Members of the Advisory Panel support the Women’s Preventive Services Initiative:

The American College of Obstetricians and Gynecologists
Women’s Health Care Physicians

NPWH
Nurse Practitioners in Women’s Health
Caring for Women

ACP
American College of Physicians
Leading Internal Medicine, Improving Lives

American Academy of Family Physicians
Strong Medicine for America
The organizations comprising the Multidisciplinary Steering Committee endorse the collaborative and consensus process of the Women’s Preventive Services Initiative:
The American College of Obstetricians and Gynecologists is pleased to submit our report “Recommendations for Preventive Services for Women” to the U.S. Department of Health and Human Services Administration. The Women’s Preventive Services Initiative is a collaborative effort between health professional societies and consumer organizations that are experts in women’s health. This report is the first in a 5-year effort to develop, review, update, and disseminate recommendations for women’s preventive health care services and identifies needs across a woman’s life span, from adolescence through adulthood into maturity. The goal of the Women’s Preventive Services Initiative is to promote health over the course of a woman’s lifetime through disease prevention and preventive health care.

In order to ensure that women of all ages receive appropriate preventive health screenings, both health care providers and patients need uniform, established guidelines. The Women’s Preventive Services Initiative recognizes that women may seek guidance for preventive services from a diverse set of experts in women’s health, including family physicians and internists, obstetrician–gynecologists, physician assistants, nurse practitioners, certified nurse-midwives, and certified midwives. It will take the collaborative effort of the Women’s Preventive Services Initiative, with its broad membership of specialty societies providing women’s health care, to share guidelines and to hold all accountable for optimizing the health and well-being of women. Efficient, effective guidelines established with evidence-based processes and vetted by women’s health experts will optimize health care delivery and outcomes.

The American College of Obstetricians and Gynecologists thanks the Health Resources and Services Administration for the opportunity to undertake this rewarding and satisfying project. We represent more than 57,000 obstetrician–gynecologists and, more importantly, the women we serve. Over the next 4 years, we look forward to the prospect of identifying and developing more topic-specific recommendations and building an implementation strategy so that the health of all women is improved in this generation and generations to come!

Jeanne Ann Conry, MD, PhD, FACOG
ACOG Past President
Chairperson, Women’s Preventive Services Initiative
EXECUTIVE SUMMARY

On March 1, 2016, the American College of Obstetricians and Gynecologists (ACOG) launched the Women’s Preventive Services Initiative (WPSI), a close collaboration of national health professional societies and consumer organizations, all with important contributions to improving women’s health. Through a 5-year cooperative agreement with the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), ACOG will coordinate the WPSI effort to develop, review, update, and disseminate recommendations for women’s preventive health care services.

The WPSI Advisory Panel provides oversight to the Initiative and is made up of representatives from ACOG and three other major professional organizations representing the majority of women’s health care providers: the American Academy of Family Physicians, the American College of Physicians, and the National Association of Nurse Practitioners in Women’s Health. The Multidisciplinary Steering Committee, which develops the preventive health care recommendations, includes representatives from medical specialty societies that oversee the majority of women’s primary care services and chronic disease management care, public health professionals, and patients and consumers (see the box).

### 2016 Multidisciplinary Steering Committee Participating Organizations

| American Academy of Family Physicians | American Osteopathic Association |
| American College of Obstetricians and Gynecologists | American Psychiatric Association |
| American College of Physicians | American Geriatrics Society |
| National Association of Nurse Practitioners in Women’s Health | Association of Reproductive Health Professionals |
| Academy of Women’s Health | Association of Women’s Health, Obstetric and Neonatal Nurses |
| American Academy of Pediatrics | National Comprehensive Cancer Network |
| American Academy of Physician Assistants | National Medical Association |
| American Cancer Society | Association of Maternal & Child Health Programs |
| American College of Nurse–Midwives | National Partnership for Women & Families |
| American College of Preventive Medicine | National Women’s Law Center |
| American College of Radiology | Patient Representative |

### Federal Partners

| Centers for Disease Control and Prevention | Office of Minority Health |
| Health Resources and Services Administration | Office of Population Affairs |
| Office of Health Reform | Office on Women’s Health |
In addition, the WPSI incorporates a strong evidence-based structure that follows the criteria specified by the Institute of Medicine (IOM, now the National Academies of Sciences, Engineering, and Medicine) for trustworthy guidelines combined with the in-depth knowledge and expertise of the WPSI’s members. The recommendations will help ensure that women receive a comprehensive set of preventive services. In its first year, the WPSI updated eight topics addressed by the 2011 IOM report, *Clinical Preventive Services for Women: Closing the Gap.* Because of the confusion caused by contradictory recommendations around breast cancer screening, the WPSI also addressed breast cancer screening for women at average risk. Additional topics will be determined by WPSI members with input from the public and addressed in subsequent years.

The benefits to women of preventive health visits throughout the life course are well documented in the literature. Evidence-based preventive health care has been shown to identify risk factors for disease and to promote early detection of disease and infection, allowing more effective management and prevention of further complications. Preventive care—including reproductive life planning, optimization of nutrition and exercise, screening for and management of chronic diseases, immunizations, management of infectious diseases, and attention to psychological and behavioral health—contributes to women’s overall health.

To ensure women of all ages receive appropriate preventive health screenings, health care providers and patients need uniform, established guidelines for recommended preventive services for women. The availability of various and sometimes inconsistent guidelines fuels provider uncertainty and patient confusion. Efficient and effective guidelines established by the WPSI’s strong evidence-based process and vetted by experts in women’s health will impact patient preventive care delivery, patient safety, and quality of care by increasing the consistency of behavior and replacing individual preferences with best practices. Because the WPSI recommendations represent the consensus of the members, the participating organizations will work together to adopt and widely promote the recommendations to help ensure that all women receive a comprehensive set of preventive services.

The WPSI partnered with physician scientists from the Pacific Northwest Evidence-based Practice Center (EPC) at Oregon Health & Science University to review and update the evidence for each topic under consideration. The WPSI methodology and process were designed to promote thorough consideration of the best available evidence, ensure transparency, minimize the impact of individual bias and conflicts of interest, and drive members to reach consensus on recommendations. The process allows for public input and periodic updating of recommendations. When evidence was lacking, the WPSI also took into account members’ clinical expertise and judgment as well as current best practices and patient perspectives.

Overall, the recommendations presented here (see page 23) apply to the general population of U.S. women at average risk for the conditions addressed. The final WPSI preventive services recommendations are presented in a single website, WomensPreventiveHealth.org, that is easily accessible by both health care providers and their patients. The recommendations contained in this report represent the conclusions of the WPSI and are not necessarily endorsed by individual organizations that participated in the Multidisciplinary Steering Committee that created them.
Executive Summary

These WPSI recommendations are the culmination of a multidisciplinary effort to identify needed services and to improve the uptake of women’s preventive services that will contribute to overall improved health. These recommendations take into account the most current evidence available, yet research gaps remain. In particular, more research is needed to address the preventive health needs of racial and ethnic minority women and underserved populations.

With the WPSI recommendations approved by HRSA, the WPSI will convene stakeholders with broad national networks for outreach and proven success in reaching their targeted audiences to promote the recommendations and increase consumer awareness of the need for and benefits of preventive care. As a result, more women will get the services they need and avoid unnecessary services as well. As the IOM stated, “Trustworthy guidelines hold the promise of improving health care quality and outcomes.”³ At the same time, ensuring that more women have access to recommended preventive health services will improve the health of women, their families, and their communities.

References


Introduction

On March 1, 2016, the American College of Obstetricians and Gynecologists (ACOG) launched the Women’s Preventive Services Initiative (WPSI). The WPSI is a close collaboration of national health professional societies and consumer organizations that recognizes important contributions of these stakeholders to improved women’s healthcare. Through a 5-year cooperative agreement with the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), ACOG will coordinate the WPSI effort to develop, review, update, and disseminate recommendations for women’s preventive health care services, including the HRSA-sponsored Women’s Preventive Services Guidelines.

The WPSI incorporates a strong evidence-based structure aligned with Institute of Medicine (IOM, now National Academies of Sciences, Engineering, and Medicine)-specified criteria for trustworthy guidelines, combined with the women’s health expertise of the WPSI’s members. Because the WPSI recommendations represent the consensus of the members, these participating organizations will work together to adopt and to widely promote the recommendations to help ensure that all women receive a comprehensive set of preventive services. ACOG has a track record of coalition-building and recommendation development, with notable success in synthesizing a wide range of information and opinions and arriving at strong consensus-based outcomes accepted across broad audiences nationwide.

In its first year, in keeping with HRSA priorities, the WPSI focused on updating eight topics addressed by the IOM in its 2001 report, Clinical Preventive Services for Women: Closing the Gap. 

Because of the confusion caused by contradictory recommendations from multiple entities around breast cancer screening, the WPSI also addressed breast cancer screening for women at average risk. Additional topics will be determined by WPSI members with input from the public and addressed in subsequent years.

This document presents the following recommendations from the WPSI:

- Breast cancer screening for average-risk women
- Breastfeeding services and supplies
- Screening for cervical cancer
- Contraception and contraceptive counseling
- Screening for gestational diabetes mellitus
- Screening for human immunodeficiency virus
- Screening for interpersonal and domestic violence
- Counseling for sexually transmitted infections
- Well-woman preventive visits
Preventive Health Care Improves Health

The benefits to women of preventive health visits throughout the life course are well documented in the literature. Evidence-based preventive health care has been shown to identify risk factors for disease and to promote early detection of disease and infection, allowing more effective management and prevention of further complications. Preventive care—including reproductive life planning, optimization of nutrition and exercise, screening for and management of chronic diseases, immunizations, management of infectious diseases, and attention to psychological and behavioral health—contributes to women’s overall health.

The role of preventive health care services, particularly in conjunction with early treatment of symptoms that may lead to worsening conditions, is the foundation of well-woman care. In its Fifth Annual Report to Congress, *High-Priority Evidence Gaps for Clinical Preventive Services: Improving the Health of Women Through Research*, the U.S. Preventive Services Task Force (USPSTF) acknowledged the larger impact of preventive interventions that improve the health and well-being of women and girls. It noted that “the experience of disease and disability among women has unique transgenerational implications not only for themselves but for their children, their parents, their spouses, and even their communities.”

Uniform Guidelines Needed

To ensure women of all ages receive appropriate preventive health screenings, health care providers and patients need uniform, established guidelines for recommended preventive services for women. The development, updating, and maintenance of recommendations for women’s preventive health services across the lifespan are not the purview of any one entity or institution. Governmental organizations and agencies may conduct high-quality, systematic reviews of existing evidence and develop recommendations. At the same time, clinical specialty societies create clinical practice guidelines, sometimes with contributions from organizations with disease-specific or population-specific interests. The availability of various guidelines, which may be inconsistent or even contradictory, leads to provider uncertainty and patient confusion about needed preventive services.

In addition, clinicians may not know that guidelines exist, may find them complex with unclear or difficult to implement recommendations, or lack the time and resources to fully adhere to recommended practice. Health care providers are more likely to use preventive health guidelines if they are evidenced-based. Therefore, efficient and effective guidelines established by a strong evidence-based process, vetted by experts in women’s health, will impact patient preventive care delivery, patient safety, and quality by increasing the consistency of behavior and replacing individual preferences with best practices.

Women must also be engaged partners in the effort to follow consistent, well-vetted recommendations on prevention. In addition, guidelines need to be updated regularly to reflect the latest scientific evidence available and address any inconsistencies between medical and specialty organizations so that providers can give women clear messages on which to base informed decision making.
The development of consistent, evidence-based guidelines is sometimes hampered by limitations of supporting evidence. For the nine topics addressed in its first year, the WPSI found insufficient evidence for use in tailoring recommendations for preventive services for underserved or special populations of women, such as racial and ethnic minorities and those at high risk to certain conditions. These populations may have different needs for routine preventive health screening and intervention, and the WPSI fully supports development of additional data and resources to clarify these needs. When evidence was lacking, the WPSI also took into account its Multidisciplinary Steering Committee members' clinical expertise and judgment as well as current best practices and patient perspectives. Overall, the recommendations presented here apply to the general population of U.S. women at average risk for the conditions addressed; where relevant data were available, the recommendations address women at increased risk.

**Overcoming Barriers to Preventive Care Uptake**

More must be done by those working in preventive women’s health to improve awareness and adoption of preventive measures. Providers need to be aware of and endorse evidenced-based guidelines and implement them in their practices. The Affordable Care Act (ACA) provides expanded access to and coverage for preventive services for all women; an estimated 55.6 million women have received no-cost coverage for preventive services since the policy went into effect. For both insured and uninsured women, affordability of care remains a significant concern. Despite clear recognition of the benefits of preventive health services—such as improved long-term health outcomes and more efficient utilization of health services—disparities persist in the use of screening procedures among racial and ethnic minorities, those with lower health literacy, and the poor. Coordination of care among providers is also required. High-quality care for women throughout the lifespan depends on use of consistent evidence-based guidelines across specialties, open communication and transparency, and patient education.
Collaborative, Multidisciplinary Approach
The WPSI is a collaboration among national professional societies and consumer organizations all with important contributions to improved women’s health. The WPSI provides a forum for reviewing evidence and reaching consensus on recommendations for preventive women’s care. The specific aims of the WPSI are as follows:

1. Establish a process for developing and regularly recommending updates to guidelines for women’s preventive service.
2. Obtain participation from health professional organizations in developing recommended guidelines for women’s preventive services.
3. Review and synthesize existing guidelines and new scientific evidence for women’s preventive services.
4. Develop recommended guidelines for women’s preventive services.
5. Disseminate HRSA-supported comprehensive guidelines for use in clinical practice.

The WPSI consists of an Advisory Panel made up of representatives from ACOG and three other major professional organizations representing the majority of women’s health care providers: the American Academy of Family Physicians, the American College of Physicians, and the National Association of Nurse Practitioners in Women’s Health. In addition, three individuals who were members of the IOM’s 2011 Committee on Preventive Services for Women serve as Advisory Panel members.

The Advisory Panel oversees two standing committees—the Multidisciplinary Steering Committee (MSC) and the Implementation Steering Committee—and any future work groups formed. The WPSI instituted a strong evidence-based structure, tailored to the IOM standards for trustworthy guidelines, to create widely accepted recommendations that apply nationwide to women at various life stages. The methodology is detailed below.

The WPSI is chaired by Jeanne A. Conry, MD, PhD, Past President of ACOG. The Advisory Panel is chaired by Maureen Phipps, MD, MPH. Members of the MSC include representatives from medical specialty societies that oversee the majority of women’s primary care services and chronic disease management care, public health professionals, and patients and consumers (see the box). The MSC also includes federal agency liaisons. In years 2–5, the MSC membership will be adjusted also to include expertise relevant to a specific topic selected. The WPSI partnered with physician scientists from the Pacific Northwest Evidence-based Practice Center (EPC) at Oregon Health & Science University to conduct reviews and updates of the evidence for each topic under consideration. Additional methodological, clinical, policy, and academic expertise came from three members of the 2011 IOM Clinical Preventive Services for Women panel. The WPSI is coordinated by ACOG staff members. Appendix 1 lists the WPSI members and staff.
The IOM’s July 2011 report, *Clinical Practice Guidelines We Can Trust*, noted a perceived lack of transparency in the derivation of some clinical practice recommendations and in managing conflicts of interest. It cites variations in guidelines development processes as one fundamental cause of a lack of consistent guidelines across specialties and groups, which contributes to provider uncertainty and patient confusion about needed preventive services. The WPSI methodology is predicated on the belief that a strong evidence-based process will improve compliance with preventive service guidelines. The WPSI process was designed to ensure a strong evidence foundation, transparency, and to minimize the impact of individual bias and conflicts of interest.

In keeping with its aim to review and synthesize existing guidelines and new scientific evidence as it develops new recommendations, the WPSI avoids duplicating or contradicting recommendations of the USPSTF; the American Academy of Pediatrics (AAP) Bright Futures Initiative for infants, children, and adolescents; and the CDC’s Advisory Committee on Immunization Practices. These sources reflect comprehensive reviews.
Ensuring Transparency
The MSC is made up of health care professionals from national organizations involved in the provision of women’s preventive health services across the lifespan. This broad representation of experienced clinicians and experts increases transparency to the public by ensuring that multiple perspectives and approaches are included. It also minimizes the impact of individual biases and opinions on the recommendations.

The MSC also includes members representing patient and consumer perspectives. These members serve as full MSC committee and subcommittee members and are involved in all aspects of recommendation development, including topic selection, defining the scope of the recommendation, reviewing the evidence provided by the EPC, and participating in the development and dissemination of the HRSA-supported recommendations. These members serve an important role in ensuring that the recommendations are made with patients’ perspectives in mind. Patient and consumer members will also be involved in dissemination efforts, including development of patient education materials, in future years.

In addition, the WPSI provided opportunity for broad public input through a public comment period that increased transparency of the process and improved balance, comprehensiveness, and quality. The dispensation of public comment responses, including changes to the recommendation or no action, was documented and retained by WPSI project staff.

Mitigating Conflict of Interest
All WPSI participants and project staff followed ACOG’s formal Conflict of Interest Policy and submitted the standard disclosure form prior to appointment to the initiative and will do so annually thereafter. Any disclosures were shared with the MSC at each meeting. Members of the Advisory Panel, the WPSI Chair, Subcommittee Chairs, and project staff were not permitted to have any financial conflicts of interest. All disclosed conflicts of interest are listed in Appendix I.
**Broad Range of Perspectives and Experience**

Members of the MSC are multispecialty, multidisciplinary representatives from national health professional organizations with expertise in women’s health care across the lifespan, including obstetricians and gynecologists, family physicians, internal medicine physicians, nurse practitioners, nurse–midwives, women’s health nurses, women’s health researchers, public health professionals, and patient representatives. They are experts in the fields of women’s health, primary care, chronic disease management, mental health, and gerontology, among others. Members were assigned to subcommittees based on clinical and methodological expertise. In coming years, subcommittees will be tasked with developing recommendations on one to two new topics each year.

**Rigorous, Thorough Evidence Review**

Physician scientists from the EPC at Oregon Health & Science University with extensive experience in systematic review methodology and clinical guideline development conducted reviews and updates of the evidence for each topic under consideration. Focused updates of evidence reviewed for the nine topics considered for revision included overviews of recent systematic reviews for the USPSTF published since the last recommendations were issued by the IOM Committee in 2011, as well as summaries of additional relevant studies published since the systematic reviews.

MSC members provided input to the EPC to refine the scope of the update based on criteria from the Populations, Interventions, Comparators, Outcomes, Timing, and Setting/Study Design (PICOTS) format, a well-established protocol for clearly articulating the topic of interest. In future years, key questions will be developed for each new topic based on the PICOTS format, and the EPC will work with the MSC to refine inclusion and exclusion criteria for the literature searches.

For the updates to the IOM’s 2011 recommendations presented in this report, a research librarian conducted searches in Ovid MEDLINE, the Cochrane Central Register of Controlled Trials, and the Cochrane Database of Systematic Reviews through August 2016 for all topics. For topics on counseling for sexual transmitted infections, interpersonal and domestic violence, and well-woman visits, searches were also conducted in PsycINFO through March 2016. Investigators also manually reviewed reference lists of relevant articles.

A best evidence approach was applied when reviewing abstracts and selecting studies to include for the updates that involves using the most relevant studies with the strongest methodologies. For most topics, systematic reviews and key studies published since the most recent systematic review for the USPSTF were included. For well-woman visits and contraceptive methods and counseling, there are no USPSTF reviews or recommendations. Therefore, other systematic reviews and studies published since the 2011 IOM recommendations for these topics were included.

Randomized, controlled trials and large (ie, more than 100 subjects) prospective cohort studies were included if they provided relevant information for a specific topic. Other study designs, such as case-control and modeling studies, were included when evidence was lacking or when they demonstrated new findings. Studies conducted in settings...
applicable to the United States were particularly targeted. Findings relevant to population subgroups were specifically included when available. The focus of each review was on gaps identified in the 2011 IOM recommendations and any new evidence that could change or additionally inform the recommendations where evidence was not previously available. Selection criteria specific to each topic were developed to address issues specific to the WPSI.

Applicability is defined as the extent to which the effects observed in published studies are likely to reflect the expected results when an intervention is applied to the population of interest under “real-world” conditions.\(^1\) It is an indicator of the extent to which research included in a review might be useful for informing clinical decisions in specific situations. Factors important for understanding the applicability of studies were considered, including differences in the interventions and comparators, populations, and settings.

No new or revised statistical meta-analyses were conducted. Studies were qualitatively synthesized according to interventions, populations, and outcomes measured. Studies and their findings were summarized in a narrative, descriptive format to provide an overview of the new evidence for each topic.

**Establishing the Strength of Recommendations**

As recommendations were developed by the MSC members, EPC investigators created evidence maps to provide a descriptive summary of supporting evidence for each component of the recommendation. Evidence maps for the WPSI updates were adapted from methods of the 2011 IOM panel. Current systematic reviews and research studies, epidemiologic data, USPSTF and AAP Bright Futures recommendations, clinical best practices, and other relevant sources were included.

**Reaching Consensus Around Evidence-Based Recommendations**

A summary of the evidence for each topic was presented to the full MSC and served as the basis for recommendation development. A subcommittee of the MSC considered the evidence in depth and formulated a draft recommendation. Draft recommendations were presented and discussed by the full MSC and revised as needed. To build consensus, the foundation for the recommendation must be transparent and clearly articulated to provide an understanding of the volume and quality of the supporting evidence and an accurate assessment of the benefits and harms for each topic. Although the recommendations were based on the evidence reviewed, some components lacked sufficient evidence. In such cases, the MSC took into account best practices and the clinical judgment of experts to formulate consensus recommendations.

Once the MSC discussion concluded, the proposed draft recommendation was put forth for a vote by the full MSC. Votes were taken by hand, without secret ballots, and recorded as “approve,” “do not approve,” or “abstain.” The MSC is required to reach at least 75% agreement from voting members for the recommendation to be adopted. If 75% agreement was not reached after one round of voting, further discussion was permitted, and an email vote outside of the meeting was permitted if additional time was needed. Although not required for these first nine topics, if after discussion and a second round of voting 75% agreement was not reached, the
recommendation would have been returned to the subcommittee for reconsideration, at the discretion of the MSC chair. The subcommittee would then determine whether the recommendation should be reconsidered after a reevaluation of the supporting evidence and information. These steps will be considered for future topics that require additional discussion to reach consensus agreement.

Inviting Public Comment and External Review
A draft of each recommendation was released online for public comment for a one-month period, based on a process mirroring that of AAP Bright Futures. Input during the public comment period was solicited from all interested organizations and individuals. Commenters represented a broad array of perspectives and expertise on women’s preventive health care. All comments were reviewed and summarized by project staff and provided to the MSC. Comments were reviewed and addressed by the corresponding subcommittee or full MSC as needed. For future recommendations, a process for in-person public comment addressed directly to the MSC will be considered as time permits.

Continual Updating of Recommendations
Recommendations will be reviewed for currency and accuracy at least every 24 months after submission to and adoption by HRSA. For each recommendation, the literature search dates, along with the proposed date for review, will be reported. The EPC and ACOG project staff will scan the horizon continuously to identify emerging evidence, assess current validity of each recommendation, and identify or clarify associated benefits and harms. Recommendations identified for updates will be included on the list of next topics to be addressed by the MSC.
WPSI RECOMMENDATIONS

Each WPSI recommendation is made up of clinical considerations and implementation considerations. The clinical considerations describe the overarching clinical recommendation. The implementation considerations address clinical and practical aspects of applying the recommendation for patient care.

The WPSI recommendations recognize that decisions about preventive health services should be based on a periodic shared decision-making process involving the woman and her health care provider. The shared decision-making process assists women in making an informed decision and includes, but is not limited to, a discussion about benefits and harms, an assessment of the woman’s values and preferences, and consideration of factors such as life expectancy, comorbidities, and health status.

ADDITIONAL CONSIDERATIONS

These WPSI recommendations are the culmination of a multidisciplinary effort to identify needed services and to improve the uptake of women’s preventive services that will contribute to overall improved health. These recommendations take into account the most current evidence available, yet research gaps remain. In particular, more research is needed to address the preventive health needs of racial and ethnic minority women and underserved populations. For example, current evidence does not sufficiently address screening strategies to eliminate disparities in breast cancer detection, treatment, and mortality for minority women.

Although access to preventive health services has expanded, coverage of important preventive services differs across payers and may be incomplete. The implementation considerations included in each WPSI
recommendation not only address practical aspects of implementation but also offer guidance to payers about what is included in preventive services based on the best interpretation of evidence.

The process established by the WPSI for developing and updating recommendations seeks to address the shortcomings noted by the IOM by ensuring transparency, mitigating conflicts of interest, incorporating multiple perspectives, and relying on evidence. However, the WPSI has opportunities to improve:

**Needs of Minority Women:** Some have been critical of the WPSI for the extent to which the needs of minority women were considered. As part of the commitment to ensuring broad representation of providers, patient representative organizations, and consumers, the MSC included individuals from ethnic and minority groups. Despite the diversity of perspective, the WPSI acknowledges the lack of sufficient scientific evidence for tailoring many of the recommendations to specific needs of racial and ethnic minority women. The WPSI recognizes the importance of addressing the needs of these often underserved women and will continue to seek relevant information to develop recommendations that are tailored to diverse populations. As the WPSI progresses in years 2–5, it will work with HRSA to determine high-priority new topics based on the availability of evidence, the identified gaps in preventive services for women, and the likelihood of impact on a broad population of women.

**Public Participation:** Although highly desirable, the timeframe for the WPSI’s first year did not allow for in-person public input into topic refinement or recommendations. The WPSI will work with HRSA to ensure that staff can plan and promote public comment opportunities with broad and meaningful outreach. These opportunities are vital to ensure transparency in the guideline development process and to give the public an opportunity to voice issues they would like the MSC to consider when developing new or updating recommendations. For future recommendations, a process for in-person public comment addressed directly to the MSC will be incorporated as time permits.
NEXT STEPS
With the WPSI recommendations approved by HRSA, stakeholders with broad national networks for outreach and proven success in reaching their targeted audiences will be convened. The second standing committee, the Implementation Steering Committee, will be convened in year 2 by engaging supporting partners from the MSC and other groups active in community and provider outreach and patient awareness activities with capabilities to reach a wide audience of women, including adolescents; reproductive-aged, mature, and older women; and those from underserved communities. The Implementation Steering Committee will work to promote the recommendations from the MSC and increase consumer awareness of the need for and benefits of preventive care.

The final WPSI preventive services recommendations are presented in a single website, WomensPreventiveHealth.org, that is easily accessible by both health care providers and their patients. All messaging surrounding the WPSI’s outreach will involve directing patients and providers to the website for consistent, up-to-date information, interactive tools, and resources for provider recommendations and patient preventive care awareness.

CONCLUSION
The WPSI is a unique collaboration of experts and advocates representing national organizations whose constituencies reflect the full spectrum of the health and well-being of adolescents and adult women in the United States. These recommendations are the result of a rigorous, transparent, and well-structured process informed by clinical and patient perspectives. They are based on the best available current evidence. The MSC members dedicated numerous hours to discussion, debate, evidence review, and draft revisions to develop recommendations that represent a consensus among clinical experts in women’s health, patient and consumer health advocates, and public health policymakers. As such, they represent the kind of reliable and trustworthy recommendations the IOM called for in its 2011 report, Clinical Practice Guidelines We Can Trust. Implementing uniform recommendations such as these for preventive services will provide clarity for clinicians and their patients. As a result, more women will get the services they need and avoid unnecessary services as well. As the IOM stated, “Trustworthy guidelines hold the promise of improving health care quality and outcomes.” At the same time, ensuring that more women have access to recommended preventive health services will improve the health of women, their families, and their communities.
References


**Final Recommendations: Preventive Services for Women**

*Women’s Preventive Services Initiative Multidisciplinary Steering Committee*

December 2016

**Breast Cancer Screening for Average-Risk Women**

*Clinical Recommendations*
The Women’s Preventive Services Initiative recommends that average-risk women initiate mammography screening no earlier than age 40 and no later than age 50. Screening mammography should occur at least biennially and as frequently as annually. Screening should continue through at least age 74 and age alone should not be the basis to discontinue screening.

These screening recommendations are for women at average risk of breast cancer. Women at increased risk should also undergo periodic mammography screening, however, recommendations for additional services are beyond the scope of this recommendation.

*Implementation Considerations*
The Women’s Preventive Services Initiative recommends, as a preventive service, that women initiate mammography screening no earlier than age 40 and no later than age 50 and continue through at least age 74. Screening mammography should occur at least biennially and as frequently as annually.

Decisions regarding when to initiate screening, how often to screen, and when to stop screening should be based on a periodic shared decision-making process involving the woman and her health care provider. The shared decision-making process assists women in making an informed decision and includes, but is not limited to, a discussion about the benefits and harms of screening, an assessment of the woman’s values and preferences, and consideration of factors such as life expectancy, comorbidities, and health status.

**Breastfeeding Services and Supplies**

*Clinical Recommendations*
The Women’s Preventive Services Initiative recommends comprehensive lactation support services (including counseling, education, and breastfeeding equipment and supplies) during the antenatal, perinatal, and postpartum periods to ensure the successful initiation and maintenance of breastfeeding.

*Implementation Considerations*
Lactation support services include counseling, education, and breastfeeding equipment and supplies. A lactation care provider should deliver lactation support and provide services across the antenatal, perinatal, and postpartum periods to ensure successful preparation, initiation, and continuation of breastfeeding. Lactation care providers include, but are not limited to, lactation consultants, breastfeeding counselors, certified
midwives, certified nurse-midwives, certified professional midwives, nurses, advanced practice providers (eg, physician assistants and nurse practitioners), and physicians. Breastfeeding equipment and supplies, as agreed upon by the woman and her lactation care provider, include, but are not limited to, double electric breast pumps (including pump parts and maintenance) and breast milk storage supplies. Access to double electric pumps should be based on optimization of breastfeeding, and not predicated on prior failure of a manual pump.

**Screening for Cervical Cancer**

**Clinical Recommendations**
The Women’s Preventive Services Initiative recommends cervical cancer screening for average-risk women aged 21 to 65 years. For women aged 21 to 29 years, the Women’s Preventive Services Initiative recommends cervical cancer screening using cervical cytology (Pap test) every 3 years. Cotesting with cytology and human papillomavirus testing is not recommended for women younger than 30 years. Women aged 30 to 65 years should be screened with cytology and human papillomavirus testing every 5 years or cytology alone every 3 years. Women who are at average risk should not be screened more than once every 3 years.

**Implementation Considerations**
The Women’s Preventive Services Initiative recommends as a preventive service, cervical cancer screening for average-risk women aged 21 to 65 years. For average-risk women aged 30 to 65 years, informed shared decision-making between the patient and her clinician regarding the preferred screening strategy is recommended.

Women who have received the human papillomavirus vaccine should be screened according to the same guidelines as women who have not received the vaccine.

These recommendations are for routine screening in average-risk women and do not apply to women infected with human immunodeficiency virus, women who are immunocompromised because of another etiology (such as those who have received solid organ transplantation), women exposed to diethylstilbestrol in utero, or women treated for cervical intraepithelial neoplasia grade 2 or higher within the past 20 years. Screening strategies for high-risk women are outside the scope of these recommendations.

Cervical cancer screening is not recommended for women younger than 21 years or those older than 65 years who have had adequate prior screening and are not otherwise at high risk for cervical cancer. Adequate prior negative screening is defined as documentation (or a reliable patient report) of three consecutive negative cytology results or two consecutive negative cotest results within the previous 10 years with the most recent test within the past 5 years. Cervical cancer screening is also not recommended for women who have had a hysterectomy with removal of the cervix and who do not have a history of a high-grade precancerous lesions (eg, cervical intraepithelial neoplasia grade 2 or grade 3 or cervical cancer within the past 20 years).
Contraception

Clinical Recommendations

The Women's Preventive Services Initiative recommends that adolescent and adult women have access to the full range of female-controlled contraceptives to prevent unintended pregnancy and improve birth outcomes. Contraceptive care should include contraceptive counseling, initiation of contraceptive use, and follow-up care (eg, management, and evaluation as well as changes to and removal or discontinuation of the contraceptive method). The Women's Preventive Services Initiative recommends that the full range of female-controlled U.S. Food and Drug Administration-approved contraceptive methods, effective family planning practices, and sterilization procedures be available as part of contraceptive care.

The full range of contraceptive methods for women currently identified by the U.S. Food and Drug Administration include: (1) sterilization surgery for women, (2) surgical sterilization via implant for women, (3) implantable rods, (4) copper intrauterine devices, (5) intrauterine devices with progestin (all durations and doses), (6) the shot or injection, (7) oral contraceptives (combined pill), (8) oral contraceptives (progestin only, and), (9) oral contraceptives (extended or continuous use), (10) the contraceptive patch, (11) vaginal contraceptive rings, (12) diaphragms, (13) contraceptive sponges, (14) cervical caps, (15) female condoms, (16) spermicides, and (17) emergency contraception (levonorgestrel), and (18) emergency contraception (ulipristal acetate), and additional methods as identified by the FDA. Additionally, instruction in fertility awareness-based methods, including the lactation amenorrhea method, although less effective, should be provided for women desiring an alternative method.
Screening for Gestational Diabetes Mellitus

Clinical Recommendations

The Women’s Preventive Services Initiative recommends screening pregnant women for gestational diabetes mellitus after 24 weeks of gestation (preferably between 24 and 28 weeks of gestation) in order to prevent adverse birth outcomes. Screening with a 50-g oral glucose challenge test (followed by a 3-hour 100-g oral glucose tolerance test if results on the initial oral glucose challenge test are abnormal) is preferred because of its high sensitivity and specificity.

The Women’s Preventive Services Initiative suggests that women with risk factors for diabetes mellitus be screened for preexisting diabetes before 24 weeks of gestation—ideally at the first prenatal visit, based on current clinical best practices.

Implementation Considerations

Women’s Preventive Services Initiative recommends screening pregnant women for gestational diabetes mellitus after 24 weeks of gestation to prevent adverse birth outcomes. Risk factors for diabetes mellitus that may help identify women for early screening include, but are not limited to, those identified by the Institutes of Medicine (now National Academy of Medicine). The optimal test for screening prior to 24 weeks of gestation...
Screening for Human Immunodeficiency Virus Infection

Clinical Recommendations
The Women’s Preventive Services Initiative recommends prevention education and risk assessment for human immunodeficiency virus (HIV) infection in adolescents and women at least annually throughout the lifespan. All women should be tested for HIV at least once during their lifetime. Additional screening should be based on risk, and screening annually or more often may be appropriate for adolescents and women with an increased risk of HIV infection.

Screening for HIV is recommended for all pregnant women upon initiation of prenatal care with retesting during pregnancy based on risk factors. Rapid HIV testing is recommended for pregnant women who present in active labor with an undocumented HIV status. Screening during pregnancy enables prevention of vertical transmission.

Implementation Considerations
The Women’s Preventive Services Initiative recommends as a preventive service for women, prevention education and risk assessment for HIV infection in adolescents and women at least annually throughout the lifespan. More frequent screening for high-risk women, as determined by clinical judgment, is also recommended as a preventive service. Annual or more frequent HIV testing may be needed and is recommended as a preventive service for women who are identified or self-identify as high risk.

This recommendation refers to routine HIV screening, which is different from incident-based or exposure-based HIV testing. Risk factors for HIV infection in women include, but are not limited to, being an active injection drug user; having unprotected vaginal or anal intercourse; having multiple sexual partners; initiating a new sexual relationship; having sexual partners who are HIV-infected, bisexual, or injection drug users; exchanging sex for drugs or money; being a victim of sex trafficking; being incarcerated (currently or previously); and having other sexually transmitted infections.

Approximately 20–26% of infected patients are not identified by risk-based screening. Early detection and treatment improves outcomes for patients and reduces transmission; therefore, based on clinical best practice, screening annually or more frequently may be reasonable.
Screening for Interpersonal and Domestic Violence

Clinical Recommendations
The Women’s Preventive Services Initiative recommends screening adolescents and women for interpersonal and domestic violence, at least annually, and, when needed, providing or referring for initial intervention services. Interpersonal and domestic violence includes physical violence, sexual violence, stalking and psychological aggression (including coercion), reproductive coercion, neglect, and the threat of violence, abuse, or both. Intervention services include, but are not limited to, counseling, education, harm reduction strategies, and referral to appropriate supportive services.

Implementation Considerations
The Women’s Preventive Services Initiative recommends as a preventive service, screening adolescents and women for interpersonal and domestic violence. Factors associated with increased risk include, but are not limited to, pregnancy; younger and older age; increased stress; lesbian, gay, bisexual, transgender, and queer (or questioning) status; dependency; drug and alcohol misuse; former or current military service; and living in an institutional setting. There are multiple screening tools that have shown adequate sensitivity and specificity for identifying intimate partner violence and domestic violence in specific populations of women. Minimum screening intervals are unknown; however, based on the prevalence of interpersonal and domestic violence as well as evidence demonstrating that many cases are not reported, it is reasonable to conduct screening at least annually although the frequency and intensity of screening may vary depending on a particular patient’s situation.

Counseling for Sexually Transmitted Infections

Clinical Recommendations
The Women’s Preventive Services Initiative recommends directed behavioral counseling by a health care provider or other appropriately trained individual for sexually active adolescent and adult women at an increased risk for sexually transmitted infections (STIs).

The Women’s Preventive Services Initiative recommends that health care providers use a woman’s sexual history and risk factors to help identify those at an increased risk of STIs. Risk factors may include age younger than 25, a recent history of an STI, a new sex partner, multiple partners, a partner with concurrent partners, a partner with an STI, and a lack of or inconsistent condom use. For adolescents and women not identified as high risk, counseling to reduce the risk of STIs should be considered, as determined by clinical judgement.

Implementation Considerations
The Women’s Preventive Services Initiative recommends as preventive service for women at increased risk for STIs, directed behavioral counseling that includes, but is not limited to, longer duration or multiple counseling sessions, motivational interviewing techniques, and goal setting.
The Women’s Preventive Services Initiative recommends as a preventive service, STI counseling regardless of whether or not STI screening takes place during the same visit and regardless of the type of sexual activity or the partners’ gender.

Well-Woman Preventive Visits

Clinical Recommendations

The Women’s Preventive Services Initiative recommends that women receive at least one preventive care visit per year beginning in adolescence and continuing across the lifespan to ensure that the recommended preventive services including preconception, and many services necessary for prenatal and interconception care are obtained. The primary purpose of these visits should be the delivery and coordination of recommended preventive services as determined by age and risk factors.

Implementation Considerations

The Women’s Preventive Services Initiative recommends as a preventive service for women, that women receive at least one preventive care visit per year. Additional well-woman visits may be needed to obtain all necessary services depending on a woman’s age, health status, reproductive health needs, pregnancy status, and risk factors. Visits should allow sufficient time to address and coordinate services, and a team-based approach may facilitate delivery of services.

Well-woman preventive services may include, but are not limited to, assessment of physical and psychosocial function, primary and secondary prevention and screening, risk factor assessments, immunizations, counseling, education, preconception care, and many services necessary for prenatal, and interconception care. Recommended services are evidence-based items or services that have in effect a rating of ‘A’ or ‘B’ in the current recommendations of the United States Preventive Services Task Force, immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved, with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration, and with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

*These are the recommendations of the WPSI and not necessarily of any individual participating organization.
WOMEN'S PREVENTIVE SERVICES INITIATIVE ROSTER

Women's Preventive Services Initiative
Chairperson
American College of Obstetricians and Gynecologists
Jeanne Conry, MD, PhD

Women's Preventive Services Initiative
Advisory Panel
American Academy of Family Physicians
Jennifer L. Frost, MD, FAAFP
American College of Obstetricians and Gynecologists
Jeanne Conry, MD, PhD
American College of Obstetricians and Gynecologists and
Multidisciplinary Steering Committee Chairperson
Maureen G. Phipps, MD, MPH
American College of Physicians
Amir Qaseem, MD, PhD, MHA, FACP
Member of the IOM 2011 Committee on Preventive Services for Women
Kimberly D. Gregory, MD, MPH
Member of the IOM 2011 Committee on Preventive Services for Women
Alina Salganicoff, PhD
Member of the IOM 2011 Committee on Preventive Services for Women
Heidi D. Nelson, MD, MPH, MACP
National Association of Nurse Practitioners in Women's Health
Susan Kendig, JD, WHNP-BC, FAAN

Women’s Preventive Services Initiative
Multidisciplinary Steering Committee
Academy of Women's Health
Melissa McNeil, MD, MPH, MACP
American Academy of Family Physicians
James J. Stevermer, MD, MSPH, FAAFP
American Cancer Society
Robert Smith, PhD
American College of Nurse-Midwives
Michelle Collins, PhD, CNM, FACNM, FAAN
American College of Obstetricians and Gynecologists
David Chelmow, MD
American College of Physicians
Linda L. Humphrey, MD, MPH, MACP
American College of Preventive Medicine
Rachel Peragallo Urrutia, MD, MS
American College of Radiology
Stamatia Destounis MD, FACR, FSBI
American Geriatrics Society
Stacy Tessler Lindau, MD, MAPP
American Osteopathic Association
Octavia Cannon, DO, FACOOG
American Psychiatric Association
Maureen Sayres Van Niel, MD
Association of Maternal and Child Health Programs
Jeanette Kowalik, PhD, MPH, MCHES
Association of Reproductive Health Professionals
Pelin Batur, MD, FACP, NCMP
Association of Women's Health, Obstetric and Neonatal Nurses
Susan Peck, RN, MSN WHNP
Appendix I

National Comprehensive Cancer Network
Therese B. Bevers, MD

National Medical Association
Edith Peterson Mitchell, MD, FACP, FCPP

National Partnership for Women & Families
Jessi Leigh Swenson, JD

National Association of Nurse Practitioners in Women’s Health
Susan Hoffstetter, PhD, WHNP

National Women’s Law Center
Janel A. George, JD

Patient Representative
Susan C. Dimock, PhD

Pacific Northwest Evidence-based Practice Center Oregon Health & Science University/WPSI Project Team

Principal Investigator
Heidi D. Nelson, MD, MPH, MACP

Co-investigators
Amy Cantor, MD, MPH
Bernadette Zakher, MBBS

Project Managers
Miranda Pappas, MA
Tracy Dana, MLS

Librarian
Andrew Hamilton, MLS, MS

Project Staff
Spencer Dandy
Sara Grusing
Liev Miller

Federal Partners

Health Resources and Services Administration
Maternal and Child Health Bureau
Michael Lu, MD, MS, MPH
Hani Atrash, MD, MPH
Kimberly Sherman, MPH, MPP
Vanessa Lee, MPH
CDR Johannie Escarne, MPH
Lee Wilson

Centers for Disease Control and Prevention
Kathryn M. Curtis, PhD
Office of Minority Health
Aracely Macias, MPH

Office of Population Affairs
Susan B. Moskosky, MS, WHNP-BC

Office on Women’s Health
Sayeedha Uddin, MD, MPH

American College of Obstetricians and Gynecologists/Women’s Preventive Services Initiative Staff

Vice President of Practice Activities
Christopher M. Zahn, MD, Col (Ret), USAF, MC

Senior Director of Gynecologic Practice
Nancy O’Reilly, MHS

WPSI Program Director
Sarah Son, MPH

WPSI Program Manager
Ariste Sallas-Brookwell, MSW

WPSI Program Specialist
Katie Ogden
Rebecca Kauma
Conflict of Interest Disclosures

The following Advisory Panel and Multidisciplinary Steering Committee members reported no financial relationships or potential conflicts of interest to disclose: Jeanne Conry, MD, PhD; Pelin Batur, MD, FACP, NCMP, CCD; Therese Bevers, MD; Gale R. Burstein, MD, MPH, FAAP, FSAHM; Octavia Cannon, DO; David Chelmow, MD; Stamatia Destounis, MD, FACR, FSBI; Susan C. Dimock, PhD; Jennifer Frost, MD; Janel George, JD; Kimberly D. Gregory, MD, MPH; Linda Humphrey, MD, MPH; Susan M. Kendig, JD, WHNP-BC; Jeanette Kowalik, PhD, MPH, MCHES; Melissa McNeil, MD, MPH; Edith P. Mitchell, MD, FACP; Susan Peck, RNC, MSN, APN; Maureen Phipps, MD, MPH; Amir Qaseem, MD, PhD, MHA, FACP; Alina Salganicoff, PhD; Maureen Sayres Van Niel, MD; Robert Smith, PhD; James Stevermer, MD, MSPH, FAAFP; Annamarie Streilein, MHS, PA-C; and Jessi Leigh Swenson, JD; Stacy Tessler Lindau, MD, MAPP, FACOG.

Michelle Collins, PhD, CNM, FACNM in 2015, served as an expert witness for a law firm that represents Bayer pharmaceuticals in the class action suit against Bayer re: Mirena IUDs. She may be called upon again for testimony, though there is doubt that it will go to trial. Susan Hoffstetter, PhD, WHNP-BC, FAANP is a Nexplanon Trainer Rachel Urrutia, MD receives salary support from KNDR Healthcare management group. KNDR Healthcare management group works to improve access to fertility awareness methods of family planning.