Original Article

The impact of peer support training on mothers' attitudes towards and knowledge of breastfeeding

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Abstract

While the benefits of breastfeeding are well established, few Scottish women exclusively breastfeed, as recommended nationally and internationally. Breastfeeding peer support can help mothers to breastfeed for longer, but the training peer supporters receive is variable and few studies have measured the effectiveness of peer supporter training. This study aimed to compare mothers' attitudes towards and knowledge of breastfeeding before and after undertaking Breastfeeding Network (BfN) peer supporter training. This study used a quasi-experimental design to investigate levels of breastfeeding knowledge and attitudes in 28 women, immediately before and after the BfN peer supporter (Helper) training programme. Data were collected using the Infant Feeding Questionnaire. Mothers had high baseline scores for attitude (88.8%) and knowledge (76.4%). After training 78% of mothers improved their attitude scores. The mean difference in attitude scores was 4.9%, which was statistically significant ($t = 4.44$, $P < 0.001$). Ninety-six per cent of mothers had increased their knowledge scores. The mean difference in knowledge scores was 10.4%, which was statistically significant ($t = 6.25$, $P < 0.001$). This study provides evidence that the BfN's accredited peer support training can improve both breastfeeding knowledge and attitudes of breastfeeding mothers. Peer supporters who have undertaken this training are therefore suitably qualified to provide mothers with the support and information required to make informed choices in breastfeeding and to contribute to effective support and promotion of breastfeeding as suggested in the National Institute for Health and Clinical Excellence guideline on maternal and infant nutrition (PH11) and Scottish Government's Maternal and Infant Nutrition: A Framework for Action (2011).

Keywords: breastfeeding, infant feeding, peer support, knowledge, attitude, training, education.

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Introduction

The benefits of breastfeeding for mother and baby are well established (Horta *et al.* 2007; Quigley *et al.* 2007, 2009; Bobrow *et al.* 2009), but despite these benefits being well recognised and understood by women (Bolling *et al.* 2007) breastfeeding rates in Ayrshire remain among the lowest in the United Kingdom and Scotland (Information Services Division 2008). In 2008, at the First Visit review (about 10 days following

birth) 29.2% of babies in Ayrshire were exclusively breastfed, receiving no food or drink, including water, other than breast milk, compared with 35% as the UK average. At the 6-week review only 18.5% of babies were exclusively breastfed, compared with the UK average of 21% (Bolling *et al.* 2007; Information Services Division 2008).

Peer support, in addition to statutory services, is one of the interventions deemed to be effective in the promotion of the initiation and duration of

breastfeeding (Dyson *et al.* 2005; Britton *et al.* 2007). In particular, it has been promoted as a way of increasing breastfeeding rates in communities with low breastfeeding prevalence where women have little personal exposure to breastfeeding (Morrow & Butterfoss 1999; Alexander *et al.* 2003).

Adequate knowledge of breastfeeding and a positive attitude towards breastfeeding are key to the role of peer supporters (Purcell & Hawtin 2010). It is therefore important that training facilitates the acquisition of up-to-date and accurate knowledge and the development of supportive attitudes towards breastfeeding.

Two studies conducted in the United Kingdom were found, which investigated the effect of peer support training on the knowledge levels of mothers (Ingram *et al.* 2005; Watt *et al.* 2006). Using a questionnaire that included a Visual Analogue Scale item to gauge mothers' self perceptions of their knowledge and ability to support other mothers (Ingram *et al.* 2005), the study found a statistically significant improvement. However, the study did not include an objective measurement of mothers' actual levels of knowledge. By using a quiz to measure mothers' knowledge levels (Watt *et al.* 2006), a statistically significant improvement was reported in mothers' knowledge after training, but it is not clear what the content and psychometric properties of the quiz are. Several studies have been carried out on parents' and mothers' antenatal attitudes and/or knowledge levels of breastfeeding (Dungy *et al.* 2008; Sittlington *et al.* 2008); however, the outcomes employed in these studies are used to predict or discuss breastfeeding

intentions. No studies could be found that investigated the impact of peer support training on mothers' attitude levels.

In Ayrshire, breastfeeding peer support is provided by the Breastfeeding Network (BfN). The BfN is an independent organisation in the United Kingdom which provides mothers with breastfeeding support and evidenced-based information. The support is provided by mothers who themselves have breastfed and who have undertaken various amounts of training. In Ayrshire, the BfN has seven breastfeeding centres, a daily service to the maternity unit and a buddy scheme. At the time of this study these services were funded by a Service Level Agreement (SLA) with the National Health Service (NHS) in Ayrshire and Arran. In the provision of these services BfN peer supporters work closely with NHS health professionals, including midwives and health visitors.

One of the objectives of the service was to train new helpers (level 1 peer support training) as part of the aim to provide effective interventions to support mothers in breastfeeding. The first level of training provided by the BfN takes approximately 24 h, over a period of 8–12 weeks. During the training mothers are offered the opportunity to discuss and reflect on their own breastfeeding experiences and are provided with more information on breastfeeding. The training programme is validated by the National Open College Network and is designed to meet the UNICEF Baby-Friendly training criteria. On completion of the training programme mothers are able to provide breastfeeding mothers with socio-emotional support

Key messages

- The accredited BfN peer support training programme can improve not only breastfeeding knowledge but also the underlying attitudes of breastfeeding mothers.
- The greatest increases in knowledge were regarding infant growth patterns, breast milk expression, management of sore nipples, and inappropriate use of glucose water.
- The greatest increases in attitudes were found in mothers' beliefs about the appropriateness of 'topping' up' babies and expectation of sore nipples.
- Unlike other training programmes the BfN's course has been shown to objectively improve knowledge and attitudes, therefore, adequately preparing peer supporters for their role providing mothers with the type of support required to succeed in breastfeeding.

and help with 'normal' breastfeeding. Mothers can also be registered as a peer support 'Helper' with the BfN.

As limited evidence could be found for the efficacy of peer support training on breastfeeding knowledge and attitudes, the study presented in this paper aimed to compare mothers' levels of knowledge of and attitudes towards breastfeeding before and after participating in the BfN Helper training programme.

Materials and methods

Design

This study used a before and after quasi-experimental design to investigate levels of breastfeeding knowledge and attitudes immediately before and after the BfN peer supporter (Helper) training programme.

Ethics

Ethical approval for the study was provided by Glasgow Caledonian University, School of Health's Ethics Committee and the Directors of the BfN. The participant information sheet and the consent form were emailed out to mothers who had confirmed that they would be attending the training programme. Mothers were given the opportunity to ask questions and invited to sign the informed consent at the beginning of the first training session. Data were stored in accordance with the Data Protection Act (1998).

Recruitment

A convenience sample of mothers were invited to participate in training to become a BfN peer supporter at level 1 (Helper) through information provided at breastfeeding centres, at community events and by informal contact with peer supporters. To be able to participate in the BfN peer supporter training course at level 1, a mother must have breastfed, but no minimum time for this is specified. All mothers who undertook training in 2010 were invited by one of the researchers (LEK/KD) to participate in the study at the first training session. Two BfN Helper training courses were run in Ayrshire in 2010 with eight

mothers participating in a first training course and 20 mothers participating in a second training course.

Intervention

The BfN peer supporter level 1 Helper training course is specifically designed for women who have breastfed their children to extend their knowledge and skills and to enable them to give practical and emotional breastfeeding support to other breastfeeding mothers in their community. The course is delivered by a qualified peer support trainer who herself has extensive experience as a breastfeeding peer supporter. The course uses a variety of learning methods including didactic input, group discussion, small group tasks, experiential learning, debriefing personal experience, active visual tasks and individual study to accommodate a variety of learning styles (Purcell & Hawtin 2010). Course content includes learning how to support breastfeeding women across a range of breastfeeding experiences by

- providing evidence based, up-to-date breastfeeding knowledge;
- learning basic breastfeeding management skills;
- developing listening and group-work skills;
- reflecting on their own breastfeeding experience;
- acquiring the skills to source and evaluate evidence-based knowledge; and
- learning about breastfeeding in a worldwide context and the need for the protection of breastfeeding from commercial interests.

The course is accredited by the Open College Network with six credits at level 2.

Data collection

The Infant Feeding Questionnaire (IFQ) (Scott *et al.* 2003) was developed with the aim of developing a reliable and valid survey tool to determine breastfeeding-related attitudes, knowledge, management practices and training of health professionals involved in the management and support of breastfeeding. The original IFQ contained three distinct sections: attitudes, knowledge and management practice.

The IFQ items were drawn from existing published questionnaires with established face validity. For example Scott *et al.* (2003) included attitude items from the Iowa Infant Feeding Attitude Scale (De La Mora *et al.* 1999). A five-point Likert scale was used for attitudinal questions to allow for varying levels of agreement or disagreement. Knowledge and management practice items were measured asking participants to respond to breastfeeding-related scenarios using multiple-choice options. The original IFQ also collected professional information and contained a section to assess the midwives' personal breastfeeding experiences. Correct answers for knowledge-based questions were verified by information in the scientific literature, published breastfeeding texts and reference guides. For the purpose of this study only the breastfeeding attitudes and knowledge scales were included. Reliability and validity were established (Scott *et al.* 2003) using a sample of 189 midwives across Scotland. Cronbach's alpha for the 33-item attitude scale was 0.86. The Cronbach's alpha for the 26-item knowledge scale was 0.70.

The authors reviewed the questionnaire for suitability for use with mothers rather than health professionals and to ensure that the wording was in agreement with up-to-date evidence and BfN principles of practice. For example the question in the knowledge section: 'What is your usual recommendation regarding the use of dummies for breastfed babies?' was removed as the evidence for the impact of dummies on breastfeeding is equivocal (O'Connor *et al.* 2009). An example of a question that was amended was the question in the knowledge section: 'Do you routinely recommend that breastfeeding should be supplemented by ... (options):' that was altered to 'Do you think that breastfeeding should be supplemented by ... (options):' as peer supporters do not make routine recommendations but would provide mothers with information about supplementation instead. The resulting adapted IFQ was piloted with experienced peer supporters ($n = 5$) in the BfN who made suggestions regarding clarity and readability of the questionnaire items. This resulted in further changes in the wording of some questions and the removal of some questions not relevant to mothers. From the 33-item attitude scale, three items were

removed and the wording of one question was amended. From the 26-item knowledge scale 1 question was removed and the wording in six items was amended (see additional file for the final version of the adapted IFQ). Approximately half of the items were negative statements and half of the items were positive statements regarding breastfeeding to avoid selection of the same value for all items. Negative item scores were reversed, meaning that a higher score represents a more positive attitude towards breastfeeding. The maximum score achievable in the attitude section was 150. The maximum score in the knowledge section was 45. A higher score indicated higher levels of knowledge. The final questionnaire took approximately 20 min to complete. Mothers completed the questionnaire during the first and last sessions of the training programme.

During the first session, mothers were also asked to complete a form with personal details including their age, profession, number of children, length of time of breastfeeding their children and whether or not they were breastfed themselves. Whether or not mothers were breastfed was recorded to allow for comparison at baseline and for changes in breastfeeding knowledge and attitude between these two groups. This aspect is known to affect breastfeeding initiation rates (Bolling *et al.* 2007) and may impact on mothers' breastfeeding environment and resulting breastfeeding experiences and attitudes.

Analysis

Minitab statistical software (version 15, Minitab, Ltd., Coventry, West Midlands, UK) was used to carry out the analysis. The Anderson–Darling normality-test was used to establish the distribution of data. Analysis was carried out on an intention-to-treat basis. Paired *t*-tests were carried out to compare scores before and after training. Two-sample *t*-tests were carried out to compare scores between mothers who were and were not breastfed themselves. The significance level was set at $P < 0.05$.

Results

All 28 mothers invited to the study agreed to participate and completed the questionnaire at the first

session (see Table 1 for mothers' details). Twenty-three mothers completed the post-training questionnaire at the final session of the training programme (attrition rate: 17.9%). Two mothers who did not complete the post-training questionnaire were from the first training programme and three mothers were from the second training programme. Of the five mothers who did not complete the questionnaire the second time, one mother did not complete the training, while four mothers still had to complete some tasks of the training programme or missed the final training session.

Most mothers were in employment while undertaking the training. This included employment in a range of professional and non-professional roles, including a dog groomer, primary school teacher, home maker, accountant and human resources advisor. The average age of mothers was 32 years [standard deviation (SD): 5.2; range: 24–46 years]. The mean number of children per mother was two (range: one to four children). The majority of mothers had a child under the age of one at the time of the training programme. Of the 28 mothers, 19 were breastfeeding their youngest child during the training programme. Mothers who had stopped breastfeeding their child had breastfed their child on

average for a period of 7.9 months (range: 0–24 months). The minimum of 0-month breastfeeding time can be explained by a few mothers who had not breastfed their first child(ren) but breastfed subsequent children.

Sixteen mothers (57.1%) were breastfed themselves as infants, while 12 mothers were not. At baseline there were no statistically significant differences in mothers' attitude ($t = 1.26$, $P = 0.22$) and knowledge ($t = 0.65$, $P = 0.52$) levels between those who were breastfed themselves and those who were not.

Breastfeeding attitude scores

The mean score obtained by mothers before taking part in the training programme was 133.3 (SD: 1.48; range: 114–147), which was 88.8% (range: 76.0–98.0%) of the maximum score that could have been obtained in this section (see Table 2). After completing the training programme the mean attitude score was 140.5 (SD: 7.9, 93.7%). The lowest score obtained was 121 (80.7% of maximum). The highest score obtained was 149 (99.3%).

After the training, 20 mothers (87.0%) had increased their attitude scores. The largest increase in the attitude score was 21 points (14.0%). Only three mothers had a decrease in their attitude scores. The difference in the mean score before and after taking part in the training programme was 7.3 (SD: 8.7). This was a 4.9% positive difference in the scores (see Fig. 1). The difference between before and after training scores was found to be statistically significant ($t = 4.44$, $P < 0.001$). There was no difference in attitude score changes after training between mothers who were breastfed and those who were not ($t = -0.78$, $P = 0.44$).

Table 1. Participant details

	Mean (SD)	Range
Mother's age	32.4 (5.2)	24–46
Number of children	2 (1.0)	1–4
Age of child(ren) in years	4.0 (4.4)	0.25–20
Length of time breastfeeding in months	8.4 (5.7)	0–23.9
Mother was breastfed herself	16 (57%)	

SD, standard deviation.

Table 2. Attitude section of the Infant Feeding Questionnaire scores

	Mean (SD)	% of maximum*	Range	Significance
Before training	133.3 (7.8)	88.8%	114–147	
After training	140.5 (7.2)	93.7%	121–149	
Difference	7.3 (8.7)	4.9%	–19 to 21	$t = -4.44$, $P < 0.001^\dagger$

*The maximum number of points to be obtained in the attitudes section is 150. † Paired t -test.

Fig. 1. Box plot comparison of attitude scores before and after training (mean scores and intelligence quotient ranges).

Knowledge of breastfeeding scores

The mean score for knowledge obtained before training was 34.4 (SD: 2.8; range: 30–40), which was 76.4% of the maximum score that could have been obtained in this section (see Table 3). After completing the training programme the mean knowledge score was 39.1 (SD: 3.9), which was 86.9% (range: 66.7–88.9%) of the maximum score. The lowest score obtained after training was 30 (66.7%). The highest score obtained was 44 (97.8%).

After the training, 22 mothers (95.7%) had increased their knowledge scores. The largest increase in the knowledge score was 12 points (26.7%). Only one mother had a decrease in her knowledge score of three points (6.7%). The difference in the mean score before and after taking part in the training programme was 4.7 (SD: 4.0). This was a 10.4% positive difference in the scores (see Fig. 2). The difference between before and after training scores was found to be statistically significant ($t = 6.25$, $P < 0.001$). There was no difference in knowledge scores before and after training between mothers who were breastfed and those who were not ($t = -0.70$, $P = 0.49$).

Discussion

The results show that undertaking BfN peer support training significantly improved attitudes to breastfeeding and breastfeeding knowledge in this specific group of mothers.

Mothers generally had high levels of breastfeeding knowledge (76.4%) and attitudes (88.8%) at baseline.

The high attitude scores of mothers were expected by the authors, as this was a group of self-selected mothers who committed to train to as peer supporters. It may also have been positively influenced by their attendance at BfN support centres or personal relationships with BfN peer supporters in the community as 24 of the mothers who undertook training had attended BfN breastfeeding centres, while four were recruited through informal relationships with BfN peer supporters. Being linked into breastfeeding centres or having informal relationships with breastfeeding peer supporters may in itself increase positive breastfeeding attitudes. This is supported by previous research that found that a social network that is supportive of breastfeeding can influence breastfeeding attitudes (McInnes & Chambers 2008).

The baseline attitude and knowledge levels in this sample were considerably higher than the knowledge (63%) and attitude (80.6%) levels of midwives ($n = 189$) in the original study of Scott *et al.* (2003). The difference between the current study and the Scott *et al.*'s study in term of participants is that the current study sample consisted of mothers who all had breastfed their child(ren). Scott *et al.* (2003) did compare breastfeeding knowledge and attitude between those who had personal breastfeeding experience (60.8%) and those who did not. They found that there was a statistically significant difference in midwives' breastfeeding attitudes but not knowledge ($P = 0.034$). This difference was on average four points (approximately 2%), which is still considerably lower than in the current study. It may, however, not be merely related to whether or not a participant had breastfed, but it may also relate to the nature of the breastfeeding experience, to the length of the time the participant breastfed or to the personal motivation for supporting women with their breastfeeding experience.

In relation to the length of time a person has breastfed and the quality of the experience in health care professionals, one study has reported that breastfeeding knowledge and attitudes were significantly higher in General Practitioner registrars if they had breastfed themselves for more than 52 weeks (Brodrigg *et al.* 2008). Those who had breastfed for less than 26 weeks had lower levels of breastfeeding knowledge and attitudes than those who had no

Table 3. Knowledge section of the Infant Feeding Questionnaire scores

	Mean (SD)	% of maximum*	Range	Significance
Before training	34.4 (2.8)	76.4%	30–40	
After training	39.1 (3.9)	86.9%	30–44	
Difference	4.7 (4.0)	10.4%	–3 to 12	$t = -6.25, P < 0.001^\dagger$

*The maximum number of points to be obtained in the knowledge section is 45. † Paired t -test. SD, standard deviation.

Fig. 2. Box plot comparison of knowledge scores before and after training (mean scores and intelligence quotient ranges).

breastfeeding experience or between 26 and 52 weeks breastfeeding experience. Interestingly, levels of knowledge and attitudes for those who had no breastfeeding experience or between 26 and 52 weeks breastfeeding experience were similar. The authors reported that all those who had reported a negative breastfeeding experience had less than 26 weeks of breastfeeding, which might explain the lower levels of attitudes and knowledge. This finding is partially supported in the current study. All mothers included in the current study had more than 26 weeks of breastfeeding experience, with 25% of mothers having breastfed one of their children for 52 weeks or more. This may explain why mothers had higher levels of breastfeeding attitudes and knowledge.

This difference between mothers' attitude and knowledge levels in this study and those of midwives in the study of Scott *et al.* (2003) may, in addition, not reflect current knowledge and attitudes found in Scottish midwives, as the Scott *et al.*'s study took place 7 years prior to the current study. The number of participating maternity units that have received UNICEF Baby-Friendly accreditation has increased

considerably, with five out of the six hospitals in the Scott *et al.*'s study being in the process of obtaining accreditation or already having obtained full accreditation. As the training of staff is central to the accreditation process, it is likely that knowledge and attitude levels of midwifery staff have increased since 2003. However, this is an area for further research.

The high pre-training scores of mothers who are committed to undertake peer support training may, therefore, have affected the transferability of the results to other populations.

While there was a significant increase in breastfeeding attitudes after training, some areas showed larger changes than others. Larger differences were found in beliefs about the appropriateness of 'topping up' with formula, expectations of sore nipples, the belief that breastfed babies are healthier than formula fed babies, the normal frequency of breastfeeding and breastfeeding as one of the great joys of motherhood. The greatest increases were in mothers' beliefs about the appropriateness of 'topping' up babies when mothers feel that they do not have enough milk and the belief regarding the expectation of sore nipples.

The increase in mothers' beliefs about the (in)appropriateness of 'topping up' is likely to be the direct result of the training course, which comprises detail on the principles of supply and demand in breastfeeding, and time is spent discussing how breast milk volume can be increased. Given the risks of early introduction of formula to babies' health, to mothers' milk supply and its implications for breastfeeding rates, this is an important clinical improvement (Whalen & Cramton 2010).

Another large change was that after training mothers believed that breastfed babies were healthier than formula fed babies. Although 93% of mothers believed before training that breastfed babies were

generally healthier than formula fed babies, only 64.3% strongly agreed with this statement. Following training 91.3% strongly agreed with this statement. The low pre-training scores in this item may be explained by the influence of media and advertising (Henderson *et al.* 2000), which may lead untrained mothers to believe that formula milk is an equally healthy choice for their baby which may play an important role in women's infant feeding decisions.

Although the large majority of mothers had an increase in breastfeeding attitude, three mothers had a decrease in attitude to breastfeeding. The authors believe that this may be related to the wording of some of the questions, which required reverse scoring, which may have lead to confusion. During completion of the questionnaire for the study, several mothers asked for clarification on the reverse-scored items in the questionnaire. This was not identified as an issue at the pilot stage, but this may have reflected the pilot participants' higher level of experience and confidence in breastfeeding, which allowed them to navigate the questionnaire more easily.

There were significant increases in breastfeeding knowledge after training; however, some areas showed larger changes than others. Larger increases in knowledge levels were found in relation to knowledge of growth patterns, the use of glucose water and the management of sore nipples. The increase in knowledge of growth patterns in the current study was reflected in an improvement in three separate items on infant growth. Specific attention was paid to growth patterns during the training as the new World Health Organization growth charts (Coombes 2009) had been published not long before the start of the first training programme, which may explain the increase in knowledge levels in the topic area. The improvement in knowledge about the inappropriate use of glucose water was addressed in the principles of exclusive breastfeeding. Seventeen out of 28 mothers stated 'unsure' in relation to the glucose water question. Following the training programme 19 out of 23 mothers stated the correct answer, while none of the mothers stated 'unsure' after the training programme. This should be viewed in the context of the local maternity unit. The Ayrshire Maternity Unit has had UNICEF Baby-Friendly accreditation since

1999 and the provision of glucose water to babies to prevent jaundice has, therefore, not likely been in practice for some time. As a result mothers would be unlikely to have come across this practice.

There was a large improvement in mothers' knowledge and beliefs about the presence of sore nipples. This is likely to reflect mothers' own experiences of breastfeeding. The experience of sore nipples has been shown to be a common experience for mothers in the United Kingdom and is the second most commonly cited reason for mothers to discontinue breastfeeding (Lewallen *et al.* 2006). However, during the training programme mothers were provided with knowledge regarding the role of position and attachment in nipple pain and, as a result, viewed sore nipples as an avoidable aspect of breastfeeding.

During the course evaluation, many mothers reported that they wished that they had completed the peer support training antenatally before commencing breastfeeding, as the knowledge they had acquired would have enabled them to avoid some of the breastfeeding difficulties experienced. Combined with previous study findings (Marrone *et al.* 2008) that positive breastfeeding attitudes are associated with breastfeeding initiation and duration, the study findings could suggest that this training programme may be beneficial to enhance women's breastfeeding experiences if provided antenatally.

There are a number of limitations to this study. The sample was a convenience sample and no power calculation was carried to establish the suitability of the sample size. Despite the limited sample size, the study was able to show statistical significance. The questionnaire used was altered to improve its suitability for use with mothers as the original IFQ was designed for midwives. Although the authors aimed to keep the changes to a minimum, no calculations were carried out to estimate the validity and reliability of the questionnaire in this participant group.

There were some flaws in the construct validity of the questionnaire. Many of the items in the attitudes section appear to reflect knowledge rather than attitudes. For example the (dis)agreement with the statement 'The benefits of breast milk last only as long as the baby is breastfed' would reflect breastfeeding knowledge rather than attitude. Another limitation as

mentioned previously was that several mothers struggled with some of the reversed scored items, a practice known to reduce internal consistency (Barnette 2000).

Further research should incorporate a larger sample of peer supporter trainees based on an appropriate power calculation. The questionnaire used in this study also needs to be further adapted and validated for use with mothers. A study to compare breastfeeding knowledge and attitudes between breastfeeding mothers, peer supporters and health professionals, using this validated scale, would provide greater insight into the prevalent range of levels of breastfeeding knowledge and attitudes in those involved in breastfeeding.

Breastfeeding peer support can help mothers to breastfeed for longer (Dyson *et al.* 2005; Britton *et al.* 2007). However, the training peer supporters receive in Scotland is variable and peer support programmes tend to be evaluated by subjective reporting on peer supporters' confidence in their skills or their levels of satisfaction with the training itself. The Scottish Government (2011) has identified the training of peer supporters as a priority in Improving Maternal and Infant Nutrition: A Framework for Action. The document recommends that accredited peer support training programmes should be provided across Scotland, which are informed by a nationally agreed framework. Given that adequate, up-to-date knowledge and a positive attitude towards breastfeeding are key to the role of peer supporters (Cowie & Wallace 2000), it is important that these aspects are included in the framework and are objectively assessed as part of training programmes. The current study provides evidence that an existing accredited peer support training programme, as provided by the BfN, can prepare peer supporters for their role supporting women by improving not only their breastfeeding knowledge but also their underlying attitudes as measured by the IFQ (Scott *et al.* 2003). Peer supporters who have undertaken this training would be well prepared to contribute effectively to the support and promotion of breastfeeding as suggested in the National Institute for Health and Clinical Excellence guidelines (National Institute for Health and Clinical Excellence 2006) and Improving Maternal and

Child Nutrition: A Framework for Action (Scottish Government 2011).

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Conflicts of interest

The authors declare that they have no conflicts of interest.

Contributions

Both authors contributed equally to the production of this paper.

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Supporting information

Additional Supporting Information may be found in the online version of this article:

Additional file 1. Adapted Infant Feeding Questionnaire.

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