

# Women's Health *REPORT*

A QUARTERLY PUBLICATION OF WOMEN'S HEALTH DIETETIC PRACTICE GROUP

## IODINE & REPRODUCTIVE NUTRITION

By **Jamillah Hoy-Rosas, MPH, RD, CDN, CDE** *Women's Health Chair*

### Overview

Iodine is a critically important nutrient in reproductive nutrition. Diets low in iodine result in iodine deficiency disorders (IDD) which are the most common cause of preventable, irreversible brain damage and mental retardation in the world today. Recent editorials in the New York Times have highlighted the importance of iodine supplementation programs for achieving optimal reproductive outcomes internationally (1). IDD is especially damaging during pregnancy, lactation and early childhood. In their most severe forms, IDD causes cretinism, stillbirth and miscarriage, and increased risk of infant death and disability (2). Even subtle or mild manifestations of IDD place iodine-deficient individuals and their communities at risk for hypothyroidism and its effects: impaired health status due to symptoms such as goiter, stunted physical and mental development, lack of academic achievement and loss of work and school productivity (2). Ensuring adequate maternal iodine nutrition during the critical time periods of pregnancy and lactation has incredible benefits for the mother-infant dyad, as well as the entire community.

### Function

Iodine is essential to human life. It is the primary component of the thyroid hormones, thyroxine (circulating hormone) (T4) and triiodothyronine (physiologically active hormone) (T3), making up 65 and 59 percent of their respective weights. To meet the body's need, the thyroid gland traps ingested iodine in circulation and incorporates it into the thyroid hormones (3). These hormones act on target tissues by binding to thyroid receptors in cells and regulating gene expression and physiologic processes such as growth, metabolism, and brain function. Thyroid hormones maintain the rate at which the body uses fats and carbohydrates, help control body temperature, influences heart rate and helps regulate the production of important proteins.

The action of the thyroid gland and the hormones it produces are controlled by the hypothalamus and pituitary in a feedback loop. The hypothalamus signals the pituitary gland to make a hormone known

as thyroid-stimulating hormone (TSH). In response to varying T4 and T3 levels in the blood, the pituitary gland releases differing amounts of TSH.

The thyroid gland, in response, regulates its production of hormones based on the amount of TSH it receives from the pituitary gland. TSH is responsible for stimulating iodine trapping and thyroid hormone production and release by the thyroid gland. In the presence of adequate iodine intake, circulating T4 levels are normal and TSH secretion is limited. If iodine intake is inadequate, circulating T4 levels decrease and TSH secretion rises. This results in increased iodine trapping and increased production and release of the thyroid hormones (3). See Diagram 1 for illustration of this process. Chronically elevated TSH levels may lead to a swelling of the thyroid gland in an attempt to increase capacity for producing thyroid hormones. This is a condition known as goiter and it is the most obvious clinical manifestation of iodine deficiency. Although goiter can be caused by a variety of factors, its presence indicates that the thyroid is working under a stressful burden. The World Health Organization uses the prevalence of goiters in a population as one way to assess the iodine status of the community (4).

### Recommend Intakes during Pregnancy & Lactation

The Recommended Dietary Allowance (RDA) for iodine was reevaluated by the Food and Nutrition Board (FNB) of the Institute of Medicine in 2001. Table 1 shows that the iodine requirements are increased from 150 mcg in adults to 220 mcg in pregnant and 290 mcg in breastfeeding women. Pregnancy and lactation are times of stress for the thyroid because of increased renal clearance of iodine and transfer of iodine to the fetus for development or to breast milk. If maternal intake of iodine is inadequate, the thyroid will not be able to meet these demands, leading to possible goiter and depleted nutrient stores for lactation and future pregnancies (5). Iodine deficiency during pregnancy has been associated with increased incidence of miscarriage, stillbirth, and birth defects. Severe prenatal iodine deficiency may also result in congenital hypothyroidism in newborns (3). Lactating women who are iodine-deficient may not be able to provide sufficient iodine from their breast milk to their infants who are particularly vulnerable to the cognitive effects of iodine deficiency. The American Thyroid Association (ATA) recommends that pregnant and lactating women consume a daily prenatal supplement with at least 150 mcg of iodine in order to meet the iodine RDA for these life stages (6).

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## from the chair **Jamillah Hoy-Rosas, MPH, RD, CDN, CDE**

This issue of the newsletter highlights an important topic in our field: the role of adequate maternal iodine in promoting optimal reproductive outcomes. Discussions about iodine have been a hot topic for many months on the WH DPG list serve and this article is a brief primer on the topic in response to those conversations. I had fun reviewing and writing about this topic and hope it serves as a reminder to members about our potential role in helping to eliminate iodine deficiency disorders and their terrible consequences in the world. There is still much work to be done and as RDs, we are on the front-lines.

My year as your DPG Chair is now sadly coming to a close. We have accomplished so much together during this time. I saw the arrival of a new child in my life while having the opportunity to help this DPG grow, offering new value to its members. Many of you may have seen me as I represented our DPG when ADA presided over the ringing of the NASDAQ stock market opening bell in March. That was great fun and you can see pictures and highlights at [http://www.nasdaq.com/reference/200903/market\\_open\\_031209.stm](http://www.nasdaq.com/reference/200903/market_open_031209.stm). It has been a wonderful year for me, both personally and professionally, and I look forward to continued service with the DPG. I will remain involved in the next membership year as your Past Chair. The DPG is going to be in wonderful hands with the incoming Chair Denise Andersen, MS, RD, LD.

I also want to say welcome to the new members of our leadership team: Chair-Elect Stephanie Bess, MS, RD, LDN, Secretary Diane Whelan, MPH, RD, Treasurer Judy Simon, MS, RD, CD, CHES, Reimbursement Chair Mable Everette, DrPH, FADA, RD and Nominating Committee members: Gail Carter Frank, DrPH, RD, CHES & Dawn Ballosingh, MPA, RD.

I also want to thank all of the outgoing volunteer leaders of this organization; you have been tremendous in your efforts. Special thanks to our current Past Chair, Cathy Fagen, MA, RD for her years of tireless service to the DPG. Cathy will now be helping the Membership Committee in their efforts to provide our members with a valuable DPG experience. In the new membership year, look forward to the continuation of our very successful series of teleconferences along with initiatives to provide other continuing education opportunities to our members. Thank you to Maria Pari-Kenner, MS, RD, CDN for her wonderful leadership of the Membership Committee this year.

I also want to give a special thanks to Nancy Turnier, MS, RD who, after two years as Treasurer, is transitioning to Assistant Publications Editor. We are grateful for her continued service. She is joining a wonderful group because the entire Communications and Publications team led by Miri Rotkowitz, MA, RD, Olivia Eisner, MPH, RD & Kathleen Pellechia, RD have been doing a fantastic job. Finally, thanks to Susan Dupraw MPH, RD for her outstanding guidance on behalf of ADA. I have been very blessed to work with such a talented group of people, who I now count as friends, as well as colleagues.

For those of you, (who have not already done so); don't forget to renew your membership! Leadership opportunities still exist in a variety of areas. If you are interested in helping to direct the future of this organization, please get involved. You may contact me at [whdpgchair@gmail.com](mailto:whdpgchair@gmail.com) to learn more. Have a great and productive summer!

**The Women's Health Report** (ISSN-3233) is a quarterly publication of the Women's Health Dietetic Practice Group (WH DPG) of the American Dietetic Association. The WH Report features articles, as well as information on programs, materials, positions, and products for use of its readers. News of members, book reviews, announcements of future meetings, requests for information, or other items of interest to women and reproductive nutrition dietetics practitioners should be sent to the Newsletter Editor by the next published deadline date.

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## We're on the web!

[www.womenshealthdpg.org](http://www.womenshealthdpg.org)



## from the editor **Olivia Eisner, MPH, RD, CLC**

To be honest, I was a little worried we wouldn't be able to pull this newsletter off. Just like with anything in life, this publication has its ebbs and flows. At times we have so many wonderful articles we have to perform serious surgical intervention to get them all out to you and at other times there is a serious drought of individuals who are able and/or willing to contribute. So, this spring I have to say a hearty thanks to our publications team who all pitched in on short notice to make this online issue possible. It remains our mission to provide our members with relevant articles on cutting-edge issues that influence your work and tickle your imagination. To this end, Jamillah Hoy-Rosas, MPH, RD, CDN, CDE is finishing off her term as the Women's Health DPG Chair with a bang, providing an insightful piece on iodine and pregnancy, that many of you may remember arose out of a hearty listserv discussion. Lisa R. Young, PhD, RD brings a somewhat shocking reminder of just how large life has gotten with a piece titled "Size Matters". As part of the steering committee in Michigan for the implementation of a grant from the U.S. Department of Health and Human Services, I bring you a look at the widely touted Business Case for Breastfeeding. And, rounding out our list of offerings we have a delectable cookbook review by Membership Chair Maria Pari-Keener, MS, RD, CDN, and a spotlight on Jamie Stang, PhD, MPH, RD, LN.

As someone who is currently (and hopefully temporarily) working outside of women's health, I rely on the Women's Health DPG and this newsletter to keep me informed on the topics that I'm passionate about. Whether it is reading the daily postings on the listserv or searching through past newsletters for that key tidbit of information to pass on to clients, friends and family alike – I have come to rely on the knowledge, expertise, encouragement and support provided by my fellow members and in particular the executive team of this DPG and close knit publications committee.

If you receive the newsletter but haven't yet signed onto the listserv, go to [http://health.groups.yahoo.com/group/WH\\_list/](http://health.groups.yahoo.com/group/WH_list/) or send an email to [WH\\_list-subscribe@yahoogroups.com](mailto:WH_list-subscribe@yahoogroups.com) to become a part of our vibrant online community of professionals. If you have been thinking about expanding your experience as a dietetic professional, we love to get our members involved and can certainly find ways, large or small, for you become a part of our team. It is my hope that as we embark on yet another year that we as the publications committee will continue to bring you cutting edge information in a way that is relevant, accessible and creative. If you have ideas or suggestions for how this newsletter can better meet your needs, please drop me a line at [whdpgpublications@gmail.com](mailto:whdpgpublications@gmail.com). Thank you and enjoy the long days of summer!

## Identification of Iodine Deficiency

Identification of deficiency is performed via testing of urine for iodine because up to 90% of the iodine consumed is lost in the urine (5). Table 2 shows the epidemiological classification system, developed by the WHO for various urinary iodine (UI) values. This type of test is not valid for individual-level assessment of iodine status because of fluctuations in iodine excretion, but it is useful for monitoring iodine deficiency at the community level. Results from this testing suggests that approximately 35 % of the world's population has insufficient iodine intake (as defined by a UI <100 mcg/L) and over 50% of the population in developing nations are iodine deficient (1). Iodine deficiency is not only present in the developing world, but also in industrialized countries such as Ireland and Italy (2). Results from tests conducted on a representative sample of the US population from 1988-1994, the National Health and Nutrition Examination Survey (NHANES III) showed a median UI excretion of 145 mcg/L, a decrease of more than half from the value of 321 mcg/L found in the 1971-1974 NHANES I. Reports from more recent NHANES studies in 2001-2002 and 2003-2004 indicate that median UI levels have stabilized at 168 mcg/L and 160 mcg/L, respectively (7,8). Despite the decreases, iodine levels are considered to be optimal for the majority of the general population of the US. However a vulnerable group, young, reproductive-aged women, were most likely to be deficient compared to other age and gender groups. In this 20-29 year-old group of women, over 40% exhibited mild iodine deficiency, 20% had moderate iodine deficiency and 5% had severe iodine deficiency. The majority of this sample was non-pregnant, however given that the majority of pregnancies are unplanned in the US and there are cognitive consequences to the child for even mild maternal iodine deficiency, this level of deficiency is troubling. It is important also to note that Non-Hispanic Black women in the US had significantly lower median UI levels (85 mcg/L: suggestive of mild iodine deficiency) than non-Hispanic whites (153 mcg/L) or Mexican-Americans (147 mcg/L) and may be at greater risk for iodine deficiency because of dietary or other factors not yet fully appreciated (7).

## Sources of Iodine

Because the body does not produce its own iodine, it must be consumed from food and/or supplements. The iodine content of foods depends mainly on the iodine content of the soil in which it is grown. In certain parts of the world, particularly areas of high rainfall and soil erosion, the land is impoverished in iodine (2). Iodized salt is used as part of a global campaign to deliver iodine to the world population and eliminate IDD. In some cases of severe community-wide iodine deficiency, water supplies are also supplemented with iodine or iodized oil is administered orally or via intramuscular injection (4). In North America, the main dietary sources of iodine are dairy products, bread, seafood, meat, and iodized salt. Table 3 lists the approximate iodine content of some iodine-rich foods (3). Despite the ubiquity of iodized salt and its low cost, recently it has fallen out of favor as more people choose sea salts, kosher salts or more expensive gourmet salts which are not supplemented with iodine. Several popular cooking websites of celebrity chefs encourage cooks to throw out their iodized salt for other varieties, stating that the iodine imparts an off-flavor and

smell to foods. Due to health concerns, many people also avoid using table salt. Because of these and other factors, it is estimated that only about 70% of consumers choose iodized salt for home use. Further, because the majority (70-80%) of the salt consumed in the US diet is from processed and/or restaurant foods which tends to not be iodized, only about 50 mcg of iodine is consumed daily from iodized salt (6). Because of this relatively small contribution of iodized salt to the iodine intake of pregnant women, ensuring adequate supplementation through prenatal multivitamins is essential. However, a recent review of the 223 prenatal multivitamins available in the US indicated that only 51% of them (n=114) contained any iodine. Of these, 89% claimed to contain 150 mcg of iodine or more in the daily dose, but there were wide variations in the amount of iodine they actually contained. Over 40% of these supplements used kelp as the source of iodine, which is of concern because there is a risk of excessive amounts of iodine being delivered via kelp (9). The ATA recommends that prenatal supplements contain 150 mcg of iodine by including 197 mcg of potassium iodine which is 76% iodine (6).

## Consequences of Deficiency

Damage done to the developing brain and other harmful effects are known collectively as iodine deficiency disorders. The most critical period is from the second trimester of pregnancy to the age of three. In areas of iodine deficiency, where thyroid hormone levels are low, brain development is typically impaired throughout the community. In its most extreme form, the result is cretinism, a disorder which presents with mental retardation, hearing impairment, speech loss, short stature and spasticity. Milder forms of iodine deficiency result in subtle degrees of brain damage and reduced cognitive capacity which can affect an entire population (10). In the United States, all newborns are routinely screened for TSH levels to detect hypothyroidism. Iodine treatment can reverse cretinism when the treatment is begun right after birth (5). A meta-analysis conducted in 1994 of 18 studies representing four continents demonstrated a loss of 12.5 intelligence quotient (IQ) points from iodine-deficient children compared to iodine-sufficient children (11). There is also some evidence that rising cases of ADHD may be associated with milder forms of iodine deficiency (12). The most severe reproductive consequences of iodine deficiency and hypothyroidism include fertility issues such as irregular or absent ovulation and pregnancy complications such as miscarriage, gestational hypertension, birth defects, and stillbirth (4). Major international efforts have produced dramatic improvements in the correction of iodine deficiency, mainly through the provision of iodized salt in iodine-deficient countries. Practitioners should ensure adequate maternal iodine nutrition during the critical time periods of pregnancy and lactation in order to prevent poor reproductive outcomes.

## Recommendations for Practitioners:

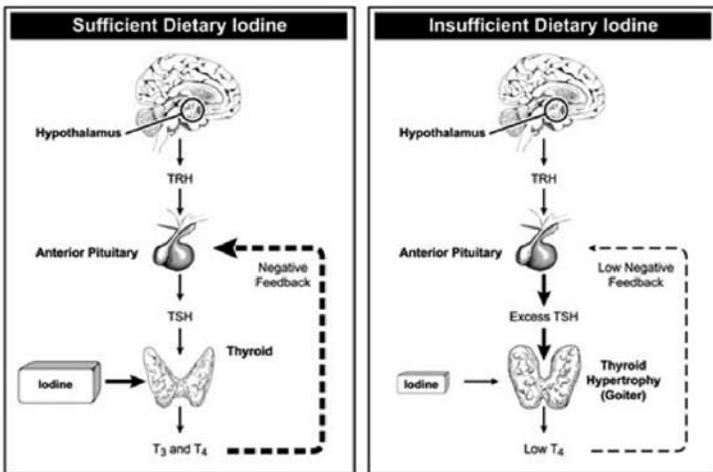
- Diet and supplement use should be carefully assessed for adequacy of iodine intake for women pre-conceptually, during pregnancy and lactation.
- Women should be encouraged to meet the RDA of 220 mcg of iodine during pregnancy and 290 mcg during lactation and stay below the tolerable upper limit for adults of 1,000 mcg.

**Recommendations for Practitioners:**

- Non-Hispanic Black women in the US may be at greater risk for iodine deficiency than Caucasian or Mexican women and should be carefully assessed during pregnancy and lactation.
- All women should be encouraged to use a prenatal MVI that contains 150 mcg of iodine during pregnancy and lactation. It is preferable that the source of iodine in the prenatal supplement be potassium iodide, not kelp because the iodine content of kelp varies widely. In some cases, high consumption of kelp could lead to excess consumption of iodine and hyperthyroidism.
- Clients should also be counseled to use iodized salt instead of other alternatives to ensure adequate daily intake of iodine.

**Diagrams & Tables**

Diagram 1



Source: Linus Pauling Institute Micronutrient Information Center  
<http://lpi.oregonstate.edu/infocenter/minerals/iodine/>

Table 1

Recommended Dietary Allowance (RDA) for Iodine			
Infants	0-6 months	110 (AI)	110 (AI)
Infants	7-12 months	130 (AI)	130 (AI)
Children	1-3 years	90	90
Children	4-8 years	90	90
Children	9-13 years	120	120
Adolescents	14-18 years	150	150
Adults	19 years and older	150	150
Pregnancy	all ages	-	220
Breast-feeding	all ages	-	290

Source: Food and Nutrition Board, Institute of Medicine. Iodine. Dietary reference intakes for vitamin A, vitamin K, boron, chromium, copper, iodine, iron, manganese, molybdenum, nickel, silicon, vanadium, and zinc. Washington, D.C.: National Academy Press; 2001:258-289.  
<http://www.nap.edu/openbook.php?isbn=0309072794>

Table 2

WHO Criteria for Assessing Community Iodine Nutrition Status Based on Median Urinary Iodine (UI) Concentration			
UI (µg/L) Concentration	Corresponding Iodine Intake (µg/day)	Classification	Clinical Implications
< 20	<30	Insufficient	Severe iodine deficiency
20-49	30-74	Insufficient	Moderate iodine deficiency
50-99	75-149	Insufficient	Mild iodine deficiency
100-199	150-299	Adequate	Optimal iodine nutrition
200-299	300-449	More than adequate	Risk of iodine-induced hyperthyroidism within 5-10 years following introduction of iodized salt in susceptible groups
>300	>449	Excessive	Risk of adverse health consequences (iodine induced hyperthyroidism, auto-immune thyroid diseases)

Source: WHO, UNICEF, ICCIDD. Assessment of iodine deficiency disorders and monitoring their elimination. Geneva, World Health Organization, 2001 (WHO/NHD/01.1).

Table 3

Approximate Iodine Content of Various Foods		
Food	Serving	Iodine (ug)
Salt (iodized)	1 gram	77
Cod	3 ounces	99
Shrimp	3 ounces	35
Fish sticks	2 fish sticks	35
Tuna, canned in oil	3 ounces (1/2 can)	17
Milk (cow's)	1 cup (8 fluid ounces)	56
Egg, boiled	1 large	12
Navy beans, cooked	1/2 cup	32
Potato with peel, baked	1 medium	60
Turkey breast, baked	3 ounces	34
Seaweed	1/4 ounce, dried	Variable; may be greater than 4,500 mcg (4.5 mg)

Source: Linus Pauling Institute Micronutrient Information Center  
<http://lpi.oregonstate.edu/infocenter/minerals/iodine/>

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# SIZE MATTERS

By Lisa R. Young, PhD, RD

Obesity is a major public health problem in the U.S. and its prevalence is increasing in adults and children. Overweight is associated with a variety of medical conditions including heart disease, hypertension, and type 2 diabetes. The portion sizes of commonly consumed foods eaten away from home have increased in size during the past 30 years. One reason for the increase in obesity rates may be that people are eating larger food portions and, therefore, more calories (1,2).

Mega size, king size, double gulp, triple burger...these are just a few descriptors you will see on a menu. A typical bagel today is equivalent to eating 5 slices of bread or 15 cups of popcorn. A steak in a steakhouse is so big that it is the equivalent in protein to eating 18 eggs.

Here are some startling examples of how portion sizes of commonly consumed foods have increased over the years.

With the focus on increasing obesity rates in both adults and children, we would hope that food companies would scale back on portions. However, according to my most recent research on portion sizes at large fast-food chains, portions are not getting any smaller (4). In many cases, they are getting bigger. Just last year, Burger King introduced BK Stacker sandwiches in four sizes: Single, Double, Triple, and Quad. The Quad size has four beef patties, weighs over 11 ounces and contains 1,000 calories.

The largest fast-food companies are also involved in sleight of name (4). For example, last year Wendy's discontinued the terms "Biggie" and "Great Biggie" to describe its French fries and soda. However, the former "Biggie" soda is now called "Medium," and the company introduced a new larger size called "Large." While McDonald's discontinued the "Supersize" soda in 2004, it is now marketing a new soda called "Hugo," the exact same volume and calorie content as the discontinued "Supersize." Unfortunately, we eat more when served large portions, and we don't even realize it.

Why should we care about large portions? With the exception of plain water, larger portions contain more calories than smaller portions. Here is a chart that illustrates this point.

**Portion Distortion: Portion Sizes Then and Now**

Food	Common Portion Size (in oz or fl oz, unless noted)	
	1960	2000
Bagel	2-3	4-6
Muffin	2-3	5-7
Coca-Cola bottle	6.5	20
Chocolate bar	1	1.5-5
Potato Chips, Bag	1	2-4
McDonald's hamburger	1.5	1.5-8
McDonald's soda	7	12-42
McDonald's French fries	2.4	2.4-7.1
Pasta entrée	1.5 cups	3 cups
Beer can	12	12-24

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**Reality Check--More Food = More Calories!**

Food	Manufacturer/ Eating establishment	Calories Regular size	Calories Large or Jumbo size
Soft drink Bottle	Coca-Cola	100 cal/8 oz	250 cal/20 oz
French fries	McDonald's	210 cal/Small (2.4 oz)	540 cal/Large (6.2 oz)
Hamburger Sandwich	Burger King	320 cal/ Hamburger (4.4 oz)	920 cal/ Double Whopper (12.6 oz)
M&M's	Mars Inc.	240 cal/Regular size (1.7oz)	770 cal/movie Megasize (5.3 oz)
Coffee Frappuccino	Starbucks	180 cal/Tall (12 oz)	300 cal/Venti (20 oz)
Ice Cream, Vanilla	Haagen Dazs	270 cal/1 scoop (1/2 cup)	810 cal/3 scoops (1 1/2 cups)
Frozen Yogart	TCBY	110 cal/Kiddie cup (3 oz)	350 cal/Large cup (11 oz)
Popcorn (popped in oil)	Movie theater	400 cal/Small, 7 cups	1160 cal/Large 20 cups
Cinnamon Bun	Cinnabon Inc.	300 cal/3-oz Minibun	670 cal/ 8-oz Cinnabon 250 cal/20 oz

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## Portion Shockers

- At Starbucks<sup>®</sup>, the Short cup of coffee, at 8 ounces, is no longer on the menu. The smallest size is Tall, a 12-ounce cup that is nearly twice as big as what used to be considered a regular cup of coffee.
- 7-Eleven<sup>®</sup> stores started selling 12- and 20-ounce sodas in the early 1970s. By 1988, they were selling the 64-ounce Double Gulp.
- The famous Hershey<sup>®</sup> chocolate bar weighed 0.6 ounce its first year on the market. Now, the standard bar weighs 1.6 ounces, almost three times its original weight. M&M/Mars increased the size of several of their most popular chocolate candy bars four times since 1970.
- In the course of just three years — between 1984 and 1987—the chocolate chip cookie recipe on the back of the Nestlé's<sup>®</sup> Toll House Semi-Sweet Chocolate Morsels package scaled down the number of cookies it makes from 100 to 60.

What can we do about large portions? Learn to smartsize! One of my favorite food facts is that you can lose 10 pounds a year by cutting back 100 calories a day. That's a few less bites of a dessert, a handful less of potato chips, or a couple of fork-twirls less of pasta. To trim calories, just trim your portions.

Here are some examples of small lifestyle changes that you can live with. Each eliminates approximately 100 calories (3).

- Use one teaspoon of olive oil instead of 1 tablespoon when sautéing your vegetables. Try putting your olive oil in a spray bottle. (One brand is Misto).

Continued on page 10

# BUSINESS CASE FOR BREASTFEEDING

By Olivia Eisner, MPH, RD, CLC

As one of 10 states selected to receive a \$10,000 grant to increase the number of businesses who provide lactation support to breastfeeding employees, the Michigan Breastfeeding Network along with a local coalition recently sponsored a Train the Trainer Program for the Business Case for Breastfeeding in Grand Rapids, Michigan.

This project, sponsored by the US Department of Health and Human Services (HHS) and the Health Resources and Services Administration's Maternal and Child Health Bureau (MCHB) sets out to increase breastfeeding exclusivity and duration rates among employed breastfeeding women through increased work-site lactation support. In addition to creating a business-friendly resource kit, HHS further developed a training curriculum "Implementing The Business Case for Breastfeeding in YOUR Community" as a train-the-trainer program for State and local breastfeeding coalitions, lactation consultants, breastfeeding educators, breastfeeding advocates, and community health care professionals. Despite the tremendous body of evidence supporting the importance of breastfeeding and the extensive efforts of lactation professionals and advocates, national statistics show large gaps between the nation's Healthy People 2010 goals and the reality. While the majority of states have met the goal for initiating breastfeeding, targets for continued breastfeeding at 6 and 12 months remain out of reach for most U.S. States. Even more elusive are the exclusivity goals with national statistics indicating that only 31.5% of infants are exclusively breastfed at 3 months and by the 6 month mark that number has dropped to an abysmal 11.9% (1). One of the major barriers according to the research continues to be a mother's return to work or school (2).

Healthy People 2010 Goals	Target
Breastfeeding Initiation	75.00%
Breastfeeding at 6 Months	50.00%
Breastfeeding at 12 Months	25.00%
Breastfeeding exclusively at 3 Months	60.00%
Breastfeeding exclusively at 6 Months	25.00%

Data from the US Department of Labor demonstrates that 60% of mothers with children under the age of 3 are in the workforce, a number which has steadily increased since the data was first collected in 1975 when mothers with young children only accounted for 34.3% of the labor force (3). Numerous studies demonstrate the impact of employment on breastfeeding duration and exclusivity. Not only does a woman's return to work impact the length of time a mother breastfeeds, but also, whether she continues to do so exclusively (4). According to a study conducted by Taveras in 2003, full-time employment decreases breastfeeding duration by an average of 8.6 weeks. Perhaps more telling is that most women wean within the first month of returning to work (5).

The training which takes place over 2 days sets out to accomplish a number of tasks, the most important of which is recommending that lactation professionals shed their "Breast is best" monologue and approach the issue of worksite lactation support from a truly business angle. Business owners and human resource profession-

als aren't interested in the warm and fuzzy mother-child bond or the potential for a child's increased IQ. At the end of the day, businesses want to know, and need to understand, that providing comprehensive lactation support is about a healthier and more productive workforce which in turn guarantees cost-savings and a more robust bottom line. The payoff is significant with research indicating a 3 to 1 return on investment for a comprehensive lactation support program.

The toolkit provides numerous resources both for businesses and for those conducting outreach in the local community. Based on comprehensive research conducted with a range of employers from Fortune 500 companies to mom-and-pop enterprises, the toolkit makes the case for lactation support based on sound business strategy while speaking directly to the perceived barriers employers share. For instance in a handout titled "The Business Case for Breastfeeding: Bottom Line Benefits" the following three points are stressed:

### Business Savings:

- ❑ Less one-day absenteeism: mothers of formula-fed infants report 3 x the number of one-day absences from work.
- ❑ Lower health care costs: "One study found that for every 1000 babies not breastfed, there were 2,033 extra physician visits, 212 extra hospitalization days and 609 extra prescriptions for three illnesses alone – ear, respirator and gastrointestinal illness (6)."
- ❑ Higher productivity and loyalty and lower turnover rates.

By focusing on how best to present the "business case" to companies, the trainers walked the attendees through a number of very helpful exercises including: 1) creating a 30 second "elevator speech," 2) role playing scenarios to help shatter the perceived barriers of employers, and 3) developing a strategic plan for rolling out this program in any community.

One of the most useful parts of the training was taking a look at various employer case studies from large businesses such as CIGNA and Home Depot to smaller and mid-size businesses such as a school in Texas or Patagonia, the California outdoor clothing company, who have successfully implemented lactation programs. Each of the showcased companies provided varying levels of support to lactating mothers. For example, when employees enroll in *CIGNA Moms* a host of services are offered at no charge including: access to a professional lactation consultant, access to Nursing Mother's Rooms, free breast pump and milk storage systems, and educational materials. This program alone provides an annual savings of \$240,000 in health care expenses, 77% reduction in lost work time due to infant illness with an annual savings of \$60,000, decreased pharmacy costs due to 62% fewer prescriptions, and increased breastfeeding rates - 72.5% at 6 months compared to the national average of 21.1% of employed mothers.

The extensive impact of lactation programs is not limited to healthcare companies or women dominated fields alone – the Pentagon, headquarters of the US Department of Defense, with its

Continued on page 7

predominantly male workforce proudly boasts a lactation support program that in addition to providing space to pump (the lactation room has over 600 visits a month), a hospital grade electric pump (each employee must purchase her own accessory kit), and educational materials, also benefits from the mother-to-mother support systems that often emerge from establishing a special and safe place for women to pump. One Pentagon employee comments: “The Pentagon is a very male-dominated environment, and having somewhere to go not only to pump, but also to talk about babies and motherhood with other employees, has been quite helpful (7).”

The 4 “**STEP**”s to ensuring the biggest cost-savings to companies include: **Support, Time, Education, and Place/Privacy**

Companies may provide one or two of these to employees, but the more comprehensive a program the larger the return. **Support** can take many different forms from a clearly written and communicated policy regarding lactation in the workplace to supportive management to mom-to-mom support systems (i.e. lunchtime support groups, electronic discussion board through a company website or a journal placed in the lactation room for mothers to share successes and stories with each other). The **Time** component can be addressed through flexible daytime breaks for pumping, part-time options for easing back into work after a maternity leave, or flexible work arrangements such as telecommuting or compressed work weeks. For employers who have trouble understanding how employee breaks can fit into their workplace, the toolkit reminds us that breaks can be planned to fit into any day, but absences cannot. The toolkit goes into great detail about how management might communicate how “these breaks” – which may feel like preferential treatment – actually benefit the wider team including most importantly fewer missed days of work. By stressing the temporary nature of the breaks and being creative about ways to provide coverage for employees who pump, lactation support can work in almost any setting.

The **Education** piece can entail anything from a library offering books and resources to providing breastfeeding/parenting classes to employees and their partners or even offering access to a lactation consultant at no charge to the employees. Finding a **Place** is often the most daunting for companies who may imagine the need for a whole conference room. Because women work in a huge variety of settings, letting employers know that a 4' x 5' room with space to accommodate a comfortable chair and a small table or shelf for equipment is all that is truly necessary. In more traditional office settings a small storage area or closet that can be converted would prove more than adequate. In less traditional settings such as in factories, farms or retail venues, companies have found a variety of creative spaces from dressing rooms to pop-up outdoor tents. Some companies whose employees travel frequently may provide information on lactation rooms/support programs in frequently traveled to sites (such as a nearby WIC program or hospital) or they may provide overnight mail services to send pumped milk home for moms who travel for days at a time. The creative solutions to employers-perceived barriers are limited only by our imaginations.

The Business Case for Breastfeeding resource kit provides the information, tools and step-by-step instructions for implementing a lactation support program in a work place. Most importantly it highlights and seeks to find solutions to the very real problems that women face in juggling motherhood and employment. Attendees at the workshop spend a great deal of time thinking through the huge variety of women's jobs and the ways lactation programs could be implemented in different workplaces from nurses to fast-food workers, from police-officers to traveling saleswomen, and from teachers to construction workers. Even in situations that appeared at the outset to offer no hope – the creative and enthusiastic group was able to come up with a variety of solutions to barriers that many might think insurmountable.

The tool-kit makes it easy for anyone to get involved in marketing this program to local businesses. By targeting employers with the message that lactation support programs and family-friendly business practices are in truth savvy business strategies, we can start to shift the pendulum toward a workplace which respects and values women and their families.

### What You Can Do In Your Community....

1. **Recognize employers that provide lactation support programs to their working mothers through a rewards program.**
2. **Send out a press-release highlighting the project.**
3. **Talk to your employers – hospitals and healthcare facilities should be already on board. If they are not, be a resource and lead the change.**
4. **Support mothers who plan to return to work – empower them to talk to their employers about their needs!**
5. **If you work one-on-one with women – minimize the stress of returning to work by having a well-thought out plan.**
6. **Work with your local coalitions to make rolling out this project a priority over the coming year.**

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## ADA MEMBER BENEFITS

By joining the nation's largest organization of food and nutrition professionals, ADA members gain access to a wide array of benefits, including professional publications, networking opportunities, and professional development resources, among many others. As a member of a dietetic practice group (DPG), you're well aware of at least one major benefit of ADA membership, but there are dozens of others—with new ones every year—that you might not know about. Of course, ADA wants you to take full advantage of all the opportunities that membership provides. Below is a listing of some of the newer resources ADA provides for its members, as well as those of particular interest to DPG members, accompanied by brief descriptions of their function. Please feel free to share this list with your colleagues.

For a more extensive list of benefits, visit the members-only section of ADA's Web site at [www.eatright.org](http://www.eatright.org) or call the Member Service Center at 800/877-1500, ext 5000, Monday through Friday, 8:00 am to 5:00 pm Central Standard Time.

**Member Interest Groups (MIGs):** Member Interest Groups are groups of ADA members who have a common interest. Unlike dietetic practice groups or affiliates, member interest groups focus on areas other than the practice of dietetics or geographic location. As divisions of the national organization, MIGs reflect the many characteristics of ADA's membership and the public it serves. In 2008, the National Organization of Blacks in Dietetics and Nutrition (NOBIDAN), the National Organization of Men in Nutrition (NOMIN), and Chinese Americans in Dietetics and Nutrition (CADN) joined Latinos and Hispanics in Dietetics and Nutrition (LAHIDAN), and in 2009, a new MIG will work to meet the needs of ADA members 50 years of age and older, as the number of MIGs continues to grow.

**Registered Dietitian Day:** Registered Dietitian Day was created by the American Dietetic Association to increase the awareness of registered dietitians as the indispensable providers of food and nutrition services and to recognize RDs for their commitment to helping people enjoy healthy lives. Registered Dietitian Day promotes ADA and RDs to the public and the media as the most valuable and credible source of timely, scientifically-based food and nutrition information. The next Registered Dietitian Day is March 11, 2009. Find out how you can participate at [http://www.eatright.org/cps/rde/xchg/ada/hs.xsl/NNM\\_2007\\_landing\\_14219\\_ENU\\_HTML.htm](http://www.eatright.org/cps/rde/xchg/ada/hs.xsl/NNM_2007_landing_14219_ENU_HTML.htm).

**National Nutrition Month Materials:** National Nutrition Month (NNM) is an annual nutrition education and information campaign created by ADA that's designed to focus attention on the importance of making informed food choices and developing sound eating and physical activity habits. ADA provides dietetics professionals with access to a wide variety of supporting materials to help convey this important message, including fact sheets, flyers, classroom guides and games, recipes, press releases, and event ideas. Visit the NNM homepage at [www.eatright.org/nnm](http://www.eatright.org/nnm).

**MNT Works Marketing Kit:** This powerful promotional tool provides food and nutrition professionals with the marketing materials necessary to influence medical nutrition therapy (MNT) coverage patterns and persuade insurers, physicians, and other health care professionals that MNT works. The kit includes information on MNT return on investment, frequently used codes for nutrition services, MNT coverage guidelines, experiences with MNT, and a backgrounder on the role of the RD. The kit can be found on

the Medical Nutrition Therapy page under the Advocacy & the Profession tab on [www.eatright.org](http://www.eatright.org).

**Consumer Education Campaigns:** ADA launches consumer education campaigns in conjunction with corporate sponsors that expand the message that RDs are the indispensable food and nutrition experts.

**Center for Professional Development:** In addition to many continuing education opportunities at the annual Food & Nutrition Conference & Expo, the Center for Professional Development offers conferences, workshops, meetings, lectures, live phone teleseminars and Webinars, Webcasts, CD-ROM and online courses, and audiotapes. Learn more at <http://www.eatright.org/cps/rde/xchg/ada/hs.xsl/education.html>.

**Leadership Institute:** ADA's Leadership Institute is an integrated, intensive, multiformat training program in the theory and practice of leadership in dietetics. The purpose of the program is to enhance the leadership competencies of ADA members both conceptually and interpersonally, through a combination of information, skill development, and practice-based educational experiences. For more information, visit [http://www.eatright.org/cps/rde/xchg/ada/hs.xsl/14606\\_ENU\\_HTML.htm](http://www.eatright.org/cps/rde/xchg/ada/hs.xsl/14606_ENU_HTML.htm).

**Policy Initiatives and Advocacy:** ADA works within the government to assure that the best interests of dietetics professionals are met. Government policy and legislation has a profound effect on the dietetics field, particularly in recent years. ADA makes a special effort to keep an eye on law changes, client liability, and other legal issues so members can focus on serving their clients. It also provides opportunities for member voices to be heard on a national level. For more information, visit <http://www.eatright.org/cps/rde/xchg/ada/hs.xsl/advocacy.html>.

**On the Pulse:** More government-focused than ADA's Daily News, On the Pulse is a weekly e-mail newsletter on ADA's legislative and regulatory priorities. It also addresses reimbursement, science, and practice-related matters. Sign up by going to ADA's member-only Web site at [www.eatright.org](http://www.eatright.org) and clicking on the "Journal/Publications" link and then selecting On the Pulse.

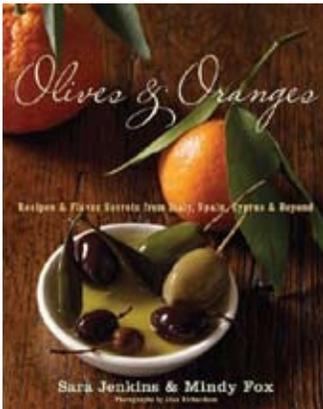
**Daily News:** A key resource for keeping abreast of the top news stories concerning dietetics and the profession, ADA's Daily News is delivered via e-mail every weekday morning and is a brief review of the nation's leading food, nutrition, and health headlines. The e-mail format allows members to click on Web links to the actual articles and the handy newsletter can be saved for later review. Sign up by going to ADA's member-only Web site and clicking on the "Journal/Publications" link.

**Nationwide Nutrition Network:** Free to members, ADA's Nationwide Nutrition Network (NNN) enables practitioners to market their services through this online referral network. NNN connects members to potential clients such as consumers, businesses, and other colleagues and allows members to list information about their practice and specialization. To obtain an enrollment form, e-mail [membrshp@eatright.org](mailto:membrshp@eatright.org) and include your name and member number. For more information, visit [http://www.eatright.org/cps/rde/xchg/ada/hs.xsl/home\\_17304\\_ENU\\_HTML.htm](http://www.eatright.org/cps/rde/xchg/ada/hs.xsl/home_17304_ENU_HTML.htm).

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## Olives and Oranges-Recipes and Flavor Secrets from Italy, Spain, Cyprus and Beyond

By Sara Jenkins and Mindy Fox



I was excited to get my hands on this cookbook of Mediterranean recipes simply because my family hails from Sicily and I enjoy this food immensely. I also thought it would be a great way to infuse new ideas into the stale repertoire of dinners I cook for my own family. Having read so much lately on the value of the Mediterranean diet, I was curious to see if the authors would use the heart-healthy ingredients in simple dishes or offer

complicated recipes that prove daunting to working moms like me.

*Olives and Oranges* opens with an inventory of the contents of author Sara Jenkins' pantry. She provides insight on the importance of these ingredients, explains where to find them and how to best judge their quality, and even recommends substitutions for the harder-to-find items. Jenkins recommends stocking two different grades of extra-virgin olive oil—a less expensive one for cooking and an estate-bottled oil for salads and finishing. She also prefers to buying olives in brine, then draining and storing them in good olive oil. I can vouch for this tip as I tried it—it really improves olives. She goes on to cover vinegars, salt, homemade chicken broth, grains and legumes, essential herbs and spices, cheeses, tomato products and nuts. Already inspired, I hadn't even gotten to a single recipe. I live in the New York City area and have access to some of the best products around, but I wonder if those living in less urban places might have a rather difficult time finding the bottarga (salted dried roe sac of tuna) or Za'atar (Lebanese spice mix of thyme, sesame seeds, sumac and salt) she suggests having on hand. Fortunately, Jenkins provides website addresses for some of these ingredients and a helpful chapter on resources.

Jenkins' flexible attitude and realistic approach to everyday cooking —“By modifying a recipe to fit what's freshest and most available to you, you will eat well at every meal” -- should immediately put cooks at ease. Aware of how pressed for time most of us are, every dish is classified as either a quick-cook or slow-cook recipe. The sheer abundance of recipes means that both vegetarians and meat-eaters have a great many selections to choose from.

The table of contents reads like a menu beginning with Small Plates, and finishing with Sweets and Cordials with every other imaginable course from salad to soup to pastas and meats in between.

The chapter on Small Plates offers mostly vegetable dishes such as **Pan-roasted Asparagus with Bacon** and **Roasted Cauliflower with Tahini Sauce** but you'll also find **Lamb and Bulgur Tartare** and **Maine Shrimp Pan-fried in Olive Oil**. In the chapter on salads, Jenkins transforms basic ingredients such as fresh Bibb lettuce and estate-bottled extra-virgin olive oil, and then demonstrates how to make the salad either a light opener or a meal in itself. After explaining the basic principals of a proper vinaigrette – mustard, vinegar and oil -- she sets forth some mouth-watering recipes over which to

pour your perfectly made dressings including **Warm Escarole Salad with Hot Anchovy Dressing** or **Orange and Mint Leaf Salad with Roasted Beets**.

I love soup, as does Jenkins who eats it for breakfast. When I took a look at the lentil soup recipe, I saw how similar it was to the one passed down from my mother, but could tell that the addition of dried red chili pepper and red wine would add a rich complexity. Other delicious sounding soups in the chapter include **Green Garlic Soup** and a unique **Turnip, Apple, and Jerusalem Artichoke Soup**. Be forewarned that the food photography is sumptuous – transporting the reader to another world. The Pasta, Risotto, and Polenta chapter was exhaustive, including classics like **Potato Gnocchi** and unusual combinations like **Spaghettini with Ground Lamb, Yogurt and Mint**. On a sunny but cold Sunday afternoon I cooked up a pot of **Classic Central Italian Meat Ragù**, which my family loved. It was fairly easy to do, beginning with a puree of carrots, celery, onion and garlic to which water, salt and tomato paste are added before the meat is simmered for 40 minutes. After more water and tomatoes are added, the sauce is cooked for 2 more hours. You don't have to do much beside the initial work, but check the sauce a few times each hour and give it a nice stir. I'd love to try other ragus such as the Southern Italian Pork Ragù or Tuscan Wild Boar Ragù since this one came out so well.

Elaborating upon her theme that dishes need not be complicated to be good, Jenkins recommends fish be “roasted, fried, or grilled and served with just a little olive oil, a squeeze of lemon juice, and a pinch of sea salt.” This delicious simplicity is on display in dishes such as **Seared Cod with Green Olive, Lemon, and Parsley Relish** and **Grilled Tuna with Tomatoes, Grilled Red Onion, and Arugula**.

The meat dishes are all about conjuring layered flavors from simple ingredients. I am looking forward to cooking her **Roast Chicken with Sage, Garlic and Lemon Peel** and the decadent sounding **Bacon-and-Herb-Rubbed Salt-Baked Chicken**, which involves pureeing a few ingredients into a rub. Knowing my husband's love of lamb chops I may try **Pan-Roasted Lamb chops with Capers, Olives, Onions, and Smashed Potatoes**.

Sara's final chapter on Sweets and Cordials wouldn't exactly entice my ten-year old, who thinks of dessert in terms of chocolate, but as an Italian-American I remember dessert was often a piece of fruit or some walnuts and that even holidays brought only simple pleasures like fried dough balls drizzled with honey. Sara draws on this heritage with recipes that even a dietitian might approve of such as **Strawberries with Prosecco** or **Pecorino and Pears with Chestnut Honey**.

This cookbook is a great introduction to eating in the traditional Mediterranean style. This cuisine's health-giving ingredients combined into magnificently delectable dishes offers something both for the heart (quite literally) and soul. So go ahead, grab a handful of fresh parsley, squeeze over some lemon juice, sprinkle a pinch of sea salt and cook up a little taste of the Mediterranean. Yum!

## MEMBER SPOTLIGHT *By Carolyn Brown*

*Jamie Stang, PhD, MPH, RD, LN, is Chair of the Public Health Nutrition Program and Director of the Leadership Education and Training Program in Maternal and Child Nutrition at the University of Minnesota, School of Public Health; Director of the National Maternal Nutrition Intensive Course.*



**Jamie Stang, PhD, MPH, RD, LN**

### **How did you get into dietetics?**

I started out as a medical technology major but fainted when I even brought a needle close to a person's body. After a few weeks of fainting it was clear I wasn't in the right major, so I started looking for other majors that would allow me to study physiology, chemistry and microbiology (the courses that initially attracted me to microbiology).

I had taken a course in cultural foods as an elective, so I contacted the instructor to find out if there were any majors that combined science and food. He told me about food science and dietetics. I completed a coordinated program in community dietetics and became a RD.

### **Where have you worked? What was your first job?**

My first job was as a clinical dietitian at a regional hospital in a very rural area. Within a year I had added outpatient, long-term care and group consulting to my clinical duties. My true passion was in prevention of disease, so I earned a Masters of Public Health in Nutrition. I worked in 2 county health departments and a student health center before going back to school to work on my PhD.

My interest in women's health and nutrition stems from my interest in prevention. The more I worked with women, especially women in their prime reproductive years, the more I realized that their habits affected not only their own health status, but also that of their offspring and families. I became committed to the ultimate prevention efforts - those affecting the fetal and neonatal programming aspects of health and nutrition through improving the health of mothers.

### **What do you consider a highlight of your career?**

That's a hard question to answer, since I've had so many interesting opportunities in my career. One of the best experiences I've had, both personally and professionally, was the 3 years I served on the Commission on Dietetic Registration. I was able to have input into decisions that directly affected RDs and DTRs and was able to help streamline some processes (such as the continuing education portfolio process and the weight management programs) based on RD and DTR input. Some of the decisions we had to make were really difficult, and not everyone agreed with all decisions, but we were all respectful of each other and came up with the best solutions possible. In my mind, it was the best group process I've even been involved with. I should also say that CDR has the absolute BEST professional staff I've ever worked with. I'd highly recommend it to anyone who is asked to participate in CDR activities.

### **What are your favorite tools and resources on women's health?**

There are so many great governmental resources available. I use the Maternal and Child Health Bureau Library and Knowledge Paths (<http://www.mchlibrary.info>) a lot because they connect you to many public and private resources on topics related to women's health and nutrition. I also find myself going to the CDC and USDA websites often to find current health and nutrition-related surveillance data, such as the pregnancy nutrition surveillance system and NHANES data, or information on common public health issues such as food assistance program participation rates. And the WH listserv is one of the very best resources around. I love the research updates sent out by Meg and Jamillah and the resources that other members share. It's the only listserv I subscribe to where I read each and every message posted!

### **What are your recommendations for the Women's Health DPG?**

I'd say continue doing what we do well, such as providing networking opportunities both on-line and in person, and putting out a very cutting edge newsletter. I'd also like to see our DPG get more visibility within ADA over time. The majority of members of our profession are women, which is our area of focus. I'm always surprised that we don't have more members just based on personal interest, even if they don't practice solely in the area of women's health.

## SIZE MATTERS *Continued from page 5*

- Spread 1 tablespoon of peanut butter instead of 2 tablespoons on bread.
- Switch from a 20-ounce soda to a 12-ounce can. Better yet, switch to water, unsweetened flavored seltzer or diet soda.
- Order a Tall cappuccino instead of a Grande next time you visit Starbucks.
- Buy small pre-packaged bags (1-ounce portion) of chips or pretzels instead of eating out of a big bag.
- Split your favorite dessert three ways.

These tips can help you smartsize your portions when dining out, food shopping and eating at home (3).

- Steer clear of restaurants with buffets and all-you-can-eat deals.
- Order "appetizer" portions or "half-size" portions. Or share an entrée.

- Eat half of what you order. Ask for a doggie bag and enjoy the rest on another day.
- When food shopping, avoid jumbo bags and boxes of food.
- Buy single-serving portions whenever possible. They may cost more, but your health and well-being is worth it.
- Read food labels. Check for the number of servings per container.
- Don't go to the supermarket when you're hungry.
- At home, don't eat directly from the refrigerator/freezer or while preparing food. Instead, sit down and enjoy your meal or snack.
- Avoid serving food "family style."
- Learn to cook. Measuring out ingredients gives you a feel for food size.

# MEMBERSHIP COMMITTEE UPDATE

By Maria Pari-Keener, MS, RD, CDN

Our committee has been very busy regularly presenting free teleconferences to our members for continuing education credits. The series has been a great success with members personally thanking me and the presenters for their wonderful presentations. I hope you were able to join us in October 2008 when April Rudat, MS Ed, RD, LDN spoke in great detail about breastfeeding, including her own experience nursing twins. In December, Ann Marie Barilla, RD, LDN spoke on the Nutrition Care Process with an emphasis on the pregnant client while in February Gita Patel, MS, RD, CDE, LD enlightened us on functional foods for women hormonal health.

Our May teleconference focused on fertility and nutrition, with guest speaker Judy Simon, MS, RD, CD, CHES. Our final teleconference in the series ends with a discussion of bariatric surgery and its effect on pregnancy by Jeanne Blankenship, MS, RD, CLE.

This summer we are happy to offer an additional free member continuing education opportunity with soy expert Mark Messina, PhD who will speak on the importance of soy for women's health. This talk will be available on our website for members to view at their convenience.

For more information, look for details on the list serve and on our website <http://womenshealthdpg.org> or email me at [whdpgmembership@gmail.com](mailto:whdpgmembership@gmail.com).

## Couldn't Tune In To Our Teleconferences?

Log onto  
[www.womenshealthdpg.org](http://www.womenshealthdpg.org)  
to download the slides  
and recordings now!

## SUMMER CALENDAR OF EVENTS

### July 22-26, 2009 International Lactation Consultants Association (ILCA)

**Annual Conference** Orlando, Florida

Call Elizabeth at 256-325-7246 or e-mail: [elizabethhps@yahoo.com](mailto:elizabethhps@yahoo.com)

### July 26-31, 2009 Focus on the Female Patient

Kiawah Island, South Carolina

Website: [http://www.sma.org/education/cmecalen dar/index.cfm](http://www.sma.org/education/cmecalen%20dar/index.cfm)

### August 5 – 8, 2009 10th Annual Conference on Women's Health

Yosemite, California

Website: <http://www.symposiamedicus.org/calendar.asp>

### August 22, 2009 Speaking of Women's Health

Salt Lake City, Utah

Website: <http://www.kued.org/productions/womenshealth/>

### August 26, 2009 The Biannual Breastfeeding Conference for

**Healthcare Providers.** Qwest Center in Omaha, Nebraska

Website: [http://www.olsoncenter.com/home/index.php?option=com\\_performs&formid=7&Itemid=9](http://www.olsoncenter.com/home/index.php?option=com_performs&formid=7&Itemid=9)

### September 11, 2009 Women's Health Annual Visit

Chicago, Illinois

Website: [http://www.omniaeducation.com/CME\\_Event.asp?eventCode=74dJo6s3Wcb4](http://www.omniaeducation.com/CME_Event.asp?eventCode=74dJo6s3Wcb4)

### September 30 – October 3, 2009 Reproductive Health 2009

Los Angeles, California

Website: <http://www.arhp.org/professional-education/annual-meetings/rh2009>

### October 16 – 18, 2009 Stages in Women's Health: A Lifespan Approach to

**Disease Management** Las Vegas, Nevada

Website: [http://www.omniaeducation.com/CME\\_Event.asp?eventCode=65Lman4o5D63](http://www.omniaeducation.com/CME_Event.asp?eventCode=65Lman4o5D63)

## WOMEN'S HEALTH LEADERSHIP CONTACT INFORMATION

### Executive Committee

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## GOALS OF THE WH PRACTICE GROUP

WH DPG promotes the development of dietetics professionals in the specialty area of nutritional care in women's health which includes preconception through pregnancy and lactation and expanded to late menopause.

### The objectives of the Women's Health DPG are:

1. Build an aligned, engaged and diverse membership.
2. Proactively focus on emerging areas of women's health.
3. Impact the research agenda in women's health and nutrition.
4. Identify and influence key food, nutrition and health initiatives specific to women.
5. Increase demand, utilization and reimbursement of services provided by WH members.

*"WH members are the most valued source of nutrition expertise in women's health"*

## ADA MEMBER BENEFITS Continued from page 8

**ADACareerLink:** ADA's online job service ([www.adacareerlink.org](http://www.adacareerlink.org)). Functionality includes posting résumés, targeting searches by specialty and geographic location, respond directly to job listings, and receive e-mail alerts about new positions. For a fee, member employers can also recruit professionals. Find more information under the Careers & Students tab at [www.eatright.org](http://www.eatright.org).

**Interactive Salary Worksheet:** Members can determine fair market value for their services by accessing the interactive salary calculator available in the Career Advancement section of the ADA Web site at [http://www.eatright.org/cps/rde/xchg/ada/hs.xsl/career\\_11495\\_ENU\\_HTML.htm](http://www.eatright.org/cps/rde/xchg/ada/hs.xsl/career_11495_ENU_HTML.htm). This salary calculation worksheet is based on a statistical model developed with data from ADA's Compensation and Benefits Survey of the Dietetics Profession 2007, offers a rough idea of what professionals with similar characteristics and in similar situations earn, on average. It also provides a sense of the relative importance of each factor in predicting salaries.

**Hot Topics:** Hot Topics are timely, one-page responses to members' questions and issues that have a significant impact on consumer health. Responses are written in consumer-friendly language and are designed to clarify a controversy or debunk a nutrition myth. Some current hot topics address trans fats, avian flu, and the glycemic index, with more to come according to member requests. Find

the current list of Hot Topics at [http://www.eatright.org/cps/rde/xchg/ada/hs.xsl/nutrition\\_7335\\_ENU\\_HTML.htm](http://www.eatright.org/cps/rde/xchg/ada/hs.xsl/nutrition_7335_ENU_HTML.htm).

### Free Online Journal Continuing Professional Education (CPE):

As of January 2008, members can easily earn up to 4 free continuing professional education credits in each issue of the Journal by completing CPE quizzes online at [www.eatright.org](http://www.eatright.org). By logging into ADA's Online Business Center and clicking the "Journal Article Quiz" button on their personal Profile Page, members can view a list of Journal CPE quizzes they've already completed and those still available to complete for credit. Quizzes are scored automatically online, and once all questions are answered correctly, CPE credit for completed quizzes may be added directly to a member's Professional Development Portfolio.

## our mission

*"Leading the future of  
dietetics in women's health."*