The Kentucky Folic Acid Partnership Meeting Minutes-**REVISED**
For: September 28, 2006, State Lab Building, Frankfort, KY

**Members Present:** Dr. Ruth Ann Shepherd, Susan Brown, Diane Sprowl, Shari Stewart, Katrina Thompson, Christie Penn, Leigh Lindsey, Deanna Hanson, Mary Sue Flora, Linda Litzinger, Elizabeth Bowling, Susan Borders, Jeanie Neikirk, Roxanne True, Hartley Feld, Linda Lancaster, Dr. Sarojini Kanotra, Tina Hembree, Sally Brunner, Jennifer Alvis, Lorry Marvin, Carolyn Robbins, Cathy Winston, and Katherine (Kathy) Chase. **Members who contacted me that they were unable to attend:** Laura Carroll, Stacy Wyatt, Emma Walters, Jill Ford, Linda Dunsmor, Kristin Augustine (on honeymoon), Dr. Robert Kuhn, and Pat Dintaman.

## Welcome and Call to order

Susan Brown, Statewide Folic Acid Campaign Coordinator called the meeting to order as members took turns introducing themselves.

## Minutes Approved

A motion was made and seconded for the approval of the REVISED- version of the minutes that reflect changes made to the section on lead from the May meeting.

## Committee Reports

1. **Community Chair-**Diane Sprowl reports that one goal the community committee had after the May meeting was to find an additional pharmacist willing to serve, since Dr. Robert Kuhn, has been inactive in recent months, due to past health problems and other issues. Kathy Chase has been recruited (Kathy and Shari Stewart entered the meeting as this was being said) and she is attending her first KFAP meeting today. (We allowed a few minutes for Shari and Kathy to also share where they were from and their work roles). Diane shared that her committee would be meeting immediately following this meeting at O'Charley's to work on the 2007 KFAP Community Committee work plans. Community, through Diane, has also been involved with the prematurity toolkit committee. She reminded the group how important the activity reporting forms are to Susan to key into the database in order to provide the monthly reports and bullets. Those members who work in a health department, and who work in community and who already report activities on a CHS report form, have the option of using activity report form #2 (a shorter form) that Susan can use for the narrative on your activity that would show up in the monthly bullets. If you don't work in public health, you would always use activity form #1. Health department staff can also

use form #1 whenever they are reporting an activity that has not been reported to the CHS system. The forms are all available on our website at www.kfap.org under "Member Resources" and they can be completed and saved (re-naming the file so you always have a saved blank version available on your computer) and then email the form as an attachment to Susan who will key your data into the system. She reminded the group that many people, to help evaluate what progress is being made across the state, use the reports. The bullets or narrative are especially helpful to read and see what other partners are doing and what works in their community to enable others to try that or something similar in their community. The only way your activity can appear in narrative form is if you've completed an activity form and sent it to Susan. And Susan reassured the group that there is no "double counting" occurring. If you reported your numbers through a CHS form, they are not re-counted with the activity form. There's a button I have to hit "yes or no" when I key, that asks whether or not this activity has already been reported in the CHS report, and it will not allow me to continue without answering that question. The form allows you to report in 4 different categories: folic acid, prematurity, folic acid and prematurity done simultaneously or "other." "Other" is any other perinatal health issue that is not one of the other three groups. The bullets are extremely helpful when it comes to "end of year" reporting to evaluate whether we have met our KFAP goals for the year. Diane also encouraged members to send digital pictures of activities they do, to place on our website. Send to DianeJ.Sprowl@ky.gov

2. **Media Chair-**Shari Stewart encouraged members to consider joining her committee and she received several new members today who include: Carolyn Robbins, Dr. Sarojini Kanotra, Jennifer Alvey, and Lorry Marvin. Shari assured members that joining the media committee did not mean you would become the persons responsible to do all PR for the KFAP. It does mean that you help develop and disseminate useful information to members that helps them to manage a media campaign in their local communities.
3. **Professional Chair-**Katrina Thompson reports that the professional committee is in good shape for the 2006 plan, with the exception of linking to the KFAP website. We need at least 5 more agencies to agree to link the www.kfap.org website from your agency's website to meet our goal, and we can also add your agency as a link on the KFAP website, if desired. If interested, please email webmaster DianeJSprowl@ky.gov with those links, and remember to cc a copy to Katrina kthompson@marchofdimes.com so she can keep track of the numbers for her committee's evaluation report. "We'll be working on our 2007 plans after this meeting, and we have many new and exciting things planned for the spring, so this is an exciting time to come and join the professional committee, as well!"

**Chairman's report-**Dr. Ruth Ann Shepherd

**Naming the grant project:** Dr. Shepherd distributed a list with 18 suggestions of possible names for the new prematurity project, being provided through a $1.5 million dollar grant from the National March of Dimes and Johnson & Johnson Company awarded to the Kentucky Department for Public Health, for members to select their top three choices for us to vote on. The group selected a combination of two names: In Due Time…The KY Preterm Birth Prevention Project, as the winner.

Dr. Shepherd seemed pleased with the choice because she feels strongly that the words she's most interested in getting out to the public are the words that show a connection between preterm birth and prevention. Just as March of Dimes is associated with saving babies, she'd like this campaign to be associated with the fact that preterm birth can be prevented. Of course, there are always going to be some preterm births that cannot be prevented, but there are many things that can be done to prevent many of them from occurring and those are the ones we need to focus on. Folic Acid is no different. While taking folic acid correctly prior to pregnancy can reduce the risk of NTDs by 70% it still doesn't prevent all of them. Does that mean we shouldn't tell people about folic acid? Absolutely not! **Brainstorming session:** When asked by Dr. Shepherd to come up with ideas or ways to get communities involved to participate in a prematurity campaign, she asked us to include ideas of some type of visible symbol that would designate someone as being a community partner in the project. (She gave examples that were used during the folic acid campaign like the ribbons, mouse pads, and certificates community partners received for participating in the FA campaign). She asked us to explore how we can help promote our message to the public, and how we can get the community onboard with our project? Suggestions were given and written on the chalkboard. It was noted that while ribbons work well for women—most men aren't going to wear them. Some ideas for items that men would use/wear included: bumper stickers, car magnets, baseball caps, wristbands, flashlights, key chains, and sunglasses. Logos for those items included the following suggestions: Worth the wait/weight! Deanna Hanson pictures a bassinet with a clock inside to represent that message. Or possibly a bassinet with the words 9-months or 40 weeks inside would also be effective. We really liked the play on words that "Worth the wait/weight" presents. I want my 40 weeks! was also suggested. An idea for the sunglasses is: "See a bright future!" Someone mentioned using labels with the desired logo printed to place on a wide variety of items. Cell phone jewelry with a message was a suggestion that may appeal to women. [We have very creative partners!!!! A special thanks goes to Deanna Hanson who was especially inspired during the brainstorming session—it turns out that in addition to her WKU Professor of Nursing credentials, she has a public relations degree, as well!]. The group also discussed several misconceptions the public may or may not have with the 9 months slogan. Many worry that the public sees 9 months as 36 weeks, but others feel the public thinks of 9 months as it is intended to be: 9 calendar months versus the 10 lunar months it actually takes to have a baby, (40 weeks with each month being 4 equal weeks=10 months). Others believe that women who are pregnant now or who have been pregnant recently are fully aware of the amount of "weeks needed" to count down to the due date. Mention was made how the number 9 when used as a pin (as with the ribbons we discussed) can easily turn down and become a 6, confusing the public even more. Dr. Shepherd also commented that in our education we plan to explain that preterm birth is when a baby comes before the 37$^{th}$ week, and then we're planning to turn around and use a slogan that states, "I want my nine months." Wouldn't, "I want my 40 weeks" be more explicit? As part of this project, we can come up with our own logo, if we want to. Mention of using labels was made suggesting possibly putting a PTB message on birth control pills or some other form of preconceptual educational materials. The

room had a good laugh over that one. Dr. Shepherd thanked the group and said that this session had been quite helpful.

**Dr. Shepherd's Conference Highlights:** Dr. Shepherd shared some information about the recent "Why Do Our Babies Die?" joint conference she attended in Tennessee a couple of weeks ago that was co-sponsored by the Meharry Medical School (which was for a long time the only African American medical school that is now integrated but remains predominantly African American) and Vanderbilt University's Medical School. "Why do our babies die?" They die because of prematurity, since prematurity is the number one killer of newborns.

"There was a very interesting talk about folic acid, and since you all (KFAP members) are the experts on folic acid, I decided to share some of that, with all of you, today." She drew a chemistry structure on the chalkboard that shows how folic acid changes homocysteine into methionine, and methionine is responsible for cell division and growth. (The chemistry lesson shared: Folic acid enters the body and becomes 5-methyl tetrahydrofolate. If sufficient levels of folic acid are present, enzymatic reactions occur (B12 is required for this conversion) changing the 5-methyl THFA into THFA (tetrahydrofolate). And it is in this form (tetrahydrofolate) that homocysteine changes into methionine. But if we have insufficient levels of folic acid (folic acid deficiency) then the opposite occurs and the homocysteine levels build up, as the folic acid becomes trapped as 5-methyl tetrahydrofolate).

**Additional info FYI:** [**In a Medline article**, Folic Acid Deficiency author Dr. Angela Gentili writes that THFA is the biologically active form of folic acid and that it plays a key role in the transfer of 1-carbon units (such as methyl, methylene, and formyl groups) to the essential substrates involved in the synthesis of DNA, RNA and proteins. More specifically, THFA is involved with the enzymatic reactions necessary to the synthesis of purine, thymidine, and amino acid. Manifestations of folic acid deficiency, understandably, would involve impairment of cell division, accumulation of possibly toxic metabolites such as homocysteine, and impairment of methylation reactions involved in the regulation of gene expression, thus increasing neoplastic risks. She writes that a healthy individual has about 500-20,000 mcg of folate in body stores. Humans need to absorb approximately 50-100 mcg of folate per day in order to replenish the daily degradation and loss through urine and bile. Otherwise, S & S of deficiency can manifest after 4 months. **Frequency in the US:** The current standard of practice is that serum folate levels less than 3 ng/mL and a red blood cell (RBC) folate level less than 140 ng/mL puts an individual at high risk of folate deficiency. The RBC folate level generally indicates folate stored in the body, whereas the serum folate level tends to reflect acute changes in folate intake. Data from the National Health and Nutrition Examination Survey 1999-2000 (Pfeiffer, 2005) indicate the prevalence of low serum folate concentrations (<6.8 nmol/L) decreased from 16% before folic acid fortification to 0.5% after folic acid fortification. In elderly persons, the prevalence of high serum folate concentrations (>45.3 nmol/L) increased from 7% before fortification to 38% after fortification. **Internationally:** Countries that don't have a mandatory folic acid food fortification program have higher rates of folic acid deficiency.

Although the prevalence of folic acid deficiency has decreased in the US since introduction of a mandatory folic acid food fortification program in November 1998, people with excessive alcohol intake and malnutrition are still at high risk of folic acid deficiency. The significance of folic acid deficiency is further compounded by:

- An association of folate deficiency with elevated homocysteine levels, leading to increased arteriosclerosis risks
- The reduced incidence of neural tube defects with folate supplementation
- The role of folate in the occurrence of cancer

Hence, folic acid clearly is of consequence in public health in the United States, especially because heart disease and cancer constitute the number 1 and number 2 causes of mortality in the United States.]

**Dr. Shepherd** mentioned that methionine is important for cell division and cell growth. Folic acid deficiency equals slow cell growth for the fetus, and thus a delayed closure of the spinal cord and the development of NTDs. But, we should keep in mind that in fetal development, there are lots of things that start as tubes and then develop into structures, so we now have an association between folic acid deficiency and other defects. Heart defects would be an example of one of those. Therefore, anything that involves cell growth and closure is at risk, and the research is showing that more and more things are related to folic acid deficiency. What could be more affected by cell growth and cell division than DNA and RNA? A big part of that is chromosomes. We've recently found that mothers of babies with Downs' syndrome are more commonly deficient in folic acid than other mothers. We now know that folic acid is important in more than just NTDs, and that it is also related to anything that involves cell growth or cell division. She referred us to the handout (from the conference in Tennessee) showing a comparison between a normal heart and a hypoplastic heart (page 6), and you can clearly see that the cells of the hypoplastic heart didn't grow as well. Sufficient folic acid also decreases the risk of oro-facial clefts by 25-50% (page 4). On page 8 there's a slide that compares folic acid and heart disease:

Every 5 micro-mol increase in homocysteine increases the risk of CAD (coronary artery disease):

- By 60% in men
- By 80% in women

And folic acid deficiency may also play a role in mothers affected with peripheral vascular disease. The effects of this to the baby could result in intrapartum hypoxic ischemic injury which leads to HIE (hypoxic-ischemic encephalopathy) which leads to CP (cerebral palsy). Infant must have HIE to have CP. (page 13).
Also on page 13: Neonatal Encephalopathy results from:

- Perinatal stroke
- Infection
- Cerebral malformation
- Genetic disorders
- Hypoxic/ischemiac*
  *Leads to Hypoxic/Ischemic

Encephalopathy or HIE

Most HIE isn't from hypoxia, but is more commonly from perinatal stroke.

Perinatal stroke:
Arterial ischemic stroke is identified in first month of life in 1:4,000 term infants

- Inherited or acquired thrombophilias (in fetus or mother)
- Placental infarcts (spiral artery thrombosis) (May affect maternal or fetal side)
- Infection

Pregnancy Complications and Homocysteine: (page 17)
Increased Homocysteinemia Associated With:

- Recurrent miscarriage
- Pre-eclampsia
- Abruption

Increased Homocysteine and Placental Infarcts (page 14)
Van der Molen et al, 2000:
Tested women with placental infarction or abruption
(vasculopathy) + stillbirth or IUGR (intrauterine growth retardation)

| | Cases (n=101) | Controls (n=92) |
|---|---|---|
| MTHFR C --> T | 13% | 4.4% |

Pregnancy Complications and Homocysteine (page 17)
Women with Preeclampsia have higher homocysteine levels than women with normal BP; and women with normal BP have lower homocysteine levels.

Dekker et al, 1995 (AJOG 173:1042)
Rajkovic et al, 1997 (Obstet Gynecol 90:168)
Leeda et al, 1998 (AJOG 179:135)
Powers et al, 1998 (AJOG 179:1605)

This needs to be studied with MTFHR

Folic Acid reduces risk of:

- First incidence birth defects
- Recurrent birth defects
- Vascular disease

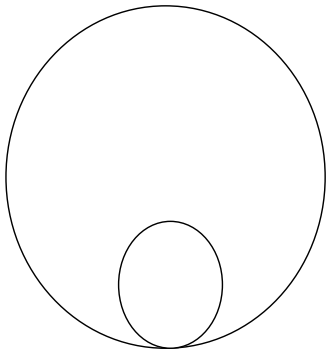
Folic Acid *may* influence: (page 17 final slide)

- Placental Vasculopathy
- Abruption, IUGR, IUFD, PreE
- Cerebral Palsy??

IUGR: intrauterine growth retardation
IUFD: intrauterine fetal demise
PreE: preeclampsia

Dr. Shepherd commented how important preconceptual health is to helping to prevent problems during pregnancy. Educating women to become as healthy as possible by developing healthier habits, and staying healthy (harder to address) and seeking medical care prior to trying to become pregnant.

Once again, Dr. Shepherd drew on the chalkboard. This time she drew a large round circle and placed another smaller circle in the bottom center of the circle.



One of the talks on infant mortality during the conference in Tennessee was about "How do we make things better?" This drawing was from a talk of a speaker from Washington State where they've done a lot of work trying to get case management and domestic violence issues addressed, along with transportation issues and daycare to assist mothers in getting to their appointments. With these interventions they've actually seen a decrease in infant mortality. These two circles are an explanation of what works. She then asked the group, "Which one of these circles do you think is the medical care?" Most answered correctly that the smaller circle represents the medical care. The larger circle represents everything else: Case management or care coordination, all the screenings, nutrition—everything else in a woman's life that isn't her medical care. And all those things in the larger circle are the most important things to a woman. In this country, we're not likely to change our medical care system, but we can change all those other things in the big circle. You and I can change it, and we can change the community so that more people know that it's this stuff that's important (big circle). And then when those kind of changes happen, if somebody in the community has poor nutrition, people will learn to say, "Hey, go down to the health department and have somebody tell you how to eat, or go to a certain website and learn what to do." The point is that we can all make a difference in the big picture.

**Dr. Shepherd's Update on the March of Dimes & Johnson & Johnson grant:** The National March of Dimes has been focused on prematurity for about two years now, as has this group (KFAP). Kentucky was picked, based in part, on this group. They are so very impressed that we have a group like this, one that goes out into the communities and actually does this kind of work—bringing awareness of perinatal health issues to the public. Even still, whenever I bring it up, they can't seem to get over how impressive that is. And it should be. Presently, the grant hasn't been publicly announced so you won't

read about it in the newspapers and such until November, when Dr. Jennifer House comes to KY from the National March of Dimes to deliver that announcement. Currently we're busy with the planning stages of the grant. We have to choose 3 different hospitals that we want to use as intervention hospitals, and we need one in the east, one in the west, and one in the middle. We have tentative approval from them as being committed to the project, and they include: Ashland's King's Daughters Hospital in the east, Trover Clinic in the west, and UK Hospital in the middle. What we plan to do at these intervention hospitals is to provide everything we possibly can to help them to make an impact on preventing preterm birth using the three pieces we've targeted for the grant. The first one is the professional education piece. We're going to go after the doctors and tell them what all the latest and greatest pediatric research on prematurity is. We'll review all the ACOG guidelines and be certain that they're aware of all the things that are supposed to be done but often don't get done (from the doctor's perspective) like smoking cessation, and screening for domestic violence, screening for possible mental health issues and making sure nutrition needs are assessed. The second piece is patient education. All of those things that the doctors need to address can also be stressed in different settings. The Trover clinic, for example has a program called centering during pregnancy, where the prenatal appointment and patient education all occur in a peer group setting. All those issues we mentioned are addressed during centering. Other places will be doing more standard prenatal visits and offering more standard prenatal classes to address all of those issues we mentioned. In addition, all the places that have the HANDS program will also see that all that information gets out into the home for those at high risk. And finally, the other people we think can assist with patient education are the case management people who can handle phone calls, and send out mailings of information addressing those same issues. The third piece is community awareness. And just as we did with folic acid, we want to go out into the communities and say, "We're trying to prevent preterm birth and this is why. Preterm birth kills babies. It's the leading cause of babies dying." So that's what the project is all about and that's what the toolkit is based on. And Shari's (Shari Stewart-Media Chair) got a lot of information that she's worked on about how we can reach the media to get our message out to the radio and TV stations in our local communities. And with this project, we're going to trial the toolkit in the three intervention areas first, and we'll be doing all the things we did with the folic acid campaign like going to the grocery stores, and hair salons, and health clubs, and women's clubs and rotary clubs, church groups and health fairs to educate the public with educational materials and presentations about preventing preterm birth—because preterm birth is the number one killer of newborns.

**Another story from the Tennessee conference:** One of the speakers told a story about a carpenter whose shop was very close to the river. And one morning as he was working he looked out and saw what appeared to be a baby drowning. He jumped into the river and he saved the baby. As he got the baby to the shore, he turned around and noticed that there were other babies in the river. He quickly went back into the river and began rescuing as many babies as he could, but it seemed as though the more babies he saved the more babies there were to be saved. He pulled babies out of the river all morning long before exhaustion finally overtook him. Sadly, he left the river and sat down on the riverbed. A thought quickly came over him, and he realized that to resolve this problem

he needed to go and quickly find out what was causing all these babies to end up in the water in the first place, and to do that he needed to find out what was going on up-stream.

Dr. Shepherd reminded us that this is exactly what we need to be doing. We need to know exactly what it is that's going on in our state that causes our babies to be born prematurely.

**Open Discussion:** Roxanne True mentioned a co-worker whose wife gave birth one month early to a baby that weighed 7-8 or 7-9 and was discharged home with the mother. Her question is whether or not this baby is considered preterm? Susan Brown responded with the fact that prematurity is not based on birth weight but rather on gestational age assessments at birth. And Dr. Shepherd added that this baby sounded exactly like the late PT babies that we're most concerned about. Those babies that are 34-36 weeks gestation and because they're larger babies—they're treated as if they're full-term, when in fact they are not. These are the babies that may be sent home only to be re-admitted back into the hospital a week or so later with temperature problems or jaundice. These late PT babies are re-admitted into NICUs six times more often than full-term babies are. They are at a higher risk for SIDS and have more complications immediately as newborns than do full-term babies. These risks go up again when these babies are school age. These babies are more costly than the micro-preemies, because there are more of them. It's a huge problem. Roxanne shared that the OB and pediatrician seemed to "gloss" over it in her co-workers' case. Dr. Shepherd mentioned the March of Dimes' website, as well as AWOHN's website to become better informed on these issues and their seriousness, and added that the physicians seem to "gloss" over it because the mortality rates are better with these bigger preemies. We used to really worry about preemie because we knew that they were going to die. But now that we have advanced NICUs the mortality rates are not extremely high, in fact about 95+% of almost any gestational age survive. So many feel that it's ok, but there are other morbidities that are still a concern. Shari Stewart mentioned that she felt we needed to include pictures in our prematurity toolkits of these late PT babies, and explain what the problems are for these "healthy looking" babies. Especially since it's the micro-preemies that usually come to mind when the public thinks of prematurity. Katrina Thompson added that another part in all of this is the fact that we don't really ever know exactly when a baby's due date really is. It's possible that the due date shows a baby to be 38-39 weeks and a cesarean section is scheduled based on that date, but when the baby comes out it could be 2-3 weeks earlier than that. Dr. Shepherd agreed and stated that even early ultrasounds can be 1-2 weeks off, and later ultrasounds can be 2-3 weeks off. Dr. Sarojini Kanotra asked, "How do we prevent this?" Dr. Shepherd replied that we must keep doing consistently what we know can work. And for this group it means going out into the community and providing factual information about preterm birth. We aren't necessarily doing anything different, but we plan to be consistent. Look at the evidence based references we have at our fingertips. Just because we have ACOG guidelines doesn't mean that everyone is practicing them consistently. Like smoking cessation. Everybody knows that the 5 A's work, are the 5 A's being consistently done anywhere? No. So it's not *what* we need to do, we have evidence-based references out there, they're just not being used consistently.

**Old Business:**

1. Committee Chairs must have their Committee's 2006 Plan evaluated and turned into Susan by January 10, 2007. These will be posted on the website by January 21, 2007. All members are responsible to have a copy with them at the next KFAP meeting on the 4th Thursday in January 2007.
2. All Committee Chairs' 2007 Plans are due to Susan by November 16, 2006 and these shall be posted on the website no later than November 30, 2006. All 2007 plans begin with December 2006 in preparation for the January Birth Defects Prevention Month activities.

**New Business:**

3. PPP March of Dimes and Johnson & Johnson Grant (already discussed above)
4. Prematurity Summit November 30, 2006-Registration forms were distributed to members present. Slots are filling quickly and the cut off is 200 participants
5. National Prematurity Month is in November
6. Prematurity Toolkit: Members meet again on October 30, 2006. Assignments are due November 20th. Linda Lancaster distributed the KFAP Toolkit Table of Contents Draft:

**KFAP TOOLKIT DRAFT**

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i Table of Contents

ii Acknowledgements

I. Guide for the Community Action Leader
   a. The role of the community action leader
   b. The message we want to give:
   c. Tips for success

II. Activities to do in your community-each activity includes:
   Advance preparation tips
   Flip chart of PPP (based on 9-months)
   Reference sheet/Talking points for presenter
   Handouts for specific groups
   List of additional resources
   a. Presentations to general groups (church groups, homemakers, women's clubs, PTA's school classes, 4-H groups)
   b. Presentations to Women of Childbearing Age (sororities, Mothers' Day Out, daycare staff, some women's clubs)
   c. Presentations to business groups (civic organizations, "education in a box" for businesses, chamber of commerce)
   d. How to set up an exhibit (health fairs, etc.)
   e. Distribution of materials
   f. How to approach the media
   g. How to have 1:1 discussions with friends, relatives, neighbors, etc.

III. Talking points

a. Five topics pregnant women should know
b. General preterm birth
c. Late preterm birth
d. Costs of prematurity
e. Short and long-term effects of preterm birth
f. C/S the risks and effects

IV. Personal stories for each audience
V. PowerPoint/Flip chart (based on I want my 9-months)
VI. Other references/resources
VII. "Train the trainer" presentations for a speaker's bureau for professional audiences who encounter families with preemies such as: Dept for Social Services, Insurance Companies, Public Health Agencies/staff, WIC, Substance Abuse professional, Dental hygienists, dentists, physicians' office staff, hospital and ER nurses

Linda asked for any input from the partners as to whether they see any gaps we might have missed and to offer any suggestions for improvement. She explained that the toolkit would enable a layperson to be fully prepared to deliver any activity desired within the kit. This hasn't been an easy task and we've had to start from scratch since there is no other prematurity toolkit available.

Dr Kanotra shared that she had attended a conference in Chicago and that she was certain they had developed a toolkit. This was a huge shock to the toolkit committee, since no amount of web searching had provided any reference to its' existence. Dr. Kanotra will send a copy of this to both Linda Lancaster and Susan Brown. She added that Florida has begun to provide preconceptual health into its' beauty school curriculums.

Shari Stewart commented that the media committee would certainly like to help reach these types of groups and the beauty and nails would certainly draw the younger age group in, that we need to reach. Also getting women's sports teams/coaches involved might be a good audience.

**Addendum to the minutes:** I have received the materials from Dr. Sarojini Kanotra from the "Closing the Gap" conference she attended in Chicago. I will attach them to the minutes for each of you to read for yourself. This was the note Sarojini sent with her email:

Enclosed is the PowerPoint Presentation of Angela Ellison, the Project Director for the program Closing the Gap, and a fact sheet for the program that has contact information.

The peer education curriculum has been developed by March of Dimes and SIDS of Illinois. I do not have the curriculum electronically to send, but the Healthy Start project manager Ryan Irvine is trying to get the hard copy version from Angela Ellison. As soon as we receive that we will mail it to you. I hope that this is helpful. Sarojini

Linda added that she has connections with a Lexington Hispanic group that meets monthly. Others mentioned various other organizations that have mentoring programs like the Girl Scouts and Boys Scouts, and a Lexington group called Girl's Rock that focuses on being healthy and taking care of yourself. It was also mentioned that several sororities and boys and girls' clubs also do mentoring.

**Ideas for Activities during November:** With November being Prematurity Month, Susan distributed two samples that were developed for the March of Dimes' Barren River PSC local Division meeting. The first is to use as a ribbon campaign. You'll need to make the ribbons by purchasing pink and blue ribbon from the dry goods section of your local Wal-Mart or K-Mart stores (or fabric shops for those who live in areas that have them). The blue and pink ribbons are curled together as one and secured with a small safety pin onto the following message:

**National Prematurity Awareness Month**

Wear this pink and blue ribbon during November to show your support for prematurity.

**Every day 1 in 8 babies born in the US arrive too soon. Preterm birth can happen to any pregnant woman, and no one knows why. It's a serious, common and costly problem. BUT YOU CAN HELP PREVENT PRETERM BIRTH!**

March of Dimes
Saving babies, together

**For more information:**
www.MarchofDimes.com/Kentucky
www.WalkAmerica.org
1-800-255-5857

The other sample is a message to be placed into a baggie of lifesavers, and also includes a bookmark "Fighting Premature Birth." The message to include reads:

Thank you for being a "Life Saver" For Babies

March of Dimes
Saving babies, together

www.MarchofDimes.com/Kentucky

Susan asked Dr. Shepherd to comment on the differences between negative and positive messages about preterm birth that we wish to send. She acknowledged that the March of Dimes uses the message that prematurity is a serious, common and costly problem. But the message she prefers to send is a more positive one that states that preterm birth can be prevented, and that by preventing preterm birth we can save babies' lives and make a

better future for our communities and our families. Christie Penn mentioned that it seems terminology is an issue, and gave the various examples that are used interchangeably: prematurity, premature, and preterm birth. Dr. Shepherd agreed that we should all use the same guidelines and that means that preterm birth is any birth that occurs prior to 37 weeks. Late PT births are those births occurring between 34 0/7 weeks through 36 6/7 weeks. Also be certain to use the terminology "late-preterm" NOT "near-term." Near-term adds to the confusion, "that everything is all right." We also need to educate that "PRETERM BIRTH can be stopped" rather than "PREMATURITY can be stopped." We're always going to have some premature babies, just as folic acid helps to decrease the risk of NTDs by 70%, but it cannot totally prevent all NTDs. Does that mean we shouldn't try to stop those 70%? Absolutely not! Our job is to change the attitude of the public that preterm birth is a problem. We do this with education. We teach them that 38-42 weeks is full-term; and that any birth prior to 37 weeks gestation is considered a preterm birth. Leigh Lindsey mentioned perhaps including a way to show the differences between life with a preterm versus life with a full-term baby, in the toolkits. The group thought that was a good suggestion and the idea of doing focus groups across the state to see what pregnant women really think about preterm birth was also mentioned. We've heard women comment that they "Don't want to have a BIG baby," and we feel certain that this may be an issue that needs to be addressed. Dr. Shepherd added that we live in a high tech society and we've come to expect that we can "FIX EVERYTHING!" Those high tech miracles cost big dollars, and we'll provide studies in the toolkits about the costs of preterm birth. Christie Penn asked if we ever have someone available to come and speak to large groups about folic acid, or preterm birth, and she wondered if that was something Susan did as part of her role as Statewide Coordinator. It was determined that if this request was a presentation to a large group that could benefit from Susan's expertise she most probably would be allowed to do this on a case by case determination from the Barren River District Health Department, and her branch supervisor.

In closing Dr. Shepherd Reminded the group that November 14th is Prematurity Day and that Dr. Jennifer House with the National March of Dimes will be in KY for that event. Unfortunately, the Governor is not available on that date and it's possible the First Lady would be filling in for him. Christie Penn mentioned that she had attended a Suicide Prevention Event a few weeks ago that the Governor was also unable to attend. Instead, his personal message was recorded and viewed via videotape up on a large screen. That is certainly an option to consider, but those in charge of the event said final arrangements have not yet been made. It was also mentioned that perhaps a second event would be scheduled at another site and date that the Governor would possibly be able to attend.

The meeting was adjourned.

Respectfully submitted and distributed per
Susan Brown, Kentucky's Statewide Folic Acid Campaign Coordinator
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