than the bride? Was he attending to a second spouse? Was he abusive? I propose that any of the previously cited factors are grounds for lack of interest and/or pleasure in sexual activity.

I comprehend that such an extensive research endeavor may have been outside the scope and time constraint of this cross-sectional study and do not argue that female circumcision undoubtedly plays a role in dyspareunia. Nevertheless, I would have liked more conclusive information encompassing factors that may have skewed the data, and a great practitioner should keep these limiting factors in mind when practicing evidence-based medicine. ■

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The author reports no conflict of interest.

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REPLY

We thank Ms Sakyi-Agyekum for her close review of our article.[1] The points she raises emphasize the difficulty in assessing sexual functioning in women with female genital mutilation/cutting (FGM/C), and we encourage other researchers to investigate this issue, taking, for example, physiological and cultural covariates into consideration.

We used the Female Sexual Function Index in our study because it is considered the gold standard assessment of sexual functioning in women.[2] Within the context of sexual functioning among women with FGM/C, we agree that it would be interesting to examine why some couples do not attempt intercourse as well as the influence of age difference between the couple, polygamy, and abuse. These issues were, as Ms Sakyi-Agyekum suggests, outside the scope of our study, but we agree that research on these issues would add valuable information to the evidence base for policies regarding FGM/C. ■

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Beyond the traditional models of group prenatal care: the case for Moms2B

TO THE EDITORS: We read with interest the review of Mazzoni and Carter[1] of the topic of group prenatal care (GPNC). As noted, GPNC is a complex and difficult model to achieve in health systems designed for individual prenatal care (IPC).

We have developed an alternative, scalable community-based group model (CGM) that addresses the barriers faced by health systems in utilizing GPNC. The model, called Moms2B, has been implemented to date in predominantly African-American neighborhoods in Columbus, OH, to address disparities in infant mortality, preterm births, and low birthweight babies.

We recently described our model and reported a 5-fold reduction in infant mortality at our first site.[2] At Moms2B, a multidisciplinary team of health professionals empowers women living in poverty through weekly, 2 hour sessions focused on pregnancy and parenting education, stress reduction, and healthy nutrition. This CGM serves as an adjunct to traditional IPC and addresses the barriers to the implementation of traditional GPNC models as outlined in the Table.

In summary, we suggest the CGM that we have developed allows health systems to continue to use their current IPC model while also addressing the social determinants of health in high-risk populations, thereby improving maternal and infant health. This alternative to GPC could be replicated in