Women's Health Issues in Baccalaureate Nursing Curricula.

Karen Basham Moody
Louisiana State University and Agricultural & Mechanical College

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UMI
WOMEN'S HEALTH ISSUES IN BACCALAUREATE NURSING CURRICULA

A Dissertation

Submitted to the Graduate faculty of the Louisiana State University and Agricultural and Mechanical College in partial fulfillment of the requirements for the degree of Doctor of Philosophy in The School of Vocational Education

by
Karen Basham Moody
B.S., University of Southern Mississippi, 1972
M.N., University of Mississippi, 1976
August, 1999

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To

Kimberly Lea

October 7, 1977 - May 31, 1986

who brought me

love, joy, laughter and hope.
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Over the course of this long, often challenging, ultimately rewarding journey, I received encouragement and support from many people, all of whom contributed to the realization of a personal goal. I am especially grateful to my major professor, Dr. Michael F. Burnett, who offered encouragement, expertise and patience from the very beginning. I would not have been successful without his guidance.

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ABSTRACT

The primary purpose of this study was to determine if, and how, selected women’s health issues are included in baccalaureate nursing curricula in the United States. The study also assessed nursing faculty’s perceptions of the importance of these selected women’s health issues to nursing curricula.

Two hundred sixty baccalaureate nursing programs were randomly selected from a population of 604 1998 National League for Nursing accredited baccalaureate nursing programs in the United States. A three-part researcher developed women’s health survey instrument was used for data collection. The instrument consisted of questions pertaining to 19 women’s health issues which were selected through an extensive literature review and in consultation with several women’s health professionals around the country. Data were collected by mailed questionnaires to the 260 selected programs. After two mailings and a follow-up reminder post-card, the useable response rate was 65%.

Results of the study included: a) most primary women’s health issues are included in baccalaureate nursing programs; b) nursing programs place greater emphasis on women’s health issues more general in nature, i.e., cardiovascular disease and substance abuse, than those more specific primarily to women, i.e., menopause and hormone therapy; c) women’s health content can be found in a wide variety of nursing courses; d) women’s health issues are considered to be very important to baccalaureate nursing curricula; and e) the emphasis placed on women’s health issues varies widely among baccalaureate nursing programs.

Recommendations included: a) follow-up nation-wide research of nursing faculty and graduating students from the same program regarding the type, amount and location...
of women’s health content in baccalaureate nursing curricula; b) development of core women’s health content by the nursing profession for inclusion in nursing curricula; c) evaluation by individual programs of the type, amount and location of women’s health content in their curricula; and d) inclusion of women’s health content in nursing diagnostic and licensure exams.
CHAPTER I
INTRODUCTION

Rationale

Women and their health is an issue that has risen to prominence within the medical and research communities of America, the federal government and the public itself over the past decade. "During the 195th Congress, at least 22 bills were introduced that dealt explicitly with women's health issues... (Kelly & Jackson, 1998)." Women's health messages abound. Television commercials urge women to talk to their physicians about menopause (WBRZ, 3/6/99). Newspaper advertisements and inserts (see Appendices A through C) tout women's health classes, clinics and providers. A newspaper magazine headline delivers the message that "illnesses affect men and women differently" (see Appendix D). Women's health is finally receiving the attention it has long needed (Walker & Tinkle, 1996; Falik & Collins, 1996). After describing a multimillion dollar federal research initiative on women's health, a speaker at a 1993 Conference on Women's Health said, "Long overdue data on women's health will emerge as a result, and it is hoped that private dollars will follow public dollars (Conference on Women's Health, 1993, p. 86)."

Women comprise over 50% of the population of the United States. The predicted average life expectancy of a female born in the United States in the year 1996 was 79 years, as opposed to 73 years for a male born in the United States in the same year (Taylor, 1998). Older women outnumber older men three to two, and the female majority in the United States continues to grow (Scura & Whipple, 1997). Although women have a longer life span than men, they are more likely to experience depression, have chronic disabilities, and are less likely to have adequate health care coverage. Women are more
likely to use health services than men—more physician visits and more hospitalizations (Falik & Collins, 1996). Dr. Judith LaRosa of the National Institutes of Health (NIH) remarked in a 1993 Conference on Women’s Health Research, “... even though women live longer than men, they have worse health overall (p. 86).” Not only are women the major consumers of health care in the United States, but today’s woman is considered the primary gatekeeper to health for herself and her family (Stichler & Weurding, 1995).

Important as the woman is, and always has been, to the health and welfare of society itself, her own health care needs have been sadly minimized, even overlooked, by the medical, research, and health care entities in America (Greenberger, 1997). In a 1994 guest editorial in the Journal of Women’s Health, Susan Blumenthal talked of how the year 1990 marked the beginning of a decade in which women’s health concerns received unprecedented attention, both in academic circles and the media.

During this watershed period, our nation became aware of the inequities in women’s health research, including the failure to include women in clinical trials, inadequate attention to gender differences in biomedical and behavioral research, insufficient funding for research on women’s health concerns, and the dearth of women in senior medical and scientific positions in our nation’s federal and academic research institutions (Blumenthal, 1994, p. 453).

Low, Joliceour, Colman, Stone, and Fleisher (1994), reiterate this theme in their article on assessing the progress of women participants in research in the journal Women and Health:

... although women constitute slightly more than half of the population and are more likely to be the recipients of both medical and psychological care, they have been underrepresented in all aspects of medical and psychological research. By excluding a significant number of women from scientific research, we have also prevented them from safely enjoying the benefits of well-tested clinical interventions (p. 81-82).
The one exception to this lack of research devoted to women’s health has been that of the childbearing role of the woman (Hagell, 1990). King and Paul (1996) affirm this with their statement from an article about a review of the depiction of women in cardiovascular literature. They said that although a historical review of the literature demonstrates that women have long been acknowledged as suffering from cardiac disease and disorder, until recently, women’s experience with cardiac disease was investigated primarily as to how the cardiac disease impinged on pregnancy or women’s ability to carry out home-related duties. King and Paul continued by stating that only in the last decade has a more appropriate and more holistic view of women’s unique experience with cardiac disease been undertaken. They attributed this new perspective in health literature, in part, to the advancement of feminist approach and critique (1996). Indeed, this historical lack of attention to the health care needs of women, along with the women’s movement of the 1960’s, 70s and 80s gave rise to the women’s health movement. As women moved into the workplace in greater numbers, they became an economic and political force to be reckoned with, and consequently became more willing to express their concerns about their health needs.

Women’s increased interest in their health care needs, coupled with three events taking place in the early 1990s, catapulted women’s health and women’s health research into the national limelight. These three events included: the findings of an audit by the General Accounting Office (GAO) revealing a lack of accurate data by the National Institutes of Health (NIH) on how much research involved women; the subsequent insufficient response to Congress by the NIH concerning the data; and, the reaction of the press to these newsworthy events (Nieman, 1994). Private and governmental
women's health agencies and institutes proliferated in response to these events. In addition, there has been a sharp increase in the amount and type of women's health research.

Along with government intervention on behalf of women's health and research, came increased expectations of and responsibilities for the health care community in regard to women's health. Federal legislation was enacted regarding the inadequacy of women's health training in medical school education (Levison, 1994). This legislation requested that medical schools be surveyed to determine the amount and content of teaching in women's health, beyond the traditional subjects of obstetrics and gynecology. In addition, the legislation mandated development of a women's health core curriculum for medical education, and the examination of issues surrounding the appropriate integration of women's health content into medical school curricula. This legislative mandate was directed to medical schools only. However, nursing, as one of the largest entities of health care providers in America, is in a unique position to influence greatly the health care of women. Nurses are very actively involved in patient care in a variety of health care settings and traditionally include health teaching in their care of others. They can provide information to women regarding the link between lifestyle behaviors and health, and, by virtue of belonging to a primarily female profession, can serve as role models for positive women's health care practices. The nurse always has been, and continues to be, both a teacher and an advocate for the patient (Scura & Whipple, 1997; Maddox & Fishbein, 1994).

The nursing profession has an important role in health care delivery, yet had received no formal mandate regarding women's health, such as their medical counterparts. Nursing as a profession, however, has a history of "policing" itself,
primarily through its' various professional organizations and state boards of nursing.

In keeping with this practice, the American Academy of Nursing (AAN), one of nursing’s most prestigious professional nursing organizations, convened The Expert Panel on Women’s Health in 1996, which studied the need for transformative change in women’s health services. The panel formulated recommendations to facilitate such change in nursing education, nursing practice and policy, so that women’s health needs could be met more effectively. In regard to undergraduate nursing education, the AAN Expert Panel recommended the following: strengthen the emphasis on women’s health and women’s health care throughout undergraduate programs; emphasize gender differences in health, including diagnosis and treatment; and strengthen public health nursing programs that are gender specific and reflect the diversity within populations of women (Writing Group of the 1996 American Academy of Nursing Expert Panel on Women’s Health, 1997). Another professional nursing organization, The American Association of Colleges of Nursing (AACN), spoke to nursing education in general concerning the state of health care in the United States and what that means as far as education and diversity of practice for nurses now and in the future, as Americans age and chronic and acute care needs rise. These remarks were included in a 1998 Issue Bulletin regarding demand for and supply of registered nurses (Mezibou, 1998). The Association spoke of the demand for registered nurses across an array of sites, from health maintenance organizations, home care agencies, and managed care companies to primary care centers, nursing homes, community clinics, and hospital outpatient facilities. New graduates with the most education and advanced skills are highly sought after as openings in front-line primary care centers, an increasing older population, and growing needs of more patients with chronic and acute illnesses contribute to a growing demand for registered nurses in
particular baccalaureate nurses. What is needed, according to recruiters and health planners, are nurses prepared in bachelor’s and graduate degree tracks and in a variety of high-need specialities. "...BSN nurses have broad education in the physical and behavioral sciences, management concepts, and community health, and have the flexibility to practice across a range of settings, both inside and outside hospitals... (Mezibou, 1998).” In a 1998 revision of the AACN Position Statement on Educational Mobility, the AACN Task Force stated, “With the explosion of knowledge in health care and the enormous changes in health care delivery systems, employers of nurses can ill afford to employ registered nurses who do not possess requisite knowledge and skills for new and emerging settings (p. 2).”

Given the importance of nursing to health care delivery, the increasing health care needs of Americans (over half of whom are women), and the increased research and knowledge related to women’s health, the researcher believed that a study of the women’s health content of baccalaureate nursing curricula and related research were appropriate at the time this study was initiated. A preliminary review of related literature found little information about women’s health content in basic undergraduate nursing curricula and not much more related to women’s health and graduate curricula. It was found that of the 295 college and university programs that offered master’s or post-master’s nurse practitioner’s degrees, only 3.9% were considered to be OB/GYN/Women’s Health programs (Association of Women’s Health Obstetric & Neonatal Nurses [AWHONN], 1998). Only one study was found that actually evaluated women’s health content in baccalaureate nursing programs. That study was conducted by Elizabeth Hagell in 1990, and involved only baccalaureate nursing programs in Canada. Another study examined lifespan issues in women’s health nursing courses (Maddox &
Fishbein, 1994), and one article talked of integrating women’s health concepts into a nursing course (Breslin, 1995). One nurse educator wrote of using a feminist approach to women’s health and nursing education (Morse, 1995), and another described the development of a women’s health course for all university students (Callister, Coverston, & Hobbins-Garbett, 1998). Little information was found that actually identified what types of women’s health issues were included in baccalaureate nursing curricula, how or where women’s health information was taught, how much of it was taught, or how many nursing programs actually teach women’s health issues other than childbearing issues.

Since the majority of baccalaureate nurses will not go on to pursue a higher degree in women’s health specifically, it is critical that they receive this content on the undergraduate level.

Purpose

Given the importance of women’s health and the paucity of information regarding if, and how, it is included in baccalaureate nursing curricula, a study of this issue was potentially beneficial to both nursing education and to the health of many women in America. Therefore, the purpose of this study was to determine if, and how, selected women’s health issues are included in baccalaureate nursing curricula in the United States. The study also assessed nursing faculty’s perceptions as to the importance of selected women’s health issues to nursing curricula.

Objectives

The specific research objectives guiding the study were to:

1. Describe participating nursing programs on the following characteristics:
   a. Type of parent institution (university/college)
   b. Location of parent institution
c. Average annual enrollment of parent institution  
d. Average annual baccalaureate nursing program enrollment  
e. Average annual number of baccalaureate nursing graduates  
f. Presence/absence of graduate nursing program  
g. Presence/absence of graduate women’s health nursing curriculum track  
h. Presence/absence of women’s health course in another department in the parent institution  

2. Describe respondents on the following characteristics:  
   a. Current position in the school of Nursing  
   b. Practice specialty  
   c. Highest level of academic preparation  
   d. Age  

3. Determine if selected women’s health issues are currently included in the curricula of National League for Nursing (NLN) accredited baccalaureate nursing programs in the United States  

4. Determine curricular placement of selected women’s health issues that are currently included in the curricula of NLN accredited baccalaureate nursing programs in the United States  

5. Determine class time allocation of selected women’s health issues that are currently included in the curricula of NLN baccalaureate nursing programs in the United States  

6. Ascertain the importance of selected women’s health issues in baccalaureate nursing curricula as perceived by nursing faculty  

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7. Determine the women’s health emphasis (WHE) of participating baccalaureate nursing programs

8. Determine if a relationship exists between the WHE Score and selected program characteristics:

9. Determine if a model existed which explained a significant portion of the variance in WHE of baccalaureate nursing programs from the following program characteristics:

   a. Type of parent institution
   b. Location of parent institution
   c. Average annual university/college enrollment
   d. Average annual baccalaureate nursing program enrollment
   e. Average annual number of baccalaureate nursing graduates
   f. Presence/absence of graduate nursing program
   g. Presence/absence of graduate women’s health curriculum track
   h. Presence/absence of women’s health course in another department in the parent institution.

**Operational Definitions**

For the purposes of this study, the following terms were operationally defined:

**Women’s health** is defined as “the field of practice, education, and research that focuses on the physical, social-emotional and political-economical well-being of women, and encompasses women’s internal and external worlds of reality” (Mulligan, 1983, p. 2).

**Baccalaureate nursing program** refers to a degree program with senior college and universities leading to the baccalaureate nursing degree. Graduates are eligible for licensure as a registered nurse and employment in a variety of inpatient care settings and
ambulatory care settings (National League for Nursing Accrediting Commission, 1997).

**Practice specialty** is an area of clinical practice in which a health professional has advanced education and training (Black & Mattassarin-Jacobs, 1993).

**Curricular placement** denotes the course in which content is placed within the curriculum for teaching purposes.

**Holism** refers to "the philosophy that, in nature, entities such as individuals . . . function as complete units which cannot be reduced to the sum of their parts" (Thomas, 1997, p. 666).
CHAPTER II

LITERATURE REVIEW

Introduction

Women’s health has become a national priority in the decade of the ’90s in America. This review of literature begins by giving pertinent facts about women—their importance to society and their health needs. Further, it continues to define women’s health and chronicles the history of the women’s health movement in the United States, including important events that stimulated the emergence of a national interest in women’s health and subsequent governmental interventions into the fields of research and medical education on behalf of women’s health.

The research community’s treatment of women’s health in the past and at present follows a historical perspective of how the medical profession has traditionally treated women and their health needs, and the profession’s response to the governmental mandates and increased interest in women’s health is presented next, including: how medical practice of women has changed; the controversy over the development of a new women’s health practice specialty; how medicine determines women’s health content; and, placement of that content in medical education. Finally, nursing’s traditional role in women’s health, and it’s response to the increased national interest is discussed, including the following: changes in nursing practice related to women; how nursing determines women’s health content; and, placement of that content in nursing education.

Women’s Importance to Society

Women are in a majority (52%) in America, and will continue to be as the aging population becomes more female (Looker, 1993; Taylor, 1998). The average American female has a longer life span (78.3 years) than that of the average American male (71.4
years) (Nieman, 1994; Scura & Whipple, 1997). Women use more health and medical services than do men, and are the major decision-makers for their families about their health care (Fogel & Woods, 1995; Griffith-Kenney, 1986; Leslie & Swider, 1986; Littlefield, 1986). Women are not only the majority of health care users, but are also the majority of caregivers, both paid and unpaid. As Emily Friedman (1994, p.1) says in An Unfinished Revolution: Women and Health Care in America, "Women and healing have a long shared history."

**Health Needs of Women**

Although women share many health problems with men, there are biological issues that affect women and for which women require specialized knowledge and care (Schaps, Linn, Wilbanks, & Wilbanks, 1993). Also, as Reeder and Hoffman (1998) point out, illnesses affect women differently than men. The literature offers many facts specific to women and disease: more women than men die from heart disease (Arnstein, Buseli & Rankin, 1996; Association of Women's Health, Obstetric and Neonatal Nurses, 1998); approximately one of every two women will die from a cardiovascular or cerebrovascular event, either myocardial infarction or stroke (Kuhn & Rackey, 1993); cardiovascular disease is the number one killer of women, yet research has been focused primarily on men (King & Paul, 1996; Sherman, 1993; Statistical Record of Health & Medicine, 1995); lung cancer is the number one cause of cancer deaths in women (Statistical Record of Health & Medicine, 1995); one in four women over the age of 60 is affected by osteoporosis (Statistical Record of Health & Medicine, 1995); and, women in large numbers are affected by many chronic conditions that affect the quality of their lives—urinary tract infection, menstrual cycle disorders, hypertension, diabetes, osteoporosis, arthritis, and eating disorders, especially obesity (Leslie & Swider, 1986).
There are many factors other than biological ones which can have detrimental effects on women and their health. According to a report of the Public Health Service Task Force on Women’s Health Issues (1987), the three most important social changes affecting women’s health are: the increasing number of women living in poverty; the unprecedented entry of women into the labor force, including women with infants and young children; and the continuing increase in longevity of women. Other psycho-social-economic issues which affect women’s health include the multiple roles of today’s woman, which in part is brought about by the above-mentioned entry of women into the work force, and domestic violence, of which women are on the primary receiving end (Lewis & Berenstein, 1996).

Defining Women’s Health

In the search of the literature, no one universally accepted definition of women’s health was found. Instead, it appeared that how women’s health is defined seems to issue forth from the ideological stance of the person, group, or profession advancing that definition. Joan Mulligan, a nurse, defined women’s health in 1983 as, “the field of practice, education and research that focuses on the physical, social-emotional and political-economical well-being of women, and encompasses women’s internal and external worlds of reality (p. 2).” In 1986, Janet Griffith-Kenney, another nurse, offered another all-encompassing, but slightly different definition, saying that women’s health is a concern “about the overall experience of women as women, their dis-eases, and not just their diseases or childbearing functions (p. 3).” These definitions stand in stark contrast to the United States Public Health Service’s 1985 definition of women’s health, which was adopted officially as recently as 1994 by the American Medical Women’s Association (Levison, 1994). A Women’s Health Issue is a disease or condition... unique to
women or some subgroups of women... more prevalent in women or some subgroups... more serious among women or some subgroups... for which risk factors are different for women, or for which interventions are different for women... (Dan, 1993, p. 101-2).

This primarily biomedical definition, when contrasted with those of Mulligan and Griffith-Kenney, exemplifies the primary differences in "nursing" definitions of women's health, which tend to be more holistic in approach, and "medical" definitions of women's health found in the literature, which tend to be more biomedical in nature.

More current definitions of women's health by nursing authors continue the theme established by Mulligan and Griffith-Kenney in the 1980s. In writing about integrating women's health into a nursing course, Eileen Breslin (1995) defined women's health as "a nontraditional approach to the... care of women" (p. 30). Fogel and Woods (1995), in their text Women's Health Care, state that, "The health of women is inextricably linked to the nature of their lives" (p. xiii). They also stated that, "women's health care focuses on women's overall well-being and quality of life as women themselves define it" (p. 133).

Some members of the medical community, primarily female physicians, have more recently begun to move away from the strictly biomedical definition of women's health. Johnson and Hoffman (1993, p. 117), provided the following definition of women's health care, "Women-centered care means creating a system around women's specific health needs and women's styles of interacting."

Although there is apparently no universally accepted definition of women's health, there are some unifying themes found repeatedly in the literature which are central to the essence of women's health. The concept of "holism" is mentioned by several authors (Breslin, 1995; Dan, 1993; Griffith-Kenney, 1986; Raftos, Mannix, & Jackson, 1997; Walker, 1998; Wilbanks & Romans, 1993). Walker (1998) defines
holistic care as care that "embraces the diversity of socio-cultural-geographic-age-
ability/disability contexts of women." Holism is defined as "the philosophy that, in
nature, entities such as individuals . . . function as complete units which cannot be
reduced to the sum of their parts" (Thomas, 1997, p. 666). These definitions of holism
and holistic care lead to another, similar, concept frequently mentioned in the literature
related to women’s health, that of "the lived experience" of the woman (Dan, 1994;
Muecke, 1996; Ruzek, Oleson, & Clark, 1997). One other concern found often in
relation to women’s health is that of concern for women as both consumers and providers
of health (Breslin, 1995; Boughn & Wang, 1994; Dan, 1993; Webster & Lipetz, 1986;
Wilbanks & Romans, 1993).

In summary of this discussion on defining women’s health, this researcher offers
three succinct quotes about what women’s health is now, compared to what it was. First,
a quote from Janet Griffith-Kenney in her 1986 text on women’s health, "There was a
time when prenatal care and an annual Pap smear were synonymous with women’s
health"(p. 3)." Secondly, from Eileen Hoffman’s 1992 critique of early women’s health,
"In the 60s and 70s, women’s health meant reproductive health (p. 243).” Finally, from
Alice Dan’s 1994 Reframing Women’s Health.

"Times have changed, although the precise definition of women’s health
is still in debate, there is little doubt that women’s health no longer
translates to reproductive health” (p. 27).

**Historical Perspective on Women’s Health**

"Women’s health is a new discipline in the process of creating itself, “ wrote

It is indeed a “new” discipline, but with origins as old as the women’s movement itself,
from which it evolved. Bernadine Healey, Editor-in-Chief of the "Journal of Women's Health," in a 1995 editorial entitled "Women's Health: The Third Suffrage Movement," described the first national women's rights convention in Seneca Falls, New York in 1848. The media of the day called it a "radical rebellion." The focus of that convention was on a woman's right to own property; the right to vote; the right not to be owned by a father, husband or son; and the right to have joint guardianship of her children. Healy went on to discuss the ratification of the 19th Amendment to the U. S. Constitution in 1920 that gave women the right to vote, calling it another milestone in the women's movement. She then talked about the "second wave" of the women's movement in the late 1960s and 1970s in which women sought educational and economic opportunity. In tying the first two suffrage movements with the third, the women's health movement, Dr. Healy explained, "Without confronting the independent integrity of women as human beings-as women, precisely-the notion of women's health would have no meaning medically, socially, politically, or even intellectually" (Healey, 1995, p. 219).

McBride and McBride, in their classic 1981 paper, "Theoretical Underpinnings for Women's Health", supported Dr. Healy's belief that the women's movement and the women's health movement are closely linked. They stated, "Interest in women's health has been an integral part of the women's movement from the start (p. 37)." They reviewed briefly "the Western tradition of medicine and philosophy that placed women in a secondary position to men's. . . using the male experience as the normative basis on which to evaluate health and disease (p. 39)."

They cited these beliefs as the basis for feminist thinkers to "reframe women's health." Given it's proclivity to confuse, bias and even inflame, the phenomenon "feminism" will be defined here before continuation of the discussion of the
interrelatedness of it and the women's health movement. For the purposes of this study, feminism will be defined as an integrative process that helps women expand their own consciousness about health and who they are (Fogel & Woods, 1981, p. 134). This is in keeping with the belief of Ruzek et al. (1997) that consciousness-raising was a key strategy of feminism in the 1960s and 1970s. Bass and Howes (1992) stated that women focused their efforts on organizing and advocating equal rights during this time period, entering the labor force in increasing numbers, and moving into nontraditional women's jobs. Concurrently, women began voicing increasing dissatisfaction with their health services (Fogel & Woods, 1981). As women's studies courses began to be introduced on college campuses in the 1970s, this increased interest in women served to legitimize the subject of women's health for study (Maddox & Fishbein, 1994; Nemiroff, 1989).

Along with the emergence of women's studies courses came the blossoming of grassroots women's groups and women's health groups. Women's health centers, self-help clinics, and home birth services provided by lay women, particularly in the state of California, helped to change obstetric care and raised consciousness about women's health (Dan, 1993; Fogel & Woods, 1981). Some of the earliest women's groups included: the Gray Panthers; the Boston Women's Health Collective; The National Women's Health Network, and the Congressional Caucus for Women. The Gray Panthers was a grassroots women's organization founded in 1970, dedicated to the social and health issues of older women (Ruzek et al., 1997). The Boston Women's Health Collective was another grassroots organization founded in 1969 by women who were beginning to question their medical care and wanted to be in control of their bodies. The group created and distributed mimeographed copies of their book, Our Bodies, Ourselves in 1971. The book, which served as an example of women taking health care into their
own hands, has been published in updated versions since the original mimeographed edition, with the latest edition appearing in 1998 (Boston Women’s Health Collective, 1998; Fogel & Woods, 1995). In 1974, founders and leaders of the women’s health movement established the National Women’s Health Network as a lobby to monitor public and private health regulatory agencies, and to provide a network of information and resources on women’s health (Eckman, 1996; Ruzek et al., 1997). Another woman’s group appearing in the 1970s was the Congressional Caucus for Women’s Issues, an organization composed of national female legislators who were very influential in moving forward women’s rights on a national level. Particularly active in the Caucus were Representatives Patricia Schroeder and Olympia Snowe (Eckman, 1996).

The 1980s saw a continued growth of nongovernmental women’s organizations and women’s health advocates. The Older Women’s League, a grassroots organization, sponsored in 1980 “The Campaign for Women’s Health” (Ruzek et al., 1997; Geary, 1995) the National Black Women’s Health Network was started in 1983 in the Southeast by women in communities to address their own health problems through self-help chapters and educational presentations. This group founded the National Black Women’s Health Project (NBWHP), a self-help and advocacy organization that sponsors annual conferences, health assessment studies and training programs. (Fogel & Woods, 1995; Geary, 1995; Ruzek et al., 1997) Other minority women’s health groups patterned themselves after the NBWHP, including the National Latina Health Organization in Oakland, California and the Native American Women’s Health Resource Center in South Dakota (Ruzek et al., 1997). Later, in 1991, the Health Resource Center for Women with Disabilities at the Rehabilitation Institute of Chicago was founded (Geary, 1995). Another grassroots organization was founded in the 1980's - The International Council on
Women’s Health issues. It produces one of the leading women’s health journals of today - Health Care for Women International. It also sponsors an International Congress on Women’s Health Issues every year, with the first one being held in 1984 (Stern, 1996).

The 1990s, like the two decades before it, saw the continued development of women’s health grassroots organizations, as well as professional women’s health organizations. In 1990, The Jacobs Institute was founded by the American College of Obstetricians and Gynecologists in Washington, D. C. It’s professional journal is Women’s Health Issues. The Jacobs Institute’s mission is a commitment to excellence in women’s health care (Romans, 1990). The Society for the Advancement of Women’s Health Research is a nonprofit, nonpartisan organization committed to improving the health of women through research that was developed in 1990. It was founded “to bring national attention to the problem of the exclusion of women from clinical trials and the need for greater federal funding for diseases and conditions prevalent in and unique to women (Greenberger, 1998, p. 11).” The professional journal of the Society is another leading one in the field of women’s health - The Journal of Women’s Health. The society has also established an annual medical conference on women’s health (Blumenthal, 1994; Eckman, 1996). Several of these organizations sponsor women’s health conferences, as noted already, but mention must be made here of one of the most frequently cited conferences held to date that dealt with women’s health - The United Nations 4th World Conference on Women. It was held in Beijing in 1995, and was the largest gathering of women and women’s rights advocate ever held. The platform of the Conference addressed the health and well-being of women and their families (Koch & Basu, 1996).

In accordance with the increased grassroots and professional interest in women’s health, the federal government joined the women’s health care arena. The United States Public Health Service (USPHS) appointed a Task Force on Women’s
Health Issues in 1980. The Task Force issued its report in 1985. Among other things, such as drafting the women's health definition cited earlier, it listed the three most important social changes affecting women's health at that time: the increasing number of women living in poverty; the unprecedented entry of women into the labor force, including women with infants and young children; and the continuing increase in the longevity of women (St. Pierre & Taylor, 1988; Woods, 1994). As noted in the introduction of this proposal, these same issues are still very much a factor today in women's health. Governmental involvement in women's health issues continued with the 1986 announcement by the National Institutes of Health (NIH) of a policy to encourage the inclusion of women in the studies it approved (Bohon & Sadler, 1991). In 1988, Dr. Florence Haseltine of the Center of Population Research at the NIH suggested that the state of women's health in the United states be examined (Bass & Howes, 1992). This prompted a request by the Congressional Caucus for Women for an evaluation of the NIH 1986 policy regarding women and research. In 1989, The General Accounting Office (GAO) audited the NIH, releasing its unfavorable report to Congress in 1990. The GAO audit revealed a lack of accurate data on how much of its research involved women (Bohon & Sadler, 1991; Woods, 1994). This report, and events directly following it, truly began a "watershed" of women's health activities and awareness. The NIH responded insufficiently to a subsequent request by Congress for an accounting of the data it had received, sparking several events. Congress passed legislation providing increased funding to the Centers for Disease Control for women's health screening, and to the Office of Research on Women's Health (ORWH), which was established by NIH that same year. In addition, Congress requested that medical schools be surveyed to determine the amount and content of teaching in women's health, beyond the usual
subjects of obstetrics and gynecology. It also mandated development of a women’s health core curriculum for medical education, and the examination of issues surrounding the appropriate integration of women’s health content into medical school curricula (Levison, 1994; Nieman, 1994).

The Congressional Caucus for Women was also instrumental in bringing forth a series of bills before Congress related to women’s health issues. They brought the Women’s Health Equity Act before Congress from 1989 through 1994, with the bulk of the Act being legislated in 1993 (Ruzek. et al, 1997). In 1991, the USPHS established the Office on Women’s Health to coordinate government activities and initiatives on women’s health. This office published its’ “Action Plan for Women’s Health” in 1991 (Looker, 1993). Of this flurry of governmental activity related to women’s health, Bass and Howes (1992, p. 5) had this to say, “The aging female population is the largest block of regular voters in this nation . . . Therefore, it is easy to see why promoting women’s health can be a popular and winning agenda for politicians.”

Some thoughts from a 1995 article on women’s health by Auerbach and Figert help summarize the history of the women’s health movement. They stated that the women’s health movement wasn’t just about feminism or the feminist movement. Also, it wasn’t a single, unified movement. It was a series of movements and perspectives. Finally, as Vivian Pinn (1992, p. 1291), the director of the Office on Research for Women’s Health once said, “By the year 2000, women’s health should be an integral part of the scientific mainstream . . .”

History of the Treatment of Women’s Health by the Research Community

Brief references to women’s health research (WHR) have been made up to this point in this literature review. A more detailed account of the research community and its’ historical treatment of women, women’s health, and WHR will be given in this
section. That there has been a significant lack of research devoted to women and their health needs is a well-documented, accepted fact (Auerbach & Figert, 1995; Bass & Howes, 1992; Blumenthal, 1994; Duffy, 1984; Grisso & Watkins, 1992; Kelly & Jackson, 1998; Kirschstein, 1991; Montgomery & Mouton, 1992; Pittman & Hartigan, 1996; Sherman, 1993; Woods, 1994; Wysocki, 1991).

Muecke (1996, p. 386) wrote, “From heart disease to AIDS, women have been left out of much of the medical research that has informed medical care. Care of women for other than reproductive functions has been based upon knowledge of the male body. . . Grisso and Watkins (1992, p.177), (two female physicians), concurred, “In the past, clinical research has focused primarily on men, and results of studies in men do not always apply to women.” Low et al. (1994) wrote about researched, proven differences in men and women and diseases, yet they said that researchers have traditionally ignored sex differences when investigating pathology. “The natural and social sciences have operated under the assumption that male based research is reflective of the population as a whole” (p. 804). They based their conclusions on a research study on gender bias in research conducted in 1993. They quantitatively examined all issues of three medical journals from two separate years-1982 and 1991-92. Specific parameters were used to critique all journal articles, and the study appeared to be valid.

Several authors cited the classic “aspirin study” (The Physician’s Health Study of 1998) to validate their beliefs that women have been neglected in research. The aspirin study was performed with male physicians as the research subjects. The use of aspirin by both the research and control groups and the subsequent rate of heart attacks for members of both groups was studies (Sherman, 1993). The study included no women, even though cardiovascular disease is the number one killer of women in the U.S. (Auerbach & Figert,
Auerbach and Figert also cited a 1984 report on a research study done on normal human aging that contained no women subjects.

Several authors cited reasons for the need for further women's health research (Haseltine, 1995; Kelly & Jackson, 1998; Low et al., 1994; Merton, 1994; Nieman, 1994; Pinn, 1996; & Sherman, 1993). Florence Haseltine stated the general need to research the differences between women and men more in terms of gender biology, which examines differences between genders in a cell, organ or individuals and what the differences tell scientists about the systems in which they function. Low et al. (1994) talked of the fact that heart disease is the leading cause of death for women in the U.S., yet research on cardiovascular disease in women has just recently received attention. Vanessa Merton (1994) listed six "serious implications" of excluding women from research, most of which have to do with biological and physiological differences between men and women and those effects on drug efficacy and safety. Kelly and Jackson (1998) talked of the need for research for both sexes to explore the interaction between environmental factors and genetic factors in the causation of human disease, for instance, breast cancer.

Sheryl Sherman (1993) talked of the long-standing practice of using male-only populations for scientific research and stated that the practice was grounded in a logical premise—that excluding women would expedite research by eliminating the effects of hormonal fluctuations or alterations in biologic state, such as those occurring in pregnancy, lactation and menopause. The potential differences or complexities in the presentation and course of disease and its' response to treatment that would occur if those hormonal fluctuations were present would be eliminated before they could begin, thus expediting the research. However, the differences or complexities that might have
occurred are the very types of information needed to be able to adequately treat women and reduce potential risks from medications and treatment modalities that have only been researched as far as their effects on men are concerned. Sherman stated:

The exclusion of women from clinical trials is particularly ironic in that women are more likely than men to take both prescription and over-the-counter drugs, yet research to identify specific indications and contraindications for alterations in hormonal or physiologic states is either rarely undertaken or reported in the literature (p. 263).

Finally, to quote Dr. Bernadine Healy again:

It has now become apparent that heavy reliance on the male model and failure to account for gender-biased differences have left women in a highly disadvantaged position with respect to access to accurate preventive strategies, diagnostic procedures and safe and effective therapeutic interventions (Sherman, 1993, p. 264).

Progress in Women’s Health Research

Although some women’s health research (WHR) was conducted prior to 1990 when the problem was nationally highlighted, it was not enough, as found in the literature. Even when women were included in studies, separate analyses by gender were rarely reported (Low et al., 1994). Perhaps the most famous and largest WHR study begun before 1990 was the Nurse’s Health Study, initiated in 1976. This study involved over 120,000 female registered nurses, was funded primarily by the National Cancer Institute, and began as a study to examine relationship between oral contraceptives and breast cancer. A longitudinal survey study, it was expanded to include relationships between lifestyle practices and chronic illnesses, and is still ongoing today (Colditz, Manson, & Hankinson, 1997).

Following the events that precipitated national and congressional interest in women’s health and WHR, the NIH issued an institute-wide directive which “directed that women and minorities must be included in all clinical study populations or an up-
front justification for their absence must be made” (p. 4). In an address to the Medical College of Pennsylvania in 1994, Dr. Florence Haseltine reiterated the scientific principle that research should be even-handed and fair. The literature is replete with women’s health research needs and initiatives, including everything from individual topics for research to overall research agendas. In 1995, in the Journal of Women’s Health Research, Dr. Haseltine said in an editorial that it’s time to reevaluate the meaning of the phrase women’s health research. She believed that everyone sees it differently as either a research issue alone, a marketing tool, or a way to segregate women’s health as special from the “business as usual” mode. Dr. Vivian Pinn, in a 1996 article about the status of black women and research today, stated that health research must address a woman’s total health across the life span. She noted the need for biomedical research to help increase the cure rate of breast cancer in black women, explaining that breast cancer tends to be more advanced when detected in black women, contributing to a decrease in survival rate. She stressed the need to include black and other minority women in clinical trials for the treatment of breast cancer, but went on to explain that there is fear of research in black women because of the Tuskegee syphilis study of black men. Montgomery and Mouton (1992), two female physicians, called for a commitment on the national level to address gender discrepancies in general in funded research.

As stated earlier, many individuals and groups had specific ideas about the type of WHR needed, but there seemed to be a need for a national WHR agenda with an administrative agency as “overseer.” There have been several attempts to rectify this situation on the national level. In 1997, the Society for the Advancement of Women’s Health Research (SAWHR) focused on “outcomes research” at their Annual Scientific Advancement Meeting. This research is being used to develop research policy and guide
decision making by the federal government, local health care facilities, purchasers, health plans and providers. The Society stresses that the entity funding research affects what priorities are chosen, how the information gets out and to whom, and how the information gets translated into improvements in women's health care (Greenberger, 1998). Dr. Haseltine noted that in 1995, the Society ascertained areas of research that were used by universities, industry and government to identify problems and opportunities related to WHR. She also pointed out the fact that the Centers for Disease Control, the NIH and the Federal Drug Administration all have programs to promote WHR. She proposed a model to be used to look at WHR systematically: use of a multidisciplinary perspective; training people from various backgrounds to approach problems in an organized fashion; use of a diagnostic perspective, using a standardized approach to problem-solving; and use of a triage perspective, providing patients and doctors and referring them to appropriate specialities.

In 1992, two female physicians, Grisso and Watkins, presented another framework for developing a research agenda in women's health. Their criteria were designed to ensure that health conditions would be selected that reflect common causes of morbidity and mortality in women, not just conditions that disproportionally affect them.

The ORWH of the NIH, created in 1990 to guide and encourage research on WHR within all the institutes, early on assigned high priority to two items on its' agenda for future research, research into effective treatment and triage of women undergoing acute myocardial infarction (heart attack), and effective interventions in smoking cessation. They followed through with part of this agenda by initiating the Women's Health Initiative (WHI), a large research study which will be described in detail later on in this review and information about which is found in Appendix E.
Nancy Fugate Woods, a women's health nurse researcher, analyzed and critiqued the U.S. WHR Agenda developed by the NIH (1994). This research agenda was based on the USPHS 1985 biomedical definition that was also the basis for the agenda proposed by Grisso and Watkins (1992). Dr. Woods included a copy of the 1991 Hunt Valley Workshop on Opportunities for Research on Women's Health. She felt that the agenda focused more on clinical dimensions of health, reflected in diseases and risk factors for diseases, and to a lesser extent on the role of performance, adaptive and eudaemonistic dimensions that women themselves had articulated. She did note that the agenda recognizes that health is embedded in women's life contexts. Dr. Woods went on to mention other WHR agendas such as Grisso and Watkins (1992), Leslie (1992), whose WHR agenda asserts that the broader context of women's lives merits attention, such as family and community factors, and the National Institute of Mental Health agenda regarding the diagnosis and treatment of mental disorders, including mental health issues of older women, violence against women, multiple role conflict and poverty. Finally, Dr. Woods put forth a proposal on how to conduct WHR, which included: seeking multiple perspectives, like those of women; researching aspects of the community or society that make women sick; and having women who participate in studies help interpret results.

A quote from Grisso and Watkins seemed especially appropriate for the ending of a rather disjointed look at WHR needs and initiatives, "It is evident that there is no clear consensus about how to set priorities for research on women's health issues, and that the criteria that have been used are limited" (1992, p. 178).

Although there is confusion about a national agenda for WHR, the country can at least be grateful for the attention being focused on the issue of women's health, and for the research studies taking place because of this attention. Two current research studies...
will be mentioned here briefly. The Women's Health Study includes 40,000 women health professionals age forty-five and older. It is testing low-dose aspirin and vitamin E supplementation in the primary prevention of cardiovascular disease and cancer (Manson & Buring, 1997). The Women's Health Initiative, begun in 1991 by the ORWH of NIH in keeping with their research agenda, is a long-term, national, multi-center, randomized clinical trial of 164,500 postmenopausal women. It is claimed to be the largest preventive health clinical trial ever mounted. It is designed to investigate the leading causes of death and disease in postmenopausal women which include heart disease, cancer and osteoporosis (Conference on Women's Health Research, 1993; Woods, 1994).

This description of the research community's response to the national interest could best be summarized with three quotes: "It is the responsibility of health care researchers and practitioners to challenge the norms and values that reduce or preclude quality of health care for women" (Muecke, 1996, p. 390); "... there is a gap among the results of clinical trials, evidence-based medicine, and the actual practice of medicine that needs to be bridged" (Greenberger, 1998, p. 12); and "It is now probably fair to say that clinical research will never be the same again" (Bernadine Healey, as quoted in Sherman, 1993, p. 262).

**History of the Treatment of Women and Their Health by the Medical Community**

Diana Taylor (1998), a nurse researcher and women's health professional at the University of California at San Francisco, opened a recent presentation to a national gathering of women's health nurses with these comments on how medicine has traditionally viewed women and their health needs, "It's either that time of the month ... or that time of life." Modern medicine is based on the biomedical disease model. Much
of the literature reviewed supported this viewpoint. Eileen Nechas and Denise Foley, in their 1994 book *Unequal Treatment: What You Don’t Know About How Women Are Mistreated by the Medical Community*, placed a quote from Marianne J. Legato, a female physician, on the jacket of the book, “Gender prejudice in health care, as the AMA (American Medical Association) itself has pointed out, is not only an unpleasant reality for women, it can be life threatening.” Another pertinent quote from the book is by another female physician, Jean Hamilton, “It’s easier to shut women up by giving them anti-anxiety pills than by trying to figure out the connection between their symptoms and the social contexts of their lives” (p. 123). These quotes from this thoroughly researched book on the way women are treated by doctors and medical researchers painted a grim picture of medical care for American women.

Further examples of this trend were found in the literature. Abou Zahr, Vlassoff, & Kumar, from the World Health Organization, talked about quality of care for women in a 1996 journal article:

> The provider-client relationship is of utmost importance to women’s health-seeking behavior. Unfortunately, health care workers often treat women in a brusque and insensitive manner, not paying attention to their concerns. Many researchers have noted that female patients are treated rudely by health care professionals and blamed for coming late for treatment (pp.456-457).

Janet Griffith-Kenney, in her 1986 book *Contemporary Women’s Health*, said,

> Traditional medicine has controlled women by mystifying medical information, usurping control of reproduction and childbirth, and fostering the view of women as innately helpless and dependent. The traditionalist’s “trust me” attitude makes the woman client subject to the practitioner’s control (pp. 12-13).

Sue Rosser, in her 1994 book *Women’s Health-Missing from U.S. Medicine*, talked of the androcentric focus in medicine, saying, “Modern medicine has failed to include women in substantive ways. Androcentrism appears to take different effects in
the various specialties" (p. 190). Sue Fisher (1995), a sociologist who conducted an in-depth qualitative study of doctor-patient relationships by actually observing in person these doctor-patient encounters, found that the doctor-patient relationship (most often a male doctor - female patient) is characteristically an asymmetrical encounter, with an almost exclusive concern with medical topics to the nearly total exclusion of the social and biographical contexts of patient’s lives.

The Commonwealth Fund conducted what it termed a groundbreaking national survey in 1993 that revealed disquieting facts about American women’s health and that refuted the assumption that women live longer because they enjoy good health. The Fund’s Commission on Women’s Health brought together a panel of expert health researchers to further analyze the data, they were so disturbed by their findings. The results of that analysis were published in a book in 1996 (Falik & Collins, 1996). The findings, which related to how physicians work with women, were summarized as follows:

Physicians often fail women when help is needed. Forty-one per cent of women have changed physicians because they are dissatisfied, compared with twenty-seven percent of men. Many women found physicians condescending or dismissive, and one in ten women would not discuss problems with physicians because they were uncomfortable (p. vii).

A quote from the 1994 book *Women’s Health: An Unfinished Revolution*, summed up the status of medicine and its’ historical treatment of women, as well as raised an important point—that much of this physician behavior is unintentional.

“Discrimination against women patients lingers today. Much of it, probably, was and is unintentional and involuntary. Nonetheless, a significant part of the history of health care’s treatment of women is a tale of neglect and paternalism” (Friedman, 1994, p. 4).

How did this paternalistic, androcentric medical view of women evolve? The answer lies in the beginnings of modern medicine and society’s historical attitude toward
women. Michelle Harrison, a female physician, detailed the history of medicine in a 1993 article in which she advocated the creation of a separate medical specialty of women's health in medicine. She began her historical account by explaining that the current separation in modern medicine of a woman's reproductive functions from her other physical needs and functions has its' roots in 19th century medicine. This medical model was founded on the model of a male body, with woman as the “other.” With the development of obstetric instrumentation and gynecological surgery, female midwives were replaced in the birthing process by male obstetricians/gynecologists. Medicine was also burdened by the 19th century sexist attitudes toward women. These attitudes appeared in medical texts until the 1970s. In these texts, women were defined by their reproductive organs and roles. Three research studies examining the issue of gender bias in human anatomy and gynecology textbooks were conducted in 1973, 1986 and 1994. The 1973 study (Scully & Bart), analyzed the contents of twenty-seven gynecology texts published in the U.S. since 1943. All texts were written from a male viewpoint. Researchers found that the texts revealed a consistent bias toward greater concern with the patients' husband than with the patient herself. Women were consistently described as "anatomically destined to reproduce, nurture, and keep their husbands happy." (p. 1045).

The 1986 study (Giacomini, Rozee-Koker, & Pepitone-Aerreola-Rockwell) had as its' hypothesis that female and male bodies were equally represented in human anatomy text illustrations. The researchers extensively studied eight major anatomy texts used in western schools at that time. Their findings revealed that in standard (non-gender-specific) text sections-male subjects were shown in 64 % of illustrations, females in 11 % of the illustrations, and both sexes were shown equally in 25 % of the illustrations.
In gender specific chapters, the percentages were 45% female and 48% male. The authors went on to talk about gender bias in grade-school, college and graduate level textbooks.

The third study, by Mendelsohn, Nieman, Isaacs, Lee, and Levison (1994), looked at 4060 illustrations that were identifiable by sex and gender in 12 commonly used anatomy and physiology diagnostic textbooks. They found 3827 illustrations that were categorized as male, female or neutral. The findings were that, on average, in 21.2% of the text illustrations, females were pictured, males in 44.3% of them, and 34.4% were neutral. Of nonreproductive anatomy illustrations, 11.1% represented women, and 43.1% men. The researchers concluded that “the finding that males are depicted in a majority of nonreproductive illustrations may perpetrate the image of the male body as the normal or standard model for medical education” (p. 1267).

In the early 20th century, the famous “Flexner Report of 1910” was issued. The report made many recommendations for medical education, and was used by licensing and accreditation boards for their respective purposes. This use of the report by these agencies eliminated the less well-established and less well-endowed medical schools which were the primary ones that were less expensive and accepted more women and minority students. During this time also, there was a strong German influence on medical education in America, causing the idea of research in medicine to become very important, and the beginnings of development of medical specialties based on technology and surgical procedures (Harrison, 1992).

Another factor contributing to the androcentricity of modern medicine was the traditional practice of organizing departments of medicine along disease specific lines. This practice still exists today to a great degree (Ness & Kuller, 1997).
This practice led to the fragmentation of medical services for women... Rather than seeing one woman's health physician for all needs, including those of a reproductive nature, women often saw (and still do) many different physicians, depending on the nature of their health problem or issue. The majority of women today have at least two physicians they see on a regular basis - the obstetrician/gynecologist and the family practice physician - as opposed to the one primary physician the majority of men utilize for their health needs (G. Kraemer, personal communication, August 5, 1998).

Modern medicine was, for the majority of the 19th and 20th centuries, a male-dominated profession. That is still true today, even though the number of female physicians is growing. In *An Unfinished Revolution: Women and Health Care in America* (1994), the plight of females in the medical profession was described, "As professionalism permeated... medicine in this century, women lost ground rapidly. Medical schools... generally would not accept them; if accepted, female graduates... often could not find work" (p. 2). Nechas and Foley (1994) found in their study that medical institutions are admitting women in record numbers, but remain hostile to women both in treatment of women students and in the curriculum. Clancy and Massion, two female physicians, in their 1992 article "A Patchwork Quilt with Gaps", cited what they considered to be improvements in women's health, such as increased research and the increased numbers of female physicians. Church and Poirire, 1986, believed that the increased numbers of female physicians are in a position to influence medicine from within. Auburdene and Naisbitt (1992) agreed, saying that, "Women’s key allies in the struggle to put women’s causes at the top of the national agenda are the growing numbers of women in medicine" (p. 160). Aubert and Figert (1995), two sociologists, disagreed with this sentiment. They said that having more female scientists and doctors won’t help.
They pointed to the educational and reward system in which scientists and physicians are trained. If those systems favor traits identified with the male gender, then increasing the proportion of female scientists or doctors makes little difference, they believed.

That medical education systems do favor "traits identified with the male gender" has been evidenced by the already discussed androcentrism of medicine; by the recent development of multiple women's health curriculum designs to be integrated into medical school curricula; and by many references in the literature, three of which are included here. A fourth year medical student was quoted in a 1985 journal article by Kathleen MacPherson as having said, “female patients are commonly portrayed as neurotics, chronic complainers, hypochondriacs and-to add spice-as sexual playthings” (p. 4).

Nechas and Foley (1994) described a medical professor who inserted slides of centerfold models into his anatomy lecture. Finally a group of female physicians, in writing about medical education, said that evaluation of gynecologic skills has achieved the greatest degree of attention in both undergraduate and graduate medical teaching because women's health has long been associated with learning about reproductive functions (Nieman, Rutenberg, Levison, Kuzma, Rudnitsky, & Beck-Weiss, 1997).

In addressing the issue of inadequate women's health content in medical school curricula, Sandra Levison (1994) said, “...that there is a real omission in the teaching of women’s health is no longer debatable” (p.387).

Progress in the Field of Medicine

The medical profession has been addressing this omission since 1990. There have been several women’s health curriculum models created, and governmental and professional organizations have been working toward meeting the 1990 Congressional mandates regarding medical education and women’s health (Association of Professors of Medicine, 1997; Cain, 1993; Levison, 1994; Roberts, Kroboth, & Bernier, 1995;...
Robertson, Brown, Flanagan, Goldman, Learman, Stevens, & Wilcox, 1997; Wallis, 1992). A survey to determine the amount and content of teaching of women’s health in medical schools (one of the mandates), beyond the usual obstetrics and gynecology training, was developed by the Office of Research in Women’s Health (ORWH) in the NIH, the Health Resources and Services Administration (HRSA) of the Department of Health and Human Services (DHHS), and the Association of American Medical Colleges (AAMC). The results of the survey are not yet complete (C. Croft, personal communication, May 8, 1998; Levison, 1994).

Reforming medical school curricula was the goal of a conference in Chantilly, Virginia in 1996 that was hosted by the Association of Professors of Gynecology and Obstetrics (APGO). The conference, the APGO Interdisciplinary Women’s Health Education Conference, included undergraduate medical educators from six national education associations. Also present were representatives from the AMA, HRSA, AAMC, and the National Academy on Women’s Health Medical Education. Each medical practice discipline was represented. The conference produced five curricular enhancements to be used in all medical schools and addressed integration of women’s health into medical school curricula, as requested by Congress (Magrane, 1997).

Other initiatives to enhance women’s health care in the medical field include: a process to evaluate women’s health programs in medical school settings (Nieman et al., 1997); the development of women’s health centers (Looker, 1993; Chez, 1993; Clancy & Massion, 1992; Hoffman, Moraldo, Coons, & Johnson, 1997; Schaps, Linn, Wilbanks, & Wilbanks, 1993); the publication of a position paper on women’s health in 1996 by the American College of Physicians; and the call for the establishment of a women’s health practice specialty (Johnson, 1992; Harrison, 1993 & Wallis, 1992). Three gentlemen
from the World Health Organization, Abou Zahr, Vlassoff, and Kumar (1996), provided some provocative thoughts germane to the long-term, often controversial process of redefining medical care, practice, and views on women and their health:

Improving gender sensitivity among health care providers at all levels will require more than the occasional awareness-raising course or exhortations to be kinder to clients. What is needed is a fundamental rethinking between providers and clients, one that removes the aura of infallibility and power of the medical person and recognizes the skills and knowledge of the client for her own health care. In addition, a sense of entitlement must be established among clients, that is, a feeling that they deserve and have the right to demand quality health services. Such a rethinking must also address the fragmented way in which women’s health needs are currently addressed (p. 463).

History of Nursing and Women’s Health

Prior to the mid-19th century and the ascendancy of the medical profession, a women’s culture of mutual help and healing existed. However, as the medical body of knowledge grew, as medical instrumentation became the norm, and as medicine became legitimized and shrouded in mystery and science, women were made to feel ignorant and disempowered, eventually becoming compliant and passive (Andrist, 1988). Rather than leave their traditional sphere, women who entered nursing would merely extend their familiar sphere into a more public area. Wittingly, or unwittingly, women submitted to society’s pressures, including the notion that women should not enter the “male” professions.

Private schools established by physicians for training nurses were firmly established in the U. S. by the time of the Civil War. Nurses were thought to provide “great value” and to have a moral and motherly influence on the wards (Church & Poirier, 1986). Although some attempts were made by nurses to diverge from the narrow focus of the medical/curative model in the early 20th century, the prevailing ideology
continued to limit the development of a scientifically and academically broader perspective for nursing schools. The emergence of nursing from the dependent apprenticeship role was slow and difficult. Threats of animosity from organized medicine toward attempts at independence in nursing education and practice were effective while nursing programs remained within the walls of the physician-dominated hospitals, as the original three year diploma schools of nursing. Once nursing education found a footing in the educational mainstream of universities and colleges, however, their vulnerability to such animosity was greatly diminished (Church & Poirier, 1986).

Linda Andrist (1988) suggested that in a system where physicians traditionally have been in control, nursing had perhaps internalized the values of medicine, consequently identifying with medicine. She felt that nursing was even more disadvantaged because of the dual subjugation of the majority of its’ members - who were both women and nurses. “Nursing has traditionally hovered in a state of ambiguity” (Church & Poirier, 1986, p. 106). Its’ long history of subjugation to the patriarchal control of medicine and internalization of the values of medicine have been in direct conflict with the very nature of the profession-caring. As far as caring for women, Abrums (1986) discussed how nurses have traditionally maintained a great deal of control over their patients, contributing to women’s lack of control of their own health. Mulligan (1983) described how the nursing profession was strikingly absent from the voluminous literature about the women’s health movement in the 1960s and 1970s. Also, at that same time, nurse authored texts and professional literature continued to reflect the mostly medical (male) view of health. This began to change in the late 70s and early 80s, when evidence was found in the literature that nurses were attending to women’s health issues (Mulligan, 1983).
There seemed to be little consensus in the literature as to the involvement of the nursing profession in either the feministic theory that influenced the women's health movement or in women's health in general. One aspect of feminism—the importance of experiential analysis—has been a basic tenant of nursing theory for many years, thereby loosely aligning the two. Morse (1995) said that nursing had "blazed the trail" in women's health programs for over a decade. Dunbar, Patterson, Burton, and Stuckart (1981), however, looked at published nursing research to provide data on nursing's attention to women's health, and found that nursing research had paid little attention to health care needs by sex differences. They said, "As a profession composed largely of women, nursing should take the lead in the critical investigation of women's health for establishing a sound theoretical basis for practice (p. 10)." Webster and Lipetz (1986) explained nurses' ambivalent attitudes toward responsibility for women's health as a reflection of their historic position of responsibility without authority.

Several other authors advocated nursing's intervention into women's health (Andrist, 1988; Taylor & Woods, 1996; Thomas, 1992). Linda Andrist (1988) said that nursing was a helping profession whose goal is the nurturance and nourishment of the whole person. She felt that nursing could therapeutically empower women through diminishing hierarchies of control and power. U. S. Representative Patricia Schroeder (1994) asked nurses to take an active role in assuring that women receive the services they need.

Nursing Education and Women's Health

Nursing education somewhat paralleled the path of the nursing profession as far as women's health is concerned. Nursing education adopted the medical model initially. A shift toward organizing nursing curricula on the basis of the nursing process began in the
The nursing process, a systematic process for the planning and delivery of care to patients, advocated care of the total patient/family situation, thus acknowledging the role of each family member in the planning and implementation of patient care (Griffith-Kenney, 1986). Among the roles acknowledged were those that a woman might play in a family situation - patient, wife, mother, daughter, and/or sister. This was a small step that nursing education took toward recognizing more of the needs and/or responsibilities of women in the health care systems.

Saunders and Taylor (1985) said that nurse educators had been slow to develop women's health courses even though the signs showed that the women's movement was beginning to influence nursing research and education. Susan Boughn said in 1987 that occasionally a school of nursing would offer a women's health course, but not often, and it was usually an elective course. Mulligan (1983) discussed in an article the fact that other departments on university and college campuses were offering women's studies courses, but nursing was not. A 1994 article from Susan Boughn and Henry Wang said that nursing curricula throughout the U.S. was just beginning to reflect gender issues in general.

There are many graduate level women's health nursing courses (Andrist, 1988; Boughn & Wang, 1994; Cohen, Mitchell, Olshansky, & Taylor, 1992; McElmurry & Newcomb, 1995), but "the creation of this broader perspective {women's health} within the existing nursing courses has not been documented" (Breslin, 1995, p. 30).

Elizabeth Hagell, a Canadian nursing professor, conducted a research study in 1990 to examine which {women's health} issues were being incorporated and which were being excluded from Canadian baccalaureate nursing programs. She found that, "There is, in fact, a dearth of information on nursing education and women's health
altogether" (p. 122). Hagell's study was the only one located in the literature review that was a close replica of this research study. Hagell surveyed all university Schools of Nursing in Canada, focusing on degree programs. She used a researcher-developed questionnaire patterned after a tool used by a colleague to survey an issue in nursing curricula. She mailed 68 questionnaires and had a 63% response rate. Her results included: issues under the heading of reproductive health were discussed to the greatest extent; female sexuality was most discussed next; and social aspects were discussed slightly more than mental health issues and diet and nutrition. Problems identified with the study were the presence of several integrated nursing curricula, making questions harder to answer, and length and design of the questionnaire, which the researcher felt contributed to the lower response rate than she anticipated. One other research study was found that dealt with surveying women's health courses across the lifespan. The purpose of the study was to ascertain if lifespan content was included in women's health courses in nursing curricula at that time. The researchers contacted 592 baccalaureate and higher degree nursing programs, using a short questionnaire. Of the 391 programs that responded, 151 of them offered women's health courses that covered the lifespan. The greatest flaw of the study seemed to be the lack of designation of the level of the nursing programs offering the courses - graduate or undergraduate. As had been stated earlier in this review, some graduate nursing programs have women's health programs, which often are on the advanced practice level, necessitating inclusion of lifespan related women's health content. Therefore, results of the study were not specific to either baccalaureate level nursing education or master's level nursing.

The literature seemed to indicate a lack of information as to the inclusion of women's health courses or women's health content in baccalaureate nursing curricula.
Christine Tanner (1996), editor of the Journal of Nursing Education, expressed some thoughts regarding nursing curricula which might help explain the absence of a large amount of content devoted to women's health issues in some baccalaureate nursing program curricula. She said it is hard for academic nursing to move content out of the curriculum to be replaced with other content. She also stated that faculty engage in endless debate and that faculty from each practice specialty bemoan that not enough time is given to their content for students to learn it. Tanner continued on to say, however, that nursing curricula needs to be responsive to the rapid changes in nursing practice. Women's health, as reflected in the literature, could be one of those rapid changes that Tanner spoke of.

The American Academy of Nursing felt strongly enough about women's health to assemble an Expert Panel on Women's Health in 1996. The Writing Group of the Panel issued recommendations for nursing practice, research and education related to women's health in 1997. As concerned nursing education, they wrote:

Nursing education and nursing practice opportunities must be expanded if advance practice nurses and other registered nurses are to contribute to the advancement of women's health care in the coming decades (p. 14).

Their recommendation for baccalaureate nursing education was to strengthen the emphasis on women's health care throughout undergraduate programs. This is a call to nurse educators to evaluate the strengths of their curricula in regard to women's health care.
CHAPTER III

METHODOLOGY

Study Design

The primary purpose of this study was to determine if selected women’s health issues were included in baccalaureate nursing curricula; and, if included, the types of courses in which they were taught, the amount of class time allocated to the issues, and the level of importance of each issue as perceived by nursing faculty. Women’s health issues which were investigated included: Screening/Risk Assessment; Health Teaching/Promotion; Nutrition; Domestic Violence; Substance Abuse; Sexually Transmitted Diseases; Sexual Abuse; Sexuality; Eating Disorders; Depression; Reproductive Cancers; Menstruation/ Menstrual Irregularities; Menopause; Hormone Therapy; Fertility/Infertility; Cardiovascular Disease; Osteoporosis; Lung Cancer; and Urinary Stress Incontinence.

Population and Sample

The target population for this study was baccalaureate degree nursing programs in the United States. The accessible population was all 1998 NLN accredited baccalaureate nursing programs in the United States. The frame of the population was established as all baccalaureate nursing programs listed in the 1998 directory published by the NLN Accrediting Agency in Washington, D.C. The sample consisted of a group of randomly selected nursing programs from the accessible population of 604 NLN accredited baccalaureate nursing programs in the U.S. in 1998. The minimum required sample size was determined using Cochran’s (1977) sample size determination formula, using a 5% acceptable margin of error, an estimate of the population variance of .25 (determined as the most conservative estimate by p x q), and a 5% risk that the actual margin of error...
exceeded the acceptable margin of error. The minimum sample size was determined to be 235. Since some oversampling is desirable in most survey design studies, the decision was made to sample 260 units from the frame of the accessible population. As all nursing programs within the NLN 1998 database were designated as being located in one of four geographic regions in the United States, the random sample of NLN accredited baccalaureate nursing programs used in the study was selected proportionately from nursing programs listed within the four designated regions in the NLN 1998 database, thus providing a stratified random sample for study use. The composition of the overall study sample of 260 NLN accredited baccalaureate nursing programs was: 73 programs from the Southern portion of the United States; 67 programs from the Northeast region of the country; 83 programs from the Midland region of the country; and, 37 programs from the Western region of the United States. The Regional Percent of responses represents the percentage of the sample from each region that provided responses to the survey. From the random sample of 260 nursing programs included in the study, 169 responded. Table 1 shows the regional breakdown of the population, sample and respondents.

Table 1

<table>
<thead>
<tr>
<th>Region</th>
<th>Population (604)</th>
<th>Sample (260)</th>
<th>Responses (169)</th>
<th>Regional Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>%</td>
<td>F</td>
<td>%</td>
</tr>
<tr>
<td>Southern</td>
<td>170</td>
<td>28.0</td>
<td>73</td>
<td>28.0</td>
</tr>
<tr>
<td>Northeast</td>
<td>156</td>
<td>26.0</td>
<td>67</td>
<td>26.0</td>
</tr>
<tr>
<td>Midland</td>
<td>195</td>
<td>32.0</td>
<td>83</td>
<td>32.0</td>
</tr>
<tr>
<td>Western</td>
<td>83</td>
<td>14.0</td>
<td>37</td>
<td>14.0</td>
</tr>
<tr>
<td>Total</td>
<td>604</td>
<td>100.0</td>
<td>260</td>
<td>100.0</td>
</tr>
</tbody>
</table>
The Midland region, which has the largest number of schools, had the lowest response percentage (54.2). Appendix F lists the states by NLN designated regions.

**Instrumentation**

A researcher-developed three-part questionnaire (see Appendix G) was used to collect data. Each respondent and questionnaire was given an identification number. Content validity of the questionnaire was obtained using a three-part method. First, women’s health issues which occurred repeatedly in an extensive literature review were identified and categorized. Next, a national sample of eight women’s health professionals who were not potential members of the sample were selected as a panel to review and evaluate the content validity of the instrument (see Appendix H). The panel was comprised of five doctoral and one masters level nursing professors, one masters prepared women’s health nurse practitioner (who was also national president of the Association of Women’s Health, Obstetric and Neonatal Nurses [AWHONN]), and one masters prepared research nurse coordinator at a women’s health research institute. Seven of the eight panel members responded. The questionnaire was then developed and critiqued by two doctorally prepared graduate nursing faculty, and three masters prepared baccalaureate nursing faculty. The first part of the questionnaire included questions related to the listed women’s health issues. These questions were used to determine if the participating nursing programs included the selected women’s health issues in their curricula, and, if so, where in the curriculum the issues were placed and how much class time was allocated to each issue. The second section of the instrument was used to determine nursing faculty’s perceptions of the importance of the selected women’s health issues to baccalaureate nursing curricula. The rating scale consisted of five levels of importance, ranging from a low of “Not Important” to a high of “Extremely Important.” The third
part of the instrument was developed to elicit demographic information on both the respondent and the parent institution of the participating nursing program.

**Data Collection**

An initial cover letter, questionnaire, stamped, self-addressed return envelope, and blank address form were mailed first class to deans/directors of the 260 randomly selected 1998 NLN accredited baccalaureate nursing programs in the U. S. (see Appendices I and J). The cover letter requested participation, offered the participant a copy of results, and assured respondents confidentiality and anonymity. Based on Dillman's (1978) suggestions for follow-up methods to increase response rate, a reminder postcard was mailed to nonrespondents 10 days after the initial mailing (see Appendix K). A follow-up mailing, sent approximately two weeks from the date of the postcard mailing, consisted of another cover letter, questionnaire, and stamped, self-addressed return envelope (see Appendix L). Results of the study were made available to all participants who requested them by returning the completed address forms included in the first mailing. A total of 169 baccalaureate nursing programs (65%) of the original 260 participated in the survey by returning completed questionnaires. When a 90% response rate was not achieved by the designated date, the following a non-response follow-up procedure was conducted:

1. A simple random sample of 25 units was selected from the non-respondents.

2. Twenty response items from the questionnaire were randomly selected since the entire instrument would be prohibitive to conduct by telephone. These response items were selected to ensure that the items constitute intelligible questions (see appendix M).

3. Each of the selected nonrespondents was contacted by telephone and requested to respond to the abbreviated instrument. If the sample member could not be reached
after three attempts, an alternative non-respondent was selected from an alternate list to replace the unreachable member. The researcher followed this procedure until the minimum designated non-response sample of 25 was achieved.

Three of the items were compared using the t-test procedure and three of them were compared using the chi-square procedure. Examination of the 20 comparisons made revealed that the groups were statistically different on six of the items. Therefore, the data from this study should be considered applicable to the respondent group only. The items on which these comparisons were made and the appropriate test results are presented in Tables 2-4. It should be noted that the possibility exists that the different data collection methods may have influenced the responses received. Therefore, the significant differences may have been the result of the variation in data collection methods.

**Data Analysis**

An alpha level of .05 was established a priori. Procedures for statistical analysis will be discussed by objective.

Objective one was to describe participating nursing programs on the following characteristics: type of parent university/college; location of parent university/college; average annual university/college enrollment; average annual baccalaureate nursing program enrollment; average annual number of baccalaureate nursing graduates; presence/absence of graduate nursing program; presence/absence of women’s health graduate nursing curriculum track; and, presence/absence of women’s health course in another department in the university/college.

Variables which were measured on a categorical scale, that is nominal or ordinal, were summarized using frequencies and percentages. Those variables that were measured on a nominal scale were: type of university/college; location of university/college;
Table 2
Comparison of Respondent and Non-Respondent Groups on Selected Women's Health Issues

<table>
<thead>
<tr>
<th>Issue</th>
<th>Respondent Mean/SD</th>
<th>Non-Respondent Mean/SD</th>
<th>t</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition</td>
<td>3.99/0.81</td>
<td>4.48/.59</td>
<td>-3.67</td>
<td>.001</td>
</tr>
<tr>
<td>Cardiovascular Disease</td>
<td>4.30/.72</td>
<td>4.67/.57</td>
<td>-2.85</td>
<td>.007</td>
</tr>
<tr>
<td>Hormone Therapy</td>
<td>3.71/.86</td>
<td>4.13/.74</td>
<td>-2.49</td>
<td>.02</td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>3.97/.86</td>
<td>4.24/.66</td>
<td>-1.86</td>
<td>.07</td>
</tr>
<tr>
<td>Lung Cancer</td>
<td>4.04/.82</td>
<td>4.30/.77</td>
<td>-1.53</td>
<td>.14</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>4.15/.70</td>
<td>4.36/.70</td>
<td>-1.41</td>
<td>.17</td>
</tr>
<tr>
<td>Urinary Stress</td>
<td>3.74/.84</td>
<td>4.00/.91</td>
<td>-1.35</td>
<td>.19</td>
</tr>
<tr>
<td>Depression</td>
<td>4.32/.70</td>
<td>4.48/.65</td>
<td>-1.14</td>
<td>.27</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>4.36/.64</td>
<td>4.48/.65</td>
<td>-0.90</td>
<td>.38</td>
</tr>
</tbody>
</table>

Table 3
Comparison of Respondent and Non-Respondent Groups on Inclusion of Selected Women's Health Issues in Baccalaureate Nursing Programs

<table>
<thead>
<tr>
<th>Issue</th>
<th>( \chi^2 )</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urinary Stress</td>
<td>.001</td>
<td>.92</td>
</tr>
<tr>
<td>Hormone Therapy</td>
<td>.01</td>
<td>.92</td>
</tr>
<tr>
<td>Health Teaching/Promotion</td>
<td>.15</td>
<td>.70</td>
</tr>
<tr>
<td>Screening/Risk Assessment</td>
<td>.45</td>
<td>.50</td>
</tr>
<tr>
<td>Nutrition</td>
<td>1.27</td>
<td>.26</td>
</tr>
<tr>
<td>Sexuality</td>
<td>3.72</td>
<td>.05</td>
</tr>
<tr>
<td>Fertility/Infertility</td>
<td>4.26</td>
<td>.04</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>7.74</td>
<td>.005</td>
</tr>
</tbody>
</table>
Table 4

Comparison of Respondent and Non-Respondent Groups on Selected Program and Demographic Characteristics

<table>
<thead>
<tr>
<th>Issue</th>
<th>( \chi^2 )</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education level</td>
<td>9.63</td>
<td>.05</td>
</tr>
<tr>
<td>Type of program</td>
<td>1.63</td>
<td>.65</td>
</tr>
<tr>
<td>Presence of Graduate Program</td>
<td>0.73</td>
<td>.39</td>
</tr>
</tbody>
</table>

Variables which were measured on a categorical scale, that is nominal or ordinal, were summarized using frequencies and percentages. Those variables that were measured on a nominal scale were: type of university/college; location of university/college; presence/absence of graduate nursing program; presence/absence of women’s health graduate nursing curriculum track; and presence/absence of women’s health course in another department in the university/college. Those variables which were measured on an ordinal scale were: annual university/college enrollment; annual baccalaureate nursing program enrollment; and annual number of baccalaureate nursing graduates.

Objective two was to describe respondents on the following characteristics: current position in the School of Nursing; highest level of academic preparation; practice specialty; and age. Those variables that were measured on a nominal scale were current position in the School of Nursing and practice specialty. Variables measured on an ordinal scale were highest level of academic preparation and age. All of these variables were summarized using frequencies and percentages.

Objective three was to determine if selected women’s health issues were currently included in the curricula of NLN accredited baccalaureate nursing programs in the U.S. Those issues were: Screening/Risk Assessment; Health Teaching/Promotion; Nutrition; Domestic Violence; Substance Abuse; Sexually Transmitted Diseases; Sexual Abuse;
Sexuality; Eating Disorders; Depression; Reproductive Cancers; Menstruation/Menstrual Irregularities; Menopause; Hormone Therapy; Fertility/Infertility; Cardiovascular Disease; Osteoporosis; Lung Cancer; and Urinary Stress Incontinence. All of these variables were measured on a nominal scale and were summarized using frequencies and percentages.

Objective four was to determine curricular placement of selected women’s health issues that were currently included in the curricula of NLN accredited baccalaureate nursing programs in the U.S. The variable “curricular placement of selected women’s issues” consisted of the following courses: Maternal/Infant Nursing; Women’s Health Nursing; Adult Health Nursing; Community Health Nursing; Mental Health Nursing; an elective nursing course; and other. Both variables were summarized using frequencies and percentages.

Objective five was to determine class time allocation of selected women’s health issues that were included in the curricula of NLN accredited baccalaureate nursing programs in the U.S. The variable “class time allocation,” was measured on an ordinal scale, and included the following categories: outside class readings only; less than one-quarter of an hour; less than one-half of an hour; from one-half hour to one hour; from one hour to two hours; from two hours to three hours and over three hours. Data was summarized using frequencies and percentages. To facilitate interpretation of the class time variable, a researcher developed scale of estimated actual time measured in hours was also used to report data.

Objective six was to ascertain the importance of selected women’s health issues in baccalaureate nursing curricula as perceived by nursing faculty. The variable “importance of selected women’s health issues” was ordinal in nature. Data were
summarized using frequencies and percentages. To aid in interpretation of the
importance data, a scale of interpretation based on the response scale used in the
instrument was developed by the researcher.

Objective seven was to determine the women’s health emphasis (WHE) of
participating baccalaureate nursing programs. The variable “WHE” was measured by the
calculation of a WHE Score for each participating program. These data were summarized
using means and standard deviations.

Objective eight was to determine if a relationship existed between the WHE score
and selected program characteristics. The program characteristics included: type of
university/college; location of university/college; average annual university/college
enrollment; average annual baccalaureate nursing program enrollment; average annual
number of baccalaureate nursing graduates; presence/absence of graduate nursing
program; presence/absence of women’s health graduate nursing curriculum track; and
presence/absence of women’s health course in another department in the
university/college.

The variable “WHE Score” was measured continuously. The relationships
between WHE Score and the selected program characteristics which were measured as
nominal dichotomous variables were determined using the t-test procedure. The program
characteristics that were nominal dichotomous variables were: presence/absence of
graduate nursing program; presence/absence of women’s health graduate nursing
curriculum track; and presence/absence of women’s health course in another department
in the university/college.

The relationships between WHE Score and the selected program characteristics
measured on an ordinal scale were determined by using Spearman’s Rank Order
Correlation Coefficient. The program characteristics that were measured on an ordinal scale were annual university/college enrollment, annual nursing program enrollment and average annual number of baccalaureate nursing graduates. The interpretation of computed correlation coefficients was based on the following set of descriptors by Davis (1971): .7 or higher—very strong relationship; .50 to .69—substantial relationship; .30 to .49—moderate relationship; .10 to .29—low relationship, and .09 or lower—negligible relationship. To determine the relationships between WHE Score and the independent variables "location of parent institution" and "type of parent institution," an analysis of variance (ANOVA) was used.

Objective nine was to determine if a model existed which explained a significant portion of the variance in WHE Score of baccalaureate nursing programs from the following program characteristics: type of parent university/college; location of parent university/college; average annual university/college enrollment; average annual baccalaureate nursing program enrollment; average annual number of baccalaureate nursing graduates; presence/absence of graduate nursing program; presence/absence of women's health graduate nursing curriculum track; and presence/absence of women's health course in another department in university/college. Determination of a possible model was accomplished using multiple regression analysis, with WHE Score as the dependent variable. The other variables were treated as independent, and were entered for stepwise analysis.
CHAPTER IV

FINDINGS

This chapter presents the Findings of this study. The results are organized by the objectives of the study.

Objective One

Objective one was to describe participating nursing programs on the following characteristics: type of parent institution (university/college); location of parent university/college; average annual university/college enrollment; average annual baccalaureate nursing program enrollment; average annual number of baccalaureate nursing graduates; presence/absence of graduate nursing program; presence/absence of women’s health graduate nursing curriculum track; and presence/absence of a women’s health course in another department in the university/college.

Variables which were measured on a categorical scale, that is nominal and ordinal scales of measurement, were summarized using frequencies and percentages. Those variables that were measured on a nominal scale were: type of university/college; location of university/college; presence/absence of graduate nursing program; presence/absence of women’s health graduate nursing curricular track; and, presence/absence of women’s health course in another department in the university/college. Those variables which were measured on an ordinal scale include: average annual university/college enrollment; average annual baccalaureate nursing program enrollment; and average annual number of baccalaureate nursing graduates.

Type of parent university/college. Respondents were asked to describe the parent institution in which their nursing program was located by indicating one of following descriptors: public; private secular; private religious; and other. Of the 169
universities/colleges described by respondents, 49.1% (n=83) were public institutions, 33.1% (n=56) were private religious institutions, 16% (n=27) were private secular institutions, and 3 (1.8%) were identified as "other." Two of these three "other" institutions were reported to be private non-secular and land grant. The third one was marked "other" but did not provide a response regarding the specific type.

**Geographic location of parent university/college.** The location of the respondent’s university/college was delineated using the four geographical regions designated by the National League for Nursing (NLN) in their 1998 database of accredited baccalaureate nursing schools. Those regions were: Southern; Western; Midland; and Northeast. The regional representation of respondents in the study was as follows: 53 (31.4%) were from the Southern region; 45 (26.6%) were from each of the Northeast and Midwest regions; and 26 (15.4%) were from the Western region of the United States.

**Institution size.** Respondents were asked to indicate the size (as measured by average annual enrollment) of the parent institution (university/college) in which their nursing program was located. Response categories provided included: less than 1000; 1001-2500; 2501-5000; 5001-7500; 7501-10,000; and over 10,000. The category indicated by the largest number of respondents, 27.8% (n=47), was that of universities/colleges having an average annual enrollment of over 10,000 students. Only 12 universities/colleges (7.2%) were reported to have an average annual enrollment of under 1000 students (see Table 5).
Table 5

Average Annual Enrollment of Parent Institution

<table>
<thead>
<tr>
<th>Enrollment Category</th>
<th>F</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 1000</td>
<td>12</td>
<td>7.2</td>
</tr>
<tr>
<td>1001 - 2500</td>
<td>40</td>
<td>24.0</td>
</tr>
<tr>
<td>2501 - 5000</td>
<td>36</td>
<td>21.5</td>
</tr>
<tr>
<td>5001 - 7500</td>
<td>19</td>
<td>11.4</td>
</tr>
<tr>
<td>7501 - 10,000</td>
<td>13</td>
<td>7.8</td>
</tr>
<tr>
<td>&gt; 10,000</td>
<td>47</td>
<td>28.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>167</td>
<td>100.00</td>
</tr>
</tbody>
</table>

* Two participants did not respond to this item.

Baccalaureate nursing enrollment and number of graduates. The average annual nursing program enrollment (size of the nursing program) was measured by respondents selecting one of the following categories: less than 50; 50-100; 101-150; 151-200; 201-250; and over 250. The category “over 250" was selected by the largest number of respondents, 25.4% (n=43). The smallest number of respondents, 9.5% (n=16), selected the category “less than 50." Responses to the request for information regarding the variable “average annual number of baccalaureate nursing graduates” were indicated using the following categories: less than 50; 50-100; 101-150; 151-200; 201-250; and over 250. Nursing programs having 50-100 graduates comprised the largest response category with 44.4% (n=75) of the 169 programs identified as being within this range. The next largest response group was that of less than 50 comprising 36.1% (n=61) of the total. See Table 6 for information on all categories related to the average annual number of baccalaureate graduates from participating nursing programs.
Table 6

Average Annual Nursing Program Enrollment and Number of Graduates

<table>
<thead>
<tr>
<th>Enrollment Category</th>
<th>Enrollment Size</th>
<th>Number of Graduates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>&lt; 50</td>
<td>16</td>
<td>9.5</td>
</tr>
<tr>
<td>50 - 100</td>
<td>34</td>
<td>20.1</td>
</tr>
<tr>
<td>101 - 150</td>
<td>33</td>
<td>19.5</td>
</tr>
<tr>
<td>151 - 200</td>
<td>22</td>
<td>13.0</td>
</tr>
<tr>
<td>201 - 250</td>
<td>21</td>
<td>12.5</td>
</tr>
<tr>
<td>&gt; 250</td>
<td>43</td>
<td>25.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>169</td>
<td>100.00</td>
</tr>
</tbody>
</table>

Graduate nursing program. The majority of nursing schools represented by study participants were reported to have a graduate nursing program (60.9%, n=103).

The remaining 66 schools (39.1%) reported not having a graduate nursing program.

Respondents who indicated that their unit included a graduate nursing program were also asked to indicate whether or not the graduate program included a women’s health curriculum track. Responses to this item revealed that only 21.2% (n=22) reported that they did have a women’s health curriculum track. The remaining respondents (n=81, 78.8%) indicated they did not have this curriculum option.

Women’s health course in other department in university/college. Participants were asked if a department other than nursing in their parent institution offered a women’s health course. Of the 164 participants who responded to this question, forty-four (26.8%) reported that their parent institution did offer a women’s health course in a department other than nursing. The majority (n=120 or 73.2%) of participating participants...
universities/colleges did not offer a women's health course in another department, according to respondents. Respondents who reported that their parent institution did offer a women's health course in another department were asked to identify the department in which the courses was offered. Among the 44 who indicated that they did offer a women's health course in another department, 38 reported the department name in which it was located. Of these, the most frequently identified department was Women's Studies (n=17). The complete list and frequency of other departments is listed in Appendix N.

**Objective Two**

Objective two was to describe respondents on the following characteristics: current position in the School of Nursing; highest level of academic preparation; practice specialty; and age. The variables that were measured on a nominal scale, "current position in the School of Nursing" and "practice specialty," were summarized using frequencies and percentages. The variables "highest level of academic preparation" and "age," were measured on an ordinal scale and were also summarized with frequencies and percentages.

**Current position in the school of nursing.** One characteristic on which the respondents were described was their current position in the nursing program. Respondents were provided a series of position titles and were asked to check all that applied to them. The position that was identified by the largest number of participants was Faculty Member, with 72 (42.6%) indicating that they held this position in their program. The next most frequently reported position was Dean/Director, which was reported by 52 (30.8%) of the respondents. The least frequently reported position was that of Assistant Dean/Director, with only 12 (7.1%) indicating that they held this position. Table 7 presents the complete list of positions reported by respondents.
Table 7

<table>
<thead>
<tr>
<th>Current Position Title Reported by Nurse Educators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Position Title</td>
</tr>
<tr>
<td>Faculty Member</td>
</tr>
<tr>
<td>Dean/Director</td>
</tr>
<tr>
<td>Course Coordinator/Chair</td>
</tr>
<tr>
<td>Level Coordinator/Chair</td>
</tr>
<tr>
<td>Curriculum Development Chair</td>
</tr>
<tr>
<td>Otherb</td>
</tr>
<tr>
<td>Assistant Dean/Director</td>
</tr>
</tbody>
</table>

* Percentages do not total 100 since respondents could check more than one position title
b Other categories reported and their frequencies ( ) included: Department Chair (6), Coordinator (2), Director of Undergraduate Studies (2), Director of Women’s Studies (2), Family Nurse Practitioner (1), Associate Dean (1), Clinical Director (1), Women’s Health Faculty (1) Program Evaluation Chair (1)

Practice specialty. Respondents were asked to identify their practice specialty from the following areas: Mental Health; Community Health; Adult Health; Child Health; Maternal/Child; Maternal/Infant; Women’s Health; and other. Many respondents selected more than one area with which to identify their specialty area. The specialty area identified by the largest number of respondents was Maternal/Infant, with 45 respondents or 26.6% selecting that option. Only four respondents identified Child Health as their specialty area. See Table 8 for complete information on practice specialties as reported by all respondents.

Highest level of academic preparation. Respondents were asked to indicate their highest level of academic preparation. Response levels provided included: Baccalaureate Degree in Nursing; Master’s Degree in Nursing; Master’s Degree in Non-Nursing Field;
Doctorate in Nursing; and Doctorate in Non-Nursing Field. The majority of respondents reported having a Doctorate, either in a Non-Nursing Field (37.3%, n=63), or in the Nursing Field (29.6%, n=50).

Forty-six respondents (27.2%) reported having a Master's Degree in Nursing as their highest degree earned. Also, 10 (5.9%) respondents indicated that their highest level of academic preparation was a Master's Degree in a Non-Nursing Field.

Table 8

Practice Specialty of Responding Nurse Educators

<table>
<thead>
<tr>
<th>Practice Specialty</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal/Infant</td>
<td>45</td>
<td>26.6</td>
</tr>
<tr>
<td>Adult Health</td>
<td>37</td>
<td>21.9</td>
</tr>
<tr>
<td>Women's Health</td>
<td>34</td>
<td>20.1</td>
</tr>
<tr>
<td>Maternal/Child</td>
<td>29</td>
<td>17.2</td>
</tr>
<tr>
<td>Other b</td>
<td>19</td>
<td>11.2</td>
</tr>
<tr>
<td>Mental Health</td>
<td>17</td>
<td>10.1</td>
</tr>
<tr>
<td>Community Health</td>
<td>15</td>
<td>8.9</td>
</tr>
<tr>
<td>Child Health</td>
<td>04</td>
<td>2.4</td>
</tr>
</tbody>
</table>

* Percentages do not total 100 since respondents could check more than one position title.
* Other categories reported and their frequencies ( ) included: Family Nurse Practitioner (6), Gerontology (4), Critical Care (2), Management/Administration (2), Nurse Midwifery (2), Gerontics (1), Oncology (1), Case Management (1)

Age. Participants were asked to give their age by responding to one of the following age range selections: less than 25; 25-34; 35-44; 45-54; 55-64; and over 64. The age range selected by the greatest number of participants, 89 (53.3%), was "45-54." The age categories selected by the fewest participants were "25-34" (n=1 or .6%) and "over 64" (n=1 or .6%, see Table 9).
Table 9

Age of Respondents

<table>
<thead>
<tr>
<th>Age in Years</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;25</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>25 - 34</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>35 - 44</td>
<td>27</td>
<td>16.2</td>
</tr>
<tr>
<td>45 - 54</td>
<td>89</td>
<td>53.3</td>
</tr>
<tr>
<td>55 - 64</td>
<td>49</td>
<td>29.3</td>
</tr>
<tr>
<td>&gt;64</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>167</td>
<td>100.0</td>
</tr>
</tbody>
</table>

* Two participants did not respond to this item.

Objective Three

Objective three was to determine if selected women’s health issues were included in the curricula of National League for Nursing (NLN) accredited baccalaureate nursing programs in the United States. The selected issues were: Screening/Risk Assessment; Health Teaching/Promotion; Nutrition; Domestic Violence; Substance Abuse; Sexually Transmitted Diseases; Sexual Abuse; Sexuality; Reproductive Cancers; Menstruation/Menstrual Irregularities; Menopause; Hormone Therapy; Fertility/Infertility; Cardiovascular Disease; Osteoporosis; Lung Cancer; Urinary Stress Incontinence; Eating Disorders; and Depression.

The women’s health issue that was reported to be included in the instructional program by the greatest number of study participants was that of “Health Teaching/Promotion” (n=167 or 99.4%). The issue “Domestic Violence” followed closely with 166 respondents (99.4%) reporting that it is included in their nursing curricula. A total of 12 of the 19 issues examined were reported as being taught in more than 90% of the
represented programs. The women’s health issue that was reported as being taught by the fewest number of respondents (n=119 or 70.4%) was “Urinary Stress Incontinence.”

Also, there were more respondents who were not certain if this issue (Urinary Stress Incontinence) was included in their curricula than there were with any other issue (n=28, 16.9%, see Table 10).

### Table 10

Inclusion of Women’s Health Issues (WHI) as Reported by Participating NLN Accredited Baccalaureate Nursing Programs

<table>
<thead>
<tr>
<th>WHI</th>
<th>Yes</th>
<th>Uncertain</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>n</td>
<td>n</td>
<td></td>
</tr>
<tr>
<td>HT/P*</td>
<td>167</td>
<td>1</td>
<td>0</td>
<td>168</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>166</td>
<td>0</td>
<td>1</td>
<td>167</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>164</td>
<td>0</td>
<td>2</td>
<td>166</td>
</tr>
<tr>
<td>STD*</td>
<td>162</td>
<td>1</td>
<td>2</td>
<td>165</td>
</tr>
<tr>
<td>Screening*</td>
<td>165</td>
<td>0</td>
<td>2</td>
<td>168</td>
</tr>
<tr>
<td>Depression</td>
<td>161</td>
<td>3</td>
<td>2</td>
<td>166</td>
</tr>
<tr>
<td>Reprod. CA</td>
<td>158</td>
<td>2</td>
<td>5</td>
<td>165</td>
</tr>
<tr>
<td>Cardio. Dx*</td>
<td>160</td>
<td>5</td>
<td>1</td>
<td>165</td>
</tr>
<tr>
<td>Nutrition</td>
<td>158</td>
<td>4</td>
<td>6</td>
<td>168</td>
</tr>
<tr>
<td>Fertility/Infertility</td>
<td>152</td>
<td>2</td>
<td>10</td>
<td>164</td>
</tr>
<tr>
<td>Sexuality</td>
<td>152</td>
<td>6</td>
<td>7</td>
<td>165</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>147</td>
<td>13</td>
<td>3</td>
<td>163</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>149</td>
<td>12</td>
<td>5</td>
<td>166</td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>149</td>
<td>11</td>
<td>7</td>
<td>167</td>
</tr>
<tr>
<td>Lung Cancer</td>
<td>144</td>
<td>13</td>
<td>8</td>
<td>165</td>
</tr>
<tr>
<td>Menstruation</td>
<td>143</td>
<td>9</td>
<td>12</td>
<td>164</td>
</tr>
<tr>
<td>Menopause</td>
<td>135</td>
<td>17</td>
<td>11</td>
<td>163</td>
</tr>
</tbody>
</table>

(table continues)
<table>
<thead>
<tr>
<th>WH Issue</th>
<th>Yes</th>
<th>Uncertain</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hormone Therapy</td>
<td>129m</td>
<td>79.1</td>
<td>21</td>
<td>12.9</td>
</tr>
<tr>
<td>USI(\textsuperscript{8})</td>
<td>119m</td>
<td>71.7</td>
<td>28</td>
<td>16.9</td>
</tr>
</tbody>
</table>

\(\textsuperscript{a}\) HT/P = Health Teaching/Promotion  
\(\textsuperscript{b}\) STD = Sexually Transmitted Diseases  
\(\textsuperscript{c}\) Screening = Screening/Risk Assessment  
\(\textsuperscript{d}\) Reprod. CA = Reproductive Cancers  
\(\textsuperscript{e}\) Cardio. Dx = Cardiovascular Disease  
\(\textsuperscript{f}\) Menstruation = Menstruation/Menstrual Irregularities  
\(\textsuperscript{g}\) USI = Urinary Stress Incontinence.

\(\textsuperscript{1}\) One participant did not respond to this item.  
\(\textsuperscript{j}\) Three participants did not respond to this item.  
\(\textsuperscript{k}\) Four participants did not respond to this item.  
\(\textsuperscript{l}\) Five participants did not respond to this item.  
\(\textsuperscript{m}\) Six participants did not respond to this item.

**Objective Four**

Objective four was to determine curricular placement (courses in which issues were taught) of selected women’s health issues that are included in the curricula of NLN accredited baccalaureate nursing programs in the United States.

Respondents were asked to indicate where each of the women’s health issues that were taught in their program was located from a curricular standpoint. They were given a list of courses to select from to relate this information. They were instructed to check all courses in which the women’s health issue was taught. The course selections included: Maternal/Infant Nursing; Women’s Health Nursing; Adult Health Nursing; Community Health Nursing; Mental Health Nursing; an elective nursing course; and other. The percentages for each of the courses in which the issue was taught is based on the total number responding “Yes” regarding the issue being taught.
Screening/risk assessment. The issue “Screening/Risk Assessment” was reported most frequently as being taught in a Maternal/Infant Nursing course (n=123 or 74.1%). A majority (n=101, or 60.8%) of the respondents also reported that this issue was addressed in a Community Health course, and in an Adult Health Nursing course (n=92 or 55.4%). The course that was identified as the location of information on this issue least often was a Women’s Health course (n=27 or 16.3%).

Health teaching/promotion. When the curricular location of information regarding the issue “Health Teaching/Promotion” was examined, three different courses were identified by a majority of the respondents as containing information on this issue. These courses included a Maternal/Infant Nursing course (n=126 or 75.0%), a Community Health course (n=116 or 69.0%), and an Adult Health course (n=98 or 58.3%).

Nutrition. A majority of respondents (79.2% or n=126) reported that the women’s health issue “Nutrition” was taught most often in a Maternal/Infant type of course. The course which was identified by the fewest respondents as the location of this issue was a Women’s Health course (n=19 or 11.9%).

Domestic violence. In examining the location of the women’s health issue “Domestic Violence” in participating nursing programs, it was found that two of course selections were reported by a majority of respondents as a location for instruction. The two courses in which “Domestic Violence” was taught most often were a Community Health Nursing course (n=100 or 59.5%) and a Mental Health Nursing course (n=91, 54.2%).

Substance abuse. Each of three different courses were identified by a majority of respondents to contain information on the issue “Substance Abuse.” The three courses were Mental Health Nursing (n=113 or 67.7%), Community Health Nursing (n=85 or 50.9%), and Maternal/Infant Nursing (n=84 or 50.3%).
Sexually transmitted diseases. The women's health issue "Sexually Transmitted Diseases" was reported by an equal number of respondents as being taught in each of two different nursing courses, Maternal/Infant Nursing ($n=103$ or 62%) and Community Health Nursing ($n=103$ or 62%). Mental Health Nursing ($n=11$ or 6.6%) was identified by the fewest respondents as the location of this issue.

Sexual abuse. Only one course was identified by a majority of respondents as a course in which the women's health issue "Sexual Abuse" was taught. This course was Mental Health Nursing, and $54.9\%$ ($n=84$) of respondents who indicated that this issue was taught in their nursing program reported it as being taught in this type of course.

Sexuality. Examination of data provided by respondents showed that a majority identified a Maternal/Infant Nursing course as a location of the issue "Sexuality" ($n=106$ or 67.9%).

Reproductive cancers. The issue "Reproductive Cancers" was reported most frequently as being taught in an Adult Health Nursing course ($n=122$ or 75.3%). No respondents reported this issue as being located in a Mental Health Nursing course in their program.

Menstruation/menstrual irregularities. In regard to the issue "Menstruation /Menstrual Irregularities," data indicated that a majority of participants identified a Maternal/Infant Nursing course ($n=98$ or 66.2%) as the course in which this issue is taught. Data also revealed that very few respondents reported "Menstruation/Menstrual Irregularities" as being taught in either a Mental Health Nursing course ($n=1$ or 0.7%) or a Community Health Nursing course ($n=2$ or 1.4%).

Menopause. No one course was reported by a majority of respondents as containing information on the health issue "Menopause." However, more participants
identified a Women's Health Nursing course as the location of this issue than any other issue in the survey (n=38 or 27%). The largest number of respondents for this issue reported that an Adult Health Nursing course (n=60 or 42.6%) is where "Menopause" is taught in their program.

**Hormone therapy.** The women's health issue "Hormone Therapy" was also not reported to be taught in any one course by a majority of respondents. The course reported by the largest number of respondents as a location for this issue was Adult Health Nursing (n=53 or 39.3%). This issue also was reported to be taught in a Women's Health Course by 35 (25.9%) respondents, second only to the issue of "Menopause" as an issue being located in that type of course (Women's Health Nursing).

**Fertility/infertility.** When examining the curricular location of "Fertility/Infertility," one course was identified by a majority of participants as containing information on this topic. The course was identified as a Maternal/Infant Nursing course (n=122 or 77.7%). The course that was identified by the fewest respondents as the location of this issue was a Mental Health course (n=2 or 1.9%).

**Cardiovascular disease.** "Cardiovascular Disease" as a women's health issue was reported by a majority of respondents to be taught in an Adult Health Nursing course (n=134 or 82.7%). The course identified as the location of information on this issue least often was a Mental Health Nursing course (n=3 or 1.9%).

**Osteoporosis.** The issue "Osteoporosis" was reported most frequently as being taught in an Adult Health Nursing course (n=97 or 63.8%). It was reported least frequently as being taught in a Mental Health Nursing course (n=1 or .7%).

**Lung cancer.** In examining the curricular location of the women's health issue "Lung Cancer," an Adult Health Nursing course (n=126 or 85.1%) was identified by a
majority of respondents as containing information on this issue. Mental Health Nursing (n=1 or .7%) was identified least often as the course in which this issue was taught in participating nursing programs. “Lung Cancer” was also taught infrequently in a Women’s Health Nursing course (n=8 or 5.4%) respondents reported.

**Urinary stress incontinence.** The issue “Urinary Stress Incontinence” was reported by a majority of respondents to be located most often in an Adult Health Nursing course (n=70, 57.4%). Respondents identified Mental Health Nursing least often as a course in which this issue was located (n=4 or 3%).

**Eating disorders.** Respondents indicated most often that the issue “Eating Disorders” was taught in a Mental Health Nursing course (n=95 or 62.9%) in their nursing programs, and least often in Community Health Nursing, Women’s Health Nursing, and elective courses.

**Depression.** A majority of respondents identified Mental Health Nursing as a course in which the issue “Depression” was taught (n=130 or 79.3%).

All of the women’s health issues and their curricular placement (courses in which they are located in the curriculum) as reported by the participants in the study are presented in Table 11. See Appendix O for a listing of “other” courses in which women’s health content is taught.
<table>
<thead>
<tr>
<th>WHI</th>
<th>Maternal/Infant</th>
<th>Women's Health</th>
<th>Adult Health</th>
<th>Community Health</th>
<th>Mental Health</th>
<th>Elective</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardio. Dx</td>
<td>(162)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>34 21.0</td>
<td>22 13.6</td>
<td>134 82.7</td>
<td>35 21.6</td>
<td>3 1.9</td>
<td>13 8.0</td>
<td>29 17.8</td>
</tr>
<tr>
<td>Depression</td>
<td>(164)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>57 34.8</td>
<td>18 11.0</td>
<td>25 15.2</td>
<td>30 18.3</td>
<td>130 79.3</td>
<td>16 9.8</td>
<td>12 0.73</td>
</tr>
<tr>
<td>Domestic V.</td>
<td>(168)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>76 45.2</td>
<td>31 18.3</td>
<td>34 20.2</td>
<td>100 59.5</td>
<td>91 54.2</td>
<td>26 15.4</td>
<td>17 10.1</td>
</tr>
<tr>
<td>Eating Dis.</td>
<td>(151)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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<td>%</td>
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<td>70</td>
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* Total number of participants responding to this item.
  
  - Cardio. Dx = Cardiovascular Disease
  - Domestic V. = Domestic Violence
  - Eating Dis. = Eating Disorders
  - Fertility/Infert. = Fertility/Infertility
  - Hormone T. = Hormone Therapy
  - HT/P = Health Teaching/Promotion
  - Menstruation = Menstruation/Menstrual Irregularities
  - Reprod. CA = Reproductive Cancers
  - Screening = Screening/risk Assessment
  - STD = Sexually Transmitted Diseases
  - Substance A. = Substance Abuse
  - USI = Urinary Stress Incontinence
Objective Five

Objective five was to determine class time allocation of selected women’s health issues included in the curricula of NLN accredited baccalaureate nursing programs in the United States. The variable “class time allocation” was measured on an ordinal scale. The data were summarized using frequencies and percentages. Respondents were asked to describe the total amount of class time spent on issues reported by them as being taught in their curriculum. They were given the following selections from which to report the total time spent on each issue included in their curriculum: outside class readings only; less than one quarter of an hour; less than one half of an hour; from one half to one hour; from one hour to two hours; from two to three hours; and, over three hours. Of all nineteen issues, “Health Teaching/Promotion” was the issue that had the highest frequency of reported time exceeding 3 hours reported by respondents. Of the 165 respondents reporting on this issue, 60.0% (n=99) indicated that more than three hours of class time was spent on “Health Teaching/Promotion” in their nursing programs. Conversely, respondents reported spending the least amount of class time on the women’s health issue “Urinary Stress Incontinence,” with 4.3% of the 117 respondents indicating that outside readings only were assigned to this and 43.6% (n=51) reporting that less than one half -hour of class time was spent on teaching “Urinary Stress Incontinence.”

To facilitate interpretation of the class time allocation data, the researcher developed a scale of estimated actual time measured in hours to be used in reporting data for this variable. Participants were provided with the seven categories described above with which to describe time allocation to women’s health issues included in their curricula. Actual time in minutes (later converted to hours) was assigned to each category by using the midpoint of the range for the category.
The resulting scale was established as follows:

- Readings only -------------- 0.0 minutes
- Less than 15 minutes ------ 7.5 minutes
- Less than 30 minutes------- 15.0 minutes
- One-half hour to one hour 45.0 minutes
- One hour to two hours ---- 90.0 minutes
- Two hours to three hours - 150.0 minutes
- Over three hours---------- 225.0 minutes

This midpoint was then used as an interval level measurement of the time spent on each issue, and the mean number of hours spent on each issue was computed. A mean time in hours was calculated for each of the women’s health issues to indicate an amount of class time spent on the issue. “Health Teaching/Promotion” received the highest mean of 2.91 hours (SD 1.15) in class time and “Urinary Stress Incontinence” received the lowest mean of .94 hours (SD .93) in class time. Table 12 shows all issues and class time selections reported for each issue.

**Objective Six**

Objective six was to ascertain the importance of selected women’s health issues in baccalaureate nursing curricula as perceived by respondents. Respondents were asked to rate the importance of including each selected women’s health issue in a baccalaureate nursing curriculum by rating each issue using the following scale of importance: 1-not important; 2-somewhat important; 3-moderately important; 4-very important; and, 5-extremely important. Data are reported in Table 12 regarding frequency of responses and mean ratings for each of the women’s health issues. The issue rated highest in importance by respondents was “Health Teaching/Promotion,” with a mean of 4.66.
<table>
<thead>
<tr>
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<th>M</th>
<th>SD</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
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<td>0</td>
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(table continued)
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<th>SD</th>
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<th>&lt;30 Min</th>
<th>30 Min to 1 Hour</th>
<th>1 Hour to 2 Hours</th>
<th>2 Hours to 3 Hours</th>
<th>&gt;3 Hours</th>
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<td>16</td>
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<td>1.03</td>
<td>5</td>
<td>3.6</td>
<td>12</td>
<td>8.6</td>
<td>23</td>
<td>16.5</td>
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<td>15.8</td>
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<td>2</td>
<td>1.2</td>
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<td>10</td>
<td>7.0</td>
<td>21</td>
<td>14.8</td>
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<td>9.5</td>
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(table continued)
| WHI (n) | M | SD | Hrs | n | % | < 15 Minutes | n | % | < 30 Minutes | n | % | 30 Min to 1 Hour | n | % | 1 Hour to 2 Hours | n | % | 2 Hours to 3 Hours | n | % | > 3 Hours | n | % |
|--------|---|----|-----|---|---|---------------|---|---|-------------|---|---|---------------|---|---|-----------------|---|---|-----------------|---|---|-----------------|---|---|-----------------|---|---|
| STD    | (158) | 1.87 | 1.16 | 2 | 1.3 | 2 | 1.3 | 9 | 5.7 | 21 | 13.3 | 37 | 23.4 | 44 | 27.8 | 43 | 27.2 |
| Substance A. | (162) | 2.38 | 1.16 | 2 | 1.2 | 1 | 0.6 | 2 | 1.2 | 22 | 13.6 | 38 | 23.5 | 42 | 25.9 | 55 | 34.0 |
| USI j | (117) | 0.94 | 0.93 | 5 | 4.3 | 15 | 12.8 | 31 | 26.5 | 26 | 22.2 | 26 | 22.2 | 9 | 7.7 | 5 | 4.3 |

a Total number of participants who responded to this item.
b Domestic V. = Domestic Violence
c Eating Dis. = Eating Disorders
d Fertility/Inf. = Fertility/Infertility
e Hormone T. = Hormone Therapy
f HT/P = Health Teaching/Promotion
g Menstruation = Menstruation/Menstrual Irregularities
h Reprod. CA = Reproductive Cancers
i Screening = Screening/Risk Assessment
j STD = Sexually Transmitted Diseases
k Substance A. = Substance Abuse
l USI = Urinary Stress Incontinence
The next highest rated issue was "Screening/Risk Assessment" with a mean of 4.43. Respondents rated "Fertility/Infertility" as the issue of lowest importance as far as inclusion in baccalaureate nursing curricula. Its mean was 3.62. The issue "Menstruation/Menstrual Irregularities" was rated slightly higher than "Fertility/Infertility" with a mean of 3.65. To aid in interpretation of the importance data, the researcher developed a scale of interpretation based on the response scale used in the instrument.

The interpretative scale developed by the researcher and its' corresponding range values was established as follows:

4.50 or higher = extremely important
3.50 to 4.49 = very important
2.51 to 3.49 = moderately important
1.51 to 2.50 = somewhat important
1.50 or less = not important.

Using the established interpretative scale, one item was classified as extremely important. All 18 of the remaining issues received mean importance ratings in the very important range. See Table 13 for complete data on ratings of women’s health issues by respondents, and Appendix P for a listing of other important women’s health issues provided in writing by respondents.
Table 13

Respondent's Rating of the Importance of Women's Health Issues (WHI)

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<th>WHI</th>
<th>Mean</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
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</thead>
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<td>72</td>
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<td>74</td>
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<td>29</td>
<td>17.2</td>
<td>80</td>
<td>47.3</td>
<td>52</td>
<td>30.8</td>
</tr>
<tr>
<td>Nutrition</td>
<td>3.99</td>
<td>0</td>
<td>0</td>
<td>10</td>
<td>5.9</td>
<td>25</td>
<td>14.8</td>
<td>90</td>
<td>53.3</td>
<td>44</td>
<td>26.0</td>
</tr>
</tbody>
</table>

(table continues)
<table>
<thead>
<tr>
<th>WHI</th>
<th>(n)</th>
<th>Mean</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eating Disorders</td>
<td>(169)</td>
<td>3.96</td>
<td>1</td>
<td>0.6</td>
<td>9</td>
<td>5.3</td>
<td>32</td>
<td>18.9</td>
<td>80</td>
<td>47.3</td>
<td>47</td>
<td>27.8</td>
</tr>
<tr>
<td>Sexuality</td>
<td>(169)</td>
<td>3.92</td>
<td>1</td>
<td>0.6</td>
<td>7</td>
<td>4.1</td>
<td>42</td>
<td>24.9</td>
<td>73</td>
<td>43.2</td>
<td>46</td>
<td>27.2</td>
</tr>
<tr>
<td>Menopause</td>
<td>(169)</td>
<td>3.90</td>
<td>0</td>
<td>0</td>
<td>8</td>
<td>4.7</td>
<td>40</td>
<td>23.7</td>
<td>83</td>
<td>49.1</td>
<td>38</td>
<td>22.5</td>
</tr>
<tr>
<td>USI f</td>
<td>(168)</td>
<td>3.74</td>
<td>0</td>
<td>0</td>
<td>13</td>
<td>7.7</td>
<td>48</td>
<td>28.4</td>
<td>77</td>
<td>45.8</td>
<td>30</td>
<td>17.9</td>
</tr>
<tr>
<td>Hormone Therapy</td>
<td>(168)</td>
<td>3.71</td>
<td>0</td>
<td>0</td>
<td>15</td>
<td>8.9</td>
<td>48</td>
<td>28.6</td>
<td>75</td>
<td>44.6</td>
<td>30</td>
<td>17.9</td>
</tr>
<tr>
<td>Menstruation g</td>
<td>(169)</td>
<td>3.65</td>
<td>1</td>
<td>0.6</td>
<td>14</td>
<td>8.3</td>
<td>55</td>
<td>32.5</td>
<td>73</td>
<td>43.2</td>
<td>26</td>
<td>15.4</td>
</tr>
<tr>
<td>Fertility/Infertility</td>
<td>(167)</td>
<td>3.62</td>
<td>2</td>
<td>1.2</td>
<td>17</td>
<td>10.2</td>
<td>56</td>
<td>33.5</td>
<td>60</td>
<td>35.9</td>
<td>32</td>
<td>19.2</td>
</tr>
</tbody>
</table>

* Total number of participants who responded to this item.

* HT/P = Health Teaching/Promotion

* Screening = Screening/Risk Assessment

* STD = Sexually Transmitted Diseases

* Cardio. Dx = Cardiovascular Disease

* USI = Urinary Stress Incontinence

* Menstruation = Menstruation/Menstrual Irregularities
Objective Seven

Objective seven was to determine the Women’s Health Emphasis (WHE) of the participating NLN accredited baccalaureate nursing programs. The WHE was measured by the calculation of a WHE Score for each participating program. The WHE Score was calculated using the following procedure: Each of the nineteen women’s health issues included in the instrument received a response regarding whether or not the participating program included instruction on that issue in their baccalaureate program. For each of the items that received a “Yes” response, a value of “1” was recorded. The respondent received a value of “0” for any of the issues which received a “No” or “Uncertain” response. Therefore, the respondent would have a score ranging from a possible low of 0, indicating that none of the issues were included in their program, to a possible high value of 19, indicating that all of the issues were included in their instructional program.

The second step in computing the WHE Score involved the responses to the item regarding the amount of instructional time spent on each of the issues. The respondents received a value that was included in the WHE Score which reflected a higher value for issues that received more instructional time and a lower value for issues that received less instructional time. Specifically, if the respondent indicated the time spent was “Outside Class Readings Only”, they received a value of “1”; if they indicated that the amount of time was “Less Than One Quarter Hour”, they received a value of “2”; if they indicated that “Less Than One Half-hour” was spent, they received a value of “3”; if they indicated that “One half Hour to One Hour” of instructional time was spent on the issue, they received a value of “4”; if they reported that “One Hour to Two Hours” of classroom time was spent on the issue, they received a value of “5”; if “Two to Three Hours” of class time was reported to be spent on the issue, they received a value of “6”; and if they
reported spending “Over Three Hours” of instructional time on the issue, they received a value of “7.” The “time” value received for each women’s health issue was then multiplied by a “0” or a “1,” the value initially received for each response regarding whether or not the participating program included instruction on that issue in their baccalaureate program. The final step in computing the WHE Score included adding the score received by a participating program in the first step of the computing process (which could range from a low of 0 to a high of 19) to the score received by the program in the second step of the calculation process (which could range from a low of 0 to a high of 133). Thus, each respondent had a calculated WHE Score that ranged from a minimum possible score of “0” to a maximum possible score of “152” (all issues were addressed and each one received more than three hours of instructional time).

Of the 155 calculated WHE Scores, the lowest was 19, while the highest score found was 149 (n=2). The mean of all participating programs was 104.93 (SD=24.85). Ninety-nine (64.4%) of participating programs received a score of 100 or above (see Table 14).

**Objective Eight**

Objective eight was to determine if a relationship existed between the WHE Score and selected program characteristics. The program characteristics included: type of university/college; location of university/college; average annual university/college enrollment; average annual baccalaureate nursing program enrollment; average annual number of baccalaureate nursing graduates; presence/absence of graduate nursing program; presence/absence of women’s health graduate nursing curriculum track; and presence/absence of a women’s health course in another department in the university/college.
Table 14

Women's Health Emphasis Scores for Participating Nursing Programs

<table>
<thead>
<tr>
<th>Score Category</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;20 b</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>20 - 39</td>
<td>2</td>
<td>1.2</td>
</tr>
<tr>
<td>40 - 59</td>
<td>5</td>
<td>3.0</td>
</tr>
<tr>
<td>60 - 79</td>
<td>10</td>
<td>6.4</td>
</tr>
<tr>
<td>80 - 99</td>
<td>38</td>
<td>24.4</td>
</tr>
<tr>
<td>100 - 119</td>
<td>53</td>
<td>33.9</td>
</tr>
<tr>
<td>120 - 139</td>
<td>37</td>
<td>23.6</td>
</tr>
<tr>
<td>140+ c</td>
<td>9</td>
<td>6.9</td>
</tr>
<tr>
<td>Total</td>
<td>155</td>
<td>100.00</td>
</tr>
</tbody>
</table>

* WHE Scores were unable to be completed for 14 participants due to one or more missing values or score components.

b The lowest score was 19 (12.5%), which one (1) program received.

c No program scored 152 (100%). The highest score was 149 (98%), which two (2) programs received.

Graduate program, women's health track, other women's health course. The variable "WHE Score" was measured as a continuous variable. The program characteristic "presence/absence of a graduate program" was measured as a nominal dichotomous variable. Data for this demographic variable was obtained by asking the respondent to check "yes" or "no" to the question, "Does your School/Department of Nursing have a graduate program"? Those respondents who indicated "yes" were then asked if the graduate program offered a women's health curriculum track. Again, the respondent was asked to indicate either "yes" or "no" in response to the question. The last demographic program variable related to this objective and measured on a nominal scale was that of "presence/absence of a women's health course in another department in..."
the university/college." To elicit this information, respondents were asked to check "yes" or "no" to the question, "Does your parent institution offer a women's health course through any department other than Nursing?" Since one of the variables involved in each of these analyses was measured as a continuous variable and the other as a nominal dichotomous variable, the researcher felt that the most appropriate way to accomplish the objective statistically was through the use of the t-test procedure comparing the 2 groups of each of the nominal dichotomous variables on their WHE Score. The t-test was chosen over the Point Biserial Correlation Coefficient on the basis of ease of interpretation.

There were no differences found in the WHE Scores by categories of the selected program characteristics of "presence/absence of graduate nursing program," "presence/absence of graduate women's health curriculum," and "presence/absence of women's health course in another department in the parent institution." Tables 15-17 show the comparisons of the WHE Scores by the categories of "presence/absence of graduate nursing program," "presence/absence of graduate women's health curriculum, and "presence/absence" of women's health course in another department in the parent institution."

Table 15

Comparison of the Women's Health Emphasis Score by the Presence or Absence of a Graduate Nursing Program

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>M</th>
<th>SD</th>
<th>t</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Graduate Nursing Program</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Present (Yes)</td>
<td>95</td>
<td>105.06</td>
<td>25.15</td>
<td>0.08</td>
<td>153</td>
<td>0.93</td>
</tr>
<tr>
<td>Absent (No)</td>
<td>60</td>
<td>104.72</td>
<td>24.56</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Represents the two tailed probability.
Table 16
Comparison of the Women’s Health Emphasis Score by the Presence or Absence of a Graduate Women’s Health Curriculum Track

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>M</th>
<th>SD</th>
<th>t</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Graduate Women’s Health Track</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Present (Yes)</td>
<td>20</td>
<td>101.35</td>
<td>29.56</td>
<td>-0.75</td>
<td>94</td>
<td>0.45</td>
</tr>
<tr>
<td>Absent (No)</td>
<td>76</td>
<td>106.17</td>
<td>24.40</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Represents the two tailed probability.

Table 17
Comparison of the Women’s Health Emphasis Score by the Presence or Absence of a Women’s Health Course in Another Department

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>M</th>
<th>SD</th>
<th>t</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presence of Other Women’s</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Course</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Present (Yes)</td>
<td>42</td>
<td>104.38</td>
<td>22.99</td>
<td>-0.06</td>
<td>150</td>
<td>0.95</td>
</tr>
<tr>
<td>Absent (No)</td>
<td>110</td>
<td>104.66</td>
<td>25.57</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Represents the two tailed probability.

Size of parent institution, size of nursing program, number of nursing graduates.

The variable “annual enrollment (size) of parent institution” was measured on an ordinal scale. Respondents were asked to select from a series of enrollment size categories to obtain this data. The categories included: less than 1000; 1001-2500; 2501-5000; 5001-7500; and 7501-10,000. Another program characteristic that was ordinal in nature was “annual enrollment (size) of baccalaureate nursing program.” Again, respondents were asked to select from a series of categories to indicate the size of the baccalaureate nursing
program of their parent institution. The categories were: less than 50; 50-100; 101-150; 151-200; 201-250; and over 250. The third program characteristic that was measured on an ordinal scale was "average annual number of baccalaureate nursing graduates." Respondents were provided with a series of categories from which to report the annual number of nursing graduates from their baccalaureate nursing program.

To determine if a relationship existed between the dependent variable "WHE Score" and any of these three ordinal independent variables, Spearman's Rank Order Correlation Coefficients were used. The only significant correlation found between the WHE Score and any of the program characteristics was that of the size of the baccalaureate nursing program, n=155, r=.18, p=.02. According to Davis' descriptors (1971), this was described as a low association. Table 18 provides information on the relationship between "WHE Score" and these demographic program characteristics.

Location of parent institution. To determine if there was a difference in the four categories of the independent variable "location of the parent institution" and the dependent variable "WHE Score," an analysis of variance (ANOVA) was used. The four categories of location were: Southern, Western, Midland, and Northeast. Examination of data in Table 19 reveals no significant differences among the four categories of location.

Type of parent institution. An analysis of variance (ANOVA) was also used to determine if differences existed in the dependent variable "WHE Score," by categories of the independent variable "type of parent institution." The variable "type" had three categories: public university/college; private secular university/college; and private religious university/college. No significant differences were found among the three categories of type of parent institution (see Table 20).
Table 18

Relationship between the Women’s Health Emphasis Score and Size of Institution, Size of Nursing Program and Number of Nursing Graduates

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>r</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size of Nursing Program</td>
<td>155</td>
<td>.18</td>
<td>0.02</td>
</tr>
<tr>
<td>Number of Nursing Graduates</td>
<td>155</td>
<td>.04</td>
<td>0.62</td>
</tr>
<tr>
<td>Size of Institution</td>
<td>153</td>
<td>.04</td>
<td>0.63</td>
</tr>
</tbody>
</table>

Table 19

Analysis of Variance of WHE Score by Location of Parent Institution

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between Group</td>
<td>3</td>
<td>666.05</td>
<td>1.07</td>
<td>0.37</td>
</tr>
<tr>
<td>Within Group</td>
<td>149</td>
<td>624.49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>152</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. Groups included Southern, Western, Midland, and Northeast.

Table 20

Analysis of Variance of WHE Score by Type of Parent Institution

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Institution</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between Group</td>
<td>2</td>
<td>891.21</td>
<td>1.42</td>
<td>0.24</td>
</tr>
<tr>
<td>Within Group</td>
<td>149</td>
<td>625.90</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>151</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. Groups included Public, Private Secular and Private Religious

Objective Nine

Objective nine was to determine if a model existed which explained a significant portion of the variance in the WHE Score of participating baccalaureate nursing programs.
from the following program characteristics: type of parent institution (university/college); location of university/college; average annual university/college enrollment (size of parent institution); average annual baccalaureate nursing program enrollment (size of nursing program); average annual number of baccalaureate nursing graduates; presence/absence of graduate nursing program; presence/absence of women’s health graduate nursing curriculum track; and presence/absence of women’s health course in another department in university/college. This objective was accomplished using multiple regression analysis with WHE Score as the dependent variable. The other variables were treated as independent variables and stepwise entry of the variables was used because of the exploratory nature of the study. In this multiple regression analysis, variables were added that increased the explained variance by one per cent or more as long as the overall regression model remained significant.

As the coding of categorical data requires the development of mutually exclusive and exhaustive categories, a coding process of dummy variables (“dummy coding”) was used to construct variables used in the multiple regression analysis (Hardy, 1993). In the dummy coding process, the respondents of a particular category are assigned a code of “1”, while respondents not in that category are coded as “0.”

In this study, two variables were reconstructed from data collected. For the variable “type of parent institution,” dummy coding was used to construct three “yes or no” variables. Variables created were: whether the parent institution was public or not; whether the parent institution was private secular or not; and whether the parent institution was private religious or not. In each instance, yes was coded as “1,” and no was coded as “0.” For the variable “location of parent institution,” four variables were created using dummy coding. Those variables created were: whether the nursing program
was located in the Northeast region or not; in the Western region or not; in the Southern region or not; and in the Midland region or not. Dummy coding (Yes=1, No=0) was used for the presence or absence of three variables: graduate nursing program; a women’s health graduate curriculum track; and a women’s health course in another department.

After examining the simple correlations (Table 21), the independent variables included in the analysis were examined for the presence of multicollinearity. This was done by regressing each independent variable on all other independent variables (Lewis-Beck, 1980). This procedure helped in establishing whether there were any cases of multicollinearity. The cumulative $R^2$ was checked to determine whether or not it approached 1.00. Whenever the cumulative $R^2$ values approach 1.0, there is high collinearity. It was determined that there were no problems with collinearity between the independent variables.

The variable entered into the regression model first was “enrollment in nursing” (size of nursing program). This variable explained 2.7% of the variance in the WHE Score of baccalaureate nursing programs related to program characteristics. “Western” (location-measured as whether or not the program was located in the Western region) was the second variable entered into the regression model. This variable explained 1.2% of the variance in the WHE Score of baccalaureate nursing programs. However, when this variable was placed in the model, the model did not remain significant. Therefore, this variable was removed from the regression model.

None of the remaining program characteristic variables entered the regression model. The final equation, therefore, consisted of one variable which explained 2.7% of the variance of the WHE Score. The results of the final multiple regression analysis are presented in Table 22.
### Table 21

**Bivariate Correlations between WHE Score and Demographic Variables**

<table>
<thead>
<tr>
<th>Variable</th>
<th>r</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size of Nursing Program</td>
<td>.16</td>
<td>Low</td>
</tr>
<tr>
<td>Private Secular</td>
<td>.13</td>
<td>Low</td>
</tr>
<tr>
<td>Northeast Region</td>
<td>.11</td>
<td>Low</td>
</tr>
<tr>
<td>West Region</td>
<td>.11</td>
<td>Low</td>
</tr>
<tr>
<td>Number of Nursing Graduates</td>
<td>.10</td>
<td>Low</td>
</tr>
<tr>
<td>Graduate Women’s Health</td>
<td>.05</td>
<td>Negligible</td>
</tr>
<tr>
<td>Public</td>
<td>.03</td>
<td>Negligible</td>
</tr>
<tr>
<td>Size of Parent Institution</td>
<td>.03</td>
<td>Negligible</td>
</tr>
<tr>
<td>Southern Region</td>
<td>.02</td>
<td>Negligible</td>
</tr>
<tr>
<td>Other Women’s Health</td>
<td>.01</td>
<td>Negligible</td>
</tr>
<tr>
<td>Graduate Nursing Program</td>
<td>.00</td>
<td>Zero</td>
</tr>
</tbody>
</table>

* Descriptors established by Davis (1971).

### Table 22

**Multiple Regression Analysis of WHE Scores of Baccalaureate Nursing Programs**

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regression</td>
<td>1</td>
<td>2484.49</td>
<td>4.103</td>
<td>0.05</td>
</tr>
<tr>
<td>Residual</td>
<td>148</td>
<td>601.51</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>149</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Variables in the Equation**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Multiple R</th>
<th>R² Change</th>
<th>F Change</th>
<th>p Change</th>
<th>Beta</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment in Nursing</td>
<td>0.164</td>
<td>0.027</td>
<td>4.103</td>
<td>0.05</td>
<td>0.164</td>
</tr>
</tbody>
</table>

* (table continues)
### Variables Not in the Equation

<table>
<thead>
<tr>
<th>Variables</th>
<th>t</th>
<th>t Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public c</td>
<td>-0.218</td>
<td>0.827</td>
</tr>
<tr>
<td>Private Secular c</td>
<td>-1.320</td>
<td>0.189</td>
</tr>
<tr>
<td>Northeast d</td>
<td>-1.142</td>
<td>0.255</td>
</tr>
<tr>
<td>Western d</td>
<td>-1.346</td>
<td>0.180</td>
</tr>
<tr>
<td>Southern d</td>
<td>-0.089</td>
<td>0.929</td>
</tr>
<tr>
<td>Size/Parent e</td>
<td>-0.629</td>
<td>0.530</td>
</tr>
<tr>
<td>Graduates/Nursing f</td>
<td>-0.008</td>
<td>0.993</td>
</tr>
<tr>
<td>Graduate Program g</td>
<td>-1.068</td>
<td>0.288</td>
</tr>
<tr>
<td>WH Curriculum h</td>
<td>-1.127</td>
<td>0.262</td>
</tr>
<tr>
<td>Other i</td>
<td>-0.137</td>
<td>0.892</td>
</tr>
</tbody>
</table>

a Twenty participants’ responses were incomplete and did not receive a WHE Score.
b Average annual enrollment (size) of baccalaureate nursing program.
c Types of parent institution (university/colleges).
d Geographic regions (locations) of National League of Nursing accredited baccalaureate nursing programs.
e Average annual enrollment (size) of parent institution (university/college).
f Average annual number of baccalaureate nursing graduates.
g Presence/absence of a graduate nursing program in the department of nursing.
h Presence/absence of a graduate women’s health curriculum track.
i Presence/absence of a women’s health course in another department of the university/college.
CHAPTER V
SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

The purpose of this study was to determine if, and how, selected women’s health issues are included in baccalaureate nursing curricula in the United States. The study also sought to assess nursing faculty’s perceptions as to the importance of those selected women’s health issues to baccalaureate nursing curricula. The selected women’s health issues included: screening/risk assessment; health teaching/promotion; nutrition; domestic violence; substance abuse; sexually transmitted diseases; sexual abuse; sexuality; reproductive cancers; menstruation/menstrual irregularities; menopause; hormone therapy; fertility/infertility; cardiovascular disease; osteoporosis; lung cancer; urinary stress incontinence; eating disorders; and depression.

The specific research objectives guiding the study were to:

1. Describe participating nursing programs on the following characteristics:
   a. Type of parent institution (university/college)
   b. Location of parent institution
   c. Average annual enrollment of parent institution
   d. Average annual baccalaureate nursing program enrollment
   e. Average annual number of baccalaureate nursing graduates
   f. Presence/absence of graduate nursing program
   g. Presence/absence of graduate women’s health nursing curriculum track
h. Presence/absence of women's health course in another department in the parent institution

2. Describe respondents on the following characteristics:
   a. Current position in the school of Nursing
   b. Practice specialty
   c. Highest level of academic preparation
   d. Age

3. Determine if selected women's health issues are currently included in the curricula of National League for Nursing (NLN) accredited baccalaureate nursing programs in the United States

4. Determine curricular placement of selected women's health issues that are currently included in the curricula of NLN accredited baccalaureate nursing programs in the United States

5. Determine class time allocation of selected women's health issues that are currently included in the curricula of NLN baccalaureate nursing programs in the United States

6. Ascertain the importance of selected women's health issues in baccalaureate nursing curricula as perceived by nursing faculty

7. Determine the women's health emphasis (WHE) of participating baccalaureate nursing programs

8. Determine if a relationship exists between the WHE Score and selected program characteristics
9. Determine if a model existed which explained a significant portion of the variance in WHE of baccalaureate nursing programs from the following program characteristics:

  a. Type of parent institution 
  b. Location of parent institution 
  c. Average annual university/college enrollment 
  d. Average annual baccalaureate nursing program enrollment 
  e. Average annual number of baccalaureate nursing graduates 
  f. Presence/absence of graduate nursing program 
  g. Presence/absence of graduate women's health curriculum track 
  h. Presence/absence of women's health course in another department in the parent institution.

Population and sample. The target population for this study was 604 NLN accredited baccalaureate nursing programs in the United States. A minimum sample of 260 NLN accredited baccalaureate nursing programs was determined a priori. A random sample stratified by geographic region was selected as follows: 73 baccalaureate programs from the Southern portion of the United States, 67 programs from the Northeast region of the country, 83 programs from the Midland region of the country, and 37 programs from the Western region of the United States. The combined regional sample comprised the overall study sample of 260 NLN accredited baccalaureate nursing programs.

Instrumentation. The instrument used in the study was researcher developed and consisted of three parts. The first part of the instrument included questions used to determine if the participating nursing programs included the selected women's health
issues in their curricula, and, if so, where in the curriculum the issues were placed. Also
to be determined was the amount of class time allocated to each issue that was taught.
The second part of the instrument was used to determine nursing faculty’s perceptions of
the importance of the issues to baccalaureate nursing curricula.

Respondents were also provided a space in this section of the instrument in which
to include other women’s health issues they felt were important, but were not part of the
instrument. The third part of the instrument was developed to elicit demographic
information on both the respondent and the parent institution of the participating nursing
program.

Data collection. Data were collected from the randomly selected NLN accredited
baccalaureate nursing programs by mailed questionnaires. The initial mailing consisted
of a cover letter to the program dean/director, a questionnaire, a stamped, self-addressed
return envelope, a blank address sheet, and a book plate. A reminder postcard was mailed
approximately 10 days from the date of the first mailing to the same program
deans/directors.

A follow-up mailing sent out approximately two weeks from the date of the
postcard reminder mailing consisted of a reminder cover letter, a questionnaire and a
stamped, self-addressed return envelope. Results of the study were made available to all
participants who requested them by returning the completed address sheets included in
the first mailing. A total of 169 baccalaureate nursing programs (65%) of the original
260 participated in the survey by returning completed questionnaires.

Non-response follow-up procedure consisted of a telephone call to the dean or
director of a randomly selected group of the nursing programs who did not respond. The
dean/director was asked to participate in a short telephone survey of randomly selected
items from the original questionnaire. A total of twenty-five deans and/or directors of non-respondent programs participated in the telephone survey.

Examination of the 20 comparisons made revealed that the groups were statistically significantly different on six of the items. Three of the items were compared using the t-test procedure and three of them were compared using the chi-square procedure. Therefore, the data from this study should be considered applicable to the respondent group only.

**Findings**

The following is a summary of the major findings pertaining to each of the objectives guiding the study:

The first objective of the study was to describe participating nursing programs on selected program demographics. It was determined that more of the parent institutions were public (n=83 or 49.1%), with 56 (33%) being private religious institutions, 27 (16%) being private secular institutions, and three being described as “other.” Two of the three “other” institutions were reported to be private non-secular and land grant. The third one was marked “other” but did not provide a response regarding the specific type. Fifty-two (30.8%) of the responding nursing programs were located in the Southern region of the United States, 45 (21.6%) in the Midland region, 45 (21.6%) in the Northeast region, and 26 (15.4%) in the Western region. Forty-seven (28.1%) of the parent institutions of participating programs were reported to have an average annual enrollment of over 10,000 students. The smallest number of parent institutions (n=12 or 7.2%) were reported to be of the smallest size category of less than 1000 students. Forty-three respondents (25.4%) reported their nursing program enrollment as over 250 students annually as an average. The smallest number of respondents (n=12 or 7.2%) indicated
that their nursing programs had less than 50 students enrolled on an annual basis. As far as the average annual number of baccalaureate nursing graduates of responding programs, more respondents \((n=75 \text{ or } 44.4\%)\) indicated that number to be between 50 and 100. The next largest number of respondents reported having fewer than 50 baccalaureate nursing graduates a year.

The majority of nursing schools participating in the study reported having a graduate nursing program \((n=103 \text{ or } 60.9\%)\). Of the 103 schools that reported having a graduate nursing program, only 22 \((21.2\%)\) indicated that their graduate program had a women's health curriculum track. The majority of represented parent institutions in the study \((72.3\%)\) were reported as not offering a women's health course in a department other than nursing in the university/college.

The second objective was to describe respondents on selected demographic characteristics. Participants were asked to check all positions in the School of Nursing that currently applied to them at the time of completing the survey. More respondents \((n=73 \text{ or } 42.6\%)\) reported Faculty Member as their current position in the School of Nursing than any other position. The next most frequently reported position was that of Dean/Director \((n=52 \text{ or } 30.8\%)\). Only 12 respondents indicated Assistant Dean/Director as their position in the School of Nursing. The practice specialty selected by more respondents was Maternal/Infant \((n=45 \text{ or } 26.6\%)\), while Child Health was indicated by the fewest respondents as their specialty area \((n=4 \text{ or } 2.4\%)\). As far as academic preparation of respondents, 113 \((66.9\%)\) indicated having a Doctorate in either a Non-Nursing Field \((n=63)\) or in Nursing \((n=50)\). The remaining respondents reported having a Master's Degree in either Nursing \((n=46 \text{ or } 27.2\%)\) or in a Non-Nursing Field \((n=10 \text{ or } 5.9\%)\). No respondents reported having a Baccalaureate Degree as their highest degree. Eighty-nine \((53.3\%)\) respondents indicated their age to be between 45 and 54 years. No
participants in the study were less than 25 years of age, and only 1 participant (.7%) reported being between 25 and 34 years old.

The third objective was to determine if selected women's health issues were included in the curricula of NLN accredited baccalaureate nursing programs in the United States. The issue "Health Teaching/Promotion" was reported to be included in the curricula of the most participating nursing programs (n=167 or 99.4%). Twelve of the 19 issues examined were reported as being taught in more than 90% of the responding programs. Those 12 issues were: Health/Teaching Promotion; Domestic Violence; Substance Abuse; Sexually Transmitted Diseases; Screening/Risk Assessment; Depression; Reproductive Cancers; Cardiovascular Disease; Nutrition; Fertility/Infertility; and Sexuality. "Urinary Stress Incontinence" was the issue reported as being taught by the fewest number of respondents (n=119 or 70.4%).

The fourth objective was to determine curricular placement of selected women's health issues that were included in the curricula of participating nursing programs. All of the included women's health issues were reported to be taught in a variety of nursing courses. Maternal/Infant Nursing and Adult Health Nursing were two courses that were reported by respondents as being the primary location of 14 of the 19 issues included in participating nursing programs.

The fifth objective was to determine class time allocation of selected women's health issues that were included in the curricula of participating nursing programs. Respondents reported spending the most class time on the issue "Health Teaching/Promotion" (M=2.9 hr, SD=1.15). The least reported amount of class time was spent on the women's health issue "Urinary Stress Incontinence" (M=94, SD=.93).
The sixth objective was to ascertain the importance of selected women's health issues in baccalaureate nursing curricula as perceived by nursing faculty. The issue rated the highest in importance by respondents was "Health Teaching/Promotion" (M=4.66). "Fertility/Infertility" was rated lowest in importance with a mean of 3.62. All issues were rated as Very Important, using a researcher developed interpretation of importance scale. The issue "Health Teaching/Promotion" was rated as Extremely Important.

The seventh objective was to determine the Women's Health Emphasis (WHE) of each participating nursing program. WHE Scores could range from a low of "0" to a high of "152." Two programs received a score of "149," and one nursing program scored "19." The mean score of all participating programs was 104.93.

The eighth objective was to determine if a relationship existed between the WHE and selected program characteristics. Using the t-test procedure, no differences were found in the WHE Scores by categories of the selected program characteristics "presence/absence of graduate nursing program," "presence/absence of graduate women's health curriculum track," and "presence/absence of a women's health course in another department in the parent institution." A Spearman's Rank Order Correlation Coefficient procedure found a significant correlation between the WHE Score and the variable "size of the baccalaureate nursing program", n=155, r=.18, p=.02. According to Davis descriptors (1971), this was described as a low association. No significant correlation was found between the WHE Score and the variables "number of nursing graduates" or "size of parent institution." An analysis of variance (ANOVA) found no differences among the three types of parent institutions and the WHE Score.

The ninth objective was to determine if a model existed which explained a significant portion of the variance in the WHE Score of participating baccalaureate...
nursing programs and selected program characteristics. Multiple regression analysis revealed that 2.7% of the variance in the WHE Score and selected program characteristics was explained by the variable "enrollment in nursing. No other demographic program characteristics explained a significant amount of the variance in the WHE Score and selected program characteristics.

Conclusions, Implications and Recommendations

Based on the findings of this study, the following conclusions and recommendations were drawn by the researcher. In interpreting the results of the study to derive meaningful conclusions, the reader should be cautioned to keep in mind that the non-respondent group was found to be different from the respondent group. Therefore, extrapolation of conclusions and recommendations from this study to the larger target population should be approached cautiously, if at all.

1. Few nursing programs in the United States have graduate women’s health curriculum tracks.

This conclusion was based on the finding that of the 103 (60.9%) reported graduate nursing programs in the study, only 22 (21.2%) offered a women’s health curriculum track. The finding is consistent with those in the literature. In 1994, there were thirty-four Women’s Health master’s degree programs in the United States (AACN,1994). In 1998, of 295 college and university programs that offered master’s or post-master’s Nurse Practitioner programs, only 3.9% (n=12) offered OB/GYN/Women’s Health as a specialty track (AWHONN, 1998).

2. Most primary women’s health issues are included in baccalaureate nursing programs.
This conclusion was based on the findings that 12 of the 19 selected women’s health issues were reported to be taught by over 90% of the participating nursing programs, and that all of the selected women’s health issues were reported to be taught in from 71.7% to 99.4% of participating nursing programs.

One implication of these findings is that participating nursing programs are effectively including these selected women’s health issues in their curricula. From this researcher’s knowledge and experience with nursing education, this finding is somewhat inconsistent. Two possible factors cause this researcher to be hesitant to accept that the participating nursing programs are effectively including these selected women’s health issues in their baccalaureate curricula. One factor is that many of the issues included in the survey can be considered to be general health issues for all persons, such as cardiovascular disease and lung cancer, and therefore would probably be included in any nursing curriculum. Although respondents were asked to consider these health issues and their impact specifically on women, it is difficult to know how much of the content reported to be taught on these general health issues is actually specific to women and how they are affected by the issue. Persons conducting related research in the future should consider this factor when designing their studies. Another factor is the question of how accurate the respondent’s knowledge was of the women’s health content in their nursing curriculum. The dean/director of each participating baccalaureate nursing program was asked to have the person most knowledgeable about women’s health issues in that program complete the survey. However, practice specialties of respondents varied widely. Also, some nursing programs have integrated curricula, which could pose a problem with one faculty being knowledgeable about all issues taught. Hagell (1990)
had the same concern about integrated curricula in her survey of women's health content in Canadian baccalaureate nursing programs.

This researcher recommends that faculty of baccalaureate nursing programs who are interested in enhancing the amount and/or quality of women's health content in their curricula assess which women's health issues are currently being included in their programs. This assessment could be accomplished by faculty evaluation of the woman's health content of all nursing courses in the curriculum, and by the administration of diagnostic tests (such as the NLN diagnostic exams typically given to baccalaureate nursing students across the country) to students in their program.

Also, it is recommended that nation-wide research be conducted which would survey both faculty and graduating students of the same nursing programs regarding the women's health content in their curricula, with data being compared for consistency and accuracy. Data from such studies, along with the findings from this study would help baccalaureate nursing faculty to know what other baccalaureate nursing programs in the country are doing with their curricula in regard to women's health.

3. Nursing programs place greater emphasis on women's health issues which are more general in nature than those issues specific primarily to women.

This conclusion was based on the findings that the percentages of respondents including the more general issues "Health Teaching/Promotion," "Domestic Violence" and "Substance Abuse" in their nursing program curricula were 99.4%, 99.4% and 98.8% respectively. The mean class time spent on the issue of "Health Teaching/Promotion" was estimated at 2.91 hours. Class times spent on "Domestic Violence" and "Substance Abuse" were estimated at 2.26 hours and 2.38 hours respectively. Percentages of
respondents including the very specific female issues “Urinary Stress Incontinence,” “Hormone Therapy” and “Menopause” in their programs were 71.7%, 79.1% and 82.8% respectively. Mean estimated class times spent on these issues were .94 hours, 1.02 hours and 1.37 hours.

One implication of the fact that “Health Teaching/Promotion” was reported to be included in the curriculum of almost every participating nursing program in the survey is that these programs are committed to two of the very basic tenants of nursing education, one being the emphasis on prevention rather than illness, and the other being the belief that patient teaching is one of the most important nursing interventions in any health care setting, and for any health topic, condition or disease process (Maddox & Fishbein, 1994; Hoff & Ross, 1995).

The finding that the women’s health topics of “Urinary Stress Incontinence,” “Hormone Therapy,” and “Menopause” were reported to be included in the fewest nursing programs is consistent with this researcher’s experience with nursing education and long-standing membership in a women’s health professional nursing organization. In this researcher’s experience, health topics which are more specific to women, such as these three topics, have not been consistently included in baccalaureate nursing curricula.

4. Women’s health content can be found in a wide variety of nursing courses.

This conclusion was based on the findings that all of the selected women’s health issues were reported as being located in a variety of courses. The reasons why the issues were taught in a number of different courses within the same nursing program may be twofold in nature. Either all of the participating nursing programs have women’s health content integrated into their curricula in a very systematic, deliberate manner in several designated nursing courses, or else the women’s health content in the participating nursing programs lacks a central focus and is haphazardly located throughout the
curricula. It is unknown which of the preceding instances is correct, but one implication of the latter scenario being true is the potential for various women’s health issues to “slip through the cracks” and not be addressed adequately anywhere in the curriculum.

This researcher recommends that nursing faculty assess not only the types of women’s health issues included in their curricula and the amount of class time devoted to these issues, but also the placement of the women’s health content within their curricula.

5. Women’s health issues are considered to be very important to baccalaureate nursing curricula.

This conclusion was based on the finding that the overall mean rating of 4.08 (using an interpretative scale of importance from 1 to 5, with 4.5 or higher being “extremely important”, and 3.50 to 4.49 meaning “very important”) was found for all issues. Another finding on which to this conclusion was based is that mean scores of importance ranged from 4.66 for “Health Teaching/Promotion” to 3.62 for “Infertility/Fertility.” In addition to these findings, many of the respondents identified other women’s health issues they felt were important by including them in the space provided for this information on the survey instrument.

A recommendation stemming from this conclusion is that national research be conducted to identify which women’s health issues should be included in baccalaureate nursing curricula. This research could be taken a step farther by having nursing faculty delineate which issues should be included in required baccalaureate nursing courses, and which should be available in an elective women’s health nursing course only. Given that class time in nursing schools is already at a premium, coupled with the phenomenal growth of health knowledge daily, this researcher believes it is unrealistic to expect that all women’s health issues must be included in generic baccalaureate nursing curricula.
6. The emphasis placed on women’s health issues varies widely among baccalaureate nursing programs.

This conclusion was based on the findings that WHE Scores ranged from 19 to 149, and that 99 of the 155 participating programs received a score of 100 or above (with 152 being the highest score possible.)

One implication of this finding is that completion of a baccalaureate nursing program doesn’t ensure that a nurse has an adequate knowledge base in women’s health. Determination of “core” women’s health content, such as would be accomplished by research to identify which women’s health issues should be included in baccalaureate nursing curricula, and to what extent, would help to eliminate inconsistencies among nursing programs in regard to the emphasis placed on women’s health. Also, to encourage nurse educators to include women’s health content in nursing program curricula, nursing diagnostic and licensure exams should reflect that content.
REFERENCES


Association of Professors of Medicine (APM) (1997). What internists need to know: Core competencies in women’s health. The American Journal of Medicine, 102(June), 507-512.


APPENDIX A

NEWSPAPER ADVERTISEMENT
Lauren F. Ogden, M.D., F.A.C.O.G.
and
Philip Hindelang, M.D., F.A.C.O.G.

formerly of Ochsner Clinic in New Orleans
proudly announce the opening of

Alliance for Women’s Health
providing routine ob/gyn care, hysteroscopic and
laparoscopic surgery, infertility, menopausal
management and hormone therapy

451 East Airport Ave., Suite A
(225) 924-9080
also seeing patients in Gonzales

Sunday Advocate 1/24/99
APPENDIX B
NEWSPAPER INSERT
Living Through The Change: AIMS with Laughter and Information

Open House for Women's Heart Health
Woman's Fitness Center
Thursday, February 11 • 3:00 p.m. - 7:30 p.m.
FREE

Presentations:

4:00 - 5:00 “Healthy Women 2000: Women's Heart Health”
Marian Limacher, M.D., Cardiologist
Professor, University of Florida College of Medicine
Chair, The Women’s Health Initiative, a large-scale, long-term study begun in 1991 to determine the benefits and possible risks of hormone replacement therapy in women.

5:15 - 5:45 “Finding Your Fitness Style”
Dawn Braud, MS, Exercise Physiologist, Director of Woman’s Fitness Center

6:00 - 7:00 “It’s Not Just a Man Thing”
Women heart attack survivors share a message of inspiration and call to action.

Taste Test Heart Healthy Recipes and Receive Free Recipe Cards.
Door Prizes!

Call Resources for Women 925-1456 to register.

Woman's Hospital
Visit our web site at: www.womans.com

1/24/99
Sandra Pinesite
APPENDIX C
NEWSPAPER INSERT
Head to Toe Info

For information about women's health, including speaker's bureau, individualized programs, video, audio and printed resource materials, call our Community Benefit Coordinator at 925-5549 ext. 3046.

Woman's Hospital’s Therapy Center to Celebrate Better Hearing and Speech Month!

Join the Audiologists and Speech Pathologists at Woman’s Hospital in promoting the importance of Hearing and speech “wellness” and the need for early intervention of speech/language and hearing problems.

Do you have concerns about your child’s speech and language? Is her speech hard to understand or different from others? Are you overly concerned about her speech? Then join us on the following dates.

May 5th – We will offer free Speech and Language screenings for children, pre-school and older.

May 20th – Join us for a free seminar entitled “Speech and Your Baby.” Learn fun techniques you can use at home with your baby to encourage speech and language development.

Do you frequently ask people to repeat themselves? Do you find yourself frequently denying hearing problems? Do you often misunderstand conversations? Do you turn up the TV volume? Then join us on the following dates.

May 12th – We will offer free Hearing Screenings for children and adults.

May 20th – Join us for a free seminar on the “Newest Technology in the Management of Hearing Loss.”

Understanding Women is the education resource from Woman’s Hospital in Baton Rouge. This catalog of classes, speakers, events, seminars and other educational opportunities offers something for women in every stage of life.

Call the Therapy Center at 925-5549 to register and for more information about these exciting, free offerings. The seminars will be from 9:00 a.m. - 11:30 a.m. in the Therapy Center conference room. Remember, space is limited, so, call early.
Have you ever felt you had a dream buried within you that you could barely get at, let alone bring to life? In a way, that's the story of the actor Matthew McConaughey, an ordinary kid from Texas oil country:

Mama's Boy Grows Up

AN INTERVIEW
By Gail Buchalter

INSIDE; Why Illnesses Affect Men and Women Differently
APPENDIX E

WOMEN’S HEALTH INITIATIVE
G.3 WHI Press Materials

G.3.1 Backgrounder

WHAT IS THE WOMEN'S HEALTH INITIATIVE?

The Women's Health Initiative (WHI) is a long-term national health study that focuses on strategies for preventing heart disease, breast and colorectal cancer, and osteoporosis in postmenopausal women. These chronic diseases are the major causes of death, disability, and frailty in older women of all races and socioeconomic backgrounds.

This $628 million, 15-year project, sponsored by the National Institutes of Health (NIH), will involve 164,500 women aged 50-79, and is one of the most definitive, far reaching clinical trials of women's health ever undertaken in the U.S. The WHI will attempt to redress many of the inequities in women's health research and provide practical information to women and their physicians about hormone replacement therapy, dietary patterns, and calcium/vitamin D supplements, and their effects on the prevention of heart disease, cancer, and osteoporosis.

THE HISTORY OF WOMEN'S HEALTH RESEARCH

Women have long been underrepresented in medical research. Historically, women's health research focused on diseases affecting fertility and reproduction. Other disease research has focused disproportionately on men.

Despite this imbalance, new drug therapies tested on men, once approved, are often prescribed to women without comparable trials of clinical safety or efficacy. For example, a few years ago a study revealed that aspirin helps prevent heart attacks in men. Women were not included in this study even though heart disease is the number one killer of U.S. women. Yet, aspirin is now recommended to both men and women as a preventive measure for heart attacks.

Women have been excluded from medical research for at least two reasons: 1) concerns about pregnancy during a trial and 2) concerns that women's changing hormone levels during menstrual cycles might skew test results.

We now know that there are no significant reasons to exclude women in medical research. In most cases both sexes respond similarly to many therapies; however, there may be exceptions. For example, women may need lower dosages and some therapies may be specific to women.

A NEW ERA IN WOMEN'S HEALTH: THE WOMEN'S HEALTH INITIATIVE

To respond to the crucial need for the involvement of women in medical research, the NIH in 1990 established the Office of Research on Women's Health (ORWH). The earliest undertakings of the ORWH included the development of a research agenda to identify and address gaps in the biomedical community's knowledge of women's health and the strengthening and revitalization of already existing NIH guidelines and policies for the inclusion of women and minorities in clinical studies.
With the growing scientific interest in research on women's health, Dr. Bernadine Healy, former director of the NIH, launched the WHI in April 1991.

HOW IS THE WHI BEING CONDUCTED?

The WHI study has three components: a randomized clinical trial, an observational study, and a community prevention study.

The randomized controlled clinical trial will enroll about 64,500 postmenopausal women between the ages of 50-79. The clinical trial has three study components. If eligible, women can choose to enroll in one, two or all three of the components. The components are:

- **Hormone Replacement Therapy (HRT):** This component will examine the effect of HRT on the prevention of heart disease and osteoporosis, and any associated risk for breast cancer. Women participating in this component take hormone pills or a placebo (inactive pill).
- **Dietary Modification:** The Dietary Modification component will evaluate the effect of a low-fat, high fruit, vegetable and grain diet on the prevention of breast and colorectal cancer and heart disease. Study participants follow either their usual eating pattern or a low-fat eating program.
- **Calcium/Vitamin D:** This component starts one year after a woman joins one or both of the other studies. It will evaluate the effect of calcium and vitamin D supplementation on the prevention of osteoporosis and colorectal cancer. Women in this component take calcium and vitamin D pills or a placebo.

The observational study will examine the relationship between lifestyle, health and risk factors, and specific disease outcomes. This component will track the medical history and health habits of approximately 100,000 women.

Recruitment for the randomized clinical trial and the observational study will last four years and participants will be followed for 8 to 12 years.

The community prevention study is a unique collaborative venture between the Centers for Disease Control and Prevention (CDC), the National Center for Chronic Disease Prevention and Health Promotion, and the NIH. Eight CDC University-based Prevention Centers will conduct and evaluate health programs that encourage women of all races and socioeconomic backgrounds to adopt healthful behaviors such as improved diet, nutritional supplementation, smoking cessation, exercise, and early detection of treatable health problems. The goal of the community prevention study is to develop carefully evaluated, model programs that can be implemented in a wide range of communities throughout the U.S.

WHERE IS THE WHI TAKING PLACE?

The WHI clinical trial and observational study are being conducted at 40 clinical centers nationwide. The Fred Hutchinson Cancer Research Center in Seattle, WA serves as the WHI Clinical Coordinating Center for data collection, management and analysis. A total of 16 vanguard clinical centers began recruitment in September 1993. The remaining 24 centers were announced in September 1994 and began recruitment in February 1995. Recruitment of women who choose to "be part of the answer" will continue through January 1998.

WHO IS ELIGIBLE TO PARTICIPATE IN THE WHI?

The WHI encourages women of all socioeconomic backgrounds and ethnicity between the ages of 50-79 to participate in the clinical trials or observational study. Study participants get the personal satisfaction of knowing that they are contributing to their own health and the health of women for generations to come. Women interested in participating in the WHI can call 1-800-54-WOMEN to be connected to a WHI clinical center in their area.
APPENDIX F

STATES BY NATIONAL LEAGUE OF NURSING REGION
<table>
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<th>States by National League of Nursing Region</th>
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* Southern region includes Puerto Rico and Guam.
APPENDIX G

WOMEN'S HEALTH SURVEY INSTRUMENT
WOMEN'S HEALTH ISSUES

IN

BACCALAUREATE NURSING PROGRAMS

SURVEY INSTRUMENT

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
DIRECTIONS

This is a three-part questionnaire that will take approximately 15 minutes to complete. The beginning of each section has instructions for completing the items in that section. Below are examples of a completed item from each section for your use.

Please answer all questions based on your knowledge of the content of your current baccalaureate nursing curriculum. There may be more than one answer to some of the questions.

Thank you for your participation.

SECTION ONE EXAMPLE - WOMEN'S HEALTH ISSUES QUESTIONS

Look at each women's health issue in the left column. Answer the questions to the right of each issue by checking the most appropriate answer. If the answer to the question in column A is YES, please answer the remaining two (2) questions. In selecting the answer, choose the one that most closely describes the women's health content in your current baccalaureate nursing curriculum.

<table>
<thead>
<tr>
<th>COLUMN A</th>
<th>COLUMN B</th>
<th>COLUMN C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issue</td>
<td>Is this issue covered?</td>
<td>In what type of course is this issue covered?</td>
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<tr>
<td>Screening/Risk Assessment</td>
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<tr>
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<td>□ Women's Health Nursing</td>
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<td></td>
<td>No</td>
<td>□ Adult Health Nursing</td>
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<td>□ Elective Nursing Course</td>
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<td>□ Other (Please Specify)</td>
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</tbody>
</table>

SECTION TWO EXAMPLE - WOMEN'S HEALTH ISSUES IMPORTANCE

Please rate each women's health issue for importance of inclusion in baccalaureate nursing curriculum by checking the appropriate box.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Level of Importance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not Important</td>
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</tbody>
</table>

SCREENING/RISK ASSESSMENT

□ □ □ □ □

SECTION THREE EXAMPLE - DEMOGRAPHICS

Please check the appropriate response to each question. Some questions may have more than one answer.

4. Which of the following BEST describes the average annual number of baccalaureate degree students graduating from your nursing program?

- □ Less than 50
- □ 50-100
- □ 101-150
- □ 151-200
- □ 201-250
- □ Over 250

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<table>
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<th>COLUMN C</th>
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<td>How many times in this course is this issue</td>
<td>How much total program time is allocated</td>
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<td>☐ Outside Class Readings Only</td>
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<td>☐ No</td>
<td>☐ From One Half (1/2) Hour to One (1) Hour</td>
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<tr>
<td>Health Teaching /Promotion</td>
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<td>Substance Abuse</td>
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<td>☐ Outside Class Readings Only</td>
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<td>Reproductive Cancers (Breast, Uterine, etc.)</td>
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<td>Menstrual/ Menstrual Irregularities</td>
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<td>Eating Disorders</td>
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<td>□ Other (Please Specify)</td>
<td>□ Over Three (3) Hours</td>
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</tbody>
</table>
## SECTION TWO - WOMEN'S HEALTH ISSUES IMPORTANCE

As the recognized expert in women's health in your program, your viewpoint about which women's health issues should be included in baccalaureate nursing programs is important. Please rate each of the following issues on their importance for inclusion in baccalaureate nursing programs by checking the appropriate box.

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<thead>
<tr>
<th>Issue</th>
<th>Not Important</th>
<th>Somewhat Important</th>
<th>Moderately Important</th>
<th>Very Important</th>
<th>Extremely Important</th>
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<tr>
<td>Screening/Risk Assessment</td>
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<td>Health Teaching/Promotion</td>
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<td>Substance Abuse</td>
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<td>Cardiovascular Disease</td>
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<td>Lung Cancer</td>
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<td>Eating Disorders</td>
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<td>Depression</td>
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</table>

If there are any other essential health issues that are either taught in your program or you feel strongly should be in a baccalaureate nursing program, please identify those issues.
DEMOGRAPHICS

Please check the appropriate response to each question. Some questions may have more than one answer.

1. The parent institution of your nursing program is?
   □ Public □ Private secular □ Private religious □ Other (Please Specify) __________________

2. Which of the following BEST describes the average annual enrollment in your parent institution?
   □ Less than 1000 □ 1001 - 2500 □ 2501 - 5000 □ 5001 - 7500 □ 7501 - 10,000 □ Over 10,000

3. Which of the following BEST describes the average annual enrollment in your baccalaureate nursing program?
   □ Less than 50 □ 50 - 100 □ 101 - 150 □ 151 - 200 □ 201 - 250 □ Over 250

4. Which of the following BEST describes the average annual number of baccalaureate degree students graduating from your nursing program?
   □ Less than 50 □ 50 - 100 □ 101 - 150 □ 151 - 200 □ 201 - 250 □ Over 250

5. Does your School/Department of Nursing have a graduate program?
   □ Yes □ No

6. If there is a graduate program in your School/Department of Nursing, does it have a women's health curriculum track?
   □ Yes □ No

7. Does your parent institution offer a women's health course through any department other than Nursing?
   □ Yes (Please identify the department) ____________________________ □ No

8. What is your current position in the School of Nursing (Please check all that apply.)
   □ Dean/Director □ Assistant Dean/Director
   □ Level Coordinator/Chairperson □ Course Coordinator/Chairperson
   □ Curriculum Development Chairperson □ Faculty Member

9. What is your highest level of academic preparation?
   □ Baccalaureate degree in nursing □ Master's degree in non-nursing field
   □ Master's degree in nursing □ Doctorate in nursing
   □ Doctorate in non-nursing field

10. Which of the following BEST describes your practice specialty?
    □ Mental Health □ Adult Health □ Maternal/Child □ Women's Health
    □ Community Health □ Child Health □ Men's Health □ Other (Please Specify)____________________

11. What is your age?
    □ 24 years or less □ 25-34 years □ 35-44 years □ 45-54 years □ 55-64 years □ Over 64 years

Thank you for participating in this study.

Please return this completed questionnaire to:

Karen Moody, RNC, MN
Louisiana State University
School of Vocational Education
Old Forestry Building, Room 142
Baton Rouge, LA 70803
APPENDIX H

PERSONAL COMMUNICATION TO WOMEN’S HEALTH PROFESSIONAL

131
August 10, 1998

Diana Taylor, RN, PhD, FAAN
Associate Professor, Family & Women’s Primary Care Program
School of Nursing
University of California
San Francisco, CA 94143-0606

Dear Diana:

We met at the AWHONN National Convention in San Antonio after your Sunday presentation for Pfizer. I am at dissertation stage in my doctoral program at LSU, and am in the process of developing an instrument to be used in my women’s health study. I am hoping you will be able to help me by looking at the enclosed list of women’s health topics and rating them for me. I developed the list of twenty predominantly identified women’s health issues after a thorough, systematic review of related literature. My questionnaire will go to a random sample of NLN accredited generic baccalaureate nursing programs in the United States. I am attempting to determine which women’s health issues, other than childbearing, are taught at the undergraduate level.

Would you please review the enclosed list and rate each issue as to its' level of importance, using the scale provided? Also, please feel free to list any other women’s health issues you feel should be included, but are not presently on the list. I have enclosed a stamped, self-addressed envelope for your response.

Your help will be invaluable to me in validating the content for my questionnaire.

Sincerely,

Karen Moody, RNC, MN
Assistant Professor
WOMEN’S HEALTH CATEGORIES/ISSUES

Please rate the following women’s health issues as to their level of importance using the rating scale below:

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not important</td>
</tr>
<tr>
<td>1</td>
<td>Somewhat important</td>
</tr>
<tr>
<td>2</td>
<td>Very important</td>
</tr>
</tbody>
</table>

**Health prevention issues**
- Screening
- Health teaching/promotion
- Nutrition

**Social issues**
- Domestic violence
- Substance abuse
- Sexually transmitted disease
- Sexual abuse
- Multiple role conflict
- Sexuality
- Poverty

**Mental health issues**
- Eating disorders
- Depression

**Reproductive issues**
- Reproductive cancers
- Menopause
- Fertility
- Hormone replacement therapy

**Physical disease issues**
- Cardiovascular diseases
- Osteoporosis
- Lung cancer
- Urinary stress incontinence
APPENDIX I

INITIAL COVER LETTER
October 20, 1998

Dear

In a 1990 report to Congress, the General Accounting Office detailed a lack of sufficient women's health research funding by the NIH. This report and subsequent legislation regarding women's health, women's health research, and its inclusion in medical school curricula, sparked considerable national interest in women's health issues. Nurses are in a unique position to promote women's health care and knowledge, and Schools of Nursing have the greatest ability and opportunity to have an influence on future generations of nursing health professionals.

Your program has been randomly selected from National League for Nursing accredited baccalaureate-nursing programs to participate in a national study of women's health issues. As one of the small number of programs selected, your participation is essential to the success of the study. The enclosed questionnaire can be completed in approximately 15 minutes. Please either complete the questionnaire personally, or ask the faculty member who is best qualified to respond regarding the women's health content in your curriculum to do so. The completed questionnaire should then be returned in the stamped, self-addressed envelope provided.

Please respond by November 9, 1998 if at all possible.

You may be assured of complete confidentiality of your individual responses. Data will be reported in summary form with no identifying respondent information. Identification numbers on the questionnaire are for follow-up and mailing purposes only.

The results of this study will be made available to the National League for Nursing and the Association of American Medical Colleges. Therefore, there is the potential for your input to have an effect on the future of nursing curricula in the U.S. I will be glad to send you a summary of the study results. You may receive a summary by filling out the address slip provided and enclosing it with the completed questionnaire.

If you have any questions, please contact me by phone at (225) 765-2324, or by e-mail at kmoodyn@selu.edu.

Thank you for your assistance. Please accept the enclosed bookplate as a small token of my appreciation for your participation in this study to help promote knowledge of women's health issues.

Sincerely,

MICHAEL F. BURNETT, Ph.D.
Director
Louisiana State University
School of Vocational Education

KAREN MOODY, RNC, MN
Assistant Professor
Southeastern Louisiana University
School of Nursing
APPENDIX J

ADDRESS SHEET
APPENDIX K

REMINDER POSTCARD
November 4, 1998

Dear Dean/Director:

You recently received a packet of research material for a study on women's health issues in baccalaureate nursing curricula. If you or a designated faculty member have already returned the completed questionnaire, thank you for doing so.

If the survey has not been returned, please DO consider becoming part of this important study by returning the completed questionnaire by November 14, 1998. THE SUCCESS OF THIS STUDY DEPENDS ON YOUR RESPONSE.

Please contact me if the materials have been misplaced, or if you need further information regarding the study. I can be reached in the daytime at (504) 765-2324; in the evening at (504) 766-8271; and by email at kmoodv@selu.edu.

Sincerely,

Karen Moody, RNC, MN

Karen Moody, RNC, MN
Louisiana State University
School of Vocational Education
Old Forestry Building, Room 142
Baton Rouge, LA 70803

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APPENDIX L

FOLLOW-UP COVER LETTER

140
November 17, 1998

Dear

About a month ago, you should have received a survey for a study to identify women's health issues in baccalaureate nursing curricula. The number of questionnaires returned is encouraging, however we have not received your completed questionnaire.

You input is important, as it will help us obtain a more complete picture of the type, time allocation and importance of women's health content in baccalaureate nursing programs.

Women's health has become recognized nationally as an important health issue. Nurses play a vital role in the care of women, yet there is very little information in the literature regarding what they learn about women's health in their undergraduate nursing programs.

If you recently returned your questionnaire, please accept our thanks for your participation. In case you did not receive the previous copy or your copy has been misplaced, another questionnaire is enclosed. I urge you to complete and return the questionnaire by December 4, 1998.

You may be assured of complete confidentiality of your individual responses. Data will be reported in summary form with no identifying respondent information. Identification numbers on the questionnaire are for follow-up and mailing purposes only.

Thank you for your assistance. If you have any questions, please contact me by phone at (225) 765-2324, or by e-mail at kmoodv@selu.edu.

Sincerely,

MICHAEL F. BURNETT, Ph.D.
Director
Louisiana State University
School of Vocational Education

KAREN MOODY, RNC, MN
Assistant Professor
Southeastern Louisiana University
School of Nursing
APPENDIX M

TELEPHONE SURVEY INSTRUMENT
WOMEN'S HEALTH ISSUES

IN

BACCALAUREATE NURSING PROGRAMS

TELEPHONE SURVEY INSTRUMENT
Women's Health Issues in Baccalaureate Nursing Programs

SECTION I

Do you teach this women's health issue in your baccalaureate nursing program?

Screening/Risk assessment    _____ Yes
                                 _____ Uncertain
                                 _____ No

Health Teaching/Promotion      _____ Yes
                                 _____ Uncertain
                                 _____ No

Nutrition                      _____ Yes
                                 _____ Uncertain
                                 _____ No

Domestic violence              _____ Yes
                                 _____ Uncertain
                                 _____ No

Sexuality                      _____ Yes
                                 _____ Uncertain
                                 _____ No

Hormone Therapy                _____ Yes
                                 _____ Uncertain
                                 _____ No

Fertility/Infertility           _____ Yes
                                 _____ Uncertain
                                 _____ No

Urinary Stress Incontinence    _____ Yes
                                 _____ Uncertain
                                 _____ No
SECTION II

How important is this issue for inclusion in baccalaureate nursing programs? Please rate the issue on a scale from 1 to 5, with 1 being least important, and 5, extremely impt.

<table>
<thead>
<tr>
<th>Level of Importance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Not</td>
</tr>
<tr>
<td>Nutrition</td>
</tr>
<tr>
<td>Domestic Violence</td>
</tr>
<tr>
<td>Substance Abuse</td>
</tr>
<tr>
<td>Hormone Therapy</td>
</tr>
<tr>
<td>Cardiovascular Disease</td>
</tr>
<tr>
<td>Lung Cancer</td>
</tr>
<tr>
<td>Urinary Stress Incontinence</td>
</tr>
<tr>
<td>Eating Disorders</td>
</tr>
<tr>
<td>Depression</td>
</tr>
</tbody>
</table>

SECTION III

Please answer the following demographic questions.

The parent institution of your nursing program is?

___ Public  ___ Private Secular  ___ Private Religious  ___ Other (Please Specify)__________

Does your School/Department of Nursing have a graduate program?

___ Yes  ___ No

What is your highest level of academic preparation?

___BS-Nsg  ___ MS-Nsg  ___ MS-Non-Nsg  ___ Doctorate-Nsg  ___ Doctorate-Non-Nsg
APPENDIX N

OTHER DEPARTMENTS OFFERING WOMEN'S HEALTH COURSES
### Other Department in Parent Institutions Offering Women's Health Courses

<table>
<thead>
<tr>
<th>Department</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women's Studies</td>
<td>17</td>
</tr>
<tr>
<td>Health Education</td>
<td>5</td>
</tr>
<tr>
<td>Physical Education</td>
<td>2</td>
</tr>
<tr>
<td>Psychology</td>
<td>2</td>
</tr>
<tr>
<td>Arts &amp; Sciences</td>
<td>1</td>
</tr>
<tr>
<td>Home Economics</td>
<td>1</td>
</tr>
<tr>
<td>Anthropology</td>
<td>1</td>
</tr>
<tr>
<td>Allied Health</td>
<td>1</td>
</tr>
<tr>
<td>Athletics</td>
<td>1</td>
</tr>
<tr>
<td>General Studies</td>
<td>1</td>
</tr>
<tr>
<td>Sociology</td>
<td>1</td>
</tr>
<tr>
<td>Physician's Assistant</td>
<td>1</td>
</tr>
<tr>
<td>Women's Center</td>
<td>1</td>
</tr>
<tr>
<td>Women &amp; Gender Studies</td>
<td>1</td>
</tr>
<tr>
<td>College of Medicine</td>
<td>1</td>
</tr>
<tr>
<td>Obstetrics/Gynecology</td>
<td>1</td>
</tr>
</tbody>
</table>
APPENDIX O

OTHER COURSES CONTAINING WOMEN’S HEALTH CONTENT
"OTHER" COURSES CONTAINING WOMEN'S HEALTH ISSUES

<table>
<thead>
<tr>
<th>Category</th>
<th>Courses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening/Risk Assessment</td>
<td>Health Assessment (20), Physical Assessment (6), Nursing Assessment (6), Health Promotion (5), Child Health (3), Wellness (2), Growth &amp; Development (2), Critical Care, Pathophysiology, Gerontology, Advanced assessment, Concepts of Community, Patterns</td>
</tr>
<tr>
<td>Health Teaching/Promotion</td>
<td>Health Promotion (20), Pediatrics (3), Family (2), Interpersonal Relationships, Nursing Synthesis, Nursing Assessment, Physical Assessment, Advanced Assessment, Clinical Teaching Methods, Fundamentals, Pathophysiology, Critical Care, Gerontology, Nursing Roles &amp; Interventions, Concepts of Community, Patterns</td>
</tr>
<tr>
<td>Nutrition</td>
<td>Nutrition (15), Health Assessment (10), Health Promotion (5), Physical Assessment (2), Wellness (2), Gerontology (2), Nursing Assessment, Children's Health</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>Family Nursing (6), Pediatrics (3), Gerontology (2), Health Assessment, Nursing Assessment, Families in Crisis, Psychosocial Transition, Adaptation, Crosscultural, Policies &amp; Politics, Women's Health Issues, Community As a Client</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>Family Nursing (6), Pharmacology (2), Professionalism (2), Health Assessment (2), Physical Assessment, Patterns, Families in Crisis, Pediatrics, Gerontology, Psychosocial Transition, Adaptation, Substance Abuse, Addiction, Adolescents &amp; Young Adults, Health Restoration, School Nurse Theory, Trends &amp; Issues</td>
</tr>
<tr>
<td>Sexually Transmitted Diseases</td>
<td>Health Assessment (5), Pathophysiology (5), Aging (2), Human development, Human sexuality, Children's Health, Family Nursing, School Nursing, Pharmacology</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>Pediatrics (6), Families in Crisis, Health Promotion, Health Assessment, Family Nursing, Adaptation, Human Sexuality, Patterns</td>
</tr>
<tr>
<td>Sexuality</td>
<td>Health Assessment (8), Health Promotion (5), Pediatrics (4), fundamentals (2), Growth &amp; Development (2), Basic Concepts (2), Family Nursing (2), Aging (2), Chronic Health Problems, Human Development, Human Sexuality, Psychosocial/spiritual, Health Restoration, Nursing roles &amp; Transitions, Patterns</td>
</tr>
<tr>
<td>Reproductive Cancers</td>
<td>Family Nursing (11), Pathophysiology (10), Health Assessment (8), Gerontology (2), Nursing Assessment, Physical Assessment, Health restoration, Chronic Health Problems, Nursing Roles &amp; Interventions, Pharmacology</td>
</tr>
<tr>
<td>Menstruation/ Menstrual Irregularities</td>
<td>Health Assessment (10), Pathophysiology (8), Health Promotion (3), Pharmacology (2), Physical Assessment (2), Family Nursing (2), Children's Health, Nursing Roles &amp; Interventions, Patterns</td>
</tr>
</tbody>
</table>
Menopause: Pathophysiology (6), Health Assessment (6), Aging (3), Health Promotion (2), Pharmacology (2), Nursing Assessment, Physical Assessment, Human Development, Chronic Illness, Growth & Development, Midlife & Older Adults, Family Nursing, Nursing Roles & Interventions, Patterns

Hormone Therapy: Pharmacology (17), Pathophysiology (5), Aging (4), Chronic Illness, Health Assessment, Human development, Growth & Development, Chemotherapeutics, Family Nursing, Nursing roles & Interventions

Fertility/Infertility: Pathophysiology (6), Advanced Nursing, Family Nursing, Adaptation, Complex Nursing, Patterns

Cardiovascular Disease: Pathophysiology (14), Aging (2), Wellness Promotion (2), Pharmacology (2), Synthesis, Women's Health Issues, Advanced Nursing, Critical Care, Complex Nursing, Children's Health, Health Restoration, Nursing Roles & Interventions, Patterns

Osteoporosis: Pathophysiology (12), Health assessment (7), Health Promotion (3), Physical Assessment (3), Aging (3), Pharmacology (2), Nutrition (2), Adaptation, Health Restoration, Family Nursing, Nursing Roles & Interventions, Patterns

Lung Cancer: Pathophysiology (12), Physical Assessment, Health Assessment, Complex Nursing, Pharmacology, Gerontology, Patterns

Urinary Stress: Health Assessment (6), Gerontology (6), Pathophysiology (4), Chronic Illness(2), Foundations (2), Physical Assessment, Wellness Promotion, Dimensions of Health, Clinical Nursing, Family Nursing, Women's Health Issues, Patterns

Incontinence: Pediatrics (8), Nutrition (6), Health Assessment (5), Pathophysiology (2), Women's Health Issues, Physical Assessment, Health Promotion, Health Restoration, Psychosocial/Spiritual, Growth & Development, Adolescents & Young adults, Family Nursing, School Nurse Theory, Patterns

Eating Disorders: Pharmacology (3), Health Assessment (2), Gerontology (2), Families in Crisis, Adaptation, Growth & Development, Psychosocial/Spiritual, Professional Nursing, Nursing Roles & Interventions, Family Nursing, Patterns

Depression: Pharmacology (3), Health Assessment (2), Gerontology (2), Families in Crisis, Adaptation, Growth & Development, Psychosocial/Spiritual, Professional Nursing, Nursing Roles & Interventions, Family Nursing, Patterns
APPENDIX P

OTHER IMPORTANT WOMEN’S HEALTH ISSUES
AS DESCRIBED BY STUDY RESPONDENTS

151
Other Important Women’s Health Issues as Described by Study Respondents

Stress management 5
Cultural diversity and women 5
Alternative health modalities 4
Family structure and dynamics 3
Promoting positive self-image 3
Access to health care 3
Assertiveness training for women 2
Crisis intervention 2
Socioeconomic issues affecting women 2
Diabetes 2
Aging 2
Assertiveness for childbearing women 2
Diagnosis of gender bias in research 2
Inactivity and resultant health conditions 2
Exercise 2
Urban and rural attitudes towards health 1
Women as consumers of health care and communicating with predominantly male medical providers 1
Women and spirituality 1
Homelessness 1
Consumerism and its impact on women’s health choices 1
Medicalization of normal development 1
Poverty 1
Childbearing options 1
Fetal versus maternal rights 1
 Athletic injuries 1
Research in women’s health 1
Ethical and legal issues 1
Rheumatoid arthritis 1
Effects of war on women in US, developed countries and third world countries 1
Autoimmune disease 1
Endometriosis 1
Skin problems 1
Grief and loss related to childbirth and infertility 1
VITA

Karen Lea Basham Moody was born in Holland, Michigan, and graduated from South Jones High School in Ellisville, Mississippi. She completed her bachelor of science degree in nursing at the University of Southern Mississippi in Hattiesburg, Mississippi in 1972. She completed her master of nursing degree in maternal-infant nursing at the University Of Mississippi Medical Center in Jackson, Mississippi in 1976. She began her studies for the doctor of philosophy degree in 1992.

Her professional career includes staff nursing roles in labor and delivery and adult health nursing, and an administrative role as nursing education coordinator at a major hospital. She has been a nurse educator for twenty-five years, eighteen of those as an assistant professor in a baccalaureate nursing program in south Louisiana. Her current faculty responsibilities include theory and clinical instruction, primarily in the areas maternal-infant and women’s health nursing. She has served on many School of Nursing and university committees throughout the years.

Current professional memberships include the American Nurses’ Association, Louisiana State Nurses’ Association, Baton Rouge District Nurses’ Association and the Association of Women’s Health, Obstetric and Neonatal Nurses. She currently serves as the Louisiana Section Chair of the Association of Women’s Health, Obstetric and Neonatal Nurses. She is also currently serving on the Louisiana Folic Acid Council.

She received, and has maintained for a number of years, certification in Inpatient Obstetric Nursing from the National Certification Council. She frequently attends professional conferences and has presented workshop programs on a variety of subjects. She was recognized in 1996 by the Baton Rouge District Nurses’ Association for her contributions to the nursing profession.

She currently resides in Baton Rouge, Louisiana. She has one son who is attending Louisiana State University.
DOCTORAL EXAMINATION AND DISSERTATION REPORT

Candidate:  Karen Basham Moody

Major Field:  Vocational Education

Title of Dissertation:  Women's Health Issues in Baccalaureate Nursing Curricula

Approved:

Michael J. Burnett
Major Professor and Chairman

Dean of the Graduate School

EXAMINING COMMITTEE:

Date of Examination:

6 May 1999