Nutrition Counseling at Planned Parenthood Centers

HELEN SMICIKLAS-WRIGHT, PhD
ROSANN IPPOLITO, MS
JOHN E. COLLINS, CNM, MSN

THE COMMITTEE ON NUTRITION of the Preschool Child, sponsored by the Food and Nutrition Board of the National Academy of Sciences, recently recommended that services in family planning programs be expanded to include dietary assessment and nutrition counseling (*1*). This recommendation reflects the Committee's recognition that some clients of family planning services may be vulnerable to nutrition problems.

Some nutritional problems of patients in family planning programs may be related to their use of oral contraceptives. Several recent studies report metabolic changes occurring in association with the use of oral contraceptives (*2–4*). The effects of these changes can be expected to be most serious among women who are nutritionally vulnerable before the use of such drugs. Some problems may be associated with IUD use; it may result in some blood loss, and increases in nutrients such as iron may be necessary. The early identification of nutritional problems combined with the appropriate counseling should be an important preventive health measure for both the woman and any child she might subsequently bear. Gold (*5*) described the importance of preconceptional and interconceptional nutritional guidance and therapy in enhancing the quality of human reproduction. Family planning programs are ideal for providing preventive interconceptional health care. Many of these programs serve populations at nutritional risk because of age or income, and they may be the only source of medical care for many women.

In recognition of the importance of good nutrition in prevention and treatment of health problems, the Department of Health, Education, and Welfare compiled a guide for developing nutrition services in health care programs (*6*). Family planning programs are clearly identified among these programs.

Dr. Smiciklas-Wright is associate professor of nutrition, Pennsylvania State University. At the time of this study, Ms. Ippolito was a graduate student at the Pennsylvania State University. She is currently director of the dietetic education program at Central Arizona College in Coolidge, Ariz. Mr. Collins is assistant professor, maternal-newborn nursing, Yale University School of Nursing, New Haven, Conn.

Tearsheet requests to Dr. Helen Smiciklas-Wright, 204 Henderson, Pennsylvania State University, University Park, Pa. 16802.

This study addresses three questions that we believe should be considered before a family planning service implements a comprehensive program of dietary assessment and nutritional counseling. What is the present extent of the nutrition education component of a comprehensive nutrition service? Who provides this education? Do family planning counselors consider nutrition education an appropriate program component?

Study Methods

The Planned Parenthood Federation of America granted us permission to conduct the study at the 31 planned parenthood centers in Pennsylvania and New Jersey. Questionnaires were mailed to the family planning centers for distribution to family planning counselors. ("Counselors" were defined as all persons who provide direct counseling to women clients.) The counselors who answered the questionnaire became the sample group.

Development of the questionnaire. The questionnaire was developed to elicit the following information:

1. What nutrition information is already available to the clients? (The operational definition of "availability" included the type of nutrition information offered clients, how it was provided, and who provided it.)

2. How acceptable is the nutrition education currently offered? (The operational definition of "acceptability" centered on whether the counselors believed that nutrition information should be provided, how they thought it should be provided, and who they thought should provide it.)

3. How aware were the counselors of the reported connection between nutrition and oral contraceptives? (Whether a counselor had heard of this connection, what his or her source of information was, and whether he or she believed the connection to be significant determined the operational definition of "awareness.")

Analysis of data. Descriptive tests that included frequencies, percentages, and means were used to analyze the data. Chi-square analyses using one-way frequency responses were conducted on appropriate variables.

Results

Of the 31 family planning centers that had received questionnaires to distribute to their counselors, 22 (71 percent) returned usable data. Among the remaining nine centers, four did not respond, and five failed to distribute the questionnaire as we specified. The health educator at one of these five centers completed one questionnaire but did not distribute the others because (as she said) "Nutritional counseling is not one of our concerns." The supervisors of the other four centers who returned unusable data completed one summary questionnaire. A total of 94 questionnaires were returned from the 22 centers that participated in the study—37 questionnaires from 9 centers in New Jersey and 57 questionnaires from 13 centers in Pennsylvania.

The individual respondents—93 women and 1 man—included personnel with a wide range of occupational titles, including "clinic nurse," "coordinator," "family planning specialist," "health educator," "receptionist," and "medical assistant." Their counseling experience ranged from 6 months to 15 years.

Availability of nutrition information. Forty-seven counselors (50 percent of the sample) reported that nutrition information was already available at their centers. They listed handouts, audiovisual materials, and individual and group counseling or a combination of the two as the methods typically used to distribute this information.

The type of information available, however, varied substantially throughout the study sample. The information elicited was separated into three general categories: (*a*) general nutrition, (*b*) nutrition and oral contraceptives, and (*c*) nutrition during pregnancy. Information in all three categories was seldom available at any one center.

As shown in the following tabulation, "weight control" was a major topic in all three categories of information. Information on the food groups was available in 66 percent of the 30 centers providing general nutrition counseling; information on nutritional requirements was available in 85 percent of the 22 centers providing nutrition and pregnancy counseling. Only seven counselors indicated that their centers provided information on the nutritional requirements of women for whom oral contraceptives had been prescribed.

Topic	*Counselors reporting nutrition information*
General nutrition	30
Weight control	30
Four food groups	21
Food shopping information	7
Other	7
Food storage and preparation	6
Nutrition and oral contraceptives	27
Weight control	25
Nutritional requirements	7
Other	3
Nutrition and pregnancy	22
Nutritional requirements	17
Weight control	14
Infant and child feeding	5
Other	8

As to who provided nutritional information at the center, nearly three-fourths of the counselors (74 per-

cent) replied that they did, and a significant number ($P < .008$) of these counselors were nurses. If someone other than the counselor provided the information, it was generally the nurse or a physician at the center. A nutritionist supplied the information in only two centers.

Although some nutrition information was available at many centers, it was rarely provided routinely. Instead, counselors reported that nutrition information was usually provided in response to a client's question.

Acceptability of nutrition education. The attitude of the counselors toward the inclusion of a nutrition component in family planning can best be described as mixed: 51 counselors (55 percent) agreed that nutrition information should be provided; 19 (21 percent) strongly agreed; 9 (10 percent) disagreed; 3 (3 percent) strongly disagreed; and 10 (11 percent) had no opinion. Not surprisingly, an association emerged between the counselors who thought nutrition information should be provided and those working in centers already providing this information.

The counselors were also asked questions about the type of nutrition information that ought to be provided at a family planning center. Seventy-two percent of the counselors saw a need for general nutrition information, 76 percent a need for information in relation to oral contraceptives, but only 48 percent saw a need for nutrition and pregnancy. Weight control was identified as a major topic in all these categories; nutritional requirements of oral contraceptive users was also identified as a necessary topic.

Counselors were asked to select the personnel they thought should be responsible for imparting nutrition information. A nutritionist was the preferred choice only for providing information on general nutrition. A nurse was the choice for the areas of nutrition in relation to oral contraceptives and nutrition during pregnancy. There was no significant relationship between the education level or job title of the respondents and their personnel selections.

Counselor awareness of the nutrition and oral contraceptives issue. Ninety-two counselors responded to the question of whether they had heard of any connection between nutrition and oral contraceptives. Of those 92 counselors, 60 (65 percent) indicated that they were at least aware of possible interrelationships between specific nutrients and oral contraceptives. Of the 60 counselors, 32 (53 percent) considered the interrelationships significant; 20 (33 percent) indicated that they did not know; 6 (10 percent) said the interrelationship was not significant; and 2 respondents did not answer the question.

A significant association ($P < .02$) emerged between those counselors who received questions from the clients about the possible interrelationships between nutrition and oral contraceptives and those counselors who had heard about the issue. Thirty-six counselors (60 percent) whose clients asked questions on the topic indicated an awareness of a relationship between nutrient metabolism and oral contraceptives. Ten counselors, however, indicated that they had received such questions but that they were unaware of any relationship. The counselors were not asked what specific information they had about nutrient-oral contraceptive interrelationships; they were asked simply to indicate whether they were aware of a possible connection.

The counselors were asked to list their sources of information on nutrition and oral contraceptives; 66 percent cited professional journals, 51 percent cited nonprofessional magazines as their source, 46 percent cited drug company literature, and 37 percent cited personal communication with physicians.

Discussion

We sought to determine what nutrition information, if any, family planning centers provided and what counselors thought about a nutrition education component in their centers. Counselors from approximately one-half of the centers indicated that nutrition information was already available. The most frequently dispensed information centered around weight control. The numerous articles on dieting and weight control that appear in the popular press may be influencing both family planning clients and counselors. We did not attempt to address the accuracy of the information provided; therefore, any concern about nutritional misinformation in conjunction with famly planning centers must remain speculative. However, conflicting information on weight control abounds, and the knowledge required to formulate and prescribe diets adequately is specialized. The tendency toward unscientific and misinformed dieting is already a recognized national health problem.

The relationship between oral contraceptives and nutrient requirements was the most neglected area of information encountered in this survey. Many more counselors indicated that such information should be provided than indicated that it was currently available at their centers. This discrepancy between interest and availability may be explained by many counselors' uncertainty about the significance of the observed relationship between oral contraceptives and nutrient metabolism. Others may have had insufficient information to discuss specific relationships.

As we mentioned earlier, much current research is being done on oral contraceptives and their dietary implications. But the data are still inconclusive, and investigators have yet to reach a consensus on the specific effects. Thus, it is difficult for a counselor to translate the complexity of scientific knowledge into uncompli-

cated advice for clients. Also, the interpretation of data and the identification of nutritionally high-risk women may well extend beyond the capability of the average counselor.

Significantly more counselors agreed that nutrition information should be available at the centers than reported its actual availability. Nurses were the main providers of this service in existing programs, and nurses were also the providers of preference in areas other than general nutrition. The question of their competency was not evaluated in this study, but some other recent research does address this issue. Schwartz (*7*), for example, investigated the nutrition knowledge, attitudes, and practices of public health nurses in Canada. The nurses she studied demonstrated a favorable attitude toward nutrition; yet, on a knowledge test, they scored lowest in areas of nutrition and pregnancy, nutrient requirements, the nutritional value of various foods, and the function of nutrients. They also scored low on items related to food budgeting, meal management, dietary fat management, and meat substitutes.

Our results and the findings of Schwartz suggest the need for continuing education among the members of the health care teams serving family planning centers and for inservice courses on family nutrition. They also suggest the desirability of placing nutritionists in family planning centers. Integrating nutritionists into the teams should affect the comprehensive nutritional counseling the respondents in our study appear to want. Gray described a program model in Solano County, Calif. (*8*), in which the nutritionist is clearly integrated into the health team and is engaged in nutrition education for both clients and personnel. Brendel and co-workers (*9*) also described a model for developing nutritional care as part of family planning programs. The Regional Training Center for Family Planning in Atlanta, Ga., recently published a training manual for a workshop on "Nutrition and Family Planning" (*10*).

Bettelheim (*11*) pointed out that the need for and the importance of delivering knowledgeable nutrition care is obvious to nutritionists, but not to other professionals. Not all of the counselors contacted in this study supported the concept of nutrition services in the family planning context. Some indicated complete disagreement with this concept, and a sizable group had no opinions about incorporating a nutrition education component into family planning. Some consideration of the factors that cause people to oppose nutrition counseling is essential to any successful adoption of this additional service. It is possible that these factors include time limitations, shortages of personnel, heavy client loads, insufficient funding, and the usual interprofessional wariness.

Many nutrition programs have been imposed upon health care professionals who are neither physically nor psychologically prepared to accept and support them. Therefore, we believe that there is a need for (*a*) a staff orientation program that carefully explains how and why professional nutrition care is an asset to family planning programs and (*b*) inservice training programs and conferences for those charged with providing the nutrition services.

Since proper nutrition care is so crucial to women seeking family planning service, it should be incorporated into the broader scope of family planning legislation. The provision of adequate nutrition counseling will, of course, require additional resources. And these programs should not entail additional duties imposed upon personnel already under time constraints and budgetary stress. Nor should these programs be left to well-meaning but unqualified personnel. Rather, the guidelines and legislation implementing such programs must support both adequate funding and the services of nutrition professionals to be effective in prescribing more healthful dietary practices among the clients of family planning centers.

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