Complete Summary

GUIDELINE TITLE

Behavioral interventions to promote breastfeeding: recommendations and rationale.

BIBLIOGRAPHIC SOURCE(S)

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 health

GUIDELINE CATEGORY

Counseling

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Nursing
Obstetrics and Gynecology
Pediatrics
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Nurses
Physician Assistants
Physicians
Public Health Departments

GUIDELINE OBJECTIVE(S)

To summarize the current U.S. Preventive Services Task Force (USPSTF) recommendations on counseling to promote breastfeeding

TARGET POPULATION

Pregnant women and new mothers seen in a primary care setting

INTERVENTIONS AND PRACTICES CONSIDERED

1. Breastfeeding education programs alone or in combination with behavioral counseling
2. Support programs (i.e., in-person, telephone support, peer counseling)
3. Supportive hospital-based practices, such as early mother-newborn contact, rooming in, and avoidance of formula supplementation and samples on discharge
4. Written material (considered but not recommended)
5. Commercial discharge packets (considered but not recommended)

MAJOR OUTCOMES CONSIDERED

- Initiation of breastfeeding
- Duration of breastfeeding (i.e., short-term [1-3 months] or long-term [4-6 months])

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

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 Oregon Health & Science University Evidence-based Practice Center (EPC) for the Agency for Healthcare Research and Quality (AHRQ) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Companion Documents" field).

Study Selection

Randomized controlled trials (RCTs) and cohort studies conducted in developed countries were included in the review. EPC staff sought studies involving any

counseling or behavioral intervention originating from a clinician's practice (office or hospital) that was implemented to improve breastfeeding initiation, duration, or both. Interventions could be conducted by a variety of providers (including physicians, nurses, lactation consultants, or peer counselors) and in a variety of settings (clinic, hospital, home, or elsewhere) as long as they originated from the health care setting. Using this definition, community-based or peer-originated interventions were not included. For interventions that had not been studied in RCTs, EPC staff included nonrandomized controlled trials, but did not include any other nonrandomized controlled trials in this review.

Search Strategy

EPC staff searched MEDLINE, the Cochrane Controlled Trials Registry, and HealthSTAR for articles from 1966 to December 2001, using the MeSH terms and keywords "breastfeeding," "counseling," "health education," "teaching materials," "medical advice," and "advice" or "advise." They also searched the Cochrane Database of Systematic Reviews (CDSR) and the National Health Service Centre for Reviews and Dissemination databases using the terms "lactation" and "breastfeeding."

Two reviewers independently reviewed all abstracts and titles for inclusion. Studies were included if they originated in the primary care setting, were conducted in a developed country, were written in English, and contained a concurrent control group.

NUMBER OF SOURCE DOCUMENTS

The literature searches selected 1,048 abstracts, of which 689 were rejected following abstract review. Full-text articles were reviewed to identify 22 randomized controlled trials (RCTs), 8 non-RCTs, and 5 systematic reviews of breastfeeding counseling.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

The U.S. Preventive Services Task Force (USPSTF) grades the quality of the overall evidence for a service on a 3-point scale (good, fair, poor):

Good

Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

Fair

Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual

studies, generalizability to routine practice, or indirect nature of the evidence on health outcomes.

Poor

Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

METHODS USED TO ANALYZE THE EVIDENCE

Meta-Analysis of Randomized Controlled Trials
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 Oregon Health & Science University Evidence-based Practice Center (EPC) for the Agency for Healthcare Research and Quality (AHRQ) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Companion Documents" field).

Data Extraction

Two EPC reviewers independently abstracted predetermined descriptive data from all included studies. EPC staff categorized interventions and breastfeeding outcomes. Disagreements between the 2 reviewers were resolved by consensus. A third reviewer independently verified the accuracy of the data within the evidence tables.

Quality Assessment Instrument

EPC staff assessed the quality of published systematic reviews and controlled trials using criteria developed by the USPSTF. Two reviewers independently reviewed each study and applied the Task Force criteria and assigned each paper a quality rating of "good," "fair," or "poor" (see Appendix B in the original guideline document). When the reviewers disagreed, a final score was reached though consensus.

Data Synthesis

EPC staff conducted separate meta-analyses of randomized controlled trials (RCTs) to examine the influence of specific components of counseling interventions on rates of 3 outcome measures: (1) initiation of breastfeeding [Y_1]; (2) breastfeeding for 1 to 3 months (short-term duration) [Y_2]; and (3) breastfeeding for 4 to 6 months (long-term duration) [Y_3]. They included trials that offered educational interventions, interventions using in-person or telephone support, or both. One RCT of support in very low-birth-weight infants was excluded from the meta-analysis. Mean differences and 95% confidence intervals were calculated for the individual and combined effects of education and support.

Within these categories EPC staff examined the effect of using written materials as a cointervention.

Random effects meta-regression models were fit on the data from the eligible RCTs. For each dependent variable Yi, EPC staff fit the following regression equation:

$Logit(Pi_i) = Alpha + Beta_1*(education) + Beta_2*(support) + Beta_3*(written\ materials) + Beta_4*Ci + Epsilon_I$,

where Pi_i represents the ith probability of outcome (initiation, short-term duration, or long-term duration) and Ci is the control group rate for the ith study (an adjustment for baseline differences in breastfeeding rates among studies). To estimate the effect of the combination of education plus support on each outcome Pi_i, EPC staff separately pooled studies that combined these interventions. Similarly, they estimated the effect of education combined with written materials by separately pooling studies that used both. To compare the effects of education or support alone to education with support or written materials, they compared these pooled estimates with the estimates of the effects of education alone and support alone derived from the model. The Bayesian data analytic framework was used to fit the models. Inference on the parameters was done via posterior probability distributions. The data were analyzed using WinBUGS software, which uses a method of Markov Chain Monte Carlo called Gibbs Sampling to simulate posterior probability distributions. Noninformative prior probability distributions were used. Sensitivity analyses were performed excluding poor-quality studies and to assess the effect of breastfeeding rates in the control group. There was no significant difference in the results when poor studies were excluded. EPC staff then fit a second model using all studies to allow for a linear association between the control group rate and the effect of the intervention.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Balance Sheets
Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

When the overall quality of the evidence is judged to be good or fair, the U.S. Preventive Services Task Force (USPSTF) proceeds to consider the magnitude of net benefit to be expected from implementation of the preventive service. Determining net benefit requires assessing both the magnitude of benefits and the magnitude of harms and weighing the two.

The USPSTF classifies benefits, harms, and net benefits on a 4-point scale: "substantial," "moderate," "small," and "zero/negative."

"Outcomes tables" (similar to 'balance sheets') are the USPSTF's standard resource for estimating the magnitude of benefit. These tables, prepared by the topic teams for use at USPSTF meetings, compare the condition specific outcomes expected for a hypothetical primary care population with and without use of the

preventive service. These comparisons may be extended to consider only people of specified age or risk groups or other aspects of implementation. Thus, outcomes tables allow the USPSTF to examine directly how the preventive services affects benefits for various groups.

When evidence on harms is available, the topic teams assess its quality in a manner like that for benefits and include adverse events in the outcomes tables. When few harms data are available, the USPSTF does not assume that harms are small or nonexistent. It recognizes a responsibility to consider which harms are likely and judge their potential frequency and the severity that might ensue from implementing the service. It uses whatever evidence exists to construct a general confidence interval on the 4-point scale (e.g., substantial, moderate, small, and zero/negative).

Value judgments are involved in using the information in an outcomes table to rate either benefits or harms on the USPSTF's 4-point scale. Value judgments are also needed to weigh benefits against harms to arrive a rating of net benefit.

In making its determinations of net benefit, the USPSTF strives to consider what it believes are the general values of most people. It does this with greater confidence for certain outcomes (e.g., death) about which there is little disagreement about undesirability, but it recognizes that the degree of risk people are willing to accept to avert other outcomes (e.g., cataracts) can vary considerably. When the USPSTF perceives that preferences among individuals vary greatly, and that these variations are sufficient to make trade-off of benefits and harms a 'close-call', then it will often assign a C recommendation (see the "Recommendation Rating Scheme" field). This recommendation indicates the decision is likely to be sensitive to individual patient preferences.

The USPSTF uses its assessment of the evidence and magnitude of net benefit to make recommendations. The general principles the USPSTF follows in making recommendations are outlined in Table 5 of the companion document cited below. The USPSTF liaisons on the topic team compose the first drafts of the recommendations and rationale statements, which the full panel then reviews and edits. Recommendations are based on formal voting procedures that include explicit rules for determining the views of the majority.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

The Task Force grades its recommendations according to one of 5 classifications (A, B, C, D, I) reflecting the strength of evidence and magnitude of net benefit (benefits minus harms):

A

The USPSTF strongly recommends that clinicians provide [the service] to eligible patients. The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.

B

The USPSTF recommends that clinicians provide [this service] to eligible patients. The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.

C

The USPSTF makes no recommendation for or against routine provision of [the service]. The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.

D

The USPSTF recommends against routinely providing [the service] to asymptomatic patients. The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.

I

The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.

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 (USPSTF) 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 systematic 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 and a final version of the systematic review before it votes on its recommendations about the service. Draft recommendations are then circulated for comment from reviewers representing professional societies, voluntary organizations and Federal agencies. These comments are discussed before the whole USPSTF before final recommendations are confirmed.

Recommendations of Others. Recommendations to promote breastfeeding from the following groups were discussed: the Canadian Task Force on Preventive Health Care, the American Academy of Family Physicians, the World Health Organization, the United Nation's Children's Fund, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American Dietetic Association, and the International Lactation Consultants Association.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations (A, B, C, D, or I) and the quality of the overall evidence for a service (good, fair, poor). The definitions of these grades can be found at the end of the "Major Recommendations" field.

The USPSTF recommends structured breastfeeding education and behavioral counseling programs to promote breastfeeding. B recommendation.

The USPSTF found fair evidence that programs combining breastfeeding education with behaviorally-oriented counseling are associated with increased rates of breastfeeding initiation and its continuation for up to 3 months, although effects beyond 3 months are uncertain. Effective programs generally involved at least 1 extended session, followed structured protocols, and included practical, behavioral skills training and problem-solving in addition to didactic instruction.

The USPSTF found fair evidence that providing ongoing support for patients, through in-person visits or telephone contacts with providers or counselors, increased the proportion of women continuing breastfeeding for up to 6 months. Such support, however, had a much smaller effect than educational programs on the initiation of breastfeeding and its continuation for up to 3 months. Too few studies have been conducted to determine whether the combination of education and support is more effective than education alone.

The USPSTF found insufficient evidence to recommend for or against the following interventions to promote breastfeeding: brief education and counseling by primary care providers; peer counseling used alone and initiated in the clinical setting; and written materials, used alone or in combination with other interventions. I recommendation.

The USPSTF found no evidence for the effectiveness of counseling by primary care providers during routine visits and generally poor evidence to assess the effectiveness of peer counseling initiated from the clinical setting when used alone

to promote breastfeeding in industrialized countries. The evidence for the effectiveness of written materials suggests no significant benefit when written materials are used alone and mixed evidence of incremental benefit when written materials are used in combination with other interventions.

Clinical Considerations

- Effective breastfeeding education and behavioral counseling programs use individual or group sessions led by specially trained nurses or lactation specialists, usually lasting 30 to 90 minutes. Sessions generally begin during the prenatal period and cover the benefits of breastfeeding for infant and mother, basic physiology, equipment, technical training in positioning and latch-on techniques, and behavioral training in skills required to overcome common situational barriers to breastfeeding and to garner needed social support.
- Hospital practices that may help support breastfeeding include early maternal contact with the newborn, rooming-in, and avoidance of formula supplementation for breastfeeding infants.
- Commercial discharge packs provided by hospitals that include samples of infant formula and/or bottles and nipples are associated with reducing the rates of exclusive breastfeeding.
- Mothers who wish to continue breastfeeding after returning to work, especially those working full-time, may need to use an electric or mechanical pump to maintain a sufficient breast milk supply.
- Few contraindications to breastfeeding exist. In developed countries, infection with human immunodeficiency virus (HIV) in the mother is considered a contraindication to breastfeeding, as is the presence of current alcohol and drug use/dependence. Some medications (prescription and non-prescription) are contraindicated or advised for use "with caution" and appropriate clinical monitoring among lactating women. Clinicians should consult appropriate references for information on specific medications, including herbal remedies.

Definitions

The Task Force grades its recommendations according to one of 5 classifications (A, B, C, D, I) reflecting the strength of evidence and magnitude of net benefit (benefits minus harms):

A

The USPSTF strongly recommends that clinicians provide [the service] to eligible patients. The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.

B

The USPSTF recommends that clinicians provide [this service] to eligible patients. The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.

C

The USPSTF makes no recommendation for or against routine provision of [the service]. The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.

D

The USPSTF recommends against routinely providing [the service] to asymptomatic patients. The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.

I

The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.

The USPSTF grades the quality of the overall evidence for a service on a 3-point scale (good, fair, poor):

Good

Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

Fair

Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies, generalizability to routine practice, or indirect nature of the evidence on health outcomes.

Poor

Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is identified in the "Major Recommendations" field.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Benefits of Breastfeeding

Breast milk is the optimal infant food. It has nutritional properties superior to formula and transmits protective immunoglobulins to the newborn. Observational studies in North America and Europe have found that breast-fed infants have reduced rates of otitis media (odds ratios [OR] 0.39-0.61) and respiratory infection (adjusted incidence density ratio 0.78) compared with non-breast-fed infants. A recent large randomized trial of breastfeeding promotion in Belarus found that breastfeeding reduces the incidence of gastroenteritis (adjusted OR, 0.60) and atopic eczema (adjusted OR, 0.54), consistent with the findings of earlier observational studies in other countries.

For the mother, breastfeeding causes more rapid return of uterine tone and has been associated with lower risk for ovarian and breast cancer.

Effectiveness of Interventions to Promote Breastfeeding

- Breastfeeding education programs combined with behavioral counseling: The U.S. Preventive Services Task Force (USPSTF) found fair evidence that programs combining breastfeeding education with behaviorally-oriented counseling are associated with increased rates of breastfeeding initiation and its continuation for up to 3 months, although effects beyond 3 months are uncertain. Effective programs generally involved at least 1 extended session, followed structured protocols, and included practical, behavioral skills training and problem-solving in addition to didactic instruction.
- Support programs: The USPSTF found fair evidence that providing ongoing support for patients, through in-person visits or telephone contacts with providers or counselors, increased the proportion of women continuing breastfeeding for up to 6 months. Such support, however, had a much smaller effect than educational programs on the initiation of breastfeeding and its continuation for up to 3 months. Too few studies have been conducted to determine whether the combination of education and support is more effective than education alone.
- Other interventions: The USPSTF found no evidence for the effectiveness of counseling by primary care providers during routine visits and generally poor evidence to assess the effectiveness of peer counseling initiated from the clinical setting when used alone to promote breastfeeding in industrialized countries. The evidence for the effectiveness of written materials suggests no significant benefit when written materials are used alone and mixed evidence of incremental benefit when written materials are used in combination with other interventions.

POTENTIAL HARMS

Not stated

CONTRAINDICATIONS

CONTRAINDICATIONS

Few contraindications to breastfeeding exist. In developed countries, infection with human immunodeficiency virus (HIV) in the mother is considered a contraindication to breastfeeding, as is the presence of current alcohol and drug use/dependence. Some medications (prescription and non-prescription) are contraindicated or advised for use "with caution" and appropriate clinical monitoring among lactating women. Clinicians should consult appropriate references for information on specific medications, including herbal remedies.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

The U.S. Preventive Services Task Force (USPSTF) recommendations are independent of the U.S. Government. They do not represent the views of the Agency for Healthcare Research and Quality (AHRQ), the U.S. Department of Health and Human Services, or the U.S. Public Health Service.

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.

Neither the resources nor the composition of the U.S. Preventive Services Task Force equip it to address these numerous implementation challenges, but a number of related efforts seek to increase the impact of future U.S. Preventive Services Task Force reports. The U.S. Preventive Services Task Force convened

representatives from the various audiences for the Guide "Put Prevention Into Practice. A Step-by-Step Guide to Delivering Clinical Preventive Services: A Systems Approach"--clinicians, consumers and policy makers from health plans, national organizations and Congressional staff--about how to modify the content and format of its products to address their needs. With funding from the Robert Wood Johnson Foundation, the U.S. Preventive Services Task Force and Community Guide effort have conducted an audience analysis to further explore implementation needs. The Put Prevention into Practice initiative at the Agency for Healthcare Research and Quality (AHRQ) has developed office tools such as patient booklets, posters, and handheld patient mini-records, and a new implementation guide for state health departments.

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 U.S. Preventive Services Task Force (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 U.S. Preventive Services Task Force materials and adapt them for their local needs. Online access to U.S. Preventive Services Task Force products also opens up new possibilities for the appearance of the third edition of the Guide to Clinical Preventive Services. Freed from having to serve as primary repository for all of U.S. Preventive Services Task Force work, the next Guide may be much slimmer than the almost 1000 pages of the second edition.

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.

RELATED QUALITY TOOLS

- Pocket Guide to Good Health for Adults

- A Step-by-Step Guide to Delivering Clinical Preventive Services: A Systems Approach

- Behavioral Interventions to Promote Breastfeeding. What's New from the USPSTF.

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 (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]

ADAPTATION

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

DATE RELEASED

2003 Jul 27

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

Task Force Members: Alfred O. Berg, MD, MPH (Chair); Janet D. Allan, PhD, RN, CS (Vice-chair); Paul Frame, MD; Charles J. Homer, MD, MPH; Mark S. Johnson, MD, MPH; Jonathan D. Klein, MD, MPH; Tracy A. Lieu, MD, MPH; Cynthia D. Mulrow, MD, MSc; C. Tracy Orleans, PhD; Jeffrey F. Peipert, MD, MPH; Nola J. Pender, PhD, RN; Albert L. Siu, MD, MSPH; Steven M. Teutsch, MD, MPH; Carolyn Westhoff, MD, MSc; Steven H. Woolf, MD, MPH

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

The U.S. Preventive Services Task force has an explicit policy concerning conflict of interest. All members and evidence-based practice center (EPC) staff disclose at each meeting if they have an important financial conflict for each topic being discussed. Task Force members and EPC staff with conflicts can participate in discussions about evidence, but members abstain from voting on recommendations about the topic in question.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site and the National Library of Medicine's Health Services/Technology Assessment Text (HSTAT) 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 Review:

- Guise JM, Palda V, Westhoff C, Chan B, Helfand M, Lieu TA. The effectiveness of primary care based interventions to promote breastfeeding: a systematic evidence review and meta-analysis for the U.S. Preventive Services Task Force. Ann Fam Med 2003;1(2):70-78

Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site.

Background Articles:

- Woolf SH, Atkins D. The evolving role of prevention in health care: contributions of the U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):13-20.
- Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.
- Saha S, Hoerger TJ, Pignone MP, Teutsch SM, Helfand M, Mandelblatt JS. The art and science of incorporating cost effectiveness into evidence-based recommendations for clinical preventive services. Cost Work Group of the Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):36-43.

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

Additional Implementation Tools:

- A step-by-step guide to delivering clinical preventive services: a systems approach. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2001. 189 p. (Pub. No. APPIP01-0001). 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 Preventive Services Selector, an application for Palm Pilots and other PDA's, is also available from the AHRQ Web site.
- Behavioral interventions to promote breastfeeding. What's new from the third USPSTF. Rockville (MD): Agency for Healthcare Research and Quality; 2003 Jul. Electronic copies: Available from USPSTF Web site.

PATIENT RESOURCES

The following is available:

- The Pocket Guide to Good Health for Adults. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2003.

Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site. Copies also available in Spanish from the USPSTF 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).

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.

NGC STATUS

This summary was completed by ECRI on July 18, 2003. The information was verified by the guideline developer on July 25, 2003.

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