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ABA-Feed Infant Feeding Training for Peer Supporters and Coordinators: Development and Mixed-Methods Evaluation

Joanne Clarke[1] | Gill Thomson[2] | Nicola Crossland[2] | Stephan Dombrowski[3] | Pat Hoddinott[4] | Jenny Ingram[5] | Debbie Johnson[5] | Christine MacArthur[1] | Jennifer McKell[6] | Ngawai Moss[7] | Julia Sanders[8] | Nicola Savory[8] | Beck Taylor[9] | Kate Jolly[1] | the ABA-Feed Study Group

[1]Department of Applied Health Sciences, School of Health Sciences, College of Medicine and Health, University of Birmingham, Birmingham, UK | [2]Maternal and Infant Nutrition and Nurture Unit, University of Central Lancashire, Preston, UK | [3]Faculty of Kinesiology, University of New Brunswick, Fredericton, New Brunswick, Canada | [4]Nursing, Midwifery and Allied Health Professional Research Unit, University of Stirling, Stirling, UK | [5]Bristol Medical School, University of Bristol, Bristol, UK | [6]Institute for Social Marketing and Health, University of Stirling, Stirling, UK | [7]Patient and Public Representative, Birmingham, UK | [8]School of Healthcare Sciences, Cardiff University, Cardiff, UK | [9]Warwick Applied Health, Warwick Medical School, University of Warwick, Warwick, UK

Correspondence: Joanne Clarke (j.l.clarke@bham.ac.uk)

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ABSTRACT

The assets-based feeding help before and after birth (ABA-feed) intervention aims to improve breastfeeding rates by offering proactive peer support to first-time mothers, regardless of feeding intention. Based on behaviour change theory and an assets-based approach, the intervention involved training existing peer supporters to become infant feeding helpers (IFHs). A train-the-trainer model was used, with coordinators delivering four 2-h training sessions to IFHs. Training covered a study overview, IFH role, role-play scenarios and signposting to local assets. Due to COVID-19, training was delivered online. Post-training questionnaires were completed by 22/30 (73.3%) coordinators and 119/193 (61.7%) IFHs, and qualitative interviews were conducted with 24 coordinators and 72 IFHs. Researchers observed training at five sites, assessing fidelity, engagement and delivery quality. Questionnaire data were analysed descriptively, and qualitative data were analysed using framework analysis. Findings indicated that coordinators valued the train-the-trainer model, particularly information on formula feeding and antenatal discussions. IFHs found training engaging and felt prepared, though some were apprehensive about formula feeding support. While online training was convenient, challenges included monitoring discussions and role-play in breakout rooms. Most participants favoured a hybrid approach, with in-person sessions for interactive activities. Observations showed high training fidelity, participant engagement and confidence in delivering intervention components. The ABA-feed training was acceptable to coordinators and IFHs and was delivered with fidelity. Future training should adopt a hybrid approach, incorporating diverse resources and prioritising in-person interactive components such as role-play.

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Summary

- Coordinators and IFHs found the ABA-feed training acceptable, particularly appreciating content on formula feeding and antenatal discussions, though some IFHs were apprehensive about supporting formula feeding.
- The online training format was well-received for its convenience, but some participants would prefer in-person training for activities like role-play. A hybrid model combining both formats was favoured by most.
- Most participants rated the training quality and resources highly, though suggestions for improvement included more inclusive training materials and additional focus on formula feeding techniques.
- The training increased confidence in delivering the intervention, with 94.2% of IFHs feeling prepared. However, some IFHs requested more detailed guidance on supporting women with specific challenges, such as preterm births or mental health issues.

1 | Introduction

Despite well-established short- and long-term health benefits of breastfeeding for infants and mothers (Victora et al. 2016), the UK has a low duration of breastfeeding, with a steep decline in rates within the first 2 weeks of life (McAndrew et al. 2012). In addition, there are health inequalities, with women who are younger, of White ethnicity, with lower educational attainment, and living in areas of disadvantage being least likely to breastfeed their babies (McAndrew et al. 2012).

Peer support is recommended by the World Health Organization (WHO) for breastfeeding initiation and continuation (World Health Organization and UNICEF 2003) and is included in UK guidance (National Institute for Health and Care Excellence 2025). Peer support is defined as 'the provision of emotional, appraisal and informational assistance by a created social network member who possesses experiential knowledge of a specific behaviour or stressor and similar characteristics as the target population' (Dennis 2003).

Grant et al. (Grant et al. 2018) conducted a UK survey on the availability of breastfeeding peer support and reported that services were available in 56% of NHS organisations surveyed. The main activities of peer supporters were reported as attendance at breastfeeding groups and working on postnatal wards. Delivery of peer support was found to be focused on group support with one-to-one support less common. Although there was wide variation in peer supporter training across services, the third sector was the most popular provider for initial peer supporter training, for example, the Breastfeeding Network or National Childbirth Trust (Grant et al. 2018).

Evidence suggests that to increase acceptability, peer support interventions should be woman-centred (Hoddinott et al. 2012; Hoddinott et al. 2012; Thomson et al. 2012) including help with formula and mixed feeding (Thomson et al. 2015; Trickey and Newburn 2014), offered proactively (Dennis et al. 2002; Hoddinott et al. 2012), span both antenatal and postnatal periods (Patnode et al. 2016) and focus on the early postnatal weeks (Hoddinott et al. 2012; Ingram 2013; McAndrew et al. 2012) but continue beyond 2-weeks post birth (Hoddinott et al. 2012; Paranjothy et al. 2017).

Within the assets-based feeding help before and after birth (ABA) feasibility study (Jolly et al. 2018), the intervention aimed to improve rates of breastfeeding initiation and continuation among first-time mothers. Women were assigned a trained peer supporter (infant feeding helper [IFH]) who provided proactive, woman-centred support for all feeding types using an asset-based approach. Assets-based approaches focus on positive capabilities of individuals and communities, instead of their needs, deficits or problems (McLean 2011). The intervention was underpinned by behaviour change theory (Michie et al. 2011), and included pre-specified Behaviour Change Techniques (BCTs) (Jolly et al. 2018; Clarke et al. 2020a). The intervention began antenatally (around 30 weeks' gestation) with a face-to-face meeting to discuss feeding and, through a conversational approach, develop an infant feeding Friends and Family diagram (i.e., genogram) of potential support (Thomson et al. 2020). Postnatally, IFHs offered daily text or phone support for 2 weeks, then reduced contact up to 5 months. At two sites in England, existing peer supporters received 6 h of face-to-face training and a study handbook to become IFHs. Led by the research team, training aimed to enhance confidence and competence in intervention delivery and study fidelity. It included role-play, simulations and group-based learning (Jolly et al. 2018). Findings from the feasibility study showed the training to be acceptable to IFHs and the intervention was feasible to deliver with adequate fidelity (Clarke et al. 2020b; Ingram et al. 2020). Feedback highlighted the need for improvements in using the Friends and Family diagram, explicit guidance on BCTs and active listening skills. Extending training duration was recommended (Clarke et al. 2020b).

The ABA-feed trial tested the intervention at 17 UK sites (Clarke et al. 2023), with results to be reported separately (Jolly et al. 2025). To aid interpretation of study findings, full details of intervention delivery, including training of intervention providers, are required (Hoffmann et al. 2014), and trials of breastfeeding peer support have been criticised for failing to provide details of the training of peer supporters (Gavine et al. 2022).

The overall aim of this paper is to describe the development and evaluation of the ABA-feed intervention training for peer supporters and coordinators. Objectives are:

1. To describe the development of the ABA-feed training programme from the feasibility study to the full trial.
2. To describe the fidelity of training delivery and the experiences of IFHs and coordinators who participated in the training.
3. To explore the implications and learning with the switch from face-to-face to remote training.
4. To make recommendations for improvements to the ABA-feed training for future implementation.

2 | Methods

2.1 | Development of Training for the Full Trial: ABA-Feed Study

In the ABA-feed trial, a 'train-the-trainer' model enabled site coordinators to deliver local IFH training, supporting sustainability and adaptability. Initially planned as face-to-face, training was conducted remotely due to COVID-19 restrictions. Coordinators (infant feeding and peer support leads) at each site were trained remotely over four 2-h sessions led by SB, an Infant Feeding Specialist. The train-the-trainer session was developed by the study team to model the training programme that the coordinators would then use locally to train the IFHs at their individual sites. The aims of the training were (1) to promote competence and confidence in delivering the intervention, and (2) to facilitate understanding of the ABA-feed study overall.

Training was delivered in four 2-h sessions, covering a study overview, intervention components and the IFH role. Sessions included skill development through videos, role-play and using the Friends and Family diagram (previously 'genogram'). Topics included formula feeding support, local assets and signposting (Table 1). Training expanded on feasibility study findings, detailing two core BCTs—'social support' and 'restructuring the social environment'—with an asset-based, woman-centred focus. BCT training introduced specific techniques using good practice examples. Additional focus on using the Friends and Family diagram was included, along with an emphasis on active listening skills. A handbook and a separate antenatal meeting guide accompanied the training.

Three cohorts (20 coordinators from 15 sites) received synchronous online training—two in February 2021 and one in April–May 2021. Sessions were video-recorded for later reference. One site withdrew due to capacity issues, and its coordinators did not train any IFHs. Another site found the formula feeding section too complex for volunteer IFHs, so a simplified version was provided.

Three additional sites joined in May 2022, May 2023 and August 2023. At two sites, coordinators completed 'train-the-trainer' sessions via recorded training, with researchers available for support before training IFHs locally. At the third site, due to capacity challenges, researchers directly trained IFHs to enable the site to start intervention delivery.

After train-the-trainer, coordinators invited existing breastfeeding peer supporters to train as IFHs. Information sessions, often attended by a research team member, outlined the study and IFH's role to aid decision-making. Due to an unplanned trial delay, participant recruitment did not begin until January 2022, resulting in a gap of up to 6 months for some IFHs between training and supporting their first woman.

2.2 | Data Collection

2.2.1 | IFH Characteristics and Record of Training

After training, IFHs completed a training log to confirm their participation. The log recorded demographic details, including years of experience as a peer supporter, age group, ethnicity, number of children and their feeding methods (breastmilk, formula, mixed). No data were collected from coordinators.

2.2.2 | Quality of Training

Figure 1 shows a schema of intervention training activities and associated data collection methods. Data collection methods to describe coordinator training quality included:

1. Survey (comprising closed and open-ended questions) to coordinators after train-the-trainers to assess their experiences and feedback. Surveys covered training quality, duration, usefulness, trainer effectiveness, training videos and resources, confidence in delivering the intervention, additional training needs and suggestions for improvement. Trainees were also asked about the suitability of the online delivery.
2. Qualitative data were collected at the end of intervention delivery. Coordinators ($n = 24$) participated in group ($n = 13$) or one-to-one ($n = 11$) interviews, separate from IFHs. Interviews explored experiences and acceptability of the intervention.

TABLE 1 | Components of ABA-feed training.

	Content	Training session
1.	Overview of the study.	1 and 4
2.	Overview of the intervention, including recommended contact frequency, explanation of the assets-based approach (seeing the woman—not the IFH—as the solution and viewing relationships as assets together with available community support), woman-centred approach (including active listening skills), infant-feeding approach, BCTs and how the intervention components are evidence-based.	1
3.	Completion of the Friends and Family diagram and how it can be used in future contacts.	2
4.	Watching simulated conversations of parts of the antenatal meeting, followed by modelling an assets-based approach (including active listening skills) and BCTs by role-play.	2
5.	Supporting mothers using formula milk.	3
6.	Understanding boundaries, safeguarding and referral to health care professionals.	3

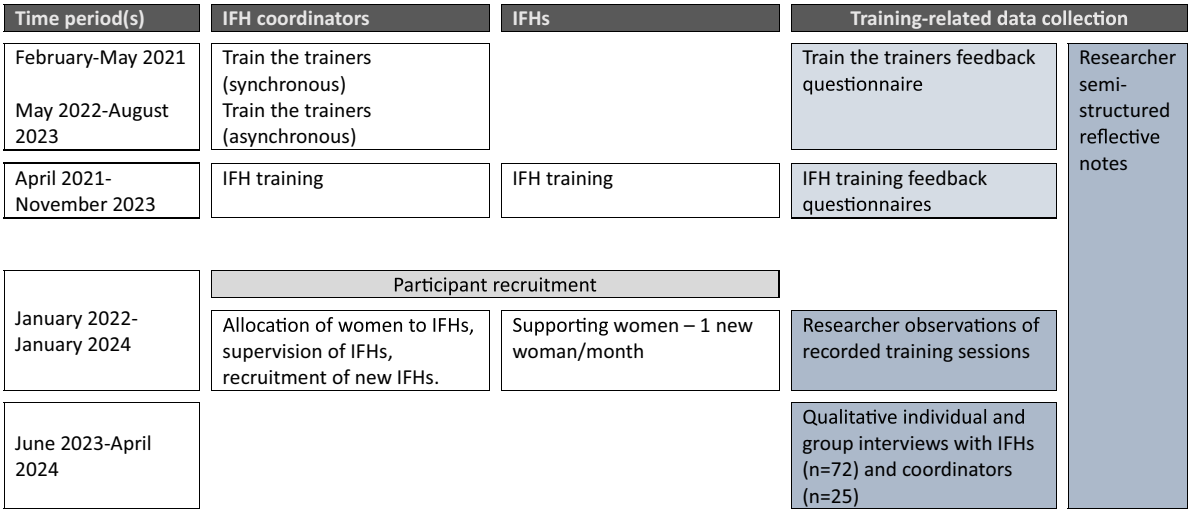

FIGURE 1 | Schema of training activities and associated data collection.

Data collection methods to describe the quality of IFH training included:

1. Survey included the same questions as for the coordinators, apart from confidence in delivering the training. At three sites, coordinators requested separate surveys after each of the four training sessions; at the remaining 14 sites, a combined survey was sent after the final session. The same questions were asked in the combined and separate evaluation forms, enabling responses to be combined. Survey data were used from Sessions 1–3 (Session 4 related to research processes and was mostly delivered by a researcher).
2. Researchers observed training at five sites. Two researchers independently reviewed the recordings, using observation checklists to assess fidelity to training topics, quality of delivery, trainer-IFH interactions, IFH engagement and any technical or other issues. Researchers then discussed and agreed on their observations.
3. Qualitative data collected at the end of intervention delivery with IFHs ($n = 72$) in group ($n = 64$) or one-to-one ($n = 8$) interviews. Interviews explored experiences and acceptability of the intervention.

This paper focuses on coordinator and IFH views of the training and their preparedness to deliver the intervention. Further details of the qualitative study, including findings relating to IFH experiences and intervention acceptability are reported elsewhere (Clarke et al. 2025).

Researchers kept semi-structured reflective notes throughout the study, documenting contextual factors influencing intervention delivery. These notes were recorded in Excel under prespecified headings, including aspects of training delivery.

2.3 | Data Analysis

IFH characteristics data, survey closed-question data and training observation data were entered into Excel and analysed descriptively. Content analysis was used to analyse the written responses for the open-ended survey questions and group them into categories.

Interview transcripts were imported into NVivo (v12) for analysis. Analysis was concurrent with data collection and carried out using a Framework Analysis approach (Gale et al. 2013). A coding framework was created initially through independent coding of three transcripts by three researchers, followed by iterative rounds of discussion and comparison with the ABA-feed logic model (Clarke et al. 2023). All transcripts were then coded using the agreed coding framework. We then summarised each individual code for every interview in a matrix in Excel, as well as an overall code summary. For this paper, we report on codes relating to train-the-trainers or the IFH training.

Researcher's reflective notes relevant to training were summarised in Excel.

Survey data, training observation data, qualitative data and researcher reflective notes were analysed together using a qualitative content analysis approach (Hsieh and Shannon 2005). Through data familiarisation, themes were identified and data were synthesised from the different sources under thematic headings. In addition, a training matrix was developed in Excel to summarise the key findings for each data set for individual sites and overall.

2.4 | Patient and Public Involvement (PPI)

PPI enabled researchers to consider the views of pregnant women and new parents throughout the study. The Trial Steering Committee and the Co-Investigators Group both included two PPI representatives. The study's PPI group included the PPI co-investigators plus four women with mixed experiences of infant feeding. The PPI group provided advice on trial processes, participant-facing study materials and dissemination, and was involved in the qualitative data analysis/interpretation.

2.5 | Ethics

The ABA-feed trial was approved by the East of Scotland Research Ethics Committee on 18 May 2021 (21/ES/0045). Capacity and capability assessment was undertaken by local NHS sites involved in recruitment or intervention delivery; where local authorities had procedures in place, separate ethical approval was obtained from local authorities that delivered the intervention. Interview participants were sent a Participant Information Leaflet and consent form via email. Informed consent for individual interviews was taken and recorded at the start of each interview, while consent for group interviews was taken in advance via telephone.

3 | Results

Twenty-two of 30 coordinators (73%) who attended train-the-trainer completed an evaluation form. Of 193 IFHs who completed the training, 119 (61.7%) completed either the combined evaluation form, or at least one of the forms for the individual sessions. IFH responses were received from all 17 sites, with site response rates varying from 21.4% to 100%. Researcher reflections about the training were recorded at 11 of the 17 study sites.

3.1 | IFH Characteristics

In total, 193 IFHs completed the ABA-feed training across the 17 study sites (Table 2). Most IFHs (59.1%) were aged 30–39 years and the majority (86.0%) were White British. Under a quarter of IFHs had fed their babies both breast and formula milk; most (76.7%) had experience of breastfeeding only. Experience as a peer supporter was highly variable, ranging from no experience to 34 years of experience. Of the IFHs receiving training, 177/193 (91.7%) went on to support at least one woman with the intervention. At 14 of the sites, IFHs were volunteers, two sites had a mix of volunteer and paid IFHs, and at one site, the IFHs were all paid.

TABLE 2 | Characteristics of trained infant feeding helpers.

		***N* = 193; *n* (%)**
Age group (years)	20–29	34 (17.6)
	30–39	114 (59.1)
	40–49	33 (17.1)
	50–59	8 (4.1)
	60+	4 (2.1)
Number of months as peer supporter	Range	0–408
	Mean	42
Number of children	1	39 (20.2)
	2	92 (47.7)
	3	49 (25.4)
	4+	13 (6.7)
Infant feeding experience	Breastfeeding	148 (76.7)
	Both breastfeeding and formula feeding	45 (23.3)
Ethnicity	White British	166 (86.0)
	White other	10 (5.2)
	South Asian	5 (2.6)
	Black	4 (2.1)
	Mixed ethnic background	6 (3.1)
	Any other ethnic background	2 (1.0)

3.2 | Themes

We identified four main themes from the datasets: 'acceptability of training content', 'acceptability of training online', 'quality of training and resources' and 'confidence to deliver the intervention and preparedness for IFH role'.

3.3 | Acceptability of Training Content

In survey responses, coordinators reported train-the-trainer to be largely acceptable, finding the information about the research study and formula feeding to be particularly useful (Table 3). Interview data confirmed the overall acceptability of train-the-trainer:

> *I don't think there was anything missing at all. I think it's obviously useful going into a trial that you want to be aware of what you are to pass over to your volunteers... there was nothing in the training we weren't aware of..., was just learning about what was required to be delivered.*
> (Coordinator, Site 7)

IFH qualitative survey responses (Table 4) reported that Session 1 (Introduction and Background) provided a clear overview of the purpose and objectives of the research, including how the IFH role differs from existing peer supporter roles. Some IFHs felt they already had the knowledge and information from previous peer supporter training, or previous study information sessions. IFHs felt that Session 2 (Antenatal Meeting) gave a clear understanding of the expectations of the meeting. They liked the structure of the meeting and the ideas around how to open a conversation about feeding. The Friends and Family diagram was understood as a key component of the intervention. In Session 3 (Postnatal Contact), IFHs felt they learnt a lot of new information, particularly about formula feeding which was new to many. They appreciated the 'woman-centred' approach. Interview data confirmed acceptability of the training to IFHs:

> *I liked the antenatal meetings for the aspect where you're able to provide information to them that they maybe didn't already know, and then that sets in motion that*

TABLE 3 | Coordinator feedback on the usefulness of the training sessions (survey data).

Category (number of responses)	Example
Formula feeding information useful and new to many (11)	'Good practical information as most IFHs may not have this experience of bottle feeding and formula milk'.
Good to have questions answered about the research (11)	'The session was very informative and was mainly new information about the processes for the research element and data collection'.
Feeling positive (8)	'Great session to get an insight into what ABA-feed is and how it is going to be useful to the people we are supporting.'
Role-plays useful and enjoyable (6)	'The role-play was useful to be able to step into the shoes of the Infant Feeding Helper'.
Not enough time for discussion (4)	'Lots of time spent on role-play and not much time left for discussion within the group'.
Not new information (4)	'I had already read and received the information about the study, so it felt a bit unnecessary and repetitive'.
Would have liked the research information earlier in the training (4)	'Felt the research information session would have been more useful at the start'.
How does ABA-feed differ from current support? (3)	'Felt there wasn't any background discussion or an explanation as to how this was going to differ from current support'.
Role-plays needed a facilitator in the breakout rooms (3)	'Think it would have been useful to have facilitators in the breakout rooms to ensure we kept on track and to guide conversations in the correct manner'.
Unanswered questions (2)	'Every area is different, and I feel this needs to be considered'.
Wanted more on behaviour change (2)	'It would have been interesting to have a bit more background around the behavioural change science'.

change of their way of thinking, going back to the training that we had for the ABA study, like changing those habits of the way people think and that kind of thing, opening up their ideas a little bit.

(IFH group interview, Site 4)

3.4 | Acceptability of Training Online

From survey data, 16 (72.7%) coordinators and 92 (88.4%) IFHs felt that participating in training online worked very well or well (Table S1). In interviews, coordinators discussed how they appreciated the convenience and efficiency of attending the training from home and meeting other coordinators from across the UK:

It was interesting to see what other areas did and didn't do, because for example we cover formula feeding in our peer support training, whereas other areas don't... it was just interesting...yeah really good training.

(Coordinator, Site 10)

Coordinators at all sites trained IFHs online, and at one site face-to-face sessions were also offered. In interviews, several IFHs and coordinators commented how the online training fitted in well with childcare, work and other commitments, although some would prefer face-to-face training. One coordinator reported:

I think it worked well online really, because... it made it easier for the Infant Feeding Helpers to attend really... they didn't have to travel, or young children they could engage with that, and I think the recordings of it as well, being able to if you did need to... I think it was a really good training package...

(Coordinator, Site 1)

From survey and interview data, the online breakout rooms were seen by some IFHs as useful for getting to know each other and role-playing how to introduce the study and open conversations about feeding. Some IFHs would have preferred to have a facilitator in the role-plays to keep the group on topic and felt the role-plays would have worked better in-person:

I think the role-play breakouts would probably work better face-to-face, because I think when we were put into breakout rooms there's just something about being in a room with somebody when you're doing something like that, because it's quite nerve-wracking.

(IFH group interview, Site 2)

This was echoed by some coordinators in the surveys and interviews who reported difficulties in monitoring IFH discussions in the online breakout rooms:

If we were delivering training and we're in a room, and we put people into little groups and they're doing their stuff, we would physically walk round that room, and we'd be listening in and engaging, yeah they have picked that up. But with [online platform] they were put into

TABLE 4 | Infant feeding helper (IFH) feedback on the usefulness of training sessions (survey data).

Category (number of responses)	Example
Session 1	
The session was interesting and gave a good overview (46)	'I enjoyed session 1 because it was all new information; about the study and behaviour change techniques. Very interesting'.
Some IFHs felt that they already had the knowledge and information (10)	'I had the majority of the knowledge already but good to chat about it'.
IFHs found the videos useful and appreciated being able to watch them in their own time (4)	'Really good to get background about the study with video from Professor Jolly and videos from peer supporters with ABA experience'.
Role-playing was useful, although some felt they needed more time or guidance (4)	'Role-playing the introduction and setting out the milestones to reach together with the 'participant' was useful'.
IFHs were interested in the research (4)	'This session helped me understand what the study is for'.
Session 2	
The session was helpful and gave clear information about what is expected in the antenatal meeting (28)	"It allowed me to gain a better understanding of what is required from me as a peer supporter within the ABA-feed study and how the antenatal meetings should be conducted'.
The role-play sessions worked well and offered an opportunity to practice skills (29)	'I enjoyed the role-play aspects and learning how to talk to different women putting any bias aside'.
The Friends and Family diagram was new and will be a helpful tool (9)	'The Friends and Family diagram will be a very useful tool in empowering women'.
The videos were useful but sometimes repetitive (5)	'The video showing role-play helped you to imagine the situations, it gave a good idea how things might go'.
Session 3	
Information and discussion on formula feeding support was useful, and new to many (45)	'Gave clear guidance regarding the sort of support we are expected to provide for formula feeding and where to find additional information'.
A comprehensive session for understanding postnatal contact and support (19)	'I found the content tonight really helpful - I feel more confident in the texting element of the role'.

> *breakout rooms, so I don't know what was happening in the breakout rooms, we didn't get to hear that, so didn't really get a feel for it.*
>
> (Coordinator, Site 8)

Researcher observations of IFH training reported some technical difficulties, for example, playing videos, organising breakout rooms, or individual participant connectivity, but overall, the online format worked well.

In surveys, 10 (45.5%) coordinators and 80 (76.2%) IFHs felt that training should be delivered as a mixture of in-person and online, 8 (36.4%) coordinators and 14 (13.3%) IFHs felt it should be online and 4 (18.2%) coordinators and 11 (10.5%) IFHs felt it should be in-person.

3.5 | Quality of Training and Resources

In survey responses, quality of the trainers, resources and videos was rated very good or good by over 85% of IFHs and over 60% of coordinators (Table S2). Several coordinators appreciated the training being provided by knowledgeable trainers although some felt that there was not always enough time for discussion.

Researcher observations showed a generally high level of fidelity, quality of delivery and discussion and participant engagement (Table 5). Trainers were reported as good at outlining the intervention and the expectations and boundaries of the IFH role. IFHs appeared engaged and enthusiastic throughout the sessions, although at one site, trainers facilitated little discussion of the training materials and videos, and questions from IFHs were limited.

In survey responses, coordinators reported that the written resources were clear. However, there were some comments relating to some videos being too long and repetitive, or having poor sound. IFHs who had received the materials found them clear and comprehensive and liked being able to refer to the handbook and the separate booklet for the antenatal meeting. IFHs found the training videos useful, particularly those showing the experiences of previous IFHs, and appreciated being able to watch videos in their own time (Table 4). In interviews, the videos were discussed as a useful training tool:

> *The videos were really useful I thought to see other people how they approach it and the types of things that they might say to actually... I think sometimes when... you're in the role-play you're very focused on what you're saying,*

TABLE 5 | Researcher observations of infant feeding helper training at five sites.

Site	Fidelity			Quality of delivery and discussion			Engagement of participants		
	Session 1	Session 2	Session 3	Session 1	Session 2	Session 3	Session 1	Session 2	Session 3
3[a]		Yes	No		Yes	Yes		Yes	Yes
5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
12	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
15	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
17	Yes	Yes	Yes	No	No	No	Yes	Yes	Yes

[a]No recording available for Session 1.

> *but actually when you're observing other people you can take it all in and make your own reflections there and then, like okay I can see what happened there, I can see how they connected in that moment, or I can see how that jarred....*
>
> (IFH group interview, Site 16)

In interviews, a few IFHs suggested improvements to the videos and training materials, including the representation of ethnic and gender diversity:

> *I thought that maybe one thing that might want to be added in is just a bit more inclusivity in terms of it's not only women who birth and breastfeed, so adding in the non-binary and trans people, and making sure that we're inclusive in that sense, because we use the word mothers and mums all the time.*
>
> (IFH interview, Site 12)

3.6 | Confidence to Deliver the Intervention and Preparedness for IFH Role

Following train-the-trainer, in survey responses, 17 (77%) coordinators felt confident or very confident, and 3 (23%) felt moderately confident to train IFHs to deliver the intervention. Concerns affecting confidence to deliver included worries about training duration, and how IFHs would respond to supporting formula feeding (Table S3), particularly as this was a new skill for many. Some IFHs interviewed reported feeling 'nervous' about supporting women intending to formula feed, with researcher observations noting that trainers were reassuring in this respect. One coordinator who was interviewed highlighted the utility of opportunities to practice formula feeding conversations:

> *I think having those formula feeding conversations was really handy, having a practice of those before going and speaking to your participants, because potentially they haven't had those conversations before, and it's a lot safer having that with somebody who is also on the study, and practising what you'd say so it sounds more authentic, rather than just going out meeting a participant and having never had those conversations before. So I think that was really good, yeah. It worked really well.*
>
> (Coordinator, Site 4)

Researchers noted in reflective notes that following train-the-trainer, most coordinators were keen to begin training IFHs, although one site wanted confirmation of the study start date first. The time between training and delivery was also discussed within the interviews: some IFHs who experienced a gap between the training and supporting their first woman felt apprehensive in getting started:

> *I think the training was really good and thorough... I think the only thing... was that gap in that I felt quite fired up at the end of it, and then by the time we went to do it I had forgotten quite a lot of it, so I had to go back again.*
>
> (IFH group interview, Site 9)

In training observations, researchers found that trainers appeared confident and enthusiastic about the intervention and components such as woman-centredness and the Friends and Family diagram. From interview data, coordinators were generally positive about their experiences of delivering the training and both coordinators and IFHs reflected on how it complemented existing peer support training. They felt it was beneficial to offer IFHs the opportunity to practice antenatal conversations and developing the Friends and Family diagram, although one coordinator felt that more training was needed on this:

> *I would probably do a little bit more training around the Friends and Family diagram, and the value of getting that right, and understanding exactly where we're coming from, building that... I don't think they... completely got the concept of it.*
>
> (Coordinator, Site 12)

Following IFH training, from survey data, 98 (94.2%) IFHs felt confident or very confident, and 6 (5.8%) moderately confident to deliver the ABA-feed intervention. Many IFHs reported that the training and their previous experiences left them feeling confident and excited to start delivering the ABA-feed intervention (Table S4). This enthusiasm was also noted in researcher observations: 'All [IFHs] very engaged – mostly had cameras on, smiley and nodding, positive body language. I felt like there was good rapport' (researcher reflection).

However, some negative reflections were captured during interviews. One IFH reported feeling 'daunted' about time

required to deliver the intervention. Some felt they needed regular training refreshers and appreciated being able to re-visit the training videos and materials. Suggestions for improvement included having more in-depth information on formula feeding and how to make up bottles safely, with a video showing the process. IFHs also felt that they would like more training on cultural differences in feeding; more on supporting women during the first 24 h post-birth, and women with premature babies, mental health issues and baby loss.

> *I felt fairly well equipped. The only time I struggled was one of my mums gave birth really quite early, at 31 weeks, and I didn't know what to do in that specific situation.*
>
> (IFH group interview, Site 15)

4 | Discussion

This paper describes the development and evaluation of the IFH training for the full ABA-feed trial. Building on the recommendations of the ABA feasibility study, the training for the ABA-feed intervention was increased in duration to include more information and practice on listening skills, how to use the Friends and Family diagram to stimulate conversation about feeding and use of BCTs. Observations of training showed a generally high level of fidelity, quality of delivery and discussion and participant engagement. Trainers appeared confident and enthusiastic about intervention components such as woman-centredness and the Friends and Family diagram.

We found that coordinators were largely positive about train-the-trainer and felt confident to train IFHs locally to deliver the intervention. Train-the-trainer is less costly than traditional methods of training and allows courses to be tailored to local issues (Yarber et al. 2015). This is important in the heterogeneous context of peer support, with local coordinators understanding contextual issues affecting training, for example, previous training and experiences of IFHs, and knowledge of local assets.

IFHs enjoyed the training and appreciated the trainers' knowledge and enthusiasm. Training IFHs locally helped to build capacity at a local level, and similar to other studies, this enhanced opportunities for networking amongst those trained (Orfaly et al. 2005). Coordinators and IFHs found the information about formula feeding and the opportunity to practice antenatal conversations useful. IFHs felt prepared to deliver the intervention although many IFHs had no formula feeding experience and reported they were nervous about supporting women who intended to formula feed. As women can be reticent about accessing peer support for fear of only receiving 'breastfeeding' messages and support (Hunt and Thomson 2017), ensuring IFHs acquire skills to talk confidently about formula feeding was an important and novel aspect of the training and support package which intended to broaden its appeal.

The COVID-19 pandemic required the ABA-feed trial to switch from face-to-face to online training, which has recognised advantages and limitations (Mukhtar et al. 2020). This study's findings confirm the viability of training delivery online, with many coordinators and IFHs appreciating the convenience of being able to train at home without any childcare or travel requirements, and the ability to 'catch up' or re-visit training through watching session recordings. However, there were some reported challenges in terms of trainers not being able to observe discussion or role-plays in breakout rooms, and trainees in breakout rooms feeling that they lacked facilitation from the trainer. Going forward, most coordinators and IFHs felt that the training would be best delivered as a mix of online and in-person.

Some volunteer IFHs reported that they would like more information and training on supporting women during the first 24 h post-birth, and women with premature babies, mental health issues and baby loss, which raises questions about the boundaries of the IFH role as a form of enhanced peer support. This suggests that despite one training session addressing boundary-setting, some IFHs continued to have anxieties about these issues. Peer support for infant feeding is predominantly seen as a philanthropic, voluntary role (Aiken and Thomson 2013). Volunteer IFHs should be supported to maintain boundaries in their role and signpost women to specialist professionals and services, rather than necessarily receiving further training.

The training videos were developed during COVID-19 pandemic restrictions and lacked ethnic diversity. Some coordinators and IFHs suggested the videos and training materials should include more representation from ethnic minority groups, and in interviews at the end of the intervention period, some IFHs requested more training on cultural differences. A systematic review of qualitative evidence to identify inequities in participants' experiences of peer support and community intervention targeting breastfeeding in the UK (Evans et al. 2025) recommends that peer support should ideally be delivered by individuals of a similar age, language or cultural background. Recruiting and retaining appropriate IFHs is challenging due to complex social needs and multiple competing pressures in deprived communities (Trickey et al. 2018).

4.1 | Recommendations

The ABA-feed training videos and resources should include greater ethnic and cultural diversity. Services would also benefit from greater diversity among the IFHs, enabling them to match women with an IFH from the same culture, age group, or location when requested by women. Cultural humility training (involving the development of skills and confidence to have respectful relationships with people from different backgrounds) may be useful for IFHs (Lekas et al. 2020).

Recognising the various pros and cons of online and face-to-face training (Mukhtar et al. 2020; Protopsaltis 2019), and the feedback from IFHs and coordinators, future delivery of the IFH training should use a mixture of online and face-to-face training, in particular the role-plays being practised in-person.

4.2 | Strengths and Limitations

This study's main strength is in the mixed-methods approach to evaluating training quality through the synthesis of survey,

qualitative and observational data. The study did not aim to compare remote with in-person training, so we cannot assess comparative effectiveness.

The response rate to post-training evaluation surveys was 73.3% from coordinators and 61.7% from IFHs; alternative views may have been missed from non-responders. Combining the IFH training log with the evaluation survey may have boosted the response rate. Similarly, the views of IFHs who did not participate in an interview may have differed. Although one site did offer face-to-face training, we do not have any data on the IFH experiences of this. The majority of the IFHs were white British; it is possible that peer supporters from other ethnic groups might have reported different experiences of the training.

Interviews with coordinators and IFHs were undertaken at the end of the intervention, up to 2 years after the initial ABA-feed training, and some struggled to remember details, potentially introducing recall bias. However, this enabled reflection on training impact, complementing evaluation responses provided immediately after training. With the evaluation largely consisting of self-reports, it is possible that there may have been some social desirability bias.

Training observations by researchers were conducted at 5 of the 17 sites, focusing on the first IFH training sessions at each site. Observing other sites or later sessions might have offered a different perspective.

This paper aimed to describe the experiences of the IFH training. The actual delivery of the intervention by the IFHs and women's experiences of receiving the intervention are addressed elsewhere (Clarke et al. 2025).

5 | Conclusion

The ABA-feed training was built on existing breastfeeding peer supporter training. The training, including the online format, was acceptable to both coordinators and IFHs and was delivered with fidelity. Going forward, the training resources would benefit from a greater degree of inclusivity, and a hybrid approach to training may be beneficial.

Author Contributions

All authors contributed to the study conception and design. J.C., N.C., D.J., J.M. and N.S. contributed to data collection. J.C., N.C., D.J., J.M. and N.S. analysed the data, and all authors supported data interpretation. J.C. wrote the manuscript with input from G.T. All authors read and approved the final manuscript.

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Conflicts of Interest

All authors report NIHR funding for the ABA-feed study NIHR129182. PH reports: A wide range of funded research related to breastfeeding; 2022-2024 National Institute for Health Research, School of Primary Care Funding Panel member; 2014-2019 National Institute for Health Research, Health Technology Assessment Commissioning Board member. KJ reports being sub-committee chair for NIHR Programme Grants for Applied Health Research until Dec 2023. The honorarium for this role went to the University of Birmingham, not directly to KJ CM reports NIHR programme grants NIHR207290 and NIHR202869 and oversight group member for the advisory group for NIHR156828. JM reports attendance at Scottish Peer Support Advisory Group. NM reports contributions to the Academy of Medical Sciences' Child Health report as part of its steering committee and to the BRIDGE Commission report. Both mention nutrition in early childhood but these were unrelated to this research. JS reports NIHR funding, self-employment as a midwifery expert witness and membership of TSC/IDMC of NIHR studies. NS reports NICE adoption and impact reference panel membership and is a clinical midwife at Cardiff and Vale University Hospital of Wales. BT reports receipt of funding from NIHR and MRC for current/recent research programmes.

Data Availability Statement

All data requests should be submitted to the corresponding author for consideration. Access to anonymised data may be granted following review.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.

Supplementary Table 1: How the online training worked for coordinators and Infant Feeding Helpers (survey data). **Supplementary Table 2:** Coordinator and Infant Feeding Helper feedback on quality of the trainers and training resources, n (%) (survey data). **Supplementary Table 3:** Coordinator feedback to explain confidence in training Infant Feeding Helpers on the ABA-feed intervention (survey data). **Supplementary Table 4:** Feedback to explain Infant Feeding Helper confidence in delivering the ABA-feed intervention (survey data).