Inaugural lecture

Professor CS Minnie

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Evidence and compassion in Maternity care

NuMiQ Research Focus Area:

Research to Advance Nursing & Midwifery

Faculty of Health Services

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Contents

1 Overview

Welcome and thank you for celebrating my career as an academic. I will start with a reflection on my journey up to now. A brief discussion of Maternity care and specific Quality maternity care will follow. I will then focus on Midwifery as a component of quality maternity care.

The symbolic components of Midwifery, namely hands, mind and heart, will then be discussed. I will conclude with my plans for the future.

2 My Journey

I started my career as a Baccalareus student in Nursing (and Midwifery), followed by an Honours degree in Psychology. While raising our family, I also practised as a community nurse and midwife. During this time, I did community work as a breastfeeding counsellor.

I worked in public and private hospitals and managed a primary health care centre that provided midwifery services.

In 2000 I started my academic career when I was appointed as Midwifery lecturer at the Potchefstroom University for Christian Higher Education. At that time, I lectured Midwifery for the third and fourth-year students. In the years following, I obtained my specialist Midwifery qualification and developed and taught in the postgraduate programme for specialist midwives.

My Magister Curationis dissertation was titled “The choice of baby feeding mode within the HIV epidemic: Health education implications’ (2003). It was a very relevant topic at the time as antiretroviral medication was not yet widely available, and breast milk contributed to mother-to-child transmission of HIV. After the project, it became clear that a woman’s HIV status must be known to get the relevant health education. I addressed this dilemma in my PhD titled ‘Best practice guidelines for counselling for HIV testing during pregnancy’ (2007). In developing the best practice guidelines, compiled from research findings from multiple sources, I realised that evidence from valid research is not necessarily usable in practice if not contextualised.

I was fortunate to be awarded a postdoctoral fellowship at the University of Alberta in Edmonton, Canada. I worked with a team of researchers developing my research program called CREAM – Contextualising REsearch to Advance Midwifery.

During my studies, I was exposed to and developed expertise in evidence-based practice (EBP) theory, implementation science, systematic review methodology, and the development of best

practice guidelines. Since 2010, I have presented workshops on these topics locally, nationally, and internationally (in Malawi and Belgium).

In 2017, I obtained a C2 NRF rating with the research program: Promoting kind and compassionate care during childbirth.

3 Maternity care

My interest field is maternity care - the care of the mother-baby dyad during pregnancy, childbirth and the first few months after that. In Midwifery, we consider the first three months after birth as the 'fourth trimester' of pregnancy as anything that happens with the mother also influences the baby mother.

For decades, maternal morbidity and mortality were the main indicators of the quality of maternity care. Global maternal health programs focused on women's access to skilled providers as the most crucial aspect to decrease maternal morbidity and morbidity (Hastings, 2015). This focus led to many more births attended by skilled health personnel in developing countries, increasing from 56% in 1990 to 68% in 2012. However, despite this expanded coverage, 800 women and 7700 newborns still die each day from complications during pregnancy, childbirth and in the postnatal period (WHO, 2016).

Other aspects of maternal health care quality were then emphasised, and the focus shifted to the practitioner's clinical skills, such as managing haemorrhage (Hastings, 2015). However, patients' rights or perceptions of their care were not considered to be relevant to quality care.

Two main threats to Quality Maternal care have been identified, too little too late (TLTL) and too much too soon (TMTS) (Miller *et al*., 2016). Too little too late describes care with inadequate resources, a standard of care below evidence-based standards, care withheld or unavailable until too late to help. This type of care often leads to high maternal mortality and morbidity.

Too much too soon occurs when there is over-medicalisation of normal pregnancy and birth. Interventions that are not evidence-based are commonly used (for example, when food and drinks are withheld during the first stage of labour), and interventions that can be life-saving when used appropriately are routinely or overused. Examples of such interventions are induction of labour and caesarean sections. TMTS can cause harm, increase health costs, and often contribute to disrespect and abuse.

TLTL is typically ascribed to low-income and middle-income and TMTS to high-income countries. However, in societies with substantial inequities, such as South Africa, both TLTL and TMTS are present (Miller *et al.*, 2016). Strategies to promote quality maternity care need to be contextualised based on local circumstances and data (Koblinsky *et al.*, 2016).

The World Health Organization's latest vision of quality of care for pregnant women and newborns signalled a substantial move from their original view. For the first time, the new standards document acknowledged two main components to quality of care: the provision and the experience of care. The framework breaks quality of care into two equal parts that influence each other: the provider's provision of care (evidence-based practices, actionable information systems, and functional referral systems) and the patient's experience of care (effective communication, respect and dignity, and emotional support) (WHO, 2016).

In 2014, The Lancet published a series of articles related to Midwifery, which also addressed the quality of maternity care. The series comprises four papers developed collaboratively by a multidisciplinary group, including academics, researchers, advocates for women and children, clinicians, and policy-makers. The papers support a system-level shift, from maternal and newborn care focused on identifying and treating pathology, to a system of skilled care for all, with multidisciplinary teamwork and integration across hospital and community settings (Renfrew *et al*., 2014). They further concluded that future planning for maternal and newborn care systems in low-income and middle-income settings could benefit from using the evidence-based framework for quality maternal and newborn care (QMNC) for workforce development and resource allocation.

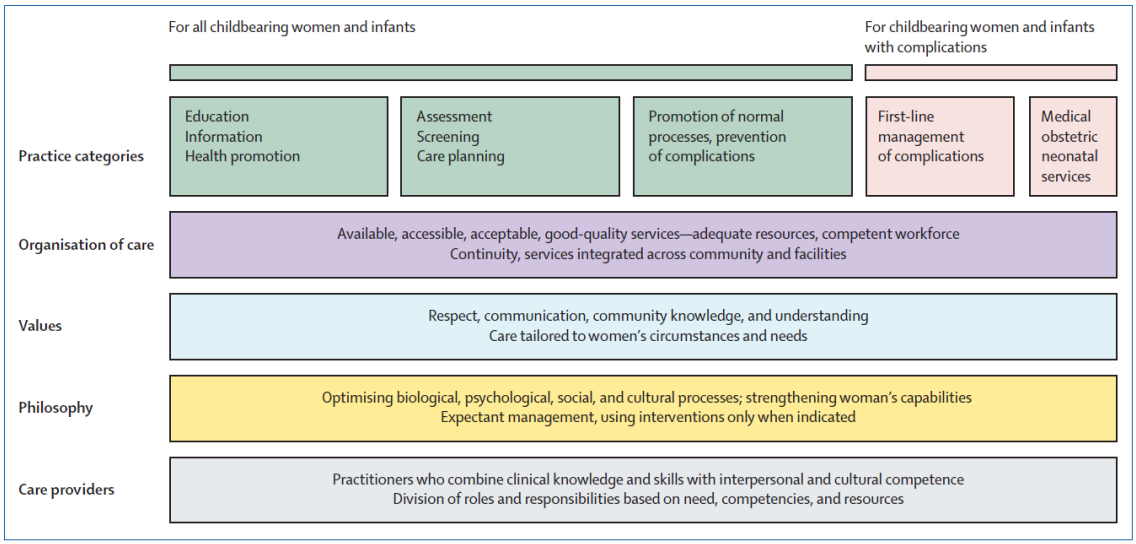

Figure 1: The framework for quality maternal and newborn care (Renfrew *et al*., 2014)

The framework was developed based on findings from a multimethod project. It included both what a health system needs to provide high-quality care, and how it delivers its functions and meets its goals within any particular context. Care led by midwives, educated, licensed, regulated, and integrated into the health system and working in interdisciplinary teams, had a positive effect on maternal and perinatal health across the many stages of the quality framework, even when compared with care led by other health professionals in combination with midwives.

4 Midwifery

Although various multidisciplinary team members can provide maternity care, the focus of my research is on the role of the midwife, who is the 'specialist' in physiological childbirth. Midwifery can be defined as skilled, knowledgeable and compassionate care for childbearing women, newborn infants and families across the continuum throughout pre-pregnancy, pregnancy, birth, postpartum and the early weeks of life.

Core characteristics of Midwifery include optimising normal biological, psychological, social and cultural processes of reproduction and early life, timely prevention and management of complications, consultation with and referral to other services, respecting women's individual circumstances and views, and working in partnership with women to strengthen women's own capabilities to care for themselves and their families (Renfrew *et al*., 2014).

Midwifery is associated with efficient use of resources and improved outcomes when provided by midwives who were educated, trained, licensed, and regulated, and midwives were most effective when integrated into the health system in the context of effective teamwork and referral mechanisms and with sufficient resources (Renfrew *et al*., 2014).

The word 'midwife' means' with woman' providing care and support in physical, psychological, emotional, and spiritual ways. It is therefore not linked to the gender of the care provider but about the woman. Women-centred care is a core concept in Midwifery.

A systematic review about what matters most to women during childbirth (Downe *et al*., 2018) concluded that what matters to most women is a positive experience that fulfilled or exceeded their prior personal and socio-cultural beliefs and expectations. This ebirth experience included giving birth to a healthy baby in a clinically and psychologically safe environment with practical and emotional support from birth companions and competent, reassuring, kind clinical staff. Most wanted physiological labour and birth while acknowledging that the birth process can be unpredictable and frightening and that they may need to `go with the flow'. If interventions were

needed or wanted, women wanted to retain a sense of personal achievement and control through active decision-making. (Downe *et al*., 2018).

In their review of published evidence in this area, Nicholls and Webb (2006) noted that a 'good' midwife must be more than technically skilled. The kindness and compassion midwives give through 'being there' provides the added dimension of being 'good'. In a qualitative study about "good midwifery and 'good leadership", Byron and Downe (2010) found that midwives consider a 'good' midwife to be competent in the cognitive (mind), psychomotor (hands) and affective (heart) domains. In the next section, I will discuss these different domains.

4.1 Hands

Midwives are expected to obtain certain psychomotor skills in their journey towards competence. The International Confederation of Midwives (ICM) (2019) specify the following competencies, each with their accompanying knowledge base, skills and behaviours. The competencies are organised in four inter-related categories, namely, general competencies, competencies specific to pre-pregnancy and antenatal care, competencies specific to care during labour and birth and competencies specific to the ongoing care of women and newborns.

Examples of psychomotor skills that are taught in the basic midwifery training are: presenting health education, prescribing medications such as antibiotics where applicable, pelvimetry, monitoring foetal wellbeing, initiating intravenous infusion, assisting during the first and second stage of labour, cutting episiotomies, suturing episiotomies or lacerations, managing the third stage of labour, basic resuscitation of the newborn, counselling and prescribing family planning methods. According to Byron and Downe (2010), a 'good midwife' should have excellent clinical skills and practice confidently.

There are, however, a global problem – not enough hands, with serious workforce issues. The State of the World Midwifery (SoWMy) report is published every four years. According to SoWMy of 2021 (UNFPA *et al*., 2021), midwives can meet 90 % of the sexual, reproductive, maternal, newborn and adolescent (SRMNAH) health needs of the world but only 75% of this need can currently be met. There is a global shortage of 1.1 million "dedicated SRMNAH equivalent" workers, of which the most considerable deficit (900,000) is of midwives. At current rates, the SRMNAH workforce is projected to be able to meet 82% of the need by 2030: only a marginally improvement on the current 75%. Globally, another 750 000 midwives are needed to meet the demands by 2030.

Interesting, as these global statistics are, the SoWMy 2021 does not include South African data. There are various reasons. In South Africa, most midwives are primarily trained as nurses (PHC approach), and it's therefore impossible to know how many of the nurses who had Midwifery training work as midwives or consider themselves midwives. A total of 174 695 persons were registered as midwives in 2020 – some as part of integrated four-year education, and others as a separate year of training after completing a three-year diploma as a nurse.

Table 1 Persons registered as midwives by the South African Nursing Council (SANC) in 2020

Registration	Number in 2020
Nurse (General, Psychiatric, community) and midwife - Female	55613
Nurse (General, Psychiatric, community) and midwife - Male	10169
Midwife (One year diploma after nurse training) - Female	97110
Accoucheur (One year diploma after nurse training) - Male	11803
Total trained in Midwifery	174 695

In South Africa, Midwifery is not considered an independent career, and direct entry midwifery training (without first being a nurse) is not supported by SANC. Midwifery training in South Africa usually last 12-18 months as part of a four-year program and is integrated with nurse training. The period falls short of the recommended duration. In their global standards of midwifery education (ICM, 2021), the International Confederation of Midwives recommends a three-year direct entry-, or an 18 months additional program after nurse education (only including midwifery subjects).

The South African Nursing Council also require fewer clinical procedures before registration than other countries. The clinical requirements include 1000 clinical hours and a minimum number of specific procedures, e.g. conducting 15 deliveries (SANC Regulation 254). In comparison, countries like, the United Kingdom, Australia, Kenya and Malawi, require attending 50 births. Midwives from South Africa need additional training to practice in these countries.

Even the United Kingdom experiences problems with their midwifery workforce. Fifty-seven percent of midwives participating in a recent Royal College of Midwives survey plan to leave their workplace in the next year (RCM, 2021). The most common reasons for considering to leave were unhappiness with staffing levels (84%), dissatisfaction with the quality of care they were able to deliver (57%) and pay (54%). The midwives do not feel valued, and burnout is higher than ever

before. Large numbers are leaving practice, resulting in the service being even more understaffed. Midwives from developing countries that already have insufficient health professionals are actively recruited for the National Health Service of the United Kingdom.

In South Africa, the understaffing of the health workforce can also be attributed to other reasons. On Friday, 19 November 2021, Minister Jo Phaahla answered a question regarding the Annual report of the National Department of Health in the Parlement portfolio committee on health. As reported by Netwerk24, there were 73 509 posts for professional nurses (who are also registered midwives) in 2020. However, 9493 of these posts were vacant. Minister Phaahla acknowledged that the provincial departments could not fill the vacancies due to budget limitations (inter alia due to corruption, mismanagement).

4.2 Mind

Evidence-based practice (EBP) is the use of the best available evidence in practice, and is situated in the area where 'hands' and 'mind' overlaps. EBP is the judicious use of the best evidence available, considering the clinician's expertise and the patient's condition and preferences (Sackett *et al*., 2000:1). When EBP is discussed in the field of Nursing (and Midwifery), the role of contextual issues such as available resources and culture are also considered (Newhouse *et al*., 2007).

My interest in evidence-based practice includes systematic (and other research -) review methodology and implementation science (the process of how primary research is synthesised, transferred/ translated) eventually implemented in practice). I collaborated with researchers from Canada and Europe and presented workshops, and published a few book chapters and articles on these aspects.

In my own PhD, I use a systematic review as a research method and develop Best Practice Guidelines. I published three articles from my thesis (Minnie *et al*., 2008, 2009, 2011).

One of my postgraduate students, Wilma ten Ham-Baloyi, completed both her Master's degree and PhD under my supervision. She did a systematic review of the best available evidence on pasteurisation of expressed breastmilk as an in-home procedure to limit mother-to-child transmission of HIV for her Master's degree (Ten Ham *et al*., 2011). In her PhD, she developed an operational plan by using benefit levers to spread best practices in health systems. She used the case of kangaroo-mother care as an evidence-based practice that is not yet universally

implemented. Three articles were published from her thesis (Ten Ham *et al*., 2015, 2016, Ten Ham-Baloyi *et al*., 2020.).

I also co-authored (with Christa van der Walt) a book chapter in the book based on the work of COST Action IS0907 Creating a dynamic European Union framework for optimal maternity care (2010-2014), namely: Innovations in practice: 'Complexities involved in knowledge transfer' (Minnie & van der Walt, 2017). We also compiled a toolkit of instruments that can be used in the process of knowledge transfer.

Article after the second COST Action IS1405 Building Intrapartum Research Through Health - an interdisciplinary whole system approach to understanding and contextualising physiological labour and birth (BIRTH) (2014-2018), I co-authored an article on 'Dissemination and enrichment of knowledge about normal birth to bring about a change to society' with four international co-authors (Gouni *et al*., 2021).

Several of my postgraduate worked on projects related to evidence-based practice. Relevant to Midwifery, the following students completed their studies:

- Dimakatso Sebopa - Barriers to research utilisation as perceived by midwives in Community Health Centres in Gauteng
- Madi Nyaloko - Factors affecting breastfeeding in public spaces: an integrated review
- Ralmarie Van Rooyen - The use of essential oils for pain relief and anxiety during childbirth: a systematic review

The following students' projects were related to nursing topics:

- Tsepiso Moati - Comorbidities of child malnutrition in low- and medium-income countries: A systematic review
- Marie-Louise Durr - The use of essential oils in relieving symptoms specific to brain malignancies: A systematic review

I also collaborated on other evidence-based practice projects. I co-authored a chapter in The Handbook of Salatogenesis (Minnie & Minnie, 2017) and worked with colleagues from various professional organisations to write 'South African Neonatal Skin care – Evidence-based clinical practice guidelines' (Geyer *et al*., 2018).

4.3 Heart

Moving to the third main domain of a 'good' midwife, the affective, I start with a practice lying in the overlap between the mind (EBP) and the heart. Companionship during childbirth is both a specific evidence-based practice and a component of compassionate maternity care.

The Cochrane review of Bohren *et al*. (2017) concluded that women value and benefit from the presence of a support person during labour and childbirth. This support includes aspects like emotional support (continuous presence, reassurance and praise); information about labour progress and advice about coping techniques, comfort measures (such as comforting touch, massage, warm baths/showers, encouraging mobility, promoting adequate fluid intake and output) and speaking up when needed on behalf of the woman (advocacy).

The review further found that the most beneficial continuous support is provided by a person who is present solely to provide support, is not a member of the woman's own network, is experienced in providing labour support, and has at least a modest amount of training (such as a doula). They further found that, compared to having no companion during labour, support from a chosen family member/ friend can increase women's satisfaction with their experience (Bohren *et al*., 2017). The support from someone from her own network is referred to as 'companionship during labour'. Pregnant women in South Africa are encouraged to identify support persons of their choice who are then orientated regarding their role.

Partners can also provide support, but as they are usually emotionally involved with the baby, they do not solely focus on the support needs of the birthing women. They often also need support!

Some of my postgraduate students investigated aspects of companionship: how women experience continuous support during childbirth (in progress), the challenges of midwives in implementing continuous support (Spencer *et al.,* 2018), and how midwives can facilitate such support even if they cannot offer it themselves (Jordaan, 2017). Two PhD students are busy developing a strategy to facilitate the implementation of continuous support during childbirth (M Bester) and a program to promote supportive interpersonal relationships between midwives, women and their companions (NM Rala).

My research on compassionate maternity care addresses the affective domain of a midwife's work (the heart). Two concepts received a lot of emphasis globally in the last ten years, namely 'Disrespect and Abuse during childbirth' and 'Respectful maternity care'. My research focuses on

building on what works - an appreciative approach, and therefore concentrate more on respectful or compassionate maternity care; I start with first an introduction to disrespect and abuse (D&A) during childbirth.

Although disrespectful practices have been reported previously, the issue attracted cam to the front with the publishing of Bowser and Hill's landscape analysis in 2010, 'Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth'. The team reviewed 150 reports from low-, medium, and high-income countries and classified the disrespect and abuse in facility-based childbirth in seven categories. These categories are physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination based on patient attributes, abandonment of care and detention in facilities. The authors acknowledged that some manifestations of disrespect and abuse fall into more than one category (Bowser & Hill, 2010).

Freedman and Kruk (2014) build on the description of D&A according to categories to define the concept that captures individual provider behaviour, such as slapping or scolding and structural disrespect and abuse, such as an overcrowded, understaffed maternity ward. Both subjectively experienced behaviour and actions intended as disrespectful and abusive are included.

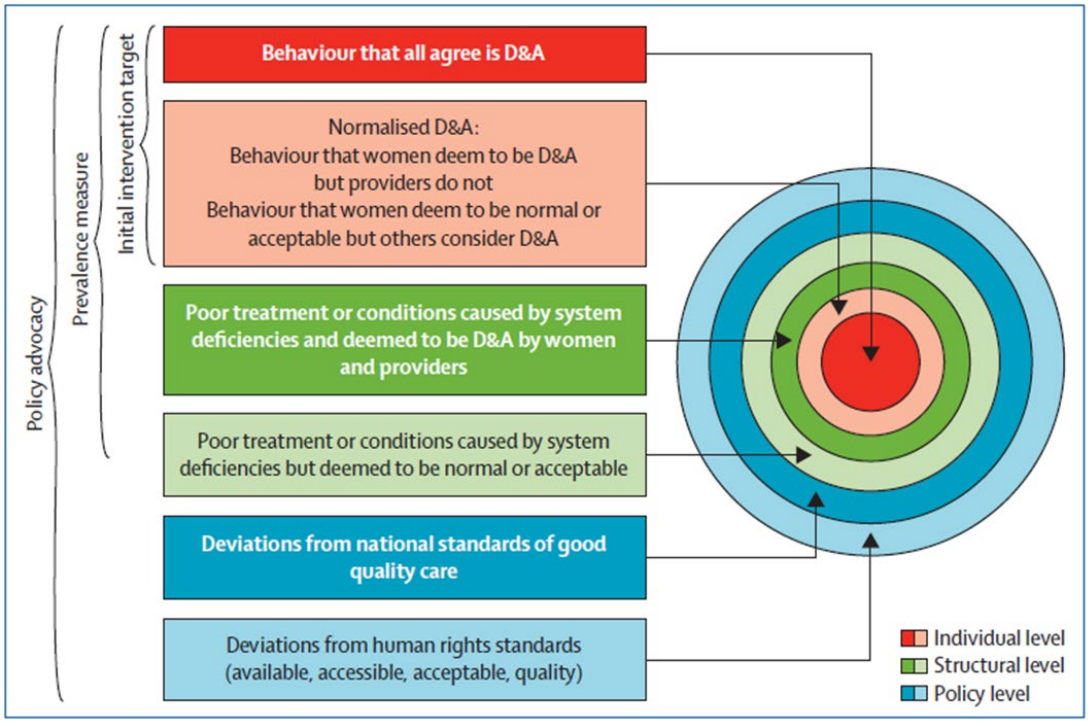

Figure 2 Bullseye-definition of disrespect and abuse of women in childbirth (Freedman & Kruk, 2014).

The bullseye captures the complex relationship among expectations, normalisation, and rights while acknowledging the link between individual action and the systemic conditions that sustain it. Defined and understood in this way, D&A is a signal of a health system in crisis—a crisis of quality and accountability.

At the most fundamental level, a health system that tolerates D&A devalues women. Moreover, D&A represents a breakdown in accountability of the health system not only to its users but also to the health service providers. If they are themselves subjected to degrading and disrespectful working conditions, providers' professional ideals often succumb to the pressure of emotional and physical survival strategies. Even a midwife providing compassionate care at one moment might be overwhelmed by the stress of unmeetable demands in the next and lash out at the women she attends (Freedman& Kruk, 2014; Mselle *et al*., 2013).

Disrespectful care affects maternal and newborn mortality and morbidity if women avoid using health care facilities.

As the sources of D&A are at multiple levels, interventions should address as many levels as possible, avoiding quick fixes that lack sustainability.

There are several initiatives to combat D&A. One of the organisations addressing the issue is the White Ribbon Alliance with their Respectful Maternity Care campaign. They developed the 'White Ribbon Alliance Charter' with seven universal rights of childbearing women (White Ribbon Alliance, 2011). These universal rights are that every woman has the right to:

1. Be free from harm and ill-treatment
2. Information, informed consent and refusal, and respect for her choices and preferences, including companionship during maternity care
3. Privacy and confidentiality
4. Be treated with dignity and respect
5. Equality, freedom from discrimination and equitable care
6. Healthcare and to the highest attainable level of health
7. Liberty, autonomy, self-determination and freedom from coercion.

The World Health Organisation also acknowledged respectful maternity care in their recommendations for intrapartum care for a positive birth experience (WHO, 2018). The first of 56 recommendations are: Respectful maternity care, which refers to care organised for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures

freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth – is recommended (WHO, 2018:19).

Advancing respectful maternity care is context-specific. Although experiences of D&A are common across cultures; Freedman and Kruk (2014) found that it runs wide and deep within the maternity services of many countries; successful solutions are deeply grounded in each local context. There is, therefore, a need for contextual studies and research about what work.

My research focuses on promoting respectful, compassionate maternity care in the South African context in various settings.

In the concept analysis of Ménage *et al.* (2017), compassionate Midwifery is defined as the interrelations of authentic presence, noticing suffering, empathy, connectedness/relationship, emotion work, motivation to help/support, empowering women and alleviating suffering through negotiation, knowledge and skills.

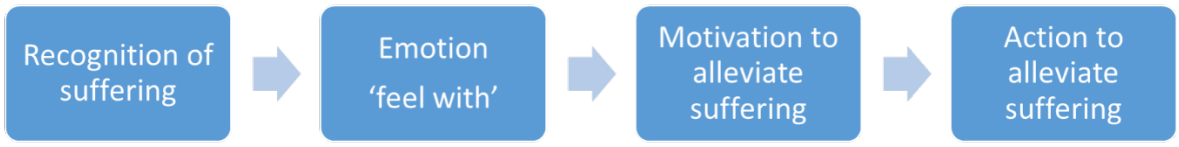

Figure 3: Continuum of components of compassionate maternity care

Several of my postgraduate students researched topics related to respectful, compassionate maternity care. S Krause investigated the characteristics of compassionate maternity care from midwives' perspectives (Krause et al., 2020), while an ongoing study explores the characteristics of compassionate maternity care from the viewpoint of new mothers.

Reliable assessment instruments are essential to assess any intervention. A current Master's study uses an integrative literature review to identify instruments to assess compassionate maternity care that can be used as-is or adapted for a specific context (A Mashedi). I plan to use the identified instrument(s) to evaluate the strategy to promote respectful maternity care that a PhD student (P Lunda) is currently developing.

The next step will be to implement and evaluate the new strategy.

Another project related to compassion links to presence. Du Plessis (2021:xiv) defines presence as ‘to attune to and connect with another for the purpose of healing and enrichment’. The concept can be applied in various contexts and professions and is especially relevant to Midwifery – to be ‘with woman’.

I contributed a chapter on Compassionate maternity care in the book ‘Reflecting on Presence in Nursing’ edited by Prof E du Plessis (Du Plessis, ed, 2021).

5 Implementation of expertise

In the last year, I applied my expertise in compassionate, respectful maternity care in contributing to two projects of the South African National Department of Health. A Guideline document was developed on Maternity care in Covid-19 times, and I’ve written the section on respectful maternity care in Covid-19 times.

RMC was weakened due to many challenges linked to the COVID pandemic (Asefa *et al.,* 2021). Health workers face high levels of personal and work stress that may make RMC feel difficult. Restrictions on contact between women and their infants or loved ones can make maternity care lonely and frightening for women, their partners and their babies.

I suggester the following ways to promote respectful maternity care during the COVID-19 pandemic:

- Promote family involvement/support

Promote the presence of the woman’s partner or another companion of choice as far as possible within the current restriction level. The women should have this companionship in the antenatal clinics, labour ward, theatre or postpartum ward. Ensure the companion does not increase the COVID transmission risk (screening, sanitation, mask-wearing, vaccination, as relevant). The companion can provide physical and emotional support and decrease the risk of health workers moving between patients. If physical presence is not possible, help the mother and her family have contact on the phone or recorded with messages.

- Keep the mother and newborn together

Keep the newborn and mother together as far as possible: for breastfeeding, skin-to-skin contact, kangaroo-mother care and bonding. The baby is not at increased risk when not with her unless the mother or newborn is critically ill.

- Ensure effective health education

Women need evidence-based information to make informed decisions and give informed consent.

- Promote a positive practice environment

A negative practice environment gets in the way of health workers being able to provide kind, compassionate and empathetic care. Managers need to provide leadership support, deal with resource shortages and conflict or poor relationships between staff.

I am also participating in the new edition of Guidelines for Maternal and Newborn care, to be published by the National Department of Health in 2022.

6 Further role as Professor

In addition to teaching, doing research and publishing in their field of expertise, a professor is expected to be a leader. I enjoy working with more junior colleagues: mentoring them to promote their empowerment and leadership development. Concerning leadership development, I've got experience presenting workshops on transformational leadership based on the 'Leadership challenge' of Kouzes and Posner (2012). They based their five practices of exemplary leadership on hundreds of case studies. The five practices and ten commitments of exemplary leadership are:

Model the way focuses on clarifying values and affirming shared values, and setting the example by aligning actions with the shared values.

Inspire a shared value includes envisioning the future by imagining exciting and ennobling possibilities and enlisting others in a common vision by appealing to shared aspirations.

Challenge the process means searching for opportunities by seizing the initiative and looking outward for innovative ways to improve as well as to experiment and take risks by constantly generating small wins and learning from experience.

Enable others to act entails fostering collaboration by building trust and facilitating relationships and strengthening others by increasing self-determination and developing competence.

Encourage the heart includes recognising contributions by showing appreciation for individual excellence and celebrating the values and victories by creating a spirit of community.

I plan to use these five practices in helping others reach their full potential.

In conclusion, I am passionate about quality maternity care and want to bring compassionate maternity care to all through my research.

According to a Norwegian proverb, the greatest joy is to become a mother, and the second greatest is to be a midwife. I want to add to this - the third greatest joy is to be part of the birth of a new midwife!

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