SYSTEMATIC REVIEW

Breastfeeding assessment tools for at-risk and malnourished infants aged under 6 months old: a systematic review [version 1; peer review: 3 approved]

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Abstract

Background: Many small and malnourished infants under 6 months of age have problems with breastfeeding and restoring effective exclusive breastfeeding is a common treatment goal. Assessment is a critical first step of case management, but most malnutrition guidelines do not specify how best to do this. We aimed to identify breastfeeding assessment tools for use in assessing at-risk and malnourished infants in resource-poor settings.

Methods: We systematically searched: Medline and Embase; Web of Knowledge; Cochrane Reviews; Eldis and Google Scholar databases. Also the World Health Organization (WHO), United Nations International Children's Emergency Fund (UNICEF), Case REport guidelines, Emergency Nutrition Network, and Field Exchange websites. Assessment tool content was analysed using a framework describing breastfeeding 'domains' (baby's behaviour; mother's behaviour; position; latching; effective feeding; breast health; baby's health; mother's view of feed; number, timing and length of feeds).

Results: We identified 29 breastfeeding assessment tools and 45 validation studies. Eight tools had not been validated. Evidence underpinning most tools was low quality and mainly from high-income countries and hospital settings. The most comprehensive tools were the Breastfeeding, Evaluation and Education Tool, UNICEF Baby-Friendly Hospital Initiative tools and CARE training package. The tool with the strongest evidence was the WHO/UNICEF B-R-E-A-S-T-Feed Observation Form.

Conclusions: Despite many possible tools, there is currently no one gold standard. For assessing malnourished infants in resource-poor settings, UNICEF Baby-Friendly Hospital Initiative tools, Module IFE
and the WHO/UNICEF B-R-E-A-S-T-Feed Observation Form are the best available tools but could be improved by adding questions from other tools. Allowing for context, one tool for rapid community-based assessment plus a more detailed one for clinic/hospital assessment might help optimally identify breastfeeding problems and the support required. Further research is important to refine existing tools and develop new ones. Rigorous testing, especially against outcomes such as breastfeeding status and growth, is key.

**Keywords**
Breastfeeding, Assessment Tools, Infants

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Introduction

Protecting breastfeeding has been described as the single most effective child survival intervention (UNICEF, 2009; WHO, 2007). It also plays a key role in reducing the global burden of undernutrition (The Lancet Series, 2008) and is one of 13 priority interventions highlighted by the international ‘Scaling Up Nutrition’ movement (SUN, 2010). Despite this, suboptimal breastfeeding practices are common, accounting for significant morbidity and 804,000 deaths per year - 11.6% of all deaths in children aged under 5 years worldwide (Black et al., 2013). The greatest burden of mortality and morbidity is in low income countries. High background mortality and high rates of undernutrition and communicable disease all make the protective effects of breastfeeding critical. With collapses in infrastructure and normal societal networks, emergency affected populations are particularly vulnerable if breastfeeding is not supported and problems are not quickly identified and addressed.

Whilst the importance of breastfeeding is widely recognised, supporting it can be challenging. Under the overall heading of ‘Promoting proper feeding for infants and young children’, the World Health Organization (WHO) lists several areas of work including: the Baby-Friendly Hospital Initiative (BFHI) (WHO/UNICEF, 2009a); promotion of exclusive breastfeeding; and the International Code of Marketing of Breast-milk substitutes. These initiatives are aimed at population level breastfeeding support; there is good evidence of their effectiveness (Beake et al., 2012). More challenging is how to help those who fall through these population ‘safety nets’: when an individual mother-infant pair presents with an established problem. Managing very small infants, those with growth failure and other high-risk characteristics is particularly complex. Breastfeeding problems are common in this group but there are many other potential underlying causes and contributory factors (Goh et al., 2016). Breastfeeding problems may be a primary cause or secondary to other causes. There is also a wide and complex spectrum of breastfeeding problems ranging from a simple positioning difficulty leading to insufficient milk intake, milk insufficiency perception, early complementary feeding introduction, to secondary milk insufficiency due to maternal depression, due in turn to lack of social support at home (Amir & Ingram, 2008; Moore et al., 2012; Pannu et al., 2011; WHO/UNICEF, 1994).

This review arose from a project exploring the Management of (Nutritionally) At-risk Mothers and Infants aged under 6 months (MAMI) Project (ENN/UCL/ACF, 2010b). The goal of the original MAMI Project was to investigate the management of malnourished infants under six months of age in resource-poor and humanitarian settings, and to contribute to evidence-based, better practice guidelines to improve practice. The project identified that the burden of infant less than 6 months’ undernutrition is significant: worldwide, 3.8 million infants are severely wasted; 4.7 million are moderately wasted (Kerac et al., 2011). Since breastfeeding difficulties are associated with undernutrition (Gagliardi et al., 2012; Gribble et al., 2011) (Gribble et al., 2011) and exclusive breastfeeding in infants under 6 months, a common treatment goal (ENN/UCL/ACF, 2010a), the report also examined breastfeeding assessment as part of overall infant assessment. It found no ‘gold-standard’ breastfeeding assessment tool that catered for inpatient and community settings. This is a critical gap; correct ‘diagnosis’ of a breastfeeding problem is vital to inform appropriate support and treatment. Building upon and updating the work of the MAMI Project, this current review thus aims to: a) identify and profile currently available breastfeeding assessment tools; b) discuss their potential application for assessing at risk and malnourished infants under 6 months (i.e. to determine the link between breastfeeding problems and malnutrition in a particular individual; to describe the nature of that breastfeeding problem). Informed assessment is critical to targeted intervention of support.

Methods

Breastfeeding assessment tools were defined as: documented guidance for clinicians, nurses, midwives, community health workers and carers on how to observe and/or assess the breastfeeding performance. These could take the form of checklists, questionnaires, algorithms, indices, history taking forms or listing of the specific aspects of breastfeeding that should be assessed.

**Inclusion criteria:** We included articles that: tested or used breastfeeding assessment tools; integrated at least one clinically relevant maternal or child outcome (e.g. duration of breastfeeding, infant weight gain); reported on tool performance. Articles describing complex interventions that included breastfeeding support could only be included if it was clear which tool had been used, and if breastfeeding assessment had been explicitly mentioned in the intervention description. There were no study design restrictions.

**Exclusion criteria:** Tools that focused just on artificial feeding (i.e. use of a breastmilk substitute) or that were designed for women after breast augmentation/reduction surgery were not considered in this review. Also excluded were tools that involved complex and expensive technology that are not designed for routine clinical use in resource poor settings (e.g. those using electromyographic methods; direct measurements of breastmilk composition; web-based tools; software to measure sucking strength/efficaceness; ultrasound measures of milk removal/swallowing). Tools that focused on wider breastfeeding support (e.g. employer support) rather than the actual process of breastfeeding were also excluded as were those focused solely on change in health worker knowledge, attitude or practice as an outcome. The literature search was restricted to English language articles with human subjects.

**Databases and search terms:** Articles were identified by searching electronic database Medline and Embase via Ovid interface (full search strategy in Extended data (Kerac et al., 2020)). Key words and MeSH terms were selected by the review on The Lancet Breastfeeding Series (The Lancet Series, 2016) and a recent similar review on feeding assessment tools (Howe et al., 2008). Searches were finalised in March 2018.
This updated an earlier search done as part of the original MAMI project performed on PubMed, Web of Knowledge, Cochrane Review, Eldis and Google scholar databases which concluded in November 2013. In that original search, highly relevant journals were also searched directly: Maternal and Child Nutrition, International Breastfeeding Journal, Journal of Human Lactation, and BMC Family Practice. Reference lists and the ‘related articles’ were used to identify further articles. A standard two-stage search strategy was used: initial screening of titles and abstracts; detailed review of full articles secondly. Since tools were few but varied, risk of bias was not formally scored for each individual study but is discussed under ‘limitations’ for studies as a whole.

Description of the tools
To understand and characterise the tools we also examined:

Tool coverage of breastfeeding ‘domains’
There are several aspects or ‘domains’ of breastfeeding. Knowing which are affected helps guide appropriate subsequent treatment. We used an established framework (Moran et al., 2000) to characterise which aspects of breastfeeding the assessment tools assessed. These included: baby’s behaviour (e.g. alertness to feed), mother’s behaviour (e.g. watches and listens for baby’s cues), positioning (e.g. baby facing mother), attachment (e.g. lower lip turned outward on breast), effective feeding (e.g. sucking, swallowing, jaw movement and signs of milk release), health of the breast (e.g. nipple trauma), health of the baby (e.g. alert), and mother’s experience (e.g. feels strong suction). We added another domain on number, timing and length of feeds. We also noted any other domains identified by individual studies.

Evidence underpinning each assessment tool
Studies were grouped according to type of evidence presented. One group looked at prediction of later breastfeeding status. Another assessed test-retest, inter-rater reliability and sensitivity and specificity of tools. A third group focuses on assessment tools used to directly improve breastfeeding technique or experience.

Results
From a total of 15,649 titles and abstracts screened, a final count of 52 papers describing 29 distinct breastfeeding assessment tools were identified (Figure 1).

Final selection of tools
Details of the 29 tools identified are summarised in Table 1.

Exclusions and reason for those are presented in web-appendix (Extended data (Kerac et al., 2020)). We were unable to get sufficient information about two tools: The LAT™ (Cadwell et al., 2004) and the Prague Newborn Behaviour Description Technique (Sulcova & Tisanská, 1994) so we could not include them in the final review.

Context
Of the 29 tools identified: 22 (76%) were developed in high-income countries and used in 31 studies carried out in high-income countries and four (14%) tools were developed in low and middle-income countries. Sixteen tools (55%) were developed for hospital settings. Of these, 24 (83%) tools were designed and/or tested for use in infants less than 6 months with breastfeeding problems; none of these were specifically designed for or tested on at risk and malnourished infants less than 6 months.

Coverage of breastfeeding domains
Table 2 shows that most tools covered a number of different domains but only one, the Breastfeeding Evaluation and Education Tool (Tobin, 1996), covered them all. Other tools covering a wide range of domains were the Baby-Friendly Hospital Initiative (BFHI) guidelines (UNICEF, 2010; WHO/UNICEF, 2009a) and the CAse REpport guidelines (CARE guidelines) (CARE, 2004). The BFHI and CARE guidelines also highlighted other items that could be useful for future testing: positions for low birth weight babies, differentiating between ‘perceived’ and ‘real’ milk insufficiency, mother’s health, and the use of BMS and dummies/pacifiers. The World Health Organization/United Nations International Children’s Emergency Fund (WHO/UNICEF) B-R-E-A-S-T-Feed Observation Form covered seven domains, missing out ‘health of the baby’ and ‘mother’s view of the feed’ (WHO/UNICEF, 1994). Additional domains identified by other tools included: mother’s comfort level, previous breastfeeding experience, other foods/liquids being given to the baby, loss of >10% of birth weight, hypertension and delivery type (Darmstadt et al., 2009; Dongre et al., 2010; Hall et al., 2002; Mannan et al., 2008; Milligan et al., 1996; Palmer et al., 1993).

Ability of tools to predict breastfeeding outcomes
In total, 12 (41%) tools had been tested for their ability to predict breastfeeding outcomes (Table 3). The present studies either tested the tools or tested the intervention or tested both. The tools with the most studies testing their ability to predict breastfeeding outcomes during an intervention study were the LATCH (n=5), the WHO/UNICEF B-R-E-A-S-T-Feed observation form (n=6) and the BAS tool (n=4). The BAS was consistently predictive in all studies, although as shown in Table 2, it covers the least number of breastfeeding domains. There were mixed findings for the LATCH tool: three studies observed positive findings, and two reported limited ability of the tool to predict breastfeeding outcomes. The WHO/UNICEF B-R-E-A-S-T-Feed Observation Form was predictive of breastfeeding outcomes in three studies, but was not predictive of exclusive breastfeeding in a fourth study. Two further studies described the determinants of poor scores on the WHO/UNICEF B-R-E-A-S-T tool including repeated crying, colic history, shorter sleeping episodes and regurgitation (Yalcin & Kuskonmaz, 2011), and primiparity, cracked nipples, mastitis, preterm and low birth weight babies and poor suckling (Goyal et al., 2011).

Evidence underpinning the tools
The extent of tool testing varied substantially; 8 tools had no validation studies: Infant Feeding in Emergencies (IFE) Module 2
EMM et al., 2007), Breastfeeding Evaluation and Education Tool (Tobin, 1996), Systematic Assessment of the Infant at the Breast (Shrago & Bocar, 1990), CARE guidelines (CARE, 2004), Via Christi, and tools identified by Walker (Walker, 1989), (Cadwell, 2007) and Righard & Alade, 1992 (Righard & Alade, 1992). Of the remaining 21 tools, we identified 45 validation studies. Of these, 32 were observational studies; 6 were randomised or cluster randomised controlled trials, two reported time trends; and 1 reported intervention baseline and endline data without a control group.

The BAS tool had four validation studies, all of which show positive results for the tool, in terms of ability to identify those at risk of breastfeeding cessation, and moderate sensitivity and specificity (Gianni et al., 2006; Hall et al., 2002; Mercer et al., 2010; Zobbi et al., 2011). The evidence to support the use of the Essential Nutrition Actions Framework tool is weak in terms of validation (i.e. no control group; not clear if the tool was routinely used) (Guyon et al., 2009). IBFAT also had a low inter-rater reliability. Furthermore, most studies were low quality (e.g. small sample size and observational designs) and were also conducted exclusively in high income settings (Furman & Minich, 2006; Matthews, 1988; Matthews, 1991b; Riordan & Koehn, 1997; Schlomer et al., 1999).

Nine tools were tested for test-retest and inter-rater reliability in eight studies - one study compared three tools. Two tools performed well: the Integrated Management of Childhood Illness (IMCI) showed good sensitivity and high specificity in highlighting breastfeeding problems judged against clinician assessments (Darmstadt et al., 2009); the Mother Infant Breastfeeding Progress Tool (MIBPT) showed high inter-rater agreement (Johnson et al., 2007). There were mixed findings for the remaining tools. Details of these studies are in Table 4.

Figure 1. Review flow chart.
<table>
<thead>
<tr>
<th>Tool name</th>
<th>Author(s) &amp; date</th>
<th>Country of origin</th>
<th>Setting of design</th>
<th>Tool description</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHO/UNICEF Baby-Friendly Hospital Initiative (BFHI) - UNICEF Breastfeeding Assessment Form</td>
<td>(UNICEF, 2010)</td>
<td>No country specified</td>
<td>Hospital</td>
<td>14 questions and observations where answers indicate effective feeding or a problem. Items cover baby's health, urine and stools, behaviour during/after feeds, frequency of feeds, mother's behaviour during a feed, breast condition, use of dummies, nipple shields, and formula. If problems identified, observe a full breastfeed, using the observation aid.</td>
</tr>
<tr>
<td>WHO/UNICEF Breastfeeding Observation Job Aid</td>
<td>(UNICEF, 2009b)</td>
<td>No country specified</td>
<td>Hospital</td>
<td>Breastfeeding Observation Job Aid: 42 items/5 scales; signs of BF going well versus problems. Breastfeeding and complementary feeding practices focusing on mother's behaviour; 5 variables assessed: mother's age, previous breastfeeding experience, latching problems, breastfeeding interval, bottles of formula. To help parents observing and assessing the evolution of breastfeeding and seek guidance from health care providers when necessary.</td>
</tr>
<tr>
<td>Breastfeeding Assessment Score (BAS)</td>
<td>(Hall et al., 2002)</td>
<td>USA</td>
<td>Hospital</td>
<td>Breastfeeding Assessment Score (BAS): 5 variables assessed: mother's age, previous breastfeeding experience, latching problems, breastfeeding interval, bottles of formula. Extra variables: breastfeeding experience, maternal hypertension, and breast surgery. To identify infants at risk for early cessation of breastfeeding before initial discharge from hospital.</td>
</tr>
<tr>
<td>Breastfeeding Evaluation &amp; Education Tool (BEET)</td>
<td>(Tobin, 1996)</td>
<td>USA</td>
<td>Community humanitarian settings</td>
<td>Breastfeeding Evaluation &amp; Education Tool (BEET): 8 sub-scales: feedings, positioning, latch, suck, milk flow, intake, output, weight gain. To help parents observing and assessing the evolution of breastfeeding and seek guidance from health care providers when necessary.</td>
</tr>
<tr>
<td>CARE training package: Breastfeeding and Complementary Feeding Basics</td>
<td>(CARE, 2004)</td>
<td>LMICs</td>
<td>Community humanitarian settings</td>
<td>CARE training package: Breastfeeding and Complementary Feeding Basics: Illustration 8 on correct positioning and counselling cards on: Signs of good positioning (4 items) and attachment (5 items), 1 illustration, 5 points, recommendations on optimal breastfeeding practices focusing on mother's behaviour; 3 common breast conditions (including photos); perceived insufficient milk; 11 ‘special situations’ including malnourished and stressed mothers, baby refusal to feed. Prevention and solutions are given.</td>
</tr>
<tr>
<td>Checklist from ‘breastfeeding and the use of pacifiers’</td>
<td>(Richard &amp; Alade, 1992; Richard &amp; Alade, 1991)</td>
<td>Sweden</td>
<td>Hospital</td>
<td>Checklist from ‘breastfeeding and the use of pacifiers’: Illustration and recommendations to ensure optimal breastfeeding. Illustration 8 on correct positioning and attachment, 9 illustrations. Illustration 9 focuses on three different breastfeeding positions and attachment, with pictures.</td>
</tr>
<tr>
<td>Essential Nutrition Action Messages (Breastfeeding guidance booklet)</td>
<td>(Guyon &amp; Quinn, 2011; Guyon et al., 2009)</td>
<td>Not stated</td>
<td>Community humanitarian settings</td>
<td>Essential Nutrition Action Messages (Breastfeeding guidance booklet): Illustration 8 on correct positioning and attachment, 9 illustrations. Illustration 9 focuses on three different breastfeeding positions and attachment, with pictures.</td>
</tr>
<tr>
<td>History Taking Form from ‘Functional assessment of infant breastfeeding patterns’</td>
<td>(Walker, 1989)</td>
<td>USA</td>
<td>Hospital</td>
<td>History Taking Form from ‘Functional assessment of infant breastfeeding patterns’ includes examination of maternal and infant’s health, history of breastfeeding, feeding patterns, and problems.</td>
</tr>
<tr>
<td>Hands off technique</td>
<td>(Ingram et al., 2002)</td>
<td>UK</td>
<td>Hospital</td>
<td>Hands of technique with rationale that covers general physical condition and breastfeeding factors: positioning, latch, suck, milk flow, intake, output, weight gain, and breast condition. Included in a breastfeeding care plan.</td>
</tr>
<tr>
<td>Tool name</td>
<td>Description</td>
<td>Country</td>
<td>Setting of design</td>
<td>Author(s) &amp; date</td>
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<tr>
<td>Integrated Management of Childhood Illness (IMCI)</td>
<td>Adapted in Bangladesh (Mannan et al., 2008)</td>
<td>Bangladesh</td>
<td>Community</td>
<td>History taking and observation classifies children as: 'not able to feed' (very severe disease), 'feeding problem', and 'no feeding problem'. Four questions ask about any breastfeeding difficulties, newborn feeding ability, feeding frequency and supplementary foods. Observations are made of a five-minute breastfeeding including: four signs of improper positioning and attachment, four signs of swallowing (slow deep sucking with occasional pausing).</td>
</tr>
<tr>
<td>Infant Breastfeeding Assessment Tool (IBFAT)</td>
<td></td>
<td>USA</td>
<td>Hospital</td>
<td>6 items measure four infant behaviours: readiness to feed, rooting, fixing &amp; sucking. Two non-scoring items: infant state &amp; maternal satisfaction with breastfeeding.</td>
</tr>
<tr>
<td>Infant Feeding in Emergencies (IFE) Module 2: Simple rapid assessment and full assessment</td>
<td></td>
<td>Not stated</td>
<td>Community</td>
<td>Simple rapid assessment includes: age-appropriate feeding, breastfeeding ease, correct positioning and attachment. Observation is made of a five-minute breastfeeding. 'Take action cards' are used to resolve breastfeeding problems.</td>
</tr>
<tr>
<td>LATCH Assessment</td>
<td></td>
<td>USA</td>
<td>Hospital</td>
<td>5 items: Latch; Audible swallowing; Type of nipple; Comfort of mother's breasts/nipples; Help needed to hold child to breast.</td>
</tr>
<tr>
<td>Mother-Baby Assessment (MBA)</td>
<td></td>
<td>USA</td>
<td>Hospital</td>
<td>5 steps in breastfeeding are assessed for both the mother and the infant: 1) Mother’s ability to attach her baby properly to the breast and observe her infant sucking during feeding; 2) the baby’s efforts to breastfeed and the progress of both partners; 3) the concept of mother infant bonding, comfort and the infant’s confidence in breastfeeding; 4) the mother’s satisfaction with breastfeeding; 5) the infant’s comfort and the mother’s satisfaction with breastfeeding.</td>
</tr>
<tr>
<td>Mother-Infant Breastfeeding Progress Tool (MIBPT)</td>
<td></td>
<td>USA</td>
<td>Hospital</td>
<td>8 items observe breastfeeding progress in the dyad: responsiveness to feeding cues, timing of feeds, nutritive sucking, positioning, latching factors, nipple trauma, infant reaction.</td>
</tr>
<tr>
<td>Neonatal Oral-Motor Assessment Scale (NOMAS)</td>
<td></td>
<td>USA</td>
<td>Hospital</td>
<td>28 items: nutritive sucking, non-nutritive sucking, swallowing, insertions, posture and positioning, head and neck control, trunk control, arm and hand movement, facial expression, vocalization, and general condition.</td>
</tr>
<tr>
<td>Tool name</td>
<td>Author(s) &amp; date</td>
<td>Country of origin</td>
<td>Setting of design</td>
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<tr>
<td>Preterm Infant Breastfeeding Behaviour Scale (PIBBS)</td>
<td>(Nyqvist et al., 1996)</td>
<td>Sweden</td>
<td>Hospital</td>
<td>Observations of developmental process of sucking during breastfeeding for preterm infants on: rooting, areolar grasp, duration of latch, sucking, tongue sucking burst, swallowing. Focuses on assessment of sucking technique as correct or incorrect. Correct defined as infant has wide open mouth, tongue under areolae, milk being expressed in low deep sucks. Incorrect defined as sucks at the nipple as if it is a toy. Visual tool.</td>
</tr>
<tr>
<td>Systematic Assessment of the Infant at Breast (SAIB)</td>
<td>(Shrago &amp; Bocar, 1990)</td>
<td>USA</td>
<td>Hospital</td>
<td>Observation of: alignment, areolar grasp, areolar compression, audible swallowing. No scoring system. Assess effective breastfeeding and milk transfer.</td>
</tr>
<tr>
<td>VIA Christi Breastfeeding assessment</td>
<td>(Riordan, 1999)</td>
<td>USA</td>
<td>Not stated</td>
<td>Breastfeed is scored 0-2 as absent, problematic, 2 as moderate problem, 3 as high problem, 4 as high risk, 5-10 as very high risk. Refer to public health nurse if score is 5 or above.</td>
</tr>
<tr>
<td>WHO/UNICEF B-R-E-A-S-T-Feed Observation Form</td>
<td>(WHO/UNICEF, 1994)</td>
<td>Community</td>
<td>Not stated</td>
<td>27 items/6 scales: signs that breastfeeding is going well versus possible difficulty: body position, responses, emotional bonding, anatomy, sucking, time suckling.</td>
</tr>
<tr>
<td>Neonatal Eating Assessment tool (NeoEAT)</td>
<td>(Pados et al., 2016; Pados et al., 2018)</td>
<td>USA</td>
<td>Hospital</td>
<td>Screener version (10 questions) is intended for clinical screening of infants to identify whether further specialised assessment or intervention is needed. Full version for NeoEAT breastfeeding (74 items), NeoEAT bottle feeding (89 items) can be used by parents or health workers to assess breastfeeding in infants less than 7 months.</td>
</tr>
<tr>
<td>Early Feeding Skills Assessment (EFS)</td>
<td>(Thoyer et al., 2018)</td>
<td>USA</td>
<td>Hospital</td>
<td>The checklist allows health workers to assess preterm infant readiness for breastfeeding. Helps to profile the infant’s developmental stage regarding specific feeding skills: abilities to remain engaged in feeding, organize oral-motor functioning, coordinate swallowing with breathing, and maintain physiologic stability to decide which help offer.</td>
</tr>
<tr>
<td>Preterm Oral Feeding Readiness Assessment Scale (POFRAS)</td>
<td>(Fujinaga et al., 2013)</td>
<td>Brazil</td>
<td>Hospital</td>
<td>18 items scale to assist health professionals to initiate preterm feeding in view of promoting safe and objective breastfeeding. Focus on baby’s ability and readiness to suckle well.</td>
</tr>
<tr>
<td>Lactation history and risk assessment form</td>
<td>(Riordan, 1989)</td>
<td>USA</td>
<td>Hospital</td>
<td>4 items form to take lactation history and evaluate breast, breast and nipples to carry out an appropriate risk assessment before feeding choice physical exam, history including baby weight gain, risk factors.</td>
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<tr>
<td>Assessment Tool</td>
<td>Baby’s Behaviour</td>
<td>Mother’s Behaviour</td>
<td>Position</td>
<td>Latching</td>
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<tr>
<td>Breast-feeding Assessment Score (Hall et al., 2002)</td>
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<td>Breastfeeding evaluation and education tool (Tobin, 1996)</td>
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<tr>
<td>Checklist from “Breastfeeding and the use of pacifiers” (Righard &amp; Alade, 1997)</td>
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<td>Essential Nutrition Action Messages (Guyon et al., 2009)</td>
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<tr>
<td>IMCI algorithm (Mannan et al., 2008)</td>
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<tr>
<td>From “Indicators of effective breastfeeding and estimates of breast milk intake” (Riordan et al., 2005)</td>
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<tr>
<td>IBFAT Infant Breastfeeding Assessment Tool___(Matthews, 1988)</td>
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<tr>
<td>Infant Feeding in Emergencies Module 2: Simple rapid assessment and full assessment (ENN et al., 2007)</td>
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<td>Assessment Tool</td>
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<tr>
<td>LATCH Assessment (Jensen et al., 1994)</td>
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<td>Mother-Baby Assessment (Martin, 1993)</td>
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<td>Mother-Infant Breastfeeding Assessment Tool (Johnson et al., 1999)</td>
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<td>MBFG - Mother-Infant Breastfeeding Progress Tool (Johnson et al., 2007)</td>
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<td>NOMAS (Palmer et al., 1993)</td>
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<td>PIBBS (Nyquist &amp; Boor, 1990)</td>
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<td>VIA Christi Breastfeeding assessment (unpublished)</td>
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<tr>
<td>NeoEAT - Neonatal Eating Assessment Tool (Pedros et al., 2018)</td>
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<td>Preterm Oral Feeding Readiness Assessment Tool (Kaynaja et al., 2015)</td>
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<td>EFS - Early Feeding Skills assessment (Thoyer et al., 2005)</td>
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<td>BRAT - Bristol Breastfeeding Assessment Tool (Ingram et al., 2015)</td>
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<tr>
<td>Lactation history and risk assessment form (Riordan, 1989)</td>
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<table>
<thead>
<tr>
<th>Number, timing, length of feeds</th>
<th>Position</th>
<th>Latching</th>
<th>Effective Feeding</th>
<th>Mother's View of the feed</th>
<th>Baby's health</th>
<th>Breast health</th>
<th>Mother's Behaviour</th>
<th>Baby's Behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need assistance to breastfeed</td>
<td>Mother's comfort level; pre-feeding behaviors</td>
<td>Pre-feeding behaviors</td>
<td>Pre-feeding behaviors</td>
<td>Pre-feeding behaviors</td>
<td>Visual tool - pictures available</td>
<td>Visual tool - pictures available</td>
<td>Visual tool - pictures available</td>
<td>Visual tool - pictures available</td>
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<tr>
<td>&gt;10% birth weight lost</td>
<td>Evaluate orofaringo-esophageal function, gastrointestinal function</td>
<td>Ability to remain engaged in feeding, ability to organize oral motor function including swallowing</td>
<td>Can be used also on tongue-tied infant</td>
<td>Estimate risk of developing a problem before giving birth</td>
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Other: Visual tool - pictures available

Note: The table above lists various assessment tools used to evaluate different aspects of breastfeeding. Each tool is associated with specific behaviors and outcomes that can help in assessing the effectiveness of breastfeeding.
<table>
<thead>
<tr>
<th>Assessment Tool</th>
<th>Author &amp; date</th>
<th>Country &amp; setting</th>
<th>Sample</th>
<th>Study design</th>
<th>Findings</th>
<th>Outcomes</th>
<th>Outcomes</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHO/UNICEF Baby-Friendly Hospital Initiative: UNICEF Breastfeeding assessment form &amp; WHO/UNICEF Breastfeeding Observation Job Aid</td>
<td>Geddes (2012)</td>
<td>UK, Community</td>
<td>Mothers and babies 5-12 days after delivery; N not given</td>
<td>Observational</td>
<td>Breastfeeding at 6-8 weeks was 60.6% after the intervention, subsequently increased each quarter to 68.9% in the third quarter post intervention</td>
<td>Breastfeeding cessation rate pre/post BFHI training</td>
<td>Breastfeeding cessation at 6-8 weeks vs baseline BFHI scores</td>
<td>No control group. Source of regional breastfeeding prevalence not entirely clear. Effort to extract influence of breastfeeding assessment tool difficult.</td>
</tr>
<tr>
<td>WHO/UNICEF Baby-Friendly Hospital Initiative: UNICEF Breastfeeding assessment form &amp; WHO/UNICEF Breastfeeding Observation Job Aid</td>
<td>Ingram et al. (2011)</td>
<td>UK, Community</td>
<td>Bristol-born children at 8 weeks of age; N not given</td>
<td>Observational</td>
<td>Babies born in 2009 were 1.57 times more likely to be exclusively breastfed at 8 weeks.</td>
<td>Breastfeeding cessation rates pre/post BFHI training</td>
<td>Breastfeeding cessation at 6-8 weeks vs baseline BFHI scores</td>
<td>No control group. Source of regional breastfeeding prevalence not entirely clear. Effort to extract influence of breastfeeding assessment tool difficult.</td>
</tr>
<tr>
<td>Breastfeeding Assessment Score (BAS)</td>
<td>Hall et al. (2002)</td>
<td>USA, Hospital</td>
<td>N=118 mothers and infants; mean age=40 hours</td>
<td>Observational</td>
<td>10.5% of mothers reported stopping breastfeeding; all tool items significantly predicted breastfeeding cessation.</td>
<td>Breastfeeding cessation rate 7-10 days post partum</td>
<td>Breastfeeding at 6-8 weeks was 60.5% at baseline, increased to 61.6%, then steadily increased each quarter to 68.9% in the third quarter post intervention</td>
<td>Many participant exclusions: women &lt;18, depression, maternal age &gt;40, birth weight &lt;2500g, gestational age &lt;37 weeks. Covariates: Adjusted for hospital differences.</td>
</tr>
<tr>
<td>Breastfeeding Assessment Score (BAS)</td>
<td>Gianni et al. (2006)</td>
<td>Italy, Hospital</td>
<td>N=175 mothers of healthy exclusively breastfed infants; birth weight ≥2500g, gestational age ≥37 weeks</td>
<td>Observational</td>
<td>Women exclusively breastfeeding at 1 month had significantly lower exclusively breastfeeding cessation at 1 month.</td>
<td>Breastfeeding cessation rates pre/post BFHI training</td>
<td>Breastfeeding cessation at 6-8 weeks vs baseline BFHI scores</td>
<td>Many participant exclusions: women &lt;18, depression, maternal age &gt;40, birth weight &lt;2500g, gestational age &lt;37 weeks. Covariates: Adjusted for hospital differences.</td>
</tr>
<tr>
<td>Breastfeeding Assessment Score (BAS)</td>
<td>Mercer et al. (2010)</td>
<td>USA, Hospital</td>
<td>N=118 mother-child pairs</td>
<td>Observational</td>
<td>Maternal age, previous breastfeeding experience, latching problems and no prior breastfeeding success negatively associated with breastfeeding duration.</td>
<td>Breastfeeding cessation rates pre/post BFHI training</td>
<td>Breastfeeding cessation at 6-8 weeks vs baseline BFHI scores</td>
<td>Many participant exclusions: women &lt;18, depression, maternal age &gt;40, birth weight &lt;2500g, gestational age &lt;37 weeks. Covariates: Adjusted for hospital differences.</td>
</tr>
<tr>
<td>Breastfeeding Assessment Score (BAS)</td>
<td>Zobbi et al. (2011)</td>
<td>Italy, Hospital</td>
<td>N=380 women</td>
<td>Observational</td>
<td>Reduced BAS (5 items) and adapted cut off for predicted breastfeeding cessation: sensitivity 71.9% and specificity 56.9.</td>
<td>Breastfeeding cessation rates pre/post BFHI training</td>
<td>Breastfeeding cessation at 6-8 weeks vs baseline BFHI scores</td>
<td>Many participant exclusions: women &lt;18, depression, maternal age &gt;40, birth weight &lt;2500g, gestational age &lt;37 weeks. Covariates: Adjusted for hospital differences.</td>
</tr>
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<tr>
<td>Checklist from breastfeeding and the use of pacifiers</td>
<td>(Righard &amp; Alade, 1997)</td>
<td>Sweden, Hospital</td>
<td>N=82 exclusively breastfeeding mothers with intention to breastfeed ≥6 months. Infants had normal deliveries/ birth weights, 4-5 days postpartum</td>
<td>Observational</td>
<td>Breastfeeding rate &amp; pacifier use (hours/day) at 2 weeks, 1, 2, 3 &amp; 4 months of pacifier and non-pacifier users and children with correct/ incorrect sucking technique</td>
<td>Pacifier users with correct sucking technique had higher levels of breastfeeding at 4 months than Incorrect sucking group. Pacifier users had significantly lower breastfeeding rates than non-users. No difference in breastfeeding amongst non-pacifier users with correct/ incorrect sucking technique</td>
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<td>Incorrect sucking technique may not be improved if pacifiers are used</td>
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<tr>
<td>Essential Nutrition Actions</td>
<td>(Guyon et al., 2009)</td>
<td>Madagascar, Clinic and community</td>
<td>Baseline n=1200, Endline n=1760 children &lt;2</td>
<td>Baseline/ Endline intervention survey</td>
<td>Infant and young child feeding indicators, feeding during illness, deworming, maternal diet and health</td>
<td>Exclusive breastfeeding &lt;6 months increased from 32% to 68%</td>
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<tr>
<td>Hands Off Technique</td>
<td>(Ingram et al., 2002)</td>
<td>UK, Hospital</td>
<td>N=395 mothers who were breastfeeding on discharge</td>
<td>Observational</td>
<td>Breastfeeding (any and exclusive) 2 &amp; 6 weeks postpartum</td>
<td>High breastfeeding technique score was associated with breastfeeding at 6 weeks.</td>
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<tr>
<td>Hands Off Technique</td>
<td>(Wallace et al., 2006)</td>
<td>UK, Hospital</td>
<td>N=245 midwives randomized to 'hands off' protocol or refresher standard care; n=370 women randomized to midwives postpartum</td>
<td>RCT</td>
<td>Duration of breastfeeding (exclusive and any breast milk) at 6 and 17 weeks postpartum.</td>
<td>No significant differences between groups on any or exclusive breastfeeding at 6 or 17 weeks, or in reported breastfeeding problems Study was statistically underpowered to detect an effect; Authors suggest initial feeding advice may be best as hands on, with 'hands off introduced later Covariates: Hospital, delivery type, maternal age, prior feeding experience, midwife grade</td>
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<tr>
<td>IMCI algorithm</td>
<td>(Mannan et al., 2008)</td>
<td>Bangladesh, Community</td>
<td>N=3495 neonates</td>
<td>Observational</td>
<td>Breastfeeding problems 1-7 days postpartum</td>
<td>Women only receiving a postnatal visit at 6-7 days were 7.66 times more likely to have breastfeeding difficulties than those receiving early and late postnatal visit (1-3 days and 6-7 days)</td>
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<tr>
<td>‘Indicators of effective breastfeeding and estimates of breast milk intake’</td>
<td>(Riordan et al., 2005)</td>
<td>USA, Hospital</td>
<td>N=82 mothers and their term infants</td>
<td>Observational</td>
<td>Significant predictors of human milk intake in children ≤96 hours and &gt;96 hours (through test weighing)</td>
<td>Swallowing and rooting in first 3 days should be included in breastfeeding assessments of term infants. Covariates: Maternal age, previous feeding experience, delivery type, infant sex, birth weight, gestational age</td>
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**Notes:**
- **Assessment Tool**: The tool used to assess breastfeeding and pacifier use.
- **Author & date**: The authors and the publication year.
- **Country & setting**: The location and setting of the study.
- **Sample**: Description of the sample size and characteristics.
- **Study design**: The type of study design used.
- **Outcomes**: The outcomes measured in the study.
- **Findings**: The findings of the study.
- **Remarks**: Additional comments or remarks about the study.
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<tbody>
<tr>
<td>Infant Breastfeeding Assessment Tool (IBFAT)</td>
<td>(Matthews, 1988)</td>
<td>Canada, hospital</td>
<td>N=60 early neonates with appropriate weight for gestational age</td>
<td>Observational</td>
<td>Breastfeeding status at 4 weeks; inter-rater reliability</td>
<td>IBFAT scores did not predict breastfeeding at 4 weeks. Inter-rater agreement=91%.</td>
<td>Authors: scores may not have predicted breastfeeding due to limited variability (80% were still breastfeeding).</td>
</tr>
<tr>
<td>Infant Breastfeeding Assessment Tool (IBFAT)</td>
<td>(Schlomer et al., 1999)</td>
<td>USA, Hospital</td>
<td>N=30; First time breastfeeding mothers of term infants</td>
<td>Observational</td>
<td>Association between maternal satisfaction &amp; breastfeeding problems from 12 hours to 1 week postpartum</td>
<td>Low predictive validity for maternal satisfaction &amp; breastfeeding problems (r=0.379, p=0.163), but IBFAT scores were negatively related to breastfeeding problems (r=-0.49, p=0.06)</td>
<td>Very small sample size and low predictive validity of maternal satisfaction with breastfeeding</td>
</tr>
<tr>
<td>LATCH</td>
<td>(Rordan et al., 2001)</td>
<td>USA, Hospital</td>
<td>N=133 mothers of healthy singletons (38-42 weeks gestational age). Mothers were intending to breastfeed.</td>
<td>Observational: post-partum and followed 6 weeks</td>
<td>Breastfeeding status</td>
<td>Mothers' breastfeeding at 6 weeks had higher LATCH scores than those who had weaned. Mothers scoring lower on comfort were less likely to be breastfeeding at 6 weeks postpartum.</td>
<td>Query that audible swallow is possible on day 4 of life. Covariates: Mother's age, intended breastfeeding duration &amp; delivery type</td>
</tr>
<tr>
<td>LATCH</td>
<td>(Kumar et al., 2006)</td>
<td>USA, Hospital</td>
<td>N=182 (4 days) N=188 (6 weeks) mother-child pairs; healthy term infants</td>
<td>Observational: day 1 till 6 weeks after delivery</td>
<td>Breastfeeding status</td>
<td>Women breastfeeding at 6 weeks had significantly different LATCH scores at 0-48 hours than those not breastfeeding. ROC curve: scores of ≥29 at 16-24 hours linked to a 1.7 times greater chance of breastfeeding at 6 weeks. Nurse/mother's scores correlated with breastfeeding duration.</td>
<td>Small sample and poor predictive validity re breastfeeding satisfaction</td>
</tr>
<tr>
<td>LATCH</td>
<td>(Schlomer et al., 1999)</td>
<td>USA, Hospital</td>
<td>N=30 first time breastfeeding mothers of term infants</td>
<td>Observational: 12 hours and 1 week post-partum</td>
<td>Association between maternal satisfaction and breastfeeding problems</td>
<td>Low predictive validity for maternal satisfaction &amp; breastfeeding problems (r=0.427, p=0.113) but LATCH scores were negatively related to feeding problems (r=-0.50, p=0.057)</td>
<td>Special sample and poor predictive validity re breastfeeding satisfaction</td>
</tr>
<tr>
<td>LATCH</td>
<td>(Henderson et al., 2001)</td>
<td>Australia, Hospital</td>
<td>N=160 first-time mothers</td>
<td>RCT: structured one-to-one positioning and attachment education versus usual postnatal care. at 6 weeks and 3 and 6 months postpartum</td>
<td>Breastfeeding status Nipple pain /trauma and satisfaction with breastfeeding</td>
<td>No difference in breastfeeding rate between groups. Experimental group had less nipple pain on days 2 and 3, but not sustained. Experimental group were less satisfied with breastfeeding using a single but not a multiple item measure</td>
<td>Mixes use of LATCH tool with hands off intervention technique. Covariates: No socio-demographic differences between groups</td>
</tr>
<tr>
<td>LATCH</td>
<td>(Tornese et al., 2012)</td>
<td>Italy, Hospital</td>
<td>N=299 mother-infant dyads</td>
<td>Observational: day 1 and at discharge from hospital</td>
<td>Non-exclusive breastfeeding at discharge from hospital</td>
<td>LATCH score in the first 24 hours predicted non-exclusive breastfeeding at discharge.</td>
<td>Covariates: Caesarean, primiparity, infant phototherapy</td>
</tr>
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<tr>
<td>Mother-infant breastfeeding assessment tool</td>
<td>(Johnson et al., 1999)</td>
<td>USA, Community</td>
<td>N=981 infants</td>
<td>Observational</td>
<td>Readmission to hospital due to child ill health or feeding problem</td>
<td>Readmission rate higher if no home visit was made to assist with breastfeeding.</td>
<td>Does not test tool reliability or validity, no covariate adjustment</td>
</tr>
<tr>
<td>NOMAS</td>
<td>(Bingham et al., 2012)</td>
<td>USA, Hospital</td>
<td>N=51, premature, tube-fed infants</td>
<td>Observational</td>
<td>Ability of NOMAS to predict readiness to move from tube to oral feeding</td>
<td>NOMAS was a poor predictor of feeding outcomes</td>
<td>Covariates: Gestational age at birth, birth weight, Apgar score, days of respiratory support</td>
</tr>
<tr>
<td>WHO/UNICEF B-R-E-A-S-T-Feed Observation Form</td>
<td>(De Oliveira et al., 2006)</td>
<td>Brazil, Hospital</td>
<td>N=74 women randomized to 30 minute breastfeeding assessment and technique advice session; N=137 standard care</td>
<td>RCT</td>
<td>Exclusive breastfeeding rate and lactation related problems in the first 30 days postpartum</td>
<td>Intervention and control groups had similar rates of EBF at 7 and 30 days postpartum; there were no differences in nipple problems or breast conditions, or quality of breastfeeding technique.</td>
<td>Authors adapted the b-r-e-a-s-t tool; a single input may not be enough to resolve breastfeeding problems</td>
</tr>
<tr>
<td>WHO/UNICEF B-R-E-A-S-T-Feed Observation Form</td>
<td>(Goyal et al., 2011)</td>
<td>Libya, Hospital</td>
<td>N=192 mother-child pairs</td>
<td>Observational</td>
<td>Grading of position, attachment and effective suckling</td>
<td>Associated with poor positioning: primiparous women. Poor attachment: primiparous women, cracked nipples, mastitis, preterm and low birth weight. Poor suckling: preterm, low birth weight &amp; early neonatal period</td>
<td>Adapted the b-r-e-a-s-t form to include a grade (poor, average, good) and a score for breast feeding aspects</td>
</tr>
<tr>
<td>WHO: Breastfeeding counselling: a training course</td>
<td>(Kronborg &amp; Vaeth, 2009)</td>
<td>Denmark, Home visits</td>
<td>N=570 mother-child pairs, 1 week postpartum. Randomised to health visitor intervention, with classification and correction of breastfeeding technique, or standard care</td>
<td>RCT</td>
<td>Duration of exclusive breastfeeding</td>
<td>Half of women had breastfeeding problems, most commonly: ineffective position and latch. Adjusted analysis: ineffective technique and pacifier use associated with early breastfeeding problems and reduced duration. A single correction not associated with duration or occurrence of problems.</td>
<td>As a single breastfeeding correction was not effective. Authors suggest ongoing support to correct problems may be necessary. Covariates: Early feeding problems, education, previous breastfeeding experience, formula supplement within 5 days of birth</td>
</tr>
<tr>
<td>WHO/UNICEF B-R-E-A-S-T-Feed Observation Form</td>
<td>(Kronborg et al., 2007)</td>
<td>Denmark, Home visits</td>
<td>N=780 mother-child pairs randomized to intervention (health visitors classified and corrected breastfeeding technique during 1-3 home visits), n=815 to standard care</td>
<td>Cluster RCT</td>
<td>Duration of exclusive breastfeeding and maternal satisfaction with breastfeeding during 6 months of follow-up</td>
<td>Intervention group had 14% lower breastfeeding cessation rate, received their first home visit earlier, had more home visits in total and more practical breastfeeding training within 5 weeks. Feeding frequency was higher, and fewer used pacifiers. Mothers reported more confidence in milk sufficiency</td>
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</tr>
<tr>
<td>WHO/UNICEF B-R-E-A-S-T-Feed Observation Form</td>
<td>(Leite et al., 2005)</td>
<td>Brazil, Home visits</td>
<td>N=1003 infants &lt;3000g n=503 intervention: 6 home visits 5-20 days postpartum, n=500 control</td>
<td>RCT</td>
<td>Feeding methods at 4 months</td>
<td>Exclusive breastfeeding was significantly higher in the experimental group than the control (24.7% vs. 19.4%) and showed a 39% increase in any breastfeeding</td>
<td>Difficult to unpick the effect of observing the breastfeed from other activities. Covariates: Socio-demographic and pregnancy variables</td>
</tr>
<tr>
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<tr>
<td>WHO/UNICEF B-R-E-A-S-T-Feed Observation Form</td>
<td>(Yalcin &amp; Kuskonmaz, 2011)</td>
<td>Turkey, Hospital</td>
<td>N=82 mothers and children 2 months of age</td>
<td>Observational</td>
<td>Determinants of score on b-r-e-a-s-t assessment</td>
<td>Female babies had better scores. Associated with worse scores: long bouts of crying, sibling history of colic, short duration of night sleeping, regurgitation.</td>
<td>The 4-item versions can be considered as routine assessment tool to assist. The sensitivity of the tools to correctly identify postnatal woman at risk of non-exclusive breastfeeding is satisfactory (cut off point 3.5 and 5.5) the specificity is poor. Acceptable internal consistency.</td>
</tr>
<tr>
<td>LATCH</td>
<td>(Lau et al., 2016)</td>
<td>Singapore</td>
<td>N= 907 mothers and children.</td>
<td>Observational within 72 hours postpartum</td>
<td>Evaluation of internal consistency, validity, sensitivity and specificity 5- and 4-item versions of LACTH. Data were filtered: preterm deliveries were excluded because of their different suckling patterns. Only 4 or 5 outcomes. The sample were infant with body weight 3.14-0.39 Kg.</td>
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<tr>
<td>LATCH</td>
<td>(Kucukoglu &amp; Celebioglu, 2014)</td>
<td>Turkey</td>
<td>N=85 low birth weight (&lt; 2500g) infants and mothers</td>
<td>Effect of an education intervention half an hour per day during the first 5 days of hospitalization.</td>
<td>low internal consistency</td>
<td></td>
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<tr>
<td>Preterm Oral Feeding Readiness Assessment Scale (POFRAS)</td>
<td>(Fujinaga et al., 2013)</td>
<td>Brazil, Hospital</td>
<td>N= 60 preterm infants</td>
<td>Observational</td>
<td>Accuracy, sensitivity and specificity of POFRA cut-off was demonstrated.</td>
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<tr>
<td>NeoEAT-Breastfeeding</td>
<td>(Pados et al., 2018)</td>
<td>USA</td>
<td>N=402 parents of 7 months old baby</td>
<td>web-based surveys</td>
<td>parents recruited were asked to use the tool to report child BF problems.</td>
<td>good evidence of reliability and content validity scoring 5.1 consistent with recommendation for health-related materials</td>
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<tr>
<td>Bristol Breastfeeding Assessment Tool (BBAT)</td>
<td>(Dolgun et al., 2018)</td>
<td>Turkey, Hospital</td>
<td>N=127 mothers of 0-6 months old baby</td>
<td>Observational: 2 pediatric nurses</td>
<td>Tool was translated. Clarity and fluency language were analysed. Current validity with LACTH tool was explored.</td>
<td></td>
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<tr>
<td>Early Feeding skills Assessment Tools (EFSAT)</td>
<td>(Thoyre et al., 2018)</td>
<td>USA, hospital</td>
<td>N=8 cases of 2 months old baby - 142 feeding observed</td>
<td>Observational</td>
<td>Current validity with Infant-Driven Feeding Scale Quality(IDFS-Q) tool, infant birth risk expressed in gestational age (GA) and infant maturity expressed in post menstrual age (PMA)</td>
<td>Correlation with IDFS-Q tool. Later gestational age associated with higher EFS score. Advanced PMA was associated with higher feed engagement subscale score.</td>
<td></td>
</tr>
</tbody>
</table>
Table 4. Studies assessing breastfeeding assessment tool reliability.

<table>
<thead>
<tr>
<th>Assessment Tool</th>
<th>Author(s) &amp; date</th>
<th>Country &amp; setting</th>
<th>Sample</th>
<th>Study design</th>
<th>Outcomes</th>
<th>Findings</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMCI algorithm (Darmstadt et al., 2009)</td>
<td>Bangladesh, community</td>
<td>N=395 neonates aged 0-8 days</td>
<td>Observational</td>
<td>Validity of community health worker identified symptoms and signs of illness/feeding problems (against clinician ‘gold standard’ opinion)</td>
<td>Health worker classifications had 73% sensitivity, 98% specificity, 57% positive and 99% negative predictive value. Identified feeding problems: ‘not sucking at all’, ‘not attached at all’, ‘not well attached’ were all confirmed by physician questioning of mother</td>
<td>There is no gold standard for breastfeeding assessment and no evidence that physician questioning is superior to IMCI</td>
<td></td>
</tr>
<tr>
<td>Infant Breastfeeding Assessment Tool (IBFAT) (Riordan &amp; Koehn, 1997)</td>
<td>USA, hospital and community</td>
<td>N=11 breastfeeding women and their newborns children</td>
<td>Observational</td>
<td>Inter-rater (n=3) and test-retest reliability of 3 breastfeeding assessment tools from n=12 randomly selected videoed feeds</td>
<td>Spearman rank order coefficients of inter-rater correlations ranged from .27 to .69 for IBFAT. Test-retest correlation=r0.88.</td>
<td>Small number of observations are unlikely to be representative</td>
<td></td>
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<tr>
<td>LATCH (Adams &amp; Hewell, 1997)</td>
<td>USA, hospital</td>
<td>N=35 first time breastfeeding mothers</td>
<td>Observational</td>
<td>Inter-rater reliability of lactation consultant scores and mothers’ LATCH scores</td>
<td>85-100% lactation consultant agreement. Correlation with maternal reports=very low-moderate</td>
<td>Mothers may focus on somatic experience</td>
<td></td>
</tr>
<tr>
<td>LATCH (Riordan &amp; Koehn, 1997)</td>
<td>USA, hospital and community</td>
<td>N=11 breastfeeding women and their newborns children</td>
<td>Observational</td>
<td>Inter-rater (n=3) and test-retest reliability of 3 breastfeeding assessment tools from n=12 randomly selected videoed feeds</td>
<td>Spearman rank order coefficients of inter-rater correlations ranged from .11 to .46. The reported test-retest correlation was .88.</td>
<td>Small number of observations unlikely to be representative</td>
<td></td>
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<tr>
<td>Mother-Baby Assessment (MBA) (Riordan &amp; Koehn, 1997)</td>
<td>USA, hospital and community</td>
<td>N=11 breastfeeding women and their newborns</td>
<td>Observational</td>
<td>Inter-rater (n=3) and test-retest reliability of 3 breastfeeding assessment tools from n=12 randomly selected videoed feeds</td>
<td>Spearman rank order coefficients of inter-rater correlations ranged from r=0.33 to 0.66; test-retest correlation r=0.88.</td>
<td>Small number of observations unlikely to be representative</td>
<td></td>
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<tr>
<td>Assessment Tool</td>
<td>Sample</td>
<td>Study design</td>
<td>Outcomes</td>
<td>Findings</td>
<td>Remarks</td>
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<tr>
<td>Mother-infant breastfeeding progression tool (MIBPT)</td>
<td>N=62 healthy mother-baby pairs; 35-42 weeks gestational age; Infants 2-5 days old</td>
<td>Observational</td>
<td>Infant feeding performance: transitional rate &amp; volume of milk consumed from the breast</td>
<td>Inter-rater agreement of tool scores: 79-95%. Test-retest of MIBPT with 4 raters = moderate to near perfect (r=0.35-0.94). Tool could incorporate new knowledge of infant swallowing.</td>
<td>No maternal or child outcome included.</td>
<td></td>
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<tr>
<td>NOMAS</td>
<td>N=35 infants, 35-49 weeks postmenstrual age, &amp; ≥1900g</td>
<td>Observational</td>
<td>Inter-rater agreement of NOMAS with 4 raters = 79-95%.</td>
<td>Percentage agreement of 3 coders: 80% agreement.</td>
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<tr>
<td>NOMAS</td>
<td>N=75 healthy &amp; very low birth weight infants; 26-36 weeks postmenstrual age</td>
<td>Observational</td>
<td>Test-retest of NOMAS with 4 raters = moderate to near perfect (r=0.35-0.94).</td>
<td>Good inter-rater reliability for observers (r=0.84-1.0). Poor inter-rater reliability for observers and mothers (r=0.27-0.86). Poor items revised.</td>
<td></td>
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<tr>
<td>NOMAS</td>
<td>N=147 preterm, but healthy infants, 32-26 weeks postmenstrual age</td>
<td>Observational</td>
<td>Infant feeding performance: transitional rate &amp; volume of milk consumed from the breast.</td>
<td>Acceptable reliability of normal &amp; disorganized categories. All categories moderately correlated with transitional milk rate.</td>
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<tr>
<td>PIBBS</td>
<td>N=24 full/preterm infants in neonatal intensive care, transitional/maternity units.</td>
<td>Observational</td>
<td>Inter-rater reliability of observers, &amp; observers/mothers.</td>
<td>Good inter-rater reliability for observers (r=0.64-1.00), but poor for observers and mothers (r=0.27-0.86). Poor items revised.</td>
<td></td>
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<tr>
<td>Infant Breastfeeding Assessment Tool (IBAT)</td>
<td>N=45 overweight and obese women, multiparas, Latinas</td>
<td>Observational</td>
<td>Inter-rater reliability of 4 lactation assessment tools applied to overweight and obese women. Swallowing evaluation was unreliable especially during the first week.</td>
<td>Inter-rater reliability was evaluated with 3 methods: analysis of variance (ANOVA), average measures intraclass correlation coefficients (ICCs), and percentage absolute agreement between raters.</td>
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<tr>
<td>Modified Via Christi (mVC)</td>
<td>USA, Hospital</td>
<td>Observational</td>
<td>Infant feeding performance: transitional rate &amp; volume of milk consumed from the breast.</td>
<td>Acceptable reliability of normal &amp; disorganized categories. All categories moderately correlated with transitional milk rate.</td>
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<tr>
<td>LACTH and modified Via Christi (mVC)</td>
<td>USA, Hospital</td>
<td>Observational</td>
<td>Infant feeding performance: transitional rate &amp; volume of milk consumed from the breast.</td>
<td>Acceptable reliability of normal &amp; disorganized categories. All categories moderately correlated with transitional milk rate.</td>
<td></td>
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<tr>
<td>RT</td>
<td>USA</td>
<td>Observational</td>
<td>Infant feeding performance: transitional rate &amp; volume of milk consumed from the breast.</td>
<td>Acceptable reliability of normal &amp; disorganized categories. All categories moderately correlated with transitional milk rate.</td>
<td></td>
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<tr>
<td>Assessment Tool</td>
<td>Author(s) &amp; date</td>
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<td>Study design</td>
<td>Outcomes</td>
<td>Findings</td>
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<tr>
<td>Bristol Breastfeeding Assessment Tool (BBAT)</td>
<td>(Ingram et al., 2015)</td>
<td>UK</td>
<td>N=34 dyads under 2 weeks old infants</td>
<td>observation and qualitative inter-rater reliability with Cronbach's alpha</td>
<td>high correlation in consistency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bristol Breastfeeding Assessment Tool (BBAT)</td>
<td>(Dolgun et al., 2018)</td>
<td>Turkı, Hospital</td>
<td>N=127 mothers of 0-6 months old baby</td>
<td>observational of 2 pediatric nurses inter-rater agreement with Kappa analysis. Consistency over time analysis and item analysis.</td>
<td>Strongly significant agreement between the two raters in terms of “positioning”, “facing” and “sucking” domains and significant agreement in terms of “swallowing” domain</td>
<td></td>
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</tr>
<tr>
<td>Early Feeding Skills Assessment Tools (EFSAT)</td>
<td>(Thoyre et al., 2018)</td>
<td>USA, Hospital</td>
<td>N=8 cases of 2 months old baby</td>
<td>Observational Inter-rater reliability with Cronbach's alpha</td>
<td>Cronbach's alpha was 0.81 indicating acceptable internal consistency on EFS total scale.</td>
<td></td>
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</tr>
</tbody>
</table>
Ability of tools to correct breastfeeding technique or improve breastfeeding experience

Few studies tested the use of tools to correct breastfeeding technique or to improve breastfeeding experience. These are shown in Table 5.

Discussion

Our review identified a number of breastfeeding assessment tools which could be used in the management of our target group of at-risk and malnourished infants aged under 6 months. Though none of the tools were developed for or tested on this group directly, characterising them and understanding the underlying evidence-base allows for better informed decisions about which might be the most helpful for future programme use.

Regarding the coverage of breastfeeding domains, only one tool (BEET) achieves full coverage of all the key assessment domains. The tools that achieve the widest coverage (IFE Module 2, BEET, and WHO/UNICEF B-R-E-A-S-T-Feed Observation Form and UNICEF/WHO Breastfeed Observation Aid) are generally those which have been developed with resource-poor low and middle income countries in mind. Although these tools are based on extensive clinical and field experience, they suffer from lack of validation research and miss some important domains (e.g. WHO/UNICEF B-R-E-A-S-T-Feed Observation Form misses health of the baby, IFE Module 2 misses positioning). These shortfalls could be addressed with minor modifications in the short term and with appropriately designed studies soon after to help determine which domains are the most important and relevant to patient care. Only 11 tools assess mothers’ own behaviour towards the baby: this is telling about her psychosocial status and can inform management. It is important to consider and account for such gaps since an infant may be effectively breastfed but at risk and malnourished for another reason, e.g. related to child health status or maternal factors. A challenge validating breastfeeding assessment tools is the lack of a ‘gold standard’ treatment option for at-risk and malnourished infants less than 6 months. This makes validation studies a challenge methodologically since it is difficult to separate out the performance of an assessment tool from the effectiveness of the subsequent management strategy in averting adverse nutrition/morbidity outcomes. It is likely that different tools and different levels of management will be appropriate to different settings, e.g.

- **In primary healthcare / community settings**: simple and rapid breastfeeding assessment tools, associated with easy-to-deliver interventions and to prompt referral for more specialised support. For use by community healthcare workers who may have limited training and experience.

- **In secondary healthcare / outpatient clinic settings**: more detailed tools could be appropriate but would need more training and staff with more background skills, expertise and time to deliver.

- **In tertiary-level inpatient settings**: more complex assessments would be appropriate to identify more complex problems. These could be delivered by more highly trained healthcare staff such as nurses and doctors.

No single tool meets all these needs. Which tool is more appropriate to a given setting and individual mother-infant situation is itself an important question that warrants further testing and exploration.

For immediate use, whilst refining current tools and developing new future ones, the WHO/UNICEF B-R-E-A-S-T-Feed Observation Form, the aids in Module 2 on IFE and UNICEF/WHO Breastfeed Observation Aid, offer the most promise for programmes targeting at-risk and malnourished infants aged under 6 months.

In future research testing current and new tools, there is a need to agree on the most appropriate outcomes for validation studies targeting at-risk and malnourished infants under 6 months. The fact that so many tools exist, and that they cover such a wide range of feeding outcomes and domains arguably reflects uncertainly and lack of consensus about how best to assess the effectiveness of breastfeeding. For example, must there always be sufficient infant weight gain associated with other measures of effective feeding? Most current evidence comes from high-income countries and hospital settings. For use in tackling the significant global burden of malnutrition in infants aged less than 6 months, this is a problem. More tools for low income countries and for community settings are urgently needed (Moran et al., 2000; Mulder, 2006; Riordan, 1998; Riordan & Koehn, 1997).

Another key finding of our review was the variable - and overall low - quality of evidence underpinning existing breastfeeding assessment tools. Often the evidence-base for a particular tool is unclear, particularly their effectiveness in identifying specific breastfeeding problems and facilitating a resolution. Prospective and ideally randomised studies testing tools’ ability to do this are important in the future (Da Costa et al., 2008). Simple checklists have been shown to be powerful if used consistently in clinical settings (Haynes et al., 2009; Pronovost et al., 2006). There is therefore an argument to develop checklist-based tools that can be incorporated into routine breastfeeding assessment, to maximize the chances of resolving breastfeeding problems. These should also be able to discriminate between different types of breastfeeding problems and lead clearly to specific interventions.

We found that tools varied in their level of complexity, and their scoring systems. This may make individual tools relevant only for specific contexts. For example, three tools involve two stages: IFE Module 2 includes a simple rapid assessment, followed by a full assessment (ENN et al., 2007); the BFHI guidelines may include initial use of the breastfeeding assessment form, leading on to the UNICEF/WHO breastfeed observation aid if necessary (UNICEF, 2010; WHO/UNICEF, 2009a); the IMCI algorithm includes both a brief history taking and observations of the breastfeed (Mannan et al., 2008).
<table>
<thead>
<tr>
<th>Assessment Tool</th>
<th>Author(s) &amp; date</th>
<th>Country &amp; setting</th>
<th>Sample</th>
<th>Study design</th>
<th>Outcomes</th>
<th>Co-variates</th>
<th>Findings</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMNCI guidance</td>
<td>(Thakre et al., 2012)</td>
<td>India, Hospital</td>
<td>N=104 babies</td>
<td>Observational</td>
<td>Breastfeeding position and attachment</td>
<td>Not clear</td>
<td>Significant improvements to breastfeeding positioning and attachment observed after IMNCI assessment and guidance.</td>
<td></td>
</tr>
<tr>
<td>IMNCI guidance</td>
<td>(Dongre et al., 2010)</td>
<td>India, Community</td>
<td>N=99 mothers and children &lt;6 months</td>
<td>Observational</td>
<td>Child feeding problems</td>
<td>None</td>
<td>Significantly more women had an observable positioning and/or attachment difficulty than other feeding problems.</td>
<td></td>
</tr>
<tr>
<td>Infant Breastfeeding Assessment Tool (IBFAT)</td>
<td>(Matthews, 1991a)</td>
<td>Canada, hospital</td>
<td>N=56 healthy breastfeeding mothers and their newborns</td>
<td>Observational</td>
<td>Maternal satisfaction with breastfeeding</td>
<td>Considered multi and primiparous separately</td>
<td>Higher ‘effective feeding’ scores linked to greater maternal satisfaction. Primiparous rated infants lower and were more dissatisfied than multiparous mothers.</td>
<td>Nurses observed 77/812 feeds to assess reliability: &lt;10% cases were significantly different.</td>
</tr>
<tr>
<td>Infant Breastfeeding Assessment Tool (IBFAT)</td>
<td>(Furman &amp; Minichm, 2006)</td>
<td>USA, hospital</td>
<td>N=34 mothers of very low birth weight infants; 35 weeks gestational age</td>
<td>Observational</td>
<td>Milk-intake (test-weighing)</td>
<td>None</td>
<td>IBFAT scores positively correlated with feeding observations and milk intake; sucking score correlated with percentage time sucking.</td>
<td>IBFAT does not discriminate adequate and inadequate milk intake.</td>
</tr>
</tbody>
</table>
is potentially a good thing. Rather than one tool trying to do everything, different tools for different levels of assessment could be helpful: e.g. a quick, basic tool for use in the community to identify and correct ‘simple problems and identify referral need, complemented by a more detailed tool if problems are suspected or identified; another more detailed one for clinic/hospital use assessing more serious and complex problems flagged by the first tools. Tool developers need to consider what the key contact points with infants are, and the associated opportunities and capacities with these contact points. Coupled with this must be the capacity to respond to any problems identified. To address breastfeeding in high mortality/morbidity settings, tools need to consider not just physiological issues and techniques around breastfeeding, but also the wider social and psychological factors, which may be contributing to or perpetuating a problem (Galipeau et al., 2017).

**Which tools for resource-poor, high-undernutrition settings**

From this review, Baby Friendly Hospital tools, the Module 2 IFE and WHO/UNICEF B-R-E-A-S-T-Feed Observation Form, have emerged as potentially useful for use in humanitarian settings with at-risk and malnourished infants under 6 months. They require a short training and they are easy-to-use. Baby Friendly Hospital tools and the Module 2 IFE could benefit from adaptation by adding the missing components that we would be considered useful for humanitarian contexts. While BFHI has become a ‘gold standard’ for maternity care in hospital setting, the effectiveness of the training course has been assessed but the evaluation of the breastfeeding assessment form requires more studies. Equally, these tools could be combined (e.g. by adding questions from one tool to another) in a way that might improve the quality of breastfeeding assessment, and that would take into account the specific needs and limitations of contexts with a high burden of undernutrition. It will be important to ascertain the feasibility of community health workers using these tools.

Based on coverage of domains, appropriateness to target population and setting, and underlying evidence, WHO/UNICEF B-R-E-A-S-T-Feed Observation Form appears to be the most suitable for assessing at risk and malnourished infants aged under 6 months. In two Danish RCTs, health visitors were trained to conduct home visits incorporating breastfeeding assessment and classification of technique problems (Kronborg & Vaeth, 2009; Kronborg et al., 2007). One study found a 14% lower breastfeeding cessation rate amongst intervention participants, and greater confidence of mothers that their breast milk was sufficient. However, the other found no difference in exclusive breastfeeding rate or a reduction in breastfeeding problems - this may be due to a single corrective intervention being insufficient to resolve breastfeeding problems. The authors argued for on-going breastfeeding support to ensure breastfeeding problems are truly resolved. This idea is corroborated by a third Brazilian hospital-based RCT with a low socioeconomic population, which found no impact of a single breastfeeding assessment and correction on exclusive breastfeeding rates, breastfeeding technique or breastfeeding problems 30 days post-partum (De Oliveira et al., 2006). A further RCT in Brazil also used the WHO/UNICEF B-R-E-A-S-T-Feed Observation Form but included a greater number of home visits (n=6). This observed a 39% increase in any breastfeeding, and a significant increase in exclusive breastfeeding. One limitation of this study is that it is difficult to unpick the effect of the breastfeeding observation and corrective advice from the other interventions during the home visit (Leite et al., 2005). This underlines the importance of not just having a good tool, but using it to maximum effect i.e. not just conducting a single assessment and correction, but providing on-going support through community outreach (Imdad et al., 2011). What is most encouraging about the WHO/UNICEF B-R-E-A-S-T-Feed Observation Form is its apparent usability in routine clinical settings, with relatively short training if conducted for the use of the tool only. As the tool is part of a broader training on breastfeeding counselling, it is recommended to explore the whole manual, but it is also possible to adapt to the situation’s needs. It would still be valuable to do further validation of this tool and possibly extend the tool components to include aspects of the baby’s health, as identified in the section on coverage of breastfeeding domains.

**Ways forward**

As well as standard validation studies, new tools or those initially developed in/adapted from resource-rich settings should be assessed for cultural relevance and sensitivity before they are considered for use in resource-poor developing country/humanitarian settings. This formative work should ideally precede detailed validation or intervention studies. Validity is likely to vary according to target patient group and studies should therefore be sufficiently powered to explore subgroups. Tools that are designed to assess breastfeeding in healthy, well-nourished infants are not necessarily as good or adequate for assessing sick or undernourished ones. As none of those tools presented above were developed and tested in malnourished children and since these infants are at particularly high risk of morbidity and mortality, specific tools should consider the needs of infants aged less than 6 months with malnutrition – the group who inspired this review in the first place. Since there are many factors potentially underlying or contributing to malnutrition, we believe that tools for this group should be part of a wider assessment of the mother-infant dyad and take an appropriately broad perspective by considering other factors known to impact on infant nutrition e.g. maternal mental health, maternal illness, and maternal malnutrition.

**Limitations**

We acknowledge the limitation of our review. Firstly, it was restricted to articles written in English; there may be useful breastfeeding assessment tools published in other languages that were not captured.

Secondly, it is possible that we missed some studies, e.g. those using a broader approach to improving infant feeding may not have explicitly mentioned breastfeeding assessment.
tools as part of their intervention protocol; those which were using a tool in a programme but were not in the title or abstract clearly evaluating/testing the tool itself; those that may have had relevant content (e.g. maternal psychosocial status) but did not meet the inclusion criteria of one clinically relevant maternal or child outcome.

Third, we did not explicitly grade the quality of individual studies – this was felt not to add significant extra value to our review since observational studies, which comprised great majority of papers identified, are by definition low quality compared to intervention/RCT type designs. Quality grading would not have helped differentiate between more/less valuable tools, since the quality of evidence underpinning them all was generally low.

Finally, we found few tools explicitly targeted to our setting and main patient group of interest. This is not ideal since it means applicability had to be extrapolated based on our judgement rather than on hard data.

Despite these limitations, we do not believe that the overall direction or message arising from our findings are affected.

Conclusion
In this review of breastfeeding assessment tools for resource poor settings and targeting the assessment of malnourished infants less than 6 months, we have identified many possible but few stand-out ‘gold standard’ options. This represents an important evidence gap and highlights an urgent need for future research. The many different tools that we did find arguably show that one tool alone is unlikely to be suitable or even desirable. Tools must strike the right balance between simplicity, feasibility of use and minimal training requirements without losing the depth of information required to help healthcare workers and the women they are working with address breastfeeding difficulties. Thus, different tools for different levels of the health care system are needed: simple, quick-to-use tools for initial triage and problem identification in the community; more sophisticated tools for use in secondary and tertiary care settings where initial attempts at support have failed. Supplementary items such as pictures of good latch, and materials to help mothers and health workers understand the nature of breastfeeding problems (e.g. ‘take action cards’ (Dongre et al., 2010)), may be helpful. For any tool at any level, it is important that it leads to clear corrective actions. A “diagnosis” or “problem label” by itself is not always useful. Hence, future tools might give appropriate weight to problems, which can most readily be solved, or those which have the biggest short and long term impact. Research on breastfeeding assessment tools needs to consider such impacts – again, good test inter- and intra-observer validity is necessary but not alone sufficient to make a ‘good’ tool. It must help improve key outcomes like breastfeeding status and infant growth. Robustly designed studies in the contexts in which they will be used are essential.

Finally, we note that time will be needed to develop and test better future breastfeeding assessment tools. Yet support for women and their infants is urgently needed now. Not having an ideal tool is not a reason to defer breastfeeding assessment of at risk and malnourished infants under 6 months. There are great opportunities at present to collect and report good quality operational data using tools that are currently available. Expanding the current literature on breastfeeding assessment will be of great benefit to future tool developers. More importantly, focus on this area will also raise the profile of and directly benefit breastfeeding as a key child nutrition, health and survival intervention.

Data availability
Underlying data
All data underlying the results are available as part of the article and no additional source data are required.

Extended data
LSHTM Data Compass: Breastfeeding assessment tools for at-risk and malnourished infants aged under 6 months old: a systematic review, https://doi.org/10.17037/DATA.00001881 (Kerac et al., 2020).

This project contains the following extended data:
- Tools excluded from the second stage of the literature search
- Full search strategy

Reporting guidelines

Data are available under the terms of the Creative Commons Attribution-NonCommercial 2.0 UK license (CC BY-NC 2.0 UK).

Acknowledgements
We are thankful to Professor Andrew Seal, UCL Institute for Global Health for his support and we are also thankful to Anne-Dominique Israel, Senior Nutrition and Health advisor at Action contre la Faim for supporting the initiative.
References


Kerac M, Blencowe H, Grijalva-Eternod C, et al.: Prevalence of wasting among...


Open Peer Review

Current Peer Review Status: ✔️ ✔️ ✔️

Version 1

Reviewer Report 19 February 2021

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Nurul Husna Mohd Shukri

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The review compares different breastfeeding assessment tools to identify suitable tools to be used among at-risk and malnourished infants. The review also evaluates the breastfeeding assessment tools by comprehensively discussing both advantages and limitation of each tool and its reliability, as well as its validity in assessing breastfeeding outcomes. This review emphasizes the need for future tools to suit different breastfeeding management levels and settings, from primary to tertiary settings.

The authors clearly outline the study limitations and provide important suggestions in developing comprehensive and target-setting specifics of future breastfeeding assessment tools. All tables are clear and well-organised.

Overall, this review critically analyses various important criteria of breastfeeding assessment tools in different settings, addressed important key gaps, and provides suggestions in establishing a better version of the tools in the future. All of these would provide a significant value to the literature.

Nevertheless, there are a few minor suggestions to consider:

1. It is suggested to describe the key term used or provide a table showing all Medical Subject Heading (MeSH) and keyword used for literature search.

2. Clarify or describe the term at-risk and malnourished infants.

3. Differentiate or explain the difference/similarity between breastfeeding outcomes and performance.

4. It is suggested for authors to proofread the paper to improve the overall writing.
Are the rationale for, and objectives of, the Systematic Review clearly stated?
Yes

Are sufficient details of the methods and analysis provided to allow replication by others?
Yes

Is the statistical analysis and its interpretation appropriate?
Not applicable

Are the conclusions drawn adequately supported by the results presented in the review?
Yes

**Competing Interests:** No competing interests were disclosed.

**Reviewer Expertise:** Mother-infant signalling, relaxation therapy during breastfeeding, breast milk hormones

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

---

**Author Response 25 May 2021**

**Concetta Brugaletta**, University College London Hospitals NHS Trust, London, UK

Thank you very much for taking the time to read the review and for all your comments, which we find it constructive and useful to clarify some concepts as below.

1. Regarding your first comment on describe the key term used or provide a table showing all Medical Subject Heading (MeSH) and keyword used for literature search; The search-strategy is deposited at LSHTM Data Compass as part of the Extended Data. Extended data contains tools excluded from the second stage of the search, full search strategy and PRISMA checklist. This was pointed out in the reference “Kerac M, Brugaletta C, Le Roch K: Breastfeeding assessment tools for at-risk and malnourished infants aged under 6 months old: a systematic review. [Data Collection]. London School of Hygiene & Tropical Medicine, London, United Kingdom.2020. http://www.doi.org/10.17037/DATA.00001881” We have added the link in the methods to make it easier to access.

2. Regarding your second comment to clarify or describe the term at-risk and malnourished infants; “A group with higher risk of mortality and morbidity are the small and nutritionally at-risk infants under six months of age compared to the infant that achieve optimal growth. At a population level, small and nutritionally at-risk children are those identified as wasted, stunted and underweight and a combination of these (ENN/LSHTM, 2021)”. We added a reference in the text of the larger project that clarify this concept: https://www.ennonline.net/ourwork/research/mami

3. Regarding your third comment on differentiate or explain the difference/similarity between breastfeeding outcomes and performance; We decided to modify the phrasing and
replaced by: ‘how to observe and/or assess the breastfeeding performance with outcomes’.

4. Regarding your suggestion for authors to proofread the paper to improve the overall writing; We have now proofread and think this looks fine in this last version. the major changes are:
   Table 2: corrected ‘behaviour’
   Table 3: corrected ‘postnatal’, ‘paediatric’
   Table 4: corrected ‘analysis’
   Text corrected ‘paediatric’

**Competing Interests:** No competing interests were disclosed.

Reviewer Report 18 February 2021

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Sandra Fucile
School of Rehabilitation Therapy, Queen's University, Kingston, ON, Canada

Brugaletta et al.'s, review of breastfeeding assessment tools for assessing at-risk and malnourished infants in resource-poor settings provides a comprehensive literature search of available tools for this highly vulnerable population. The authors reveal there is no ‘gold standard’ tool available for at-risk and malnourished infants in resource-poor settings. However, they highlight three ready available tools, the Breastfeeding, Evaluation and Education Tool, UNICEF Baby-Friendly Hospital Initiative tools and CARE training package, that can be used with this population and emphasize the need for refining or developing new breastfeeding tools to meet the needs of infants in resource-poor settings.

Overall, the authors provide a very thorough introduction with a clear rationale for undertaking this study. The authors perform a systematic in-depth literature search, which included seven online database resources. The authors identified 29 breastfeeding assessment tools and 45 studies related to the tools’ psychometric properties. They found that the evidence and psychometric properties of the tools was low quality and mainly from high-income countries. The strengths and weakness of these 29 breastfeeding tools were described in terms of the tool content of breastfeeding domains, predictive validity, reliability, and evidence underlying the content each tool. The tables provided clearly synthesize and integrate the strengths and weakness of each tool. In the discussion, the authors address the limitations of the study and bring to light the drawbacks of current available tools in achieve the defined outcome in this study.
The findings from this review are clinically significant and I have minor suggestions:
  ○ I encourage the authors to thoroughly reread the manuscript to ensure there are no grammatical and editorial errors.
  ○ Figure 1 appears to be adopted from the PRISMA framework, ensure that this is referenced.
  ○ Use of terminology, the authors refer to Table 3 as validation studies, I recommend rewording to use predictive validity studies.
  ○ I recommend including specific definitions for high vs low income countries, define at-risk infants, define malnourished infants either in the introduction or methods section.
  ○ The authors note 29 tools were identified, 22 were developed in high income countries, 4 low income countries. Three tools are missing such designations.

**Are the rationale for, and objectives of, the Systematic Review clearly stated?**  
Yes

**Are sufficient details of the methods and analysis provided to allow replication by others?**  
Yes

**Is the statistical analysis and its interpretation appropriate?**  
Yes

**Are the conclusions drawn adequately supported by the results presented in the review?**  
Yes

**Competing Interests:** No competing interests were disclosed.

**Reviewer Expertise:** Oral feeding in critically ill infants.

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

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**Author Response 25 May 2021**

**Concetta Brugaletta**, University College London Hospitals NHS Trust, London, UK

Thank you for taking the time to read the review and write your suggestion.

Regarding your advice to proofread the manuscript to ensure there are no grammatical and editorial errors; We have proofread and we think this looks fine in the new version of the manuscript.

Regarding your advice to ensure the reference on Figure 1; we added the reference at the base of the figure in the new version of the manuscript.
Regarding your suggestion on the use of a different terminology for Table 3; We hope it is okay to stick with validation studies as it is commonly used in the literature. For reference, see: https://www.equator-network.org/reporting-guidelines-keyword/validation-studies/

Regarding your recommendation to include a specific definitions for high vs low income countries, define at-risk infants, define malnourished infants either in the introduction or methods section; We added the following references that will help clarifying the definition and the concept as follow:

- High and low income countries: as classified by The World Bank
- At-risk infants: https://www.ennonline.net/ourwork/research/mami

Regarding your comment "29 tools were identified, 22 were developed in high-income countries, 4 low income countries. Three tools are missing such designations"; The tools that do not give any information about country of origin (described in the table 1 as not specified) are:

- Baby-friendly Hospital Initiative (BFIH) Worldwide (When the Baby-friendly Hospital Initiative was conceived in the early 1990s in response to the 1990 Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding call for action, there were very few countries that had dedicated Authorities or Committees to oversee and regulate infant feeding standards.)
- Essential Nutrition Action Message (Guyon & Quinn 2011) Low and middle-income countries
- Infant Feeding in Emergency (IFE) (ENN 2007) Low and middle-income countries
- Neonatal Eating Assessment tool (NeoEAT) This is a USA based organisation: AWHONN, the Association of Women's Health, Obstetric and Neonatal Nurses. https://www.awhonn.org/

We amended the information above in table n1 of the new version of the manuscript. In the text of the new version of the manuscript we clarify the follow information: “Of the 29 tools identified: 22 (76%) were developed in high-income countries and used in 31 studies carried out in high-income countries, six (21%) tools were developed in low and middle-income countries and one (3%) was developed worldwide”.

**Competing Interests:** No competing interests were disclosed.
This review by Brugaletta et al. addresses the important gap in tools and evidence for effective case management of at-risk and malnourished infants aged under 6 months old in low-resource and humanitarian settings. The authors focus specifically on the availability and quality of breastfeeding assessment tools for use in this population. They start with an excellent introduction highlighting the importance of this theme – describing the essential role of breastfeeding in protecting the health and lives of children and the subsequent place it has in global priority interventions, and the challenges that remain in properly addressing persistently suboptimal breastfeeding practices.

Results of the review are presented in clear tables, summarizing important features of the various tools identified. The authors provide a clear breakdown of these features into the following categories: context, coverage of breastfeeding domains, ability to predict breastfeeding outcomes, evidence underpinning the tools, and ability to correct breastfeeding technique or improve breastfeeding experience. The analysis also addresses not only technical or academic features of the tools, but also “real world” implementation issues, and ability to bring about the desired outcomes – improved breastfeeding.

The discussion highlights strengths and gaps of individual tools, as well as the overall “collection” of tools identified. The authors are clear to state that none of the tools were directly developed for or tested on at-risk and malnourished infants aged under 6 months, nor do any of the tools fully meet the various needs in terms of categories outlined above. The authors do nevertheless identify three tools that could be used “for immediate use, whilst refining current tools and developing new future ones”.

We appreciate the overall approach to this review – identifying and analyzing current tools, recognizing that we do not currently have an ideal tool, explaining the key gaps and ways forward, and importantly – providing temporary best options. Minor suggestions to consider in subsequent versions:

1. In the abstract the authors list the following as part of their search: the World Health Organization (WHO), United Nations International Children's Emergency Fund (UNICEF), CAse REport guidelines, Emergency Nutrition Network, and Field Exchange websites as parts of the search. These are not mentioned in the database and search terms of the methods section. They are perhaps listed in one of the references, but it might be helpful to include them in this later section of the manuscript as well.

2. In figure 1 it is unclear where the “Handsearch Papers” fit. This part of the search could be expanded upon in the methods section.

3. Under context the authors state: “Of the 29 tools identified: 22 (76%) were developed in high-income countries and used in 31 studies carried out in high-income countries and four (14%) tools were developed in low and middle-income countries.” What about the 3 tools, not included in the 22 developed in high-income countries and the 4 developed in low- and
middle-income countries?

4. The introduction does a nice job addressing the particular challenges associated with “managing very small infants, those with growth failure and other high-risk characteristics”. It also highlights the complex spectrum of breastfeeding problems including potential underlying causes and contributory factors, including but not limited to maternal wellbeing and social support. Although these essential topics are touched upon very briefly in the results and discussion sections, and in a bit more detail in the ways forward section, the review could benefit with expansion of these critical topics.

5. In the discussion section the authors note that only one tool, BEET, achieves full coverage of all the key assessment domains. Yet, this tool is not included amongst those listed as potentially useful for immediate use; it could be useful to note why this is the case.

6. In the initial paragraphs of the discussion, the authors suggest: “For immediate use, whilst refining current tools and developing new future ones, the WHO/UNICEF B-R-E-A-S-T-Feed Observation Form, the aids in Module 2 on IFE and UNICEF/WHO Breastfeed Observation Aid, offer the most promise for programmes targeting at-risk and malnourished infants aged under 6 months”. Later, under the heading Which tools for resource-poor, high-undernutrition settings, they suggest: “From this review, Baby Friendly Hospital tools, the Module 2 IFE and WHO/UNICEF B-R-E-A-S-T-Feed Observation Form, have emerged as potentially useful for use in humanitarian settings with at-risk and malnourished infants under 6 months.” Referring to the tools listed in the tables, we imagine that the Baby Friendly Hospital tools and UNICEF/WHO Breast Observation Aid noted above are referring to the same tool. If so, the same naming convention should be used in both instances for clarity.

7. There are a number of minor typos and grammatical errors throughout the paper and tables that should be corrected.

Are the rationale for, and objectives of, the Systematic Review clearly stated?
Yes

Are sufficient details of the methods and analysis provided to allow replication by others?
Partly

Is the statistical analysis and its interpretation appropriate?
Not applicable

Are the conclusions drawn adequately supported by the results presented in the review?
Yes

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Pediatric and nutrition programming and case management in low-resource and humanitarian settings.
We confirm that we have read this submission and believe that we have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

Author Response 25 May 2021

Concetta Brugaletta, University College London Hospitals NHS Trust, London, UK

Thank you very much for taking the time to read the manuscript and share your comments and constructive advice.

1. Regarding your first comment where you point out that we mentioned the World Health Organization (WHO), United Nations International Children's Emergency Fund (UNICEF), CAREport guidelines, Emergency Nutrition Network, and Field Exchange websites as parts of our search but we didn't mentioned these in the database and search terms; we have now clarified this in the methods search under the databases and search terms paragraph as follow: “We also included hand search papers form grey literature, WHO and ENN websites”.

2. Regarding your second comment for figure n1 where was unclear where the “Hand search Papers” fit; we amended figure n1 in the new version of the manuscript. We also add a reference Preferred Reporting items for Systematic Reviews and Meta-Analyses (PRISMA) diagram of literature search results. Diagram retrieved from: http://prisma-statement.org/PRISMAStatement/FlowDiagram.aspx

3. Regarding your request of clarification for the paragraph “Of the 29 tools identified: 22 (76%) were developed in high-income countries and used in 31 studies carried out in high-income countries and four (14%) tools were developed in low and middle-income countries.”

Three tools are missing such designations”; The tools that do not give any information about country of origin (described in the table 1 as not specified) are:

- Baby-friendly Hospital Initiative (BFIH) Worldwide (When the Baby-friendly Hospital Initiative was conceived in the early 1990s in response to the 1990 Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding call for action, there were very few countries that had dedicated Authorities or Committees to oversee and regulate infant feeding standards.)
- Essential Nutrition Action Message (Guyon & Quinn 2011) Low and middle-income countries
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We amended the information above in table n1 of the new version of the manuscript. In the text of the new version of the manuscript we clarify the follow information: “Of the 29 tools identified: 22 (76%) were developed in high-income countries and used in 31 studies carried out in high-income countries, six (21%) tools were developed in low and middle-income countries and one (3%) was developed worldwide”.

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4. Regarding your comment on considering complex spectrum of breastfeeding problems including potential underlying causes and contributory factors, including but not limited to maternal wellbeing and social support; It is a great suggestion; the number of words required does not allow us to expand on this very interesting and crucial topic. We have however added a reference of the MAMI website, which is regularly being updated and a note saying “The mother-infant dyad is at the heart of approaches to treat malnutrition, but wider family and community relationship are also important but cannot be treated extensively in this review”. (ENN/LSHTM, 2021)https://www.ennonline.net/ourwork/research/mami https://www.ennonline.net/mami/practice

5. Regarding your comment on the discussion section where only one tool, BEET, achieves full coverage of all the key assessment domains. Yet, this tool is not included amongst those listed as potentially useful for immediate use; Thank you for your comments. The justification is in the paragraph on evidence underpinning tools: ‘The extent of tool testing varied substantially; 8 tools had no validation studies: Infant Feeding in Emergencies (IFE) Module 2 (ENN et al., 2007), Breastfeeding Evaluation and Education Tool (Tobin, 1996)’. This is why we do not include for immediate use. We have added a note in the text “only one tool (BEET) achieves full coverage of all the key assessment domains, but there was no validation study at our knowledge”.

6. Regarding your comment on request of clarification if the Baby Friendly Hospital tools and UNICEF/WHO Breast Observation Aid are referring to the same tool. We would like to explain their difference and the rational for our subtle considerations:
- The Baby Friendly Hospital tools: is a checklist (12 to 14 items) designed with the aim to identify area of problem and give advice. These tools take in consideration health professional background and day of life of the baby and one can also be self-administered. This means there are 4 slightly different tools available: for mother and midwife, for mother and health visitor, for neonatal and for mother alone. The domain covered are: baby’s and mother behaviour, positioning, lactating, effective feeding, breast health, baby health, mothers view (in addition these tools look at urine and stools, formula). (https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/implementing-standards-resources/breastfeeding-assessment-tools/).
- The UNICEF/WHO Breastfeeding Observation Aid is a checklist of identify dichotomous items ( 42 items/5 scales) list signs that represent that BF is going well versus possible difficulties. It cover similar breastfeeding domains of the BFH tools but is a more simple checklist and doesn't offer possible solutions. (https://www.scribd.com/document/353627133/Breastfeed-Observation-Job-Aid)
This is why we maintained 2 different names and we advise to use the BFHT for resource-poor, high undernutrition settings where it is useful to have alongside the assessment also some initial advice.

7. Regarding your advice to proofread the paper to improve the overall writing; we have proofread and now we think this looks fine in this last of the manuscript.

**Competing Interests:** No competing interests were disclosed.
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