



PULSE

A MONTHLY NEWSLETTER FROM THE ASSOCIATION OF MATERNAL AND CHILD HEALTH PROGRAMS

Prematurity and Preconception Health November 2009

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From the President

Prematurity and Preconception Health

By Phyllis J. Sloyer, RN, PhD, FAHM, FAAP



Our prematurity rate is still a double digit number and if you drill down into the causes of prematurity you will find multiple reasons, not the least of which include poor nutrition, substance use, poverty, as well as more clinical issues including the increasing number of c-sections.

A friend of mine who is a developmental pediatrician from Canada once said that we have to pay more attention to preparing women for a healthy and safe pregnancy long before they are pregnant. He said this to me about 20 years ago when we were tackling issues of early intervention in the early childhood period. Isn't it ironic that we now are placing a strong emphasis on preconception health as a means to reducing prematurity?

This issue will provide you with a lot of information and tools that you can use to improve your efforts of creating a healthy and safe climate for women and, of course, raising a new generation of healthy children.



ASSOCIATION OF MATERNAL & CHILD HEALTH PROGRAMS

From the CEO

Prematurity: Taking a Public Health Approach

By Mike R. Fraser, PhD

Several months ago I had the chance to visit our good partners at the March of Dimes at their national headquarters in White Plains, New York. In their offices is a fascinating display on the March of Dimes' successful history fighting polio and their current campaign to prevent premature birth. At the center of the display is an "Iron Lung" – a reminder of what many patients had to go through to stay alive in their own battles against polio. And next to it, though much smaller, is an "Isolette" machine – an incubator – something many of us are much more used to seeing these days in our hospitals than an iron lung.

The iron lung and the incubator were striking reminders to me of our investments in and hopes for medical solutions to our most pressing health problems. Both machines have saved the lives of hundreds of thousands. Both machines represent the best of the science of their times. We have a lot to be thankful for as we look at the technological advances that have led to the eradication of polio and our expert care of the many babies born prematurely, and their mothers, today. But also in the display were posters highlighting health promotion messages and sharing public health messages related to both polio (then) and prematurity (now). No plugs needed, no complicated monitoring required, these low-cost health promotion

interventions caught my eye. There were photos of people talking to one another and sharing health information in living rooms, in exam rooms, in classrooms. These low-cost techniques highlighted the public health approaches to addressing both polio and prematurity which included population based health information sharing and community mobilization around pressing health issues. While not as flashy, and admittedly without the beeps and blips of medical technology, it struck me that these public health "technologies" were equally important in saving lives and preventing disease.



The Institute of Medicine estimated that an infant born prematurely in 2005 cost the United States \$51,600 each for a total annual cost of \$26.2 billion dollars. The report also estimates that the average first-year medical costs, including both inpatient and outpatient care, were about 10 times higher for preterm babies (\$32,325) than for full-term infants (\$3,325). Wow. If we could even reduce prematurity rates by just 10 percent we're talking about substantial improvements in both quality of life for infants and their families, and significant savings in medical and economic costs related to treating and caring for premature births.

While technological advances improve the way we treat and care for our tiniest citizen and their families, the time is now to recommit ourselves to the low-cost, high-yield interventions that we know are effective in preventing premature birth. We know that late or no prenatal care, using alcohol and illegal drugs, and smoking increase the risk of premature birth. We also know that stress, including the stress of racism, lack of social support, exposure to domestic violence and abuse, increase the risk of a premature birth. These are risks for which we have effective public health interventions but our opportunities to use them are compromised by budget cuts, staffing shortages, and lack of political will to support public health programs serving women, children and families.

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From the CEO CONT.

Taking a Public Health Approach

Those of us who spend our lives advocating for maternal and child health programs should be concerned by the rising rates of prematurity in our nation. Equipped with public health interventions that work we know we can help reduce the social and economic costs of prematurity. As we look to new ways of preventing premature birth can we imagine a day when an iron lung and an Isolette are **both** uncommon sights to future generations of Americans? I can, and with all of us working together to raise awareness of and support for public health approaches to prevent premature birth I know we can get there.

Feature

March of Dimes Big 5 State Prematurity Collaborative

By **Scott D. Berns, MD, MPH, FAAP**

Senior Vice President, Chapter Programs, March of Dimes National Office, White Plains, NY



Together, five states (California, Florida, Illinois, New York and Texas) account for nearly 40 percent of all births and 36.8 percent of preterm births in the United States. Known as the “Big 5”, these states not only share high birth rates, they also face many of the same challenges in implementing programs to improve birth outcomes. Given these similarities, what are the unique opportunities the Big 5 can leverage to significantly impact birth outcomes? In 2006, the March of Dimes began asking how the Big 5 states could identify opportunities and leverage initiatives to impact birth outcomes. This led to a collaboration among the Big 5 states that continues to evolve today.

The foundation of this collaboration began with a meeting spearheaded by the March of Dimes in 2007. 50 invited Big 5 state representatives from a cross section of provider disciplines, including state maternal and child health leadership, hospital systems, as well as leading

prematurity experts participated in a three-day summit to identify potential areas for ground breaking change to reduce preterm birth. Promising programs currently being carried out were shared and relationships were built. However, there was a common challenge articulated throughout the meeting — improving program evaluation to understand the impact programs have on birth outcomes. This desire to obtain better data to validate programmatic efforts sparked the energy and commitment of the Big 5 to continue their collaborative endeavor.

Now more formally organized, the March of Dimes Big 5 State Prematurity Collaborative is exploring data driven perinatal quality improvement through the development and adoption of evidence based interventions and the data systems and tools required to track changes in specific perinatal issues and indicators. Recent efforts in California, Kentucky, New York, Ohio, North Carolina, and other states have led to innovative population-based data driven approaches that provide information on potentially effective initiatives. Lessons have been learned in states that have implemented such approaches and the Big 5 have reviewed these and other efforts to identify a shared agenda focused on eliminating elective deliveries < 39 weeks.

Currently, states are working within and in partnership to establish the data mechanisms required to track the growing rate of elective deliveries, reviewing and developing change models and determining implementation strategies needed to bring this initial plan to fruition. Synergy exists around this data driven project which will not only establish an effective programmatic framework but also a network that can be instrumental in facilitating the rollout of future maternal and child health initiatives among the Big 5 states, and perhaps beyond.

Feature CONT.

Spotlight on Assisted Reproductive Technology

By Maurizio Macaluso, MD, DrPH

*Chief, Women's Health and Fertility Branch
Division of Reproductive Health
Centers for Disease Control and Prevention*

Assisted reproductive technology (ART) has been used in the United States since 1981 to help women become pregnant, most commonly through in vitro fertilization (IVF) of human eggs followed by transfer of the embryos into the woman's uterus. In 1992, Congress passed the Fertility Clinic Success Rate and Certification Act, requiring Centers for Disease Control and Prevention (CDC) to collect data from all ART clinics and report success rates, defined as live births per ovarian stimulation procedures, for each ART clinic. In a typical ART procedure, eggs are retrieved from a woman's ovary, combined with sperm in the laboratory, and the resulting embryo(s) are transferred back into the woman's uterus or fallopian tubes. An ART cycle is defined as a process in which (1) a woman has undergone ovarian stimulation or monitoring with the intent of having an ART procedure (even if the cycle was subsequently canceled and no embryos were transferred) or (2) embryos previously frozen have been thawed with the intent of transferring them to a woman. Types of ART procedures include in vitro fertilization (IVF) with and without intracytoplasmic sperm injection (ICSI), gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT).

Data from the National ART Surveillance System (NASS) indicate that in 2006, 138,198 ART cycles were performed at 426 reporting clinics in the United States, resulting in 41,343 live births (deliveries of one or more living infants) and 54,656 infants. Although use of ART is still relatively rare as compared to the potential demand, it has doubled over the past decade and ART-born infants now account for over 1 percent of all United States-born infants. This proportion is larger in states where statutes mandate insurance coverage of infertility treatment.

A critical decision in the performance of ART is about how many of the embryos obtained through IVF will be transferred back to the uterus with the purpose of establishing a pregnancy. In general, the more embryos are transferred the higher the likelihood that at least one

will implant, giving rise to a clinical pregnancy and a live birth. Currently, almost 75 percent of the procedures performed in the United States involve the transfer of two or three embryos. Elective single embryo transfer, however, is not widely practiced. Only about 11 percent of IVF cycles in 2004 involved the transfer of just one embryo. Multiple embryo transfer is associated with an increased probability of establishing a multifetal pregnancy. Whereas ART-born infants account for over 1 percent of all United States-born infants, they represent 18 percent of all multiple births.

Multifetal pregnancies increase the risk for maternal complications such as gestational diabetes. Multiple-birth infants are at increased risk for low birth weight, preterm delivery, infant death and disability among survivors. Recent systematic reviews of the literature indicate that ART-conceived singletons also face increased risks for low birth weight, very low birth weight, preterm delivery, and fetal growth restriction. These findings have been confirmed in population-based studies in the United States. As many of the ART singletons are delivered after a multifetal pregnancy, a proportion of the adverse outcomes observed in these infants are attributable to multiple embryo transfer. A recent analysis used six years of data (2000-2005) from the National ART surveillance system, and national birth certificate data during the same period to compute the proportion of low birth-weight infants born after ART, whose low birth weight status is attributable to the practice of multiple embryo transfer. The results, presented at the 2009 conference of the European Society for Human Reproduction and Embryology in Amsterdam, suggest that between two thirds and three quarters of the burden of low birth weight experienced by ART infants in the United States is due to multiple embryo transfer, and that the underlying infertility condition (a factor also known to be independently associated with adverse birth outcomes) is likely to explain no more than 10 percent. Thus, it is appropriate to expect that widespread adoption of single embryo transfer could translate in a large reduction of the burden of low birth weight and possibly other adverse infant outcomes associated with ART in the United States.

Feature CONT.

Early Intervention and Babies Born Prematurely

By **Diana Autin**

Executive Co-Director, Statewide Parent Advocacy Network of New Jersey

Babies who are born prematurely are more likely to have disabilities and developmental delays, including cerebral palsy, visual and hearing impairments, respiratory problems and cognitive disabilities. In New Jersey, babies who are born prematurely and/or who are born with disabilities or developmental delays are automatically registered with the electronic Birth Registry. The New Jersey Department of Health and Senior Services' Special Child Health Services Registry is a confidential record of infants and children who have birth defects and special health care needs or who are at risk of developing such needs. Infants and children with a birth defect diagnosed through five years of age must be reported to the Registry.

Early intervention services are designed for infants and toddlers with disabilities and developmental delays, including babies who are born prematurely. Infants with birth defects and special healthcare needs who are reported to the Registry are referred to New Jersey's Early Intervention System, part of the Department of Health and Senior Services' Division of Family Health Services. To help families, professionals, and advocates decide whether or not a baby could be eligible for early intervention services, the Department developed and disseminates a parent-friendly brochure, *Your Child's Development: Important Milestones (Birth-36 Months)*. The brochure gives information on critical developmental milestones in the areas of movement, language, hand and finger skills, and social-emotional development. It also summarizes the eligibility criteria for early intervention in New Jersey, what an early intervention evaluation will tell the family about their child, available resources, and how to contact the early intervention system.

The mission of the New Jersey Early Intervention System is to enhance the capacity of families to meet the developmental and health-related needs of children birth to age three who have delays or disabilities by providing quality services and support to families and their children. The Early Intervention System is committed to having families from diverse racial, cultural and socio-economic

backgrounds be involved in decision-making at every level of the design, implementation and evaluation of the Early Intervention System.

In 2008, the New Jersey Early Intervention System regionalized the system point of entry for referral of infants and toddlers with developmental delays and disabilities. Families and primary referral sources call one toll-free number to start the process. To start the evaluation process, families are connected to evaluation teams and evaluation Service Coordinators housed at the four Regional Early Intervention Collaboratives (REICs). The REIC Boards include parents, providers, and community representatives. The REICs ensure that potentially eligible infants and toddlers, including babies born prematurely, receive a comprehensive evaluation and assessment to determine eligibility and identify their strengths and needs as well as their family's priorities, resources, and concerns. Once a baby is determined to be eligible, an Individualized Family Services Plan (IFSP) is developed with the family, containing needed services for the infant or toddler as well as their family.

At this point, a Service Coordinator from the Service Coordination Unit in the county where the family lives assumes responsibility to ensure that needed services are provided. The Service Coordinator also connects families to other needed supports including those offered by the Statewide Parent Advocacy Network's Parent to Parent program, Family Voices and Federation of Families for Children's Mental Health chapters, Family to Family Health Information Center, Parent Training and Information Center, or New Jersey Inclusive Child Care Project, as well as other supports such as disability-specific organizations, Family Support Center, and other state agencies such as the Division of Developmental Disabilities.

The REICs are available to provide ongoing information to families and providers in the Early Intervention (EI) system. Each REIC has full or part-time Family Support Coordinators who are parents of children with disabilities. The Family Support Coordinators facilitate workshops including "Welcome to EI" and "Transition from EI to Preschool." They answer parent questions, help resolve disagreements between parents and their service

Feature CONT. Early Intervention and Prematurity

providers, and work to develop parent leadership. They also represent a family voice within the early intervention system. The REICs provide professional development to service coordinators and service providers on topics such as procedural safeguards, providing services in natural environments, and providing family-centered services.

In most counties, the Service Coordination units are housed in the same site as the county Special Child Health Services Case Management Units (SCHS CMUs). Case managers at the SCHS CMUs provide case management services for children and youth with special healthcare needs through age 21, and their families. Having Service Coordinators and Case managers housed at the same agency makes the transition process smoother for families. Both the early intervention system and the SCHS CMUs are part of the Division of Family Health Services Using funds from New Jersey's Title V agency, the Parent Training and Information Center grant, and the Integrated Systems for Children and Youth with Special Healthcare Needs grant, SPAN houses part-time Family Resource Specialists at each of the 21 county SCHS CMU to provide information, technical assistance, and support to families, especially at the transition to preschool stage when families move from one system (early intervention) to a very different system (preschool special education).

Service coordinators also connect families to other resources such as New Jersey's Catastrophic Illness in Children Relief Fund, which helps families pay for uncovered medical expenses; health insurance including Medicaid, Family Care (New Jersey's Children's Health Insurance Program), and Family Care Advantage (for families of any income who do not have insurance for their children; families can "buy into" a CHIPRA-comparable health plan for their child at the state rate, which is much less expensive than purchasing insurance at market rates, especially for children with disabilities and special healthcare needs).

Because of the early intervention service coordination and SCHS Case management services provided by the Division of Family Health Services, and the partnership with SPAN, the state's Parent Training and Information Center, Family to Family Health Information Center, and

Family Voices chapter, families of babies born prematurely in New Jersey have access to a wide array of services and supports to help them maximize the healthy development of their baby and address the special needs that often accompany prematurity.

Member to Member

What are you doing related to health promotion and prevention across the lifespan?

Nebraska

Paula Eurek
Administrator, Lifespan Health Services Unit
Nebraska Department of Health and Human Services



In 2007, the Lifespan Health Services Unit, Nebraska Department of Health and Human Services, initiated a strategy development process for two of the state's MCH priorities: overweight among children and women of child bearing age, and preterm birth/low birth weight. Using the [Family Health Outcomes Project's planning methodology](#), stakeholder work groups developed logic models for both priorities. This planning process and the logic models resulted in several preconception health strategies within a life course framework.

Subsequently, the Lifespan Health Services Unit integrated the life course framework into its work. An RFP was issued for MCH community-based services that incorporated the work groups' logic models, resulting in a number of preconception health projects that reach adolescents and young adults. Three of the projects enhance preconception health services within Title X/Family Planning clinics. A fourth project integrates a life course model of preconception health into medical education. The logic models were also key to the preparation of a successful application for the First Time Motherhood/New Parents

Member to Member CONT.

What are you doing related to health promotion and prevention across the lifespan?

Initiative grant. Nebraska's project, now in its second year, has as its target audience young women, ages 16 to 25. Market research with this audience is currently being used to develop a campaign with original music as the "hook" to connect this group of Millennials to positive and empowering health messages. For more details on this project, which is undergoing a transformation from "Building Bridges" to "Tune My Life," visit [here](#).

New Jersey

**Dr. Linda Jones-Hicks, D.O.
FACOP, FAAP**

Director, MCCH (Maternal Child Community Health) Family Health Services, New Jersey Department of Health & Senior Services



In New Jersey, the issue of preconception health has been a priority for several years.

As a result, several statewide collaborative steps have been taken to provide education and information through Family Planning agencies, to expand the Department of Education's core curriculum on health and physical education, and under the direction of the Department of Health and Senior Services, Division of Family Health Services, a Statewide Prenatal Task Force was created which addressed additional recommendations. These initiatives have created the framework by which New Jersey addresses preconception health to stress health before and during pregnancy.

The Family Planning program has clinic sites on some college campuses. These sites provide preconception health counseling and family planning services. New clients are provided information about prenatal vitamins, the role of folic acid, the importance of cessation of smoking, decreasing alcohol use and avoiding stress.

The Department of Education (DOE) developed Core Curriculum Content Standards which mandate

comprehensive health and physical education. The Department of Health and Senior Services collaborated with the DOE to help students develop an understanding of how the physical, emotional and social aspects of human relationships and sexuality support a healthy, active lifestyle. Additionally, students learn medically accurate information about contraception, including abstinence and the skills needed to reduce or eliminate sexually transmitted diseases, HIV/AIDS and unintended pregnancies. The comprehensive health and physical education core standards have three strands: Relationship, Sexuality and Pregnancy/Parenting, each with a prescribed set of indicators, that build upon the knowledge and skills gained in preceding grades, beginning with Grades 7, 8, and culminating in Grade 12.

In 2008, Health and Senior Services Commissioner, Heather Howard convened a Prenatal Task Force. The Task Force's Final Report increased public awareness of the importance of preconception health, improved knowledge (by professionals and the community at large) of risks and behaviors that impact preconception health. The Task Force Report stressed the importance of entering planned pregnancy in optimal health and in obtaining proper first trimester prenatal care. Recommendations for policies to promote family planning as a priority are important not only because they reduce unintended pregnancies but also because they can improve the initiation of early prenatal care which promotes better health outcomes for both mother and babies throughout life.

AMCHP's CAREER CENTER

The Career Center is the premiere online job board for individuals seeking employment in Maternal and Child Health programs. Whether you are looking for an entry-level position or are a more seasoned professional looking for new opportunities, AMCHP's Career Center has great openings for great people! Searching our database is free and open to all job-seekers. AMCHP members receive a discount on job-postings — so [sign up](#) today!

Member to Member CONT.

What are you doing related to health promotion and prevention across the lifespan?

Rhode Island

RI's Preconception Health Efforts for Adolescents and Young Adults

Ana Novais, MA

Executive Director, Division of Community, Family Health & Equity, Rhode Island Department of Health



Rosemary Reilly-Chammat, Ed.D.

*Adolescent Health Manager
Perinatal and Early Childhood Team
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Rhode Island approaches preconception health within the context of prevention and social determinants of health. Rigorous laws and policies on tobacco use and nutrition have created a strong foundation for efforts to support preconception health among young people in schools and the community. Further environmental changes, such as safe walkways, promote physical activity. Injury prevention program supports school and community based initiatives on suicide prevention and teen dating violence. The Title X program includes the Women's Health Screening and Referral Program to identify at risk women including teens, who have a negative pregnancy test. When risks are identified, such as tobacco use, the woman is referred to tobacco cessation services.

Access to health care is another key area. Adolescent well child visits serve as an important indicator of care. In 2008, Rhode Island health plans reported an average of 60 percent of enrolled adolescents with well care visits. While this number meets the United States benchmark of 59.6 percent, improving access will serve to improve preconception health. To that end, Rhode Island's newest endeavor is the development of adolescent medical homes where a myriad of providers coordinate comprehensive

services and care for teens in their geographic area. If you are interested in more detail of any of these efforts, please contact [Ana Novais](#) or [Rosemary Reilly-Chammat](#).

Texas

Sam Cooper, MSW, LMSW

*Title V MCH Director
Texas Department of State Health Services*



The Texas Department of State Health Services (DSHS) is launching the Texas Healthy Adolescent Initiative (THAI) to improve the overall health and well-being of Texas adolescents, age 10 to 18 years. THAI provides funding for Local Community Leadership Groups (LCLG) to conduct a needs assessment and develop a strategic plan for their community to address adolescent health through a comprehensive youth development approach. To help ensure a comprehensive approach, LCLG members have a variety of expertise including adolescent health and mental health, school advisory councils, community resource coordinating groups, juvenile justice, faith-based services, sports and recreation and parents of adolescents.

THAI strives to incorporate evidence-based youth development principles throughout all levels of interaction with youth in each community. THAI grant recipients will incorporate strategies such as involving families, strengthening academic skills and opportunities for youth and family members and school-to-work programs. Strategies may also include mentoring programs, referrals to health and mental health services and activities that enhance self-esteem. By putting these strategies into place, local communities should improve protective factors such as future orientation and reduce risk taking behaviors among youth.

DSHS is also producing the "Get Fit Kit," a toolkit for school nurses to use with adolescents who are identified as overweight or obese through the state's physical assessment test. This toolkit was developed in response

Member to Member CONT.

What are you doing related to health promotion and prevention across the lifespan?

to school nurses that voiced the need for a resource tailored for them about nutrition and physical activity specifically for adolescents. The toolkit includes lessons for students on MyPyramid, portion control, physical activity and BMI, fast food and snacking, reading nutrition labels and diabetes. There is also an interactive GetFitKit.org [website](#) to complement the toolkit that provides access to the lesson information for both students and nurses. There are interactive games and quizzes, including a pretest and posttest to help evaluate whether students are learning key messages from the toolkit.

Wisconsin

Linda Hale, RN BSN EMT

Chief, Family Health Section

Bureau of Community Health Promotion

Division of Public Health

Wisconsin Department of Health Services

Wisconsin is working to bring a preconception health focus to many of our programs:

As part of the First Time Motherhood New Parents Initiative grant a social marketing campaign The Journey of a Lifetime was launched in October, targeting African American teens and young adults in the southeastern region of the state. This multi-media campaign consists of the key message – a lifetime of maternal health and stress control is the best recipe for a healthy baby. For more information, visit [here](#).

As part of a statewide MCH contract the Infant Death Center of WI has developed the Take Control brochures series. These multi racial and ethnic brochures include messages on taking control of your body, health, environment, habits, and mental health. The brochures are available [online](#) to all of our partners.

The Family Planning and Reproductive Health Program partnered with Prenatal Care Coordination to implement Women's Health Now and Beyond..Pregnancy. This initiative is targeting all women during pregnancy to introduce a post-partum contraceptive plan and intervention in the third trimester, and preconception messages on

women's health and a reproductive life plan during the third trimester and following delivery. To view some of the materials for this initiative, visit [here](#).

Preconception Health and Adolescents Action Learning Collaborative: Bridging Adolescent and Women's Health

AMCHP's Adolescent Health and Women's Health teams are working to bridge the gap in women's and adolescent preventive health efforts. The overall goal of this venture is to work with state maternal and child health (MCH) programs to build partnerships and create strategies that focus on wellness across the lifespan. AMCHP is working collaboratively with the Maternal and Child Health staff at the Association of State and Territorial Health Officials (ASTHO), to implement the first project in this effort - expanding preconception health efforts to include adolescents. AMCHP and ASTHO are working to implement an Action Learning Collaborative (ALC) with six state teams that were selected through a competitive application process: Missouri, Oregon, Ohio, Pennsylvania, South Carolina and Utah. The ALC teams for this project have been charged with creating strategies to implement Centers for Disease Control and Prevention (CDC) Recommendations to Improve Preconception Health and Health Care with adolescent populations. The teams were selected in October 2009 and have been preparing for an in-person meeting in November 2009.

The ALC Model brings multi-disciplinary teams together for an 18 to 24 month period during which they develop and implement action plans, share strategies and problem solve across communities around a particular issue. The teams are composed of state departments of health and education staff, members of community-based organizations, youth leaders, and other key stakeholders. The project will provide teams an opportunity to strengthen their partnerships, enhance their project plans, and move toward action. Through this project, states will develop innovative approaches for applying and incorporating the preconception health guidelines into current MCH programs, policies, practices, systems and culture, and will be able to share knowledge and lessons learned from their experiences with the larger MCH community.

Real Life Stories

Youth Involvement in AMCHP's Preconception Health and Adolescents Action Learning Collaborative: An Interview with Hillary Merick

Missouri was selected as one of six state teams to participate in AMCHP's Preconception Health and Adolescents Action Learning Collaborative. While the team is in the early planning stages, they have proposed to work with schools to incorporate preconception health strategies and messages into educational materials. Their target audience is youth ages 14 to 19. The team — comprised of state health and education agency staff and community stakeholders — invited Hillary Merick, a high school student from Zalma, Missouri, to participate on the team as a key stakeholder. Below is a brief interview with Ms. Merick.

Hillary, could you please tell me a little bit about yourself?

I am a senior at Zalma High School in Zalma, Missouri and am currently the class Valedictorian. During the week I focus on school work and all of the extra-curricular activities I am involved in. I am currently taking dual-credit classes so that when I graduate high school I will already have most of my core classes finished. For my extra curricular activities, I am the FCCLA (Family, Career, and Community Leaders of America) State 1st Vice President, and I am in Future Business Leaders of America (FBLA), Student Council, Senior Beta, and Choir, for all of which I am the President. I am also my Senior Class President and participate in Smokebusters and First Priority.

On weekends I like to just do the normal teenager stuff. I like to hang out with my friends and boyfriend and just kind of calm down from all the rush of the week. I'm very excited to graduate even though I haven't made up my mind completely on what I would like to do afterwards. The first idea is to attend St. Louis College of Pharmacy (if accepted) and go into Pharmacy. The second option is to major in Political Science and then go on to Law School. I would like to work as a lawyer for a few years and then possibly run for a public office sometime in the future since I love government. My

two paths are so completely different which is what makes it so difficult but hopefully I can figure out something soon.

How did you become part of the Missouri Preconception Health and Adolescents Action Learning Collaborative Team?

I was appointed to the Missouri Preconception Health and Adolescents Action Learning Collaborative Team by Christine Hollingsworth and Cynthia Arendt. They are both part of the Family and Consumer Sciences and Human Services Section (FACS) at the Department of Elementary and Secondary Education.

What is most exciting for you about the project?

The most exciting part for me about the project is getting to come up with a way to help teenagers. I believe a lot of the problem with the issue of sex is peer pressure and there really is no way to stop that completely but hopefully with this program we can find a way to show young people some consequences of their actions and help them to realize that you don't have to go with the crowd to be "cool." People will respect you more for doing your own thing than following others.

What is most exciting for you about participating on the team?

I think the most exciting thing about getting to participate on this team is getting to meet the rest of the members on the team and learning from them and their life experiences. They have already made a name for themselves, so to speak, and by working with them directly I feel that I can gain knowledge about not only this team, but the other organizations they are a part of as well.

What do you think could be the benefits of applying the idea of preconception health to education and health programs for young people?

I believe that by strengthening the curriculum in health classes in schools, especially child development classes, etc., we will be able to make sure that teenagers are actually

Real Life Stories CONT.

being educated on the topic. However, this is where the controversy arises. Some parents may not agree that a teacher should be teaching sex education to their children so we aren't sure how we are going to do this quite yet. We do want to make sure that the teachers are comfortable with the information themselves so they aren't embarrassed to teach it. The main concern though is the consent of the parents. We are also hoping to bring organizations into this. I am the FCCLA State 1st Vice President, and at our State Leadership Conference we always have many workshops for members to go to throughout the three days and we are hoping to focus a workshop around this. Right now we are working on a way to reword "Preconception Health" so that it sounds appealing to teenagers and to people in general.

Why do you think preconception health and sex education are important topics?

I have realized that most people my age don't think about the consequences before they act. I hear stories everyday about freshmen and sophomore girls having one night stands, with or without protection, with guys they don't really even know. All they can think about is how to become more popular or make guys notice them but what they are forgetting to think about are the life long consequences they could have to deal with because of these actions. I'm hoping that as a team we can develop a way to raise awareness of all these consequences to all teenagers--girls and boys--across the state.

Success Stories

Even before the Centers for Disease Control and Prevention released the Recommendations to Improve Preconception Health and Health Care in April of 2006, many state Title V programs were already implementing approaches designed to improve both women's health and pregnancy outcomes. Since then, most state Title V programs are looking at ways to incorporate preconception health into their programmatic activities. Below are some state success stories taken from the Title V Information System.

Florida

Every Woman Florida: A preconception health initiative that increases awareness on the importance of good preconception health. One of the goals of this initiative is to improve the integration of preconception health within all clinical settings. Another goal is to ensure the health of women of childbearing age. This initiative is a partnership of the Florida Department of Health and the Florida March of Dimes, in other partnerships with March of Dimes there has been a Folic Acid Campaign and the Florida Prematurity Work Group which also has focus areas that address preconception health. The Every Woman Florida website serves as a portal for preconception information for both providers and patients. The Every Women Florida Preconception Health Council is responsible for guiding the integration of preconception care in clinical and public health practice throughout Florida. You can access information and tools for the initiative [here](#).

Oklahoma

Preparing for a Lifetime, It's Everyone's Responsibility: Part of Oklahoma's Infant Mortality Campaign, the information covered by the campaign includes all the information a couple needs to know before and after they become pregnant. You can access the tools for the initiative [here](#).

Wyoming

Coming of the Blessing, a Pathway to a Healthy Pregnancy: An informational booklet specific to both major tribes represented in Wyoming, will continue to be distributed to American Indian clients. Culturally sensitive information includes the role of the father during pregnancy and postpartum, the importance of preconception health, nutrition (including folic acid use), risk of substance use and domestic violence to birth outcomes, preterm labor signs and symptoms, and importance of prenatal care.

View from Washington Health Reform Jumps Huge Hurdle in the House

By Brent Ewig, MHS
*Director of Public Policy &
Government Affairs, AMCHP*

Late in the evening of Saturday November 7, the U.S. House of Representatives narrowly passed H.R. 3962, the “Affordable Health Care for America Act.” Detailed summaries are available from Congress [here](#) and from the non-partisan Kaiser Family Foundation [here](#). And while these resources are comprehensive, I’m sure you are asking what specifically is in this bill for maternal and child health?

The short answer is - a lot. The bill takes a giant step forward in providing affordable coverage to an estimated 36 million currently uninsured people, including millions of children and women of childbearing age. It also takes steps to stabilize coverage for those currently insured by making several reforms to the insurance market.

The bill includes a package of insurance reforms that promote both continuity of coverage and affordability by ending increases in premiums or denials of care based on pre-existing conditions, race, or gender; eliminates co-pays for preventive care, caps out-of-pocket expenses, and guarantees catastrophic coverage that protects every American family from medical bankruptcy.

There are extensive additional reforms, and while the price tag is significant – slightly over \$1 trillion over ten years – the Congressional Budget Office has indicated that the bill is fully paid for and would result in a net reduction in federal budget deficits of \$104 billion over the 2010–2019 period.

The bill also is not perfect and certainly reflects the many trade-offs inherent in attracting the majority of votes needed for passage. Two of the biggest catches at this point center on the eventual costs to states due to the expansion of Medicaid eligibility to 150 percent of poverty. For the first two years the federal government will assume



full costs of this expansion for newly eligible populations, with a required match after that. The bill also requires Medicaid payment rates to increase to Medicare levels, with full federal financing for the first two years but 10 percent required state match after that. The future cost shift to states is an important factor that is being negotiated intensely and needs to be watched carefully.

Additionally, the bill proposes that most children currently eligible for CHIP would move into plans offered through the new exchange which could mean that after 2014 currently CHIP eligible children would likely have a slightly reduced benefits package and less cost-sharing protections than available under current CHIP programs.

Beyond these two sticking points, the bill includes several important and relatively non-controversial MCH-related provisions, including:

- Creation of a new Public Health Investment Fund that would generate close to \$10 billion per year in mandatory funding above current appropriations levels to support a range of public health programs. At full implementation, this includes \$1.6 billion annually for “Delivery of Community-Based Prevention and Wellness Services”; \$1.3 billion for “Core Public Health Infrastructure and Activities for State and Local Health Departments”; approximately \$1.1 billion for Health Workforce Training and Development; \$300 million for Prevention Research; \$4 billion to support community health centers; and \$350 million per year for “Core Public Health Infrastructure and Activities for CDC.”
- Creation of a new grant program to states for quality home visitation programs for families with young children and families expecting children, starting at \$50 million a year, growing to \$250 million in the fifth year. The bill also allows optional state Medicaid coverage for nurse home visiting services.
- Creation of a \$1.2 billion grant program to states

View from Washington CONT.

(over five years) to support expansion of medical homes.

- Finally, plans participating in the exchange must include standardized, comprehensive and quality health care benefits that include physician services, hospitalization, prescription drugs, rehabilitative services, mental health and substance use, preventive services recommended by U.S. Preventive Health Services Task Force, vaccines recommended by CDC, maternity benefits, well baby and well child care, and oral health, vision and hearing services for children under 21.

It is important to stress that while House passage clears a huge hurdle, the Senate still needs to release and pass their bill. Then a conference committee needs to take place to resolve the expected substantial differences between the passed House and expected Senate versions. So the process is still fluid, there is much hard work ahead, and final passage is not assured. Still, the House action is a major step forward on the road to reform, and AMCHP will continue to advocate for our priorities on your behalf.

Who's New

AMCHP Welcomes New Senior Program Manager for CYSHCN Treeby Brown



Treeby Brown is AMCHP's new Senior Program Manager for Children and Youth with Special Health Care Needs (CYSHCN). She will be primarily serving as the Project Manager for the autism and birth defects cooperative agreements. Treeby previously worked at AMCHP as a

Senior Policy Analyst from 1995-2001, and more recently has provided consultant services to AMCHP on a variety of projects, including Women's and Infant Health, Family Involvement and best practices for CYSHCN. Treeby also has extensive policy and legislative experience, including working as a legislative analyst for former North Carolina Governor, Jim Hunt. We are delighted to welcome Treeby back to AMCHP!

Get Involved

AMCHP Board Nominations Extended!

The AMCHP Board has extended nominations for all open Board positions through November 30 to encourage more members to nominate themselves or their AMCHP peers to serve on the Board. For more information, visit [here](#).

Register Now for AMCHP's Annual Conference!

Register today [online](#) to attend AMCHP's Annual Conference to convene on March 6-10, 2010, in Washington, DC. If you have any questions, please contact Registration Manager Lynn Parrazzo, lynnporrazzo@conferencemanagers.com or call AMCHP's Conference Department at (703) 964-1240.

Save the Date – Text4Baby Webinar

AMCHP will sponsor a webinar for Title V programs on Thursday, December 3 from 3 to 4:30 p.m. (EDT) to provide an overview of Text4Baby, a free mobile information service designed to promote healthy birth outcomes among underserved populations. Text4baby is made possible by a public-private partnership that is coordinated by the National Healthy Mothers Healthy Babies Coalition (HMHB), Johnson & Johnson, Voxiva,

Get Involved CONT.

the CTIA Wireless Foundation, the White House Office of Science and Technology Policy, and the U.S. Department of Health and Human Services. Please join AMCHP to learn about this exciting new program and the pilot implementation in the Virginia Title V program. Speakers will include: Judy Meehan, HMHB, Paul Meyer, Voxiva, Joan Corder-Mabe, Virginia Department of Health, and Sabrina Matoff-Stepp, HRSA. Call-in information will be disseminated in a separate email to Title V programs. If you have any questions about the webinar please contact [Lauren Raskin Ramos](#).

AMCHP Rolls Out the Innovation Station

Are you curious about how states are addressing the needs of Children and Youth with Special Health Care Needs? Do you want to know more about programs that tackle preconception health or infant mortality? Then visit the [Innovation Station](#), AMCHP's new searchable database for finding emerging, promising and best practices across the United States. You'll also find useful links to other best practice databases and resources to help you evaluate your public health programs. Check out [Innovation Station](#) to learn more about what's being done to improve the health of women, children and families!

If you are interested in contributed to this growing database, please [submit](#) your work to AMCHP's best practices program. Applications are accepted on a rolling basis, however, to be considered for the next round of reviews, please submit your application by Friday, December 4. If you have questions about the process, contact [Darlisha Williams](#) at (202) 266-3057.

Call for Applications

The Maternal and Child Public Health Leadership Training Program is now accepting applications for fall 2010 for the two-year, full-time in-residence Master of Public Health (MPH) degree pathway. This pathway provides training in program management, policy formulation, assessment, evaluation, and research focused maternal and child populations in the United States. In addition to academic training, students also complete a practicum and a thesis project. If you know of someone who has clinical or public health experience with underserved maternal and child populations and would like to assume new professional responsibilities in working with these populations, please forward this email on to them. The program is interdisciplinary: students apply either to the Department of Epidemiology or the Department of Health Services. The deadline for the Department of Epidemiology is December 1; and the deadline for the Department of Health Services is January 15. For information about the program, visit [here](#). For information about admissions, visit [here](#).

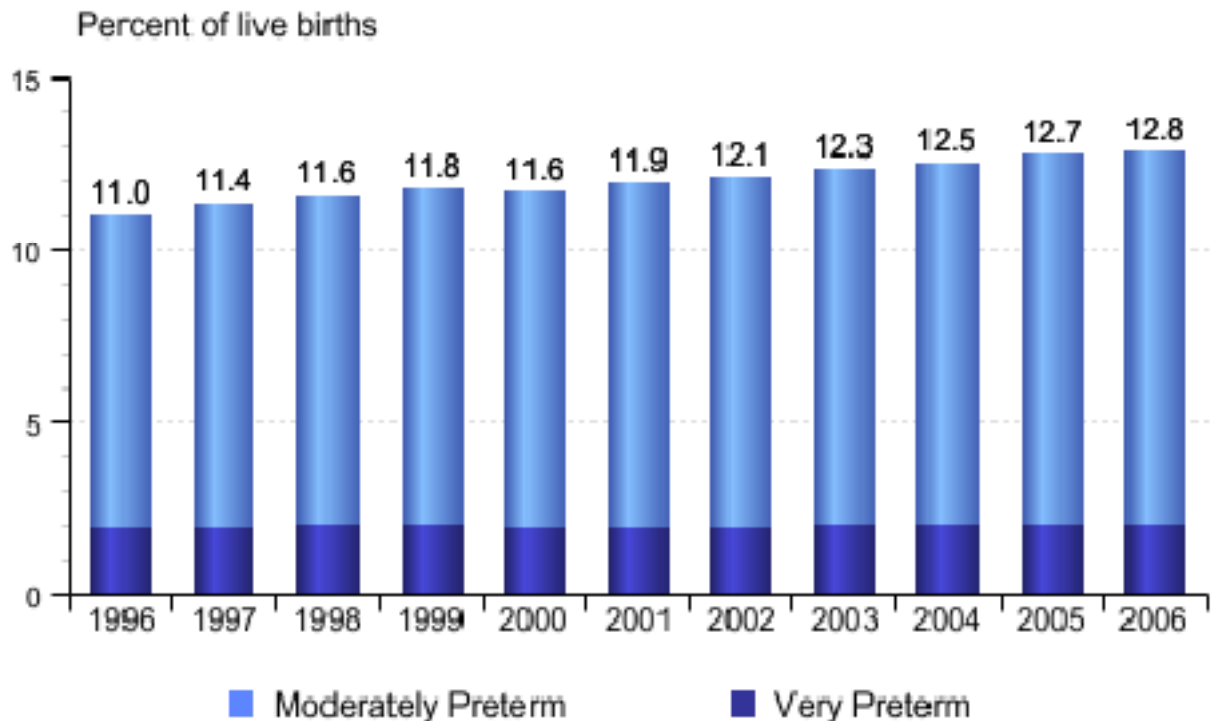
Call for Materials

The National Maternal and Child Oral Health Resource Center is looking for materials that highlight concepts of health literacy and oral health-related materials that integrate those concepts. Share your publications, such as brochures, fact sheets, curricula, policy statements, tool kits, manuals, and protocols, with OHRC for inclusion in their library. To submit materials in hard copy, send it to: Sarah Kolo, National Maternal and Child Oral Health Resource Center, Georgetown University, Box 571272 Washington, DC 20057-1272. Submit electronic materials via [e-mail](#). With either method, include citation information including the publication year, author(s), publisher name and place, and URL if appropriate. Also indicate whether hard copies are available, from whom and at what cost.

Data and Trends

Preterm births

US, 1996-2006



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Preterm is less than 37 completed weeks gestation. Very preterm is less than 32 completed weeks gestation. Moderately preterm is 32-36 completed weeks of gestation.

Source: National Center for Health Statistics, final natality data. Retrieved April 8, 2009, from www.nchs.gov/data/tables.

Resources

AMCHP Resource

[Using Data to Advance Preconception Health and Health Care: A Hawaii Case Study](#). This case study provides an overview of innovative approaches to preconception health and health care implemented by the Hawaii Maternal and Child Health (MCH) Branch of the Department of Health (DOH).

Preconception/Prenatal

[Contra Costa County- The Life Course Initiative](#). The Life Course Initiative, launched in 2005, is a 15-year Family, Maternal and Child Health (FMCH) Programs initiative based on the Life Course Perspective. The mission of the Life Course Initiative is to reduce disparities in birth outcomes and change the health of the next generation in Contra Costa County by achieving health equity, optimizing reproductive potential, and shifting the paradigm of the planning, delivery, and evaluation of maternal, child, and adolescent health services. Visit the Life Course Initiative's [website](#) for project fact sheets, bibliography, resources for professionals and families, and the recently released National MCH Life Course Meeting Report and Policy Brief.

[Preventing Prematurity and Adverse Birth Outcomes: What Employers Should Know](#). Prematurity and other adverse birth outcomes (such as low birth weight and birth defects) represent significant costs for employers, and these problems have become more common in recent years. This [issue brief](#) highlights the importance of preconception care and provides strategies employers can use to help employees get healthy before they even consider becoming pregnant.

[Women's Health USA 2009 Data Book](#). The eighth edition of the Women's Health USA data book is available now from the Health Resources and Services Administration (HRSA). Women's Health USA 2009 is a collection of current and historical data on some of the most pressing health challenges facing women, their families, and their communities. The book is intended to be a concise reference for policymakers and program managers at the federal, state and local levels to identify and clarify issues impacting the health of women. New topics in this edition

include data and information on women veterans, bleeding disorders, hearing problems, and severe headaches and migraines. A new section provides state-specific data on leading causes of death, overweight and obesity, and smoking among women.

Resources for Professionals

[Agency for Healthcare Research and Quality \(AHRQ\): Women's Health](#). Provides clinical information about [maternal health and pregnancy](#). Presents data from the [Healthcare Cost and Utilization Project \(HCUP\)](#), [National Guideline Clearinghouse](#), and [National Quality Measures Clearinghouse™ \(NQMC\)](#). AHRQ is the health services research arm of the [Department of Health and Human Services \(DHHS\)](#). Recent publications include:

- [Gestational diabetes: Caring for women during and after pregnancy](#). (2009). [Clinician's guide].
- [Primary care interventions to promote breastfeeding](#). (2008).
- [Screening for bacterial vaginosis in pregnancy](#). (2008).

[American College of Obstetricians and Gynecologists \(ACOG\)](#). Contains brochures, booklets, policy statements, and other materials about preconception and pregnancy for health professionals. Topics include health care for underserved women, perinatal HIV, smoking cessation, and women with disabilities. Also presents an [online directory](#) of physicians. Note: Many resources on the site are accessible to members only.

[Association of Women's Health, Obstetric, and Neonatal Nurses \(AWHONN\)](#). Offers clinical practice information and continuing-education resources about preconception, pregnancy, labor and delivery management, and postpartum care.

[Centers for Disease Control and Prevention \(CDC\)](#).

Contains information about preconception and pregnancy. Resources and initiatives include:

- [CDC's Division of Reproductive Health](#). Contains links to reports, data, and other resources about pregnancy and prenatal care, including maternal

Resources CONT.

morbidity and mortality; smoking; alcohol use; folic acid consumption; violence; workplace hazards; and racial and ethnic disparities. Recent resources include:

- [Safe motherhood: Promoting health for women before, during, and after pregnancy. At a glance.](#) (2008).
- [CDC's Morbidity & Mortality Weekly Reports \(MMWR\)](#). Presents data based on weekly reports to CDC by state health departments. Also offers online [continuing-education courses](#) for health professionals that coincide with several preconception and pregnancy-related guidelines published in MMWR. Recent reports about preconception and pregnancy include:
 - [Achievements in public health: Reduction in perinatal transmission of HIV infection -- United States, 1985-2005.](#) (2006).
 - [Monitoring progress toward achieving maternal and infant Healthy People 2010 objectives --19 states. Pregnancy Risk Assessment Monitoring System \(PRAMS\), 2000-2003.](#) (2006).
 - [Perinatal Group B Streptococcal Disease after universal screening recommendations --United States, 2003-2005.](#) (2007).
 - [Recommendations to improve preconception health and health care -- United States: A report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care.](#) (2006).
 - [Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings.](#) (2006).
 - [Surveillance of preconception health indicators among women delivering live-born infants -- Oklahoma, 2000-2003.](#) (2007).
- CDC's [National Center for Health Statistics \(NCHS\)](#). Provides data about preconception and pregnancy, including:
 - [Estimated pregnancy rates by outcome for the United States, 1990-2004.](#) (2008).
 - [Maternal mortality and related concepts.](#) (2007).
 - [Prenatal care: FASTATS A to Z.](#) (2007).
 - Also see NCHS's [Data2010](#), and Health [Data for All Ages](#).
- CDC's [National Center on Birth Defects and Developmental Disabilities \(NCBDDD\)](#). Offers scientific publications and tools, guidelines, educational materials, an [electronic discussion group](#), and information about research projects and public health campaigns to identify the causes of birth defects. Preconception and pregnancy-related topics include folic acid consumption, preventing alcohol-exposed pregnancies, medication use during pregnancy, and using family history information in obstetrics and pediatrics.
- Other resources and initiatives about preconception and pregnancy from CDC:
 - [Critical needs in caring for pregnant women during times of disaster for non-obstetric health care providers.](#) (2007).
 - [Guidelines for vaccinating pregnant women, rev. ed.](#) (2007).
 - [Guide to Community Preventive Services](#). Contains information about a systematic review of studies to develop recommendations for reducing the number of pregnancies affected by neural tube defects.
 - [One Test, Two Lives](#). Provides resources for health professionals and materials for their patients to help encourage universal voluntary prenatal testing for HIV.
 - Also see CDC's [Pregnancy Risk Assessment Monitoring System \(PRAMS\)](#), [Pregnancy Surveillance System \(PNSS\)](#), and [VitalStats](#).

Resources CONT.

[Centers for Medicare and Medicaid Services \(CMS\).](#)

Contains program information, eligibility criteria, publications, forms, and data about Medicaid, which offers coverage for eligible pregnant women. CMS administers Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP).

[CityMatCH.](#) Contains tools and resources for implementing the Perinatal Periods of Risk (PPOR) approach for mobilizing urban communities to reduce feto-infant mortality in U.S. cities. Also presents publications about perinatal HIV prevention in urban communities.

[Healthy People 2010.](#) Offers information about this national health-promotion and disease-prevention initiative. It is coordinated by the [Office of Disease Prevention and Health Promotion \(ODPHP\)](#). [Healthy People](#) contains 467 objectives, and 31 focus on pregnancy. To identify them, [search](#) the objectives by selecting pregnancy under Topic. Click on Submit. [Healthy People](#) provides background information on the initiative; the complete text, [Healthy People 2010: Understanding and improving health, 2nd ed.](#) (2000) and [Healthy People 2010 Midcourse Review](#) (2006); a list of the [Healthy People](#) partners and related sites; and other [Healthy People publications](#). Also see [Data2010](#) for data about the [Healthy People 2010](#) pregnancy objectives. See too the [HP2010 Information Access Project](#) for access to published literature related to the [Healthy People 2010](#) objectives about pregnancy and family planning.

[Kaiser Family Foundation \(KFF\): Women's Health Policy.](#)

Provides fact sheets, issue briefs, meeting materials, [data](#), and [news](#) for policymakers, journalists, advocates, and public health professionals about women's reproductive health and access to care, including pregnancy-related care. KFF is an independent philanthropy focusing on national health care issues.

[March of Dimes \(MOD\).](#) Offers [perinatal statistics](#), continuing-education modules, and medical reference information on topics that include preconception, pregnancy, prenatal screening, and genetics. Recent publications include:

- [Costs of maternity and infant care.](#) (2007).
- [Healthcare costs of having a baby.](#) (2007).

[Maternal and Child Health Bureau \(MCHB\).](#) Describes MCHB's projects and initiatives on behalf of America's women, infants, children, adolescents, and their families. Programs include the Title V block grant to states (see the [Title V Information System](#) for state and federal budget and expenditure data on prenatal care and information about states' efforts to improve pregnancy outcomes). MCHB has a [fact sheet](#) about prenatal care in English and Spanish that includes a hotline number to help pregnant women find prenatal care services in their communities. The [Maternal and Child Health Library](#) and the [Discretionary Grant Information System \(DGIS\)](#) offer additional information about the initiatives and programs supported by MCHB that pertain to prenatal care. MCHB is part of the [Health Resources and Services Administration \(HRSA\)](#).

[National Birth Defects Prevention Network \(NBDPN\).](#)

Presents a [collection of materials](#) to assist state program administrators and health professionals in promoting birth defects prevention. Each year, NBDPN selects a different theme to highlight, and the [2009 theme](#) is obesity prevention and weight management before, during, and after pregnancy. Preventing infections in pregnancy, preconceptional health, fetal alcohol spectrum disorders, cardiac defects, neural tube defects, and cleft lip and cleft palate are themes for earlier years for which there are materials.

[National Healthy Start Association \(NHSA\).](#)

Describes the Healthy Start program and provides general information about infant mortality, low-birthweight infants, and racial disparities in perinatal outcomes. Includes a directory of Healthy Start programs nationwide and a [newsletter](#). Funded by the [Maternal and Child Health Bureau \(MCHB\)](#), Healthy Start provides community-based, culturally competent, family-centered, comprehensive perinatal health services to women, infants, and their families in communities with very high rates of infant mortality.

[National Institute of Child Health and Human Development \(NICHD\): Women's Health Research.](#)

Contains research and grant information, publications, and other resources on topics that include preconception and prenatal care, miscarriage and stillbirth, preterm labor and premature birth, disorders of pregnancy, drug safety in pregnant

Resources CONT.

women, and reproductive health among women with physical disabilities. NICHD is part of the [National Institutes of Health \(NIH\)](#).

[National Perinatal Association \(NPA\)](#). Offers a collection of position papers about access to perinatal care, breastfeeding, domestic violence, medical liability reform, substance abuse in pregnancy, and transcultural perinatal care. Also offers information about NPA's resource guide and training program about transcultural perinatal care.

[National Sudden and Unexpected Infant/Child Death and Pregnancy Loss Resource Center](#). Includes resources about stillbirth and miscarriage for health professionals, policymakers, and families. The resource center and the [Maternal and Child Health \(MCH\) Library](#) are co-located at Georgetown University's National Center for Education in Maternal and Child Health and are supported with funding from the Maternal and Child Health Bureau (MCHB).

[UNC Center for Maternal and Infant Health](#). Presents preconception and pregnancy research and program information, algorithms for the management of high-risk pregnancies, a family history questionnaire, and information about cystic fibrosis, maternal age and pregnancy, prenatal screening, and prenatal diagnosis. Offers patient-education fact sheets in English and Spanish on pregnancy topics, genetics, and serious pregnancy and fetal conditions. The Center is part of the University of North Carolina at Chapel Hill School of Medicine.

[World Health Organization \(WHO\): Partnership for Maternal, Newborn and Child Health](#). Offers program information and resources in English and five other languages about pregnancy, childbirth, maternal mortality, and infant and child mortality worldwide. Fact sheets, press materials, an advocacy kit, presentations, and reports are among the resources presented.

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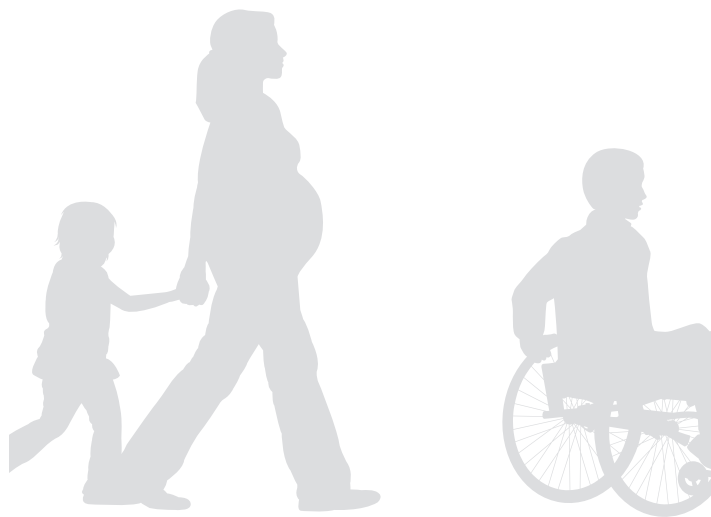
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