

Group Prenatal Program Aims for Empowerment

BY SHERRY BOSCHERT
San Francisco Bureau

SAN FRANCISCO — A group prenatal care program designed to empower pregnant women is spreading across the United States, Margaret Hutchison said at a meeting on antepartum and intrapartum management.

More than 60 sites offering prenatal care in 28 states have started CenteringPregnancy programs—mostly in public clinics, with some in HMOs and military clinics, said Ms. Hutchison, a certified nurse-midwife at San Francisco General Hospital, a teaching hospital of the University of California, which also sponsored the meeting.

Developed by a certified nurse-midwife and pilot-tested in 1993, the CenteringPregnancy model groups 8-12 women of similar gestational age for 10 facilitated 2-hour meetings starting at gestational weeks 12-16. The groups usually meet monthly for the first 4 months and twice monthly after that. The women do self-care activities, such as measuring weight, taking blood pressure readings, and charting.

"This is an important part. It's not a group to just sit and talk," Ms. Hutchison

explained. "Empowerment is the key."

The group discusses specific topics related to pregnancy and parenting, guided by "self-assessment sheets," with the emphasis varying among core topics, such as smoking cessation or community building.

Ms. Hutchison said she started a CenteringPregnancy program at San Francisco General Hospital to help the many immigrant Hispanic females seen at her institution who seemed socially isolated. "I wanted them to have someone to call after we've sent them home with a baby," she said.

Ms. Hutchison said she has no financial relationship with the nonprofit group that owns the program trademark, the Centering Pregnancy & Parenting Association Inc.

During group time, the women take turns having "mat time" with a health provider who conducts pregnancy risk assessments within the group space, sometimes on a floor mat that can be behind a screen if privacy is needed.

Staying in the room to conduct assessments is important, she explained. Moving a woman into a separate room interrupts the group process and reasserts the traditional hierarchical relationship between providers and patients.

Because the program, which demands change from health care providers, is so different from traditional care, it is not an easy one to implement. (See box.) Billing has not been an issue, because the program fits into standard reimbursement systems, she said.

The program improved birth weights in a nonrandomized trial of 458 low-income women at two institutions. The women either participated in a CenteringPregnancy group or received traditional care, with the groups matched by age, race, parity, and date of delivery.

Average birth weight in the CenteringPregnancy group was 3,228 g—significantly higher than the average of 3,159 g in the control group.

The CenteringPregnancy group showed a nonsignificant trend toward fewer low-birth-weight babies. In that study, 7% of babies born to the CenteringPregnancy group and 10% in the control group had low birth weights, defined as less than 500 g (Obstet. Gynecol. 2003;102[pt. 1]:1051-7).

The rate of preterm deliveries did not differ between groups, but preterm babies in the CenteringPregnancy group were significantly older and larger, born at 34.8 weeks and 2,398 g, compared with 32.6

Pregnancy Care Models Differ

Traditional Care

Physical assessment is primary.
Education is mostly one-on-one.
Communication is didactic.
Process of care is disempowering.
Psychosocial support is incidental.

CenteringPregnancy Care

Physical assessment is simply one aspect of care.
Education is both group-based and interactive.
Communication is both interactive and facilitated.
Process of care is empowering.
Psychosocial support and community-building are primary.

Source: Ms. Hutchison

weeks and 1,990 g in the control group. The first randomized, controlled trial of CenteringPregnancy involves thousands of women and should conclude in the next 6 months, Ms. Hutchison said. ■

Researcher Urges Broadening Of 'Prenatal Care' Definition

BY JOYCE FRIEDEN
Associate Editor, Practice Trends

WASHINGTON — The term "prenatal care" should be rethought to include much more of a woman's life cycle, Dawn Misra, Ph.D., said at a meeting sponsored by the Jacobs Institute of Women's Health.

"We have to go beyond the [typical] prenatal period" that covers only a few months before pregnancy, said Dr. Misra of the University of Michigan, Ann Arbor. When it comes to chronic illnesses that may affect pregnancy, for example, "We have to plan strategies to address these matters across the life course; if we want to fix them, we can't wait until pregnancy to [address] them."

Dr. Misra gave hypertension as an example. "There really is no good treatment for hypertension once you're pregnant," she said. "You can do some things to try to moderate its effects and lessen its impact, but you can't fix it. So [instead] we could prevent women from having hypertension and entering pregnancy with hypertension." This involves addressing such chronic health problems in the preconception period as well as between pregnancies.

She gave several reasons why providers haven't taken this approach. "Public health and medical professionals are wedded to the notion that prenatal care is fundamental," she said. "There have been a lot of successes with prenatal care, but I would like to take a step back and think about how prenatal care is not the only answer." ■

The health care financing system has encouraged this model of prenatal care by the way it reimburses for care, she continued. As a result, "Very few women get no prenatal care, yet we haven't achieved much improvement in terms of infant outcomes."

Changing this system of care would also mean increasing involvement by providers outside the specialty of ob.gyn., such as pediatricians, Dr. Misra said. "Pediatricians are taking care of future mothers. They could spend time from that perspective thinking about chronic illnesses, keeping [these patients] well, and thinking about what future concerns might be."

Some of these changes might be fostered by improving medical school training. In addition, people from outside the medical profession such as coaches and personal trainers could be involved in these types of issues, she said.

Pediatricians could also help provide better record transfer, Dr. Misra noted. "We have young girls moving from the pediatrician to the ob.gyn. or the nurse-midwife. A lot is lost when young girls move to those providers, and we need to find better ways to relay their health history." This is a challenge that needs to be met, especially in the wake of a study showing that 25% of pregnant women have a chronic health condition, Dr. Misra added.

On a broader level, public health officials need to rethink their method of separating chronic disease care from maternal and child health programming, Dr. Misra said. ■

Risk Reduction in Expectant Fathers Can Positively Impact Family Health

BY DIANA MAHONEY
New England Bureau

BOSTON — Prenatal care providers are bypassing a "golden opportunity" to improve the long-term health of families by not addressing the health-risk behaviors of expectant fathers, according to Kevin Everett, Ph.D., of the University of Missouri-Columbia.

Pregnancy often is viewed as a "teachable moment" because women become receptive to and are more likely to follow health advice that could positively impact their children, and men's health-risk behaviors are rarely considered during this time, Dr. Everett said at the annual meeting of the Society of Behavioral Medicine.

To better understand paternal health-risk behaviors and determine whether the inclusion of a prenatal care component focusing on reducing them would be favorably received, Dr. Everett and his colleagues conducted a telephone survey of 138 expectant fathers from rural, low-income families who were at least 18 years old and had consent from their pregnant partners.

The participants answered questions about their health behaviors, including tobacco use, problem drinking, physical activity, body mass index, and nutrition. Sociodemographic variables and ratings of health beliefs also were recorded.

The median age of the men surveyed was 27. They were predominantly white (87%), and more than half (66%) were high school graduates. Approximately 86% of the men were employed at the

time of the survey, and nearly 62% were married to their partners. More than half of the study population (61%) reported being in "excellent" or "very good" health.

With respect to health-risk behaviors, nearly half of the men (49%) were smokers and almost one-third (30%) engaged in hazardous drinking. Most of the men (94%) were deemed to have poor nutritional habits, and approximately one-quarter were obese.

Ironically, Dr. Everett said, "many of the [respondents] reported health beliefs are incongruent with these behaviors." Nearly 95% of the men acknowledged the importance of a healthful diet. More than 98% knew smoking around children or babies was unhealthy, and nearly 90% reported that they thought it was not okay to drink alcohol around children.

Of particular interest was the respondents' receptiveness both to learning about potential health changes and implementing them, he said. Nearly 98% of the men expressed a willingness to change their own behaviors to help their partners change their potentially harmful behaviors. About 93% of the men were confident in their ability to make these changes, and 83% expressed a desire for getting information about making changes.

By not considering the health behaviors and attitudes of expectant fathers, "providers are missing an important window," Dr. Everett said. "Health behavior changes made by men may be the critical factors for determining early and long-term family health by enhancing partner health behavior change." ■