Helping to Build a Culture and Tradition of Breastfeeding

Traditionally, women have relied upon the wisdom and experience of other women to learn about mothering and breastfeeding. In the United States, however, this once-standard mother-to-mother interaction was almost nonexistent by the mid–20th century. Recent advances in the understanding of the benefits of breastfeeding for maternal and child health have led most professional organizations to advocate breastfeeding as the norm of infant feeding. Promotional breastfeeding efforts over the past 3 decades include strategies to strengthen support for breastfeeding in the health care system and in the community. Breastfeeding peer counseling represents a model of mother-to-mother support which emerged in the 1980s as a community-based resource to provide mothers with the support and assistance needed to establish and maintain breastfeeding in the early weeks and months postpartum. This article describes the role, training, and effectiveness of breastfeeding peer counselors and discusses ways that mothers and peer counselors might benefit from the connection and relationship that develops between the breastfeeding mother and her peer counselor. An exemplar of a breastfeeding peer counseling program is presented. J Midwifery Womens Health 2007;52:631–637 © 2007 by the American College of Nurse-Midwives.

**keywords:** breastfeeding, mother-to-mother support, peer counseling, peer support

### INTRODUCTION

Throughout history, women have sought other women for support, information, and guidance during the perinatal period. In many cultures, a new mother is still cared for during and after childbirth by a network of experienced mothers, family, friends, and neighbors. In the United States, however, this culture of woman-to-woman (or mother-to-mother) support was almost nonexistent by the mid–20th century. Despite the disappearance of this age-old practice of providing social and emotional support, groups of women have always known the value of this support. La Leche League International began in 1956 when “breastfeeding was a lost art, and bottle feeding was in its heyday.” It was founded by a group of neighborhood women who got together at each other’s homes to share their experiences and support each other in breastfeeding and mothering. The resurgence and growth of the profession of nurse-midwifery in the US—with its emphasis on women-centered care—is another example of women being responsive to and supportive of the needs of other women and their families. In addition, the recognition of the value of continuous emotional and physical support from one woman to another during childbirth and the postpartum period gave birth to professionalized doula care in the early 1990s. A model of mother-to-mother support that emerged in the 1980s is breastfeeding peer counseling. This article describes the role, training, and effectiveness of breastfeeding peer counselors and discusses ways that mothers and counselors might benefit from the interpersonal relationship that develops.

The development of breastfeeding peer counseling practices formalized a role in the US health care system that women have always performed. Although considered an outgrowth of the mother-to-mother approach to breastfeeding support, peer counseling practices are a relatively recent phenomenon in the United States, only appearing in the nursing and allied health literature in the past 30 years. In recognition of the importance of breastfeeding as a public health issue, the Office of the Surgeon General convened the first workshop on breastfeeding and human lactation in 1984. The principal goal of this workshop was to establish breastfeeding as the norm of infant feeding in the United States. Recommendations that emerged from the workshop were designed to protect, promote, and support a woman’s decision to breastfeed. Recommended strategies included strengthening support for breastfeeding in the health care system and extending this support into the community by developing a broad range of community-based resources to encourage and assist lactation and continued breastfeeding.

One result of efforts to promote this broad base of support for breastfeeding was the establishment of community peer counseling programs. Women recruited for these programs as peer counselors are typically mothers who have breastfed their own babies, are passionate about breastfeeding, and have the desire to connect with mothers from similar backgrounds to provide breastfeeding information, practical assistance, and emotional support. Contemporary peer counselors have completed a specialized training program designed to provide them with basic breastfeeding information and effective counseling techniques. A primary goal of the breastfeeding peer counseling process is facilitating the development of an environment that is conducive to initiating and sustaining lactation.
Breastfeeding patterns and the need for breastfeeding support and information have changed markedly over the past 100 years. Until the early 20th century, breastfeeding was the primary means of nourishing a baby, and babies were often nursed to 1 year of age and older. Although other forms of infant feeding have been used for centuries when the mother could not or would not nurse her infant, these practices were always the exception. This custom was reversed by the 1930s, as physicians and chemists working for infant food companies began to prepare and market scientific substitutes for mother’s milk. The resulting commercialization of infant formula, combined with the medicalization of maternal–child health care, trust and confidence in the medical profession, and the prevailing view of the time that equated science with progress, helped to establish an environment that made artificial feeding acceptable and often preferable, but undermined women’s success at breastfeeding. By 1955, only 29.2% of all week-old babies were receiving any breast milk, and this was most often combined with supplemental formula. Breastfeeding rates continued to decline and reached their nadir in 1971, when only 24.7% of women breastfed upon hospital discharge.

Social influences also contributed to this dramatic decline in breastfeeding. Economic growth and prosperity early in the 20th century led to a change in the pattern of family life. The increasing mobility of Americans led to the breakup of social networks and stable communities as people moved more freely out of their towns and neighborhoods. Women no longer had the ready support of female friends and relatives. Breastfeeding culture, traditional knowledge, role models, and valuable patterns of mothering were gradually lost to women and society. The concept of women supporting and learning from each other and passing their knowledge and experience from neighbor to neighbor or mother to daughter was replaced by trust and reliance in medical professionals as authority figures. Today, many family and friends in a woman’s social network have never seen a breastfed infant at the breast, and may be unfamiliar with the process of lactation, leaving them unable to provide adequate or appropriate breastfeeding support, encouragement, and modeling behavior.

The last three and a half decades, however, have shown a sustained trend toward breastfeeding. Through the efforts of La Leche League International and other consumer advocacy groups, women are becoming more educated about the benefits of breastfeeding. At the same time, they were aware that they needed accurate information and support as they learned how to breastfeed. Currently, almost three-quarters of American mothers initiate breastfeeding in the hospital, but the numbers decrease significantly by 3 months postpartum. This short duration of breastfeeding suggests that mothers need support to establish and maintain breastfeeding in the early weeks. A successful start can help to create the foundation for rewarding and successful long-term breastfeeding. Conversely, lack of support or inappropriate or insensitive assistance with breastfeeding could undermine mothers’ efforts.

The role of the peer counselor is an extension of an age-old concept. Traditionally, women have been supported after childbirth by experienced family and friends who assist with her postpartum care. An essential component of this care is helping the mother establish breastfeeding. One aspect of support that enhances a mother’s success with breastfeeding is termed “mothering the mother,” which refers to a mother’s need to be nurtured and cared for after childbirth. In an anthropologic study, Raphael noted that the presence of someone who cares for the mother was the one element in most cultures which consistently facilitated success at breastfeeding. That finding describes the essence of the peer counselor’s primary role, which is to focus on facilitating the transition to the parenting role within the context of supporting and nurturing the breastfeeding relationship between a new mother and her baby.

Within this relationship, peer counselors offer emotional, informational, and instrumental support. Peer counselors provide informational support related to breastfeeding physiology and management, as well as practical assistance or instrumental support with the physical mechanics of breastfeeding, such as latching on and proper positioning. Emotional support occurs by “mothering the mother.” New mothers value expressions of caring, compassion, encouragement, reassurance, reflection, and attentive listening. Peer counselors can help create a rewarding and satisfying breastfeeding experience by validating a woman’s experiences and feelings.

The basis of peer support is the shared experience. Therefore, while peer counselors are not part of the mother’s family or immediate social network, they are often of a similar ethnic background or socioeconomic status, or have other qualities in common. Women who possess similar characteristics to their clientele are assumed to be able to relate in a more intimate manner because they share cultural, ethnic, or economic norms and possess an understanding of the community’s health beliefs and barriers to breastfeeding. Because they are members of the community or culture that they work with, trained peer

Beverly Rossman, RN, MS, is a doctoral candidate at the University of Illinois at Chicago, Department of Maternal–Child Nursing.
counselors can create effective support programs or interventions by relating their experience and knowledge to local issues and cultural traditions. Peer counselors support breastfeeding as the norm of infant feeding by providing a role model for women. The counselor’s credibility is derived from her personal breastfeeding experience and through the sharing of her experiences. Peer counselors work to demystify the practice of breastfeeding by providing accurate information, addressing socioeconomic and cultural barriers and influences, and acknowledging the incongruity between initial idealized expectations and the difficulties that are often a part of early breastfeeding. A peer counselor normalizes the new mother’s experience by reassuring her that her experiences are normal, and encouraging her to persevere and develop her own strategies to deal with problems. The end result is women taking pride in their breastfeeding experience.

Training
Training is essential to the success of a breastfeeding peer counseling practice. Training programs are structured to orient the peer counselor to program objectives, to promote the attainment of skills that enable the use of their breastfeeding knowledge, and to promote understanding of the needs of the target population. Thus, most training programs include breastfeeding specifics, such as the physiology and management of breastfeeding, counseling and support techniques, and cultural awareness. The World Health Organization (WHO) recommends that the duration of training should be at least 18 hours and include an additional 3 hours of clinical/hands-on practice. Trained peer counselors can provide individual-level counseling to mothers, lead breastfeeding support groups, or give community-based talks to groups about breastfeeding.

The amount of time allocated for training varies considerably and is dependent upon the administering organization. Researchers have utilized training programs that ranged from a low of 9 hours to a high of 56 hours. The length of the training program depends primarily on whether the training is a standardized program from La Leche League International or WHO/UNICEF, or whether it is developed specifically for a research trial.

There are several advantages to using a standardized training program. Programs such as La Leche League International or WHO/UNICEF ensure the accuracy and consistency of the breastfeeding information given to women by providing peer counselor trainees with a solid background of the most current, evidence-based science on breastfeeding, in combination with counseling techniques for providing support. The use of well-developed, replicable, and copyrighted programs allows researchers to make reliable and valid comparative analyses of the efficacy of different peer counselor practices. Researchers evaluating training programs for the most recent Cochrane Database of Systematic Reviews on breastfeeding support found that exclusive breastfeeding was significantly prolonged with the use of WHO/UNICEF trained peer counselors.

Effectiveness of Peer Counselors
The most evaluated effects of the breastfeeding peer counseling process are the improved clinical outcomes of increased breastfeeding rates at birth and in the postpartum period, and the longer duration of exclusive breastfeeding. The first scientific trial to evaluate the effectiveness of community-based breastfeeding peer counselors was conducted by Kistin et al. at Cook County Hospital in Chicago in 1989. The Chicago Breastfeeding Task Force established a breastfeeding peer counseling program to determine whether peer support would increase breastfeeding rates in low-income women. The researchers found that women who received support from peer counselors had significantly (P < .05) greater rates of initiation, exclusivity, and a longer duration of breastfeeding than a cohort of women without the support of counselors. Subsequent studies in the US also demonstrated the effectiveness of peer counselor interventions in promoting breastfeeding, particularly for non-Hispanic blacks and socioeconomically disadvantaged groups of women who consistently breastfeed at lower rates than the overall national average.

To date, there have been nine primary research studies, including three randomized controlled trials (RCT), and most have shown significant results in the hypothesized direction. Studies of breastfeeding initiation at or shortly after childbirth have demonstrated significant increases in initiation of breastfeeding. Statistically significant increases in exclusive breastfeeding were found in studies that examined this variable. Women with peer support were 1.5 times more likely to exclusively breastfeed to 3 months, and peer counseling increased the duration of exclusive breastfeeding by 2.6 to 4 weeks. Peer counselor support produces significant increases in the duration of breastfeeding, up to 16 weeks postpartum. Differences in duration between the control and intervention groups in all of the studies were insignificant by 6 months. Table 1 provides details of these studies. These results are consistent with results from the 2007 Cochrane review of breastfeeding support, which demonstrated that peer support is effective in promoting any breastfeeding and in prolonging exclusive breastfeeding. The effects on the duration of any breastfeeding are less clear, because the support was typically offered to women who had decided to breastfeed, but may have intended to breastfeed for only a short period of time.
<table>
<thead>
<tr>
<th>Study</th>
<th>Purpose</th>
<th>Design</th>
<th>Setting/Sample</th>
<th>Intervention</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anderson et al. (2005)</td>
<td>To measure the efficacy of PC on rates of exclusive breastfeeding</td>
<td>RCT; longitudinal to 3 months</td>
<td>Urban Baby Friendly Hospital, low-income Latina women (n = 162)</td>
<td>40-hour WHO/UNICEF PC training. Prenatal and PP home visits and in-hospital after childbirth by PC</td>
<td>Statistically significant* increase in breastfeeding exclusivity</td>
</tr>
<tr>
<td>Arlotti et al. (1998)</td>
<td>To examine the effect of PC on duration and exclusivity of breastfeeding</td>
<td>Quasi-experimental; longitudinal to 3 months</td>
<td>African American women who were WIC recipients (N=36)</td>
<td>20-hour La Leche League International PC training. PP visits at WIC clinic or by phone</td>
<td>Statistically significant* increase in breastfeeding exclusivity; no significant increase in duration of breastfeeding but trend in expected direction</td>
</tr>
<tr>
<td>Chapman et al. (2004)</td>
<td>To evaluate the effectiveness of PC on initiation and duration of breastfeeding</td>
<td>RCT; longitudinal to 6 months</td>
<td>Urban Baby Friendly Hospital, low-income Latina women (n=165)</td>
<td>30-hour La Leche League International PC training. Prenatal and PP home visits and in-hospital after childbirth by PC</td>
<td>Statistically significant* increase in initiation and duration; however, differences in duration of breastfeeding were non-significant at 6 months</td>
</tr>
<tr>
<td>Gross et al. (1998)</td>
<td>To assess the efficacy of PC and/or motivational videotapes on duration of breastfeeding</td>
<td>2 × 2 factorial design with random assignment by clinic; longitudinal to 16 weeks</td>
<td>African American women who were WIC recipients (n=115)</td>
<td>25-hour PC training. Prenatal and PP contact by PC alone or in combination with breastfeeding video (unspecified mode)</td>
<td>Statistically significant* increase in duration of breastfeeding, but no significant differences between videotape alone, PC alone, or in combination</td>
</tr>
<tr>
<td>Kistin et al. (1994)</td>
<td>To determine whether PC increases initiation, duration, and exclusivity of breastfeeding</td>
<td>Quasi-experimental; longitudinal to 12 weeks</td>
<td>Urban, low-income African American women (n=102)</td>
<td>16-hour PC training. Prenatal and PP phone contact</td>
<td>Statistically significant* increase in initiation, duration, and exclusivity of breastfeeding</td>
</tr>
<tr>
<td>Long et al. (1995)</td>
<td>To evaluate the effectiveness of PC on initiation and duration of breastfeeding</td>
<td>Quasi-experimental; longitudinal to 6 months</td>
<td>Urban, low-income Native American women (n=141)</td>
<td>12-hour PC training. Prenatal and PP home, phone, or clinic contact</td>
<td>Statistically significant* increase in initiation and duration of breastfeeding; however no differences in duration at 6 months</td>
</tr>
<tr>
<td>Merewood et al. (2006)</td>
<td>To evaluate whether PC impacted duration of breastfeeding for premature infants</td>
<td>RCT; longitudinal to 6 weeks</td>
<td>Urban Baby Friendly Hospital, low-income, African American mothers of premature infants (n=108)</td>
<td>5-day PC training. Face-to-face visits in NICU while infant hospitalized, then phone contacts</td>
<td>Statistically significant* increase in duration of provision of breast milk and/or breastfeeding</td>
</tr>
<tr>
<td>Schafer et al. (1998)</td>
<td>To evaluate the effectiveness of PC on initiation and duration of breastfeeding</td>
<td>Cross-sectional; pre- and posttest for intervention group</td>
<td>Women attending rural WIC clinic (n=207)</td>
<td>9-hour PC training. PC contact at each PP WIC visit and phone contact between visits</td>
<td>Statistically significant* increase in initiation and duration of breastfeeding</td>
</tr>
<tr>
<td>Shaw and Kaczorowski (1999)</td>
<td>To examine effectiveness of PC on initiation and duration of breastfeeding</td>
<td>Retrospective survey</td>
<td>Women attending rural WIC clinics (n=291)</td>
<td>56-hour PC training. PC contact at each PP WIC visit</td>
<td>Statistically significant* increase in initiation and duration of breastfeeding</td>
</tr>
</tbody>
</table>

Abbreviations: NICU, neonatal intensive care unit; PC, peer counselor; PP, postpartum; RCT, randomized controlled trial; WIC, Women, Infants, and Children program.

*P < .05
Benefits of the Peer Counselor–Mother Relationship

The research also suggests that there are numerous psychological and personal benefits associated with the use of breastfeeding peer counselors. Maternal benefits include enhanced self-esteem and empowerment, greater satisfaction with the breastfeeding experience, fewer breastfeeding problems, facilitation of the mother–infant connection and transition to motherhood, and strengthening a mother’s existing support, particularly if her support is compromised because of geographic isolation, or her informal network is opposed to breastfeeding.15,29,38 One of the most promising benefits is that mothers who work with peer counselors often express an eagerness to share their knowledge and mastery in the art of breastfeeding with others.31 In this way, they can become role models for others and begin to build a breastfeeding tradition within their community.34

Benefits for the peer counselors include increased community status and enhanced self-esteem and empowerment through recognition, by themselves and others, of their social usefulness.12,29,31 External recognition and valuation of the peer counselor’s knowledge and skills, particularly by health care professionals, often serve as a catalyst for engaging in other related activities by participating in advanced training programs, furthering their education, or finding employment.12,15,39 This last element is critical, because many of the peer counselors come from the same low-income communities as the mothers they serve.

Exemplar of a Breastfeeding Peer Counselor Program

An example of a Breastfeeding Peer Counselor Program is the Rush Mother’s Milk Club, an evidence-based program of breastfeeding interventions for mothers with very low birth weight (VLBW) infants hospitalized in the special care nursery at Rush University Medical Center in Chicago, IL.40 Mothers are presented with specific information regarding the importance of their milk for their VLBW babies and are introduced to the special services that have been designed and implemented to address the unique needs of this population.41 One evidence-based component of the Mother’s Milk Club is the use of breastfeeding peer counselors to provide support and education and to serve as role models for the mothers.

Breastfeeding a VLBW infant is a complex process. Mothers encounter numerous barriers and challenges to successful breastfeeding that are not experienced by mothers of full term, healthy infants. Because many of these infants are unable to sustain nutritive suckling at the breast, mothers must initiate and maintain lactation for an extended period of time through the use of a breast pump. Lactation care for these mothers includes labor-intensive and time-consuming education, supervision, and support.40 The breastfeeding peer counselors in this program work in partnership with the infants’ health care team and assume responsibility for making sure that families receive the help they need to ensure that breastfeeding is a positive experience. Although there are no statistics related to breastfeeding outcomes specific to peer counselor interventions, breastfeeding rates for the first 2 years of the Rush Mother’s Milk Club exceeded the national average for the same time period (72.9% vs. 64.3%, respectively).17,40 Similarly, even though black women were least likely to provide breast milk for their VLBW infants, their rates were also higher than the corresponding national rates for black mothers of healthy infants (63.4% vs. 44.9%, respectively).17,40

The peer counselor program is exemplified by the stories of its peer counselors, Jameca and Fabiola, two extraordinary women who embody the essence of the peer counselor role. Both women have personally experienced the challenges associated with providing breast milk for and breastfeeding their VLBW babies. As a teenager, Jameca had to confront her own fears of inadequacy as a mother while dealing with the stress associated with having an infant born at 25 weeks. Jameca also suffered from low milk volume after receiving a hormonal birth control injection. For Fabiola, expressing breast milk for her baby born at 28 weeks was an easy decision, as all of the women in her family had breastfed their babies. The challenge for her was the difficulty in believing that someone so small could ever successfully breastfeed, and the frustration of having to wait to put him to her breast.

Both peer counselors feel that sharing their experiences with mothers whose infants are hospitalized in the special care nursery helps them to establish trusting connections with the mothers and their families. Personal disclosure by the peer counselors makes it easier for the mothers to reciprocate and creates an opportunity for the mothers to begin to process their child’s hospitalization.42 The sharing of stories also allows the peer counselors to decide how best to provide care in the context of the mother’s current situation. What emerges is a true peer relationship based on partnership and friendship enhanced by the shared experience. As Fabiola describes it, “Every mother becomes a new friend” (personal communication, 2006).

Although a typical day for the Rush peer counselors is spent providing informational support as well as practical assistance (i.e., discussing the benefits of breastfeeding, helping mothers secure breast pumps, getting new mothers started with pumping, and providing follow-up with mothers of discharged babies), providing emotional support underlies everything that they do. Whether visiting an expectant woman in antepartum to talk about the benefits of breastfeeding, determining which aspects of the mother’s medical and drug history are relevant to their milk supply, or arranging transportation for a mother to attend the weekly Rush Mother’s Milk Club luncheon meeting, the peer counselors emphasize to each mother that they are available and dedicated to helping
them with their breastfeeding needs and challenges. The supportive actions of the peer counselors vary according to the mother’s needs at the moment and the peer counselor’s assessment of the situation. Jameca’s and Fabiola’s support, therefore, is personal and tailored to the individual mother. Their support may be viewed as a buffer against the technological environment of the special care nursery.

The defining moment of being a peer counselor for the Rush counselors is when they help a mother put her baby to the breast for the first time. In sharing their experiences, they both agreed that this is the most satisfying and enjoyable aspect of their work (personal communication, 2006). Many mothers have expressed to them that putting the baby to breast was the moment they knew they were truly a mother. Although the mothers come and go, memories of these moments remain and sustain Jameca and Fabiola in their passion and dedication to helping mothers breastfeed.

Although not typical of a community-based peer counseling practice because of the unique needs and issues of the VLBW population, this model highlights essential aspects of how peer counselors nurture the breastfeeding relationship of a new mother and her infant. Both counselors provide informational and instrumental support as they help mothers with milk supply questions, breast pump use, and feeding babies at the breast. Their first-hand knowledge of how difficult it can be to provide milk and breastfeed while coping with the emotional stress of having a hospitalized infant enables them to give compassionate, caring, and considerate emotional support.

CONCLUSION

Breastfeeding peer counseling has emerged as a valuable and effective means of providing women and their families with reliable and situationally appropriate sources of information and social support to help women initiate and continue breastfeeding. Peer counseling has been deemed beneficial for increasing rates of breastfeeding for women in low-income communities or those without a supportive culture or tradition of breastfeeding who may be particularly susceptible to early weaning. By providing culturally sensitive breastfeeding education and support, advocating for new mothers’ needs, and assisting mothers in obtaining needed services, breastfeeding peer counselors help to ensure that every mother has sufficient knowledge and support to breastfeed successfully.

The author thanks Janet Engstrom, CNM, RNC, PhD, for her help in the preparation of this manuscript.

REFERENCES


“When we trust the makers of baby formula more than we do our own ability to nourish our babies, we lose a chance to claim an aspect of our power as women. Thinking that baby formula is as good as breast milk is believing that thirty years of technology is superior to three million years of nature’s evolution. Countless women have regained trust in their bodies through nursing their children, even if they weren’t sure at first that they could do it. It is an act of female power, and I think of it as feminism in its purest form.”

–Christiane Northrup, MD, Women’s Bodies, Women’s Wisdom, Bantam Dell Publishing Group, 2006.

Reprinted with permission from Christiane Northrup, MD.