



Complete Summary

GUIDELINE TITLE

Primary care interventions to promote breastfeeding: U.S. Preventive Services Task Force recommendation statement.

BIBLIOGRAPHIC SOURCE(S)

U.S. Preventive Services Task Force. Primary care interventions to promote breastfeeding: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med* 2008 Oct 21;149(8):560-4. [11 references] [PubMed](#)

GUIDELINE STATUS

This is the current release of the guideline.

This release updates a previously published guideline: U.S. Preventive Services Task Force (USPSTF). Behavioral interventions to promote breastfeeding: recommendations and rationale. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2003 Jul 27. 12 p. [28 references]

COMPLETE SUMMARY CONTENT

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SCOPE

DISEASE/CONDITION(S)

Infant and maternal health

GUIDELINE CATEGORY

Counseling

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Nursing
Obstetrics and Gynecology
Pediatrics
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Nurses
Physician Assistants
Physicians
Public Health Departments

GUIDELINE OBJECTIVE(S)

- To summarize the U.S. Preventive Services Task Force (USPSTF) recommendations and supporting evidence on counseling to promote breastfeeding
- To update the 2003 USPSTF recommendations on counseling to promote breastfeeding

TARGET POPULATION

Pregnant women, new mothers, and young children

Note: Interventions to promote and support breastfeeding may also involve a woman's partner, other family members, and friends.

INTERVENTIONS AND PRACTICES CONSIDERED

Interventions to promote and support breastfeeding during pregnancy, at delivery, and after birth:

- Formal breastfeeding education for mothers and families
- Direct support of mothers during breastfeeding observation
- Training of primary care staff about breastfeeding and techniques for breastfeeding support
- Peer support

MAJOR OUTCOMES CONSIDERED

Key Question 1: What are the effects of breastfeeding interventions on child and maternal health outcomes?

Key Question 2: What are the effects of breastfeeding interventions on breastfeeding initiation, duration, and exclusivity?

Key Question 3: Are there harms from interventions to promote and support breastfeeding?

Key Question 4: What are the benefits and harms of breastfeeding on infant or child health outcomes?

Key Question 5: What are the benefits and harms of breastfeeding on maternal health outcomes?

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review was prepared by the Tufts-New England Medical Center Evidence-Based Practice Center (EPC) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Availability of Companion Documents" field).

Data Sources

This systematic review focuses on recent evidence (September 2001 to February 2008) and updates a previous systematic review conducted for the U.S. Preventive Services Task Force to support its 2003 recommendation on counseling to promote breastfeeding. EPC staff searched for English-language articles in MEDLINE, the Cochrane Central Register of Controlled Trials, and CINAHL from September 2001 to February 2008 by using such Medical Subject Heading terms and keywords as *breastfeeding*, *breast milk feeding*, *breast milk*, *human milk*, *nursing*, *breastfed*, *infant nutrition*, *lactating*, and *lactation*. They also reviewed reference lists of a related systematic review for additional studies.

Study Selection

EPC staff included randomized controlled trials (RCTs) published from September 2001 to February 2008 that included any counseling or behavioral intervention initiated from a clinician's practice (office or hospital) to improve the breastfeeding initiation rate or duration of breastfeeding among healthy mothers or members of the mother-child support system (such as partners, grandparents, or friends) and their healthy term or near-term infants (≥ 35 weeks' gestation or ≥ 2500 g). The review was focused on studies conducted in developed countries; however, because of the widespread interest in the Baby-Friendly Hospital Initiative (BFHI), RCTs of the BFHI that were conducted in Brazil and Belarus were also included.

EPC staff considered interventions conducted by various providers (lactation consultants, nurses, peer counselors, midwives, and physicians) in various

settings (hospital, home, clinic, or elsewhere) to be eligible as long as they originated from a health care setting. Maternity services were considered to be primary care for this review. Such health care system interventions as staff training were also included. Community- or peer-initiated interventions were excluded. Control comparisons were any usual prenatal, peripartum, or postpartum care, as defined in each study. Studies needed to report rates of breastfeeding initiation, duration of breastfeeding, or exclusivity of breastfeeding to be included. Figure 1 in the Evidence Review (see the "Availability of Companion Documents" field) shows the search and selection process.

NUMBER OF SOURCE DOCUMENTS

Thirty-eight randomized controlled trials (RCTs) met the eligibility criteria: 32 parallel RCTs described in 33 publications, 4 clustered RCTs, and 2 quasi-RCTs described in 3 publications.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Meta-Analysis
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review was prepared by the Tufts-New England Medical Center Evidence-Based Practice Center (EPC) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Availability of Companion Documents" field).

Data Extraction and Quality Assessment

One investigator extracted data from each study, and another confirmed them. The extracted data included study setting, population, control, description of intervention (type, person, frequency, and duration), definitions of breastfeeding outcomes (initiation, exclusivity, and duration), definitions of health outcomes in both mothers and children (when provided), and analytic methods.

Data Synthesis and Analysis

EPC staff calculated the rates of breastfeeding initiation and short-term, intermediate-term, long-term, and prolonged breastfeeding for both the intervention and control groups in each study. They recorded the exclusivity of breastfeeding and did the same calculations for the exclusive breastfeeding rates.

Meta-analysis and Meta-regression

EPC staff used the rate ratio (relative risk) as the metric of choice to quantify the effectiveness of each breastfeeding promotion intervention. The DerSimonian and Laird model for random-effects meta-analysis was used to obtain summary estimates across studies. EPC staff tested for heterogeneity by using the Cochran Q test, which follows a chi-square distribution to make inferences about the null hypothesis of homogeneity (considered significant at $P < 0.100$) and quantified its extent with I^2 . The I^2 statistic ranges between 0% and 100% and quantifies the proportion of between-study variability that is attributed to heterogeneity rather than chance.

Random-effects meta-regression (fitted with restricted maximum likelihood) was used to explore whether the effectiveness of breastfeeding interventions depends on breastfeeding duration, provided that at least 6 studies with relevant information were available.

Subgroup Analyses

EPC staff performed subgroup analyses according to various study factors, such as study quality, timing of intervention (prenatal, postpartum, or combined prenatal and postpartum), and different components of breastfeeding interventions. The EPC staff used a Z test to compare summary estimates between the subgroups.

EPC staff used Intercooled Stata, version 8.2 (Stata, College Station, Texas) for all analyses. All P values are 2-tailed and considered significant when less than 0.05 unless otherwise indicated.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Balance Sheets
Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) systematically reviews the evidence concerning both the benefits and harms of widespread implementation of a preventive service. It then assesses the certainty of the evidence and the magnitude of the benefits and harms. On the basis of this assessment, the USPSTF assigns a letter grade to each preventive service signifying its recommendation about provision of the service (see Table below). An important, but often challenging, step is determining the balance between benefits and harms to estimate "net benefit" (that is, benefits minus harms).

Table 1. U.S. Preventive Services Task Force Recommendation Grid*

Certainty of Net Benefit	Magnitude of Net Benefit			
	Substantial	Moderate	Small	Zero/Negative
High	A	B	C	D

Certainty of Net Benefit	Magnitude of Net Benefit			
	Substantial	Moderate	Small	Zero/Negative
Moderate	B	B	C	D
Low	Insufficient			

*A, B, C, D, and I (*Insufficient*) represent the letter grades of recommendation or statement of insufficient evidence assigned by the U.S. Preventive Services Task Force after assessing certainty and magnitude of net benefit of the service (see the "Rating Scheme for the Strength of the Recommendations" field).

The overarching question that the Task Force seeks to answer for every preventive service is whether evidence suggests that provision of the service would improve health outcomes if implemented in a general primary care population. For screening topics, this standard could be met by a large randomized, controlled trial (RCT) in a representative asymptomatic population with follow-up of all members of both the group "invited for screening" and the group "not invited for screening."

Direct RCT evidence about screening is often unavailable, so the Task Force considers indirect evidence. To guide its selection of indirect evidence, the Task Force constructs a "chain of evidence" within an analytic framework. For each key question, the body of pertinent literature is critically appraised, focusing on the following 6 questions:

1. Do the studies have the appropriate research design to answer the key question(s)?
2. To what extent are the existing studies of high quality? (i.e., what is the internal validity?)
3. To what extent are the results of the studies generalizable to the general U.S. primary care population and situation? (i.e., what is the external validity?)
4. How many studies have been conducted that address the key question(s)? How large are the studies? (i.e., what is the precision of the evidence?)
5. How consistent are the results of the studies?
6. Are there additional factors that assist us in drawing conclusions (e.g., presence or absence of dose–response effects, fit within a biologic model)?

The next step in the Task Force process is to use the evidence from the key questions to assess whether there would be net benefit if the service were implemented. In 2001, the USPSTF published an article that documented its systematic processes of evidence evaluation and recommendation development. At that time, the Task Force's overall assessment of evidence was described as good, fair, or poor. The Task Force realized that this rating seemed to apply only to how well studies were conducted and did not fully capture all of the issues that go into an overall assessment of the evidence about net benefit. To avoid confusion, the USPSTF has changed its terminology. Whereas individual study quality will continue to be characterized as good, fair, or poor, the term *certainty* will now be used to describe the Task Force's assessment of the overall body of evidence about net benefit of a preventive service and the likelihood that the assessment is correct. Certainty will be determined by considering all 6 questions listed above; the judgment about certainty will be described as high, moderate, or low.

In making its assessment of certainty about net benefit, the evaluation of the evidence from each key question plays a primary role. It is important to note that the Task Force makes recommendations for real-world medical practice in the United States and must determine to what extent the evidence for each key question—even evidence from screening RCTs or treatment RCTs—can be applied to the general primary care population. Frequently, studies are conducted in highly selected populations under special conditions. The Task Force must consider differences between the general primary care population and the populations studied in RCTs and make judgments about the likelihood of observing the same effect in actual practice.

It is also important to note that 1 of the key questions in the analytic framework refers to the potential harms of the preventive service. The Task Force considers the evidence about the benefits and harms of preventive services separately and equally. Data about harms are often obtained from observational studies because harms observed in RCTs may not be representative of those found in usual practice and because some harms are not completely measured and reported in RCTs.

Putting the body of evidence for all key questions together as a chain, the Task Force assesses the certainty of net benefit of a preventive service by asking the 6 major questions listed above. The Task Force would rate a body of convincing evidence about the benefits of a service that, for example, derives from several RCTs of screening in which the estimate of benefits can be generalized to the general primary care population as "high" certainty (see the "Rating Scheme for the Strength of Recommendations" field). The Task Force would rate a body of evidence that was not clearly applicable to general practice or has other defects in quality, research design, or consistency of studies as "moderate" certainty. Certainty is "low" when, for example, there are gaps in the evidence linking parts of the analytic framework, when evidence to determine the harms of treatment is unavailable, or when evidence about the benefits of treatment is insufficient. Table 4 in the methodology document listed below (see "Availability of Companion Documents" field) summarizes the current terminology used by the Task Force to describe the critical assessment of evidence at all 3 levels: individual studies, key questions, and overall certainty of net benefit of the preventive service.

Sawaya GF, et al. Update on the methods of the U.S. Preventive Services Task Force: estimating certainty and magnitude of net benefit. *Ann Intern Med*. 2007;147:871-875 [5 references].

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

What the United States Preventive Services Task Force (USPSTF) Grades Mean and Suggestions for Practice

Grade	Grade Definitions	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	The USPSTF recommends the service. There is high certainty that	Offer or provide this service.

Grade	Grade Definitions	Suggestions for Practice
	the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	
C	The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is moderate or high certainty that the net benefit is small.	Offer or provide this service only if there are other considerations in support of the offering/providing the service in an individual patient.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I Statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality or conflicting, and the balance of benefits and harms cannot be determined.	Read "Clinical Considerations" section of USPSTF Recommendation Statement (see "Major Recommendations" field). If offered, patients should understand the uncertainty about the balance of benefits and harms.

USPSTF Levels of Certainty Regarding Net Benefit

Definition: The U.S. Preventive Services Task Force defines certainty as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.

Level of Certainty	Description
High	The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by factors such as: <ul style="list-style-type: none"> • The number, size, or quality of individual studies • Inconsistency of findings across individual studies • Limited generalizability of findings to routine primary care practice • Lack of coherence in the chain of evidence

Level of Certainty	Description
	As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.
Low	<p>The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of:</p> <ul style="list-style-type: none"> • The limited number or size of studies • Important flaws in study design or methods • Inconsistency of findings across individual studies • Gaps in the chain of evidence • Findings not generalizable to routine primary care practice • A lack of information on important health outcomes <p>More information may allow an estimation of effects on health outcomes.</p>

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Comparison with Guidelines from Other Groups
 External Peer Review
 Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Peer Review. Before the U.S. Preventive Services Task Force makes its final determinations about recommendations on a given preventive service, the Evidence-Based Practice Center and the Agency for Healthcare Research and Quality send a draft evidence review to 4 to 6 external experts and to federal agencies and professional and disease-based health organizations with interests in the topic. They ask the experts to examine the review critically for accuracy and completeness and to respond to a series of specific questions about the document. After assembling these external review comments and documenting the proposed response to key comments, the topic team presents this information to the Task Force in memo form. In this way, the Task Force can consider these external comments before it votes on its recommendations about the service. Draft recommendation statements are then circulated for comment from reviewers representing professional societies, voluntary organizations and Federal agencies. These comments are discussed before the final recommendations are confirmed.

Comparison with Guidelines from Other Groups. Recommendations for screening from the following groups were discussed: the American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Obstetricians and Gynecologists.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The US Preventive Services Task Force (USPSTF) grades its recommendations (A, B, C, D, or I) and identifies the levels of certainty regarding net benefit (High, Moderate, and Low). The definitions of these grades can be found at the end of the "Major Recommendations" field.

Summary of Recommendation and Evidence

The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding. **This is a grade B recommendation.**

Clinical Considerations

Patient Population under Consideration

This recommendation applies to pregnant women, new mothers, and young children. In rare circumstances involving health issues in mothers or infants, such as human immunodeficiency virus (HIV) infection or galactosemia, breastfeeding may be contraindicated and interventions to promote breastfeeding may not be appropriate. Interventions to promote and support breastfeeding may also involve a woman's partner, other family members, and friends.

Interventions

The current literature does not allow assessment of the individual aspects of multicomponent interventions or comparative effectiveness assessments of single-component interventions. The promotion and support of breastfeeding may be accomplished through interventions over the course of pregnancy; around the time of delivery; and after birth, while breastfeeding is under way. Interventions may include multiple strategies, such as formal breastfeeding education for mothers and families, direct support of mothers during breastfeeding observations, and the training of health professional staff about breastfeeding and techniques for breastfeeding support. Evidence suggests that interventions that include both prenatal and postnatal components may be the most effective at increasing breastfeeding duration. Many successful programs include peer support or prenatal breastfeeding education, or both.

Other Considerations

Implementation

Although the activities of individual clinicians to promote and support breastfeeding are likely to be positive, additional benefit may result from efforts that are integrated into systems of care. System-level interventions can incorporate clinician and team member training and policy development, and through senior leadership support and institutionalization, these initiatives may be more likely to be sustained over time. Although they are outside the scope of this recommendation and evidence review, community-based interventions to promote

and support breastfeeding, such as direct peer-to-peer support, social marketing initiatives, workplace initiatives, and public policy actions, may offer additional sizeable benefits.

Definitions:

What the United States Preventive Services Task Force (USPSTF) Grades Mean and Suggestions for Practice

Grade	Grade Definitions	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer or provide this service.
C	The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is moderate or high certainty that the net benefit is small.	Offer or provide this service only if there are other considerations in support of the offering/providing the service in an individual patient.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I Statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality or conflicting, and the balance of benefits and harms cannot be determined.	Read "Clinical Considerations" section of USPSTF Recommendation Statement (see "Major Recommendations" field). If offered, patients should understand the uncertainty about the balance of benefits and harms.

USPSTF Levels of Certainty Regarding Net Benefit

Definition: The U.S. Preventive Services Task Force defines certainty as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.

Level of Certainty	Description
High	The available evidence usually includes consistent results from well-

Level of Certainty	Description
	designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	<p>The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by factors such as:</p> <ul style="list-style-type: none"> • The number, size, or quality of individual studies • Inconsistency of findings across individual studies • Limited generalizability of findings to routine primary care practice • Lack of coherence in the chain of evidence <p>As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.</p>
Low	<p>The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of:</p> <ul style="list-style-type: none"> • The limited number or size of studies • Important flaws in study design or methods • Inconsistency of findings across individual studies • Gaps in the chain of evidence • Findings not generalizable to routine primary care practice • A lack of information on important health outcomes <p>More information may allow an estimation of effects on health outcomes.</p>

CLINICAL ALGORITHM(S)

None available

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Effectiveness of Interventions to Change Behavior

Adequate evidence indicates that interventions to promote and support breastfeeding increase the rates of initiation, duration, and exclusivity of breastfeeding.

POTENTIAL HARMS

Harms of Interventions

No published studies focus on the potential direct harms from interventions to promote and support breastfeeding. The review did not include a search for potential harms of breastfeeding itself. The U.S. Preventive Services Task Force (USPSTF) has bounded the potential harms of interventions to promote and support breastfeeding as no greater than small.

CONTRAINDICATIONS

CONTRAINDICATIONS

In rare circumstances involving health issues in mothers or infants, such as human immunodeficiency virus (HIV) infection or galactosemia, breastfeeding may be contraindicated and interventions to promote breastfeeding may not be appropriate.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- The U.S. Preventive Services Task Force (USPSTF) makes recommendations about preventive care services for patients without recognized signs or symptoms of the target condition.
- Recommendations are based on a systematic review of the evidence of the benefits and harms and an assessment of the net benefit of the service.
- The USPSTF recognizes that clinical or policy decisions involve more considerations than this body of evidence alone. Clinicians and policy-makers should understand the evidence but individualize decision making to the specific patient or situation.
- Recommendations made by the USPSTF are independent of the U.S. government. They should not be construed as an official position of the Agency for Healthcare Research and Quality or the U.S. Department of Health and Human Services.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The experiences of the first and second U.S. Preventive Services Task Force (USPSTF), as well as that of other evidence-based guideline efforts, have highlighted the importance of identifying effective ways to implement clinical recommendations. Practice guidelines are relatively weak tools for changing clinical practice when used in isolation. To effect change, guidelines must be

coupled with strategies to improve their acceptance and feasibility. Such strategies include enlisting the support of local opinion leaders, using reminder systems for clinicians and patients, adopting standing orders, and audit and feedback of information to clinicians about their compliance with recommended practice.

In the case of preventive services guidelines, implementation needs to go beyond traditional dissemination and promotion efforts to recognize the added patient and clinician barriers that affect preventive care. These include clinicians' ambivalence about whether preventive medicine is part of their job, the psychological and practical challenges that patients face in changing behaviors, lack of access to health care or of insurance coverage for preventive services for some patients, competing pressures within the context of shorter office visits, and the lack of organized systems in most practices to ensure the delivery of recommended preventive care.

Dissemination strategies have changed dramatically in this age of electronic information. While recognizing the continuing value of journals and other print formats for dissemination, the Agency for Healthcare Research and Quality will make all USPSTF products available through its [Web site](#). The combination of electronic access and extensive material in the public domain should make it easier for a broad audience of users to access USPSTF materials and adapt them for their local needs. Online access to USPSTF products also opens up new possibilities for the appearance of the annual, pocket-size *Guide to Clinical Preventive Services*.

To be successful, approaches for implementing prevention have to be tailored to the local level and deal with the specific barriers at a given site, typically requiring the redesign of systems of care. Such a systems approach to prevention has had notable success in established staff-model health maintenance organizations, by addressing organization of care, emphasizing a philosophy of prevention, and altering the training and incentives for clinicians. Staff-model plans also benefit from integrated information systems that can track the use of needed services and generate automatic reminders aimed at patients and clinicians, some of the most consistently successful interventions. Information systems remain a major challenge for individual clinicians' offices, however, as well as for looser affiliations of practices in network-model managed care and independent practice associations, where data on patient visits, referrals, and test results are not always centralized.

IMPLEMENTATION TOOLS

Foreign Language Translations
Patient Resources
Personal Digital Assistant (PDA) Downloads
Pocket Guide/Reference Cards

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

U.S. Preventive Services Task Force. Primary care interventions to promote breastfeeding: U.S. Preventive Services Task Force recommendation statement. Ann Intern Med 2008 Oct 21;149(8):560-4. [11 references] [PubMed](#)

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1996 (revised 2008)

GUIDELINE DEVELOPER(S)

United States Preventive Services Task Force - Independent Expert Panel

GUIDELINE DEVELOPER COMMENT

The U.S. Preventive Services Task Force (USPSTF) is a federally-appointed panel of independent experts. Conclusions of the U.S. Preventive Services Task Force do not necessarily reflect policy of the U.S. Department of Health and Human Services (DHHS) or its agencies.

SOURCE(S) OF FUNDING

United States Government

GUIDELINE COMMITTEE

U.S. Preventive Services Task Force (USPSTF)

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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**Members of the Task Force at the time this recommendation was finalized. For a list of current Task Force members, go to www.ahrq.gov/clinic/uspstfab.htm.*

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

The U.S. Preventive Services Task Force has an explicit policy concerning conflict of interest. All members disclose at each meeting if they have a significant financial, professional/business, or intellectual conflict for each topic being discussed. Task Force members with conflicts may be recused from discussing or voting on recommendations about the topic in question.

GUIDELINE STATUS

This is the current release of the guideline.

This release updates a previously published guideline: U.S. Preventive Services Task Force (USPSTF). Behavioral interventions to promote breastfeeding: recommendations and rationale. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2003 Jul 27. 12 p. [28 references]

GUIDELINE AVAILABILITY

Electronic copies: Available from the [U.S. Preventive Services Task Force \(USPSTF\) Web site](#) and from the [Annals of Internal Medicine Web site](#).

Print copies: Available from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to <http://www.ahrq.gov/news/pubsix.htm> or call 1-800-358-9295 (U.S. only).

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

Evidence Reviews:

- Chung M, Ip S, Yu W, Raman G, Trikalinos T, DeVine D, Lau J. Interventions in primary care to promote breastfeeding: a systematic review. Evidence Synthesis No. 66. AHRQ Publication No. 09-05126-EF-1. Rockville, Maryland: Agency for Healthcare Research and Quality, 2008 Oct. Electronic copies: Available from the [U.S. Preventive Services Task Force \(USPSTF\) Web site](#).
- Chung M, Raman G, Trikalinos T, Lau J, Ip S. Interventions in primary care to promote breastfeeding: an evidence review for the U.S. Preventive Services Task Force. *Ann Intern Med*. 2008; 149:565-582. Electronic copies: Available from the [Annals of Internal Medicine Web site](#).
- Primary care interventions to promote breastfeeding: clinical summary of a U.S. Preventive Services Task Force recommendation. Rockville (MD): Agency for Healthcare Research and Quality, 2008. Electronic copies: Available from the [U.S. Preventive Services Task Force \(USPSTF\) Web site](#).

Background Articles:

- Barton M et al. How to read the new recommendation statement: methods update from the U.S. Preventive Services Task Force. *Ann Intern Med*. 2007;147:123-127.
- Guirguis-Blake J et al. Current processes of the U.S. Preventive Services Task Force: refining evidence-based recommendation development. *Ann Intern Med*. 2007;147:117-122. [2 references]
- Sawaya GF et al., Update on the methods of the U.S. Preventive Services Task Force: estimating certainty and magnitude of net benefit. *Ann Intern Med*. 2007;147:871-875. [5 references].

Electronic copies: Available from [U.S. Preventive Services Task Force \(USPSTF\) Web site](#).

The following is also available:

- The guide to clinical preventive services, 2008. Recommendations of the U.S. Preventive Services Task Force. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2008. 249 p. Electronic copies available from the [AHRQ Web site](#).

Print copies: Available from the Agency for Healthcare Research and Quality Publications Clearinghouse. For more information, go to <http://www.ahrq.gov/news/pubsix.htm> or call 1-800-358-9295 (U.S. only).

The [Electronic Preventive Services Selector \(ePSS\)](#), available as a PDA application and a web-based tool, is a quick hands-on tool designed to help primary care clinicians identify the screening, counseling, and preventive medication services that are appropriate for their patients. It is based on current recommendations of the USPSTF and can be searched by specific patient characteristics such as age, sex, and selected behavioral risk factors.

PATIENT RESOURCES

The following are available:

- Summaries for patients. Health care strategies to promote breastfeeding: U.S. Preventive Services Task Force recommendations. Ann Intern Med 2008 149:I-52. Available from the [Annals of Internal Medicine Web site](#).
- Women: stay healthy at any age. Your checklist for health. Rockville (MD): Agency for Healthcare Research and Quality. AHRQ Pub. No. 07-IP005-A. February 2007. Electronic copies: Available from the [USPSTF Web site](#). See the related QualityTool summary on the [Health Care Innovations Exchange Web site](#).

Print copies: Available in English and Spanish from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to <http://www.ahrq.gov/news/pubsix.htm> or call 1-800-358-9295 (U.S. only).

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

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