

work for the 2011 report, which will focus on the implications of health system change in rural communities. The meeting will include an address by HRSA Administrator

Dr. Mary Wakefield as well as presentations by experts in the fields of hospital and health care delivery as well as workforce. Committee discussion on the issues and an overview of rest of the meeting will follow. The Wednesday meeting will close at 5 p.m.

Thursday morning, February 18, at 9 a.m., the Committee will open with presentations by experts in the area of human service delivery and will be followed by another presentation by a speaker from the Rural Policy Research Institute. This will be followed by Committee discussion and overview from staff to the Committee. Following these presentations, Subcommittees will be selected and meet for small group discussions. There will be a review of the Subcommittee meetings and action items will be developed for the Committee members and staff. The formal meeting for Thursday will close at 5 p.m.

The final session will be convened Friday morning, February 19, at 9 a.m. The Committee will hear additional presentations on emerging rural policy issues from both internal and external experts. This will be followed by Committee discussion on the Report format and an overview of the Work Plan. The Committee will draft the letter to the Secretary and discuss the June meeting. The meeting will be adjourned at 10:30 a.m.

*For Further Information Contact:* Anyone requiring information regarding the Committee should contact Thomas F. Morris, MPA, Acting Executive Secretary, National Advisory Committee on Rural Health and Human Services, Health Resources and Services Administration, Parklawn Building, Room 9A-42, 5600 Fishers Lane, Rockville, MD 20857, Telephone (301) 443-0835, Fax (301) 443-2803.

Persons interested in attending any portion of the meeting should contact Michele Pray Gibson, Office of Rural Health Policy (ORHP), Telephone (301) 443-0835. The Committee meeting agenda will be posted on ORHP's Web site <http://www.ruralhealth.hrsa.gov>.

Dated: January 14, 2010.

**Sahira Rafiullah,**

*Deputy Director, Division of Policy Review and Coordination.*

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### National Institutes of Health

#### NIH Consensus Development Conference on Vaginal Birth After Cesarean: New Insights; Notice

Notice is hereby given by the National Institutes of Health (NIH) of the "NIH Consensus Development Conference on Vaginal Birth After Cesarean: New

Insights" to be held March 8-10, 2010, in the NIH Natcher Conference Center, 45 Center Drive, Bethesda, Maryland 20892. The conference will begin at 8:30 a.m. on March 8 and 9 and at 9 a.m. on March 10, and it will be open to the public.

Vaginal birth after cesarean (VBAC) is the delivery of a baby through the vagina after a previous cesarean delivery. For most of the 20th century, once a woman had undergone a cesarean (the delivery of a baby through an incision made in the abdominal wall and uterus), many clinicians believed that all of her future pregnancies required delivery by cesarean as well. However, in 1980, an NIH Consensus Development Conference panel questioned the necessity of routine repeat cesarean deliveries and outlined situations in which VBAC could be considered. The option for a woman with a previous cesarean delivery to try to labor and deliver vaginally rather than plan a cesarean delivery was thus offered and exercised more often from the 1980s through the early 1990s. Since 1996, however, VBAC rates in the United States have consistently declined, while cesarean delivery rates have been steadily rising.

The exact causes of these shifts are not entirely understood. A frequently cited concern about VBAC is the possibility of uterine rupture during labor because a cesarean delivery leaves a scar in the wall of the uterus at the incision site, which is weaker than other uterine tissue. Attempted VBAC may also be associated with endometritis (infection of the lining of the uterus), the need for a hysterectomy (removal of the uterus) or blood transfusion, as well as neurologic injury to the baby. However, repeat cesarean delivery may also carry a risk of bleeding or hysterectomy, uterine infections, and respiratory problems for the newborn. Having multiple cesarean deliveries may also be associated with placental problems in future pregnancies. Other important considerations that may influence decisionmaking include the number of previous cesarean deliveries a woman has experienced, the surgical incision used during previous cesarean delivery, the reason for the previous surgical delivery, her age, how far along the pregnancy is relative to her due date, and the size and position of her baby. Given the complexity of this issue, a thorough examination of the relative balance of benefits and harms to mother and baby will be of immediate utility to practitioners and pregnant mothers in deciding upon a planned mode of delivery.

A number of nonclinical factors are involved in this decision as well and may be influencing the decline in VBAC rates. Some individual practitioners and hospitals in the U.S. have decreased or eliminated their use of VBAC. Professional society guidelines may influence utilization rates because some medical centers do not offer the recommended supporting services for a trial of labor after cesarean (e.g., immediate availability of a surgeon who can perform a cesarean delivery and on-site anesthesiologists). Information related to complications of an unsuccessful attempt at VBAC, medico-legal concerns, personal preferences of patients and clinicians, and insurance policies and economic considerations may all play a role in changing practice patterns. Improved understanding of the clinical risks and benefits and how they interact with legal, ethical, and economic forces to shape provider and patient choices about VBAC may have important implications for health services planning.

To advance understanding of these important issues, the Eunice Kennedy Shriver National Institute of Child Health and Human Development and the Office of Medical Applications of Research of the NIH will convene a Consensus Development Conference from March 8 to 10, 2010. The conference will address the following key questions:

- What are the rates and patterns of utilization of trial of labor after prior cesarean, vaginal birth after cesarean, and repeat cesarean delivery in the United States?
- Among women who attempt a trial of labor after prior cesarean, what are the vaginal delivery rate and the factors that influence it?
- What are the short- and long-term benefits and harms to the mother of attempting trial of labor after prior cesarean versus elective repeat cesarean delivery, and what factors influence benefits and harms?
- What are the short- and long-term benefits and harms to the baby of maternal attempt at trial of labor after prior cesarean versus elective repeat cesarean delivery, and what factors influence benefits and harms?
- What are the nonmedical factors that influence the patterns and utilization of trial of labor after prior cesarean?
- What are the critical gaps in the evidence for decision-making, and what are the priority investigations needed to address these gaps?

An impartial, independent panel will be charged with reviewing the available published literature in advance of the

conference, including a systematic literature review commissioned through the Agency for Healthcare Research and Quality. The first day and a half of the conference will consist of presentations by expert researchers and practitioners and open public discussions. On Wednesday, March 10, the panel will present a statement of its collective assessment of the evidence to answer each of the questions above. The panel will also hold a press telebriefing to address questions from the media. The draft statement will be published online later that day, and the final version will be released approximately six weeks later. The primary sponsors of this meeting are the NIH Eunice Kennedy Shriver National Institute of Child Health and Human Development and the NIH Office of Medical Applications of Research.

Advance information about the conference and conference registration materials may be obtained from the NIH Consensus Development Program Information Center by calling 888-644-2667 or by sending e-mail to [consensus@mail.nih.gov](mailto:consensus@mail.nih.gov). The Information Center's mailing address is P.O. Box 2577, Kensington, Maryland 20891. Registration information is also available on the NIH Consensus Development Program Web site at <http://consensus.nih.gov>.

**Please Note:** The NIH has instituted security measures to ensure the safety of NIH employees, guests, and property. All visitors must be prepared to show a photo ID upon request. Visitors may be required to pass through a metal detector and have bags, backpacks, or purses inspected or x-rayed as they enter NIH buildings. For more information about the security measures at NIH, please visit the Web site at <http://www.nih.gov/about/visitorsecurity.htm>.

Dated: January 11, 2010.

**Raynard S. Kington,**  
Deputy Director, National Institutes of Health.  
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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Health Resources and Services Administration

#### Ryan White HIV/AIDS Part C Early Intervention Services (EIS) Program

**AGENCY:** Health Resources and Services Administration, HHS.

**ACTION:** Notice of Non-competitive Replacement Award.

**SUMMARY:** The Health Resources and Services Administration (HRSA) is

issuing a non-competitive replacement award to the Orange County Health Department, Orlando, Florida, that will ensure continuity of Part C, Early Intervention Services (EIS), HIV/AIDS care and treatment services to women, infants, and children without disruption from Orlando Health Incorporated's HUG-ME Program, in Orange County and the surrounding areas.

#### SUPPLEMENTARY INFORMATION:

*Intended Recipient of the Award:* Orange County Health Department, Orlando, Florida.

*Amount of the Award:* \$303,018.00.

*Period of Support:* The period of the supplemental support is from October 1, 2009, through March 31, 2010.

*Authority:* This activity is under the authority of the Public Health Service Act as amended, Section 2651 and 2693 of the Public Health Service Act, as amended (2 USC 300ff-51 and 42 USC 300ff-121). The authority for the exception to competition is HHS Grants Policy Directive 2.04, Awarding Grants.

*Catalogue of Federal Domestic Assistance Number:* 93.918.

*Justification for the Exception to Competition:* Critical Funding for HIV/AIDS care and treatment to the target populations in Orange County, Orlando, Florida, and surrounding areas will be continued through a temporary, non-competitive replacement award to the Orange County Health Department as the new recipient. This temporary award is needed because the former grantee, Orlando Health, Incorporated, has relinquished, effective September 30, 2009, the HUG ME Program and the HRSA Grant award supporting it (original Project Period April 1, 2008, through March 31, 2010). The Orange County Health Department is known Statewide as an exceptional site for HIV/AIDS care and treatment services. It has administered its own HRSA Ryan White HIV/AIDS Program Part C EIS Grant for the past 9 years and is well suited to undertake operations of the HUG-ME Program under the previously approved scope of project activities. Additionally, this organization has a thorough understanding of the characteristics and needs of HIV/AIDS-infected populations. The HIV/AIDS Bureau (HAB) and its Division of Community Based Programs are not aware of any other organization that could provide good quality care and treatment services to the impacted service populations without additional time and resources being devoted to bringing that organization's service capacity up to the level needed under the project scope of this award. This non-competitive replacement award

will permit the new recipient to ensure continuity of services to the HIV/AIDS-infected populations. The supplemental funding will provide support for 6 months. Additional funding beyond March 31, 2010, will be provided through a limited service area competition that will be announced in the future.

#### FOR FURTHER INFORMATION CONTACT:

Deborah Parham Hopson, Associate Administrator, HRSA/HAB, 5600 Fishers Lane, Rockville, Maryland 20857; phone 301-443-1993; [DParham@hrsa.gov](mailto:DParham@hrsa.gov).

Dated: January 13, 2010.

**Mary K. Wakefield,**  
Administrator.

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## ADVISORY COUNCIL ON HISTORIC PRESERVATION

### Draft Program Comment for the Department of the Navy for the Disposition of Historic Vessels

**AGENCY:** Advisory Council on Historic Preservation.

**ACTION:** Notice of Intent to issue program comments for the Department of the Navy for the disposition of historic vessels.

**SUMMARY:** The Advisory Council on Historic Preservation is considering issuing a Program Comment for the Department of the Navy setting forth the way in which it will comply with Section 106 of the National Historic Preservation Act with regard to the determination of National Register of Historic Places eligibility of its vessels and the treatment of adverse effects that may result from their disposition.

**DATES:** Submit comments on or before February 12, 2010.

**ADDRESSES:** Address all comments concerning this proposed Program Comment to Dr. Tom McCulloch, Office of Federal Agency Programs, Advisory Council on Historic Preservation, 1100 Pennsylvania Avenue, NW., Suite 803, Washington, DC 20004. Fax (202) 606-8647. You may submit electronic comments to: [tmcculloch@achp.gov](mailto:tmcculloch@achp.gov).

**FOR FURTHER INFORMATION CONTACT:** Dr. Tom McCulloch, (202) 606-8554, [tmcculloch@achp.gov](mailto:tmcculloch@achp.gov).

**SUPPLEMENTARY INFORMATION:** Section 106 of the National Historic Preservation Act requires Federal agencies to consider the effects of their undertakings on historic properties and to provide the Advisory Council on