THE BENEFITS OF GROUP PRENATAL CARE IN THE HISPANIC ADOLESCENT POPULATION

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Abstract

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Pregnant teens are known to be reserved about accessing prenatal health care. Lack of prenatal care may result in unfavorable pregnancy outcomes. The purpose of this article is to discuss the benefits of a group-oriented prenatal care model on pregnancy outcomes with Hispanic adolescents. This is conceptually framed by the CenteringPregnancy model. The social learning theory is implied in the CenteringPregnancy model. A comprehensive literature review was conducted using a variety of research journals. There are many benefits to group prenatal care when compared to one-on-one prenatal care. Advanced Practice Nurse Practitioners should incorporate this group prenatal care paradigm into professional practice in order to enhance the patient and health care provider partnership to improve perinatal outcomes.
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The Benefits of Group Prenatal Care in the Hispanic Adolescent Population

Introduction

It is estimated that in the United States more than 850,000 women under the age of 20 are becoming pregnant each year, even though it has been shown that adolescent pregnancy rates have decreased over the past decade (Bloom, 2005). “Because early and regular prenatal care is an important factor in improving pregnancy outcomes, improved access to prenatal care for all women is a fundamental component of the national public health agenda” (Bloom, 2005, p. 213). Adolescents are one of the age groups that are most prone to unplanned pregnancy. “Despite declining teen births since 1991, adolescent pregnancy remains a public health concern because it has the potential to negatively impact both mother and child” (Talashek et al., 2006, p. 14). According to the National Center for Health Statistics out of Pediatrics,

The birth rate for teen mothers continued to fall, dropping 1% from 2003 to 2004 to 41.2 births per 1000 women aged 15 to 19 years, which is another record low. The teen birth rate has fallen 33% since 1991; declines were more rapid for younger teens aged 15 to 17 (43%) than for older teens aged 18 to 19 (26%). The proportion of all births to unmarried women is now slightly higher than one third (Hoyert et al., 2006, p. 168).

Adolescent mothers have increased risk for delivering a premature infant or an infant with low birth weight. This is reason enough to increase public awareness and to take focused action to improve adolescent prenatal outcomes as much as possible. Sociodemographic risk factors such as low-income, low education level, low self-esteem, substance abuse, poor nutritional intake, unmarried, late prenatal care, and of a non-white
ethnic group all contribute and correlate to low birth weight. Adolescent pregnancy alone doesn't equal low birth weight; at least one other risk factor is always present (Anderson et al., 2000).

Different cultures have different traditions so acculturation into mainstream norms must be looked at as well. As far as sociocultural factors are considered, one study showed that “female Hispanic adolescents with higher acculturation levels were more likely to be sexually active than adolescents with lower acculturation levels” (Adam et al., 2005, p. 1879). Hispanic pregnant teens were more likely to live outside of their family’s home and “also more likely to date, have more sexual partners, have gang member boyfriends, and at a younger age have their first date, first intercourse, and first drink” (Talashek et al., 2006, p. 19-21).

Many factors influence increased sexual activity in adolescents. Poverty, strength of religious beliefs, family structure and discipline, and sociocultural/ethnic factors are a few of these. Increased sexual activity in adolescents is also seen more often when there is substance abuse, loose parental guidelines, low self-esteem, peer pressure, and a history of abuse (Anderson et al., 2000).

Lack of prenatal care is known to result in unfavorable pregnancy outcomes as compared to older females who have thorough prenatal care. Teens are reluctant to access prenatal care. Late or no prenatal care as well as poor nutrition results in inadequate folic acid intake which is vital in beginning pregnancy to prevent certain birth defects (Maunder, 2006-2007). Sufficient prenatal care is instrumental in lowering the incidence of preterm births and low birth weights of term infants. Group prenatal care has been shown to increase the success of breastfeeding and decrease the use of
Group Prenatal Care

Triage/assessment centers in family birth centers as well as emergency rooms by pregnant women. Group prenatal care would be beneficial with Hispanic adolescents because it could help each individual become accountable for her health while pregnant. In addition, group care has been shown to increase compliance. Clients will potentially be more satisfied with their prenatal care in the long run when they feel properly educated. Satisfaction will be confirmed with the evaluations of group prenatal care that are completed by the clients involved (Centering Pregnancy & Parenting Association, Inc., 2007).

Purpose

The purpose of this article is to discuss the benefits of a group-oriented prenatal care model on pregnancy outcomes with Hispanic female adolescents. This particular model replicates the Centering Pregnancy Program model (CPP) (Bloom, 2005). The benefits of the group-oriented prenatal care have been compared to traditional one-on-one prenatal care. It has been shown that pregnant adolescents who participate in group-oriented prenatal care have improved attendance during prenatal care throughout pregnancy, as compared to those who participate in traditional, one-on-one prenatal care (Centering Pregnancy & Parenting Association, Inc., 2007).

The group prenatal care model should be widely instituted, because research shows that healthier prenatal outcomes are achieved with the patients who have been involved in this model when compared to the traditional model. Particularly, this is accurate because the group model provides more effective means of comprehensive education (Centering Pregnancy & Parenting Association, Inc., 2007). Pregnant adolescents tend to be hesitant to access prenatal care, especially when they are ashamed...
of pregnancy and/or think they are invincible with their risky behavior by not going to all appointments. Commonly, adolescents don’t put health care as their main priority at this age (Anderson et al., 2000). “Low self-concept has been shown to be associated with adolescent pregnancy and has been associated with decreased attendance at prenatal and postnatal care” (Ford, 2001, p. 16). Many teens go through a roller coaster of emotions around the stigmas with being pregnant and the fear they may have with being a mother at such a young age. This is true of the Hispanic adolescent population as well (Shaffer, 2002).

There are many barriers to teens of all ethnicities seeking prenatal care. In addition, Hispanic women have many barriers as well. These barriers are “poverty, embarrassment, reproductive or mental health care problems (which are private and/or personal matters to most people), parental consent requirements, concern with confidentiality, geographic proximity, office hours that clash with school or work schedules, limited availability of counseling and health education services, and a fragmented system of ambulatory care” (Anderson et al., 2000, p. 356). Additional barriers mentioned only specific to the Hispanic population are discussed below under the Literature Review section.

The group prenatal care pregnancy model may be more successful with this population, because it will be more favorable to overcoming these patients’ barriers. The problem at hand lies within the possible negative pregnancy outcomes if these individuals don’t seek early and consistent prenatal care. The chances of premature births and low birth weights of full-term infants increases in individuals who encounter more stress and don’t get consistent, comprehensive prenatal care. Since literature shows that Hispanic
immigrant populations have had a sudden rise in preterm births and it is known that increased maternal stress can equate to shorter gestational ages; it is imperative that stress be limited during pregnancy (Ruiz et al., 2006). Consistent group prenatal care should decrease stress levels.

The group-oriented prenatal care model creates more time for patients to get together with a health care provider for their prenatal care when compared to the common, traditional method of one-on-one prenatal care appointments. Group education provides an environment that makes educational material more likely to make a lasting impression. “Meeting in a circle supports socialization and moves the leader into the group as a member, not an authority figure or ‘sage on the stage’” (Reid, 2007, p. 385). The participants feel they are important because they are receiving a considerable amount of quality time with their health care provider, and other women who are experiencing the same care needs. The lengthier time and social support patients are getting with group-oriented prenatal care improves patient satisfaction (Handler et al., 1996).

CenteringPregnancy

The conceptual framework of the CenteringPregnancy model was designed by Sharon Schindler Rising in the 1970s. CenteringPregnancy is a model used as part of a study to evaluate group prenatal care. “The idea for CenteringPregnancy came from Rising’s experience with the Childbearing Center established in Minnesota in the 1970’s. There during final weeks of pregnancy and the first three months of postpartum group discussions were used to augment prenatal care” (Reid, 2007, p. 384). A group setting provides an atmosphere of great social support which is needed for some individuals more than others. “The influence of social support on the positive outcome of pregnancy
is well-documented. Support indicates that a person is a valued and integral part of the group” (Reid, 2007, p. 385-386).

Social support provides a comfortable setting that enhances education for teens in group-oriented prenatal care. Stress levels are reduced with social support (Crockett et al., 2007). In addition, it improves attendance during prenatal care, creates lower incidence rates of premature births as well as low birth weights of full-term infants as pregnancy outcomes (Massey et al., 2006). The social learning theory proposes that a non-threatening learning environment has been shown to enhance learning. One of the general principles of the social learning theory is that people learn by observing the behaviors of others and behaviors can be learned through modeling (Ormrod, 1999).

Literature Review

According to Balcazar, Hartner and Cole, “Mexican-Americans (also known as Hispanics) had a higher proportion of maternal risk factors and higher proportion of lack of prenatal care compared to other non-Hispanic whites” (1993, p. 198). These investigators found that “low risk pregnancy and adequate prenatal care equaled lower prevalence of low birth weight and pre-term delivery” (1993, p. 198). Hispanic women have a history of late prenatal care due to a variety of barriers (Shaffer, 2002).

Many Hispanic women have large families so transportation can be an issue that impedes prenatal care. Some Hispanic women are embarrassed by the physical examination that is part of the prenatal care. One of the major barriers is language and possible illegal immigration status. Many Hispanic women are from low-income families and have low education levels. With the large families, long wait times, and decreased financial resources to pay for the health care services (which may be due to lack of job
skills), it seems to be easier for these women to put off their prenatal care. With the lack of education or resources to gain more education or job skills, these women may not fully understand the significance of the prenatal care recommended in the United States (Shaffer, 2002).

Review of the recent literature is unanimous in showing that group prenatal care improves pregnancy outcomes. Despite ethnicity, there seems to be an overall belief that the most motivating factor that influences pregnant women to seek prenatal care is that these women equate care with healthier outcomes (Handler et al., 1996). “The group setting reduces the power differential between a woman and her health care providers, creating a more balanced relationship” (Massey et al., 2006, p. 288). When a setting is calmer and warm in nature it creates a more conducive learning environment in hopes that these women retain more of the learned information. Group prenatal care is in line with Hispanic women’s cultural norms. Some Hispanic women’s cultural norms are “close interpersonal relationships; warm, personalized styles of interaction; a relaxed sense of time; and a comfortable and informal atmosphere for communication (Marin, G. & Marin, B., 1981). Group prenatal care will better match Hispanic cultural norms for this female adolescent population than the traditional one-on-one prenatal care will.

Group prenatal care affects preterm birth rates and low birth weight rates (LBW). A previous study performed by Rising in 1998 consisted of 111 women in the sample. Five out of the 111 were preterm births and six out of the 111 were low birth weight, however five of the low birth weights were premature as well (Reid, 2007). The study by Grady and Bloom in 2004 discovered that:
Adolescent participants in a CenteringPregnancy group had a lower no-show rate when compared with women seen for traditional prenatal care (19 percent vs. 28 percent, respectively). There were statistically significant differences in the incidence of preterm birth (10.5 percent) and LBW infants (8.9 percent) when compared with two groups of adolescents receiving traditional prenatal care (preterm birth rates were 25.7 percent and 23.2 percent, and rates of LBW infants were 22.9 percent and 18.3 percent, respectively) (Reid, 2007, p. 386-387).

However, the study in 2003 by Ickovics et al. found no statistical differences with preterm birth weights except that preterm birth weights of the mothers in group prenatal care were larger than preterm birth weights of mothers in traditional prenatal care; this was also true regarding the overall weights of the infants as well.

Most of the literature involving studies looking at group prenatal care has excluded patients with chronic medical conditions or high-risk status from their samples (Bloom, 2005). The women who participated in these studies were independent samples who had their estimated date of delivery determined by their last menstruation date. If there were any questions involved regarding those dates, an ultrasound was used to clarify. Many of the studies examined other factors that influence pregnancy such as economic factors, demographic factors, sociocultural factors, and physiological, psychological, and cognitive maturity. It was important that these women in the study groups had similar due dates so that they were all going through similar experiences during each stage of the pregnancy (Ickovics et al., 2003).

Bloom (2005) placed 10 teens, ages 14-18, into the CenteringPregnancy Program and 53 teens went into the traditional prenatal care. In performing a qualitative study
using in-depth questionnaires as well a pre/post test determining baby knowledge among the group of the 10 self-selected teens, there were no significant differences between groups for any pregnancy complications among the 29 adolescents for whom follow-up data were available. However, the CenteringPregnancy Program “promotes increased attendance and participation in prenatal care as well as participant satisfaction” (Bloom, 2005, p. 217). The fact that there were uneven group sizes, particularly the small number in the group prenatal care, created a weakness in this study.

The goal of prenatal care is to deliver the most current, pertinent prenatal information in the most effective way to expecting parents. Group prenatal care is one way to meet the needs of pregnant teens. An area that still has not been discussed much in the literature involves how significant the role of social support is in group prenatal care and how group prenatal care decreases use of triage centers at hospitals by pregnant patients. Another area that has not been discussed is the role of the father of the baby in group prenatal care among pregnant Hispanic teens.

Implications for Advanced Nursing Practice

Group prenatal care provides care to the community that is exciting and energizing for the patients and facilitators as well as being cost-effective (Centering Pregnancy & Parenting Association, Inc., 2007). These expecting mothers and support persons will gain a more comprehensive education around their pregnancy and becoming a new parent. This makes for a new generation of parents who will become more empowered as parents. Social skills for life’s challenges will be enhanced from the group experiences and will be passed down to their children through confidence and the modeling of it.
Knowledge improves self-confidence and the more self-confident adolescents have less chance of abuse (Centering Pregnancy & Parenting Association, Inc., 2007). Low self-esteem is a common characteristic of teen pregnancy and sexual abuse (Kanddakai & Smith, 2007). Due to the more commonly found barriers that Hispanic females have to overcome, this CenteringPregnancy group prenatal care model suits this population and other populations very well as the patient benefits. Hispanic teens involved in group prenatal care should have increased self-confidence, which should lower all types of abuse incidence rates.

It may be that Hispanic pregnant adolescents who participate in group prenatal care will have improved attendance during prenatal care and will have lower incidence rates of premature births as well as low birth weights of full term infants when compared to traditional, one-on-one prenatal care. The group prenatal care model strongly focuses on comprehensive education and this type of model could be beneficial in other clinical practice settings such as pediatrics. There are some research studies that exhibit how group prenatal care positively changes the nursing practice and is greatly beneficial to the consumer. Another way group prenatal care is beneficial to the consumer and society as a whole is that “historically, non-English speakers under-attend childbirth preparation and parenting classes, missing information relevant to maternal and child health, such as contraception method options and childhood immunization programs, and details of the state and federal programs which financially support them;” but with the education that is comprehensively covered in the group prenatal care this information won’t be missed (Maunder, 2006-2007, p. 3).
Job satisfaction of the group health care providers and co-facilitators will increase because it is more exciting and energizing compared to the same repeated routine. Groups provide for an efficient use of professional time so they are generally more cost-effective. Society at-large will benefit because group prenatal care promotes healthy family development, reduces family violence, and unintended pregnancies. As more women attend the group prenatal care model instead of the traditional prenatal care model it frees up exam room space that can be used for a variety of other patient care since the group sessions are held in a conference room. This also creates less maintenance expenses for the clinics using this model. Over-all census increases due to women who hear of the group prenatal care model in the community and want to be a part of it (Centering Pregnancy & Parenting Association, Inc., 2007).

Implications for research that still may be useful include how the group model would be beneficial for paternal pediatric care. If a nurse practitioner wanted to do further research the following explains how it could be designed. In a group setting of 8-10 same aged children and their parents, the health care provider could facilitate discussion with everyone in the group concerning topics of nutrition, sleep patterns, what’s appropriate at each age range-expected milestones, growth chart, behavioral issues and discipline for specific ages, communication, interactions with other children, self-esteem, and parenting issues, questions, or concerns. During the group there would be time for refreshments and socialization for the rest of the group, while other patient’s are having their individual private times with the health care provider. The socialization time helps to promote cohesion. A variety of studies could document the effectiveness of this practice (Centering Pregnancy & Parenting Association, Inc., 2007).
Currently at Healthy Steps for Women and Children Clinic located in Vancouver, Washington, the clinic is trialing a Healthy Steps Group Prenatal Care Program that was initiated in the fall of 2006 with pregnant Hispanic females (two groups with different gestational ranges) and adolescents (one group of teens). This has been “advocated to encourage early entry to prenatal care, remedy knowledge deficits, identify risk factors, and better access to existing community resources for prevention of preterm birth, low birth weight, avoidable birth defects, and the effects of cigarette and/or illicit drug use” (Maunder, 2006-2007, p. 3). A goal of group-oriented prenatal care with Hispanic adolescents would be to have improved attendance. It is hypothesized that pregnant Hispanic adolescents who participate in group-oriented prenatal care will have a lower incidence of premature births than those who participate in traditional, one-on-one prenatal care. It is also hypothesized that pregnant Hispanic adolescents who participate in group-oriented prenatal care will have a lower incidence of low birth weights of full-term infants than those who participate in traditional, one-on-one prenatal care.

Conclusion

In summary, group prenatal care offers better outcomes for families expecting a new addition to the family. With this model, Hispanic adolescent females will have their questions fully answered instead of feeling rushed (Tandon et al., 2005). “Moreover, they are encouraged to articulate and discuss their cultural norms and values of pregnancy” (Tandon et al., 2005, p. 317). The group prenatal care model overall benefits the Hispanic population by supplying a comfortable atmosphere to enhance the learning environment. Any stress related to the pregnancy that these families experience is greatly
reduced with the social support provided at the group prenatal care appointments. When stress levels are down it also makes for more effective learning.

Comprehensive education provides more opportunities for self-assurance and independence. Without comprehensive education people aren’t as empowered. The more empowered and educated the public is, the more people will be accountable for their own health care decisions. “Knowledge of how the characteristics of prenatal care affect women’s satisfaction can help increase use of care and ultimately improve perinatal outcomes” (Handler et al., 1996, p. 31). Since research demonstrates that more education creates better prenatal outcomes it only seems logical to utilize a model in which thorough education is easily efficient.
References


Ford, K. (2001). Effects of a prenatal care intervention on the self-concept and self-


