

# The Life Course Perspective: How Did We Get Here and Where Are We Going?

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# Objectives

- Describe the history of the Preconception Health Movement in the US and North Carolina's pioneering role.
- Explain how the life course perspective and preconception health promotion are intertwined.
- Become familiar with some of the current directions for advancing preconception health and the life course perspective.
- Begin to formulate a plan for your own work with women, men and families to advance a healthier tomorrow in Forsyth County

# Disclosure Statement

- I have had no financial relationships with commercial interests related to this topic in the last 12 months.

# Summary

- Prenatal care, the usual approach to prevention of poor pregnancy outcomes, is largely ineffective in meeting primary prevention needs of pregnant women and unborn children
- Impacting the health of the next generation requires new prevention approaches through an emphasis on women's health and the life course perspective



# The Underpinnings for Reframing the Prevention Paradigm

# **We Ask Too Much of Prenatal Care:**

“As attractive and relatively inexpensive as prenatal care is, a medical model directed at a 6-8 month interval in a woman’s life cannot erase the influence of years of social, economic, [physical] and emotional distress and hardship.”

Dillard R, NCMJ,

# Prenatal Care: Unlikely to Impact Major Causes Infant Mortality/Morbidity

- Association of prenatal care with improved outcomes most likely represents a selection bias rather than causal relationship
- Despite increased access/utilization of prenatal care prematurity/low birth weight rates increase and disparities are essentially unchanged
- **(NOTE: I am not arguing for the elimination of prenatal care. . .but that's another talk)**



**In obstetrics. . .**  
most contributors to  
poor outcomes  
(and some  
outcomes,  
themselves) are  
already present  
before we ever  
meet our pregnant  
patients

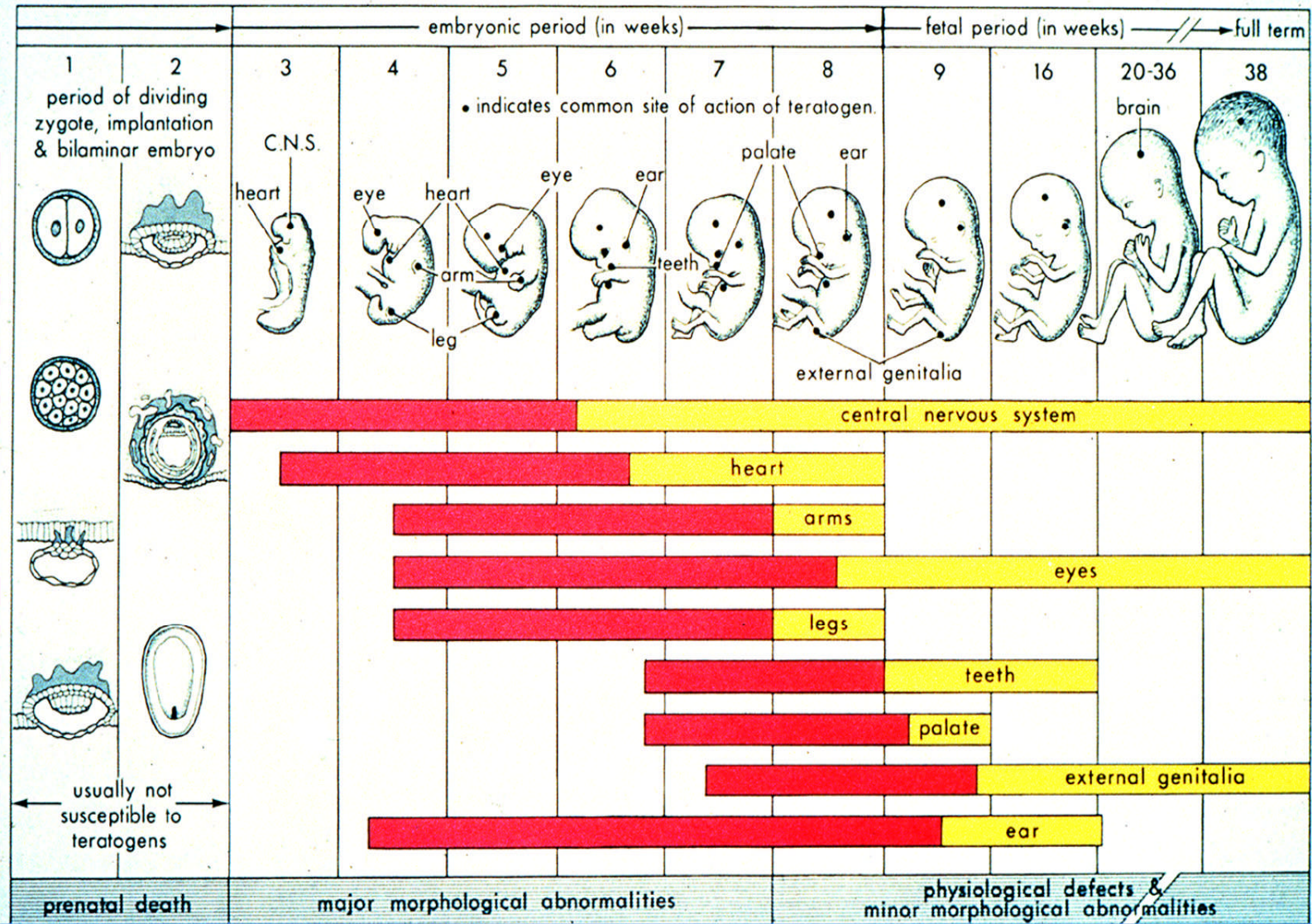


# Important Examples

- Intendedness of conception
- Interpregnancy interval
- Maternal weight
- Maternal age
- Abnormal placentation
- Chronic disease control
- Congenital anomalies
- Timing of entry into prenatal care

# **Importance of First Trimester on Pregnancy Outcomes**

## CRITICAL PERIODS OF DEVELOPMENT (RED DENOTES HIGHLY SENSITIVE PERIODS)



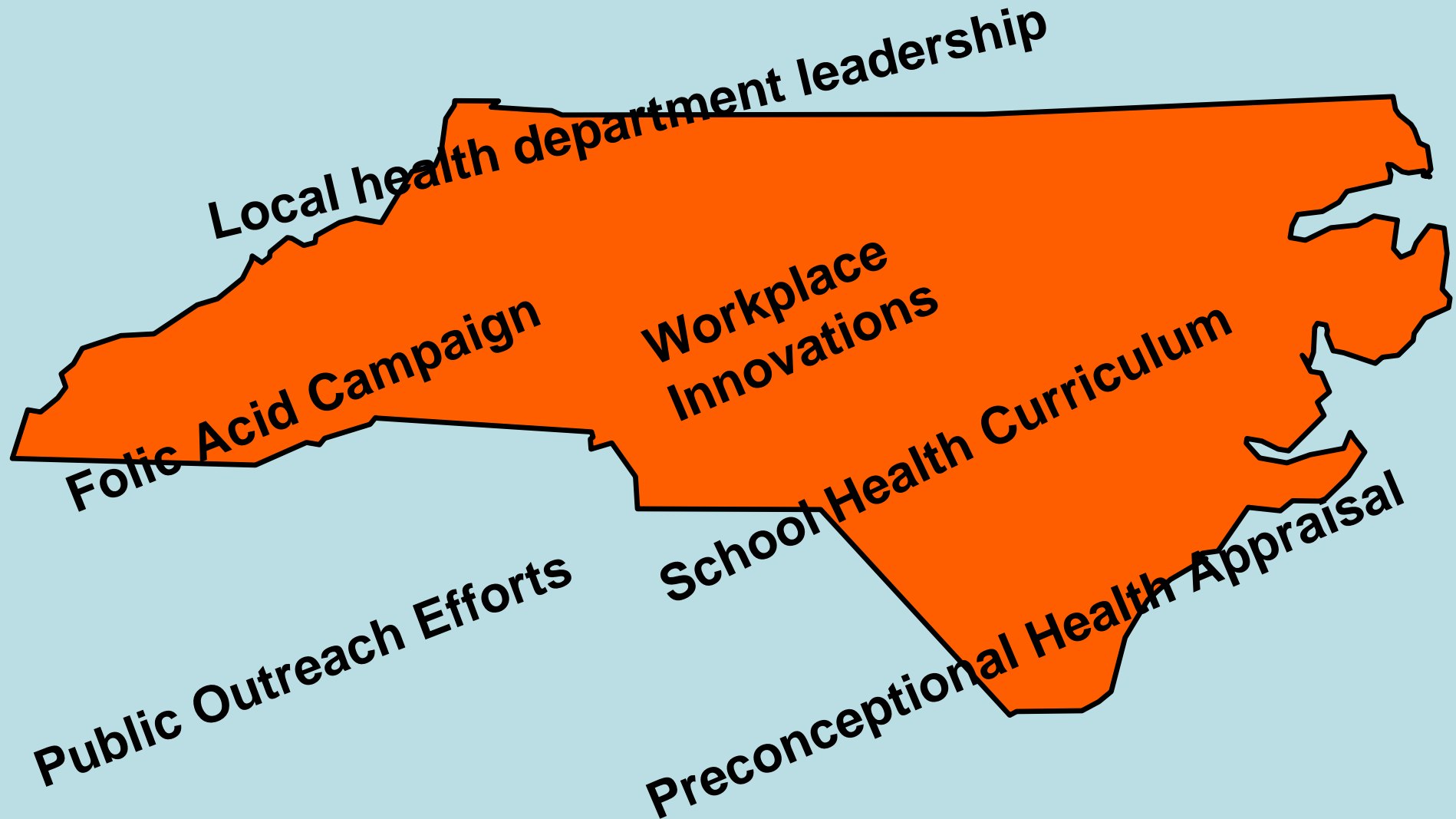
**Over time, it has come to be  
recognized that  
Prepregnancy Health Status and  
Preconception Health Care  
provide pathways to**



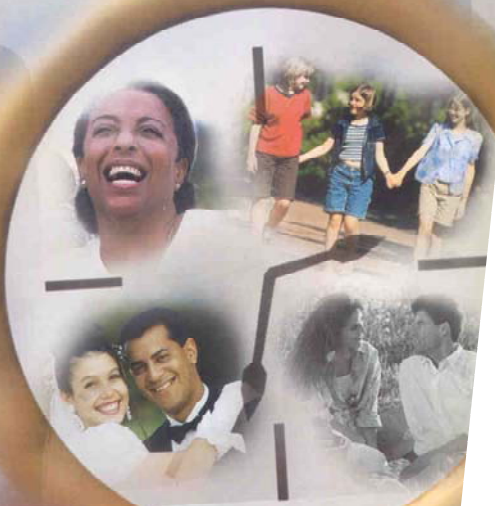
**the Primary Prevention of many  
poor pregnancy outcomes beyond  
that available through traditional  
prenatal care**

**...AND NORTH CAROLINA  
has LED THE WAY!**

# North Carolina's Pioneering Efforts



# National Summit on Preconception Care



June 21 - 22, 2005

The Atlanta Marriott Century Center  
Atlanta, Georgia



## MMWR™

Morbidity and Mortality Weekly Report

Recommendations and Reports

April 21, 2006 / Vol. 55 / No. RR-6

### 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

INSIDE: Continuing Education Examination

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR DISEASE CONTROL AND PREVENTION

# Preconception Care Framework



# Goals for CDC/Select Panel Initiative to Improve Preconception Health

- **Goal 1:** Improve the knowledge, attitudes and behaviors of men and women related to preconception health
- **Goal 2:** Assure that all US women of childbearing age receive preconception care services—screening, health promotion and interventions-that will enable them to enter pregnancy in optimal health
- **Goal 3:** Reduce risks indicated by a prior adverse pregnancy outcome through interventions in the interconception period
- **Goal 4:** Reduce disparities in adverse pregnancy outcomes

# Vocabulary important to the preconception movement

- **Preconception health promotion:** Includes but is not limited to clinical care because many influences interact to support or undermine high levels of wellness in individuals of childbearing age (examples include family and community relationships; environmental exposures in workplace, public policies, etc. (Moos, Badura, Posner, Lu, 2010))
- **Preconception:** A woman's [or man's] health status and risks before the first pregnancy and before subsequent pregnancies. Often used as a synonym for "interconception. (Moos, 2006; Moos, Badura, Posner, Lu, 2010)

- **Periconception:** The maternal health status and risks around the time of conception through the period of organogenesis (Moos, 2006)
- **Interconception:** The period between the end of one pregnancy and the conception of the next pregnancy. The interconception period must be treated as an open-ended time frame because it can only be accurately defined after the next conception has occurred ((Moos, Badura, Posner, Lu, 2010)

# Quick Definitions

## Preconception

- Period before conception

## Periconception

- Immediately before conception through organogenesis

## Interconception

- Period between pregnancies



# Moving Away From Concentration on Pregnancy to a Life Course Approach



**INFANT DEATH IN OUR COMMUNITY**

Infant Mortality Reduction Coalition  
[www.HelpOurBabies.org](http://www.HelpOurBabies.org)

February 2007



# The “Womb to Tomb” Framework

# Two Models Foundational to the Life Course Perspective

- Early Programming Model:
  - Early life exposures (including in-utero exposures) influence health status throughout lifetime as well as reproductive outcomes (builds from “Barker hypothesis”)
- Cumulative Pathways Model
  - Chronic accommodation to stress results in wear and tear on the body’s adaptive systems thus affecting health status over time and, thus, reproductive outcomes



**Moving Away from Reproductive  
Health Silos  
to  
Women's Preventive Health Care:  
"Every Woman, Every Time"**

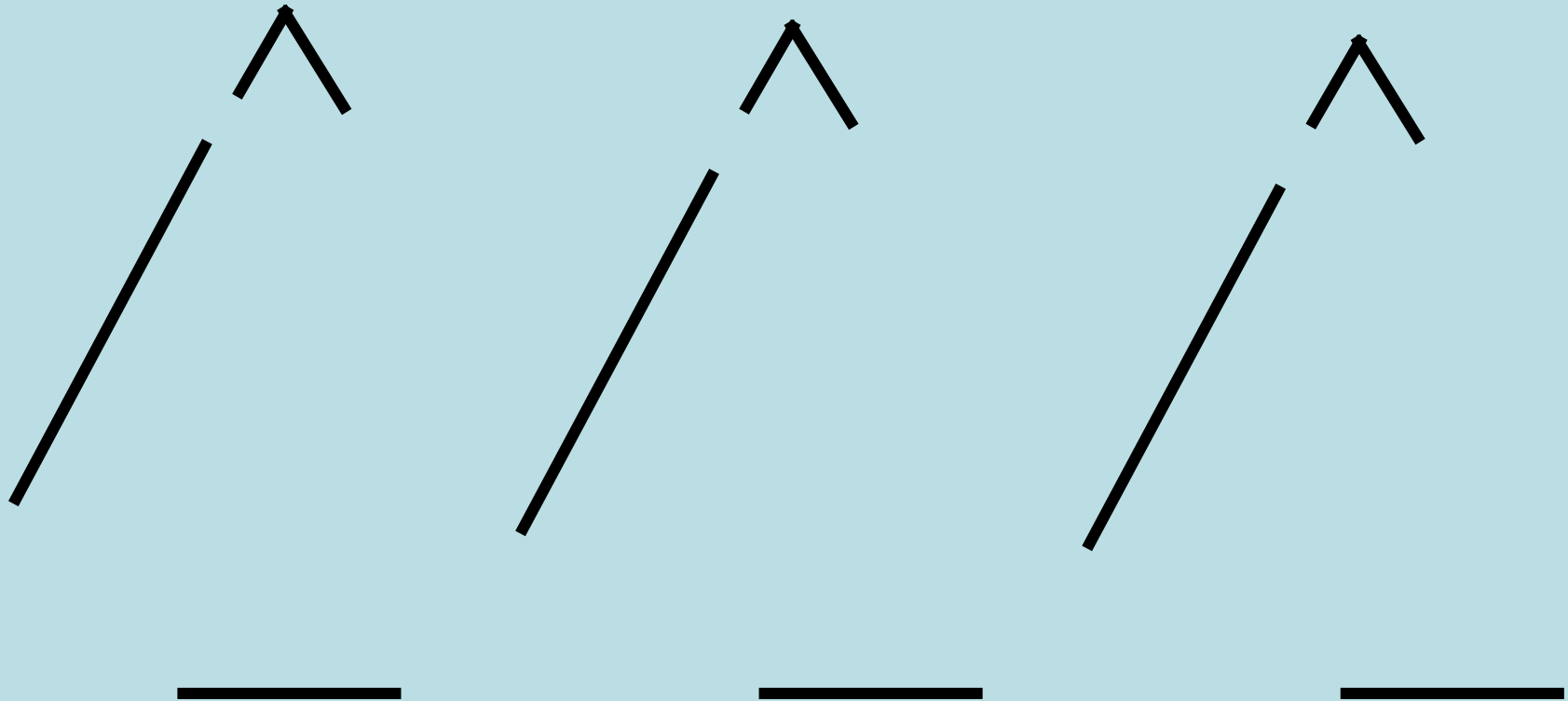
# What Drove the Course Correction?

- The health status and habits of women in the US places them at risk for short and long term morbidities and early mortalities
- Promoting high levels of health in all women is likely to result in preconceptional health promotion for those who become pregnant
- Categorical care serves programs not people
- Nearly 50% of pregnancies in the US are categorized as unintended
- Preconception movement viewed as pronatalist by some (i.e. “fetocentric” rather than “womancentric”)



# How This Is Different from the “Usual”

# “Usual” Perinatal Prevention Paradigm

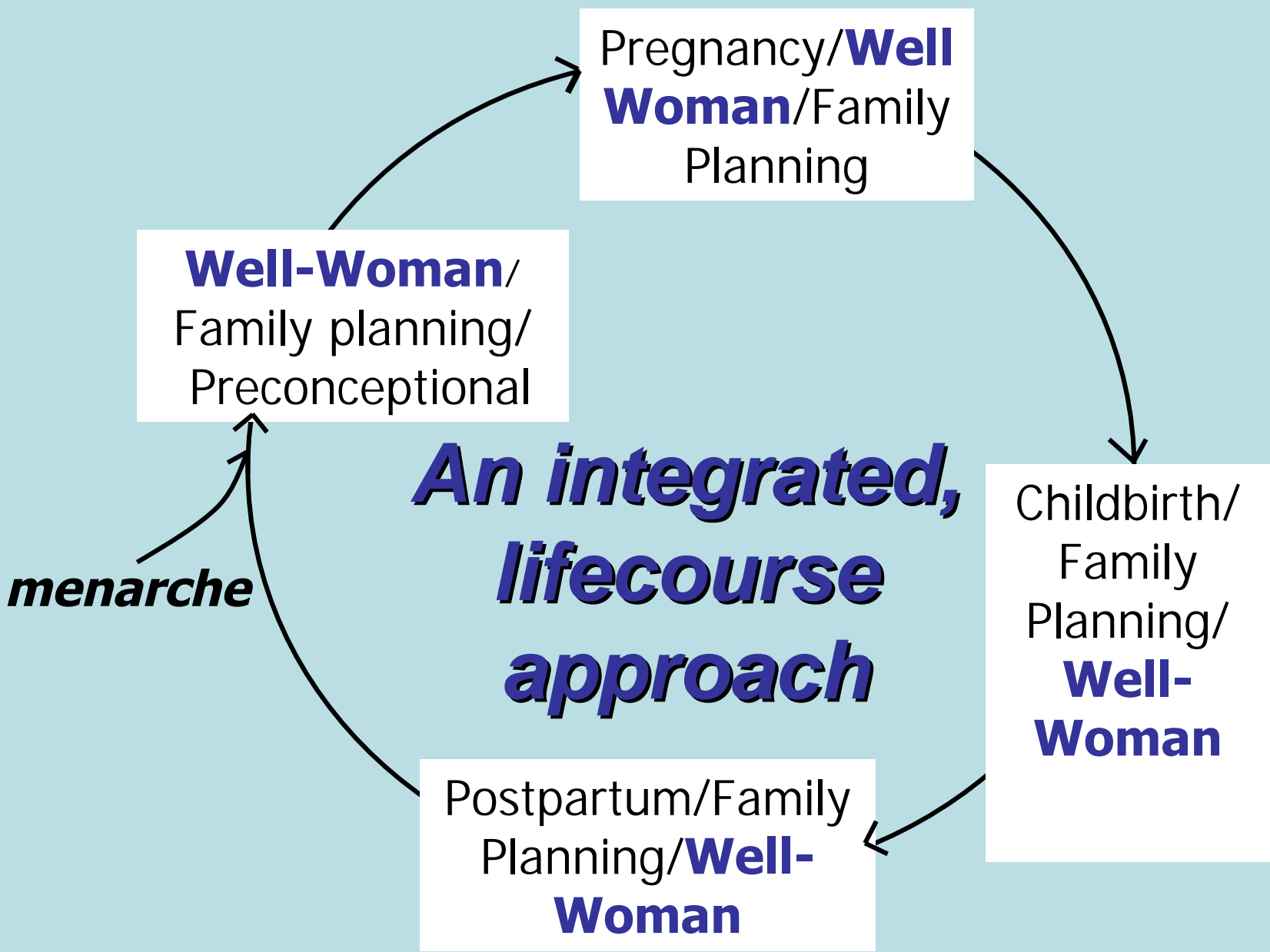


# Current Dominant Perinatal Prevention Paradigm

- Relies on patient-medical service interface
- Features categorical focus with little integration with woman's preexisting care or with her future health needs
- Initiated at first prenatal visit with
  - Risk assessment
  - Health promotion and disease prevention education
  - Prescription for prenatal vitamins
- Ends with the postpartum visit (if there is one)

# Features of Current Categorical Approach

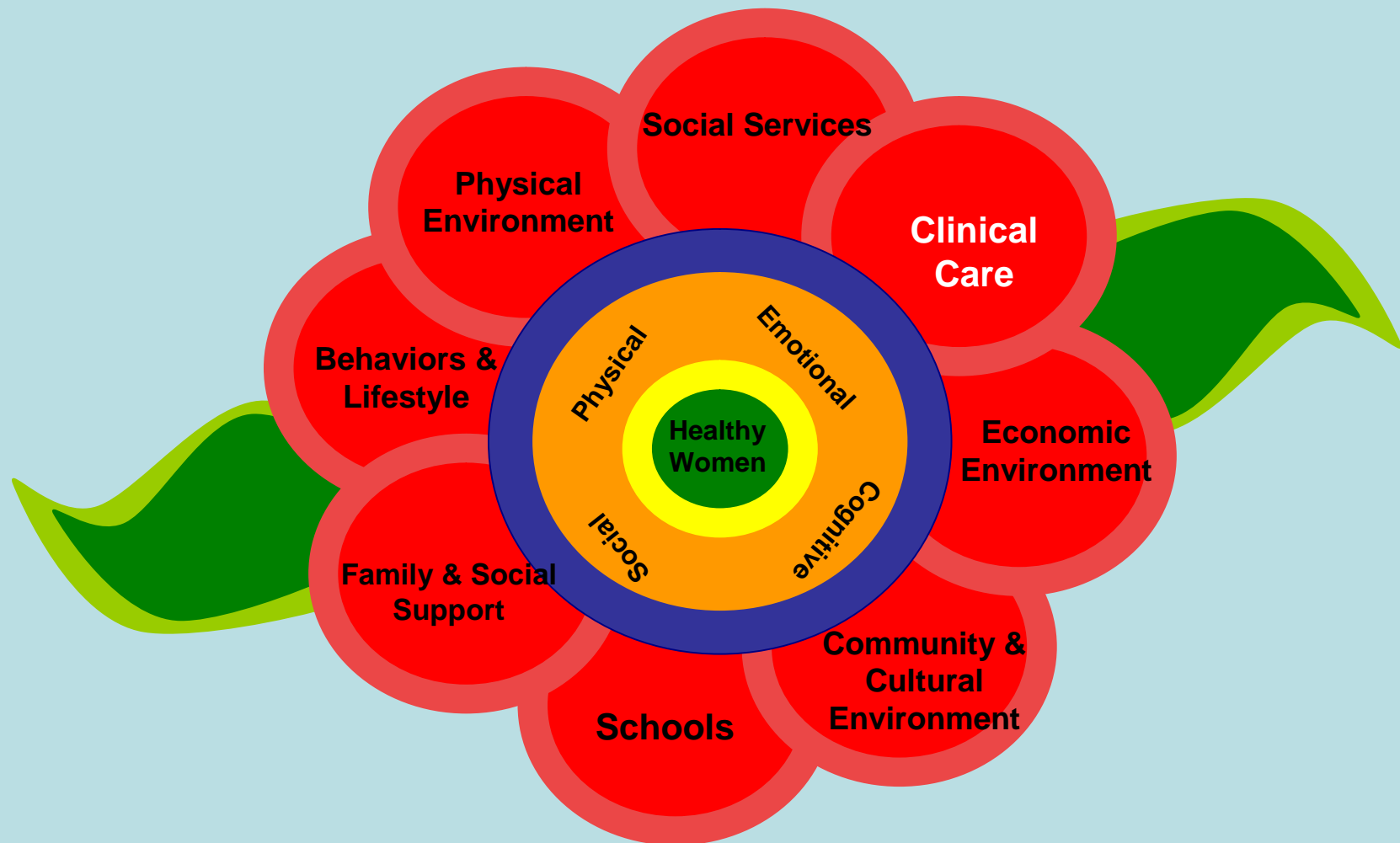
- Episodic
- Disjointed
- Inefficient
- Too often ineffective. . .especially for those at disproportionate risk



# The Benefits of a Life Course Approach to Women's Wellness

- It is very likely that we will achieve better “before and between” pregnancy health status by addressing women's wellness “every woman, every time”
- Higher levels of women's wellness before pregnancy will result in healthier pregnancy outcomes (and may impact health equity)
- Higher levels of women's wellness will result in healthier women across the lifespan, thereby impacting “beyond pregnancy”

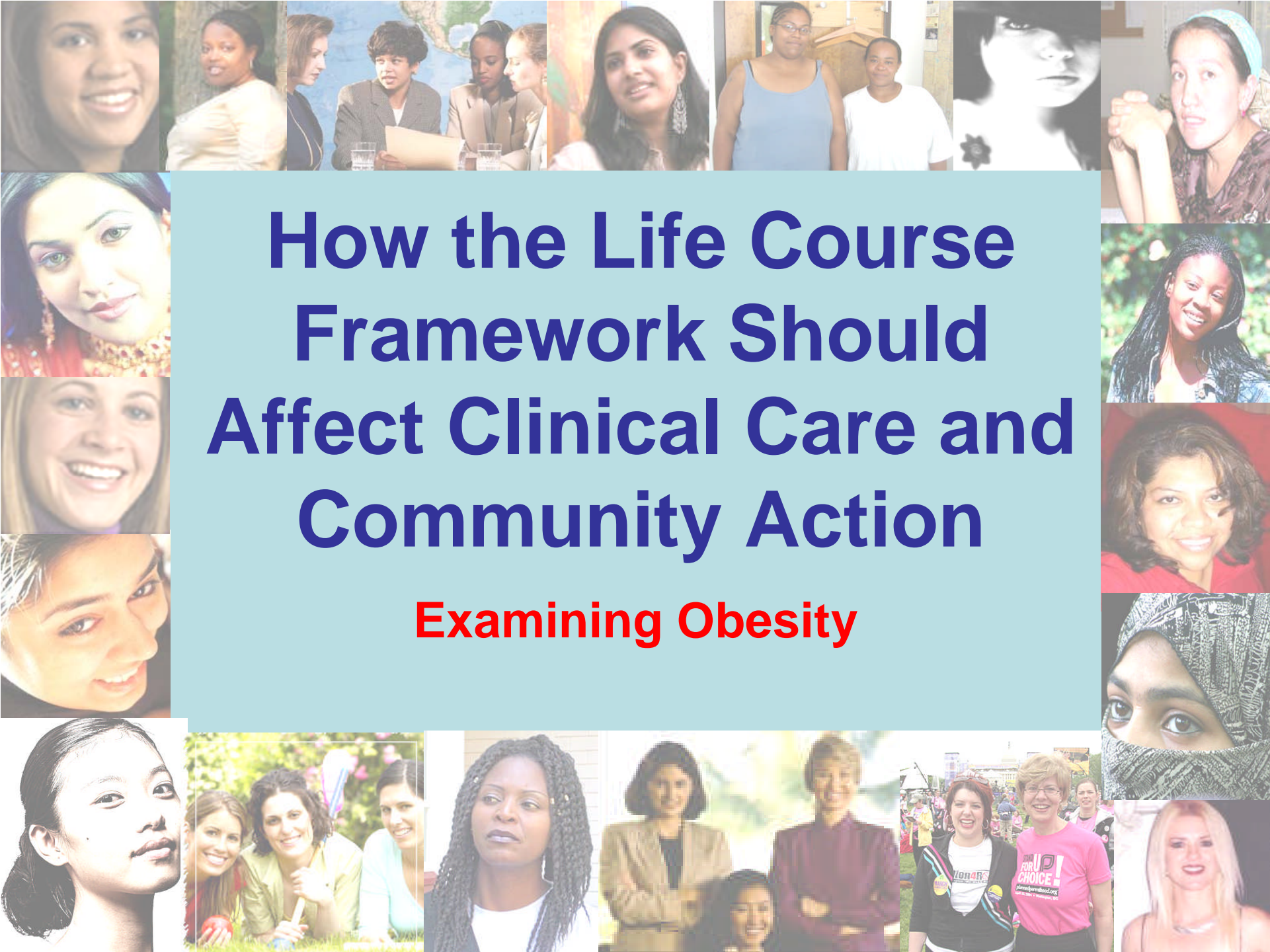
# A Clinical Approach to Impacting the Life Course Cannot Stand Alone



*Used with permission of The Nemours Foundation, Division of Health and Prevention Services. Adapted from the 2005 Delaware Children's Health Chartbook.*

# My Challenge for Each of You **Today**

Develop three action steps that  
advance women's health  
. . .for today and tomorrow  
**irrespective** of pregnancy  
status



# How the Life Course Framework Should Affect Clinical Care and Community Action

## Examining Obesity

# Why Obesity is Important

- Obesity is a gateway to poor health before, between and beyond pregnancy
- Obesity is positively correlated with excessive weight gain in pregnancy
- Weight gain in pregnancy is a gateway to overweight/obesity
- Obesity is a risk factor for poor pregnancy outcomes

## **Obesity and Women's Health**

- Diabetes
- Hypertension
- Cardiovascular disease
- Disabilities

## **Obesity and Pregnancy**

- Glucose intolerance of pregnancy
- Pregnancy induced hypertension
- Thrombophlebitis
- Neural tube defects
- Prematurity

# Usual Approach to Addressing Weight Status in Women of Reproductive Age



Orange lines=some but inconsistent guidance; purple lines=little, if any, guidance

**A Life Course  
Clinical Model  
Relative to  
Obesity  
Prevention**

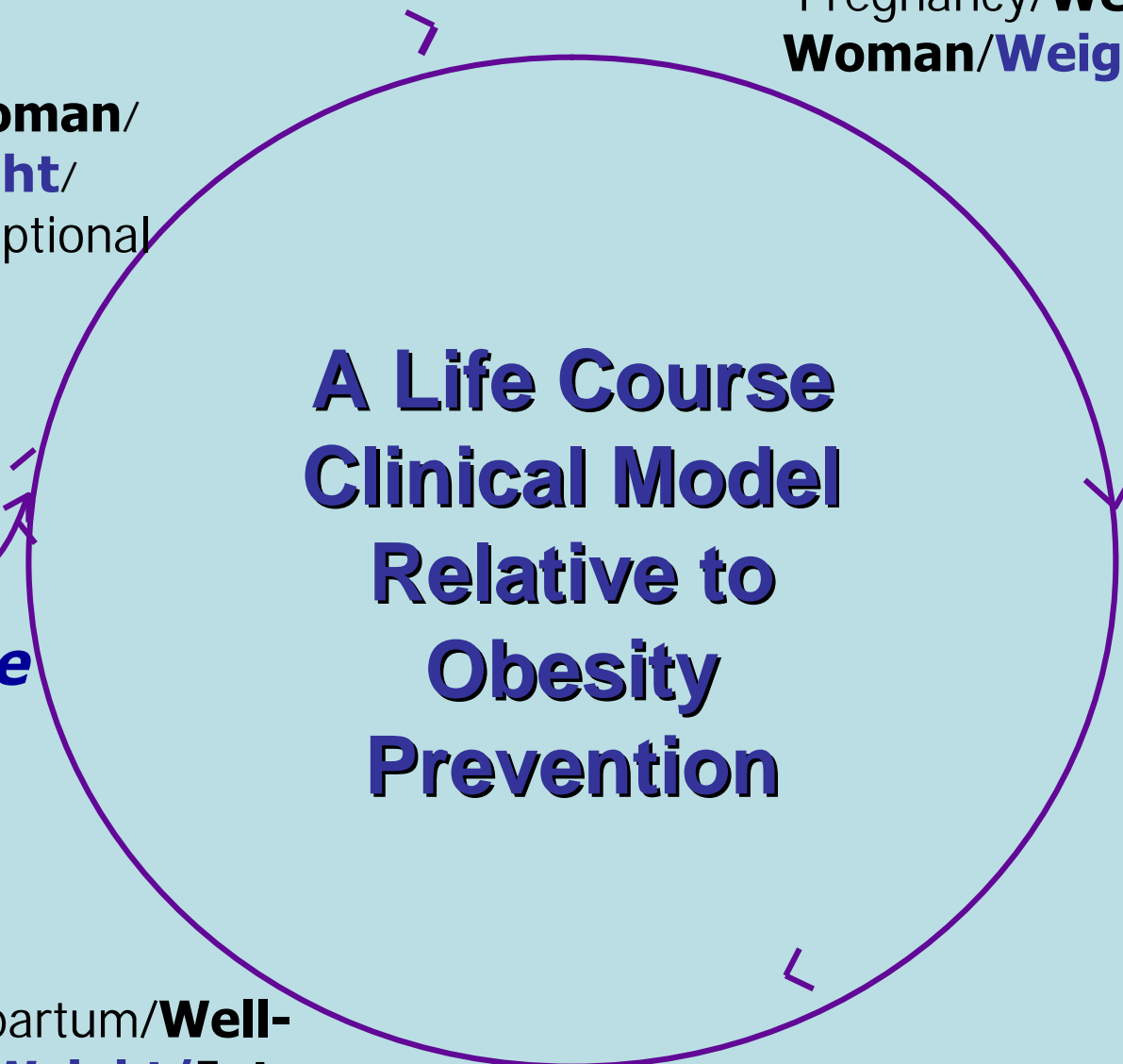
Pregnancy/**Well  
Woman/Weight**

**Well-Woman/  
Weight/  
Preconceptional**

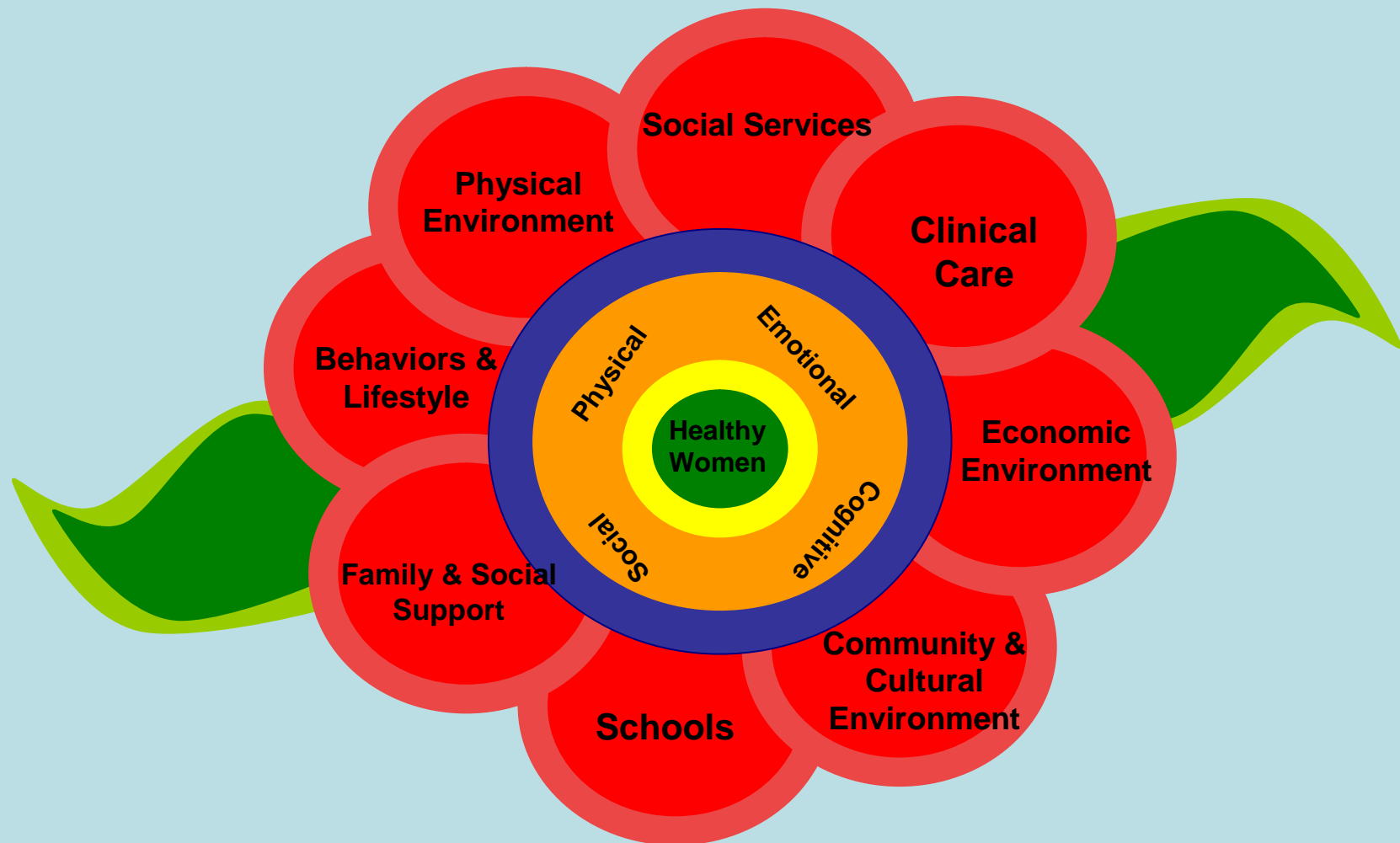
Childbirth/  
**Well-  
Woman/  
Weight**

**Menarche  
(and  
before)**

Postpartum/**Well-  
Woman/Weight/Intercon-  
-ception**



# It Takes Far More Than Advice



*Used with permission of The Nemours Foundation, Division of Health and Prevention Services. Adapted from the 2005 Delaware Children's Health Chartbook.*

# The Challenge for You and Your Community in Promoting Healthy Weight

When and how are a woman's weight status **assessed and addressed** for:

- Her own immediate health?
- Her long term health?
- The health of any children she may conceive?
- (Having her step on a scale and recording the number is NOT enough)

How can individual, clinical care and community assets and challenges be assessed, addressed and integrated? (Individuals and organizations will not change their priorities or behaviors until it makes a difference for them to do so)

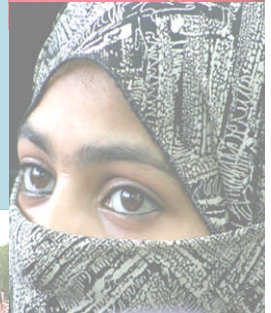
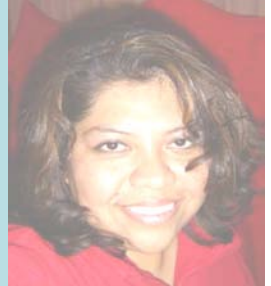
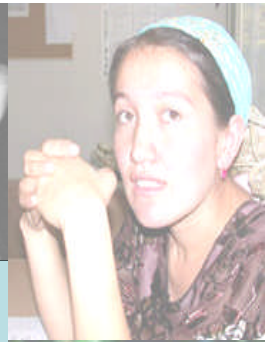
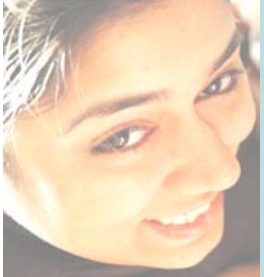
How can cultural and ethnic considerations in promoting healthy weights being identified and accommodated?

# Back to the BIG Picture

**Goals for the Nation and  
Related Action Steps:**



**CDC/Select Panel Goal 1:**  
Improve the knowledge, attitudes  
and behaviors of men and women  
related to preconception health



# Progression from Goal to Recommendation to Action Step

## Recommendation:

Every woman, man and couple should be encouraged to have a reproductive life plan

## Action Step:

Develop, evaluate and disseminate reproductive life planning tools respecting variations in age, literacy, and cultural/linguistic contexts

# What is the Rationale for a Reproductive Life Plan?

- “if it happens, it happens” isn’t a plan
- As many as 50% of pregnancies are unintended
- 48% of unintended pregnancies occur in a month in which the woman used contraception
- Unintended pregnancy, based on 2002 NSFG data, is likely to go up

# Why is Intendedness Status Important?

- The latest data indicates that 49% of pregnancies are unintended
- Unintended pregnancies are not usually unwanted but, rather, mistimed
- Unintended pregnancies are associated with:
  - increased likelihood of abortion
  - exposures to potentially harmful substances
  - poor pre-pregnancy disease control
  - late entry to prenatal care
  - increased likelihood of low birth weight in offspring
  - maternal depression
  - reduced school completion and lower income attainment (if woman not married)

# Who Is at Risk for Unintended Pregnancies?

- The short answer is: everyone who has sexual intercourse because there is NO perfect contraceptive (including sterilization)

Proportion of women who became pregnant while using contraception  
(Data from 2002)

IUDs	1.0%
Injectables	6.7%
Pills	8.7%
Condoms	17.4%
Withdrawal	18.4%

- 48% of unintended pregnancies occur in a month in which the woman **used** contraception

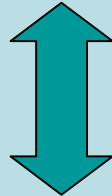
# Theoretical Advantages of Reproductive Life Planning:

- Can impact pregnancy intendedness by helping men and women recognize they have choices around risk taking for pregnancy
- Can help individuals plan, based on their own values and resources, to formulate a set of personal goals about whether or when to have children.
- Encourages ownership of decisions
- Possibility that method matching to short and long term goals will result in increased adherence to chosen/prescribed method

# Framework

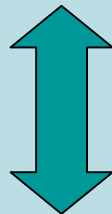
Life Plan

(What do I want to do with my short/long term future?)



Reproductive Life Plan

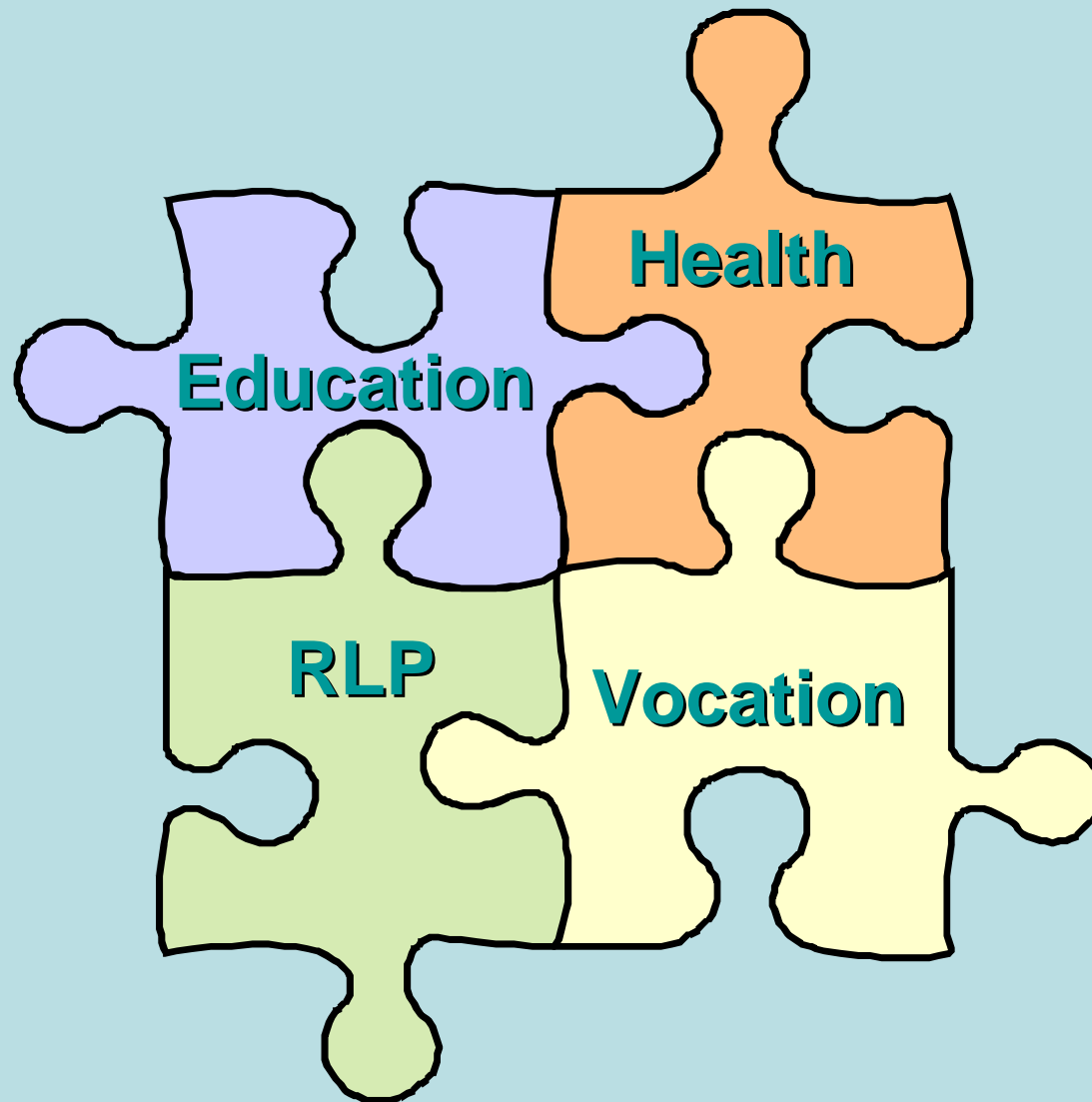
(What do I want to do with my reproductive future?)



Reproductive Plan Assessment

(Clinical interface with RLP and matching with appropriate contraceptive choices, counseling and contingency planning)

# Overall Life Plan



## Other Pieces in the Life Plan:

- Relationships
- Economic status
- Spiritual connections
- Social outlets, etc.

Delaware  
Created a  
Life Plan  
by and for  
Teens--



# Example of a Reproductive Plan Assessment

- Do you hope to have any (or any more) children?
  - If no, what are you planning to do to prevent becoming pregnant (again)
  - If yes, ask:
- How many (more) children do you hope to have?
- How long would you like to wait until you become pregnant (again)?
- What do you plan to do to prevent getting pregnant until then?
- What can I do to help you achieve your plan?

Adapted from: Moos, MK. Unintended pregnancies: A call for nursing action. *MCN*, 2003; 28: 25-31.

# Important Considerations, Irrespective of Tools

- Reproductive life plans are NEVER right or wrong\*
- Reproductive life plans are fluid\*
  - They should never be considered set in stone because “life happens”
- Reproductive life planning should be offered to everyone, irrespective of assumptions or biases about the woman’s (man’s) circumstances

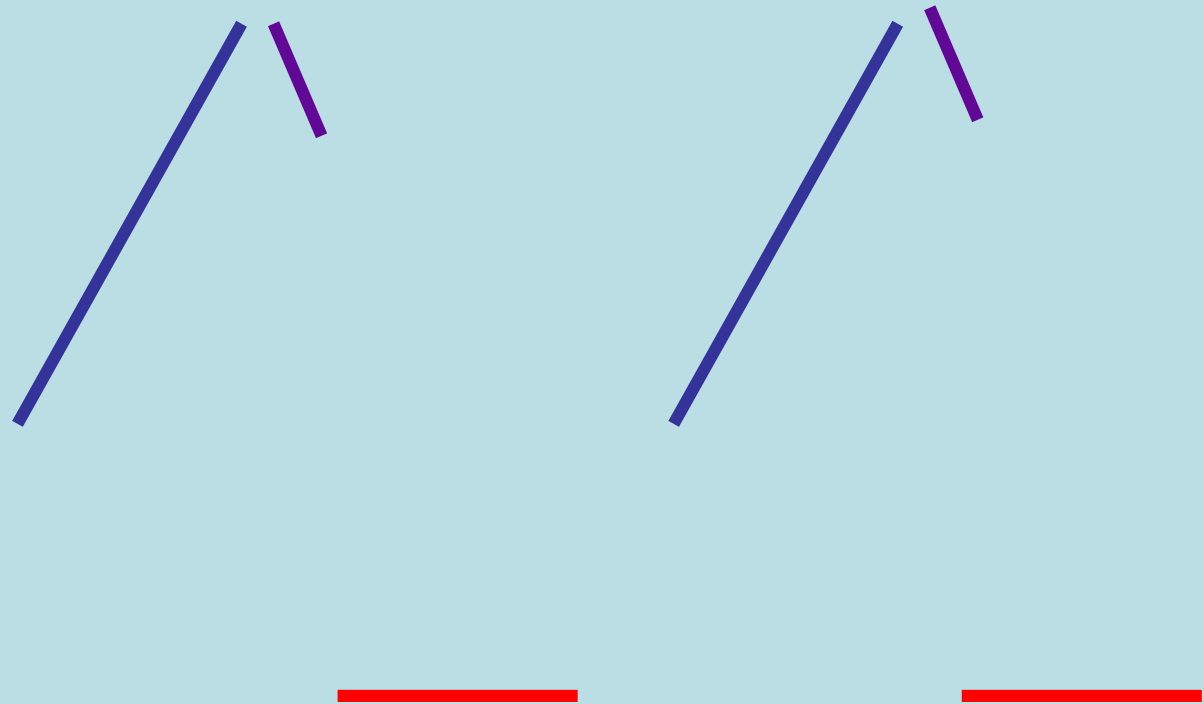
\*From deliberations of Ad Hoc Committee of PCCHC Select Panel on Reproductive Life Planning, Washington, DC, November 23, 2009

# Examples of “Everyone”:

- SJ is a 15 yo who states has never had sexual intercourse
- BW is a 26 yo Lesbian
- TB is a 40 yo with two living children
- NG is a 34 yo with no children
- CK is a 24 yo whose infant is in the NICU
- TK is a 29 yo with two adopted children
- FW is 31 yo with six children

Note: gender unstated for most of these examples!

# Usual Approach to Addressing Conception Decisions in Women of Reproductive Age



Orange lines=some but inconsistent guidance and often not patient centered; purple lines=little, if any, guidance

**Well-Woman/  
RPAssessment/  
Preconceptional**

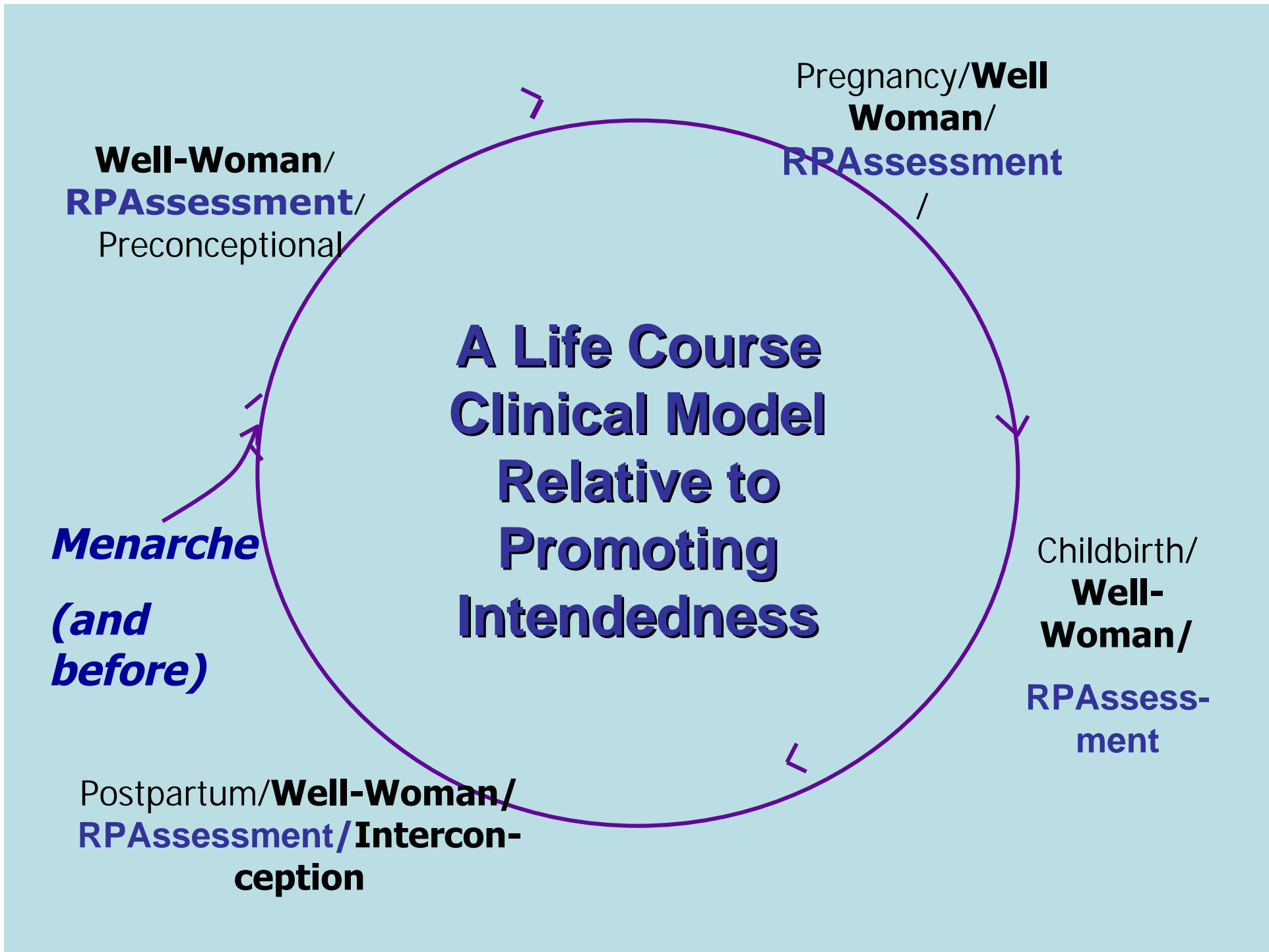
Pregnancy/**Well  
Woman/  
RPAssessment**

**A Life Course  
Clinical Model  
Relative to  
Promoting  
Intendedness**

Childbirth/  
**Well-  
Woman/  
RPAssess-  
ment**

**Menarche  
(and  
before)**

Postpartum/**Well-Woman/  
RPAssessment/Intercon-  
ception**



# Usual Approach to Addressing Unintendedness in Men of Reproductive Age

**NONE** —


Orange Line=that would be **zilch!!!**

## **The Challenge for You and Your Community to Promote Deliberate Decision Making about Future Conceptions “Every Woman, Every Time”**

When and how are a woman’s (man’s) pregnancy desires assessed and addressed?:

How can individual, clinical care and community assets and challenges be assessed, addressed and integrated?  
(Individuals and organizations will not change their priorities or behaviors until it is perceived to make a difference for them to do so)

How can cultural and ethnic considerations in promoting deliberate decisions about childbearing be identified and accommodated?



**CDC/Select Panel Goal 2:  
Assure that all US women of  
childbearing age receive  
screening, health promotion  
and interventions that will  
enable them to enter  
pregnancy in optimal health**

# Progression from Goal to Recommendation to Action Step

## **Recommendation:**

As part of primary care visits provide services to reduce reproductive risks and improve pregnancy [and general] health outcomes.

## **Action Step:**

Consolidate and disseminate existing guidelines to develop a recommended screening and health promotion package

# **Caring for Our Future: The Content of Preconception Care**

**What is the evidence to recommend provision of clinical services before pregnancy for the purpose of improving reproductive outcomes?**

The Clinical Workgroup of the CDC Select Panel on Preconception  
AJOG, December 2008. Available for free download at  
[www.beforeandbeyond.com](http://www.beforeandbeyond.com)

# **Healthier Women, Healthier Reproductive Outcomes: Recommendations for the Routine Care of All Women of Reproductive Age**

Moos MK, Dunlop AL, Jack  
BW, Nelson L, Coonrod D,  
Long R, Boggess K,  
Gardiner P

# Health Promotion Recommendations for “Every Woman, Every Time”

- Family planning and reproductive life plan
  - Assess and address intentions about future pregnancies in order to match remaining care to need
- Physical activity
  - Assess and address weight bearing and cardiovascular exercise needs



# Health Promotion Recommendations for “Every Woman, Every Time”

- (more nutrient assessment:)  
Osteoporosis prevention\*

Assess and address calcium intake and Vitamin D exposure

- Substance use

Assess and address tobacco use with at each encounter; assess and address alcohol use at least annually

\*not included in *The Clinical Content of Preconception Care*

# Health Promotion Recommendations for “Every Woman, Every Time

- Immunizations                      Assess and address immunization needs annually
  
- STI Risk                                Assess and address STI Risk at least annually

# Disease Prevention Recommendations for “Every Woman, Every Time”

- Prescription and non-prescription drug exposures
  - Assess and address safety of all medications in light of risk for pregnancy
- Chronic disease
  - Assess and address risks of chronic diseases for woman’s immediate and long term health and for reproductive outcomes

# “Every Woman—Every Time” is Opportunistic Care

- Takes advantage of all health care encounters to stress prevention opportunities throughout the lifespan
- Addresses conception and contraception choices at every encounter
- Involves all medical specialties—not only those directly involved in reproductive health



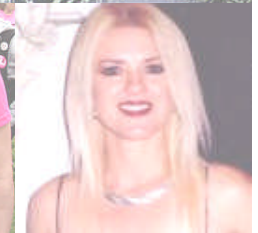
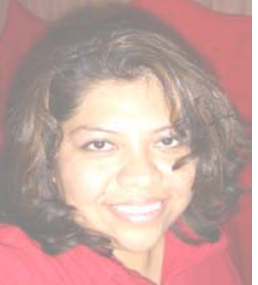
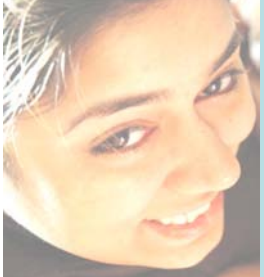
# Risks We See Every Day

- NC women ages 18+ who smoke: 20.0%
- NC women ages 18+ who binge drink: 5% (? Percent who drink more than one drink on any occasion?)
- NC women who do not meet minimum recommended physical activity: 62%
- NC women ages 18+ who are obese (BMI 30.0+): 27%
- Lack of immunity to preventable diseases
- Poor dental care practices
- Folic acid deficiencies: progress is SO disappointing!



**What Are Some Action Steps to Reach Every Woman, Every Time?**

**What Are Some New Partnerships?**



# Recommendations to Practice

- Identify and address risks prospectively (we often identify but do we address?)
- Compute the BMI on every woman and show her where she fits on the chart (we are coaches not best friends)
- Ask women to identify 1-3 health goals for the year and support her in developing a realistic plan (small and doable is better than big and overwhelming)

- Refer to behavior change support programs
- Work to develop support programs in resource poor areas (e.g. Mother-daughter walking groups; Weigh-In Chats, Gossip Hours, etc)
- Authorize WIC to include interconceptional messages in all counseling to postpartum women

- Expand expectations of well baby visits to promote advantages of interconceptional spacing; to promote targeted interconceptional care for mothers of special needs infants, to encourage postpartum/well woman visits, etc
- Engage pharmacists in more active “outreach” to women with known risks for poor pregnancy outcomes (e.g. women with diabetes, women taking teratogenic drugs, etc)

**Caution:** Don't get caught in the “not quite perfect” cycle of inaction:

- Embrace others' innovations
- Adopt
- Adapt (with recognition)
- Evaluate
- Share

**WOMEN'S WELLNESS Rx**  
(because not all habits are bad!)

Name \_\_\_\_\_ Date \_\_\_\_\_

BP \_\_\_\_\_ Next Pap smear due \_\_\_\_\_

Next mammography due \_\_\_\_\_

- Self breast exam monthly
- 30 minutes of exercise most days of the week
- Sunscreen daily
- 1200 mg calcium daily, or other \_\_\_\_\_
- 5-9 servings fruits and vegetables daily

Take a **Multivitamin DAILY**  
with 400 mcg **FOLIC ACID**

signature \_\_\_\_\_

**FOLIC ACID** GET IT NOW [www.getfolic.com](http://www.getfolic.com)



**Prescription for a Healthy Future™**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

**Rx**

Take a multivitamin with 400 micrograms (mcg) of folic acid every day.

Be active and get to a healthy weight.

Eat a variety of healthy foods and drink plenty of water.

Quit smoking and avoid secondhand smoke.

Get help for any drug and/or alcohol problems.

Get any health problems under control.

Get regular mental, dental, and health check-ups.

Keep yourself safe.

Plan for a healthy pregnancy when and if you want a baby.

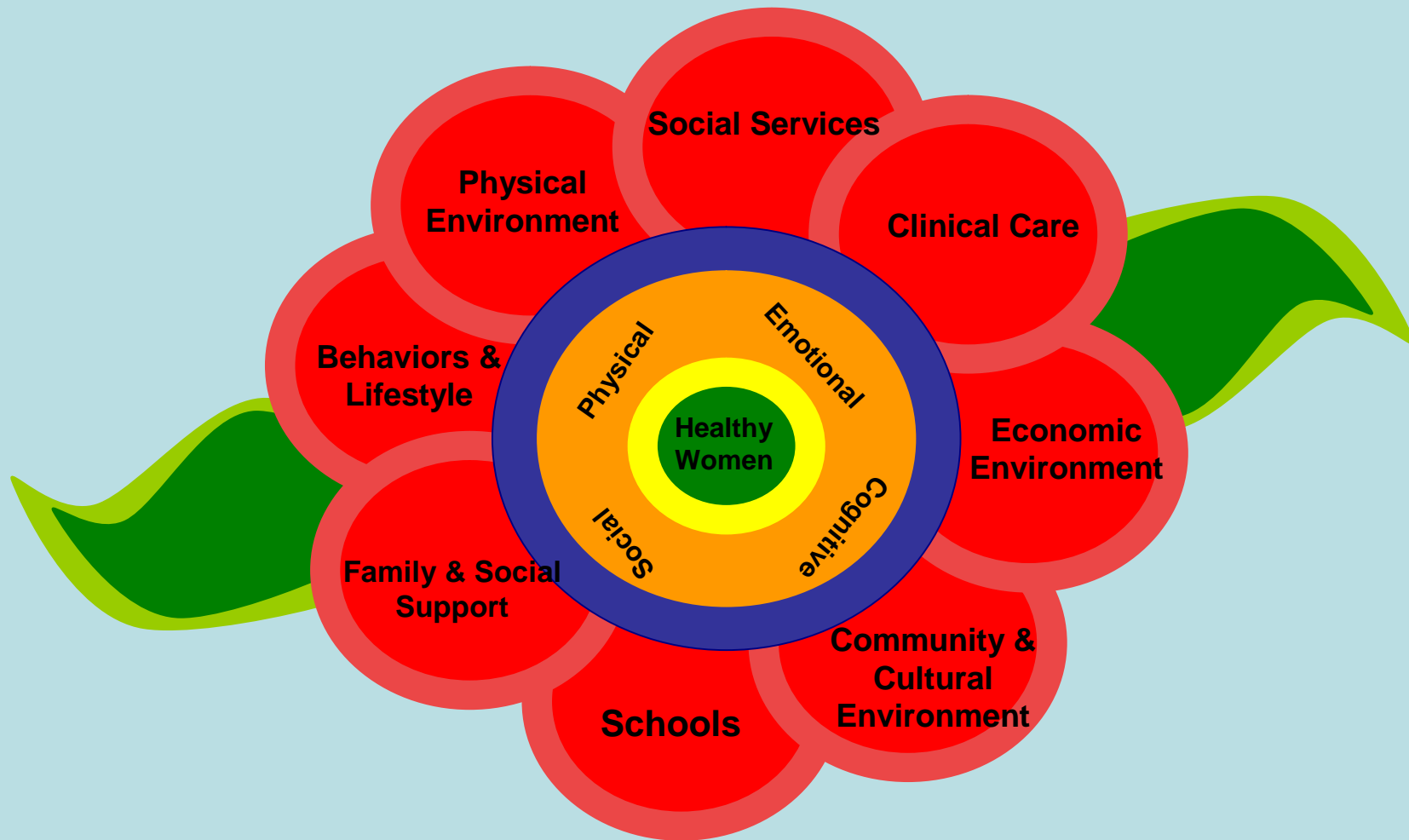
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Signature \_\_\_\_\_

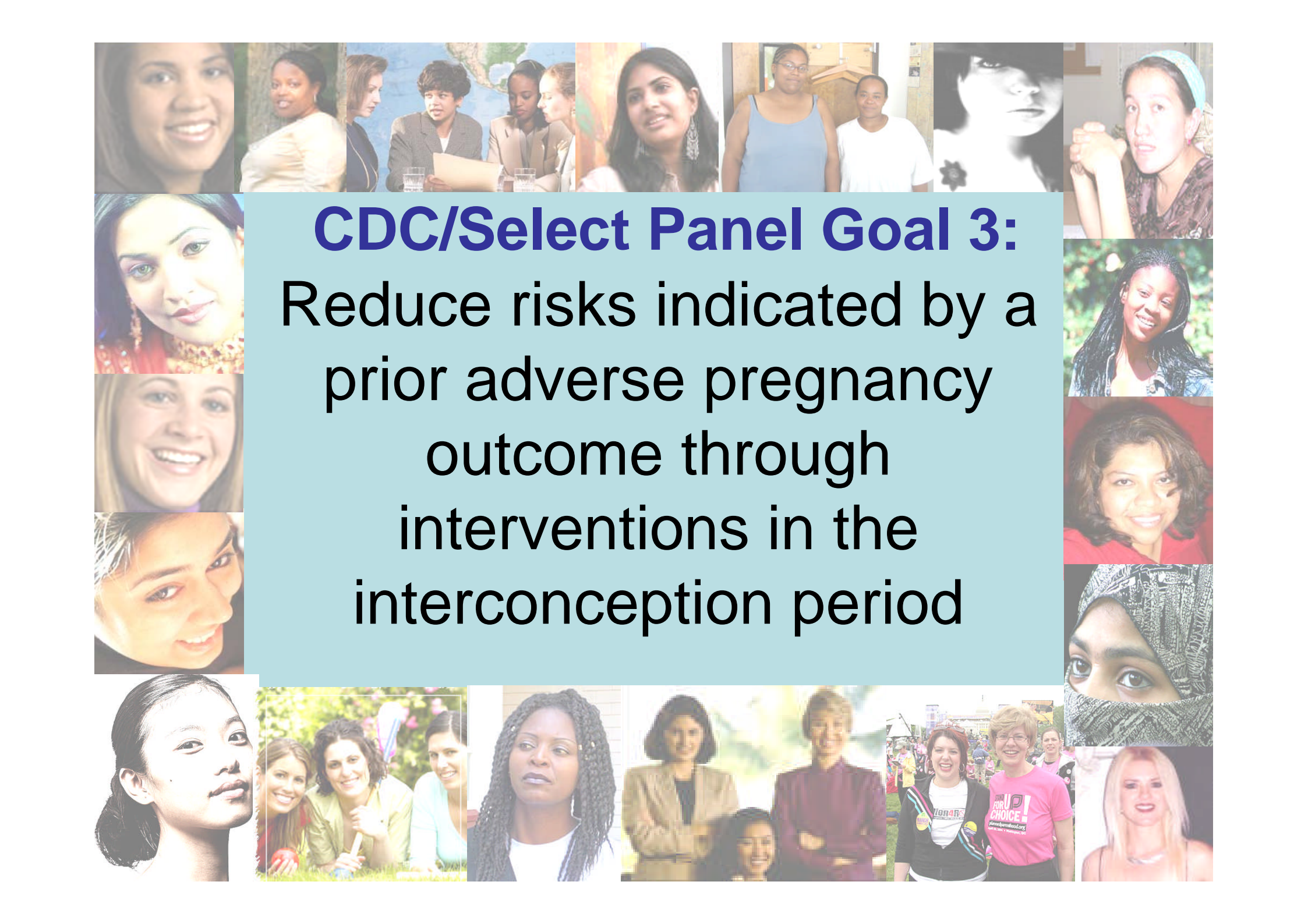
Look on the back of this prescription for where to find more information about each of the prescription items.



Western Washington University  
Prescription Date



*Used with permission of The Nemours Foundation, Division of Health and Prevention Services. Adapted from the 2005 Delaware Children's Health Chartbook.*



**CDC/Select Panel Goal 3:**  
Reduce risks indicated by a  
prior adverse pregnancy  
outcome through  
interventions in the  
interconception period

# Progression from Goal to Recommendation to Action Step

## **Recommendation:**

Use the interconception period to provide intensive interventions to women who have had a prior poor pregnancy outcome

## **Action Step:**

Develop evaluate and replicate intensive evidence-based interconception care and care coordination models for women at high social and medical risk.

# Why Interconception Period Important

- The highest predictor for a future poor pregnancy outcome is a previous poor pregnancy outcome.
- An independent and additive risk for poor pregnancy outcomes is short interconceptional length
- An important predictor of future disease development in women is their previous pregnancy complications.

# Pregnancy Is a Stress Test for Life

A previous pregnancy is useful in predicting:

- Subsequent pregnancy outcomes (between pregnancy focus)
- Woman's own health risks (between and beyond pregnancies)

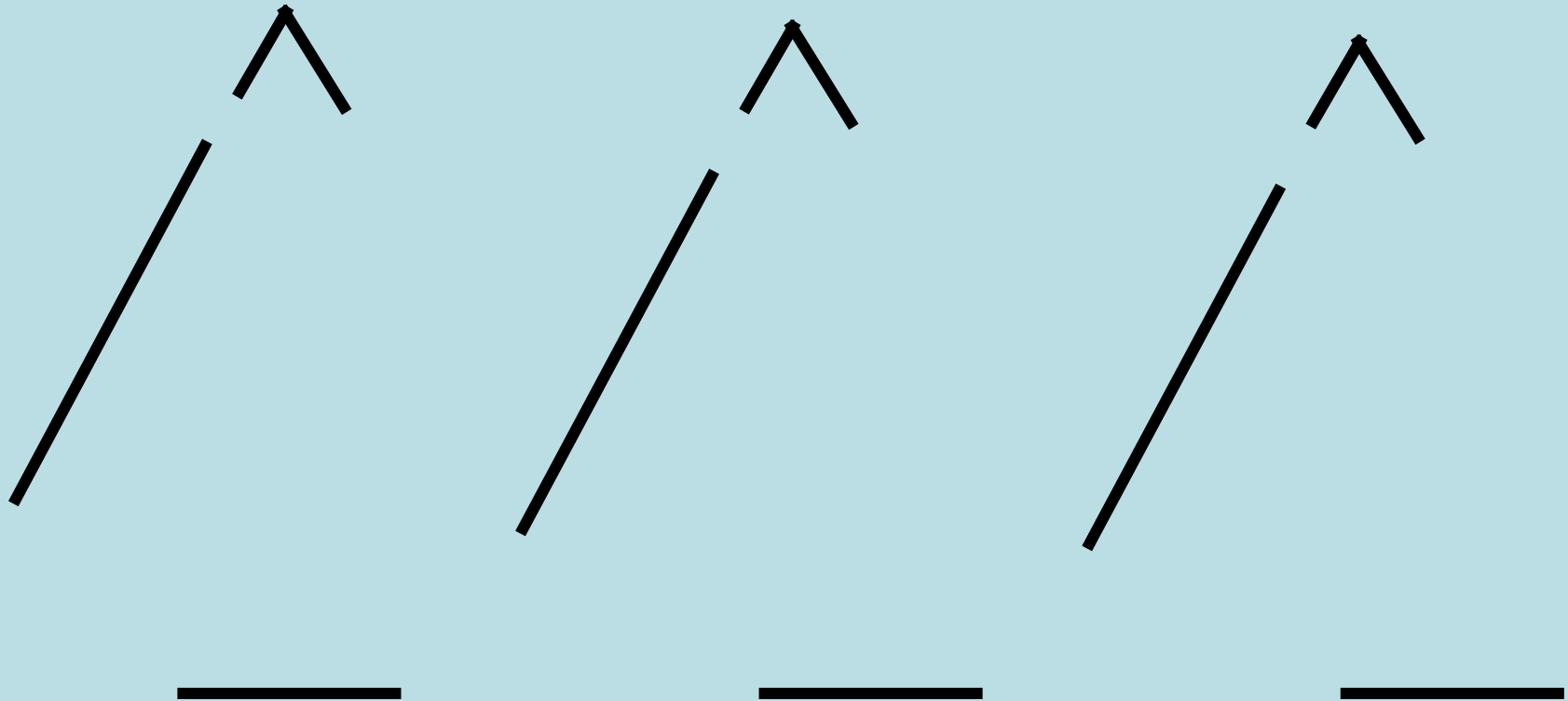
Appropriate follow-up of known risks is often absent leaving women at risk for their own health and the health of their future pregnancies and children

# A Very Common Illustration of Missed Opportunities

- SW is g2 p1 who had a 1500 gm infant 7 months ago. She is presenting for a new ob visit. During her previous pregnancy she was noted to be
  - Underweight (BMI 17.5)
  - Smoker at 1 ppd
  - Experiencing an unintended pregnancy
  - Depressed

As you review her record you note that none of these issues has been revisited since her last delivery—despite contact with the neonatal care unit for 6 weeks, a routine postpartum visit and routine and high risk pediatric care

# “Usual” Perinatal Prevention Paradigm



# What Research Tells Us about Short Interconceptional Lengths and Pregnancy Outcomes

- Birth Spacing and Risk of Adverse Perinatal Outcomes (Meta-analysis of 67 studies covering 11,000,000+ births)  
Conde-Aquedo, JAMA 2006; 295:1809-1823
  - Those with interpregnancy intervals < 18 months had markedly increased risks of preterm birth, low birth weight and SGA births in their next pregnancy
  - For each month less than 18 months of interpregnancy interval, the risk increased dramatically
  - Intervals greater than 59 months were also associated with increase PTB, LBW, SGA

# Science and Practice Do Not Always Align

In 2010 survey, 66% of respondent physicians supported a waiting time of < 6 months for parents bereaved by stillbirth who desired another pregnancy. . . (which may place them at higher risk for another poor outcome).

**This begs the question:** how do we advance evidence-based care?

Gold, Leon and Chames. National survey of obstetrician attitudes about timing the subsequent pregnancy after perinatal death. *AJOG* 2010;202:357, e1-6.

# The Best Predictor of Poor Pregnancy Outcomes Is a Previous Poor Outcome

- **Previous pregnancy affected by ONTD**
  - One previous ONTD (as isolated birth defect) 3-5% recurrence risk
  - Two previous ONTDs (as isolated defect) 6-9% recurrence risk
- **Previous preterm delivery**
  - One previous PTD 15% recurrence risk
  - Two previous PTD 41% recurrence risk
- **Previous genetic related anomaly**
  - May be same as background, may be as high as 50%

# Pregnancy Also Predicts a Woman's Future Disease Challenges: It Is a "Stress Test for Life"

- **Gestational Diabetes**

50% risk of Type II diabetes within next 5 years

- **Pregnancy induced hypertension**

(preeclampsia/eclampsia)

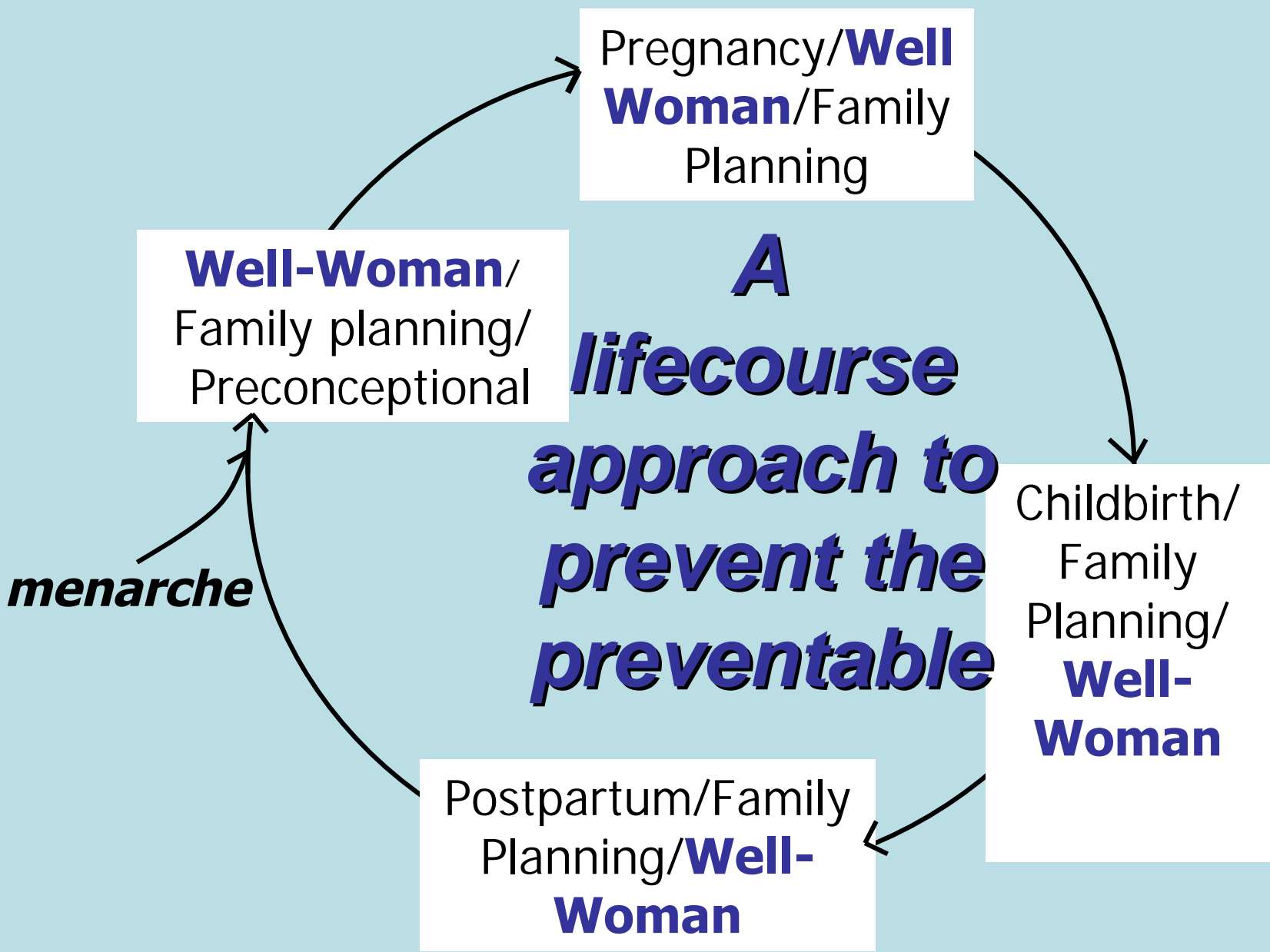
Relative risk 1.4-3.98 to develop chronic hypertension

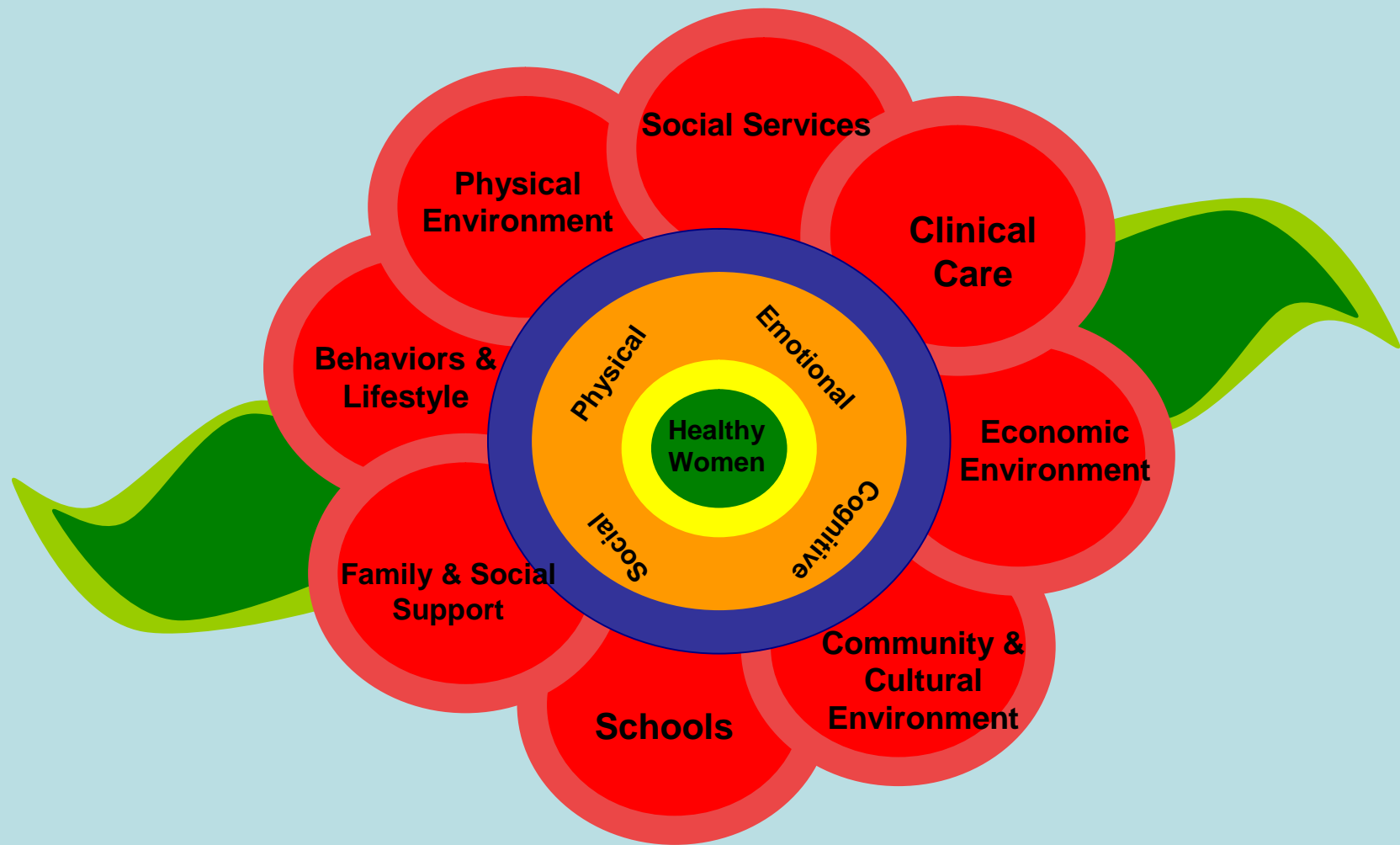
There is scant evidence that any group of woman receives appropriate follow-up and guidance to address risks or achieve timely diagnosis.

Because black women are disproportionately afflicted by these diseases, they are disproportionately disadvantaged by poor follow-up.

# The Interconception Conundrum: Which of These Women Will Become Pregnant Again?







*Used with permission of The Nemours Foundation, Division of Health and Prevention Services. Adapted from the 2005 Delaware Children's Health Chartbook.*



**CDC/Select Panel Goal 4:  
Reduce disparities in adverse  
pregnancy outcomes**

# Progression from Goal to Recommendations to Action Steps

## **Recommendation:**

Every thing applicable but nothing specific.

## **Action Step:**

Every thing applicable but nothing specific

Meetings such as this and the March of  
Dimes Tri-State Summit are essential for  
establishing new coalitions and community  
appropriate action steps!

## **Top Points in 12 Point Plan to Decrease Black-White Disparities in Birth Outcomes**

Lu, et al. Ethnicity & Disease, Vol 20, Winter 2010 (S2-62—S2-76)

1. Provide interconception care to women with prior poor outcomes
2. Increase access to preconception care for AA women

“We have evidence,  
consensus, and  
guidelines.

**So, why don't we do it?”**

**. . .maybe it's because we are making something quite simple way too hard!!**

If you take care of women of reproductive age, it's not a question of whether you provide preconception care, rather it's a question of what kind of preconception care you are providing.

Joseph Stanford

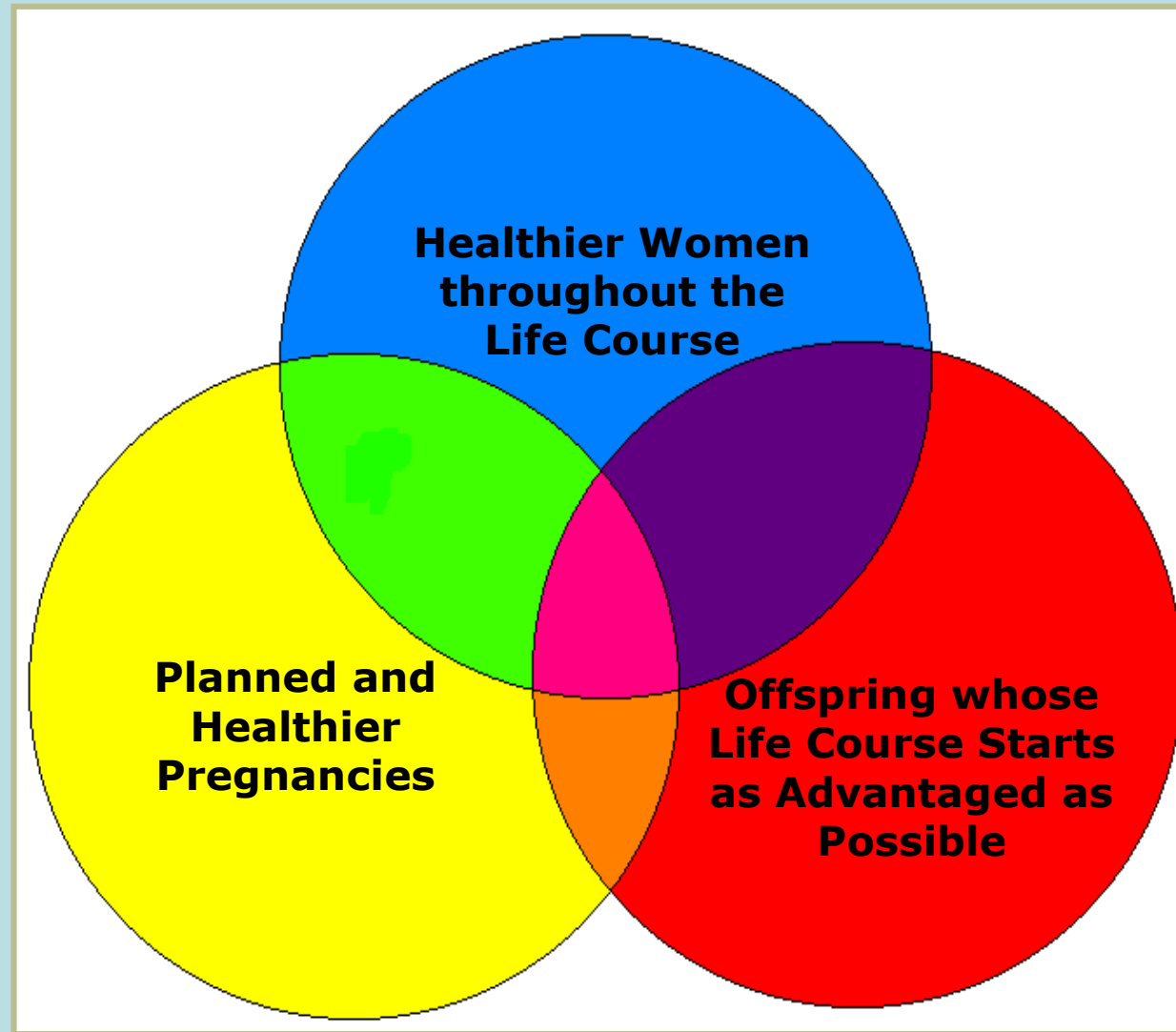


# My Challenge for Each of You

Develop three action steps that  
advance women's health  
. . .for today and tomorrow  
**irrespective** of pregnancy  
status



# Continuing North Carolina's Pioneering Role for a Healthier Tomorrow



**The child cannot wait. Many things we need can wait, but she cannot. . . To her we cannot say “tomorrow” for her name is today.**

***Neither the child nor the  
woman***

**^ can wait. Many things we  
need can wait, but they  
cannot...To them, we cannot  
say “tomorrow” for their  
names are “today”.**

With hopeful forgiveness from  
G. Mistral