have either of the terms, and “NOT” was used to exclude certain terms in the search. For word combinations, quotation marks were used. In addition, the truncation symbol “*” was used in order to expand the search to include all the terms which contained the root word. (Polit & Beck 2012, 99-100.)

The combinations of terms, such as: HIV, care, nursing, patient, race, stigma, self-management, antiretroviral therapy, multicultural, cultural competence, and culturally competent care were used in the present study. Initially, the word “AIDS” was used as a search word. However, due to many resulting hits that focused only on AIDS, and the fact that the focus of the thesis was on HIV, AIDS was ultimately excluded from the search words.

The inclusion criteria for the articles was that they be written in English, published between 2002-2012, and peer-reviewed. The focus of the selected articles was on HIV nursing care. The articles which were not available in free full text, or concentrated on issues not specifically relevant to the thesis, such as prevention, were excluded. Due to the fact that Kankkunen and Vehviläinen-Julkunen emphasize that the selected literature

should be relevant to Finnish nursing practices, this thesis attempted to honor that theory in its use of material (Kankkunen & Vehviläinen-Julkunen 2010, 196).

The search was conducted in the Finnish health science electronic database Medic. In Medic, it is only possible to use three search words at a time. The research process is shown in table 3. When the criteria were “hiv OR aids AND nursing”, years 2002-2012, English language, and full text, 18 hits were found. However, after implementing the exclusion criteria of peer-reviewed articles, no suitable articles were found. Fifteen of the hits were doctoral theses, one was a Master’s thesis and two were National Public Health Institute publications. The search “culturally competent nursing care OR multicultural care AND hiv” produced three hits, two of which were doctoral theses and one of which was a Master’s thesis. One of the doctoral theses, Mockiene’s “The impact of an education intervention on nurses’ knowledge of and attitudes towards HIV and willingness to take care of HIV-positive people in Lithuania” produced one hand-picked suitable article for the thesis. The research found was recent (2010) and had been carried out in Finland and the Baltic States. Overall, the Medic search produced one hand-picked article by Suominen et al. (2010).

TABLE 3. Medic searches

Searches	Hits
hiv OR aids	811
hiv	643
hiv OR aids AND nursing	651
limit hiv OR aids AND nursing to year 2002-2012 and English language	31
limit hiv OR aids AND nursing to year 2002-2012, English language and full text	18
care OR nursing OR “nursing practice”	14 324
“culturally competent nursing care” OR “multicultural care” OR “transcultural nursing”	69
limit “culturally competent nursing care” OR “multicultural care” OR “transcultural nursing” to year 2002-2012, English language and full text	242
“cultural competen*” OR transcultur* OR “multicultural patient”	71
"culturally competent nursing care" OR multicultural care AND hiv	3

The search on MEDLINE was initially conducted widely (table 4). Subsequently, limitations (human subjects, year 2002-2012, English language, free full text, and adult) were added to narrow the results. These limitations were used in all of the searches. Due to the fact that the nursing journal database allows for some limitations, this aided the initial search (Polit & Beck 2012, 100). The Boolean operator with term prevention was also used in some of the searches.

The first search with the term “HIV” produced 249,662 hits. When the limitation to humans was added, the hits only dropped to 221,532. Once the limitation to the years 2002-2012 was added, as well as English language text, free full text, and adults over 19 years of age, the search produced 16,081 hits. Then the limitation of nursing journals was added. This produced 127 hits. When the Boolean operator added “NOT prevention”, the hits dropped to 80. The article topics were reviewed, and the articles which were not relevant to this thesis (including but not excluding age, maternal issues, comorbid conditions such as tuberculosis, HIV testing, sexual orientation, substance abuse, rural setting, or peer support) were excluded. For the articles which explored this thesis’ area of interest (Polit & Beck 2012, 104) the abstracts were read. From those, four suitable articles were selected for this study.

Additional searches using the terms “hiv AND care AND patient”, “hiv AND care AND race”, “hiv AND care AND stigma”, “hiv AND self-management”, “antiretroviral therapy AND care”, “antiretroviral therapy AND nursing”, and “hiv AND cultural competence OR cultural competent care” were carried out. These searches produced three more articles. Overall, the searches on MEDLINE produced seven articles.

TABLE 4. MEDLINE by PubMed searches

Searches	Hits
hiv	249 662
limit hiv to humans	221 532
limit hiv to humans, year 2002-2012, English language, free full text and adult	16 081
limit hiv to humans, year 2002-2012, English language, free full text, adult and nursing journals	127
limit hiv NOT prevention to humans, year 2002-2012, English language, free full text, adult and nursing journals	80
hiv AND care AND patient	21 367
limit hiv AND care AND patient to humans, year 2002-2012, English language, free full text and adult	2 182
limit hiv AND care AND patient to humans, year 2002-2012, English language, free full text, adult and nursing journals	44
limit hiv AND care AND patient NOT prevention to humans, year 2002-2012, English language, free full text, adult and nursing journals	34
hiv AND race	5916
limit hiv AND race to humans, year 2002-2012, English language, free full text and adult	1024
limit hiv AND race to humans, year 2002-2012, English language, free full text, adult and nursing journals	15
hiv AND race AND care	1640
limit hiv AND race AND care to humans, year 2002-2012, English language, free full text and adult	295
limit hiv AND race AND care to humans, year 2002-2012, English language, free full text, adult and nursing journals	10
hiv AND care AND stigma	1135
limit hiv AND care AND stigma to humans, year 2002-2012, English language, free full text and adult	197
hiv AND self-management	3755
limit hiv AND self-management to humans, year 2002-2012, English language, free full text and adult	555
limit hiv AND self-management to humans, year 2002-2012, English language, free full text, adult and nursing journals	26
antiretroviral therapy AND care	7019
limit antiretroviral therapy AND care to humans, year 2002-2012, English language, free full text and adult	1109

limit antiretroviral therapy AND care to humans, year 2002-2012, English language, free full text, adult and nursing journals	14
antiretroviral therapy AND nursing	748
limit antiretroviral therapy AND nursing to humans, year 2002-2012, English language, free full text and adult	83
limit antiretroviral therapy AND nursing to humans, year 2002-2012, English language, free full text, adult and nursing journals	9
hiv AND cultural competence OR hiv AND culturally competent care	62
limit hiv AND cultural competence OR hiv AND culturally competent care to humans, year 2002-2012, English language, free full text and adult	18

The CINAHL search was conducted similarly to the MEDLINE search. CINAHL allows limitation to peer-reviewed articles, and this guided our search. The search on CINAHL was initially conducted widely (table 5). Subsequently, the limitations (human subjects, year 2002-2012, English language, full text, peer reviewed, and adult) were added to narrow the results. The search was conducted using terms “hiv”, “hiv AND care AND patient”, “hiv AND care AND race”, “hiv AND care AND stigma”, “hiv AND self-management”, “antiretroviral therapy AND care”, “antiretroviral therapy AND nursing”, and “hiv AND cultural* competen*”. The limitation to nursing journals and Boolean operator NOT was partly used in the search.

Once again, the article topics were reviewed and the articles which were not relevant to this thesis (including but not excluding age, maternal issues, mental illness, music or drawing therapy, alternative medicine, comorbid conditions such as tuberculosis, HIV testing, sexual orientation, high risk behavior, life habits such as substance abuse, smoking or alcohol use, rural setting, peer support and family caregivers) were excluded. For the articles which explored this thesis’ area of interest, the abstracts were read (Polit & Beck 2012, 104). From those, four suitable articles were selected for this study. However, all of the articles had already been found in the previous searches.

TABLE 5. CINAHL by EBSCOhost searches

Searches	Hits
hiv	48 170
limit hiv to humans	19 042
limit hiv to humans, year 2002-2012, English language, peer reviewed, free full text and adult	3 436
limit hiv to humans, year 2002-2012, English language, peer reviewed, free full text, adult and nursing journals	319
limit hiv NOT prevention to humans, year 2002-2012, English language, peer reviewed, free full text, adult and nursing journals	219
hiv AND care AND patient	2 713
limit hiv AND care AND patient to humans, year 2002-2012, English language, peer reviewed, free full text and adult	368
limit hiv AND care AND patient to humans, year 2002-2012, English language, peer reviewed, free full text, adult and nursing journals	43
limit hiv AND care NOT prevention to humans, year 2002-2012, English language, peer reviewed, free full text, adult and nursing journals	99
hiv AND race	1152
limit hiv AND race to humans, year 2002-2012, English language, peer reviewed, free full text and adult	233
limit hiv AND race to humans, year 2002-2012, English language, peer reviewed, free full text, adult and nursing journals	11
hiv AND race AND care	370
limit hiv AND race AND care to humans, year 2002-2012, English language, peer reviewed, free full text and adult	94
limit hiv AND race AND care to humans, year 2002-2012, English language, peer reviewed, free full text, adult and nursing journals	5
hiv AND stigma AND care	593
limit hiv AND stigma AND care to humans, year 2002-2012, English language, peer reviewed, free full text and adult	197
hiv AND self-management	59
limit hiv AND self-management to humans, year 2002-2012, English language, peer reviewed, free full text and adult	22
limit hiv AND self-management to humans, year 2002-2012, English language, peer reviewed, free full text, adult and nursing journals	4
antiretroviral therapy AND care	1033
limit antiretroviral therapy AND care to humans, year 2002-2012, English language, peer reviewed, free full text and adult	237

limit antiretroviral therapy AND care to humans, year 2002-2012, English language, peer reviewed, free full text, adult and nursing journals	14
antiretroviral therapy AND nursing	134
limit antiretroviral therapy AND nursing to humans, year 2002-2012, English language, peer reviewed, free full text and adult	14
limit antiretroviral therapy AND nursing to humans, year 2002-2012, English language, peer reviewed, free full text, adult and nursing journals	7
hiv AND cultural* competen*	173
limit cultural* competen* AND hiv to humans, year 2002-2012, English language, peer reviewed, free full text and adult	13

The eight selected peer-reviewed articles that adhered to the inclusion and exclusion criteria to be analyzed in the literature review are presented in Table 6:

TABLE 6. Selected literature for the review

<ol style="list-style-type: none"> 1. Chen, W-T., . Shiu, C-S., Simoni, J., Fredriksen-Goldsen, K., Zhang, F. & Zhao, H. 2010. Optimizing HIV Care by Expanding the Nursing Role: Patient and Provider Perspectives. 2. Erlen, J.A., Cha, E.S., Kim, K.H., Caruthers, D. & Sereika, S.M. 2010. The HIV Medication Taking Self-efficacy Scale: Psychometric Evaluation. 3. Fazeli, P.L., Marceaux, J.C., Vance, D.E., Slater, L. & Long, C.A. 2011. Predictors of Cognition in Adults with HIV: Implications for Nursing Practice and Research. 4. Leeman, J., Chang, Y.K., Lee, E.J., Voils, C.I., Crandell, J. & Sandelowski, M. 2010. Implementation of Antiretroviral Therapy Adherence Interventions: a Realist Synthesis of Evidence. 5. Lin, S.X. & Larson, E. 2005. Does Provision of Health Counseling Differ by Patient Race? 6. Suominen, T., Koponen, N., Mockiene, V., Raid, U., Istomina, N., Vänskä, M-L., Blek-Vehkaluoto, M. & Välimäki, M. 2010. Nurses' Knowledge and Attitudes to HIV/AIDS - An International Comparison Between Finland, Estonia and Lithuania. 7. Uys, L., Chirwa, M., Kohi, T., Greeff, M., Naidoo, J., Makoae, L., Dlamini, P., Durrheim, K., Cuca, Y. & Holzemer, W.L. 2009. Evaluation of a Health Setting-Based Stigma Intervention in Five African Countries. 8. Webel, A.R. & Higgins, P.A. 2012. The Relationship Between Social Roles and Self-management Behavior in Women Living with HIV/AIDS.

4.3 Data analysis

A qualitative content analysis method was used for the information gleaned from the chosen articles to help guide the recommendations. Qualitative content analysis is a research method that systematically and objectively describes phenomena. The method answered the research questions, deepened the understanding of the data found, and ultimately successfully provided new information, evidence-based methods, practical tools and relevant resources for nurses working with culturally diverse HIV-infected patients (Elo & Kyngäs 2008).

The purpose of the literature review was to present a thorough analysis of peer-reviewed articles on HIV nursing care. The articles for this thesis were thoughtfully analyzed, debated and discussed. This allowed for an in-depth investigation of the research topic (Parahoo 2006, 126) that was then reported in a narrative style that is practical, applicable and easy to read. As a result the working partner received the most optimal and current recommendations on culturally competent nursing care of HIV-infected patients. These recommendations are based in a review of articles which include rigorous studies conducted in order to determine what are the best practices for nursing HIV-infected patients.

Peer-reviewed articles that provide research and analysis on the subject of culturally competent care of HIV-infected patients were used. To illuminate the background of the study, a variety of other materials, such as statistics, governmental reports and reports from organizations that work with (culturally diverse HIV-infected patients were also used. A matrix of the literature in the review was created (see Appendix 1). The selected peer-reviewed literature was synthesized by presenting a discussion of the diverse information included in the articles. In the analysis of the chosen articles, common themes presented themselves.

5 FINDINGS

The objective of the thesis was to provide nurses with relevant recommendations of culturally competent best practices. The aim of the thesis was to provide the rationale for culturally competent nursing care of culturally diverse HIV-infected patients so that nurses would be more likely to employ these recommendations to more effectively nurse their HIV-infected patients. This thesis presents its findings according to, and in order of, the three research questions explored.

5.1 How can nurses provide HIV nursing care best practices?

This thesis' findings unanimously revealed that nurses have a central and crucial role to play in HIV-infected patients' abilities to manage their disease. This study found that if nurses are able to openly and comfortably discuss all aspects of the patient's illness and how it affects their life and their family's life, it is much more likely that nurses will be able to help patients cope more effectively with the illness. Nurses can then help patients better adhere to their medications, manage changes in their disease, manage new symptoms, and alter their behavior and attitude so that they are able to function more effectively (and with less shame) with the illness. Patients can therefore also increase their knowledge about the disease and about how to best care for themselves and their family (Webel & Higgins 2012, 27-28).

First and foremost, nurses can take a step forward when they recognize that their culturally diverse HIV-infected patients may have different nursing care needs and expectations in relation to their disease than what the nurses expect. Nurses need to establish effective communication and rapport with their patients so that they can find out what their patients need (Uys 2009, 1060, 1065).

Nurses are often the primary health care workers who assess patient history and condition. As a result, nurses need to understand not only what HIV symptoms and adverse effects are possible, but how severe they can become. Nurses should also be familiar with HIV treatment options. Nurses can have a positive impact on patient treatment ad-

herence and quality of life, if they are able to help patients deal with the problems of HIV symptoms, adverse effects and treatment options. (Webel & Higgins 2012, 31.)

According to Leeman et al. (2010), HAART for HIV-infected individuals has resulted in significantly improved patient well-being and life span. However, the challenge to help HIV-infected individuals adhere to their HAART continues (Leeman et al. 2010, 1915-1916). Lack of adherence not only limits HAART's benefits for the HIV-infected individual, but will actually have a significant negative effect on the HIV-infected individual. The infected individual's HIV symptoms will worsen, the disease is likely to progress more quickly, and their immune system will likely be even less effective (Erlen et al. 2010, 2561.)

HIV-infected individuals are more likely to accept nursing support to help them adhere to HAART, if they are confident that their care provider protects their confidentiality, if appointment scheduling is flexible, and if they have a good relationship with the nurse who is working with them on their care plan (Leeman et al. 2010, 1915-1916). Leeman et al. (2010) found that HIV-infected individuals were more likely to adhere to HAART over a longer period of time if they had a strong relationship with a specific care provider over time (Leeman et al. 2010, 1919). HIV-infected individuals considered social support, trust and positive reinforcement from their nurse as key aspects of receiving the help they need to adhere to HAART (Leeman et al. 2010, 1921).

Leeman et al. (2010, 1921) concluded that telephone consultations between the HIV-infected individual and their nurse were an effective means of facilitating HAART adherence due to the flexible and confidential nature of telephone contact. However, in-person consultations were found to be still more effective than telephone interventions. This was due to the fact that in-person meetings were found to be more effective at developing a strong relationship between the nurse and the HIV-infected individual. (Leeman et al. 2010, 1921.)

Erlen et al.'s (2010, 2561) research identified similar patterns. They found, for example, that HIV-infected individuals were more likely to adhere to HAART if they felt self-confident in their ability to manage their disease and medication and had supportive relationships. According to Erlen et al. (2010, 2562), HIV-infected patients' overall treatment plans generally include nutrition, exercise and daily activities in addition to

their HAART. Just as with HAART adherence, patients are often challenged to be consistent and accountable in carrying out their nutrition, exercise and daily activity routine. Erlen et al. found that indeed social support and a good relationship with the patients' care provider improved overall treatment plan adherence rates.

This research also found that regular telephone consultations with their nurse helped HIV-infected individuals problem-solve, self-monitor, and give and receive feedback about their disease management and lifestyle (Erlen et al. 2010, 2564). On-going, reliable consultations with the patient's nurse was found to help facilitate behavior modification, habit change and improved HAART adherence (Erlen et al. 2010, 2561, 2564).

According to Fazeli et al. (2011), one of the key factors in providing optimal nursing care for HIV-infected patients is to educate patients on medication adherence, as well as the interactions between different medications (Fazeli et al. 2011, 41). Nurses have a central role in encouraging patients' self-care, including supporting their sleep, nutrition and exercise habits. (Fazeli et al. 2011, 40.)

Depression and mood disorders are not uncommon for HIV-infected patients (Fazeli et al. 2011, 37). Due to the fact that nurses tend to have frequent and extended contact with patients, nurses are in a key position to observe and address cognitive changes in their HIV-infected patients. Adherence to exercise routines, proper sleep and nutrition are important components of mood disorder management. In addition, nurses can educate patients about foods that help or hinder medication absorption (Fazeli et al. 2011, 40).

Fazeli et al.'s (2011, 41) research shows that cognitive function in HIV-infected patients tends to decline more severely over time with age and years with the disease than in non-infected patients. Therefore, activities that stimulate the brain can positively affect patients' cognitive function. Due to nurses' role as health educators, they have the critical job of promoting patients' continued learning activities to stimulate their brain function.

A recent thorough study in China found that nurses play a key role in HIV-infected patients' ability to receive improved care for management of their disease. As the researchers note, nurses need to be supported to fully carry out their role as caregivers

who have frequent, meaningful contact with patients (Chen et al. 2010). This research found nurses to be optimally positioned to provide excellent support and encouragement to HIV-infected patients. In fact, Chen et al. suggest nurses are the key actors in the healthcare setting to be able to develop a strong relationship and provide good quality care for HIV-infected patients. (Chen et al. 2010, 268.)

When patients are diagnosed with HIV and/or struggling to manage their HIV-infected status at any and every stage of the disease, nurses are likely to be the health care providers most in contact with patients in the healthcare setting at any given time (Chen et al. 2010, 267). As such, Chen et al.'s (2010) research found that nurses play a key role in HIV-infected patients' ability to receive improved care to manage the disease (Chen et al. 2010, 268). Indeed, nursing support can help patients implement improved self-care and disease management (Chen et al. 2010, 264).

5.1.1 Factors that impact HIV-infected patients' disease management

The results of Webel and Higgins' (2012) study identify factors that impact HIV-infected patients' management of the disease. According to Webel and Higgins, management of HIV includes the following: adhering to one's HIV medication, managing one's comorbid conditions, monitoring one's symptoms, modifying one's diet appropriately, implementing effective hygiene, maintaining physical activity, and not transmitting the disease to others (Webel & Higgins 2012, 27-28).

In addition, Webel and Higgins found that health care providers, such as nurses, who provide much of the direct patient care, can significantly positively or negatively impact their patient's motivation to do self-care. (Webel & Higgins 2012, 29). Webel's and Higgins' (2012) research found that once the patients felt able to disclose their positive HIV status, they had already accepted that they had the disease and had found the strength to face the stigma and possible discrimination. As identified in numerous studies, self-acceptance of the disease improves one's ability to manage the disease. (Uys et al. 2009; Webel & Higgins 2012.) In other words, self-acceptance outweighs the negative effects of stigma and discrimination.

5.1.2 Stigmatized patient

However, as Webel and Higgins found, the stigma is evident and problematic among patients themselves, patient families, the larger community, and among healthcare providers. Due to the stigma that persists around HIV, it continues to be difficult to be public with one's HIV status, care for oneself as needed, and receive the necessary nursing care to manage the disease. Stigma continues to be a significant barrier to the provision of effective care (Webel & Higgins 2012, 29-30, 32).

If one is unable to rise above the sense of stigmatization around one's HIV-infected status, the effects of being stigmatized can be damaging. As Webel and Higgins identified, the sense of stigma negatively affected patients' motivation to do self-care around the disease. They also found that it negatively impacted patients' ability to obtain the medical help they needed, and obtain social support. (Webel & Higgins 2012, 30, 32).

Clearly, one of the strategies to provide effective care to HIV-infected patients is to address the stigma among nurses. According to Uys et al. (2009), some strategies have been found to help reduce the stigma (Uys et al. 2009, 1059). In Uys et al.'s study, patients and nurses worked together to identify ways to mitigate the stigma both on the part of the patients and of the nurses. The study found positive results when nurses and patients came together to talk with each other about HIV stigma and experiences with the disease. As a result of gathering to share, infected patients and nurses experienced increased empathy and communication. Patients also reported decreased stigma and increased self-esteem and empowerment (Uys et al. 2009, 1060, 1065).

5.2 What factors influence the care of an HIV-infected patient?

Lin and Larson (2005, 652) found that when HIV-infected individuals had a consistent source of care that they could count on and that they felt positive about, they were more likely to seek out the care they needed. However, their research revealed that often there was less-than-adequate communication between HIV-infected patients who were from culturally different groups from their care provider. Lin and Larson suggest that the lack of good communication between the provider and the HIV-infected patient limited the patient's ability to receive effective mental and emotional support from their provider.

This in turn has a negative effect on the patients' ability and motivation to manage their disease and care for themselves (Erlen et al. 2010, 2564; Lin & Larson 2005, 652-654).

According to Suominen et al. (2010), nurses' positive attitudes and willingness to care for their HIV-infected patients was one of the most significant factors influencing the provision of quality care. In addition, nurses' education and level of knowledge about HIV were also shown to have a positive effect on nurses' willingness to care for HIV-infected individuals. (Suominen et al. 2010, 145).

Suominen et al. (2010) found that when nurses had participated in HIV-specific trainings and education, their attitudes toward their HIV-infected patients were more positive and more knowledgeable. This research found that there was a direct and positive correlation between the amount of education nurses had and the depth of their knowledge of HIV (Suominen et al. 2010, 145). Surprisingly, the number of years of nursing experience did not have any positive impact on the nurses' attitudes toward their HIV-infected patients (Suominen et al. 2010, 139).

Chen et al.'s (2010) findings echo Suominen et al.'s (2010) study results. Their research found that nurses' training that addresses the support nurses can give to HIV-infected patients and their families can positively affect nurses' attitudes toward their HIV-infected patients and their families. Additionally, nurses' continued education on HIV had a positive effect on their attitudes toward their HIV-infected patients and their families. The quality of care that nurses provide HIV-infected patients and their families will likely improve when nurses have more positive attitudes toward their patients and their families. (Chen et al. 2010, 268.) Chen et al. (2010, 268) found that nurses need to be able to have more time to meet the unique and challenging physical and psychosocial needs of their HIV-infected patients. In addition, they need to be able to give time to support the patients' families.

Uys et al.'s (2009, 1060) research found that stigma reduction interventions were highly useful in helping patients and nurses engage in better care. Specifically, they found that the contact between the nurses and the HIV-infected individuals, as well as nurses' increased knowledge about HIV, and the infected individuals' knowledge about the

disease, all resulted in reduced stigma on the part of both parties. Subsequently, nurses and patients alike felt more empowered to work with each other, and with the disease (Uys et al. 2009, 1060).

5.3 Why is culturally competent nursing care necessary for HIV-infected patients?

Adherence to HIV treatment dramatically affects how HIV-infected patients' disease progresses. It also impacts the patients' quality of life. The analysis of the literature in the present study revealed that among many other factors, patients' adherence to their HIV treatment is improved when the nurse respects and works with the patient's distinct cultural needs in relation to their disease (Uys et al. 2009).

Culturally competent nursing care has been determined to improve nurses' ability to assess, develop and implement nursing interventions that meet the patients' needs (Chen et al. 2010, 264, 268). Culturally competent nursing care for HIV-infected patients is important so that nurses account for the ways in which the patient's experience of their disease is connected to their cultural beliefs and background. As a result, nurses incorporate the HIV-infected patient's cultural reality in their care plan.

The literature review also illustrates that patients have improved health outcomes when they receive culturally competent care. Improved patient-nurse communication, interactions, negotiations, decision-making processes, and expectations for treatment results improve when nurses have tools in cultural competency (Erlen et al. 2010, 2561-2562; Lin & Larson 2005, 652).

It is important for nurses to do thoughtful reflection on their own professional and cultural reference points. Ideally, nurses will also develop more awareness of their personal opinions and understandings in relation to client populations. Arguably, this would cause nurses to be less likely to project stereotypes or prejudices when caring for their culturally diverse HIV-infected patients (Uys et al 2009, 1060).

It is also important that nurses have knowledge about a variety of cultural and ethnic communities so they can better understand how their patients understand their HIV sta-

tus, and how their cultural identity influences how they are, and how they think, act, and react (Webel and Higgins 2012, 33). By gathering significant cultural information related to their patients' concerns, nurses are also able to carry out assessments of their patients that are culturally astute. When nurses have these tools, they will be less likely to miss important information about their patients and their patients' disease management. (Leeman et al. 2010, 1920.)

If nurses demonstrate a genuine interest in their patients' cultural reference points and world view, they are more likely to ask questions and have an open attitude that allows them to know their patient better. They are more likely to listen with an open mind. Patients are then more likely to trust. The cumulative result is that nurses are then more likely to be able to provide their patients with better care. (Leeman et al. 2010, 1916.)

6 DISCUSSION

6.1 Applying the findings

Indeed as the Finnish State asserts, all HIV-infected individuals residing in Finland have a right to quality nursing care in Finland. And culture is an important factor that influences every level of the nursing process (Mahoney et al. 2006; Kodjo 2009; Berlin et al. 2010; Flowers 2012; Long 2012). As of 2012, Finland now has almost as many non-Finnish HIV-infected patients than Finnish HIV-infected patients.

The findings unanimously revealed that nurses have a central and crucial role to play in HIV-infected patients' abilities to manage their disease. The present study found that if nurses are able to openly and comfortably discuss all aspects of the patient's illness and how it affects his/her life and his/her family's life, it is much more likely that nurses will be able to help patients cope more effectively with the illness. Nurses can then help patients better adhere to their medications, manage changes in their disease, manage new symptoms, and alter their behavior and attitude so that they are able to function more effectively (and with less shame) with the illness. Patients can therefore also increase their knowledge about the disease and how to best care for themselves and their family. (Bradley-Springer et al. 2010, 37.)

Due to the fact that HIV-infected patients must adhere to a complicated medication routine, Hekkink et al's study confirmed that patients place a high priority on nurses' help with medication dosing schedules. For HIV-infected patients, nurses' help with providing and clarifying information on treatments, side effects of medications, and the medications they require are of utmost importance to patients (Hekkink et al. 2003, 192).

Culturally competent nursing care for HIV-infected patients is nursing care that recognizes, validates and takes into account a patient's unique cultural reality when providing HIV care for culturally diverse HIV-infected patients. Culturally competent nursing care for HIV-infected patients understands that the patient's management of his/her disease is culturally mediated in certain ways. Culturally competent nursing care understands that nurses can only effectively care for their HIV-infected patients if they account for the ways in which the patients' experience of their disease is connected to their cultural

beliefs and background. As a result, nurses incorporate the HIV-infected patient's cultural reality in their care plan.

First and foremost, nurses can take a step forward when they recognize that their culturally diverse HIV-infected patients may have different nursing care needs and expectations in relation to their disease than what the nurses expect. Nurses need to establish effective communication and rapport with their patients so that they can find out what their patients need. It has been noted that in the Finnish context, "flexibility and cooperation" are key to addressing the nursing care needs of culturally diverse HIV-infected individuals and families in Finland. (Clarke 2009, 25.)

Nurses are often the primary health care worker who assesses patients' history and condition. As a result, nurses need to understand not only what HIV symptoms and adverse effects are possible, but also how severe they can become. Nurses should also be familiar with HIV treatment options. Nurses can have a positive impact on patients' treatment adherence and quality of life if they are able to help patients deal with the problems of HIV symptoms, adverse effects and treatment options. (Bradley-Springer et al. 2010, 37)

6.2 Validity

The present study was carried out by doing a traditional narrative literature review. Its purpose was to provide recommendations for nursing care of HIV-infected patients. Peer-reviewed articles that provided research and analysis on the subject of culturally competent care of HIV-infected patients were used. To illuminate the background of the study, a variety of other materials such as statistics and reports from organizations that work with culturally diverse HIV-infected patients were also used.

In order to make the study sound, credible, and therefore valid, the study sought to be trustworthy, dependable, transparent and authentic. The thesis is credible because "— the research methods engender confidence in the trust of the data and in the researchers' interpretations" (Polit & Beck 2012, 197). Therefore, a variety of studies that illustrate the importance of culturally competent nursing care for HIV-infected patients were presented.

After systematically selecting the peer-reviewed articles for the topic, a thorough analysis of studies on HIV nursing care was carried out. The articles were thoughtfully analyzed, debated and discussed in this thesis in a narrative style, allowing for an in-depth investigation of the research topic (Parahoo 2006, 126). As a result, the working partner was provided with the most optimal and current recommendations on culturally competent nursing care of HIV-infected patients. These recommendations are based on a review of articles whose rigorous studies identified best practices for nursing HIV-infected patients.

So as to avoid possible misinterpretation, or questionable validity, almost exclusively primary source material was used for the study and literature review (Polit & Beck 2012, 95). In addition, the study relied solely on material published in the past decade, since 2002. In addition, the research process was carefully explained so that the study could be replicated. This has made the study transparent, dependable and trustworthy as well (Polit & Beck 2012, 96-97).

The study complies with all ethical requirements. This study was approved by the Pirkanmaa Hospital District in accordance with Finnish research standards. Due to the fact that this study did not directly involve patients, an ethics board has not evaluated this study. The hope is that the study will benefit nurses' work in Finland. The present study seeks to benefit society in general (Polit & Beck 2012, 162).

6.3 Evaluation of literature review

A critical evaluation of the chosen articles for the literature review illustrates that, as with any research, this study had strengths and weaknesses. The major strengths of the selected material include that the eight articles were peer-reviewed and were systematically selected and analyzed in accordance with the research topic. The chosen articles were not only directly relevant to the research questions, but indeed answered the research questions. The articles offered sound results from various countries. The results also all concurred that culturally competent nursing care improves patient care. The articles also all provided tangible ways in which nurses can provide culturally competent care (Webel & Higgins 2012; Fazeli et al. 2011; Chen et al. 2010; Erlen et al. 2010; Leeman et al. 2010; Suominen et al. 2010; Uys et al. 2009; Lin & Larson 2005).

The articles in and of themselves were solid and agreed with one another. However, as with any study, the research is not exhaustive. The literature review reveals that there are best practices from many nursing communities that have not been researched. Internationally, to date, there is still a shortage of peer-reviewed studies that specifically address culturally competent care for HIV-infected patients (Webel & Higgins 2012; Fazeli et al. 2011; Chen et al. 2010; Erlen et al. 2010; Leeman et al. 2010; Suominen et al. 2010; Uys et al. 2009; Lin & Larson 2005).

6.4 Limitations

This thesis depended on Tampere University of Applied Sciences' databases. As a result, the research sources may have been limited. However, extensive and internationally recognized peer-reviewed research material for the topic was located. Arguably, the fact that the thesis relied on primarily English-language sources was a research limitation. As noted by Kankkunen and Vehviläinen-Julkunen (Kankkunen & Vehviläinen-Julkunen 2010, 197), this could limit Finnish nurses' ability to fully integrate the valuable peer-reviewed material into their nursing philosophy, methods and implementation.

Due to the fact that health care services vary by country and culture, research recommendations from a wide range of international contexts may not all be suitable for the Finnish health care system (Kankkunen & Vehviläinen-Julkunen 2010, 71). It therefore remains the work of individual nursing wards and medical institutions to find the ways in which these research findings may be best applied in their unique nursing context.

Although systematically selected, the eight peer-reviewed articles that illuminated the findings of this thesis are of course not able to capture all the evidence-based material available on effective culturally competent nursing care for HIV-infected patients. It is worth bearing in mind that these selected articles cannot be expected to shed light on all, or even the majority of, potentially valuable strategies for nursing care of HIV-infected culturally diverse patients.

7 RECOMMENDATIONS FOR FURTHER RESEARCH

Further study is needed to explore the ways in which men and women may experience and manage their HIV-infected status differently. It would be interesting to investigate whether, for example, societal gender roles impact how one interacts with one's disease. If gender roles do impact how one manages the disease, then what are the specific influences? And, for example, how might this vary based on different cultures' gender roles?

A greater understanding of how gender roles impact one's relationship with one's HIV-infected status is important so that nurses can more effectively help their patients navigate their disease. For example, if nurses are aware that gender roles may affect one's disease management, nurses are equipped to ask their patients relevant questions. Perhaps one's role as mother, or primary caregiver, actually helps a mother be more motivated to care for herself and stay on track with her treatment plan. Or perhaps, the fact that she has so many responsibilities as a mother inhibits her ability to care for herself. In this case, her nurse is well-positioned to help the mother receive the help she needs with her children so that she can better care for herself.

It was stated by Uys et al. (2009) and Leeman (2010) that HIV and the HIV stigma were understood and experienced on different levels in different countries and settings (Uys et al 2009, 1059; Leeman 2010, 1917). Based on that, further study is recommended on how the stigma is experienced in Finland and how one's country of origin may affect the experience of stigma in a Finnish setting. It could be interesting to examine whether one's experience of the stigma changes over time in a different culture. This could help health care workers to better meet patients' needs. It could also very likely affect medication adherence and one's ability to care for oneself.

8 CONCLUSION

The goal of this study was to illuminate the current state of knowledge about HIV nursing care. This thesis sought to determine how culturally competent nursing care can help nurses provide optimal care for their culturally diverse HIV-infected patients. The aim was to provide recommendations for culturally competent nursing strategies for nurses' culturally diverse HIV-infected patients (National Minority Aids Council 2003).

Through a rigorous analysis of the literature on care for HIV-infected patients and culturally competent nursing best practices, this study was able to provide nurses with knowledge and tools to help them provide improved and more effective care for their culturally diverse HIV-infected patients. The thesis presented, reviewed and analyzed the most up-to-date methods for nurses to provide culturally competent care to their HIV-infected patients.

The synthesis and analysis of this research revealed unquestionably that culturally competent nursing care improves the quality of life of HIV-infected individuals. Due to the fact that the study was able to answer the three research questions, it is the authors' hope that nurses are equipped with concrete tools to implement best practices in the care of their HIV-infected patients. The study was also able to identify what factors influence the care of an HIV-infected patient so that nurses have valuable reference points for the kinds of questions and concerns they need to be prepared to address with their culturally diverse HIV-infected patients.

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APPENDICES

Appendix 1. Research matrix

(1/4)

Author, Year, Country	Aim	Research method and sample size	Major strengths and weaknesses	Major findings
Chen, W, . Shiu, C., Si- moni, J., Fred- riksen-Goldsen, K., Zhang, F. & Zhao, H. 2010. USA, China.	The aim of the study was to explore how to optimize HIV nursing care.	Qualitative in-depth interviews with HIV-infected patients (N=29). And in addition, one focus group consisting of healthcare workers (N=6) in an infectious disease hospital in Beijing, China.	Strengths: The health care workers consisted of nurses (n=4) and physicians (n=2) and they had at least 5 years' working experience in HIV-related care. Interviews with 29 HIV-infected individuals were carried out in Mandarin Chinese by native speaking interviewers who also spoke English. Weaknesses: The study was conducted in only one hospital and therefore it may not represent the bigger picture. The HIV-infected individuals were recruited by clinic staff which may affect on the results. The focus group results could be biased due to hierarchy considerations within the group of health care workers. There may be some interpretation mistakes due to the bilingual research.	Due to the highly specialized HIV treatment in the Chinese healthcare system the patients are transferred from one institution to another and they may not receive any information on their HIV diagnosis. A clearer division of tasks between nurses and physicians is needed as well as more time for patient care to meet the physical and psychosocial needs of the patients and their families.
Erlen, J.A., Cha, E.S., Kim, K.H., Caruthers, D. & Sereika, S.M. 2010. USA.	The aim of the study was to further assess the psychometric properties of the HIV Medication Taking Self-efficacy Scale (HIV MT SES).	Cross-sectional, correlational design. The sample size was 326 HIV infected patients. The data was collected using several questionnaires.	Strengths: A large and diverse group of HIV-infected patients were part of the study. The study was carried out in five intervals with a variety of methods allowing for more in-depth coverage. The study was carried out over a four-year period which adds to the study's strengths as well. Weaknesses: The study size and location was limited. The inclusion and exclusion criteria were also limiting and therefore the study may not accurately reflect the bigger picture.	Social support and a good relationship with the patients' care provider improved overall treatment plan adherence rates. Regular telephone consultations with the nurse helped HIV-infected patients problem-solve, self-monitor, and give and receive feedback about their disease management and lifestyle. On-going, reliable consultations with the patient's nurse was found to help facilitate behavior modification, habit change and improved HAART adherence High self-confidence in medication-related tasks increases medication usage.

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(2/4)

Author, Year, Country	Aim	Research method and sample size	Major strengths and weaknesses	Major findings
Fazeli, P.L., Marceaux, J.C., Vance, D.E., Slater, L. & Long, A.C. 2011. USA.	The aim of the study was to examine possible predictors affecting cognition of HIV-positive adults.	Cross-sectional study. The sample size was 98 HIV-positive adults. The data was collected by individual interviews, several questionnaires and tests.	Strengths: A large and diverse group of HIV-infected patients were part of the study. The qualitative study with in-depth one-on-one interviews is a significant strength of the study. In addition extensive quantitative, medically-based material and methods were used. Weaknesses: The study size and location was limited. The inclusion and exclusion criteria were also limiting and therefore the study may not fully reflect the bigger picture.	Nurses are in a key position to observe and act on cognitive changes in their HIV-infected patients. Adherence to exercise routines, proper sleep and nutrition are important components of mood disorder management.
Leeman, J., Chang, Y.K., Lee, E.J., Voils, C.I., Crandell, J. & Sandelowski, M. 2010. USA.	The review's aim was to explain when, why and how implementation of HAART adherence work well. The purpose was to identify complex behavioural change interventions.	Systematic review using an adaptation of Pawson's realist synthesis method and the explanatory model. The sample size was 52 articles in the final analysis.	Strengths: A thorough systematic review of the literature was conducted. Weaknesses: There were no direct studies with patients. The inclusion and exclusion criteria were limiting and therefore the study may not completely reflect the bigger picture.	HIV-infected individuals are more likely to accept nursing support to help them adhere to medication if they are confident that the care provider protects their confidentiality, if appointment scheduling is flexible, and if they have a good relationship with the nurse who is working with them on their care plan. In-person meetings were found to be more effective at developing a strong relationship between the nurse and the HIV-infected individual.
Lin, S.X. & Larson, E. 2005. USA.	The study's aim was to examine does health counselling at primary care setting differ by race in The United States.	The study was a secondary data analysis from the National Ambulatory Medical Care Survey. The sample consisted 22,480 adult patients' visits to their own primary care provider. The sample consisted visits made by Whites (n=19,912) and Blacks (n=2,568).	Strengths: A large and diverse group of HIV-infected patients were part of the study over a three-year period. A wide variety of aspects of the patients' lives and HIV care were explored in the Survey. Weaknesses: The study was a secondary data analysis from one Care Survey. The inclusion and exclusion criteria were also limiting and therefore the study may not complete the bigger picture.	The lack of good communication between the provider and the HIV-infected patient limited the patient's ability to receive effective mental and emotional support from their provider. When HIV-infected individuals had a consistent source of care that they could count on and that they felt positive about, they were more likely to seek out the care they needed.

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(3/4)

Author, Year, Country	Aim	Research method and sample size	Major strengths and weaknesses	Major findings
Suominen, T., Koponen, N., Mockiene, V., Raid, U., Istomina, N., Vanska, M., Blek-Vehkaluoto, M. & Välimäki, M. 2010. Finland, Estonia, Lithuania.	The study aimed to describe and compare nurses' knowledge of HIV and AIDS, and their attitudes towards patients with HIV or AIDS in Finland, Estonia and Lithuania.	International cross-sectional survey. The sample size was 681 registered nurses from 3 countries including Finland (n=322), Estonia (n=191) and Lithuania (n=168). The data was collected by questionnaire.	<p>Strengths: The study was qualitative, and based on in-person interviews. It reached a large and diverse selection of nurses in three countries. The nurses worked extensively with HIV-infected patients.</p> <p>Weaknesses: The study was limited by the fact that most of the nurses interviewed were female and worked in medical, surgical or in the women's disease ward in the participating hospitals.</p>	Nurses' knowledge about HIV is rather average and the variation between the countries was considerable. Significant variation between the countries was also found on attitudes towards people with HIV as well as attitudes towards homosexuals. Previous experience in providing care for patient with HIV or knowing somebody with HIV had positive influence on knowledge as well as attitude. Years of working experience had negative impact on the knowledge and attitude. Length of education affected positively on all factors.
Uys, L., Chirwa, M., Kohi, T., Greeff, M., Naidoo, J., Makoae, L., Dlamini, P., Durrheim, K., Cuca, Y. & Holzemer, W. 2009. South Africa, Malawi, Tanzania, Lesotho, Swaziland, USA.	The aim of the study was to find out if an intervention can reduce stigma in nurses and in HIV infected patients.	An international multiple-case study conducted in five African countries. The sample size was 218 people including people living with HIV or AIDS (n=41), team nurses (n=43) and setting nurses (n=134). Each intervention team in each country had approximately 10 people living with HIV or AIDS and 10 nurses. The data was collected by reports, semi structured interviews and questionnaires.	<p>Strengths: The Study included five countries with high numbers of HIV-infected individuals. The Study created teams of nurses and HIV-infected patients who worked together in workshops around intervention. The study has strong results due to the high level of interaction in the workshop setting.</p> <p>Weaknesses: The Study could be considered more susceptible to bias due to the fact that the Study was based on intervention teams of nurses and patients working together where relationships develop more strongly.</p>	Most of the participants (92,6%) evaluated the intervention positively. The intervention was seen increase the knowledge and understanding of HIV stigma. Nurses who participated in the intervention did not have any change in stigma, and the difference in self-esteem or self-efficacy was not significant but voluntary testing for HIV increased by the end of the study (from 79,1% to 93%). The HIV infected people who participated experienced significant decrease in stigma and significant increase in self-esteem

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(4/4)

Author, Year, Country	Aim	Research method and sample size	Major strengths and weaknesses	Major findings
Webel, A. & Higgins, P. 2012. USA.	To explore the main social roles of HIV infected women and how these impact to their self-management of HIV.	Semistructured interview. The sample size was 48 HIV-infected women. The data was collected by demographic survey and 12 focus group interviews, each group containing 2-10 women.	<p>Strengths: The study included a high volume of in-person interviews with HIV-infected patients who had been living with HIV for some time. The study included women from diverse ethnic, age and socioeconomic sectors.</p> <p>Weaknesses: The study was limited in size, location and timeframe. The inclusion and exclusion criteria limit the applicability of the study to larger generalizations.</p>	The social roles which interviewed HIV infected women experienced and which impacted their self-management were mother/ grandmother, believer, advocate, stigmatized patient, pet owner and employee. The role of mother/ grandmother had both positive and negative effect on self-management; children were seen as a purpose and joy but responsibilities of single women were sometimes seen to have a negative effect. Spiritual faith as well as practical faith in their physician had a positive effect on self-management. The social role of advocate had a positive effect on one's illness. Pet ownership had a positive effect on mental health. Stigma affected negatively on self-management by prohibiting the woman e.g. to seek social support or medical care. The HIV infection was seen to be affecting the choice of work and a fear of discrimination is a barrier to rejoin the workforce.