

Peer Counselors for Breastfeeding Mothers in the Hospital Setting: Trials, Training, Tributes, and Tribulations

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Abstract

Boston Medical Center (BMC), an inner-city, Baby-Friendly teaching hospital with approximately 2000 births per year, has employed breastfeeding peer counselors since 1998. The Breastfeeding Center frequently receives requests for information on our peer counselor program. This article reviews program models, training methods, practicalities, benefits, and challenges associated with employing breastfeeding peer counselors in the hospital setting. Specifically, it focuses on 3 different models of peer counseling programs used at BMC: the telephone model, the postpartum model, and the neonatal intensive care model, and it considers the benefits and issues associated with each model. *J Hum Lact.* 19(1):72-76

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Breastfeeding peer counselors are used around the globe in varying situations and with varying degrees of success, primarily to increase breastfeeding duration and exclusivity among women from communities with

low breastfeeding rates.¹⁻¹¹ Peer counseling programs usually train and employ women from the local community, who share the mother's social and cultural heritage. Peers assist the new mother with breastfeeding and often provide her with emotional support.

In the United States, many peer counseling programs operate in Women Infant and Children Supplemental Nutrition Program (WIC) settings, helping new mothers through the first few weeks postpartum, in person or by telephone. The Massachusetts WIC Program funds 19 such programs statewide (personal communication, Rachel Berman, state breastfeeding coordinator and nutritionist, Massachusetts WIC Program, May 2002). Perceptions and models of peer counseling programs gained from the National WIC Breastfeeding Peer Counselor Survey are discussed in detail elsewhere.¹²

Peer counselors are used less frequently in hospital settings, perhaps because establishing and maintaining such programs goes beyond traditional medical practice and raises concerns around cost and liability. Although many studies have been published on outcome, little has been written about peer counselor training and the practicalities of employing peers on a daily basis in the hospital setting.

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School of Medicine, with approximately 2000 births per year: 57% of women giving birth are black, 23% are Hispanic, 10% are white, and 10% are of other races/ethnicities; 55% receive Medicaid benefits, and 35% are uninsured.¹³ BMC became the only WHO/UNICEF Baby-Friendly hospital in Massachusetts in 1999.¹⁴ With the gaining of the Baby-Friendly designation, breastfeeding initiation rates rose from 58% in 1995 to 87% in 1999 ($P < .001$); exclusive breastfeeding rates rose from 6% to 34% ($P < .001$), and initiation rates among US-born blacks rose from 34% to 74% ($P = .001$).¹³

The Breastfeeding Center at BMC has employed peer counselors since 1998 to provide services to breastfeeding women. The peer counseling service was created in part because of the high percentage of new mothers from disadvantaged backgrounds and in part to offset the level of breastfeeding support needed due to limited financing for lactation professionals. This article reviews the experience of employing hospital-based peers, with a view to providing insights for other, hospital-based lactation programs interested in employing peer counselors in a similar setting.

Trials and Training

The Telephone Model

Initially in 1998, we created a traditional, telephone-based, peer counseling program titled “One Mother to Another.” Eight peer counselors (all women who had breastfed their own children) were recruited from Parents as Partners, a family-centered care initiative of the BMC Department of Pediatrics, which employed BMC parents in a variety of settings. Their ethnic backgrounds were African American, Hispanic, and white, representing the three major population groups at BMC, and the approximate age range was from 19 to 40. Two women worked as breastfeeding peer counselors for WIC programs, 2 were La Leche League leaders, and 2 had personal experience of breastfeeding an infant in the neonatal intensive care unit (NICU). The peers were trained on site by BMC lactation staff, on 4 consecutive full-day Saturdays, using an adaptation of the Massachusetts State WIC peer counselor manual for 1998. In addition to learning the basics of breastfeeding, peers received training in counseling skills. The Breastfeeding Center provided each peer with a copy of the *Breastfeeding Answer Book* for reference,¹⁵ and each peer counselor shadowed the lactation consultant (LC) on hospital rounds at least once.

The program operated in the following manner. When the LC identified new mothers going home from the hospital in need of extra assistance, she matched a peer with the mother, and the peer and the mother exchanged telephone numbers. “Needing extra assistance” covered a wide range of possibilities, from women whose infants would not latch, to women who believed they did not have enough milk, to teen mothers needing moral support. Mothers and peers were matched by age, ethnicity, and language whenever possible. Peers were instructed to offer basic breastfeeding assistance and moral support by telephone. If the mother’s problem became complex, they were taught to refer the mother to the LC or the pediatrician. In particular, peers were trained to spot “red flags” among newborns, such as a reported lack of stooling, a “good” or “sleepy” baby, and any medical issues such as fever in the infant.

At first, the program appeared to run well. Peers and mothers connected by phone, peers offered advice, and spot-check phone calls from the Breastfeeding Center to women receiving peer assistance revealed a high level of satisfaction. However, over time, certain problems emerged. First, peer counselors did not consistently fill out the paperwork requested by the Breastfeeding Center. A written record of phone conversations was to serve as documentation regarding questions asked, advice given, and the peer’s hours of work. Second, only 2 to 3 out of 8 peers regularly attended scheduled monthly meetings in the hospital, aimed at peer education and program monitoring. This made it difficult to track peers and to ensure consistent dissemination of accurate information. BMC, then pursuing the Baby-Friendly designation, was—and remains—committed to providing evidence-based breastfeeding information to a large volume of high-risk women. Breastfeeding Center leaders concluded that a lack of communication between peers and supervisors made it too difficult to guarantee the level of consistent, accurate breastfeeding information to which we aspired. It was also time consuming, and we decided that, with an identified need for extra support within the hospital, we should streamline the model to use peer support more efficiently. Thus, after approximately 6 months, this model was discontinued. Instead, we encouraged the most reliable peer counselors to move into the hospital setting. Because this required them to work onsite during weekdays, however, several could not make this commitment. However, 2 peers (the La Leche League leaders)

offered to work part-time teaching the then twice-weekly breastfeeding class. One peer counselor changed focus and trained to become a lay childbirth assistant at BMC, and another peer began working regularly on the BMC maternity service under direct LC supervision.

The Postpartum Model

Employing hospital-based peers has proved successful and popular with patients and nursing staff; this model continues today. Since 1999, 4 new peer counselors have worked alongside original peers from the phone-based model. All subsequent peers have been recruited from the Birth SistersSM, a program operated by the BMC midwifery service.* To our advantage, these women have already been screened and trained in childbirth and basic breastfeeding management by the Birth Sisters program. All peer counselors also attend a 5-day breastfeeding course offered by the Center for Breastfeeding Healthy Children 2000 project. In addition, all peers receive hands-on training on the BMC maternity service with the LC. At present, 2 women, an African American and a bilingual Hispanic woman, who have breastfed a total of 13 children between them, work on the postpartum unit. Peer hours are limited by available funding to Monday, Tuesday, Thursday, and Friday, for 4 hours each day, from 10 AM to 2 PM, with each peer counselor working 2 mornings. Peers also work extra hours in the NICU (see below).

On a typical weekday, the LC meets briefly with the attending pediatric team to learn of breastfeeding issues identified on morning rounds and then delegates certain mothers for peer counselor support. Generally, the LCs manage complicated issues such as hyperbilirubinemia, twins, and excessive weight loss, while peers assist with positioning, latch issues, and engorgement. Currently, the thrice-weekly breastfeeding classes are taught by LCs and nursing staff, but peers assist at the classes, and the Hispanic peer provides Spanish translation. In addition, peers help nurses who request extra breastfeeding support for their patients. Peers are also trained to counsel women who choose to feed both breast milk and formula in the hospital. Often, this “doing both” is culturally based, and peers from the mothers’ cultures are well-positioned to reassure women, for example, about the adequacy of the milk supply. Given that two main reasons women quit breastfeeding in the hospital setting are perceived lack of milk supply and sore nipples,¹⁶

intensive peer support around supply questions and positioning is warranted.

The NICU Model

It soon became clear that peer counselors were providing not only practical breastfeeding assistance but moral support for new mothers in difficult social situations. Since the most needy women were often the mothers of sick or premature infants, in 1999 we began training our peers to work in the BMC NICU. Peers learned to assemble and operate breast pumps, to explain the process of milk pumping and storage, to assist with the positioning and latch on of premature infants, and to assist the mother with kangaroo care (skin-to-skin holding, which improves outcomes in premature infants¹⁷⁻²⁰). Breastfeeding Center staff created an *NICU Peer Counseling Training Manual* and a posttest for internal use. However, the peer’s prime role is often simply to listen and to befriend the mother amid the white coats, monitors, tubes, and wires of the NICU. Many women fear seeing or visiting their frail premature infant or are unclear why the infant is in the NICU but are nervous about asking the medical personnel. Approximately 17% of BMC NICU mothers are Hispanic; for them, the Spanish-speaking peer becomes a vital figure.

In 2000, the Breastfeeding Center applied for and received a 3-year grant from the Bureau of Maternal Child Health (MCHB) in Washington DC (grant 1 R40 MC 00252), which allowed us to launch a 30-month, randomized controlled trial to test our hypothesis that peer counselors increase breastfeeding duration among mothers of infants admitted to the NICU. Mothers of premature infants between 26 and 37 weeks gestational age are randomly assigned to the intervention or control group; women in the control group receive standard-of-care treatment (LC support, nursing support, and a double setup electric breast pump for home use), while women in the intervention group receive standard-of-care treatment *and* peer counselor support. The assigned peer meets with the mother in the hospital before she goes home, then contacts the mother on a weekly basis for 6 weeks. The contacts are in person if the infant remains in the NICU or by telephone once the infant goes home. After each contact, the peer counselor completes a checklist detailing the material covered in the meeting or conversation, which is then handed to the LC. For example, the peers show all intervention mothers a video, *You Can Make the Difference*, created in the

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BMC NICU for breastfeeding women. The peer records whether the video was shown, whether the mother pumped during the meeting, and whether the mother and the peer went together into the NICU. In this way, the peer is prompted about suitable meeting content. She also records her own feelings about how breastfeeding is going for this mother. Peers are encouraged to talk with the LC if they have any concerns, and the research team meets regularly, within the peer's scheduled working hours, to review the study's progress. Currently, the two peer counselors on the postpartum unit also work on this project. The first women were enrolled into the study in January 2002, and evaluation of the intervention (whether the peers impact breastfeeding duration) will be made when sufficient numbers of women have entered the study for results to have statistical significance.

Funding

Initially, peers were funded at \$10 per hour plus fringe benefits, through Parents as Partners, an initiative of the BMC Department of Pediatrics. Since then, the Breastfeeding Center has successfully written and obtained a series of small grants ranging from \$2500 to \$7200, which have supported peer counselors on both the postpartum unit and in the NICU. The Kids Fund and the Alpert Foundation are BMC based; the Boston Evening Clinic and the Lenny Fund are local foundations. In 2000, the MCHB grant described above provided additional funding for peer hours spent counseling NICU study mothers. Currently, peers are paid \$12 an hour plus fringe benefits.

Tributes

Peer counselors have brought unique insights to BMC's breastfeeding service. Typical of the patient tributes paid to the peers was 1 mother of a premature infant, who told her pediatrician, months later, that the only thing she remembered about her own postpartum stay was the peer counselor braiding her hair. Countless women have held their infants skin to skin, confided their fears, and braved the hospital system with more confidence as a direct result of peer counselor contact. We have learned that teenagers often relate as well to an older "mother figure" from their own culture as they do to a younger peer: our mother-of-10 peer counselor is particularly adept at dealing with adolescent mothers.

The peers in turn have brought unique strengths to the program. One particularly insightful peer counselor created the following clinical tips, which BMC LCs have adopted: (1) If the infant is not latching, first relax the mother. Sit with her, rub her back, talk to her. This peer counselor sensed when arching in babies was connected with extreme anxiety in the mother. Sometimes, she sat with the mother for an hour or more simply talking. She was the most successful member of the lactation team at persuading infants to latch on to the breast. (2) If breastfeeding hurts when the baby latches on, count slowly to 5. If it still hurts, take the baby off and start again. (3) When explaining the need for the infant to open his mouth wide for latch-on, run the mother's finger around the areola, where ideally the infant's mouth should close. The physical contact seemed to clarify the concept in women who had difficulty understanding the principal of a correct latch.

Tribulations

Peer counselors are recruited for their unique ability to relate to women from diverse cultural and socioeconomic backgrounds, and their ability to do this is based, not least, on the fact that they share the same background. Inevitably, this essential strength can prove a challenge. Women from impoverished backgrounds, especially women with young children, often lack support and survive in unstable circumstances. One BMC peer counselor became homeless and was moved with her 2 children to a suburban motel, another frequently missed work due to family-related court appearances, another was the sole provider for her ailing mother, and another peer (a teenage mother) had no paternal support, no childcare, and no means of transportation. These circumstances can lead to chronic unreliability: at one point it seemed necessary to employ 3 peer counselors to cover 1 position reliably. This has been of particular concern in the MCHB study, where peers must meet with mothers in the NICU on a regular basis for a specified number of weeks. The combination of difficult circumstances for both mother and peer make such meetings tenuous and has caused many anxious moments for Breastfeeding Center leadership. Our experience has led us to attempt to hire older, more stable women and to nurture those peers who are most reliable. We have assisted individual peers to secure affordable housing, buy a working refrigerator, obtain subsidized childcare, and have funded their attendance

at breastfeeding courses and conferences, realizing that as we offer this assistance, we empower the peer as well.

Summary

Woman-to-woman support has long been a successful component of the lay breastfeeding movement. Although the current peer counselor model frequently employs women on an outpatient or telephone-contact basis, our experience leads us to fully recommend including breastfeeding peer counselors in the hospital setting. While not a replacement for the LC, and despite some issues with reliability, peers add unique insights, abilities, and cultural diversity to the postpartum unit. They can manage time-consuming issues such as social support, while the LC is freed up to deal with potentially high-risk or medically complex issues and are, in our experience, a cost-effective and uniquely beneficial addition to the hospital-based lactation team. Moreover, they may beneficially affect breastfeeding duration among mothers of NICU infants, and our ongoing study will investigate this hypothesis.

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Resumen

Madres consejeras para madres lactantes en el hospital: Pruebas, Entrenamiento, tributos y tribulaciones

El Boston Medical Center (BMC), localizado en el centro de la ciudad, hospital de enseñanza Amigo del Niño con aproximadamente 2000 nacimientos al año, ha empleado consejeras de lactancia desde 1998. El Centro de Lactancia Materna con frecuencia recibe solicitud de información sobre nuestro programa de madres consejeras. Este artículo revisa los modelos del programa, métodos de entrenamiento, asuntos prácticos, beneficios y retos asociados al empleo de madres consejeras para trabajar en el hospital. El programa se enfoca en 3 diferentes modelos del programa de madres consejeras que se utilizan en el BMC: el modelo del teléfono, el modelo postparto y el modelo de la unidad de cuidados intensivos neonatales, y describe los beneficios y asuntos asociados a cada modelo.