Special Feature

NURSES IN FAMILY PLANNING[1,2]

"A nurse with a good sense of values is able to cope with the fact that the inconceivable of one age becomes the commonplace of the next." (1)

Introduction

In the very brief time during which family planning programs have become active, nurses all over the world have been called upon to adapt their basic knowledge in order to take an active part in the educational and service aspects of these programs. In many areas this has been a natural outgrowth of their work with women in the child-bearing years. In others it has required a new awareness of how family planning relates to comprehensive health care for individuals and families.

Perhaps no other health profession has quite the same opportunity for disseminating knowledge on family planning. The nurse is everywhere—in hospitals, clinics, schools, industry, health centers, physicians' offices, homes—and is also a citizen in her own community. She knows the problems of affluence and the frustrations of poverty. By tradition she has been one to whom people turn in time of stress. Quality in nursing skills given with warmth and compassion have been the goals of her profession.

In this era of emphasis on preventive medicine, new elements have been added to her responsibilities. She has become an educator, a case-finder, a counselor, a supporter, and an implementer of programs designed to strengthen the health of the people. She seeks out those in need, informs them of services available, provides basic knowledge, refers them for care, interprets and explains physicians' orders, and assists physicians in carrying out their treatments. No nurse, whether she is working in the hospital, the health center, or the community, can fail to observe the relationship of physical health to emotional and social welfare. There is no nurse who has not at some time cared for a woman who either did not want her pregnancy or for whom it was a medical or social tragedy. The products of these pregnancies, the unwanted children, frequently have more than their share of problems as well.

Case-finding

Much has been written about the components of good maternal health services—premarital medical examination and counseling, pre-conception evaluation, prenatal care, delivery, postpartum care, family planning, and interconceptional care. Many physicians and modern health services realize these components are interrelated, and if they cannot provide all of these services themselves will refer patients to facilities where they can be obtained. As obvious and important as this interrelationship may be to those responsible

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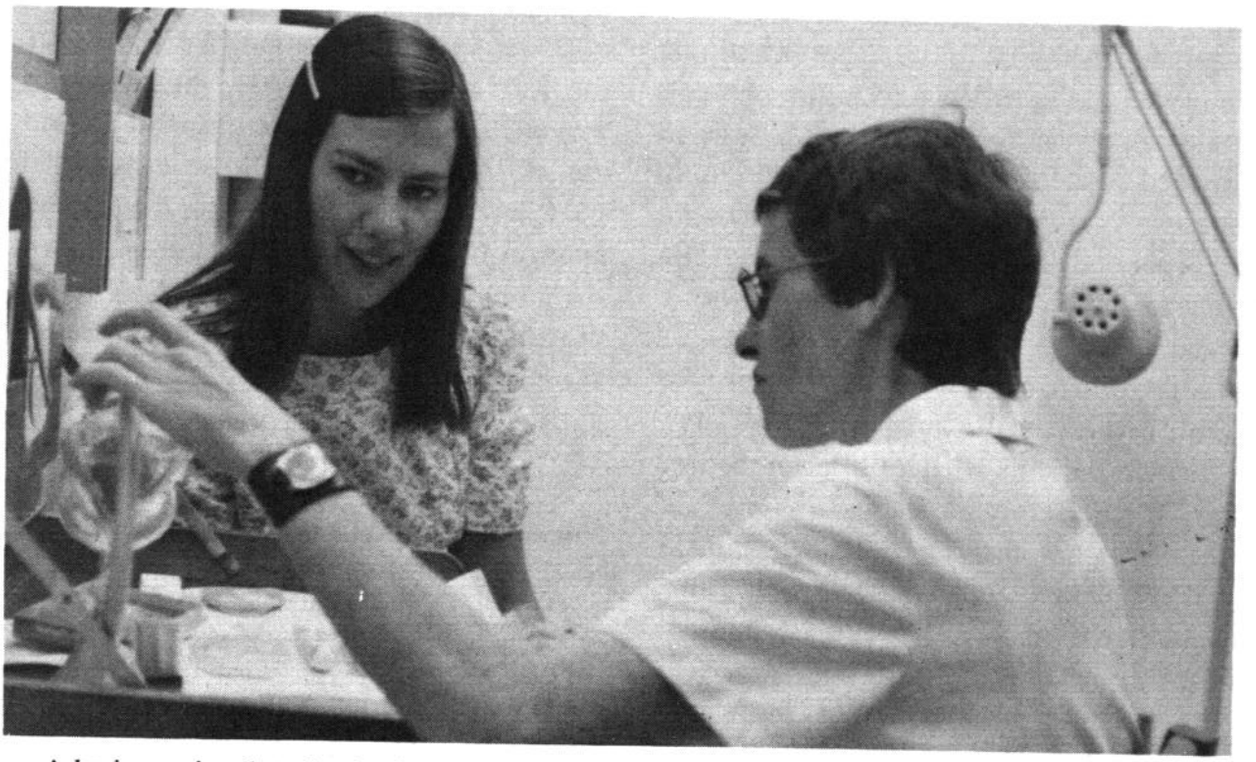
[2] Revised and updated version of an article previously published under the same title in *Manual of Family Planning and Contraceptive Practice*, M. Calderone (ed.), Baltimore, Williams and Wilkins, 1970.



A basic nursing duty in the family planning field is to provide the patient with information about physical and emotional aspects of reproduction in terms she can easily understand.

for maternity care, the reasons why it is important and the fact that facilities are available must be made evident to women who are potential recipients of family planning services. In the maternal and child health program, the nurse has many opportunities to find the right time for initiating discussions to determine the patient's readiness and knowledge, and to correlate her own teaching with that of the physician or other health workers who are in contact with the patient.

One study (*2*) found that physicians and nurses were reluctant to raise the subject of family planning for fear of offending the patient. Another study (*3*), done at about the same time at another location, asked mothers about who they felt should bring up the subject. Overwhelmingly (92 per cent of 181 women), their answer was that physicians and nurses should bring up the matter because most women are shy or embarrassed and many do not even know enough to ask. Fortunately, in many places the gap is now narrowing and there is less reticence on the part of the professional worker and the patient to approach the subject.

Many nurses ask for guidelines on how to approach the matter. This uncertainty prompted one nursing consultant in a large health department to set up a series of in-service classes on family planning interviews. She found that nurses needed an appropriate vocabulary, communication adapted to the patient's level of understanding, and practical information useful to the individual. There are many approaches that are natural and that can be adapted to the situation at hand. For example, during the prenatal period the subject can be included in a general conversation about many kinds of planning—planning for medical care, planning for the new baby, and planning the ultimate number and spacing of children.

Experience has shown that the period following delivery, before the mother leaves the hospital, has been one of the most productive periods for finding patients who are interested in family planning. If the hospital stay is short, this must be done within one or two days. Opportunities present themselves to the nurse when she is caring for the mother or admiring the baby, or when the husband comes to visit his wife and child. In addition to bringing up the subject, the nurse can discuss and show the various methods available, point out the health benefits of leaving a suitable period of time

between pregnancies, and insure that the couple has the means and knowledge to follow through on whatever advice the hospital or physician has provided concerning postpartum and family planning care. In many hospitals this advice is also incorporated into a group-teaching session on maternal and baby care before the mother is discharged.

Some physicians, feeling that it is not wise to wait six weeks for the postpartum visit, may either provide patients with an interim method or insert an IUD before discharge. Whatever the case, the nurse has the responsibility to make sure that the patient understands the measures taken and has some place to turn should she experience any difficulty.

In some countries a majority of the women still deliver their babies at home, and a wide variety of people act as birth attendants—nurses, auxiliaries, professional midwives, traditional midwives, and family members. Most of the mothers nurse their infants, and thus many of them consider themselves protected against pregnancy. Nevertheless, studies and experience have shown that ovulation returns to 65 per cent of nursing mothers within 24 weeks postpartum, and to 5 per cent within as few as six weeks (*4*).

The pediatrician's office and the child health clinic are other places where family planning information can be offered. Some physicians leave such counseling in the hands of the nurse. In this context, direct referrals to family planning facilities have been most effective. Frequently, the period when a mother is making her maximum effort to cope with a new child is a time when she is highly motivated to wait for her next baby.

Important as the traditional maternal and child health services are for case-finding, more programs need to be designed to include family planning information and to make family planning resources available to patients in other medical and social settings. For example, when either parent has cancer, heart disease, mental illness, tuberculosis, venereal disease, or any other disabling medical condition, the prevention or postponement of pregnancy can be as important to the patient's progress as any medical treatment. Other interested parents may be found at pediatric or mental retardation clinics, or at facilities for the treatment of behavior problems. Moreover, the nursing program in the community is family-centered, and the nurse can find many opportunities to provide information about family planning as she evaluates the total needs of the families she visits.

Nursing Care and Counseling during the Visit to the Family Planning Clinic

A critical point of contact for someone attending a family planning clinic is the first person she meets on her first visit. This is a time when attitudes and behavior set the stage for acceptance, comprehension, and the feeling that someone cares about her as an individual. It may not be feasible in busy, overloaded health centers for the nurse to greet the patients before they are registered, but she can at least make sure that this first contact is a warm and meaningful one.

Persons making their initial visit for family planning services are embarking on an educational experience. Some will come well-prepared, needing little more than encouragement and reasurrance from the nurse; however, this background preparation must be explored and never taken for granted. Others will come with little knowledge and considerable discomfort or apprehension.

During the first interview the nurse evaluates the client's knowledge, attempts to determine her cultural, ethnic, and religious values, and to judge her degree of motivation. At this time she may need to give basic information about the physical and emotional aspects of reproductive physiology in terms that are appropriate and easily understood by the client. Often, too, the nurse can provide the words clients need to know in order to pose questions, as well as reassurance that it is all right to ask. This is the time to present information enabling the client to make a choice of contraceptives, to clear up

points of misunderstanding, and to explain clinic procedures (*5*).

The second step is often a group session with new clients. This is usually conducted by a nurse, or in some cases by a health educator or social worker. Sometimes lay workers can perform this function, provided they are adequately prepared and supervised. Group sessions are valuable for communicating knowledge to a large number of people in a short time, and also for introducing clients to others interested in planning their families. Occasionally the shy or reticent woman finds her questions asked by others and receives an answer without revealing her own lack of knowledge.

Discussion of the need for pelvic examination and preparation of the client are also the responsibility of the nurse. Although most clients have already experienced this type of examination in connection with childbirth, there may be some who are extremely apprehensive and who do not understand why it is necessary. Explanations about the pelvic examination should include information about the Papanicolaou smear, since unless the clients understand the reasons for the procedure they often conclude that their chosen method of contraception may produce cancer or other diseases. In addition, during the examination the nurse or auxiliary has two responsibilities: first, to see that the client is ready, properly draped, and as comfortable as possible; and second, to work with the physician to insure that an adequate examination can be made. This, of course, includes reassuring the patient and assuring the presence of proper instruments and equipment as well as adequate lighting. The nurse or auxiliary should also listen to conversation between the physician and the patient, so that she can interpret and reinforce the physician's instructions.

After the educational proceedings, laboratory work, medical counseling, and physical examination are finished, and after the patient has selected a contraceptive method, most clinics provide for a final interview with the nurse. During this interview the nurse reviews all the things that have happened since the client came to the clinic, asks her to repeat the instructions she has received, clarifies and amplifies where further explanation is needed, and makes provision for follow-up action. If a method other than the IUD is chosen, the necessary materials are usually supplied at this time.

Whenever possible, a post-clinic conference attended by the physician and the nurses in the clinic is advisable and extremely useful. It permits the participants to review the patients they have seen that day, to discuss those who may need immediate follow-up or referral on a more intensive basis, and to evaluate the efficiency of clinic procedures and improve use of personnel time; moreover, and this is probably the most valuable gain of all, the exchange of information between physician and nurses provides a learning experience for all concerned.

The Nurse's Follow-up Responsibilities

Follow-up intervals may be governed by such factors as the number of professional and other personnel available, the existing hospital and health center resources, the type of contraceptives selected, the distance the patient must travel for a visit, and other variables. In small clinics, with a limited number of personnel, the nurse or nursing auxiliary may have to be responsible for setting up a return visit file and for keeping other records. However, in some clinics this is done by other lay or volunteer personnel.

Some programs provide for a routine follow-up clinic visit after the first visit. However, other programs consider a home visit to be of crucial importance, and carry out such a visit whenever circumstances permit. These visits may be made by nurses working in either family planning or public health, or by trained and supervised auxiliary or lay personnel. The purpose of any type of immediate follow-up is to help the patient before she encounters serious difficulties, and to either encourage her

current method or else let her know that other methods are available.

Some family planning programs provide a "hot-line"–a direct telephone service or other means of rapid communication that can provide information, emergency referral, and reassurance. The value of such a service is that some new users of contraceptives may experience usual or unusual side-effects that can assume gigantic proportions (either real or imaginary) unless the patients' anxieties are relieved or their symptoms investigated. The "hot-line" may be manned by a lay worker provided with pertinent data about each patient; however, it is important that this service have professional assistance available. Some programs have estimated that 60 per cent of the calls can be handled by a well-informed lay worker and 30 per cent by the nursing staff, leaving only 10 per cent that need referral to a physician.

Follow-up home visits are also made to clients who fail to keep their clinic appointments. For a woman who has been motivated enough to come in for a first visit, there is usually some reason for her failure to keep the second or third appointment. Reasons far removed from the medical aspects of family planning may be responsible–for example, transportation, family responsibilities, inconvenient clinic hours, objection of husbands or other family members, or doubts instilled by peers. Another reason–this one related to medical aspects of family planning–may be fear associated with complications such as bleeding, nausea, vomiting, weight gain, or chloasma. The benefits of finding out why a patient has not returned are three-fold: first, serious medical complications may be avoided; second, the health center may need to change some of its procedures or methods; and third, the client is made to feel that someone is genuinely interested in her welfare. Helpful attitudes are of primary importance in a follow-up visit; in particular, the client should not be made to feel guilty, delinquent, or uncooperative. Also, whatever resources are used for follow-up, it is important that communication be maintained with the original source of family planning care–and this is often a nursing responsibility.

Sensitive Areas and Controversial Issues

Along with the rapid increase in world population has come an explosion of new knowledge, new ideas, and new concepts. Subjects that were once taboo are becoming acceptable for open discussion. Traditional procedures are demanding reassessment to meet the demands of today's realities. Nurses encounter this challenge in all aspects of their service, but perhaps especially in the area of family planning.

In many countries, religious concerns dominated the family planning picture during the last decade. However, one nursing sister noted in an article in a nursing journal that "Definition of the nurses' role can be the same for all nurses regardless of their religion. All religions favor responsible parenthood, solidarity of the home and family, and the health and welfare of family members." (*6*) Another nurse writing on the religious aspects of family planning stated: "It is not the nurse's role to make the decision to use or not use a contraceptive, nor is it her decision regarding which method is chosen. That decision belongs to the patient." (*1*) A nurse, however, has the responsibility of sharing public knowledge in the matter of fertility regulation. She may open up the topic in general terms when circumstances make it apparent that some method of family planning may be needed, and at the direction of the physician she may assist in the fitting of contraceptive devices and in giving instructions under his direction. She may also inquire how the client is getting along with a particular method (*7*). By putting the client's needs first, all nurses can, in good conscience, provide the type of service that is most likely to meet these needs.

The problems of illegitimacy and adolescent pregnancy have been increasing in many countries within the last few years. The social significance of a pregnancy to an unmarried woman will vary according to the cultural and religious patterns of her community. However, the medical aspects of pregnancy in the adolescent are most apparent in terms of risk to mother and infant. The end product of a

pregnancy conceived by a young unmarried girl may be an unwanted child who enters life dependent on people ill-equipped to provide the basic necessities for growth and development.

Some nurses find it difficult to give impartial care to the unwed mother—and yet that mother may be most in need of kindness and understanding, explicit instructions for the care of herself and the baby, and acceptance as a person. Some nurses find it even more difficult to guide and counsel the unwed mother in contraception or family planning. Nevertheless, in an effort to turn the tide of illegitimate pregnancy, efforts are now being made in some areas to provide contraceptives to the sexually active, nulliparous adolescent. Such programs are meeting resistance from some nurses, who wonder whether such a policy may not actually promote promiscuity or a complete breakdown in sexual prohibitions. However, if the nurse can reexamine her role in the light of her professional objectives, she can see that the decision to provide this service is not hers. Her decision is grounded on the needs of each individual, and on this basis she should be able to work effectively.

In a number of countries, hospital beds are filled with patients who have had complications following crude abortion attempts carried out either by themselves or by illegal abortionists. Maternity mortality rates are high in many of these countries, and the chief cause is death from hemorrhage or infection following provoked abortion. There is increasing concern about the magnitude of this illegal practice that violates medical and legal ethics. In some countries this has led to greater acceptance of family planning, and in some cases to adoption of a government family planning policy designed to combat the high induced abortion rate with its drastic consequences for the women involved.

A number of procedures formerly considered within the sole competence of the physician are now being reassessed in terms of the nurse's abilities and responsibilities. Pelvic examinations, Papanicolaou smears, IUD insertions, and administration of oral contraceptives fall within this category. In some countries midwives and nurse-midwives have been carrying out these procedures for a number of years. More recently, a few programs have been developed to prepare nurse practitioners to function in this extended role. In view of the extensive need for services, not only in urban but in rural areas, it is imperative that full consideration be given to the variety of manpower resources available. Each country will need to examine its ratio of physicians to nurses, its supply of auxiliary personnel, the educational background of its personnel, the supervisory personnel available, and its patterns of health manpower distribution in order to provide the personnel needed to deliver an adequate and safe type of family planning service.

In many family planning programs a new category of personnel has been introduced. This consists of lay workers who have been brought in for training and to perform supervised tasks. In many areas the responsibility for this training and supervision has been assigned to the nursing service. Depending on the quality of selection and training, of the administrative structure, and of the supervision received, some of these lay worker programs have been extremely successful. The workers are used in case-finding, clinic, and follow-up activities. Among other things, the "satisfied user" of contraceptives has been particularly successful as a lay worker. This is partly because her personal experience permits easy discussion of family planning matters with her neighbors and peers.

Some health professionals are now challenging this lay worker role because they see it as interfering with their on-going relationship with families in the community. On the other hand, some nurses see the lay worker as a valuable means of extending nursing care to a group of people that might otherwise be inaccessible.

All of these issues concern the nursing profession. Some guidelines will arise out of experience and the findings of research. Other matters will remain controversial because of their complexity.

The Nursing Component of Multidisciplinary Action

Program planning committees for family planning should involve a number of representatives from professional and lay groups in the community. Because of the heavy involvement of nursing in the educational and service aspects of the program, it is imperative that nursing representation be included from the beginning. Hospital nurses contribute their knowledge of in-patient and out-patient services, the numbers and backgrounds of nursing personnel needed to staff clinics, and opportunities available to integrate family planning counseling into other hospital services. Public health nurses contribute their awareness of local resources or existing problems within the community, their experience with interagency referral systems, and frequently their contacts with key people in health and social welfare programs as well as in cultural, ethnic, and religious groups in the community. In sum, as objectives are defined, policy determined, target populations identified, staffing needs discussed, and educational and service projects created, nurses can contribute to all aspects of program development.

Equally important to planning is program evaluation. Frequently it is the nurse who is familiar with community reactions and can tell why programs do or do not go well. Often she recognizes some lack of communication and can suggest new approaches. Perhaps the problems are timing and location of clinic services, lack of transportation, or unfavorable rumors spreading throughout the community. Although nursing representatives on planning and evaluation committees should come from the administrative levels of local nursing services, some means should also be established to enable the clinic nurse or public health nurse to communicate the practical, everyday problems she encounters in delivering the service in her district.

Though the problems in a health center where many disciplines are employed may be great, the problems of delineating functions in the community are of equal magnitude. In programs that reach out to the target groups, there is often confusion about the roles of the nurse, the social worker, and the health educator. Obviously some of their responsibilities overlap, but each one has a contribution which is unique to her profession. Each also has something unique to give to the others. Leaders in each profession need to discuss their contributions together, to identify areas of concern, and to identify which activities can be shared. The key word in any inter-disciplinary action is communication. If one can learn to listen, tell what one is doing, express opinions, and discuss differences, the service ultimately provided will tend to be far more effective. This is true not only in family planning programs, but in any type of cooperative endeavor.

Development of a Professional Nursing Attitude

Underlying all the activities and functions of a nurse in family planning are her attitudes toward the role of women in society, her awareness and acceptance of her own sexuality, and her understanding of the social, cultural, and religious mores of her own environment and the environment in which she works. Her earliest concepts, in all probability, came from her own mother and the family in which she was born and grew up. Later her peer groups, school companions, and teachers influenced her awareness. Today students may be married before they enter nursing school, and so they may bring the experience of marriage to their early basic education in nursing. Nevertheless, in a free society where social experiences have been accelerated, many nursing students experience shock about some aspects of patient care. This has sometimes occurred in the area of obstetrical and gynecological services. Wise teachers try to anticipate such confrontations with the realities of life.

Ideally, the nurse who works in a family planning program or who recruits clients for it, is visualized as a warm, sensitive person who can approach all areas of discussion of the reproductive process with ease, lack of embarrassment, empathy, and understanding of the client's needs and right to information. Realistically, each nurse brings the flavor of her

personality, her beliefs, her experience, and her skills to the task at hand. She can also bring negative attitudes which, however, can be modified by new knowledge, purposeful discussion, willingness to learn, and life experiences. Even if deep-seated basic attitudes are not changed, the nurse can be helped to recognize her biases, to evaluate her opinions, and to adapt her behavior in a professionally appropriate manner so that her capacity to serve will not be inhibited. Through in-service education, case-conferences, and expert guidance from her supervisor, the nurse can find opportunities for personal growth. The profession of nursing draws from many sources–medicine, psychology, social sciences, and others; and at the same time nursing research is developing information, insight, and materials of value. All of these streams of information have common elements which must be adapted by nurses to their own particular professional approach.

Guided by her desire to provide the best possible care to clients for whom she is responsible, and equally by the public's right to have confidence in those who provide health care, the nurse–through her skills, knowledge, and understanding–can make an effective contribution to family planning programs no matter where they are located. These are the opportunities as well as the responsibilities encountered by the nurse of today. For the nurse of tomorrow, the future holds out the promise that more effective and acceptable methods of contraception, new understanding of family interaction, fuller awareness of the relationship of health to socioeconomic development, and many other factors will permit the effectiveness of her contribution to increase.

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