

Using *Loving Support*©  
To Implement Best Practices  
In Peer Counseling

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# EXECUTIVE SUMMARY

Peer counseling is a commonly recognized intervention in public health programs that provides community-based peer education and support from among a particular population group. The use of community-based peers, with origins in the 1950's (Bronner 2001), has grown among clinical specialties in which professionals have previously had limited success in changing behaviors. Peer counseling programs employ a wide range of activities directed at changing behavior, including one-on-one counseling, hospital or home visits, group classes and support groups, and referrals to appropriate health and social services.

Peer counseling helps improve initiation and duration rates of breastfeeding among women in a variety of settings, including disadvantaged and WIC populations representing diverse cultural backgrounds and geographical locations (Arlotti 1998).

The Department of Agriculture's Food and Nutrition Service (FNS) contracted with Best Start Social Marketing to develop a breastfeeding peer counseling program model, "Using *Loving Support* to Implement Best Practices in Peer Counseling." This project is designed to prepare staff within the Special Supplemental Nutrition Program for Women, Infants, and Children Program (WIC) to implement and expand breastfeeding peer counseling programs in order to provide support for breastfeeding mothers in the WIC Program.

In this study interviews were conducted with WIC Program administrators and staff who work among three assigned categories of WIC Programs: programs with current peer counseling programs, programs that once utilized peer counseling but have discontinued, and programs that have never attempted to implement peer counseling. Peer counselors currently serving WIC mothers were also interviewed.

Interviews were also conducted with non-WIC organizations that employ peer counseling. In addition, a limited number of peer counseling curricula were screened and assessed to ascertain the common components shared by the respective curricula.

The difficulties encountered or anticipated among the interviewed programs are shared across all organizations. Among those barriers to successful program implementation and maintenance are:

- Inadequate or non-existent legislative, regulatory, and policy mandates
- Inadequate or non-existent support from multiple levels of public health administration
- Insufficient resources for program initiation
- Funding stream discontinuity
- Inadequate or lack of compensation for peer counselors
- Lack of administrative/program structure consistency
- Inexperienced program developers

- Lack of a WIC specific program model
- Lack of a standardized training model
- Lack of science-based peer counselor practice parameters
- Inadequate supervision of peer counselors
- High turnover rates among peer counselors

Peer counselors provide a different perspective at the frontline of peer counseling programs. Peer counselors view their job as an opportunity to help other mothers and guide them toward a successful breastfeeding experience. They value the knowledge they have received as a result of their work. Some are empowered to move on to higher paying jobs or to further their formal education.

Peer counselors would like an increase in their monetary compensation and continuity of funding. In addition, many would like to have access and availability to ongoing trainings. Some feel a better working relationship with hospitals needs to be established where they are part of the spectrum of care for prenatal and postpartum mothers. Peer counselors also acknowledge the important role supervisor play in supporting and encouraging their work.

Recommendations for effective peer counseling programs are also shared among staff and administrators from the various programs. One important recommendation is the need for flexible program structures that provide a baseline quality of standards within which State and/or local WIC agencies can implement programs appropriate for their respective situations.

Other recommendations include that peer counselors:

- Have defined practice parameters and job descriptions;
- Be trained using a model that has consistency, continuity, and is science based;
- Are compensated positions in the WIC human resources system; and
- Be a service mandate in WIC.

# BACKGROUND

The Department of Agriculture's Food and Nutrition Service (FNS) contracted with Best Start Social Marketing to develop a breastfeeding peer counseling program model, "Using *Loving Support* to Implement Best Practices in Peer Counseling." This project is designed to prepare staff within the Special Supplemental Nutrition Program for Women, Infants, and Children Program (WIC) to implement and expand breastfeeding peer counseling programs in order to provide support for breastfeeding mothers in the WIC Program.

Best Start is employing social marketing to develop and implement this program. A literature review, an assessment of current practices and peer counseling curricula, and formative, qualitative research have been used to identify program needs. Peer counseling program administrators, supervisors, WIC staff, and WIC peer counselors working in the field are the respective audiences that have been interviewed. This collection of information sources will guide strategy formation and be the foundation upon which the peer counseling program model will be designed and implemented. This model includes the following elements:

- Develop a peer counseling management curriculum for program managers;
- Develop a peer counselor training model; and
- Deliver regional trainings on peer counseling program management to administrative and professional staff who work with peer counselors.

## PROJECT GOALS

The project is designed to equip WIC Programs throughout the country with a model to aid them in designing, building, and sustaining breastfeeding peer counseling programs that will improve initiation and duration rates.

Project goals are to:

- Understand barriers to successful peer counseling program development, maintenance, and sustainability;
- Learn how existing successful peer counseling programs are managed;
- Develop a peer counseling program implementation and management model that is effective and feasible within the various organizational structures found among WIC Programs throughout the nation;
- Develop a peer counseling management training curriculum, *Using Loving Support to Manage Peer Counseling Programs*;
- Present *Using Loving Support to Manage Peer Counseling Programs* to State staff attending seven separate regional USDA training conferences;
- Develop and deliver a "train the trainer" peer counselor skills-building curriculum, *Loving Support through Peer Counseling*, which includes Best Start's *3-Step Counseling Strategy*® as

well as a training manual addressing basic promotion, support, and management of breastfeeding issues for which peer counselors are typically responsible; and

- Provide telephone and electronic technical assistance to all participating States, Territories, and Indian Tribal Organizations (ITO's) that attend the training and initiate peer counseling programs.

## **METHODS**

Although research using true experimental design is lacking in the literature, the bulk of evidence from quasi-experimental studies suggests that peer counseling is highly effective at improving initiation, exclusivity, and duration of breastfeeding among low-income populations. However, the perspectives of WIC Program staff on implementing, managing, and sustaining peer counseling programs are less understood. In order to understand all aspects of starting and maintaining a peer counseling program, the research phase consisted of three data collection strategies that include: (1) a literature review; (2) a current practices assessment; and (3) in-depth interviews.

*Please note: All tables and other means of identifying States or organizations within which research was conducted have been eliminated to assure confidentiality of research subjects.*

### **Research Objectives**

Research objectives are to:

- Understand administrative perspectives of peer counseling program management;
- Understand perspectives of direct services staff regarding peer counseling program management;
- Identify internal WIC barriers to integrating WIC peer counseling with hospitals and other community partners;
- Identify barriers and motivators to implementing and sustaining peer counseling programs;
- Identify factors that contributed to the demise of peer counseling programs within WIC;
- Identify factors perceived to contribute to successful peer counseling programs;
- Identify requisite training needs for WIC staff to support successful implementation and maintenance of peer counselor programs; and
- Identify requisite skills and training needs for peer counselors.

### **Literature Review**

As a foundation, Best Start utilized the literature review on peer counseling prepared by Abt Associates for FNS (Abt Associates, 2003). This was supplemented by an additional literature review to include any information published subsequent to Abt Associates' literature review.

In addition to published research findings and reports, experts and organizations involved with breastfeeding peer counseling efforts have been contacted to access results from unpublished studies and reports.

### **Current Practices Assessment**

Best Start conducted a current practices assessment of WIC and non-WIC breastfeeding peer counseling programs and curricula. This assessment included two components: (1) in-depth interviews with respective programs' key informants; and (2) reviews of the programs' curricula. This review was performed to obtain a better understanding of current program policies and procedures, job descriptions, documentation and monitoring tools, training programs, and evaluations conducted. An assessment form was used to review the following areas in each program's curriculum (see Appendix A for Assessment Form):

- Guidelines for recruiting, hiring, and supervising staff;
- Methods used to retain staff;
- Modes of compensating staff;
- Job descriptions (including contact schedules);
- Training program models;
- Documentation and monitoring;
- Any in-house evaluations of the programs that may have been completed; and
- Skills required of peer counselors.

Due to the limited number of curricula, the current practices assessment includes all known peer counseling programs and curricula in WIC and non-WIC settings. This assessment represents a variety of peer counseling programs and is representative of the geographic and ethnic diversity among population groups served by WIC. Program managers were asked to share their programs' curricula. These were reviewed by two members of the research team. Researchers used the Assessment Form (Appendix A) to identify and summarize the key and common components of the various curricula. The Assessment Form, a tool designed to assist researchers to identify content diversity among curricula, was developed based on primary training components for peer counselors working in the WIC Program. Additional components discovered apart from the assessment tool will be noted and included in the summary.

Six interviews were conducted with key informants from non-WIC peer counseling programs. Another six interviews were conducted with key informants from current WIC peer counseling programs. The WIC interviews were grouped and analyzed with the in-depth interviews discussed in the following section.

Peer counseling training curricula were requested from WIC and non-WIC Programs. Thirteen curricula from WIC Programs and four from non-WIC Programs were received.

### **In-depth Interviews**

Best Start conducted formative research using in-depth telephone interviews with administrative and direct service staff in urban and rural WIC settings including ITO WIC Programs. States were selected from among those that are currently providing peer counseling programs, those that have not yet implemented peer counseling programs, and those that have discontinued peer counseling programs. The perspectives are predicted to be significantly different among these three groups. A comparative analysis will help provide insight into strategies needed for the development of new programs and those required to support and enhance existing programs.

Best Start also conducted in-depth interviews with peer counselor in urban and rural WIC settings including ITO programs. Peer counselors provide frontline service delivery to WIC clients. Understanding their unique perspective on the requirements for a successful peer counseling program is essential to the growth of peer counseling in WIC. In particular, understanding what they need, including training needs, in order to improve their capacity to provide services to their clients will help build clients' self-efficacy.

In order to facilitate a relatively rapid turnaround on data collection and reporting of findings to USDA, individual in-depth interviews were conducted via telephone to gain thorough understanding of the factors that influence peer counseling program efficacy. The interviewers used a semi-structured interview guide that combines open-ended questions with structured questions. Three in-depth interview guides were developed to conduct data collection with State WIC administrative and local/direct services staff who: (1) currently have peer counseling programs; (2) have not yet implemented peer counseling; and (3) had previous programs that have been discontinued (see appendices B through D for interview guides). A fourth interview guide was also developed to conduct data collection with peer counselors (See Appendix E). All data and subject information were kept confidential.

Preliminary analysis of the interviews was conducted to determine if theoretical saturation had been achieved. Additional interviews were conducted, as needed, to assure that the most salient issues within each audience segment were clearly understood. However, the proposed number of interviews was more or less in order to achieve theoretical saturation.

### **Target Audience and Sampling Frame**

Formative research was conducted in locations throughout the seven regions established by USDA, and among ITO's. This allowed full coverage of the diversity found throughout the WIC Program nationally.

Target audiences included the following WIC staff:

- State-level directors;
- State nutrition education coordinators;
- State breastfeeding coordinators;
- ITO staff;
- Local/direct services staff; and

- Peer counselors.

This varied group of staff offers diverse viewpoints on establishing, supporting, and sustaining peer counseling programs. Managerial staff have the responsibility of implementing, managing, and sustaining the programs. Local staff interface with peer counselors and are involved with making referrals and providing ongoing support for both the peer counselors and WIC clients.

Peer counselors provide actual service delivery with WIC clients. It is beneficial to learn from their unique perspective and determine what they need from the program, specifically their training needs that will help build self-efficacy in providing services to clients.

WIC staff were selected from the previously described program categories to include: (1) those currently providing successful peer counseling programs; (2) those that have not yet implemented peer counseling; and (3) those with previous programs that have been discontinued.

#### *Recruitment of Administrative and Direct Services Staff*

Best Start and FNS identified the formative research sites. Several steps and considerations were taken into account during the selection of research sites. First, all States were separated into the three different target audience groups. Several ITO's were also identified and separated into these three audience groups. Second, certain States were selected from each group to provide a representative sample of the diversity found throughout the seven regions established by the USDA and the WIC Program. Rural and urban environments were also taken into account in the selection of States.

A total of 37 interviews were conducted with Current Peer Counseling programs' staff; 10 interviews with staff from Discontinued Peer Counseling Programs; and 24 interviews with staff from Never Initiated Peer Counseling Programs.

#### *Recruitment of Peer Counselors*

State and local WIC staff currently providing peer counseling identified peer counselors for interviews. Peer counselors were categorized based on the *ethnicity of the population they predominantly served*. Table 4 illustrates the populations' ethnicities and the completed number of peer counselor interviews.

Interviews were conducted with peer counselors serving: (1) Spanish-speaking Hispanics; (2) African-Americans; (3) Anglo-Americans or English-speaking Hispanics; (4) Native Americans; and (5) mixed ethnicities. The 'mixed ethnicities' sample group represents peer counselors serving a diverse population. Thirty-eight peer counselor interviews were completed.

#### **Pilot Testing**

In-depth interview guides were pilot tested with a small number of WIC staff in several States. The research instruments were pilot tested to determine if the questions were comprehensible, elicited the information desired, generated a conversation that flowed smoothly and logically, and were not confusing or offensive to respondents.

Pilot testing revealed the Current and Discontinued Peer Counseling Program and Peer Counselor interview guides required more than one hour to complete the interview. All three guides were revised to shorten the interview time to no longer than one hour. Minor changes were also made to the Never Initiated and Peer Counselor interview guides for comprehension purposes.

### **Data Analysis**

In-depth interviews were tape recorded, transcribed, and entered into a microcomputer. Transcripts were loaded into *Ethnograph*, a software package that allows text to be numbered, coded, and sorted. After most of the interviews were completed, research staff read the transcripts and identified categories using the constant comparative method (Glaser, 1978). Coding was compared for inter-rater consistency and appropriate adjustments were made in how codes were assigned. *Ethnograph* was used to sort transcripts by coded topics. All material filed by each topic was read by two researchers. They identified recurring themes and the range of diversity in responses, made summary and interpretive statements, and marked passages worthy of quotation. Within each topic, sorted passages for specific subgroups were read separately to facilitate comparison of responses. Researchers compared notes on each topic for consistency and agreed on statements to be included in the research findings.

# LITERATURE REVIEW

## **What is Peer Counseling?**

Peer counseling is a commonly recognized intervention in public health programs that provides community-based peer education and support from among the target population group. The use of community-based peers, which actually had its beginnings in the 1950's (Bronner 2001), has grown in clinical specialties in which professionals have previously had limited success in changing behaviors.

Peer support has been used successfully in a multitude of public health arenas over the years, including:

- counseling about AIDS education in an inner-city adolescent AIDS clinic (Slap 1991);
- smoking cessation programs (Orleans 1991);
- teen pregnancy prevention (Minter 1990);
- partner abuse program (Henderson 1995);
- drug cessation program with adolescents (Alford 1991); and
- doula support (female labor coach) also significantly associated with longer breastfeeding rates (Barron 1998).

In 1957 the concept of peer support was brought to the breastfeeding arena through the international mother-to-mother volunteer organization, La Leche League, founded by seven breastfeeding mothers. The heart and soul of La Leche League has been peer counseling throughout the history of the program (La Leche League 1997).

Through the years, however, as La Leche League spread internationally, its membership seemed to be dominated by women who were professional, well-educated, and knowledgeable, meaning that low-income women with less education were not their peers and were thus underserved (Lawrence 2002). Beginning in the 1970's, the peer counseling model began with a low-income group in Augusta, GA, and is now an integral part of the breastfeeding support services provided by WIC Programs throughout the country (Lawrence 2002).

Peer counseling programs employ a wide range of activities directed at changing behavior, including one-on-one counseling through telephone contacts, visits in the hospital or home, group classes and support groups, and referrals to appropriate health and social services.

## **Impact of Peer Counseling on Breastfeeding Initiation and Duration Rates**

Peer counseling has been found to be a significant factor in improving both initiation and duration rates of breastfeeding among women in a variety of settings, including disadvantaged and WIC populations representing diverse cultural backgrounds and geographical locations (Arlotti 1998). Lay support has also been found to be highly effective in promoting exclusive breastfeeding (Sikorski 2002).

Some examples of successful programs that have been formally evaluated:

**Adolescent Peer Program in a Florida High School (Volpe 2000)**

A program called the "BEST Club" (Breastfeeding Educated and Supported Teen) offered pregnant adolescents a creative, fun way to learn about breastfeeding with weekly one-hour interactive classes and follow-up with a teen peer counselor during pregnancy and during the postpartum period for as long as they chose to breastfeed. Among the intervention group, 65.1% initiated breastfeeding compared to 14.6% in the control group.

**Baltimore WIC African-American Intervention (Caulfield 1998; Ross 1998)**

A study consisted of 3 interventions: (1) Best Start video and posters in waiting room; (2) peer counseling before and after delivery; and (3) combination of both interventions. Breastfeeding promotion alone was not significant in increasing breastfeeding rates; however, when combined with peer counseling, it was found to be positively associated with the continuation of breastfeeding at 7 to 10 days, a critical weaning period. In addition, 70-75 % of women who received at least one or both of the interventions were breastfeeding at 8 weeks and 40-52% at 16 weeks. Only 23% of the control groups were breastfeeding at 8 weeks and none at 16 weeks.

**Chicago Cook County Hospital with Black Urban Low-Income Women (Kistin 1994)**

Peers from this program were extensively trained in breastfeeding promotion, management, and counseling, and they made routine calls with clients before delivery and postpartum contacts for at least 2 months. Ninety-three percent of women with a peer counselor (PC) carried out their plans to breastfeed compared with 70% of those without a PC. Duration was also affected: 64% in the PC group breastfed >6 weeks and 44% breastfed >12 weeks, compared to 28% and 21% in the control group. Rates of exclusive breastfeeding were also higher: 77% of women with a PC exclusively breastfed >6 weeks compared to 40% of those without a PC. Twenty-nine percent were exclusively breastfeeding >12 weeks compared to 16% of the control group. The study found that the presence of peer counselors helped women carry out their intended plans to breastfeed; no data were available as to whether they were effective at changing the mind of a woman who previously planned to bottle feed.

**Inner-City Hospital-Based Peer Counseling Program (Wilson 1991)**

A hospital-based peer counselor program at District of Columbia General Hospital provided anticipatory guidance during pregnancy, in-hospital support with positioning and latch of the infant and follow-up telephone support. Among women in the intervention group, 64.5% initiated breastfeeding.

**Iowa Peer Counselor Intervention Program (Schafer 1998)**

This 2-year trial project provided trained peer counselors in 2 counties for in-home and one-on-one lessons about breastfeeding and healthy eating to new mothers. Women in the intervention group improved their dietary intake compared with the control group, and were significantly more likely to breastfeed. Eighty-two percent of the intervention group compared with 31% of the control group initiated breastfeeding; at 4 weeks, 56% of the intervention and 10% of the control group were breastfeeding. The mean duration was 5.7 weeks for the intervention group compared with 2.5 weeks for the control group.

### **Low-Income Mid-Atlantic Peer Counselor Trial Program (Pugh 2002)**

This intervention compared a control "usual care" group with a group that received added interventions of home and hospital visits from a nurse/peer counselor team and peer support by telephone for up to 6 months. Results found that women in the intervention group breastfed longer than the usual care group, used significantly less formula, had fewer sick visits to the doctor, and needed fewer medications. The \$301 per mother cost was partially offset by the cost savings on formula and health care.

### **Mexico City Peer Counselor Program (Morrow 1999)**

Peer counselors were trained extensively by La Leche League and a physician study coordinator with a week of classes, 2 months of lactation clinics, participation in mother-to-mother support groups, field observation, and 6 months practice in a neighborhood to refine communication and problem-solving skills. The study found that the peer counseling intervention significantly affected initiation and duration rates of exclusive breastfeeding. At 2 weeks, 80% of those receiving 6 visits, 62% of those receiving 3 visits, and 24% of the control group without visits were exclusively breastfeeding. At 3 months, the rates were still high for the PC group: 67% of the 6-visit group, 30% of the 3-visit group, and 12% of the control group were exclusively breastfeeding. Also, in the 6-visit group, women were significantly more likely to return to exclusive breastfeeding if they temporarily supplemented for perceived illness, stress, or doctor's advice.

### **Mississippi WIC Peer Counselor Program (Grummer-Strawn 1997)**

The Mississippi program, available in seven of the nine public health districts, employed three levels of staff trained extensively for their appropriate role. The program includes peer counselors, lactation specialists, and lactation consultants, and provides WIC clients with frequent prenatal and postpartum telephone contacts, home and hospital visits, and referrals for health services. Prenatal classes and postpartum support groups were also provided by these program staff, along with breast pumps and resources. Clinics in which the program was provided had substantially higher rates of breastfeeding initiation compared with those that did not. The program was found to be a "national model for developing similar programs in other States."

### **North Carolina Breastfeeding In-Home Support Program (Baker 2003)**

The North Carolina Cooperative Extension Program has entered into a partnership with the WIC Program to provide an extensive breastfeeding peer counseling program using Cooperative Extension paraprofessionals from the EFNEP (Expanded Food Nutrition Education Program) in 38 of the State's 100 counties. An extensive 5-week training program covers such topics as nutrition, food safety, lactation, and counseling skills. Educators make telephone contacts with WIC mothers at designated intervals, home visits within 72 hours of hospital discharge, and daily home visits as needed for reinforcement. Professionals of a higher level, designated lactation professionals, make hospital visits and assist with risk situations. In-state analysis of breastfeeding rates has shown significant increases in duration rates among mothers participating in the program.

### **Rural Low-Income Peer Counselor Program in West Tennessee (Shaw 1999)**

A postpartum survey and chart review with a WIC population in rural west Tennessee found that women who received peer counseling were significantly more likely to breastfeed (53% vs. 33%), and continuation was also higher at 6 weeks (26% vs. 13%). Although improvements were also seen among women who were previously undecided about breastfeeding or planning to formula feed, the results were not statistically significant.

### **Sagkeeng First Nation's Community Health Nurse and Peer Counseling Program (Martens 2002)**

The Sagkeeng First Nation had a community-based program to promote breastfeeding which consisted of a prenatal education program and a postpartum peer counselor program for breastfeeding women. The prenatal education was provided by community health nurses from 1992 to 1997, and focused on the importance, benefits and barriers to breastfeeding. The postpartum peer counselor program, initiated in mid-1996, provided women with support for the purpose of making breastfeeding a positive and successful experience. Initiation rates increased from 38% in 1995 to 60% in 1997. The peer counseling program also showed a causal relationship between having peer support and a decreased risk of weaning, as a result of a decrease in breastfeeding problems experienced by mothers. Women who reported experiencing 2 or more problems during pregnancy were 7.6 times more likely to wean than women having one or no problems.

### **Salt Lake City Indian Health Care WIC Program (Long 1995)**

The peer program with Native American WIC participants included prenatal and postpartum contacts at 1, 2, and 4 weeks postpartum. The program improved breastfeeding initiation and duration rates: 84% vs. 70% initiation, and 49% vs. 36% breastfeeding at 3 months. Rates at 6 months did not improve, but this was attributed to the lack of emphasis on long-term breastfeeding by the program.

## **Why Peer Counseling Seems to Work**

Many women, particularly disadvantaged women in communities where breastfeeding rates are low, have never seen anyone breastfeed in public, and often view breastfeeding as "impossible" due to the demands of their life (Guttman 2000). Best Start research conducted with WIC clients in 10 pilot States as a part of the National WIC Breastfeeding Promotion found that there were three significant barriers to breastfeeding: embarrassment, time and social constraints, and lack of social support (Best Start 1996). Women who feel overwhelmed with barriers and multiple roles to perform often believe breastfeeding is too great a challenge. Women without peer support often speak of being fearful, worried, and unconfident about their new role as mothers and their ability to make breastfeeding work (Martens 2002).

In contrast, having a peer to model breastfeeding for her can make breastfeeding seem far less intimidating by providing role models (Dykes 1998). Naber (1994) and Bronner (2001) also found that peer counselors were especially effective in communities where role models for breastfeeding behaviors, knowledgeable health care providers, and cultural practices that include breastfeeding as the norm, are scarce.

Many studies have demonstrated the powerful effect of peers from within the cultural group in helping women choose to initiate or continue breastfeeding. This is especially true for women without previous breastfeeding experience, who are significantly more likely to initiate breastfeeding when they receive positive messages about breastfeeding from family and peer groups (Humphreys 1998). Mitka (2001) found that lack of peers among the African-American community is one factor that helps explain the lower breastfeeding rates among African-American women, and Raj Krishna (1998) showed that having a friend or peer who is breastfeeding is a significant factor in increasing a woman's intention to breastfeed among both adolescent and African-American groups. Women who are able to attend peer support groups are four times less likely to report breastfeeding problems, and three times less likely to supplement (Raj Krishna 1998).

Naber (1994) reports that peer counselors tend to be passionate about their mission, making themselves available to mothers at all hours during the early postpartum period, and offering ego support and instilling a sense of purpose in the lives of women they serve. Through this process of empowerment, the peer counselor serves as a resource mobilizer to facilitate access to personal and environmental resources that foster a sense of control and self-efficacy (Bronner 2001).

Mothers who have benefited from peer support state that the peer counselor gave them confidence in their ability to breastfeed and a way out of their worries and lack of confidence (Martens 2002). Mothers also believe peer counseling helped increase their self-esteem, and therefore their ability to incorporate breastfeeding into their lives (McInness 2000). Effective peer programs with low-income women, in particular, provide mothers with role models, accurate information about breastfeeding, and support and encouragement that can result in increased duration rates (Raisler 2000; Schafer 1998). Mothers who have benefited from a peer counselor say the support they received was invaluable, and helped them persevere during difficult times and "stick" with breastfeeding longer (Dennis 2002; Raisler 2000; Wilson 1991).

In a series of seven focus groups conducted with low-income mothers in Southeast Michigan (Raisler 2000), new mothers who received help from a peer counselor said they especially valued the prompt response to distress calls and the caring concern exhibited by peer counselors, which helped the women feel comfortable to share concerns and ask questions they were not comfortable asking their health providers. Mothers said the peer counselor functioned as a "trusted member of the extended family," available to them around the clock for hands-on assistance and establishing a connection that helped them trust her information. Many said without their peer counselors, they would have stopped breastfeeding (Raisler 2000).

Several studies found that although peer support seems to be very effective in increasing duration rates, the impact seems to be greatest among mothers who had already decided to breastfeed, leading many to conclude that the primary value of peer counseling is in helping women follow through with their initial breastfeeding decisions (Bronner 2001; Grummer-Strawn 1996; Kistin 1994; Shaw 1999). McInnes, Love and Stone (2000) also found that women receiving prenatal peer support were twice as likely to initiate breastfeeding at delivery than women without any prenatal peer support.

Peer counseling, however, is a valuable strategy that can impact breastfeeding rates when accompanied by other initiatives within the community (Bronner 2001). For instance, peer counseling as part of a nurse follow-up community health intervention resulted in significantly longer breastfeeding and substantially lower amounts of infant formula used (Pugh 2002). In Mississippi, where a comprehensive WIC National Breastfeeding Promotion Project was successfully implemented, the greatest increases in breastfeeding initiation and duration rates occurred in counties of the State where WIC peer counseling program staff were in place to provide follow-up support to new mothers (Khoury 2002).

### **Reasons Why Peer Counseling Programs Fail**

According to Walker and Avis (1999), there are several common reasons for the demise of peer counseling programs. These reasons include:

- Absence of defined program goals and objectives;
- Discrepancy between the program's goal and design;
- Lack of continuity among personnel and funding;
- Insufficient training and support for staff;
- Lack of set job responsibilities and expectations for staff; and
- Failure to establish external support.

### **Components of a Successful Peer Counselor Program**

Studies of successful peer counseling programs provide clues as to best practices that can make a peer counseling program most effective:

#### **Training and Experience**

- Having a greater number of highly trained program staff appears to be more effective in increasing breastfeeding rates (Grummer-Strawn 1997; Kistin 1994)
- Staff members with more experience and staff who are older appear to be more effective than newer, younger staff (Grummer-Strawn 1997)
- Peer counselors who were previous or current WIC clients are significantly more successful than those who have never been on WIC (Grummer-Strawn 1997)
- Peers recruited from among the target population being served are more effective (McInness 2000)
- Effective programs provide intensive training that includes breastfeeding promotion and management techniques, counseling techniques, field observations, shadowing a seasoned peer counselor, and practice opportunities in problem-solving skills (Grummer-Strawn 1997; Kistin 1994; Morrow 1999)
- Peer counselors should not be expected to have a professional background; they should, however, be given sufficient training to provide accurate information and problem-solving support for mothers (Morrow 1999)

## **Contacts with Mothers**

- The more contacts or overall time spent with a mother, the more likely it is she will initiate and sustain breastfeeding (Dennis 2002; Morrow 1999; Grummer-Strawn 1997; Dennis et al., 2002)
- Contacts during a woman's pregnancy are important in increasing duration rates (Kistin 1994; Grummer-Strawn 1996; Long 1995)
- Repetitive contacts throughout a woman's pregnancy are effective in increasing initiation of breastfeeding (Best Start 1996; McInnes et al., 2000)
- Programs involving in-hospital visits from peer counselors with anticipatory guidance and support with positioning and latch are effective (Pugh 2002, Wilson 1991)
- The more home and hospital visits made by peer counselors the higher the rates of exclusive breastfeeding at 2 weeks, 3 months, and 6 months (Dennis 2002; Morrow 1999)
- Calls initiated by peer counselors are more effective at increasing duration rates than waiting for mothers to call the peer counselor (Martens 2002)
- Regular, frequent contacts at critical weaning intervals are effective at providing support during high need periods (Martens 2002; Raisler 2000; Kistin 1994)
- Successful programs generally provide routine contacts during pregnancy and the early days of breastfeeding, and weekly contacts during the first month or two, with contacts tapering off as the baby ages, and continuing until the baby weans (Martens 2002; Pugh 2002; Kistin 1994)
- Mothers value information from peer counselors on latching the baby, growth spurts, feeding frequency, building milk supply, pain, expressing milk, supplementation, and infant stools (Raisler 2000)
- Mothers value home and hospital visits for technical assistance with positioning and latching baby, and help getting started with breastfeeding (Raisler 2000)

## **Educational Approaches**

- Peer counselors who are passionate and utilize good interpersonal skills in helping women address their barriers help foster a sense of control and self-efficacy among clients (Naber 1994)
- Effective educational settings are highly interactive, in a fun learning environment, and use a nonjudgmental approach (Volpe 2000)

## **Characteristics of Peer Counseling Programs in WIC**

Only 16.7% of WIC service delivery sites in the United States were providing peer counseling as part of their breastfeeding support programs in 1998 (USDA 2000). In addition, one WIC Program in the Midwest discontinued a peer counselor program reportedly because of problems with misinformation disseminated by the peer counselors (Fox 1998).

Bronner (2001) completed a national WIC peer counseling study to examine the current peer counseling models being provided in WIC. The study involved four separate surveys with (1) State WIC Breastfeeding Coordinators; (2) local WIC agency managers; (3) WIC staff; and (4) peer counselors. The sample of 37 State WIC agencies represented all of the seven USDA geographical regions. Findings revealed inconsistent and varied methods and policies being used among programs across the country.

- *Demographics...* WIC peer counselors and clients do not often share similar characteristics in race, income, education, or marital status. Peer counselors are mostly Caucasian, married, and college educated.
- *Compensation...* 68% of WIC peer counselors receive some sort of monetary compensation or stipend; 24% receive none.
- *Training...* varied individuals provide training for peer counselors, ranging from a peer counselor coordinator to local agency managers or the State WIC Breastfeeding Coordinator. Although there is wide diversity in the types of training programs used, topics normally include benefits of breastfeeding, resolving common breastfeeding problems, pumping/storing milk, and counseling techniques. Some programs also discuss other public health issues such as HIV, drug abuse, and alcohol abuse education. Most peer counselors perceive that the training they received is sufficient to prepare them to manage the questions of clients.
- *Job Description...* role delineation varies widely from program to program. Although most programs involve primarily telephone contacts, 44%-57% make prenatal home visits, and 41%-51% make postpartum home visits. Around 50-60% phone clients around the time of the baby's due date to receive an update on delivery status and follow-up with breastfeeding mothers.
- *Recruitment of Clients...* Clients are primarily recruited through WIC clinics, although local community partners and providers sometimes assist in making referrals. Not all programs actively make contacts with clients; some wait for them to contact a peer counselor if they are having difficulties. Hospitals rarely refer new mothers to local peer counselors.
- *Quality Assurance...* Half of all WIC Programs do not have policies and procedures on recruitment, training, and job responsibilities of peer counselors. Daily activity logs are maintained by 72% of peer counselors, but random monitoring of these logs is conducted only around 45% of the time. Around 27% of WIC managers solicit evaluation from clients to determine effectiveness of staff.
- *Retention...* Nearly half of peer counselor coordinators say it is very difficult to retain peer counselors once they are hired and trained.
- *Interactions with Staff...* Despite the noticeable gap in standardized training, recruitment, quality assurance, and program policies, most local WIC managers and staff believe peer counselors are competent to perform assigned tasks, and describe their interactions with other members of the WIC team as positive. State WIC Breastfeeding Coordinators are not as optimistic about their effectiveness or the degree of positive interactions within the organization. Over half of the peer counselors report less than optimal experiences working with other health providers.

## Challenges of Peer Counseling Programs

Despite the great successes enjoyed with peer counseling programs, a number of challenging factors have been associated with needed improvements in programs. These include:

- Inconsistent follow-up of mothers...peer counselors often wait for the mother to call them if they are experiencing problems, but the reality is that women rarely initiate contacts (Kistin 1994)
- Inadequate training and supervision (Dennis 2002; Bronner 2001; Giblin 1989)
- Poorly defined job descriptions (Bronner 2001; Giblin 1989; Kistin 1994)
- Inconsistent record-keeping and poor evaluation process (Bronner 2001; Giblin 1989; Kistin 1994)
- Among low-income peer counselors, the limits of their own stressful life as a low-income woman (Merewood 2003; Bronner 2001; Kistin 1994)
- Low retention rates, stemming primarily from peer counselors taking other jobs, having limited time, or having another baby (Dennis 2002; Lawrence 2002)

Interestingly, the high turnover rate among peer counselors can be directly attributed to the success of the program. Dennis (2002) found that the very process itself of training and empowering peer counselors often results in improving the self-esteem of the peer counselor herself, who finds during her growth as a peer counselor that the contribution she is making to the lives of her peers results in improvement of her own sense of self-efficacy and empowerment. The critical turnover rate among peer counselors occurs, however, not because they were dissatisfied with the program, but because they had achieved sufficient self-esteem to realize they could indeed enter the work force and become a productive member of society (Lawrence 2002).

Hiring low-income peers from within the disadvantaged population, while another successful feature of many peer counseling programs, also poses many unique challenges. Merewood (2003) describes the experiences of Boston Medical Center, which implemented a hospital-based peer counseling program to provide telephone support for new mothers, matching mothers with peer counselors based on ethnicity, primary language, and skills/needs. The model had to be revised, however, when numerous problems arose, including peer counselors consistently not completing required paperwork and not attending staff meetings at the hospital, and excessive time required by supervisory staff to track and monitor their work. The revised model required peer counselors to actually conduct their work onsite at the hospital, but this, too, posed challenges, including the inability of mothers with children to work away from home, and hardships posed by their low-income life, including lack of childcare and transportation, housing problems, and family stresses, all of which contributed to unreliability of peer counselors. The hospital began recruiting older, more stable women, and began nurturing the peer counselors, providing assistance and connecting them to service programs that could help.

## Recommendations for Peer Counseling Programs

In a randomized control trial conducted in Toronto, Ontario (Dennis 2002), peer counselors offered recommendations to improve retention and make their jobs more meaningful. These include:

- increase the amount of training they receive, including periodic updates to maintain and increase their knowledge level;
- establish a recognition program to recognize accomplishments of peer counselors;
- provide social interaction opportunities to interface with other peer counselors and share experiences;
- ensure that the mothers they are assigned to truly *want* peer support; and
- disseminate positive results of the efforts being made by peer counselors

To improve peer counseling programs within WIC, Bronner (2001) recommends the following strategies:

- initiation of a Peer Counselor Certificate Program to help with recruitment and training, allow for benefits, and improve the settings in which peer counselors could be used;
- provisions for transportation and childcare for peer counselors in training and work settings to limit financial stresses and to encourage more home visits with WIC clients;
- strategies to incorporation of peer counseling into hospital and clinic settings; and
- development of partnerships with local community colleges to certify peer counselors seeking degree programs in allied health fields to avoid repeat coursework, to assist with data collection, and to assist in grant-writing to meet peer counseling training certification and employment objectives.

\*\*\*Peer counseling literature lacks studies using experimental design. The US Preventive Services Task Force of the Agency for Healthcare Research and Quality found ‘insufficient evidence to recommend for or against peer counseling used alone and initiated in the clinical setting’ (US Preventative Services Task Force, 2003).

# RESEARCH FINDINGS

## OVERVIEW

This section summarizes the research findings. The findings are divided into six main categories: (1) Current WIC Peer Counseling Programs; (2) Discontinued WIC Peer Counseling Programs; (3) Never Initiated WIC Peer Counseling Programs; (4) Peer Counselors; (5) Non-WIC Peer Counseling Programs; and (6) Peer Counseling WIC and Non-WIC Curriculum Assessments.

## CURRENT WIC PEER COUNSELING PROGRAMS

### Overview

Interviews were conducted with 10 States and 4 ITO's that currently run peer counseling programs. Most of the current WIC peer counseling programs recognize the benefits of the program and perceive peer counseling as having a positive impact on breastfeeding rates. The following sections summarize the structure and management of peer counseling programs as described by the State and local level administrative WIC staff. This section also highlights the issues encountered in managing and sustaining these programs. Recommendations and suggestions for successful peer counseling programs were captured and reported in the following sections.

### *Administrative Perspectives*

There is little consistency in how programs are administered. In some States, programs are administered by a coordinator at the State level. In others, local breastfeeding coordinators administer the program, and in yet other States consortia may be involved in grant writing and decision making. The lack of a current Federal mandate to fund or endorse peer counseling programs is valued because of the flexibility it allows. Most States have had peer counselor programs of some kind for the past 10-15 years but they have not been a priority for funding. What has been mandated is a breastfeeding promotion program with State and local breastfeeding program coordinators. Each State and local agency therefore must have at least these positions funded. Each of the interviewed States assigned these positions/titles to WIC certifiers (CPAs), International Board Certified Lactation Consultants (IBCLCs), or administrators. In the States where the program is coordinated at the State level, interviewees had better access to information on funding sources, budgets, personnel, hours worked, training provided, and clients served.

### *Internal WIC Barriers to Integrating Peer Counselor Programs with Community Partners*

Integrating peer counseling programs with other community partners is seen as necessary. Productive partnerships with hospitals and other community groups are the norm. None gave dramatic examples of negative experiences working with other community partners. Some of the barriers that were identified were lack of staff time to build and sustain relationships, concern about liability, and peer counselors' limited transportation options.

### *Barriers and Motivators to Implementing and Sustaining Peer Counseling Programs*

Lack of funding is one of the key barriers to implementing and sustaining peer counselor programs. Two interviewees mention special funding as one of the motivators for implementing

the program. Other barriers to implementing a program are: limited staff time, limited trained staff, low caseload of breastfeeding mothers, small agencies, large rural communities, language barriers, shift in priorities, inadequate peer counselor recruitment and retention, and limited or inadequate supervision of the peer counselors.

#### *Factors Contributing to Success*

All of the coordinators are proud of the accomplishments of the peer counseling programs in their States. Factors perceived to have contributed to success include:

- integrating peer counseling programs into the breastfeeding promotion effort;
- standardized and timely training for peer counselors and other staff;
- leadership;
- administrative support;
- appropriate supervision;
- adequate funding of breastfeeding coordinators;
- retention of peer counselors; and
- ongoing funding.

#### *Training Needs - Staff*

Staff in all of the States interviewed are provided with basic breastfeeding information and counseling skills training. This training was one of the few consistent factors mentioned. The method for training varies from State to State. One State has modular continuing education. Some have regional or statewide training and others have local in-service trainings. Some States provide Certified Lactation Counselor training for breastfeeding coordinators and CPAs. Some States hire IBCLCs as consultants or breastfeeding coordinators. The requisite skills for the breastfeeding coordinator are the same as those required of a peer counselor, but also include a more advanced level of knowledge, administrative skills, 3-step counseling skills, and lactation management experience.

#### **Perceptions of Peer Counseling**

The most commonly used word to describe peer counseling by WIC State and local administrative staff is “support,” referring specifically to peer counselors giving support to breastfeeding moms. Peer counseling is seen as filling a unique and vital role in the WIC Program. Peer counselors provide the kind of support that health professionals and other staff are unable to give to women with questions or problems related to breastfeeding. Often this is due to time constraints on the part of the other staff members. Many staff feel that peer counselors are “beneficial” in assisting WIC clinic staff with client flow.

*They are just there to kind of fill in the blanks for what the program can't provide for that participant in terms of support...following up with families in between WIC appointments...that missing link that we don't necessarily have in our day-to-day flow.*

*Support. Well, that's ideally what they do. Emotionally, and technically, and physically, all three.*

The ability of the peer counselor to provide effective support is directly related to how much the breastfeeding mothers can identify with them.

*Just finding somebody who can support you, who is like you. Having an extra friend in a special area.*

*Talking with another mother that you can identify with as being like yourself who has successfully breastfed is a real confidence builder, where mothers are able to say "oh, it's not just the nurses and the nutritionist and WIC staff who can breastfeed. It's other people like me who can breastfeed." So it's somebody they can identify with.*

*It's much more valid to our mothers if they are receiving the support and the information and encouragement from another WIC mother. It's more like a friendship than instruction.*

According to WIC staff, "influence" and "helpful" are also good terms to describe the effect that peer counselors have on breastfeeding mothers.

*The concept of the peer counselor is that talking with another mother that you can identify with as being like yourself who has successfully breastfed is a real confidence builder.*

*Peers are actually better able to understand and relate to the clientele. Because they have been there and so they are generally a lot more helpful in understanding the position the mothers are in.*

Peer counselors are also seen as referral sources that understand the community and know what community resources are available. A term used to describe this awareness was "familiar." Others thought of the word "friend" to describe peer counseling.

*That word encompasses trust and a solid relationship...if the mom is out there and needs help, she doesn't hesitate to call the Peer Counselor because of that established relationship."*

*It's much more valid to our mothers if they are receiving the support and the information and encouragement from another WIC mother. It's more like a friendship than instruction.*

*Peer counseling was also described by the word "enthusiasm" to describe how motivated, creative, and hard-working peer counselors are and how dedicated they are to helping other people.*

### **The Benefits of Peer Counseling Programs**

Administrators believe that peer counseling programs are beneficial to the WIC Program, clients, and the peer counselors themselves. The most obvious advantage has been improvements in

breastfeeding initiation and duration rates. One State also reports that the program had improved WIC enrollment and participation rates. In addition, interviewees report that peer counselors help reduce work loads for other clinic staff by taking on the time-consuming task of helping mothers work through their difficulties with breastfeeding.

The program also has significant advantages for the peer counselors themselves. Of primary importance is the sense of empowerment that being a peer counselor provides. Learning new job skills and growing professionally and personally through the experience often means that peer counselors have the confidence to go on and find other full-time jobs or return to school. Some also mentioned that personal breastfeeding rates among peer counselors are quite high due to all of the training and support.

*This job gives them the confidence that they have done something worthwhile in their life and they really develop a lot of self-confidence.*

With that self-confidence many peer counselors go on to continue promoting and supporting breastfeeding within their communities even after they leave the job.

### **Program Implementation**

Implementing peer counseling programs requires overcoming barriers. The chief obstacle is maintaining dedicated funding for the program, including funds for staffing and training peer counselors. Programs that began with volunteer peer counselors were especially adamant about the need to begin with adequate funds to support paying peer counselors.

*You have to have a source of dedicated funding that is sustainable, because it does take a good proportion of a supervisor's time at the local level to recruit, train, supervise, and mentor the peer counselors.*

Lack of support from administrative and/or local WIC clinic staff is also cited as an obstacle. This is related to feeling "overwhelmed" with the responsibilities and tasks involved in setting up a peer counseling program.

*Our biggest obstacle was getting started!*

*Sometimes it takes a longer time when you are working with local government in order to establish positions, fill them, and train them. There can be a year delay or more in going through that whole process... And this isn't a very good period to do this, either, because the State and local governments are in really bad fiscal shape. Almost everywhere!*

*Staff are just overwhelmed already. They can't fathom how they would fit that into their program.*

### **Program Structure**

Nearly all WIC Programs currently providing peer counseling services operate as strictly "optional" programs, and are structured and managed at the local level.

*If peer counseling is going to happen, it must be embraced by the local agencies.*

This means that the local agency WIC director, nutrition education coordinator, or other local level administrative officer ultimately determines the need for a peer counseling program in the agency.

Many State offices do provide encouragement for local agencies to implement peer counseling, and are often available for technical support. One State conducted a needs analysis among local agencies to identify factors that contribute to higher breastfeeding rates, and discovered that a modified form of peer counseling through mother-to-mother support (breastfeeding mother "plants" in WIC clinic waiting rooms and prenatal classes to talk about their experiences) was extremely effective at improving the clients' interest and confidence with breastfeeding and, consequently, led to higher breastfeeding rates. The model was then offered to other local agencies for consideration, and ultimately grew into a statewide peer counseling program.

In two of the States researched, the State's central administrative office determines standardized policies and procedures for the program, and local agencies that implement peer counseling must follow those procedures even though staff are hired and supervised and the program is managed at the local level.

A few States indicate that their program began as a small pilot. Once the program was deemed successful, the model was replicated in other agencies.

### **Personnel**

Nearly all of the programs hire part-time peer counselors who work anywhere from 4 to 30 hours a week providing breastfeeding support services to WIC clients. The average peer counselor, however, works around 10 hours per week. A few programs researched provide volunteer staff in some of their local agencies. In three States, programs use WIC clerks as paraprofessionals to provide peer counseling duties as 50% of their job. Two programs provide full-time peer counselors. Some States provide a mix of full- and part-time peer counselors, as well as volunteers, depending on the needs of the local agencies.

A few States report that they also employ IBCLCs as part of their program staff to assist with program coordination and oversight.

One State provides a three-tiered system of peer counselors, lactation specialists (more highly trained peer counselors), and IBCLCs (for high risk management). All three levels of staff work part-time, although lactation specialists typically work between 20-30 hours per week.

*If you just have peer counselors that's asking an awful lot of them to handle high risk situations. And if you just have lactation specialists, well, the majority of the moms don't necessarily need a lactation specialist. They may just need a peer to talk with to help them get through the majority of the stuff that goes on in those first couple of weeks of nursing. And then sometimes you have a situation where you really need a lactation consultant. With the tiered system you have a team of people who can cover the needs of that county.*

## **Program Coordination**

Virtually all of the peer counseling programs interviewed provide peer counseling services at the local agency level. Most States report that while the State office encourages peer counseling and provides technical support, decisions about starting a program and day-to-day coordination are managed by local agency staff, usually the local agency breastfeeding coordinator.

In a few States, a peer counselor coordinator manages the program at the local or regional level as her primary job.

In two programs, the WIC Program has formed a partnership with the State's Cooperative Extension Service. In both States, the Extension Program handles the day-to-day administration and coordination of the program, while the WIC Program assists with funding and often handles the initial training component.

## **Program Funding**

### *How States Pay for Peer Counseling Programs*

State and local WIC agencies use a variety of means to fund their peer counseling programs, ranging from federal allocations to grants and local level endowment or assistance programs. In at least one local agency breast pump companies assist in paying expenses associated with sending peer counselors to training. Two of the States researched collaborate with their State's Cooperative Extension Program. None of the other States researched fund their programs through collaborations with other organizations. One agency is funding its program through a DHHS "Community Demonstration Grant" awarded to implement the DHHS/Ad Council National Breastfeeding Awareness Campaign.

Many of the programs are funded through the State's required percentage of nutrition education funds that must be spent on breastfeeding promotion and support. These States then allocate a portion of those funds to local level agencies that would like to implement peer counseling, and are usually divided based on funding formulas designed by the State. Funding formulas are typically based on such factors as the ratio between numbers of pregnant and breastfeeding women and numbers of peer counselors, breastfeeding rates among WIC clients in the local agency, and breastfeeding promotion program plans of the local agency. One State reported that some of their local agencies use the funds for peer counseling, and other agencies use their allocation for other breastfeeding promotion activities and use volunteer peer counselors instead.

Several programs noted that they are funded through *Operational Adjustment Funding* allocated through the regional USDA offices, or through USDA's *Operational Assistance Fund*, which they report allows them to use a category of unspent moneys left over at the end of the fiscal year.

### *Concerns about Funding*

Most program staff indicate that funding is a major issue due to instability of funding levels and that there is "never enough" to cover peer counselor salaries. States report that their annual federal allocation amounts vary due to WIC caseload variability and that regional funds are also

unpredictable. States also report that State level priorities often affect the levels of funding available. One State reports that their "Operational Assistance Funds" were diverted one year to expenses of the State's new automation system, and peer counseling funds were not available at all that year. Another State reports that their collaborative program with the State's Cooperative Extension Program was in jeopardy due to other priorities within the Food Stamp Program.

*We are always having to scramble for funds to support the program.*

*We beg all the time. We beg for anything from nursing bras for our moms to just about anything we need. Funding comes from anywhere. Sometimes there's just funding left over, because we didn't spend our supplies, so it's real creative. Every year it is different.*

#### *Reporting Necessary to Maintain Funding*

States using regional funds and *Operational Assistance Funds* indicate that they submit an annual budget and narrative report to reapply for these funds yearly. A few States also mention being required to submit a copy of their Nutrition Education Plan to show how the peer counseling program will be implemented.

#### **Compensation**

Agencies vary dramatically in their compensation policies. Peer counselors in some agencies work strictly as volunteers. Some agencies provide stipends of around \$50/month for following a small caseload of WIC clients. Some peer counselors are given gift certificates to Wal-Mart or a local grocery store because the local agency is unable to enter new staff onto the payroll.

Of those who pay hourly rates to peer counselors, there are many variations, as well. Some staff are paid through the Cooperative Extension Service and work as full-time employees. Most, however, work part-time at pay rates equivalent to entry-level WIC clerical positions, or at or around minimum wage of approximately \$5.50 to \$7 per hour, although one agency reported its peer counselors, employed as part-time community health workers, were paid \$17/hour. Some are employed as employees of the city or as community health workers. Others are hired as contractual employees or paid through a temporary payroll service.

One program provides a three-tiered system of staff, paying peer counselors \$6.50/hour, higher trained lactation specialists \$9.50/hour, and board certified lactation consultants \$11.50/hour.

Others form of compensation are also offered. A few programs provide travel allowances to staff. Some provide a stipend for reimbursement of phone charges, or a training and continuing education stipend. One agency provides incentives in the form of small stipends for numbers of WIC clients who breastfeed exclusively to three and six months and are followed by peer counselors.

One Indian Inter-Tribal Organization (ITO) is piloting a "fee-for-service" arrangement, paying peer counselors \$5 for every contact they make with WIC clients. The fee will include time spent on the contact as well as doing the required documentation. At least one other State agency is also interested in exploring a "fee-for-service" compensation program, providing a set fee for hospital visits, home visits, telephone consults, etc. Both of these agencies believe this type of system will simplify the pay system, encourage more contacts with WIC clients, and will

be easier for peer counselors to keep up with than tracking minutes. Also, the ITO reported that tribal compensation policies made current hourly wage structures cumbersome.

Despite the wide variations in compensation, nearly all programs are unanimous in their belief that compensation programs are not adequate and that peer counselors need to be paid more. Many report that peer counselors often go "above and beyond the call of duty" due to their dedication to their clients and their passion to help mothers with breastfeeding.

*Some of our peer counselors go way over and beyond the call of duty. There must be a better way of recognizing that, and somehow increasing their stipend to the ones who go over and beyond the call.*

*I really wish they could be paid more. I wish they had more opportunities to personally learn and grow more. We don't right now have a system where they can move up, including salary wise, and it's important for them to grow personally and professionally.*

*When we are paying \$5.50/hour and most peer counselors work 10 hours a week, they honestly can make more at McDonald's.*

Several indicate they would like to see a fair and equitable system that allows for employee benefits, as well.

*I think [name of State] does a lot. Would I love to do more? Of course. I think they [peer counselors] have an important job, and I would love to be able to offer them some type of benefits. I have staff who have worked here for 5, 6, 7, 8 years. I would love to be able to offer them inexpensive healthcare insurance and other benefits.*

A few indicated they would prefer to see peer counselors mainstreamed into the State personnel system so that peer counselors would be permanent positions.

Despite the universal feeling that peer counselors should be paid more, some programs report that they must be careful with compensation packages as peer counselors who depend on such government program benefits as WIC and Food Stamps may no longer be eligible.

## **Recruitment**

### *Who Hires the Peer Counselors?*

In most States the local agency or local health department hires peer counselors. Some believe this is important because the local staff know the WIC clients well and can ascertain potential peer counselor prospects within their community. On the local level, it is often a nutritionist or a clinic breastfeeding coordinator involved with hiring. In States where WIC and the Cooperative Extension Program collaborate to provide peer counseling, it is a local county extension agent that is involved in recruiting and hiring peer counselors.

Aside from local agencies, peer counselors are also hired by a variety of different levels of staff, including regional or district wide breastfeeding coordinators, a peer counselor manager, or even a State level breastfeeding coordinator or WIC director.

#### *Identifying Potential Peer Counselors*

Peer counselors are generally recruited from among the current WIC caseload of clients. This includes referrals from local WIC clinic staff, as well as county extension offices in those States providing collaborative programs, as well as job notice flyers and posters in the clinic or local community settings such as grocery stores, churches, laundromats, and other locations. In States where large numbers of peer counselors are employed, the peer counselors themselves assist in identifying potential peer counselors from among their own caseload of breastfeeding mothers.

If the WIC caseload does not reveal clients who are prospective peer counselors, staff will go outside the WIC setting to recruit from the community, including referrals from local providers, or advertisements in local newspapers.

### **Peer Counselors**

#### *Definition of a Peer Counselor*

Most WIC Programs currently providing peer counseling programs define a peer counselor as a WIC client with personal breastfeeding experience who wants to help other mothers enjoy a positive and successful experience with breastfeeding. Most programs are in general agreement that the definition of a "peer" is someone from the same population group as the WIC client service area. Peer counselors come from a variety of backgrounds. Some are older counselors with older children who have been with their respective programs for many years; others are younger mothers. Some are college graduates; others have only finished a GED. Peer counselors also represent many ethnic backgrounds and cultures.

*A peer counselor is a mom who has successfully breastfed her own baby and wants to help other mothers to have a good experience with breastfeeding, who wants to be there for them to give them information and encouragement and support so the mom can be as successful as she would like to be in nursing her own baby.*

#### *Similarities with the Population Group*

Current programs are generally in agreement that the "ideal" peer counselor is a WIC client who shares the same ethnicity, age, and cultural background as the women she is counseling. Programs that employ peer counselors from a variety of backgrounds try to "match" their counselors with the WIC participants to encourage a strong relationship.

While all programs attempt to recruit and hire peer counselors from the population group served by WIC, many do not believe this is an absolute requirement, as long as peer counselors can adequately empathize with the mothers. Many believe that peer counselors can be taught basic information about the WIC Program, as long as they have the ability to understand and relate well to women.

*Okay, I think it's really important to tell you the truth. If you can only have a couple of peer counselors, then I think it's better to have that mother-to-mother support, whether or not you are of that ethnicity or not. It's better than not having any support at all. But if you have a choice, I think it is nice to match the moms up with not only language, but also culture.*

*I think it makes their job easier being familiar with the [WIC] program, but I don't think it would stop them from making a good example.*

The following similarities are found to be the most important in recruiting and hiring peer counselors in the WIC Program:

- Age...particularly in dealing with adolescent mothers.
- Ethnic background. Some programs believe being a part of the community and sharing ethnicity is more important than currently being or having been a WIC participant. Ethnicity was also seen as especially important among staff in the Indian Tribal Organizations, who believe clients are more receptive to people who are a member of their tribe.

*Anytime you are trying to encourage someone to do something out of their normal [experience]...and you have someone that is in the same culture or in the same age group, yeah, it's going to make a big difference if they choose to breastfeed or not. I really believe that.*

- Language...particularly in areas of the country where there are high populations of Hispanics.

Programs are divided in their opinion of the importance of sharing the same socioeconomic status.

*We require folks to come from the population we are serving. That is what makes them peers. That is what makes them understand the problems of the population because they had experienced them themselves. To me it's critical because you get people who are too professional who come across as, you know, 'I'm here to save you,' which, unfortunately, is not uncommon, and they can't identify with the population. They can't identify with problems of getting childcare or paying bills this month, or working two jobs just to make ends meet.*

*Economically do they have to be a true peer? I don't think so. I think if she is enthusiastic and she's got good communication and listening skills, she doesn't have to be making the same kind of money.*

### *Criteria for Effectiveness as a Peer Counselor*

Current programs are fairly unanimous in their agreement of the most important criteria to consider in hiring peer counselors for the WIC Program:

#### *Previous Breastfeeding Experience*

All programs believe that previous breastfeeding experience of the peer counselor is critical. Even the WIC/Cooperative Extension collaborative programs, which hire paraprofessionals as full-time employees of the County Extension Program, look for staff who have personally breastfed. Nearly all WIC Programs require peer counselors to have personally breastfed one infant at least six months, as they believe this helps them better relate to mothers with breastfeeding issues beyond the early postpartum period. Several programs indicate that they do not require a mother to have breastfed without problems, and that, instead, they believe peer counselors who have overcome challenges are especially effective in helping mothers work through difficulties. The key is how mothers feel about their breastfeeding experience, ultimately, not how enthusiastic they are at the beginning.

#### *Passion*

All programs believe that being enthusiastic about breastfeeding and having a "passion" for helping other mothers are the most important criteria for a successful peer counselor. Women who are enthusiastic and passionate are viewed as highly motivated to be available to mothers through the difficult times.

*I want to see enthusiasm, that they are truly, truly enthusiastic about it, because if you get a person that's really enthused about breastfeeding, they are going to reflect that while they are in the clinic, and it's...contagious. Everybody catches on to it!*

*We have found our most successful peer counselors are the ones who are already doing this on their own. They are already running into moms and sharing their experiences and telling them, 'Oh, you should consider breastfeeding because it was so wonderful for me.'*

#### *Communication Skills*

Most programs also look for peer counselors who are able to relate well to people, who are good listeners and able to communicate well. Being bilingual is viewed as an extra bonus in some areas of the country where there are large numbers of Hispanics.

*I want someone who is enthusiastic and is a good communicator and a good listener. If they are just going to yak at the moms, I mean, I don't necessarily need someone who can talk nonstop. They need to be able to stop and listen, too.*

#### *Important Factors for Hiring Peer Counselors*

In addition, program administrators frequently mention other important factors to look for in hiring peer counselors, including:

- ◆ Current or previous WIC clients
- ◆ Access to transportation (for making home or hospital visits, delivering breast pumps, and going to the clinic for staff meetings or to provide counseling in the clinic setting)
- ◆ Access to a working telephone
- ◆ Flexibility to be available to clients 24/7
- ◆ Hold high school diploma or GED certificate

One State providing a comprehensive Statewide peer counseling program provides three staffing levels: (1) Peer counselor (who must have at least six months of personal breastfeeding experience); (2) Lactation specialist (who must have a 4-year degree and at least one year of personal or clinical breastfeeding experience); and (3) Lactation consultant (a board certified lactation consultant – IBCLC).

### **Peer Counselor Job Responsibilities**

Peer counselors provide counseling to WIC mothers in a variety of ways. Some common practices include telephone calls, home visits, hospital visits, and/or one-on-one sessions at the WIC office. Depending on the WIC agency at which they work, peer counselors offer clients at least one of the above practices or a combination of them.

*Mostly, telephone calling, one thing is, if a client calls them and they are in the hospital needing help, they will go and assist them.*

*...they are assigned to certain WIC clinics so they go. They are supposed to go to these WIC clinics. How we have it set up is that most of our clinics have a day either morning or afternoon when they see a lot of pregnant women and they are enrolling them in the program as initial pregnant women. That is an opportunity they have to go to the clinic and try to recruit to all these pregnant women in the waiting room.*

*I'd say 75% of the counseling occurs in the WIC clinics. The other 25% would either via the telephone or through home visits.*

*Well, the first one is to meet with pregnant moms often at WIC clinics if that can't happen for some reason, our peer counselors would make phone calls and would possibly try to get together with them at some point. Either meet with them at the office, or meet with them at their home...*

However, the most common practice among peer counselors throughout WIC agencies tends to be telephone calls to WIC mothers.

*...every month, they will get a list of pregnant women to call and set up a relationship with these moms, new moms to be, and introduce themselves, that they are going to be there for them, by telephone only. They don't go out to any sites, they don't go to the hospitals or anything like that. It's just telephone support.*

WIC administrative staff disagree on their preferred and most effective methods to provide peer counseling. Some staff feel the telephone calls are sufficient. Others feel a combination of telephone calls and face-to-face counseling is the most effective method, whereas some do not feel telephone calls have an impact.

*I think when the peer counselors are in the clinic is the most effective way. And I think home visits are also effective. I'm not so sure about telephone counseling and how much that really helps.*

### *Breast Pump Program*

Peer counselors also participate in the breast pump program. However, the level of involvement varies by agency. In some States, peer counselors are only responsible for informing mothers of the availability of breast pumps. In other States, peer counselors are responsible for calling the mothers utilizing breast pumps and offering them tangible support. Some peer counselors are in charge of the cleaning and tracking of breast pumps. In a few instances, peer counselors are responsible for issuing breast pumps to WIC clients.

*Well, they are supposed to be notified when a mom picks up a pump if she picks it up from WIC. Then she needs to call that mom every two weeks to be sure she is actually using the pump and just stay in touch with the mom in case she has any questions or concerns.*

*Our peer counselors are able to instruct a mother how to use a breast pump ... if she is having a breast pump difficulty or a breast pump issues. They can help to troubleshoot some of that over the phone. But they do not issue breast pumps. Only our lactation specialists do.*

*Also, in most of our agencies the peer counselors are responsible for distributing pumps, both manual and electric and to explain the use of them to mothers.*

### *Support Groups and Classes*

Some peer counselors attend breastfeeding classes to introduce themselves to the mothers, while others actually conduct the breastfeeding classes. At some agencies peer counselors teach prenatal, breastfeeding, and/or nutrition classes.

*They will assist in teaching classes on the advantages of breastfeeding and the management of normal breastfeeding experiences.*

In a few agencies, peer counselors also run support groups for pregnant and/or breastfeeding mothers.

*When mother support groups were held here they were facilitated by peer counselors but there was always a lactation specialist present. But we did allow the peer counselors to prepare those meetings and facilitate them.*

### *Education and Support*

Peer counselors help clients understand what breastfeeding is, why it is important, and its advantages and disadvantages. Peer counselors talk to women about breastfeeding to inform them and help them through problems. Some topics that peer counselors address include latching, soreness, positioning, and milk supply.

*They provide obviously basic encouragement, information on positioning and latch. Things like how to know if your baby is getting enough. They do basic counseling.*

*They will address concerns, specific concerns of expectant mothers; they will correct any misinformation, which may prevent a pregnant woman from breastfeeding. They will learn techniques for approaching pregnant women while breastfeeding without making them feel defensive or inadequate. They will share motivational materials with pregnant mothers when peer counseling is initiated. They will counsel pregnant and breastfeeding mothers on a one-on-one basis, they will enable new mothers to avoid breastfeeding problems.*

### *Availability*

Some agencies expect peer counselors to be available to the mothers 24 hours a day, 7 days a week.

*Mothers have her number and they are able to call her at any time if they have a problem...Our staff are considered on call 24/7.*

*The participant knows that they have peer counselors' phone numbers and they can call them at any time that they need the help.*

### *Number of Client Contacts*

All WIC agencies have their respective ideal protocols for when and how often a peer counselor should make contact with a prenatal or postpartum mother.

*Ideally, the model is that they are suppose to contact each of their [clients] during the early part of the pregnancy once a month. During the 8<sup>th</sup> month, twice, during the 9<sup>th</sup> month once a week, to give encouragement, support... help the clients overcome barriers to breastfeeding and whatever information is requested. And then, it's sort of the reverse of that once the baby is born. We ask them to make two calls during the first two weeks. Two calls each, during each of the first two weeks. Then once a week up to 8 weeks, and then once a month beyond that, or more often at their discretion. In other words if they feel like the mom needs extra support or needs extra help there, they are encouraged to call more than once a week.*

*They are supposed to be calling the moms prenatally if they are WIC participants. Then moms get a call around their 7<sup>th</sup> month of pregnancy until the baby is delivered, so maybe a couple of contacts before the baby is delivered. Then after the baby delivers they need to call moms between 2 to 3*

*days after. Then at 7 days and 145 days, one month and then after that 3 months, 6 months, 9 months, and 12 months.*

However, administrators recognize that peer counselor are often unable to make the expected number of contacts due to lack of funding, size of caseload, and/or inability to reach mothers at home.

*But in a lot of the cases we simply don't have the funds to have peer counselors have as many hours as they need and so obviously not all of those contacts ends up happening simply because of the lack of time and the funding part on the part of our peer counselors.*

#### *Breastfeeding Referral to Peer Counselors*

The majority of the breastfeeding referrals to the peer counseling program come from WIC staff. Two methods of providing referrals through WIC are mentioned:

- (1) including peer counselors as part of the normal, routine clinic flow so that peer counselors visit face-to-face with clients to provide education and support; and
- (2) listing WIC clients needing follow-up on an official "Referral Form," which is then picked up in the clinic weekly by the peer counselor.

In addition, peer counselors obtain referrals from the local health department, health clinics, community organizations and/or hospital. Physicians, nurses, and social workers also refer mothers to the peer counseling program. Another common referral method is through previous WIC mothers who in the past have benefited from the peer counseling program; they tend to refer friends to the peer counselors.

#### *Caseload*

There is significant variation in the number of hours peer counselors spend with clients per week and the number of clients for which each peer counselor is responsible. Most peer counselors work approximately 10 to 20 hours per week, with several having full-time positions. As such, caseloads vary from only a few cases to 80 to 90 cases per week.

#### *Paperwork*

Supervisors require their peer counselors to collect certain information from the clients they serve. They record the number of contacts, and type of contact (whether it was made by phone, a home visit or hospital).

*Well, each time there is a new client they fill out a record with basic information about the mom and her WIC number and if she has had children before or if she has already given birth and just basic things she would need from counseling in order to counsel.*

*What we have is a one page, front and back document that becomes part of the client's permanent record...then it has a checklist down the left of the most common things that we talk to moms about like sore nipples, going back*

*to school, multiple births, how to tell the baby is getting enough. And they check off the little box that they discussed that. Across the top of the page...they put the date of the contact and what kind of contact it was, if it was hospital, clinic, home, telephone.*

In addition, some agencies provide peer counselors with forms they can complete as they speak with a mother to assist them in remembering specific personal information about the mother. Other agencies provide peer counselors with a form to assist them in obtaining a sense of how the mom is doing with breastfeeding. Supervisors have made attempts to keep the required form simple and user friendly.

*We have a peer counselor form that we ask for them to keep on each client. We have tried to modify it so that it doesn't require a lot of written documentation. We have listed the common problems, like engorgement or whatever. So they can just check it or date it versus having to write everything out. So we try to keep written documentation to a minimum because we would rather have our peer counselor's time actually be done in counseling versus paperwork.*

#### *Limitations*

Peer counselors refer mothers to professional staff for follow-up when the problems a mother is experiencing are outside their realm of expertise. During training, peer counselors learn about circumstances in which they should refer a mother to professional staff.

*If it's a basic management problem about which she is knowledgeable and can counsel them, she does. And if it's not, she refers them to the lactation specialist.*

#### *Referrals to Community Services*

Peer counselors make referrals to community services for issues other than breastfeeding. However, peer counselors are not trained in making referrals. Most obtain information about services from flyers and by word of mouth, thus generating their own file of community services. Referrals are generally made to WIC, Medicaid, Medicare, Food Stamps, and for birth control, immunization, post partum depression, spousal abuse, food, and clothing. For those who do not make referrals, peer counselors cite reasons including the lack of services in their community and the fact that referrals are made only by social workers.

*"I make referrals if I have a WIC eligible mom who is not on WIC I refer her to WIC. If I have a mom who has more than one child at the WIC eligible age I will try to encourage her to get the WIC for one child and refer her to get commodities for the other. I have referred moms to the State House Shelter and that is a shelter for women who have been abused. I refer moms to the County Independence Agency. I refer moms to the clothing places, whatever their needs are. If I know anything about it I refer moms to whatever their needs are."*

According to administrators, peer counselors are there to concentrate on breastfeeding support and are not required to make referrals to community services. WIC agencies expect the peer counselor to refer the mother to WIC if she is inquiring about other services not related to breastfeeding.

*That's more WIC staff who would take care of things like that. The peer counselors aren't trained, I mean they are basically trained to focus on breastfeeding.*

### *Liability Protection*

In some WIC agencies, peer counselors have liability protection as city, county, or State employees. In some instances, supervisors do not know whether peer counselors are protected.

*I don't know. I suspect they would be covered under the same liability insurance that all WIC local agency staff would be. But I don't know that for sure.*

*I don't think so, because they are volunteers. We do ask them to sign a confidentiality agreement.*

Liability protection becomes a concern to administrators when their peer counseling programs offer home and/or hospital visits to clients.

## **Supervision of Peer Counselors**

### *Who Supervises Peer Counselors*

Program managers report that supervision of peer counselors is usually handled at the local level. In most States, it is a local level breastfeeding coordinator, nutritionist, or lactation consultant or "specialist" who supervises peer counselors and monitors their work. Several program managers indicate that it is time-consuming to supervise peer counselors; one State reports that 25% of the supervisor's time is tied up with supervisory and oversight responsibilities.

Some managers indicate their State agency hires district level breastfeeding coordinators or peer counselor managers whose primary job is to supervise the work of peer counselors, and this works very well. A small number of States indicated that other staffing levels are involved in supervision, including the State Breastfeeding Coordinator, a local agency WIC director, or a private lactation consultant hired to assist. In two States the direct supervision of peer counselors is handled by the State's Cooperative Extension Program through local level county extension agents.

Very few States have standardized supervision and monitoring systems in place. Most States allow local agencies to set their own policies and procedures.

### *Ways Supervision Occurs*

States provide similar ways of supervising the day-to-day operation of the peer counselor program:

### *Monthly Staff Meetings*

Nearly all programs rely heavily on monthly staff meetings as an opportunity to touch base with peer counselors and discuss their work. Monthly staff meetings are used to share case scenarios and issues that seem to be coming up frequently among staff, as well as to provide ongoing support with one another. Several programs mention allowing peer counselors to bring their infants/children to the meeting. A few programs also report that these meetings are used for peer counselors to turn in required paperwork.

### *Weekly and Monthly Reports*

Supervisors also depend on client contact sheets and monthly reports submitted by peer counselors to identify trends in contacts being made, and to ascertain whether appropriate advice is being given to mothers.

### *Initial Contact with Peer Counselors*

A few States mention that their most important role as a supervisor is in the early days of the peer counselor's job when she is first learning about her role. Supervisors often make weekly calls to make contact with peer counselors, assess needs, and provide guidance. One State asks peer counselors to work in the clinic setting during the first week of their job so the supervisor can listen to their phone conversations and provide guidance.

*It helps to be able to hear what they are saying and give them advice as far as the information they are giving to clients.*

A few States view the role of the supervisor as a "mentor" during the early days of the peer counselor's new job, teaching her job skills and professional behavior, and guiding her in her new role as a counselor. If a lactation consultant is available to the program, she may also be used in this role of "mentor" to provide ongoing help and assistance to peer counselors.

*They need mentoring. They need support because they are supporting these mothers, especially in this urban population they are going through a lot of changes, difficult life situations, so they need that same type of nurturing that they are providing their mothers.*

### *Support Needed by Peer Counselors*

Program managers are nearly unanimous in their opinion that peer counselors should be provided with excellent initial training from the outset to get the peer counselor off to a good start. They also believe ongoing training with program and breastfeeding updates is absolutely essential. Other common types of support they believe peer counselors need include:

- Access to other peer counselors (deemed one of the most important things peer counselors need);
- Access to a lactation consultant or breastfeeding coordinator for immediate help with breastfeeding questions;
- Regular, systematic contact with their supervisor;
- Affirmation and praise (including recognition that they are doing a good job);

- Positive work environment (with such elements as a work space or desk, supportive WIC staff, a place to pump their breasts during the workday, and, many believe, the opportunity for peer counselors to bring their infant in arms to the clinic setting).

*They like to talk with other peer counselors. It's number one. To see how the other agencies are doing things and hear the other people's experiences. They find out they are not alone with the kinds of things that come up."*

*They need lots and lots of affirmation. It's very demoralizing to sit and call 25 women in a row and have every one of those contacts be a bad experience, either be told she doesn't live there anymore, or 'No, I ain't gonna do that,' or leave a message, leave a message, leave a message, but no one ever returns the call.*

*Without emotional support, they burn out.*

*They need to have the breastfeeding coordinator available to them if questions arise about high risk situations...If the breastfeeding coordinator is not available they need to have access to the State breastfeeding coordinator for questions.*

#### *Program Monitoring*

Most programs provide some system of monitoring, though it is rarely a standardized program. Most program monitoring occurs when supervisors review client contact sheets and monthly reports for insight as to whether the peer counselor is making the required number of calls, or when they ask clients they happen to see in the clinic if they are pleased with the help they are receiving from their peer counselor.

Two States with comprehensive Statewide peer counseling programs provide a structured monitoring system that includes weekly "spot checks" of moms listed on client contact sheets, chart audits to match information documented on contact sheets with information in the client's chart, and formal audit tools to observe peer counselors teaching classes, or providing home and hospital visits.

*With our weekly spot checks, the supervisor will probably look for a mom who maybe the peer counselor spent a lot of time with, and she'll call her and say, 'I'm just calling to see if you got answers to your concerns' to make sure that things were handled well.*

A few States mentioned that they do not provide formal monitoring of the program.

*Monitoring? We don't do a real good job of that, probably...*

*Monitoring is a little bit of a struggle for us. Basically those [peer counselors] who keep in touch with me and let me know about moms who are having problems, I can tell that they are doing their work.*

## **WIC Staff Support**

Most programs report that support from WIC staff at the local and State levels is very positive, and that peer counselors have been welcomed as vital members of the overall WIC team. They report that peer counselors are greatly appreciated by staff and valued for the important role they provide for new mothers.

*We worked as a team. I really wanted their input all the time. I think that was really very important in making the program work.*

Some mention that in the early days of the program, staff are not as supportive. Issues centered on the peer counselor's work habits, including irregular schedules and bringing infants to clinics during their work shifts. Some staff feel that peer counselors are not dependable.

*When I first started in the program it was horrendous. It was like feuding families on opposite sides of the fence. Now, we have areas...where we just implemented the program, and the clinic staff are so glad to have lactation staff people that they would hrow a party for them every day if they could.*

*They (WIC staff) resented the hours the breastfeeding staff worked ... none of them are required to go sit in the clinic from 8:00-5:00. Some of them thought they have this cushy job and they get to home whenever they want. But they are also on call 24/7, and many staff don't realize that means getting calls at 11 o'clock at night or 2 o'clock in the morning.*

*These really are great jobs. They are fun. I mean, you're working with moms and you're working with babies, and you work a lot with the community and with the breastfeeding networks in your community. It's a very creative job.*

Other programs report that some staff are suspicious of new programs because they have seen many public health programs come and go due to unstable funding. One State mentions that the staff themselves have some of the same barriers to breastfeeding that the mothers do...lack of time, embarrassment, and lack of social support.

Most of the program representatives say that in time, however, staff have come to appreciate the role of peer counselors, but that it does take time to build trust in the program.

*They really look at the peer counselors as being a really important part of the team. And it probably wasn't always that way, but after ten years, that's how it is.*

*They are part of our WIC family. We take them under our wing and treat them just like they are part of our team.*

### *Strategies for Building Teamwork with WIC Staff*

A number of suggestions are offered by current programs as ways to improve the relationship between peer counselors and local WIC staff. These include:

- Training peer counselors thoroughly in WIC issues so they can make appropriate referrals to WIC staff (regarding such issues as immunizations, WIC enrollment or food voucher pick-up, etc.). This includes bringing peer counselors in on routine WIC staff meetings and in-service trainings.
- Keeping staff informed of what the peer counselors did with the referrals made and how the client is doing.
- Teaching staff about the importance of breastfeeding, or even including staff in the general peer counselor training program so everyone will be providing consistent information.
- Educating staff about the role of mother-to-mother support in improving breastfeeding rates, as well as about the peer counselor's actual job duties outside the clinic setting, i.e., being on call 24/7 even on holidays and weekends.

*It's also the responsibility of WIC staff to promote breastfeeding and help the client with any problems, making her feel very comfortable that she can come to any of us.*

*(We encourage the peer counselors) ... to not just follow up with the mom, but to call the staff person back and say, 'Thank you for that referral. I called the mother and this is our plan.'*

### **Partners**

Most peer counseling programs have partnerships with the following organizations:

- Breastfeeding Coalitions or Taskforces;
- La Leche League;
- OB clinics;
- Pediatricians' offices; and
- Extension Services.

Some agencies have also established other partnerships, including:

- Midwives;
- Middle schools and high schools;
- Community churches;
- Day care centers;
- Diabetes programs; and
- Local businesses.

All of these partners are used in a variety of ways but most often for referrals to the peer counseling program. Partners are invited into the WIC office to talk to breastfeeding mothers, to aid in the training of peer counselors, and for collaboration during World Breastfeeding Week. Many agencies participate in health fairs, which are a great opportunity to identify potential partners and increase community awareness. Keeping potential partners informed of the role and purpose of the program enhances future buy-in from the community and referrals.

*Sometimes we've worked with a La Leche League coordinator. She also happens to be a lactation consultant at a local hospital.*

*There may be midwives in the community, or mid-wifery services that there will be a relationship.*

*Well we have the Breastfeeding Coalition which are members of the health department and of WIC. We have a unique Breastfeeding Coalition in this area that is pretty active.*

*Besides the hospitals, we let OB and Peds offices know what we are about, really anybody who is going to interact with our clients, we want them to know what it is that we do so they will refer us for that.*

## **Hospital**

The most successful referral systems with hospitals seem to be those in which the peer counselor can go into the hospital to talk to mothers right after giving birth or when the hospital notifies the WIC Program of any new mothers. Although there are various difficulties in establishing partnerships with hospitals, those that have them feel they are among the most important components to a successful peer counseling program.

*That's the nice thing about being in the hospital that you know when the moms are delivering. You are able to help them right away whereas before when we weren't in the hospitals it was just like hit and miss.*

*We've developed relationships with a lot of hospitals and we are working on a referral guide. So hospitals know contact information for WIC clinics and WIC clinics know contact information for hospitals, the lactation people there, just to work on improving communication in general.*

Frequent contact and outreach are essential to the effective collaboration between peer counselors and hospitals. Peer counselors who work in the hospital usually are able to establish a good relationship with the lactation consultant and the nursing staff at the hospital. Peer counselors have to participate in various training programs required by the hospital before they are allowed entry.

*I know the hospitals have our peer counselors going through orientation once they do come on board. They go through safety orientation, CPR, and Infant CPR.*

*What we do is every year we send the hospitals and their physicians outreach letters where we tell them what the WIC program is all about and how the breastfeeding is working.*

*Well we spoke to the lactation consultant that worked at the hospital who runs their lactation program and she was able to help us.*

A lot of hospitals do not have a lactation consultant on board or do not support breastfeeding in general. Another barrier to these partnerships is having to continually re-establish every time there is staff turnover in the hospital. It is important to the relationship that WIC keep reminding the hospital staff of the importance of breastfeeding and what the peer counseling program is all about. It needs to be constantly advertised and marketed to the hospitals to keep the relationship fresh.

*It's just hard to get them in the hospital because you have lots of barriers to break down with hospital policies.*

*They don't really do it through the hospitals unless they're like teaching a class there.*

*We used to...but he is no longer there so they have a new charge nurse so we just need to go in and introduce ourselves and try to get that established again.*

As stated above, the ideal referral system is one that gives the birth information to the WIC agency and to the peer counselor as soon as possible after delivery. There are various methods suggested for how to accomplish this, including a daily or weekly listing of the mothers who have given birth to be provided by the hospital. This can be e-mailed, faxed, or phoned to the WIC agency. In hospitals where the peer counselor is allowed into the hospital, she would get a listing.

*We get referrals for those moms who are having difficulties or who need pumps. But if there were some sort of system either written or by telephone that we could get information about so and so came through here. Here's her phone number, yes she was breastfeeding. That might be of good assistance to her.*

*When we are working optimally the mothers know before they get to the hospital who they need to contact and most of them do contact their peer counselor or their lactation specialist within the first two weeks postpartum.*

*Well, we partner with hospitals where they sponsor the trainings...I think the ideal would be that when a pregnant woman who is enrolled in WIC enters the hospital in labor that the hospital would contact us to say the woman is there and having her baby soon.*

## **Training Curriculum**

Among WIC Programs currently providing peer counseling programs, there are a wide variety of curriculum materials in use. Most have developed their own curriculum, contracting with a private lactation consultant or utilizing breastfeeding experts within their State and local regions. Many of these were developed after State officials reviewed existing peer counseling curricula being used by other WIC Programs, and adapted them to meet the needs of their State. Several States indicate they simply use the curriculum program of another WIC agency.

### *Core Components of the Training Program*

#### Management Curricula

Most States do not have a curriculum program specifically designed for managers; however, some provide scheduled training events to go over how to teach their State's peer counseling curriculum. Only two States mention that they provide a manual for managers that primarily includes information on how to teach the peer counseling training. One program mentioned providing a State level training in the State Office to teach its State's curriculum for peer counselors, and to answer questions that local staff might have about starting a peer counseling program. One State also mentions sending program supervisors to a La Leche League formal peer counselor administration program.

#### Peer Counseling Curricula

Most programs report they provide formal training for peer counselors, as well as a manual for peer counselors to use as a reference. Several also commented that they expect peer counselors to supplement the formal training with self-study readings from La Leche League's *Womanly Art of Breastfeeding* or *Breastfeeding Answer Book*, or other selected readings. One State created an exam with short tests to take at the end of reading each chapter of the *Womanly Art of Breastfeeding*, and its peer counselors are not able to charge for their reading time until they turn in the exam.

Another State requires peer counselors to read the State's WIC breastfeeding and nutrition related pamphlets and materials, including videos, so they are familiar with materials to which the clients will be exposed.

Two States include shadowing a lactation consultant or another peer counselor as part of the training process of new peer counselors. In these States, peer counselors observe a home and hospital visit, along with a prenatal class or breastfeeding support group.

#### Length of the Formal Training Program

The length of the training programs varies widely from State to State. Some States provide the La Leche League "model" of a 20-hour, 4-day course. Others consolidate the training into a 1-, 2-, or 3-day course of 8 to 14 hours. Still others prefer to break down the classes into small 2-hour lessons taught over 6-10 weeks.

### How Trainings are Delivered

Nearly all of the formal training programs are delivered at the local level, due to transportation and childcare issues of peer counselors, although a few States have also conducted regional-based trainings. Many of the States indicate that because the numbers of peer counselors being hired are usually quite small (1 to 5) they open the training events to other WIC staff and community partners such as hospital and private clinic nurses, Early Head Start program staff, and other related groups. Most of the trainings are offered two or three times a year; some are provided quarterly.

Several States also mention providing State or regionally based "train the trainer" events to train local staff on how to deliver the training in their local community. These "train the trainer" events are often scheduled three or four times a year.

### What Staff Like about the Peer Counselor Training

Many staff indicate that they are most pleased by their curriculum's focus on counseling principles, and love the modular format that allows them to be flexible with its use to fit their situation. Other commonly mentioned aspects liked by staff include:

- Discussion questions
- Case scenarios
- Interactive elements
- Comprehensive (all materials needed to teach the training, such as handouts, visuals, and step by step instructions, are included)
- Easy for peer counselors to understand

### Changes Staff Propose

Among the changes staff would like to make to the current curricula used by their State, most mention that they would like even greater emphasis on counseling principles, better discussion of cultural diversity issues, and more interactive and facilitated discussion components.

Several also mention they would like to see the training shortened to only the most important elements peer counselors truly need to begin their job, with more information on supporting mothers *after* initiation (addressing duration issues). Several mention the need to update their curriculum, or indicate they planned to update it soon.

*It's hard for anyone, even our WIC staff, to sit through 8 to 10 hours of peer counseling training. All that knowledge isn't really necessary for the majority of women who have questions about breastfeeding.*

*It's a one-inch thick training manual. That's stupid, because some of it they are never going to encounter, or some of it is something that I've encountered in 20 years of practice...once.*

*Even if we were to provide them with very intensive training, if you're training on*

*something that is not a common issue, by the time it comes up you don't remember what you learned about it anyway.*

### Topic Areas Covered

Program managers interviewed report a wide variety of topic areas included in the training curriculum provided by their State, with a number of common elements to nearly all programs:

- Counseling strategies (with many reporting that they incorporate principles from the Best Start 3-Step Counseling Strategy©)
- Cultural sensitivity and diversity (although several mentioned they only briefly touch on this area)
- Benefits of breastfeeding
- Helping mothers address their barriers
- Basic breastfeeding techniques and management
- Dealing with common problems
- When and how to make referrals
- Completing required paperwork
- Dealing with breastfeeding equipment and devices

Other isolated issues include: helping mothers return to work or school, maternal and infant nutrition, and more detailed information on unusual breastfeeding problems. Only one program mentions including information on getting family support, and none mentions strategies for helping mothers deal with their mother or female relatives.

*The main idea behind our training is to help peer counselors to develop a relationship with the mother, and to encourage her to try breastfeeding.*

### Values

Program managers generally feel that the most important values to impart to peer counselors through the formal training program is how to listen to WIC clients, and how to form a relationship with them.

*They gotta learn how to talk to moms. That's number one.*

### Initial Training Needs

A wide variety of topic areas were discussed by program managers as initial training needs for peer counselors; however, *all* interviewees indicate that an emphasis on counseling should be the most important consideration. One State reports that if they could revise their training curriculum they would place counseling training at the beginning because of its importance. Other commonly mentioned topic areas are:

- Basics of breastfeeding (how the breast makes milk, and simple breastfeeding techniques)

- Dealing with common breastfeeding problems
- Overcoming obstacles/addressing barriers
- Addressing problems impacting duration that are unique to mothers in the local community (including latch-on difficulties, jaundice, and returning to work or school)
- Completing required paperwork

One State mentions the importance of teaching peer counselors organizational skills, and how to balance their job with their home life.

### Ongoing Training

All programs interviewed indicate that continuing education for peer counselors is an important priority of their program for keeping peer counselors updated, motivated, and feeling part of the WIC team.

*I think peer counselors need continual continuing education. They just need to be kept up to speed.*

The vast majority of programs interviewed provide monthly staff meetings with peer counselors and use this opportunity to practice counseling skills through role plays; discuss case scenarios that came up the month before; and provide breastfeeding information updates. Topics vary according to the types of issues that peer counselors report they deal with frequently.

*We really strongly recommend they do a monthly meeting or in-service with peer counselors. Sometimes this might be on a topic in the news. Here it is the Vitamin D stuff we are having to deal with. Or peer counselors might say, 'Oh gosh, everybody is worried now that there are chemicals in their breast milk because they heard something on the news. What are we supposed to do about this?'*

One State recommends keeping the monthly meetings to no more than 1.5 to 2 hours, since peer counselors always bring their babies and children.

Many States also mention sending staff to State level breastfeeding conferences or La Leche League conferences, as well as to WIC staff in-services (such as Civil Rights trainings) and staff meetings. Regularly providing peer counselors with new studies and journal articles is also cited as an important way to help peer counselors update their breastfeeding knowledge. One State indicates that to encourage both WIC staff and peer counselors to work toward the IBCLC credential, they offer a packet of materials on how to prepare for the IBCLC that staff can check out from the Central Office.

*There are all kinds of bizarre situations that can come up. They just need a lot of times a refresher in this information...a refresher and reinforcement.*

Ongoing training can sometimes be a challenge, a few States report, due to other job commitments of supervisors and managers.

*If we trained a new crop of peer counselors right now, I would have significant concern that we wouldn't be able to provide the level of ongoing training that we have been able to do in the past. The 8-week initial training is great, but it's important that they have the continued contact with the breastfeeding coordinator and attend the monthly meetings. We have had to suspend a lot of those meetings in our State.*

### Trainer

Most States indicate that "train the trainer" peer counseling programs for program managers, if offered, are usually provided by State level staff, such as the State breastfeeding coordinator, breastfeeding educator, or peer counselor program manager.

Training programs for peer counselors in most States are taught by local level breastfeeding coordinators, peer counselor supervisors, or nutritionists. A few States mention that they have board certified lactation consultants on staff at the State or regional level who provide the training, or their local agency contracts with a lactation consultant to provide the breastfeeding portion of the training. In the programs that are structured as collaborative programs with the State's Cooperative Extension Service, program administration training is handled by Extension Service Educators.

In one State, experienced peer counselors also participate as trainers to share their personal experiences about being a peer counselor, and to provide encouragement to the new staff. This State also asks experienced peer counselors to bring WIC breastfeeding clients and their babies to the training so the new peer counselors can observe first-hand proper positioning and latch, pumping techniques, and hand expression.

Among the qualifications discussed as important for trainers, the most common is that the trainer be a board certified lactation consultant with up-to-date breastfeeding knowledge. A few, however, feel that being a lactation consultant is not a requirement, as long as the trainer is knowledgeable and can answer the questions that frequently come up. Previous training/public speaking experience is essential. Another important trainer qualification is an understanding of the WIC environment.

*Someone who is personable and who can make it fun and exciting. Someone who understands that peer counselors are not paraprofessionals, and this may be the first formal type of job they have ever had. Someone who can help them feel safe while learning new things.*

## **Curriculum Needs**

States currently providing peer counseling programs made the following suggestions to USDA to incorporate into curriculum materials.

### *Management Curriculum*

Staff indicate they would like information on: (1) how to recruit and support the peer counselor; (2) motivating staff; (3) supervisory skills; and (4) addressing staff turnover/retention issues.

*One of the most important things for program managers to learn is how to nurture and support the peer counselor. They can get burned out very easily, because they are listening to somebody's problems all the time. You have to know how to support them. Listen to their issues, their concerns, their problems, and then help them work through theirs.*

One State would like the curriculum to provide online access to Web-based modules that could easily be downloaded. Another State would like to have "Best Practices" from WIC peer counseling programs already in place around the country.

Another concern is the need for program managers to know the "details," such as how to schedule peer counselors, how many hours they should work, how many clients they should follow, what the best settings are, and working with HIPPA guidelines.

### *Peer Counseling Curriculum*

Most States feel a peer counseling curriculum should provide flexibility so the training can be used in varied settings and situations (for one-on-one training of a single peer counselor to group trainings). States also mention the importance of keeping the training short and simple, with complete step-by-step instructions for trainers, and lots of interactive suggestions for games and activities to keep the training fun and interesting for peer counselors.

*The curriculum should focus on the practical stuff. Role plays. Practice telephone counseling. When to refer to a lactation consultant.*

*There are lots of different curriculums that are available. But I think that if the program wants to be effective what they need to do is look at why are the initiation rates low, and why are the duration rates low? Why do women not breastfeed or quit breastfeeding, and give staff strategies to deal with that.*

Other helpful items include sample tracking forms, reproducible training handout masters, case studies, training graduation certificates, referral cards, and bilingual tear-off sheets for clients.

One State strongly recommends that the program provide both a trainer manual with detailed, step-by-step instructions, and a trainee manual to serve as an ongoing reference for peer counselors. Other States mention the need for the training to be comprehensive...with slides, handouts, and all materials packaged together and able to be reproduced as needed by local agency staff. Another concern is the need for the training program to adapt to different levels of technology...from simple overheads to computer Power Point slides.

Another State suggests that USDA simply replicate their State's curriculum. Several States indicate a high level of understanding of their own curriculum, and prefer to continue using what they have developed.

*I can't think of a thing I would leave out of our curriculum. I would be concerned if they (USDA) came back and said, 'You have to use our curriculum and that's the way it's going to be.' We've used this one for years and it's been real successful for us.*

### **Strengths of the Peer Counseling Program**

Many administrators feel effective recruitment of peer counselors is key to the success of the program. Recruiting directly from the WIC Program assures that counselors are knowledgeable about WIC, represent true peers, and are individuals enthusiastic about promoting breastfeeding.

*They did a really good job of recruiting the right people. People that are really enthusiastic. I think that's really the key to the success is that we've just really had some wonderful women who have taken this work on.*

*I guess the things that work well is that the recruitment is done right through WIC and from WIC participants so that we know who our very committed breastfeeding moms are.*

Another important factor for a program's success is monetary compensation for peer counselors.

*I think the other issues that have added to its effectiveness is that the peer counselors are actually paid staff....I think that has helped the program.*

Continuous encouragement of peer counselors from their supervisors is an essential part of a successful program. Peer counselors need to be recognized as an integral part of WIC by all staff.

*It is very beneficial and we do a lot of innovative programs and encourage and support our peer counselors and the more that we do encouraging and supporting them, the better they are at working with their moms.*

Some programs feel that their ability to have peer counselors at the clinic for one-on-one client counseling has been the key to their success.

*I really think that the strengths of our program are the fact that we talk to the moms one on one. I think that's the most effective way to do what we need to do here.*

Time is another important factor for a program to be successful. According to administrators, an effective peer counseling program requires a full-time person to manage and coordinate it.

*Like I said our most successful peer counselor program was with a district breastfeeding coordinator and that is all she did. She was not a nutritionist. She did not work the clinic. She just came in and actually handled the peer counselor program.*

Another strength of having a peer counseling program is that peer counselors address many breastfeeding problems that would have to be handled by professional staff in their absence. Hence, the peer counselors help free up professional staff time to address breastfeeding problems and concerns needed at their level of training.

*And if you have lactation specialists, well the majority of the moms aren't necessarily going to need a lactation specialist. They might just need a peer to talk to help them get through the majority of the stuff that goes on in those first couple of weeks of nursing or however long they breastfeed.*

The ability of the peer counselors to make contact with mothers soon after delivery is key to a mom continuing to breastfeed. Most of the breastfeeding problems occur in the first couple of weeks. Without a peer counseling program those problems would come to the WIC staff's attention after the mom has already stopped breastfeeding.

*Well I think getting in touch with moms as soon after delivery as possible is really important. So having peer counselors in the hospital is something that has been successful.*

### **Program Sustainability**

Almost all State and local WIC administrators feel the primary issue to sustaining a peer counseling program revolves around money. While initial funding is the catalyst to initiating and implementing a peer counseling program, ongoing funding is crucial for sustainability. Many feel that having guaranteed ongoing funding would help address sustainability issues, such as supervision and retention of peer counselors.

*Right now I would say it's consistent funding for the program. In the past that's why people quit. When they did have a successful program for a few months and people quit because it was a non-reimbursed program. So I know that the reimbursement is going to help a lot.*

*Budget number one. That someone has provided the funding. So it's funding, funding, funding. That's the number one.*

*Well, our very low breastfeeding rate definitely helps sustain the program...I think that helps sustain funding for the program.*

As mentioned earlier, having specific time allotted for the coordination and management of the peer counseling program is important for its success, and the program's sustainability. However, this is not the case for many programs in which WIC employees seem to wear many hats and lack the required amount of time to supervise the program. In many instances, the breastfeeding coordinator is also the nutrition educator for a WIC agency, which leaves her very little time for supervising and running a peer counseling program.

*I wish I could put 100% of my time into that. And I can't. That's the downside to it. Because I have to be able to maintain our clinic load there.*

*The ability of the coordinator to run the program with sending out in a timely manner the prenatal sheets, sending out in a timely manner the postpartum information, maintaining a rapport, as important as the rapport is between the participant and the peer counselor, the rapport between the peer counselor and the coordinator is just as important. So the time to make it happen.*

*Well again I think it becomes very time intensive to do the continual recruitment and even...I think that having sustainable funds is a good place to be but it's also the continual recruitment of peer counselors and the amount of time it takes. I think that can be a problem.*

Buy-in on several levels is important for the sustainability of a program. WIC staff must recognize the vital role peer counseling plays to support the program. Staff can assist the peer counselors by making referrals and promoting the program among clients.

*Having the staff's buy in. Most of the staff's buy in, Because if it just sort of comes in from the outside or the State and the State says okay you have to do this and people at the local agencies really aren't interested, it's not going to work. So they need support from the local agency staff.*

It is also important that the local community support the program. With their support the WIC Program can develop partnerships and utilize community resources to better serve clients.

*I guess one thing is, actually getting them involved in the community too. I think once you get community to buy into it, it's pretty easy after that.*

*I think the accessibility for clients, the fact that they know there is someone there if they have a question and they know how to get in touch with them.*

High turnover of peer counselors can be a major barrier to a peer counseling program. While reasons for turnover are many, one major factor is funding. The inability to compensate peer counselors results in decreased dedication and accountability.

*We have a higher rate of turnover than I would like to see and part of that is related to they are only authorized to work so many hours a week, and the low level of pay. So it makes it difficult for them to sustain that.*

## **Recommendations**

Staff were asked to provide recommendations and suggestions for how USDA and/or other States could establish peer counseling programs in those locations currently not using the model.

Specifically they were asked:

*What recommendations do you have for USDA in designing the ideal peer counseling program?*

*What recommendations do you have for other States that might be interested in beginning a breastfeeding peer counseling program?*

This line of inquiry served to assure that issues explored earlier in interviews had been properly addressed, and to make sure that respondents had an opportunity to clarify or add information they may not have included. Thus, recommendations are embedded throughout the report. This section is intended to highlight the key points regarding the process of establishing and institutionalizing a peer counseling program.

The key staff recommendations fit into four primary categories: funding, skills building, program structure and administration, and support.

Funding is the number one reported priority among staff. The need for long range sustainable program funds, the ability to pay decent, full-time wages to peer counselors, and the importance of funding managerial/supervisory staff who are assigned specifically to manage peer counseling are the key components.

Long range funding is reported as the most fundamental element; it creates a safety net within which new initiatives can be started without the additional stress over whether resources will be available, improves the chances of bringing competent staff and peer counselors into the program, and demonstrates a firm commitment from administrative divisions that is highly valued by State and local agencies.

*Committed funding. Good resources in terms of ways to recruit, train, and retain peer counselors.*

*...Have funding that is sustainable. And if you're going to pay peer counselors make sure that it is there and it's not a threat of not having the money there.*

Paying good wages to peer counselors is frequently cited as a key element.

*I really wish they could be paid more. We don't have a system where they can go up...salary-wise.*

Funding staff who are directly and primarily responsible for managing peer counseling programs is a strong recommendation.

*...maybe she's a breastfeeding coordinator...she's got that hat and it's thrown on to that other hat that she is already wearing. That doesn't work. You really need somebody who is focused on just management of a breastfeeding program.*

*Not just designated on top of her other jobs but designated and dedicated to just that (peer counseling) for the most part.*

Skills-building and professional development is another significant interest among staff. This is reported as important for peer counselors and professional/supervisory staff.

Along with a solid pay structure, peer counselors need a career track and career development structure to help assure high quality services and increase job satisfaction and employee retention.

*I think it's really important for them to be able to grow professionally and personally and not keep doing the same thing...to gain more skills and gain more knowledge.*

*It would be great if...the peer counselors could move into more of a peer counselor coordinator position. First of all to get them more money but also to expand their skills and have a sense that they are learning more and moving.*

Professional staff who work in peer counseling could benefit from professional development. Their new skills would be a direct benefit to peer counseling programs.

*Some of the coordinators had never done anything like that before and I think they would have liked support...knowing things about personnel issues...hiring, firing, managing problems with employees.*

*I think management skills would be important. How to motivate staff, how to cope with federal paperwork. How to deal with the peer counselor who maybe is not doing what you asked her to do.*

Program structure and administration recommendations are consistent throughout the interviews. Staff believe that starting peer counseling as a pilot program in limited sites is optimal.

*I wouldn't start with too many too quickly.*

*Don't start statewide. Start with a pilot program in a few agencies.*

Establishing strong participation and buy-in from staff and administrators is valued.

*Having the staff's buy-in. Because if the State says you have to do this and people at local agencies really aren't interested it's not going to work.*

*It's really important that my administration is on board. Every level needs to be on board.*

Flexibility is a shared value among staff. They know that program elements and personal styles are variable throughout the WIC system and that within any given State or local WIC agency, change is a feature of the organizational cultures in which peer counseling is to be implemented.

*I think they need to look at diversity and flexibility...as far as setting one (a program) up-that is going to require flexibility.*

Flexibility with peer counselors is also cited as important.

*One of the important things they need to consider is that these people are moms and a lot of them really need flexible schedules because some are still breastfeeding and others are either stay at home moms or working another job.*

And a few staff believe flexibility is needed when considering the peer counseling mandate itself.

*I would say that for States such as ours who have already created our own training course to allow us to continue with that. I think the other thing is not to require States to use certain educational materials. If we have already designed our own let us go with those.*

Even though staff want flexible structure in the peer counseling program they also understand that established practice parameters and basic structural continuity are important ingredients.

*How is it going to run? What is going to be considered? Are they part-time? No benefits? How are they going to pay them? Where do they fall in the clinic (structure), supervise-wise...the chain of command?*

*How do they truly see them fitting into the WIC setting?*

*I think we need to provide them with resources and training on all aspects of peer counseling and not just peer counselor training but how to recruit, how to keep them, how to schedule...you have to assure that peer counselors are used appropriately. You would need to create policy and procedures for what peer counselors can and cannot do.*

Patience is a recurring theme that is related to program initiation and structure. As reported previously, using pilot programs as the initial step in program initiation is preferred. Staff among programs that have been through the early stages of developing their peer counseling programs know how complex the transition can be from providing breastfeeding support exclusively through professional staff to sharing that role with an expanded service delivery approach and team. Because of this many staff recommend building patience into new initiatives as a valuable program component.

*Don't expect, necessarily, that your numbers are going to miraculously go up. Maybe they will and maybe they won't. But you are accomplishing things even if your numbers don't (go up). They (peer counselors) accomplish so much more and you've had an impact on individuals who maybe would have stopped after three years and they ended up nursing for a year.*

Staff understand that peer counselors are unique individuals with competing demands. Peer counseling programs embody a unique organizational element that is more weighted to the emotional than the cerebral, and that places significant demands on the psyches of those who

work in peer counseling programs. Thus, it isn't surprising that support for peer counselors is an integral part of successful peer counseling programs and is a common theme among interviewees.

*One of the most important things for program managers to learn is how to nurture and support the peer counselor. Because they can get burned out easily. Because they are listening to somebody's problems all the time.*

Staff recommendations for what needs to be included in a peer counseling program are summarized in this interview subject's comment.

*Well, I'm not sure there is one ideal peer counseling program. It needs to have flexibility. I would like to see something where people definitely have to have a supervisor with qualifications, whether that person is a certified lactation consultant or somebody who is very knowledgeable. I'd like to see something outlined of what people are really going to be doing. I'd like to see the money being long-lasting and not just one year.*

## **DISCONTINUED WIC PEER COUNSELING PROGRAMS**

### **Overview**

State and local WIC Programs highlight issues that contribute to the demise of peer counselor programs in the WIC arena. These issues include funding, lack of State agency support and guidance, and sustaining support of the field staff. Peer programs in these States were add-on programs with no specific funding plan. People who worked in these programs felt that these initiatives were predictably dropped.

Most of the State agencies gave control of the peer counselor program to the local agency for development. The State program did not provide standard training, job descriptions, or funding lines. Most of these programs relied on volunteer peer counselors and experienced high turnover, which in turn required more staff time for retraining efforts. Some program staff feel that when they lost the person(s) that spearheaded the original efforts, the program died due to lack of interest from the remaining or replacement staff.

These programs were initiated around the time of the welfare-to-work legislation. The new guidelines for welfare mothers made finding volunteers increasingly difficult. Women who once made up a large volunteer base suddenly needed full-time employment. These mothers could not balance full-time employment, childcare during their off hours, and the demands of being on-call for breastfeeding mothers, while fulfilling the ongoing training needs and documentation demands of the peer counseling programs.

Supervisory duties were divided into two groups. Some programs hired or assigned a specific person to manage the peer counselors while most of these programs added these duties to already existing FTE at the local agency level. The breastfeeding coordinator and the nutrition education coordinator were the most likely to receive the new workload.

One program found the management of funding so cumbersome that it started displacing WIC Program work. They were funding their peer counselors through grant moneys. The grantors regularly changed the data requirements, causing ripple effects throughout the management of the WIC Program. These data set changes led the local agency to discontinue the grant. They then went to the State Agency and got funding for one year. This funding was year-to-year and the local agency felt it was not secure enough to continue management of such a time intensive program.

### **Personnel**

These programs were managed at the local level. The interviewees feel the logistics of supervising peer counselors from the State agency were too difficult in most geographical regions.

Supervisory duties were usually added to existing job descriptions of nutrition education coordinators or breastfeeding coordinators. This practice caused huge issues in agencies where the nutrition education coordinator handled the duties of both positions. Most of these supervisors did clinic contact with WIC certifications and nutrition education as well as their

peer counselor program duties. Some of these supervisors had as little as 15-20 hours per month to dedicate to peer counselor program management.

All the interviewees feel that each peer counselor program must have a qualified lactation consultant (IBCLC) to oversee and supervise the peer counselors. The peers need to have someone they can call for help with advanced breastfeeding issues they encounter when working with mothers. It is also felt that having lactation support on the WIC staff is more reliable and preferable over contracting with private sources.

*I just think you have to have a structure where you have peer counselors and then you have a qualified consultant, or lactation consultants. And then you have the State supporting those efforts in the community.*

### **Funding**

Funding is cited as the main reason for the dissolution of all of these programs. The interviewees feel that in order to maintain these types of programs the local agency must have not only start-up dollars but moneys to sustain the program over long periods of time – at least 5 years – and monies to train counselors, and pay peer counselor support staff and managers. The local agency staff are already doing all they can do in the time allotted for their positions.

*You have to have somebody who has the time to do it, which talks money. Someone who can dedicate the time to do the training and supervise the staff, the peer counselors, and money to pay them. I think some places don't pay their peer counselors. I don't think we could get anybody to do it unless we paid them.*

Funding lines from State Agencies are becoming more and more difficult to access. In most areas the State government is in the business of growing smaller. This shrinking State government funding causes problems when new staff is needed to supervise and train peer counselors. Getting new positions approved at the State level is impossible in most regions. This leaves the WIC Program dependent on Federal funding for program development. The local agencies are getting less and less funding from county governments and much of it is in-kind funding. This might include phone service, housing the program, or other physical support of WIC Programs. As the local agency looks at this funding model they find they must protect and increase the amount of Federal funds they can access. They do this by increasing caseload. Breastfeeding is dropped because it is time consuming and is not perceived as a caseload builder. Formula feeding builds and preserves the caseload, with formula feeding mothers having more incentive to keep their appointments and use their vouchers.

Grant funding was explored and used by several of these programs. This method of financial support also creates barriers to consistent and well managed programs. One program used tobacco money to finance peer counselor programs throughout the State. These funds were only available for 2 years. When that time period ended the incidence of peer counselor programs dropped from 75% of the local agencies to about 5% of local agencies. Another program cites high data demands from grantors as the final straw in their program. After the grant was received the grantors requested new goals and data. These changes were taking place weekly and monthly, becoming both time-consuming and nerve-wracking. The program finally had to

withdraw from the grant to preserve WIC services and the peer counselor program was discontinued.

All those interviewed feel that making breastfeeding and peer counselor programs a priority must be backed up by funding.

*I don't want to have to be sitting down writing for outside grants and moneys. It's either a priority or it's not...I'm very interested in revitalizing, or redoing again a peer counselor program but financially that is going to be a biggie...I don't want it to just dissolve again.*

### **Compensation**

Even though these programs varied in their payment of peer counselors – including strictly volunteer positions, small stipends, or salaried positions – the interviewees agree that paying peer counselors is key to sustaining a program. Everyone agrees that volunteers cannot fulfill the job requirements fully without some compensation for transportation expenses and childcare. Some programs paid peer counselors as an hourly, part-time position with no benefits but found that the women they employed wanted and needed full-time positions. One local agency program that survives in a State where all the other programs have been discontinued pays their peer counselor staff through county funds for family support workers.

*Some reimbursement for travel and time, even just a small stipend I think would have helped people feel like what they were doing was valued.*

*I think it would be a little more prestigious or, I hate say, that they would be more valued if there were some monetary pieces for it.*

Programs state that they trained peer counselors and lost 75% of the trainees because of no pay. Those trainees that were left often did not fit the WIC population profile. These remaining mothers were more likely to be middle-class, stay-at-home mothers who had the family resources to maintain their volunteer status.

### **Recruitment**

*In the WIC population, you would want to have people of different ethnic backgrounds that would match the ethnicity within your clinic. You'd want to have appropriate language. You'd want to have either from a similar socioeconomic background or at least, pretty significant experience and knowledge of the issues that confront people from the WIC socioeconomic background that have positive breastfeeding experiences. Preferably training on counseling and knowledge of breastfeeding and working with breastfeeding problems. They must be able to counsel other moms.*

Everyone agrees that recruiting the peer counselors from the WIC population is the ideal. They report desired characteristics that reflect shared experiences and background:

- Ethnic compatibility
- Cultural sameness
- Language (bilingual)
- Education level
- Socioeconomic status
- Personal experience with breastfeeding (at least 6 months)
- Empathy
- Similar or same family structure
- Same age group

One program hired from outside the WIC population and found that these workers fit more into the mold of WIC staff. They seemed to have better connection to the staff. These women did not work exclusively in the mother-to-mother support arena but rather in a more professional lactation staff model. This program said that the reliability of these higher level employees worked better in their local agency. However, they found that these women were less likely to be bilingual and this left a huge gap in their ability to cover their caseload of WIC clients.

Two programs sought out peer counselors from community resources like La Leche League, a local mother-to-mother support organization, and doula programs. They sought women from programs that provided home visitation and trained these employees with WIC peer counselors. Although these folks had the training, they were not employed or supervised by WIC. This approach broadened lactation support in the community.

### **Supervision**

All of these programs feel that it is essential to show a chain of responsibility that initiates with the State Agency support, passes through the local agency, and culminates with peer counselor employees. They believe this kind of support is the only way to sustain these programs.

Most State administrators agree that lactation oversight is important to prevent peer counselors from providing breastfeeding support related to areas they not qualified to cover. These lactation professionals should be responsible for continuing education of the peer counselors and for answering any questions that might arise in the context of the peer counselor job parameters. They should be available in a reasonable timeframe and should be on WIC staff for the best outcome. One interviewee suggests that this lactation supervisor shadow a new peer counselor for a certain length of time to help with adjusting to the new peer counselor role.

Overall management of the program should come from a WIC staff member, most likely a dietitian. Many feel it is important for the manager to have face-to-face contact with the peer

counselors, and be at the local level, not the State agency. In large States or States with large rural components, this may introduce additional communication difficulties.

Most want peer counselors to work from WIC clinics, not from their homes, thereby giving the local supervisor direct supervisory opportunities and helping to integrate the peer counselors into the WIC staff team. When the peer counselor work is done from the clinic it allows the supervisor to monitor paper work, phone manners, and actual hours of work. When the peer counselors were allowed to do some work from home or at a local hospital, supervisors sometimes questioned the hours reported.

It is strongly felt that it is the supervisor's responsibility to establish clear expectations of the peer counselor position – both from the agency standpoint as to what should be expected from the WIC staff and what is expected from the peer counselor. It is also believed that the peer counselors should be told in as much detail as possible, prior to training, what to expect in terms of time and emotional commitment on their part.

### **Evaluation**

Evaluation proved to be both a negative and positive aspect of peer programs. Some feel that if positive reinforcement and feedback to the peer counselor were practiced it would help with retention issues. An interviewee from one program reported they abandoned their peer counseling because of the evaluation requirements of the funding grant. Another interviewee wants to see an evaluation tool that measures increases in initiation and duration rates due to the peer counselor intervention. Most of the people interviewed had no way of reporting impact of the programs on initiation or duration of breastfeeding in the affected population.

### **Liability Issues**

In programs where the peer counselors are actually WIC employees and hold full-time positions, they are covered by the liability insurance that the agency carries. Other programs do not cover liability for peer counselors, stating that this had never been a problem because the practice parameters are narrow and do not include medical advice. Two programs do not allow home visits for peer counselors because of liability issues. One issue is the safety of the peer counselor in the homes of clients and another is transportation. Agency cars are not available to volunteer or part-time employees and most of these programs did not reimburse mileage accrued from home visits.

### **Peer Counselors' Job Responsibilities**

Those interviewed followed several models for contact points in the course of following a WIC mother. Discontinued programs lacked information on individual peer counselors' caseloads. In fact, several of them asked for guidance in this area. They also had little to no information on how much time a peer counselor could anticipate spending with each client. This may be because the discontinued programs staff was no longer employed and therefore unavailable for interviews.

State administrators agreed that prenatal education is essential in getting peer counselors connected with their clients. This is the time frame that allows the peer counselor and the client

to get acquainted and develop a relationship which is so important to the duration of breastfeeding in the postpartum period.

Discontinued programs managed contacts between the peers and the clients by various means. Virtually all peer counselors did some work via telephone. The location where this occurred varied according to space available at the clinic and how much trust was given to the peer counselors to report their contact times accurately. Most provided time for peer counselors to meet clients in the clinic for assessing breastfeeding problems. This was often difficult for the clinic to manage due to space restrictions and telephone availability. All agree that WIC clients need to be able to reach the peer counselors when they need them. Most stayed away from saying 24/7 availability but recognized that in certain situations the peer counselor would have to work on evenings, weekends, and holidays, and sometimes late nights if a mother was having a breastfeeding crisis.

Most of these managers found that set clinic hours for the peer counselors to be available to WIC clients worked well. Some found that having the peer counselor available for prenatal certifications helped foster the peer counseling relationship and also offered the opportunity to provide prenatal breastfeeding education, either at the certification appointment or through breastfeeding or infant feeding class opportunities.

Peer counselor contacts with clients are varied in settings. These include home visits, breastfeeding support groups in the WIC clinics, and contact with WIC mothers as they delivered their babies in the hospitals. This proved helpful in establishing a relationship with the mothers and with the continuity of care that is so important in getting mothers through the first two weeks of breastfeeding a new baby. These contacts were all hands-off contacts, strictly introduction and support meetings with the new mothers in hospital environments.

*I think it's a combination of both, I mean, obviously the phone is so immediate and can handle emergent need, but the home setting is so supportive, you know where there are actually two women who are able to sit down together and talk.*

Most programs had peer counselors help with their breast pump projects. This responsibility was looked at as a benefit to the other staff. Some peer counselors were charged with entering their own data into the WIC system. This placed another layer of qualifications on the peer counselor profile. Women had to learn and handle the data system at WIC.

#### *Required Documentation*

All agree that record keeping by peer counselors is very important. This information is anything that could be collected related to a peer counseling contact. Some had this information placed in the WIC data system under the babies' records. Examples of information included:

- Number and type of contacts
- Time spent during contact
- Assessment of infant status information (weight gain, feeding frequency, birth weight etc.)

- Delivery date
- Documentation of any problems that are addressed
- Pump usage
- Weaning date

Some kept this information locally with the peer counselors until the weaning occurred but others wanted this information added to the WIC system as it happened. One program had mothers sign a release of information to the peer counselor at their prenatal appointments or at the feeding class contact. Peer counselors placed these forms in a tickler file for follow-up.

State administrators agree that waiting for WIC clients to initiate calls to peer counselors is not a reliable option. Most State administrators agreed that WIC mothers did not call until they had quit breastfeeding and wanted formula. This alludes to the impact on duration rates of early peer counselor initiated follow up during early postpartum.

### **Limits of Practice**

All programs had clear limits to the practice parameters for peer counselors. This was seen as absolutely essential in protecting the WIC Program from liability issues and providing accurate and safe information to new mothers. One program spokesperson compares the practice parameters to the differences between a dietitian and a paraprofessional. Training must provide a very clear scope of practice to both the peer counselor and the WIC staff who may be supporting her efforts.

All agree that entry-level peer counselors should be restricted to basic concerns and support of breastfeeding. Peer counselors must know at what point and to whom to refer when a problem arises. All State administrators agree that this referral source must have advanced training in lactation and preferably be an IBCLC. Some advocate for a tiered system of peer counselors, where there is an extended training curve that allows peer counselors with experience to take on more complicated issues. This model must also be carefully communicated to supervisory staff and peer counselors alike.

### **Referrals**

Most referrals to community service programs were handled by the WIC certifying staff. Some programs trained their peer counselors to refer to other government agency programs. Breastfeeding referrals were much more common and carefully monitored for safety of the infant.

Most WIC Programs were only comfortable with lactation backup support from their own staff or from health clinic staff that they were associated with on the program level. The peer counselors were trained to refer more complex breastfeeding issues to an IBCLC, trained RD, or back to the lactation support staff at the delivering hospital in these programs. Issues arise when the local hospital does not offer lactation support and the WIC Program becomes the only source of care for breastfeeding mothers.

## **Training**

All agree that at least one member of the training team needs to be an IBCLC. This level of breastfeeding expertise is not normally found in the WIC environment in most areas of the country.

*A trainer, well they have to be able to, I guess to speak to the audience on their level that they understand it, understand the audience....have knowledge of the topic.*

State administrators feel defined job responsibilities and expectations help in setting up a peer-counseling program. Most were unaware, as they set out to implement peer programs, of retention difficulties that might arise and were not prepared to design record keeping tools or to interface those tools with existing WIC computer tracking systems. One program took years to develop forms and recruiting notices, only to have the program abandoned. It was felt that if a standard format could have been provided with the option to adjust it to their program needs, it would have saved them time in the preparation and implementation stages. One manager would like all the program training packaged together so that it flows from program development to peer counselor training with continuity.

The following items were mentioned:

- Participant information forms
- Timesheets
- Training plans
- Protocols for referral
- Steps to administrating a peer counselor program
- How to gain entrance to the hospital for referral opportunities
- Estimate of costs in time, staff and monies
- Group dynamics and working with volunteers
- Staffing models (in-house, contractor, partnership)
- Small and large clinic model
- Rural and urban models
- Best Practices and literature review
- Ability to modify this information to local settings (format on CD)

There is consensus on the training topics for peer counselors. Most of these revolve around basic breastfeeding management issues such as latch, positioning, sore nipples, and how to tell if milk is being transferred and if baby is getting enough to eat. There were some interesting areas that may not have been addressed in training plans in the past, including addressing the risks of

formula feeding, child development, addressing barriers to breastfeeding like support and embarrassment, cultural sensitivity, and diversity as well as returning to school and work.

Most of these discontinued programs used training programs from other States or organizations that were modified for their own purposes. The most predominant one was the La Leche League Peer Counseling Training module.

All agreed that the initial training was not enough, and that ongoing training and skill-building through staff meetings, conference opportunities, and case studies are important. Some would like to see continuing education available to peer counselors by computer access, either Web-based or self-paced. Continuous training can be obtained with open access to an IBCLC for questions that arise in the peer counselors' practice.

Several State administrators agree that providing networking opportunities for the peer counselors affords an opportunity for continuing education. It allows the peers to learn from each other through actual case studies that they bring to the table. These opportunities also empower the peer counselors to continue to offer help to young mothers. They share the excitement of having a counseling encounter go well, which can act as a model for behavior in their own practice.

Most administrators used a monthly staff meeting to reinforce administrative duties like forms, timesheets, and work behavior. Some offered breastfeeding conference opportunities in the local area to peer counselors. This was seen as helpful in building confidence among peer counselors.

One program suggests offering advanced training after 2 years as a peer counselor to build a tiered program plan. This would add layers of expertise to the peer counselor core of employees. Examples of this model cited by State administrators include the Mississippi Peer Counseling program and the Miami-Dade WIC Program in Florida.

### **Partnership**

Many different partnership avenues were explored by areas with discontinued peer counselor programs. Some of these partnerships arose because of the need to have peer counseling training done by qualified people. La Leche League proved valuable to several of these programs as both training and an information resource. La Leche League was able to assist one program in finding out where the WIC mothers went for delivery.

Partnering with local mother-to-mother support groups seemed to be beneficial to both groups. WIC found that some mother-to-mother support groups were willing to have their own phone counselors available to WIC clients who were unable to reach their own peer counselor for some reason. This gave the WIC population another place to seek help during off hours at the clinics. These groups include La Leche League groups, Nursing Mother's Council Groups, Healthy Start, family support networks, and other organizations that work with the new families in the community.

The most common reason for not seeking partners was the lack of lactation support in the local community. They found that the hospital was not supportive of breastfeeding. However, it was

felt that the hospital was causing some of the issues the peer counselors dealt with when contacting new mothers. Professional lactation resources are limited in rural areas of the country. Most State administrators wish to see a model in which the WIC clinics, the local health clinics, local MDs, employers, and the hospital refer to peer counselors for follow-up with new mothers.

One program experienced success when the peer counselors were able to go into the hospital maternity unit and contact new moms. This partnership evolved to include a peer counselor on the hospital's own breastfeeding workgroup and resulted in the hospital seeking guidance from WIC for becoming Baby-Friendly. True information sharing occurred and benefited organizations as well as the mothers and babies. This program was able to have a peer counselor at the hospital on a daily basis identifying breastfeeding WIC mothers for referral to peer counselors. After this model was in place for a period of time WIC found that physicians were referring mothers to WIC on a more regular basis. An essential piece of this model is training the hospital staff and administrative people on the peer counselor scope of practice.

*...with many of them she just sort of almost seemed like part of their staff.  
You know, she'd come on the floor and all the nurses would know her and tell  
her they have someone down in this room that just delivered and she's on  
WIC.*

Being hospital based for referrals does not seem to work well in rural areas. Indian Tribal Organizations have specific issues that relate to distances their women must travel to the delivering hospital. The Indian Health Service stopped maternity services some years back and many women must travel up to 100 miles for delivery. The distance and the fact that the WIC Program does not exist geographically within the area of the hospital are huge barriers to partnership.

### **Reinstating Peer Counseling Programs**

To restart or reinstate peer counseling programs, State administrators reflect program management issues and funding issues as the most critical needs to address. These programs want a train-the-trainer program for their own staff to attend, staff that will be involved in the day-to-day supervision of the peer counselors. One State administrator asked for some personal type of interaction during program interaction, perhaps in the form of conference calls every quarter or a resource they could access on an ongoing basis for technical assistance.

They want help in establishing policies that will support the peer counselors but not demoralize the environment in the clinics. They want to know how to address the issue of peer counselors bringing their children to the clinic during work hours. They would also like to address issues of space and funding. These programs with discontinued services are cognizant of the investment of time and energy involved in implementing and sustaining the program. They want designated funding for implementation and staff, and time to ensure the success of these efforts the next time around. They need "accurate" information on time commitment, training, supervision, and oversight of the whole program before they will venture into this again. They want to have some guidance as to how to structure these programs – who should be in charge and who should have direct supervision duties.

They also would like to have guidance in preserving the breastfeeding support and promotion that their existing WIC staff is already doing. They perceive that if a peer counselor is available for breastfeeding support their existing staff will take this as an excuse to discontinue all other efforts. These programs do not want to see this happen. Many see the peer counselor program as a way for the WIC staff to pass on the breastfeeding issue to someone else. This allows them to address other issues they encounter with WIC families, such as obesity initiatives.

*Many agencies expected too much of peer counselors. I think oftentimes they were looking at peer counselors to replace and do the work of paid staff and that became a problem.*

Some ways to garner staff support of peer counseling programs might be to show WIC staff that support programs increase initiation and duration in the WIC population. Peer counselors can offer support and help in the offering of classes to WIC clients. Many want to be able to show WIC staff the relationship between breastfeeding and other health issues that they address with clients. State administrators feel one step that would help gather support for peer programs is having more WIC staff input in the planning and designing stages. One State administrator feels that if there could be a link shown between peer counselor programs and caseload size maintenance it would increase WIC staff support.

These programs that have disbanded warn that it may take several years before the benefit of a peer counselor is apparent. They feel clients may even need a couple of years to understand the peer counselor's role and to feel comfortable in using this service.

Most State administrators feel the peer counselors themselves benefited from the programs. They believe that these women were prepared to enter the work force by the training they received at WIC. They feel that the peer counselors were empowered to do something for others and had increased self-esteem and self-confidence.

There were mixed reactions to questions of reinstating discontinued programs. Some sounded interested and felt they would do it differently next time. Some were open to a new program because they weren't involved in the demise of the first program. One program manager that witnessed the disbanding of a peer program stated:

*Of course our rates did go down, but I also see it affected the WIC staff in that the morale went way down. They weren't as enthusiastic to push breastfeeding because they kind of felt like they didn't have momentum or support. I'm now trying to build that up again with additional training of the WIC staff. But it takes a long time.*

Some agencies report that the State agency has no one to oversee breastfeeding on a daily basis. These States have a nutrition professional who has breastfeeding as an additional duty. This is seen as a tremendous disadvantage to those States that work under those conditions. There is a strong sentiment among State administrators that to prioritize breastfeeding in the WIC Program consistently throughout the country the Breastfeeding Coordinator position needs to have qualifications and a budget to fund those qualifications. Absence of lactation credentialing and training pulls down the positive programs that could be successful.

These programs want to see a five year commitment in funds for peer counselor programs. They feel that at a minimum it will take this long to get the staff and community support and obtain positive results from adding peers to an already strained program mandate.

One State's breastfeeding coordinator said:

*Reinstate? It's not going to happen unless a miraculous funding comes down from somewhere that is going to pay women to do this because we do not have the funds or the staffs time to do it. Very few agencies are able to keep it going anymore. We don't even have the money to keep our agencies fully staffed with people they have to have. And peer counseling is seen very often by many agencies as some sort of frill. You can't even get a lot of agencies that have a qualified breastfeeding educator on staff much less peer counselors.*

### **Sustainability**

All of the interviews carry the thread of sustainability through them. As previously noted in this report, funding issues are seen as central to the demise of these programs. This issue was closely followed by the need for stability in staffing plans for peer counselor program management. The interviewees feel strongly that permanent program staff needs to be in place for the program to function at its best. Staff must have adequate time allotted to devote to a program of this intense nature. A third factor is the ability to pay the peer counselors a wage for their work.

*My concern would be that there are callers to start with to get things going, and then is it going to be truly sustainable in terms of the monies to educate these women and pay these women and be able to find appropriate support staff, or a support manager for them. I don't see the local agency staff having anything to do with all that.*

Retention of trained counselors has historically been a complaint of peer counselor program managers. State administrators feel that retention issues can be greatly improved by enacting the following interventions:

- Design the peer counselor position as full-time or nearly full-time (90% FTE) with a salary, a career ladder that allows for advanced practice (tiered program plan), benefits, and a carefully outlined job description with strict adherence to those duties when placed in the clinic setting.
- Peer counselor training should fully explore all aspects of the peer counselor position with the trainees, informing them of the negative as well as the rewarding and positive aspects that come from participating in this kind of work. Keep the job duties to mother-to-mother support only; do not allow the clinic staff to add additional duties that pertain to other WIC work.

Interviewees have some insight into changes they would adopt if starting a program again. The most common change suggested is hiring fewer peer counselors so they could have full-time or nearly full-time positions. This would give each peer counselor more hours and address their

need for full-time work. Interviewees would also want a training course for the peer counselor supervisor. Several feel that there is no body of information to look at; these programs were started with the idea that supervisors would learn as they went along. They also suggested that supervisors need some training on being a proactive supervisor.

### **Impact of Program Demise**

Factors leading to the demise of these programs have been discussed throughout this portion of the research report. State agencies have all articulated issues of funding, staffing, and program durability. Impact of program demise was harder to ascertain. None of the programs had any data based information to share. One program did have information reflecting a 14% rise in breastfeeding rates with the introduction of the peer counselor program in a local agency; however, they were unable to find out how much the rates dropped when the program was discontinued. Anecdotal information shared by these programs indicates that part of the job duties the peer counselors performed have been taken over by the paraprofessional certifiers working at the local level. This does not include any coverage for mothers when the clinic is not operating, however. General loss of morale in the WIC staff when the program was discontinued was reported by one program.

*The four counties that had it, you know a sort of structured program. They all would love to start, see it start up again. So that's success and then obviously they felt like it was really helping moms.*

### **Recommendations for USDA**

The most common recommendation for USDA has to do with program supervision and management. They ask that each agency that is to adopt peer counselor programs have an assigned and funded peer counselor supervisor. They suggest the initiative be designed in such a way as to allow for adequate time to implement the program and for it to be in effect long enough to reflect the impact on breastfeeding rates. This program needs time to become a part of the WIC culture both for the staff and for the clients. They must understand what the peer counseling program is for and how it works.

At least one breastfeeding coordinator feels that any adoption of a program is a waste of time without money for continuing the initiative. She feels that this is all a waste of time without proper funding and back-up regulations to ensure its continuance. This same person feels that designing a peer counselor training program for States to use is not a good idea, as there are plenty of programs out there already. This should be balanced by the program manager that asked for a literature review to be included in the training programs – she felt a need to have more information on what is out there already and to learn from where others have gone before with their programs.

These programs would like to have some models for staffing supplied to them. They would like to see how to make in-house supervision work as well as how to implement contractual program supervision. They would like to see some guidance for small local agencies as well as large agencies. They would like to know if there is a difference in managing programs in rural vs. urban areas. They would like to have information on staffing formulas, how many clients per peer counselor, how many peer counselors each supervisor might reasonably be expected to

supervise, and what impact geographic issues might have on the peer counselor/supervisor relationship.

These program supervisors would recommend that all agencies contemplating starting programs have a thorough knowledge of the literature available concerning peer counselor programs. Much of this literature is rather new in nature and may not have been available when these programs were initiated. They also recommend having a portion of the start-up period devoted to motivating existing staff in the local agency and at the State level. They suggest having already existing WIC staff as active planners and part of the implementation process. A clear communication plan from the State agency and from the local agency program manager to local agency staff and to the organizations that house the local agencies seems to be a reasonable suggestion. Open and active communications will serve both management and the peer counselors themselves.

## NEVER INITIATED PEER COUNSELING PROGRAMS

### Overview

Most of the WIC Programs currently without a peer counseling program expect to implement a program in the near future. However, they identify a variety of issues that need to be addressed for successful implementation and sustainability of a program. Funding is the main concern of most programs. The following sections discuss these programs' perceptions of peer counseling and their intentions for and impediments to implementing a program in their WIC agency.

### Perceptions of Peer Counseling

The perceptions of peer counseling among programs vary. Agencies are aware of several States that currently have peer counseling programs, many of which are successful. Several in the group note that studies have found peer counseling to be the most effective means to increase breastfeeding initiation and/or duration, especially among the WIC population.

However, many have also heard that having a peer counseling program is labor intensive and requires a great deal of oversight, monitoring, and training. Agencies express concerns about initiating a program, such as adequate and ongoing funding, recruitment of potential peer counselors, staff turnover, and liability issues. Others are not entirely cognizant of the specifics of having a peer counseling program but perceive peer counseling as positive.

Some administrators describe peer counseling as “support,” specifically, support for breastfeeding mothers. Many think of a peer counselor as a mother with breastfeeding experience providing support to new mothers wanting to have a successful breastfeeding experience.

*A mom who has breastfed, who offers support and encouragement to other moms to encourage them to breastfeed and to continue breastfeeding.*

*Women that have breastfed before sharing their experiences and maybe some of the hurdles that they had early on and solutions with women who are pregnant and have not breastfed before or women who breastfed previously and had difficulties..*

Other administrators think of peer counseling as “comfortable” and “helpful.” Administrators view the peer counselor as a comfortable source of education and support for a WIC mom. The peer counselor is helpful to new mothers because she is perceived as someone who has real breastfeeding experience.

*A lot of time a professional person helps you but it's still good to talk to someone who is actually going through or has experienced what you are going through.*

*Clients feel more comfortable when it's coming from someone who they see as an equal to themselves rather than someone that they feel is above themselves and who may be talking down to them.*

*Some people feel more comfortable with speaking to someone who they see as a friend rather than just an educator.*

*If someone who looks like the client, or lives in the same areas as the client, or perhaps, somebody that the client sees in a setting that is very similar to his or her own setting they feel much more comfortable with sharing their concerns, problems, issues, or deterrents to breastfeeding.*

### **Perceived Benefits**

According to administrators, an increase in initiation and duration breastfeeding rates would be a significant benefit of implementing a peer counseling program. Having peer counselors allows the WIC Program to provide support to mothers at the critical times that often deter mothers from breastfeeding. Administrators are aware that moms are most likely to stop breastfeeding during the first couple of weeks postpartum as she experiences breastfeeding problems. This is also a period of time in which, traditionally, the mother doesn't come to the WIC clinic. A peer counselor would be able to check on moms and address any breastfeeding problems encountered during that time. Moms would get more emotional support from a peer counselor than from a professional who would talk about the science of breastfeeding. Intangible rewards to the community of having healthier babies who are breastfed are also noted.

*Well, I'm thinking that it would increase the initiation and duration. I think that should really be our goal anyway, all of WIC, to have all of our babies breastfed because it's just the basic nutrition and it's good for both the mom and the baby and I think that it provides a good bond for the family, too.*

*I think really a lot of support, not only to the mothers but to the staff as well. That they would be able to follow-up more with the mothers, you know to call them and check on them. Even making contact with them while they are pregnant.*

*Also because the relatively cheap versus registered dietician or lactation consultant providing one on one, you get more bang for the buck.*

*It would be a healthier population in my community. I think it would be a more intelligent population for my community. I think it would be a more socially responsible population for my community. And I think it would also put some, it would bring us closer to some of the goals and objectives of Healthy People 2010.*

The perceived benefit to WIC clients is easy access to support immediately, without a long wait for a lactation consultant to respond to basic questions. Peer counselors are perceived to be a grassroots approach to building more awareness about breastfeeding in the community.

*I think that is one of the factors that may be a deterrent to breastfeeding because when they need help, when they are trying to breastfeed right, then they can't wait 3 hours for somebody to call back.*

*It would be that one- on-one support that a woman initially needs since most problems aren't Lactation consultant level, they are just pretty much common*

*problems and since self confidence is such an issue especially with low income women, peer counselors fit very nicely into that niche in providing support.*

*Probably a sense of accomplishment. "Look what I did. I was able to do this." And a sense of knowing they have absolutely provided the best possible they can provide the best care in the world. And I think a lot of WIC mothers need that.*

Perceived benefits for peer counselors include returning to the workforce, helping to build their confidence, and developing skills that can be applied to future employment. Being a peer counselor can also lead to a better, higher paying position within WIC or a in a hospital setting as they learn new skills.

*I guess you know like if the person was being a peer counselor, if they could kind of say this is work doing because maybe it will lead to a full time job, or it will lead to you know some kind of step up into the workforce, or something like that.*

### **Program Initiation and Implementation**

Some view the prospect of starting a peer counseling program as too large an undertaking. Starting a program means having to motivate people, recruit and retain peer counselors, and manage the overall operation.

*It's a big undertaking to get someone motivated and really to begin a project because you have to, it's really like starting a company in a way. You have to find the employees, people that are willing to do that. You have to provide the training. You have to have the money to do it. And somebody to oversee it.*

*They are going to have difficulty being able to have the professional level staff person or people available to organize these programs in their agencies and to do the recruitment of either the volunteers or employed per counselors and do the training and do the oversight, so that's going to be the biggest obstacle I think in almost half of the agencies in getting that resource out there that can really do the work.*

WIC Programs that have never initiated a peer counseling program identify several areas of concern and potential barriers to implementation. These concerns and potential barriers include:

- Initial and ongoing program funding
- Selection of program sites
- Potential rural agencies as sites
- Program coordination
- Required personnel
- Recruitment of peer counselors
- State and local level support
- Training curriculum

- Potential partnerships

### *Funding*

Capacity for implementation is directly associated with funding. There are three main funding concerns: (1) initial funds; (2) continuous funds; and (3) sufficient funds. Many administrators report that without a belief that a guaranteed continuous funding source will be available, implementation of the program is unlikely. This is a significant impediment to implementing a program.

*I think the reason I mentioned earlier why we didn't start one is confidence that we would have the necessary funding to keep it going once we invested the money to get it up and running.*

*Another issue that we can't leave out is sustainable funding. You can't just start a program like that and say we are going to fund it for a year and then as soon as the money is gone, boom, you're on your own.*

*Again, I get back to the money, the funding, both to get it up and to know that we would be able to sustain them on an ongoing basis.*

However, having initial and continuous funding is not enough. Sufficient funds need to be allocated to ensure that minimal quality standards are maintained during implementation and for sustainability of any program. Quality and structural standards include compensation for peer counselors, travel reimbursement, and ongoing funding for other administrative and management costs. Some feel that the NSA grant is too small to implement this program across the country and certainly not enough to sustain peer counseling nationwide.

*The current NSA grant in my opinion is not sufficient to add this as one of our core services, so there would have to be an increased appropriation and an adjustment to the NSA funding formula to make the resources.*

*Being able to set up a program that is effective bothered some of the participants. They would love to set up a peer counseling program as long as there is funding to make it an effective program. They don't want to set up a marginal program and feel that that would be doomed for failure and would rather use the money somewhere else.*

*So, where there is potential need for additional money to pay for the management types of responsibilities that come with the peer counseling program. It's not just the paying of the peer counselors, it's the various costs associated with it, if it's travel or phone or whatever. But it is also the administrative costs.*

A few agencies are also concerned about current and future State budget cuts and hiring freezes.

*I think as of next year we will take quite a budget cut. So having the money and the funding to be able to financially support a peer program.*

*Our county umbrella is definitely a barrier. It's very tough with starting new programs right now because of all the [budget] cuts.*

*Right now, we have a freeze on hiring. So we might be able to get the position and it might be funded but we might not be able to fill it. That's one crazy situation.*

### *Site Selection*

According to some administrators, selecting the program site is key to the effectiveness and sustainability of the program.

*I think the most important thing is the selection criteria of where to initiate the program.*

*My apprehension about doing pilot testing is that unless you are very careful in picking the right pilot site there is no guarantee that you are going to be able to translate those successes to other parts of the State.*

*We need it so the designated areas where we initiate it would have to be very progressive and supportive. I think the most important thing is the selection criteria of where to initiate the program.*

### *Rural Agencies*

The smaller agencies and counties, specifically rural areas, feel implementing and sustaining a program would be difficult. The most difficult issue is recruiting competent peer counselors and staff to run the program. Transportation across long distances is an impediment to effective management of the program.

*But to our smaller agencies, it would be a challenge for them to have the professional staff person who could commit the necessary time to it.*

*I think in our urban areas we wouldn't have as much of a problem but in rural areas there are transportation problems and we have frankly very low breastfeeding rates in the western part of the State.*

### *Program Coordination and Personnel*

The preferred coordination structure would be located at the local level with the States providing technical assistance, resources, and funding.

*We are not going to run our own peer counseling program. It would be local agency based and we would probably just provide technical assistance, resources, possible funding through like grants which they would have to apply, be we wouldn't be directly running the program.*

### *Support and Supervision*

Administrators want to know the time needed to manage a peer counseling program, specifically, the time a supervisor should expect to allocate for supervision of peer counselors. Many feel overseeing a peer counseling program would require a full-time employee.

*I would just want to make sure that I had enough time that I could incorporate that program in with the duties that I already have. Because I see that there would be enough work and I would see enough work in managing that kind of an operation that it would take a full time person to do it.*

Some agencies have been overwhelmed by the prospect of initiating a peer counseling program and the time they feel it would take to oversee the program. However, staff also report that the benefits of having a peer counseling program would make dealing with the difficulties of starting a program worth the effort.

*Oh yeah, I think that's why our State breastfeeding coordinator was overwhelmed because she could see that would take a full time job just to do that.*

*But as time goes by, they will see how much support the peer counselor does get then they will be able to see that their breastfeeding rates do improve and that maybe the duration rates do increase. And that this may give them more of an opportunity to be able to do classes, breastfeeding classes.*

Staff believe that salaries of the existing administrative staff that may assume the responsibility of overseeing the peer counseling program are not likely to increase. They also assume that additional work demands may be overwhelming in already demanding work schedules.

*But of course, if we have a peer counselor program my salary wouldn't be increased, you know. So I would still have my current job duties plus the responsibility of this technical supervision which I would have to be one dedicated gal to want to do that, which I am.*

*I think a lot of our breastfeeding coordinators wear multiple hats in the field and the reality of it is they can't be that effective when they are wearing that many big hats*

Administrators contemplating a peer counseling program want guidance on human resources management, specifically, information on how to recruit and hire peer counselors, how many hours they should work, should they work full-time or part-time, how the position should be funded, and how they should be compensated.

*So I would feel better if we had more guidelines to run the program. The hiring, and the actual job descriptions, and what to expect as far as pay, how many hours are involved. It's my understanding that these are like a part time*

A few have contemplated contracting the responsibilities out and leaving the peer counseling program to an outside agency. However, the idea of contracting with an outside organization is accompanied by concerns of liability, accountability, and the level of training peer counselors would receive.

*The next thing is if this process were like, if it was contracted out, requested proposals were put out there and people had the opportunity to see it, or managing this process, then I would be concerned about accountability and the liability and the level of training.*

### *Recruitment of Peer Counselors*

Most staff believe that current WIC participants are the most obvious source of peer counselors. Three recruitment methods are discussed:

- Paraprofessionals, who are most familiar with WIC clients, could assist administrators in identifying potential peer counselors;
- Recruitment could be conducted through word of mouth among WIC participants; and
- Recruitment could be conducted through advertisements in the local newspapers or WIC newsletters.

*Well the first process would be referrals from my paraprofessionals in each of our offices; moms that they think would do a good job.*

*And finding women and talking to our paraprofessionals about the participants they have or have had who would be good peer counselors.*

*I think a lot of it would be good if you could find them within the WIC Program, that were familiar with the program.*

*Word of mouth a lot of times is just a good thing.*

Some staff want more information regarding the characteristics of the ideal peer counselor. A few question whether the peer counselor needs to be a current or former WIC participant, be breastfeeding currently, or if the length of time she breastfed matters. As mentioned earlier, administrators would like information on effective ways of recruiting, interviewing, and hiring peer counselors.

*I think how to find appropriate peer counselors would be great information. What to look for in a person...how to interview them, that would be really important.*

### Compensation

Compensation is a significant issue. Most respondents feel that for the program to function properly peer counselors need to be paid. They see compensation as key to gaining full dedication and commitment from peer counselors. Many acknowledge the problem of retention of peer counselors and feel paying them is one solution.

*My understanding is that in the most effective programs they are paid, because that keeps them engaged, it's a job, it keeps them otherwise there's more turnover and more need for ongoing training of new people versus enhancing the skills of the existing ones.*

*I have talked to mothers who wanted to be peer counselors with our State and my thing is most of these moms don't want to do it on a voluntary basis. They want to be paid.*

*Pay them a decent wage. I know, sometimes they are paid poorly and they don't stay.*

Compensating peer counselors for their time highlights again the need for sufficient funds to sustain these paid positions.

*I guess my concern is if all the peer counselors do want to be paid how we would fund that.*

*But again the money would need to be there. And since that varies so much by State with salaries then I'm not sure exactly how they would do that.*

### Retention

Administrators recognize retention of peer counselors as another key to the program's success. Two situations have a negative impact on retention: low pay and everyday family demands. Furthermore, turnover means increased costs for recruiting and training new peer counselors.

*Turnover is a normal occurrence in positions like this as well as in your WIC staff who would be managing the program. So you have to have some plans for addressing that.*

*I think that it would be a lower paid job. Then they would move on to something else. Or their kids would need, they would need to help their children as they got older.*

### The Peer Counselor

Administrators define a peer counselor as a mom who has breastfed, who is a member of the population that she serves, and who offers support and encouragement to other moms to encourage them to breastfeed and to continue breastfeeding.

*....is a person who is from the population that we are serving or certainly has been a part of that population herself, generally (is) successful in breastfeeding, and has been trained with some basic skills to be able to provide assistance to a breastfeeding mother and infant, and also trained at where she needs to make a referral for a more clinical level of intervention.*

*I think that it's really critical that the peer counselors are actually representative of the community that they are providing services for.*

A good peer counselor should have a strong desire to help other people, be a problem solver, communicate well, and be a bit of a teacher. A number of the responders feel it is important for the peer counselor to be from the same ethnic background as their clients.

*I think it's another mother maybe who has breastfed who is enthusiastic about breastfeeding and has a passion for it and desire to help other mothers learn....*

*Is she community minded in that does she have a problem communicating with other people? Does she have a good attitude towards family?*

*I believe that they would be able to help in the education of young moms who come in to help them realize the benefits that come from breastfeeding.*

*I think people from where we are located at now they actually will open up to somebody in their own ethnic background.*

### *The WIC Program and Peer Counseling*

Administrative support is essential to sustaining an effective program.

*But if we happen to come across a local agency coordinator that wasn't interested in pursuing this or that would make it difficult.*

*Well if you lose the moral support of your administration the program would suffer.*

Support from staff who have adequate time to assist with peer counseling is key in obtaining referrals, feedback to supervision, and follow-up.

*Our State WIC Program would have to be supportive. Our county agency would have to be supportive. Our WIC director definitely has to be supportive.*

*I believe the support from our agency, our ability to see the need is important.*

*The most important thing you would need would be a dedicated, people who are actually dedicated to the project and were interested in sustaining it for a long period of time.*

Among the administrative levels cited as being important sources of support are the State WIC office, the county agency, and the local WIC director.

Along with funding there has to be a State level person to maintain the program and to provide the resources needed on an ongoing basis.

*Again it would be funding. Maintaining a person who is in charge of it at the State level, and being able to communicate with the local agencies, providing them with all the resources they will need.*

*Like I said only if the USDA mandated like a half an FTE per local agency that is devoted just to that project and that it is funded.*

Local level support by WIC staff is also considered a key to successful peer counseling programs. Staff would be responsible for interfacing with peer counselors and their clients and providing client referrals to peer counselors. Also, as the front line for client contacts, they are in a position to promote and encourage the use of peer counselors. If they are supportive of breastfeeding in general and the peer counseling program in particular, the program will run smoothly.

*But if you don't have their support you're not going to get anywhere.*

*They would be the ones probably making the bulk of the referrals or connecting participants with the service. They would probably be assisting and identifying women who could be peer counselors, they themselves may choose to become part of the peer counseling team or project in some kind of way, so I think that the clinic staff are going to be critical in the success of the initiative, just as they are critical to our success in promoting breastfeeding overall. It is really the frontline staff that has the greatest impact on our overall image as far as breastfeeding promotion.*

Most staff fear that incorporating peer counseling on the local level would take up additional time and space within the local WIC agency. Some see it as part of the prenatal system, some see it as a new educational piece within WIC, and some see it as something that has to be mandated with set policies and procedures to follow. The logistic needs for the program vary; some see the peer counselor sharing space within WIC, and some see peer counselors working out of their homes and reporting to WIC periodically, with several variations on those two premises. Current WIC staff believe they will have to rethink how they operate if a peer counseling program is initiated. They believe they would have to give up some of their duties, and be unable to see all breastfeeding clients personally in order to allow peer counselors to function properly. Some staff fear that it could create friction and territorial jealousies.

*Incorporating it, it would have to bring that into just a part of what we do already. A part of our counseling. A part of the prenatal system, too. It would have to definitely start at the prenatal part.*

*I'd almost have to say that we would have to make it a policy. This is something, a directive that we are to do. And then we would have to set up some type of policy, procedure. I guess in that respect it would have to be a formal incorporation into the program through policy and procedure being issued.*

*I think I would either have access to a prenatal educational piece that could be used so the peer counselor would probably deliver breastfeeding messages or information at the WIC visits that the clients come to in small groups, prenatally. So that would be one of the ways that we would initiate it.*

Referrals are most frequently mentioned as the primary reason for needing the support of WIC staff. From the receptionist through the breastfeeding coordinator, the system would require staff buy-in to assure an efficient referral system for the peer counselor program.

*If you have most of them off site where they are doing most of their work by telephone, and you are only getting the referrals through staff then it's just getting staff on board to provide the names.*

*Because a large percentage of your referrals might be coming from there, and of course our personal staff is very supportive of that.*

*If they don't believe in it then you would probably not get very many referrals that way.*

### *Potential Partnerships*

Agencies identified the following groups and organizations as potential partners for peer counseling programs:

- Breastfeeding coalitions;
- La Leche League;
- Extentions Services (EFNEP);
- Perinatal programs;
- Schools; and
- Churches.

Ideally, these partners would make referrals to the program but also assist in setting up the program.

*Well first one that comes to mind would be EFNEP, the cooperative extension. We have a wonderful relationship with them and I'm sure that they would give us any assistance they could in helping start a peer counseling program.*

*We work closely with the La Leche League as well and they are also part of that task force.*

*I think the first one that comes to mind with our clientele is the Faith Based Community, the churches. We work with a teen pregnancy education group. So community based education in schools.*

A number of responders also state that they would have so much initial work to do to get the peer counseling program up and running that it would be premature to even consider partnerships.

*I think you know we have to start in house first. And feel firm footed about it and then go for the push of letting other agencies know.*

Maintaining good communication with your partners is also considered important.

*If there was a situation where a hospital or providers, healthcare providers in a community or a local area that were not believers did not think that this was a good idea, it could be brought down pretty quickly.*

*If you really don't have very good communication with all your community partners so that they really don't support what is happening, I think that could make it difficult to sustain too.*

### Hospitals

A number of agencies have existing partnership with local hospitals. In some cases, WIC Programs are located in hospitals and they believe that partnering with them would be relatively easy. Some existent collaborations are rooted in the hospital staff's involvement in the local breastfeeding task force or coalition.

*Plus, with our coalition we have a lot of hospitals represented on our coalition.*

*I think it would be very, very easy for us seeing that we are in-house.*

*We do have some of those people that are part of the Lactation Task Force and then we also have that training with folks from Best Start that come in here, and we had quite a few LC's from hospitals that were at the training. So I think we work well with them as well.*

Some report that they could not or do not want to form partnerships with hospitals. In large part this is related to hospitals' relationships with formula companies. Some feel that the number of women a peer counselor can talk to in a day in a hospital is one-third the number of those they can talk to over the phone. And in rural areas with no hospitals readily available it is impractical to partner with them.

*You know in other areas it is going to be a real struggle to form that relationship. There's all this sensitivity over infant formula that gets in the way I think of building partnerships.....there is the fiscal issue there for them so it is a hard situation.*

*In our particular situation it's a little more difficult because we are rurally located.*

*I have experience with the hospitals too and we kind of backed out of it just because we didn't have enough funding, but also I just needed to contact more women by telephone.*

Confidentiality, liability, and having a good understanding of and communication with partners are also cited as issues regarding partnerships. Consistent contact points are also important, and coordination of appropriate referrals is a significant concern among staff.

*We would have to have some type of Memorandum of Understanding type agreement.*

*Confidentiality are still being worked out with HIPPA and WIC, privacy.*

*I guess consistency in how we are communicating.*

*One of the other issues that might be relevant would be what if somebody needs a peer counseling program but they are not eligible for the WIC Program?*

### *Training Curriculum*

Training is a primary factor in starting a new peer counseling program. Most know there will need to be training for internal staff who are responsible for peer counselor and general WIC staff training.

*Probably the first thing that comes to mind is training.*

*And other trainings. I think the whole staff would have to be part of the training and part of what the peer counselor does.*

*The training issues as to how much training they are going to need to have before you actually turn them loose. I think they would need counseling, how to ask open ended questions that type of thing.*

Most feel that the 'train the trainer' training would need to occur on the State level, and that the curriculum should be presented to them from USDA, their Regional Office, or the State office. Most feel that peer counseling training would be best if held at the local office by one of the breastfeeding professionals. There is a minority who feels that local staff are already too overworked and that the peer counseling training should be handled at the State level.

*Because our clinics are short staffed now and it would be easier to initiate at the State level.*

*I'm hoping that Regional Office would come up with a peer counseling training.*

For those who don't want a prepackaged training curriculum provided, La Leche League's training program for peer counselors is thought highly of and they would be willing to send their own peer counselors to that training.

*I know right where I can go to get the training. So I know that's not a barrier I know La Leche League has this excellent training several times a year throughout the State, and a wonderful training manual.*

Ideas for curriculum content include the use of a multi-module structure with information on:

- How to start;
- Selecting a peer counselor;
- Training the peer counselor; and
- Program evaluation;
- Instructional techniques;
- Using open-ended questions;
- Soliciting open responses from clients;
- Working with unresponsive clients;
- Correcting misinformation tactfully; and
- Basic breastfeeding management

*I think in modules. Maybe break it down to the 0-6 months, or even maybe that first starting out pregnancy through the first month of breastfeeding, and then breastfeeding an older baby, and then managing back to work and pumping. 3 to 4 components maybe with each component to have a quiz at the end of each portion. And hands on.*

*Like how to help a group open up and try to get people to try and talk, how to uh, get someone that has all the answers and talks a lot. Help them give someone else a chance to talk. How to tactfully correct gross misinformation.*

*Probably you know classroom type of thing. Lecture. Video tapes. Maybe some kind of hands on role playing type of thing. If it would involve things like breast pumps, then have breast pumps there for the person to become familiar with, hand on touching.*

*Well I would like to have a thorough training for the problems and come up with breastfeeding that they will have to deal with and um, I think they also need to know when something is more serious and they have to pass it on to a health professional.*

The basics of breastfeeding are particularly important in the training and should include how breastfeeding works, the anatomy of the mother while pregnant (including what is happening to her breasts at this time), how breast milk is produced, common breastfeeding problems, and how to know if the baby is well fed.

*But she would also have to go to some kind of training to make sure she understands how everything works with breastfeeding. Also how to access if the infant is being adequately fed.*

*I think you would certainly want to know the anatomy of the breast, how breast milk is produced, how the body produces breast milk. What a mother can expect through pregnancy, the changes in her body and breast, through pregnancy and then after birth. And any special problems she would have.*

The WIC staff also need to know when to refer to a peer counselor and when to refer to a professional staff member. The peer counselors need to be trained on proper practice parameters so that they can refer to professional staff when appropriate.

*They would need to know how to refer and when to refer and say I'm sorry, I cannot help you with this. That would be one of the biggest things because we just could not take that either. We couldn't handle a diagnosis by a peer counselor.*

*Making sure the guidelines and the lines of responsibility, the limits of responsibility, are clearly identified so the peer counselors know where they fit in within the WIC clinic staff setting and WIC clinic staff know where the peer counselors fit in.*

*They would have to need to know their limits yes. They were having someone dealing with a sick baby or a baby with a cleft pallet they might not be able to, they would need to be referred.*

### Liability Concerns

There seems to be a real concern about issues of liability in the WIC clinics regarding what a peer counselor can and cannot say to a client. In some cases peer counseling was not attempted because of this issue. There is a real need for clear-cut definition and resolution of these issues in many areas.

*I think it gets back to again really these peer counselors really have to be trained to know when a referral for clinical or medical intervention is warranted so that there are not issues of liability.*

*I think it's you know we have guidelines of stipulations to begin with and hopefully that can be nipped before it is an issue.*

*Well there is always a concern about liabilities and I think that you probably would have to address that in your training of the peer counselors, and just by direct observation.*

The potential for peer counselors to provide incorrect information to WIC mothers has deterred some agencies from starting a program.

*But our lactation coordinator before this one previously really had some issues with liability if one of our peer counselors gave out information that would be maybe not as accurate as what they should be for medical information and the patient would take that instead of going and consulting with their doctor or actually seeing a nurse.*

## **Needs for Implementation**

Administrators mention the need to have set guidelines and instructional manuals on how to start a peer counseling program. The use of existing models and the sharing of information on successful programs would help them. Evidentiary and science based information on the effectiveness of this type of program is preferred. Several would like to see, visit, or talk to other WIC agency staff who are currently running a successful peer counseling program.

*Being able to see either in actual practice or these programs that were up and running and were successful...but when you actually see them working then that tends to make it easier to implement your own program.*

*Some kind of manual would be good just to start out with and you know when you are implementing the peer counseling program, here are some of the models.*

*Of course outlines, maybe some handouts that are helpful, maybe some case studies of common BF problems so that they could practice. Sharing information or facilitating some of the guidelines.*

*I think that having reference; materials, the resources, all pulled together in one place, including information on the effectiveness, a summary of what the data does show as far as the impact of these programs and particularly different levels of effectiveness of different models.*

As mentioned in the liability section these agencies want guidelines from the USDA regarding when it is appropriate for them to refer a mother to a professional. They understand the need for these policies but are not certain what they entail.

*I think...just something written up about as far as when the peer counselors would refer to a nutritionist or a nurse.*

*I would think a referral mechanism you have responsibilities of who can do what. And what a peer counselor or an IBCLC needs to do.*

*I guess we would have to draw up some type of guidelines with this, this, and this and if this then you have to do that, or you have to refer to a doctor so we would have to make guidelines I guess for the people to follow.*

## **Additional Recommendations to the USDA**

Several question the possibility of creating a universal model that would be applied to anywhere in the country. They would like the flexibility to take existing training materials and adapt them to their own particular needs.

*The first thing that comes to mind is whether or not there is a single model that really fits the needs of all of our agencies.*

*Letting States tailor the program for their own State. Give evidence and models that support that.*

Most stress the need for the USDA to develop a program that is not only user-friendly but adaptable to each individual State in both urban and rural regions. The program needs to take into account the regional differences and the cultural differences as well.

*Make it where it would be user friendly or State friendly. That it would be something that each State could use.....For example, that it would work for small States that didn't have a whole lot of support versus States that have a lot of support.*

*Make it as consumer friendly as possible. Not to make it too terribly heavy in policy and procedure. Allow States freedom and flexibility in how they go about implementing programs because every State, every region, is a little bit different and they need the flexibility to be able to adapt things to their area.*

*I guess the different regions, you know rural and urban, and taking that into account.....In the south, they need to keep in mind that we are still very modest and they would have to have training to be tactful.*

*So some consideration of the regional and cultural differences, again looking at Best Practices, pass those on to us, you know, give us ideas for funding give us as much specific information as possible especially in regards to like ratios, what is the ideal ratio.*

Another concern is how breastfeeding rates should be tracked and reported. Many want an evaluation form or tracking sheet useful in recording their breastfeeding rates to evaluate the impact of the program.

*So then our consultants when they go out to do the reviews then they would have to evaluate the peer counseling program as well. We would need to have an evaluation sheet form.*

*Then how do you quantify some of this? How to show that you have improved things. One of the best ways you can show that you've made an impact is looking at your rates of breastfeeding so that would be one of the other things I would want to be working on, how to report that and show your rates.*

*The only way I can think of at this point in some regards is to look at the overall breastfeeding data that we are collecting. And to monitor the initiation and duration rates.*

Some also see the need for a vision statement from the USDA in general on where the WIC Program is heading in the future and, in particular, where the peer counseling program is headed and why there is a need for it.

*Having the peer counselor manual all set, ready to go.....And then having technical advice and probably access to Best Practices, what has been proven to work and have the tools that show us that we don't have to reinvent the wheel.*

*There should be some kind of vision statement I would think, you know, or some kind of over arching guide why are we are doing this whole peer counseling thing. What are we working towards as a nation, the WIC Program?*

## PEER COUNSELORS

### Overview

Peer counselors invariably see their work in a positive light. They are happy to have a chance to help other women with breastfeeding, enjoy being able to use their experiences in productive ways, and are focused on the opportunity to provide a service to others like themselves.

### Key Findings

#### *Perceptions*

Peer counselors, when describing what peer counseling means to them, use words such as “helpful, support, learning, exciting, fulfilling, challenging, purpose, and rewarding.”

*I'd say help. Because that's what it's all about. It's moms helping moms.*

*Purpose, because helping other mothers to successfully nurse their children and giving them information that's correct and accurate is a wonderful purpose.*

*Support means I guess to me, well, first of all it's educating someone so they can make an informed decision on how to feed their baby but once they decide to breastfeed I think mothers need a lot of support because our society doesn't necessarily support breastfeeding.*

#### *Job Responsibilities*

Peer counselors describe their responsibilities in three general categories: educational, supportive, and administrative. Within these categories, peer counselors tend to have varying responsibilities based on their years and levels of experience. Peer counselors who have attained higher levels of education or experience sometimes handle special cases, such as clients with premature infants, or work in a supervisory role over other peer counselors.

Peer counselors are responsible for providing general breastfeeding support for women. Support includes, but is not limited to, education, home visits, hospital visits, telephone calls, and follow-up support. Telephone counseling is one of the most common forms of education and support offered. This provides a flexible means by which clients can optimize their contact time with relative ease and low cost. Some peer counselors are available to their clients at anytime, “24/7.” However, for the most part, clients call peer counselors during regular hours. When a client does contact the peer counselor late, it is typically when she is at a point of desperation or is experiencing a significant problem.

*I'm 24 hours a day. I have girls calling me in the middle of the night in my home and I don't care. You know I mean, I'm not a 9 to 5 lactation consultant. Mothers need help more than between 9 and 5. Mothers need 24 hour support.*

Peer counselors' work locations vary and include working from one clinic location to several, from their home and the clinic, or strictly from their home.

Peer counselors make their initial contacts with clients at various points in time, i.e., during the first trimester to as late as the last month of pregnancy. Most peer counselors will have received information on the client, but will not contact them until later in the pregnancy. Some counselors will call to introduce themselves, while a few will send information packets with an introductory cover letter. Some peer counselors see women on their first clinic visit and meet with mothers as part of routine visits. At this point the peer counselor will assess the woman's interest in breastfeeding and provide initial information. Counselors, during the woman's first visit to the clinic, may also schedule a separate appointment for breastfeeding counseling.

*Basically my job is to inform, to help through problems, and to be available to the moms with any concerns or questions they may have.*

Peer counselors provide breastfeeding education through a variety of activities: telephone counseling, one-on-one counseling, classes, informational packets, and breast-pump education.

*I see our prenatal women and basically give them information and facts and let them know about resources, try to help them understand the benefits of breastfeeding.*

Follow-up after the initial appointment includes educational efforts to provide detailed information and instruction on breastfeeding. Some peer counselors offer one-on-one educational support. A few peer counselors lead breastfeeding classes, while others assist the nutritionist or lactation consultant with such classes. Most peer counselors are involved to some extent with the breast pump programs. Responsibilities include maintaining records of breast pumps, cleaning breast pumps, and following up with women who have breast pumps. A few peer counselors also provide instruction on the use of breast pumps. Some peer counselors also coordinate special events for their clients. These are sometimes referred to as breastfeeding showers or picnics. Typically, the peer counselors will try to have refreshments and prizes available for these events.

Postpartum support, while still educational, places a greater emphasis on emotional support, encouragement, and trouble-shooting for the breastfeeding mother. Many peer counselors believe it is important to follow up with the client while she is still in the hospital, although only a few actually provide this service. This is typically due to restrictions on visitations imposed by hospital regulations.

*I have not done any hospital visits. That is something I would like to see changed. I would like to find some form that the hospital could contact me and have me come in if they are having trouble.*

Some peer counselors conduct home visits after delivery but this is unusual. If home visits are conducted typically they occur as a result of a request by the client or in special cases, such as if the patient has a lack of transportation or is experiencing a serious problem. A few counselors do not make home visits because of safety issues, as well as liability issues. In general, follow-up continues until the baby is weaned from breastfeeding. Continued follow-up can occur from a weekly basis to a monthly basis, depending upon the peer counselor.

## Documentation and Record-Keeping

Most peer counselors consider it useful and engage in some form of documentation to track client contacts. Methods of documentation include the use of paper forms, patient files, and computer files.

Client documentation includes when, where, and what the intention of the contact was as well as a detailed description of what was discussed or provided to the client. Contact documentation enables peer counselors to provide more efficient follow-up with clients. Some peer counselors also include a projected contact date so they know when the next contact with the client should be made. And in some agencies peer counselors used standardized initial assessment forms to help them identify whether the client is interested in breastfeeding and what type of information the mother needs.

During postpartum follow-up, peer counselors may also document the baby's weight, number of wet diapers in a day, and number of feedings to help monitor the client's breastfeeding progress. Peer counselors who work with breast pump leasing programs have additional paperwork, including monitoring the use and maintenance of pumps.

## Caseload

The typical schedule for a peer counselor can run from less than 10 hours a week to full-time at 40 hours a week. Caseloads for peer counselors also vary depending on the client contact method they employ. Those who use only phone calls may have between 20-150 client contacts a month. Others working in the WIC clinic only see fewer people in person, one-on-one. Other counselors not only see clients one-on-one, but also teach breastfeeding classes and take phone calls.

Peer counselors' feelings regarding their caseload are varied. Some who work even the largest caseloads feel that the workload is manageable. Others report that the number of moms that they have to see is overwhelming.

*It's always overwhelming. I think any caseload you have.*

*It's been working out great, but I kind of have shifts where I have a lot of women that are just having their babies and then I have times where I don't have any at that time, but it seems to work out just fine.*

*For me I think it's not enough. I think [my caseload] should be a little bit higher personally, but then I think I should be trying to conquer the whole world and get the whole world breastfeeding.*

## Recruitment and Hiring

Most peer counselors are hired using similar recruiting methods. Some learned about peer counseling positions as a result of becoming a WIC client or from having an appointment at the health department, where jobs are posted. Some are recruited by their own peer counselor. Others learn about the position through a friend, in the newspaper, or from outside organizations like La Leche League or EFNEP. The application and interview process could be as simple as being hired "on the spot" to one of extensive testing, applications, and interviews before being hired.

*I came and filled out an application and we did have a panel interview, where someone from my office, I think someone from maybe from the health department sat on the panel.*

*I heard about it through my friend and then it was in the newspaper.*

*Actually, I am a living example of a WIC mom. I was going to get my WIC coupons and I saw a poster and I wasn't working, I had just had my son. My son is four now. And I saw the job posted and I said Hey, I breastfed, I qualify for this.*

*Well I'm also a La Leche League leader and I thought well, if I knew who was expecting in town, I thought, and I have a lot of knowledge about that so I might as well share it.*

### *Compensation*

While most of the peer counselors are paid, some work as volunteers. One of the more significant concerns among peer counselors is whether funding will continue and whether or not they will lose their jobs if it is cut. Most recognize that peer counseling is a low paying job but still are happy to be working. Some counselors report that they would work as a peer counselor for free because they love doing it so much. To these women the job, which pays from \$6.50 an hour to \$10.50 an hour depending on the situation, is not about the money but about helping other women.

*I put in about 30 hours a week and I get paid for 20. That's the maximum I can get paid.*

*I think it is well paid. We did have some raises three years ago but they don't have money to give us more. So we are really fortunate to have a job. It is a very low paying job and there are very few people I think that would actually take the job.*

*Right now I'm a volunteer. I've been doing this for 10 years when my middle child was born. The funding was cut... the funding is not there for paid peer counselors.*

*I would have done it for free. It was just an added bonus to be paid.*

### *Reasons for Being Hired*

Most peer counselors believe that their own breastfeeding experiences are the main reasons they are hired for their positions. Upon beginning employment, most are WIC participants and several have experience with their own breastfeeding problems. Several have had a peer counselor from whom they received encouragement to also become a peer counselor.

*Probably because they could see that, I was really interested in breastfeeding and that I was really enjoying it and trying to keep doing it. And because I spoke both Spanish and English.*

*Personal experience. Like I breastfed like I said four children and also the fact that I was a WIC participant.*

*Because I already breastfeed my babies so I know what to experience in breastfeeding the babies. When I have some problems, I can share with those moms.*

### *Job Expectations*

The most significant job expectation of peer counselors is to help other mothers and guide them toward successful breastfeeding experience. Peer counselors want to be a positive influence in women's lives. They feel the need to teach others what they have learned and are committed to breastfeeding. They are motivated by service and not by money.

*Just the fact that I was hoping I could do a job well, that I would be able to be empowering to help somebody, to learn things myself.*

*More women to put baby to breast and have that experience of putting baby to breast. It is an experience I can't even put into words, it's an awesome thing.*

Peer counselors feel that they are helping not only individuals but society in general. They want other mothers to know that there are people out there who care about them.

*So those situations are just, it makes every time I go to a mom or meet with a mom, things like that, you know when things don't work well and there is a success it just makes all the difference. And I feel like, I've made a difference. And I feel like, I've made a difference in this person's life.*

*Basically after I found out what it was about I wanted to be able to touch other people's lives and show them that there is people out here that do care and it's not always about the money.*

*Experience, and being able to help other people, because I am really, really passionate about breastfeeding, I think it is the best form of nutrition and I think it has a lot of advantages, so I just really wanted to help other people and help them to understand how important it is.*

### *Benefits Received as a Peer Counselor*

Peer counselors value the knowledge they have received as a result of their work and some are interested in furthering their formal education, including certifications such as IBCLC.

*Just being able to share with family, friends outside of WIC I run a doula company. I help women through childbirth and just, and it helps me help them. Everything that I have learned.*

*To be honest a couple of times I felt like okay, is this worth it? Because I haven't felt like I've gotten the feedback or the interest like I've been putting into it.*

Peer counselors feel that they have grown personally by becoming a peer counselor. They feel more mature, have become less shy, feel more confident, and have gained more self-esteem. These women are passionate about their work and they feel fulfilled to be helping other women.

*I feel more mature. It is really fulfilling me myself as a person and as a woman. It really feels good...It make me feel important. I make a difference in somebody.*

*It made me a lot more confident. It's really hard to go out and speak to someone about personal things.*

*I think it kind of builds up my self-esteem some, being able to talk to people about breastfeeding.*

Most of the respondents feel that their training to become peer counselors is beneficial. They enjoy their classes and are gratified by the opportunities to attend conferences and further their education.

*I love the training. All the conferences that they send us on. They were really helpful. I've gained a tremendous amount of knowledge on different things about breastfeeding and about parenting.*

But the most powerful benefit reported by peer counselors is the gratification that comes with the actual client contact during which they get to see other women learning to breastfeed. The look of awe on the faces of mothers when they succeed for the first time, getting to see a mother and baby bonding as they nurse exceed all other rewards associated with being a peer counselor.

*I just love newly delivered moms and there's nothing more gratifying than to help a mom feed her baby, what I consider is the right way. So successfully having a baby breastfeed is my number one reason.*

*Really, I think the most important thing is when you are able to help someone that has a problem with breastfeeding but they really want to breastfeed.*

However, a small number of peer counselors feel like they are not accomplishing all their goals. For example, they report that they are not successful at recruiting mothers to breastfeeding classes or into peer counseling services.

#### *Family and Friends' Reaction*

Peer counselors' family and friends are positive and supportive of their position as peer counselors. Even though some family and friends have to be helped to understand what a peer counselor does and the value of that role, they are supportive once they learn more.

*I had to do some education about that. Everybody in my family knows that they breastfeed their kids. So I had nothing but positive reinforcement and support.*

*Friends, very supportive. My own children, very supportive. My sisters, negative. They are against breastfeeding.*

*My uncles are embarrassed, they don't like to talk about it, my mom is, my mom and my sister are both nurses and so they are just as happy as they can be.*

### *Training*

Peer counselors are trained in a range of topics that include:

- breast anatomy;
- benefits of breastfeeding;
- milk production;
- establishing a good milk supply;
- the importance of positioning and latching;
- what is normal for breastfeeding;
- what is not normal for breastfeeding; and
- common problems with breastfeeding.

The majority of peer counselors attend trainings they refer to as “the breastfeeding basics.” Some peer counselors were trained on the use of electric breast pumps so they may provide instruction to new mothers. Some peer counselors are trained on special topics related to breastfeeding such as breastfeeding and cesarean sections, medications, diet, contraception, smoking, and milk collection and storage. Only a few peer counselors are trained on topics related to diversity issues and working with different cultures.

Peer counselors feel that increased knowledge and the ability to use technical information enhance their credibility and capacity to handle more difficult issues with their clients. In general, peer counselors feel that any training they receive is useful. Peer counselors would like training to include more information on different ethnic groups and breastfeeding (specifically African Americans), continued updates on the latest breastfeeding information, and special topics such as postpartum depression and new techniques.

### Training Format

The format for peer counselor training varies in duration from a 2-day class to several hours a day for 4 weeks. All peer counselors receive some form of a peer-counseling manual or book that is used in their training. A few peer counselors attend trainings that involve only a thorough

review of the manual. Some peer counselors attend trainings that utilize videos, take-home assignments, and quizzes. Some attend trainings that include role-playing, such as acting out different scenarios for home visits. A few peer counselors participated in observations and shadowing as part of their training. This includes observing peer counselors teaching classes, doing home visits with peer counselors or lactation consultants, or touring various WIC clinics. A few peer counselors attend ongoing meetings or seminars with other peer counselors where they share stories and compare notes on their experiences. Peer counselors find this type of format particularly helpful. Other formats that peer counselors also find helpful are open discussions, observations, hands-on activities, and hearing real stories.

*All I can say about all the training is if they interact with the audience it's better for us. We learn and we retain it better than just a straight up lecture. Lectures are kind of boring. They will put me to sleep. So I love the ones when they actually had us interact with each other. And did things. Or had to stand up and be a part of it. I was able to retain more knowledge and utilized a lot of it when we were all hands on.*

### Needed Skills

Skills training is one component that most peer counselors mention as important and beneficial in their work. Skills training refers to job skills that peer counselors need to conduct breastfeeding peer counseling. Examples of skills provided in training include counseling skills, asking open-ended questions versus close-ended questions, listening skills, rapport building, communication skills, observation skills, and even completing paperwork. Some peer counselors shadow more experienced counselors to see peer counseling in action. Peer counselors who have had this experience feel it helps them to develop their own approach or style.

*I couldn't just go out there and just counsel a parent with not knowing how to speak with the person or how to approach the person or to have open-ended questions that you need to keep the conversation going or to end it. I learned how to handle and to counsel the parents in a different way than I probably would have if I would not have the training. They give you a proper way to handle the client and the way of going by counseling a client. A lot of times to be able to listen you can learn more about that than just hello, I am a peer counselor. But to stop and see what they have to say. How they are doing. To listen to them and to just be a listener and see what their needs are. To be able to listen and see where they are...*

### Ongoing Training

Peer counselors are provided with opportunities for continuing breastfeeding education. Vehicles for continuing education include local hospitals, state conferences, annual in-services, and La Leche League trainings. Some peer counselors receive ongoing training through breastfeeding updates provided by their managers or lactation consultants. A few peer counselors attend monthly or quarterly meetings with other peer counselors at which they share their experiences and ideas. A few peer counselors pursue CLC and IBCLC training. Peer counselors welcome ongoing training to keep them up to date on the newest breastfeeding information available.

### *Breastfeeding Referrals to Peer Counselors*

The majority of peer counselors obtain referrals from WIC staff. Pregnant clients complete questionnaires that serve to identify mothers needing a peer counselor. In some locations WIC advertises the services on television and as a result clients may call the peer counselors directly. The WIC nutritionist and the Health Department staff are the most frequent sources of client referrals.

*The clinic usually they send me an envelope with, when the moms first go in to the WIC clinic to say, okay, I'm pregnant and I would like to be in the program or something, they have them fill out a paper saying what their feelings are about breastfeeding.*

*They usually call me from the Health Department if they have a referral, and sometimes I make house visits, most of the time I just talk to people on the phone.*

*Actually the [WIC] nutritionist makes all the referrals.*

### *WIC Staff and Peer Counselors*

In general, peer counselors feel that WIC staff are supportive of their role. For peer counselors to be able to do their job, they feel it is important for all staff to be supportive and knowledgeable about breastfeeding and peer counseling. Counselors believe that all staff, from clerks to physicians, must be prepared to be able to refer clients to the peer counselor. Some peer counselors feel that until the staff became familiar with what and who the peer counselor is, there is some awkwardness between staff and peer counselors.

*The WIC staff is pretty supportive. They respect me when I come in. They give me referrals.*

*We have a staff that does a great job. They know immediately if a mom calls you know with a breastfeeding [problem], they page me, right away. They do a good job at that.*

### *Breastfeeding Referrals to Professional Staff*

Peer counselors are trained to refer mothers to professional staff, usually a lactation consultant, for follow-up if they feel the problems the mother is experiencing are outside her realm of expertise. Yet, the need to refer mothers to professional staff varies with the level and years of experience among peer counselors. Veteran peer counselors are comfortable addressing certain issues novice counselors are likely to need assistance handling.

*Normally, unless it's medical I will handle pretty much everything. If it's like thrush, mastitis, different things that happen with breastfeeding, then those are situations where they need to see a doctor. If it's just something basic medically speaking but as far as the process, the how to, different things that are going on, building up a milk supply, low milk supply, weaning, I do all of it. As long as it is not a medical situation like if a mother is nursing and she says I'm getting blood...I say 'you need to go to call your doctor.' Because I can't help her with that.*

*If I'm on the phone and the client asks me a question that I can't truly answer, give her a definite answer for, I will get back to her with that question immediately. After I get done talking to her I call, I get in contact with my supervisor, and I get the correct answer.*

### *Referrals to Community Resources and Services*

Peer counselors make referrals to community services for issues other than breastfeeding. However, peer counselors are not trained in making referrals. Most obtain information about services from flyers and by word of mouth, thus generating their own list or file of community resources. Referrals are generally made to WIC, Medicaid, Medicare, and Food Stamps; they are made for needs such as immunization, birth control, post partum depression, spousal abuse, and clothing. For those who do not make referrals, peer counselors cited reasons including the lack of services in their community and the fact that referrals are made only by social workers or through the WIC office.

*I make referrals. If I have a WIC eligible mom who is not on WIC I refer her to WIC. If I have a mom who has more than one child at the WIC eligible age I will try to encourage her to get the WIC for one child and refer her to get commodities for the other. I have referred moms to the State House Shelter and that is a shelter for women who have been abused. I refer moms to the County Independence Agency. I refer moms to the clothing places, whatever their needs are. If I know anything about it I refer moms to whatever their needs are.*

*Actually the Department of Health just gives us flyers and stuff as they hear about different things.*

### *Partnerships*

La Leche League is an important partner for peer counselors.

*Once in a while I do mention La Leche League, that we do have La Leche League meetings to a mother if she is having problems or needs more support or information about breastfeeding, that we do have meeting in town once a month. I do post a sign around town.*

*We work a little bit with La Leche League. They've given us handouts and stuff to hand out and we let the people, some of the breastfeeding people, know about it. We don't really endorse it or say that that is where they should go but we do give them that option that if they would like to, they can.*

Peer counselors also welcome partnerships with retail stores, for example Target, Toys-R-Us, and baby stores. Often, peer counselors build relationships with community groups and organizations for special events and occasions, such as World Breastfeeding Week.

*The times that [community organization and I] come together is like for World Breastfeeding Week, we engage ourselves with each other's agencies and do different things together as a community.*

Peer counselors also welcome partnerships with organizations serving prenatal and postpartum mothers.

### *Hospitals*

The relationships between peer counselors and hospitals are mixed. For some, peer counselors have great relationships with hospital staff including OB/GYN doctors. For others, however, there are turf issues between peer counselors and lactation consultants that play out in the hospital setting. Some lactation consultants, employed by hospitals, believe that peer counselors are an unneeded service.

*Very rarely [do home visits]. We have a fine line that we are not allowed to cross because most of the hospitals in the area have a lactation consultant on staff and to walk in on their area, they get a little cranky sometimes...*

Ideally, peer counselors would like doctors and nurses to refer patients to them once they have delivered, even in situations where there is a lactation consultant.

*I think I would have them, like have my number and when a woman that was coming in to have her baby, that I would like to have them talk to her and say, do you plan on breastfeeding or are you going to try? And if she is I would like them to call me, tell me that she is going to be having her baby and just let me know as soon as she does have her baby that they could call me I and I'll already be prepared to go in and help her.*

*I would like more [help] with the postnatal. Like when they are coming home from the hospital. I wish that the hospital would fax or something... 'hey this patient needs to be followed-up' ...I feel we need a referral on every patient that gets discharged.*

### *Supervision*

Nearly all peer counselors are working under supervision. The level of supervision ranges from a hands on direct services supervision to nominal oversight. A few peer counselors report that while they may have been assigned a supervisor, they are not actually supervised.

Various personnel supervise peer counselors including nutritionists, breastfeeding coordinators, program directors, and lactation consultants.

Some peer counselors receive an annual review, as a group, from their supervisor. Others receive monthly oversight in regularly scheduled meetings. Some peer counselors communicate by telephone with their supervisor. A few report that they are supervised in an informal manner, such as conversations and phone calls. Some are required to turn in paperwork that documents their client contacts, how many cases they see, how many they close, and the time worked. A few peer counselors have notebooks that are checked regularly to monitor their work. Some have

supervisors who will call clients to double check that peer counselors have been making their contacts. A few peer counselors are required to submit monthly or annual reports to their supervisor, which typically include information related to their caseload.

*I am pretty much on my own.*

*Not really supervised. No one goes in the home with me. Looks at my chart notes.*

Peer counselors agree that support by their supervisors is important. Peer counselors want access to someone who has knowledge, experience, and offers support. According to peer counselors, support includes more education, ongoing training, encouragement, and job praise. Peer counselors want positive feedback, i.e., to know if they are doing a good job. They also expect open communication with their supervisors. Peer counselors want supervisors to be readily available and accessible to them.

*I think I have it (support). Just being able to call my supervisor when I need to. Being able to contact somebody if necessary. What works is we talk on a weekly basis.*

*I think all peer counselors need to have good open communication with their supervisor and a good open communication with the coordinator of the statewide program.*

### *Challenges*

The administrative side of peer counseling presents unique challenges. Peer counselors have such a passion for helping moms breastfeed that they hate to take time away from that to deal with paperwork and other administrative duties. Another challenge is a perceived lack of support from the WIC administration, especially when they are not allowed to attend breastfeeding seminars.

*Paperwork, that's always a stickler.*

*The administration, they are not very supportive of a lot of the things that we want to do.*

Peer counselors are frustrated when mothers give up on breastfeeding. They are particularly frustrated when they are unable to reach clients because phones have been disconnected.

*So that's a little frustrating that they gave up instead of call you for more help.*

*Just getting a hold of everyone. Everyone is not available all the time when I call or they've had their phone disconnected.*

Many counselors said that they must contend with doctors who do not support breastfeeding and that their work with clients can be undone in the hospitals by unsupportive staff and formula discharge gift packs.

*We had a lot of doctors in the area that were not against breastfeeding but they did not advocate it. So that was difficult.*

In addition, peer counselors are frustrated by the lack of adequate support at home from their clients' family.

*Sometimes when a participant wants to breastfeed, they are having severe, severe problems, and they don't have any support at home. It's kind of difficult because sometimes since they have the support here at WIC but they don't have it at home, most likely they might give up for not having the support at home.*

*To keep the women breastfeeding who are not too sure about it in the first place and don't have a lot of support of a husband or boyfriend who doesn't want them to breastfeed, and their mother or mother-in-law wants to give the baby a bottle.*

Many counselors find it challenging to work from home and deal with their own family life. Even if they work at WIC, the home demands sometimes can be problematic.

*The number one is working from home and dealing with my family life. That's the number one challenge.*

#### *Similarities Between Peer Counselors and Clients*

Peer counselors agree that similarities between the client and themselves are important. The common thread is breastfeeding. Peer counselors feel that for clients to feel comfortable with them, they must know that the peer counselor has breastfed. Peer counselors are split on whether or not similarities such as ethnic background, economic status, or culture are important. Some peer counselors feel that if you are good at establishing rapport with women, ethnic and cultural boundaries do not matter. However, some believe age and ethnicity are significant factors in their ability to effectively interact with women.

*I hate to say age and race, but it's age and race. I watch some of the younger African American ladies that come to my class and it's so obvious. They wriggle their little noses and no. And we've had an African American volunteer peer counselor, and they just related to her differently than how they did to me. I hate to say it but it's true.*

*I think experience is heavier than anything else, ethnicity or education, just pure know-how is enough to make people feel like you know what you are talking about and they can trust your judgment. You can't be all things to all people so there is no way that I could say that we have a Black peer counselor in this office and Asians in that one and Hispanics in that one. It would help if there could be a rainbow of opportunities for WIC clients to*

*come in and speak to a specific person of their ethnicity but it is probably impossible.*

Others feel that having a common cultural background and/or understanding helps in correcting cultural misperceptions and myths.

*I think the first thing that anyone should understand is basically the culture the person comes from. If you understand a little bit about how they were raised or how they grew up, things that they do that you might not do. If they just understand some of their culture it makes [counseling] a little easier.*

Language is of course an important issue when it comes to helping mothers with breastfeeding.

*I have Hispanic clients that speak Spanish and I can't so it's hard for me to even do anything with them. I did a home visits once with a girl that didn't speak English and so it was just pretty much showing her how to position the baby. That was hard.*

#### *Needed Changes*

Many peer counselors say they would not change anything about their job. They love what they do and enjoy coming to work.

Changes that were mentioned include additional pay, more hours, and not having to deal with breast pumps. Several women would like more educational opportunities and to be more fully reimbursed for continuing education. They would like hospitals to stop giving out formula to breastfeeding moms and for the hospital to notify them more quickly when a woman has delivered her baby.

*I wish I could change how much monetary support I get to further my education.*

*One thing I would change too at the hospitals is that they don't give out formula to babies if it's a breastfeeding mom. But I have no control over that.*

*I think that I would just change, change that it would be easier for, like me to know exactly when the women have had their babies.*

#### *Client Feedback*

Peer counselors enjoy receiving feedback from their clients. Clients are often appreciative and will send letters share compliments in person.

*But the baby took to the breast, latched on, and I've touched base with her three times since then and she keeps saying, "God Bless you. Thank you, thank you so much."*

*I've got thank you letters from a lot of them and that I really helped them a lot and I helped them make it so they were able to breastfeed longer.*

*Just them saying, oh I thought I didn't have any milk, but you explained it to me that the more I breastfeed the more milk I'm going to have. That really helps a lot. Just in general when they come back and say that the information we gave them helped a lot.*

### *Program Strengths*

Peer counselors view the strengths of their programs as having a good follow-up system with clients, valuing each client equally, providing consistent breastfeeding reinforcement from all staff, maintaining contact with mothers, and consistently following through.

*I think [the program] is good that we have a system for following up once someone has their baby. We call them every so often. Writing notes down so if [another peer counselor] comes into the office and calls that person she can see what's going on. I think initial follow-up within the first two weeks is the most critical and I think trying to work more intensely in that time has been helpful to help [the moms] keep on breastfeeding.*

*I think that the way we have got it going now that each client feels just as important as the last one, and they are being treated as human beings, that they are not just another person with another problem, they are a person with a problem, and they are individualized and not lumped together into a big pile.*

### *Improvements to Current Programs*

Peer counselors would like to see a reduction in conflict between hospital policies and what's best for mothers and babies, more regular communication with pregnant women, and the formation of a support group for breastfeeding women.

*I think I would like to basically get across to women how beneficial it is to breastfeed and have a higher rate of breastfeeding women.*

*I think the only thing I can think of is that I would change is trying to get to see the mother more often, during the pregnancy, as it is I believe I see them every other month...The more time I could spend with them the [more] I could educate them on something different every time and hopefully by the time the end of the pregnancy did get here they would have decided to breastfeed.*

*I would definitely like to improve the ability to get it out there that WIC offers this particular service...because a lot of moms are not aware...*

### *Recommendations*

Peer counselors' recommendations include:

- Increased pay;
- Strong training programs;
- Peer counseling programs initiated throughout the States; and

- Recruitment of prospective peer counselors from among the WIC clientele who have breastfed.

Some peer counselors shared the following thoughts in regards to their recommendations:

*I know it is a granted position, so the rate of pay is probably pretty much locked down, pretty low, but if they are looking for a specific education or a specific type of person, being that that person either is bilingual or something like that they would definitely need to increase the pay.*

*I would like to see [our state] have more education for the peer counselors because sometimes I feel like we don't have enough information available to us at times.*

*I would say start off with a good training program...Just offering support on training after the peer counselor gets going is helpful too.*

*I just think they ought to do it. It is so important. With healthcare costs the way they are. What a difference [breastfeeding] makes and the money even the government would save by putting money into breastfeeding and peer counselors.*

*I would say get some of their [WIC] clientele, people that have breastfed that have been successful, train them, have a training and get them started on working. The peer counselor, ideally, is supposed to be people that are like [the WIC client]. That's what the peer means. And I think that works really, really well. They have someone that is like them.*

## NON-WIC PEER COUNSELING PROGRAMS

### Hospital-Based Peer Counseling Programs

Best Start researchers interviewed one hospital-based peer counseling program, which is an excellent example of this type of program but is by no means indicative of the many ways these programs can be administrated. This particular program is set up as a stand-alone program. There is no partnering outside the hospital in terms of referral or sharing duties with other agencies.

This program is funded through several sources; it has a long-term grant from a federal agency plus several other local foundation grants that allow for hiring of additional peer counselors. The program recruits its peer counselors through a doula (female labor coach) program in the hospital. The employees are shared by the two programs.

*I think with peer counseling it's all about the quality of the peer. So the problems that we have run into have been peers that haven't been responsible or reliable.*

*...the most effective peer counselors for us are women who come from the same community who are of the same ethnicity and race and speak the same language as our families. So to qualify for that they have struggles in their lives. So the biggest obstacle has been to help them to overcome their struggles so that they can hold down a job and be reliable and responsible... a lot of times we lose our peers because the job brings with it self-esteem and they take advantage of that and of their new contacts and they go on to school and bigger and better things, which is what we want.*

Peer counselors are trained by hospital staff, specifically lactation professionals (IBCLC). They are closely supervised by lactation consultants when they are working with patients. The practice parameters are very carefully outlined, and peer counselors only provide basic promotion and support. If other issues arise, including a need for referral to another program such as social services, the lactation consultant takes over the case. Health professional staff are receptive to peer counselor involvement with patients. Staff appreciate the availability of peer counselors to provide extended support for mothers having trouble with latch or positioning. This frees professionals from what is perceived to be a large time commitment associated with initiating breastfeeding.

*We are finding, in terms of our evaluation, that it's an effective program for the NICU setting in terms of increasing breastfeeding duration rates for our families.*

Peer counselors primarily work with mothers whose premature infants are in the neonatal intensive care unit (NICU). If time permits they also work the regular floor and see other mothers. They are closely supervised by the lactation consultant on duty, are paid an hourly wage, and work 9-12 hours per week. They do no phone calling and do not provide follow-up for mothers once they leave the hospital. Referrals to other agencies for follow-up are not

provided. The interviewee is not aware of any peer counseling programs in the area that are administered by other agencies.

Peer counselors keep records of their contacts with mothers, issues they deal with, and other pieces of information that are used in an ongoing evaluation of the program. They do not put information in patients' charts. Notes are shared with their supervisor and the data analysis staff who evaluate the program.

### **Programs with Multiple Agency Partners**

Interviews were conducted with two programs that work with multiple partners for funding, program administration, and training peer counselors. These partners are WIC, Cooperative Extension Service, and local hospitals. This third partner, the hospital, is regional in nature within each State and is not a consistent partnering agency.

Both programs see the partnership model as the strength of the program. One of the programs requires a partnership with a hospital in the region and the other uses the hospital as an optional partner. This second program has experienced resistance to non-hospital employees involved in the care of patients.

*Sometimes two of the three partners (WIC, Extension, local hospital) are interested and one is not. If so we don't go. Because we just really believe it needs the partnership to make it work. And how we divide the responsibilities is we believe in having key members from these three organizations, and clearly WIC and Extension do the lion's share of the work. But the hospital is a key player because they give us access to their patients at a critical time.*

*Sometimes WIC offices are very busy and they have a tendency to be short staffed so sometimes our peer counselor, the program itself, can be looked at as just another thing to do. It's another person to work with. But that's probably the biggest struggle that we have in those offices that they just don't have the time...so then it's tough for our peer counselors to get referrals and they have to work a little harder.*

Funding issues are a recurring theme in all of these settings. With these partnership models funding comes from multiple sources. WIC and Extension provide most of the funding. In areas where hospitals are in the partnership, in-kind funding is provided by allowing hospital staff time to work with peer counselors. This can be up to 5% of a lactation consultant, patient education staff or obstetrical nursing staff time. When this occurs the Peer Counseling Program can apply for matching funds from foundation sources up to the value of that time. One of the programs has partners with a research center at a university. This partner provides additional expertise in training program development and evaluation.

Both programs are set up in similar fashion. Extension provides program administration and money management and most often is the lead agency in finding funding sources. Peer counselors in this setting are employees of Extension as 90% FTE's. They make about \$18,000 per year and have liability coverage, health benefits, mileage reimbursement, pagers, and, in some cases, cell phones supplied for work purposes. One program has the additional benefit of

offering reimbursement to peer counselors for undergraduate and graduate classes at the university after 3 years of service.

*For a lot of these peer counselors this is the first work position they've ever held and so we are empowering them also so that's what works best...I'm seeing the trend of them becoming lactation consultants and moving into that rather than moving into Extension Educator role. I have three Peer Counselors that have gone on to get their IBCLC so that's wonderful.*

WIC's role in the partnership is on several levels. WIC provides access to a pool of potential peer counselors. Both of these programs seek potential peer counselors from the WIC population. WIC also provides lactation expertise in the form of an IBCLC or nutritionist with advanced lactation training for back-up support of the peer counselor. Peer counselors are restricted in their scope of practice to support and promotion activities. If something out this practice parameter is encountered they refer to a professional health care provider, either their lactation supervisor or a physician/health clinic. WIC participates in training peer counselors, usually providing technical breastfeeding material, while Extension provides administrative training. Some areas have contractual professional lactation support through local private practice lactation consultants or a hospital-based IBCLC.

*Any time you are putting non-professionals out there in the world they need to be tied to the apron strings of a professional.*

*Her scope of work is to educate the moms about breastfeeding, the benefits of breastfeeding, what it can do for her, what it can do for the baby. It's empowering her to make that decision. What we ask them to do is to give the mom all the information...and then they really be there as her support. They go into the home. They will meet them at their WIC appointment and work with them there. They teach WIC classes, prenatal classes and breastfeeding classes to reach the moms there...the goal is to just really be a friend.*

*Some will go to the hospital and do the prenatal education at the hospital. Some of them are going to community centers, daycare centers, educating about breastfeeding and breast milk and that type of thing.*

*It (the peer counselor) has to be a person that is comfortable talking about breastfeeding, comfortable observing a mom breastfeeding because sometimes it takes that, to observe. It takes someone that is very patient, that is a good communicator, sensitive to mom's decisions.*

*We hire them from the population that we are serving. We use that WIC population to look for our new peer counselors because that's what makes it a peer. Those are the people that these mothers are going to talk to...the moms just do so much better with someone that is at their level whether it is financially, family-wise, the experiences that the peer counselor has had herself for them to say I know it's tough.*

Each of these programs uses its own training curriculum. These programs are similar because they share information. However, each has developed its own administrative tools that the peer counselors use to document their contacts, expense reimbursements, time, and data collection. Extension tracks its employees carefully. Housing the program in the Extension offices is the standard. Peer counselors have performance reviews each year, have opportunity for advancement within the program, and are monitored monthly from caseload reports and other documentation of contacts.

In both programs “benefits to families” is the main reason they continue to fund and manage this service. The positive impact on the families served and the subsequent outcomes make the effort required to overcome difficulties worth it.

*We find that the mothers call and that those are the times when if they couldn't get an answer they would've gotten formula. And they tell us that over and over. If you hadn't helped me today I would've given my baby formula. We are sometimes contradicting what they are hearing from their mothers or their mother in laws or somebody else in that neighborhood.*

### **Other Program Models**

Three other programs interviewed primarily train peer counselors for agencies that employ peer counselors and manage their programs internally. These programs use different approaches to training and have distinct philosophies regarding the role of peer counselors in the health care system.

The first program is a training organization that provides training and funding for community agencies during the first year of a peer counselor's employment. This organization has been training peer counselors for nearly 20 years and has had great success in placement of their trainees. The funding structure provides 100% funding for 6 months with decreasing amounts over the course of the second half of the year. In the second year the agency takes on the entire cost. Peer counselors work for a set stipend, and funding is provided through grants and foundation funds as well as philanthropic donations. Data collection is designed so that it is flexible enough to be done with paper and pencil or on a computer. Collection systems that are too complicated or threatening for the peer counselors limit the useful reporting of data.

*We found that if we want to continue getting funding to place peer counselors in different agencies we really need to strengthen our own program evaluation. So we need number of contacts in a month and number of women served, outcome measure for breastfeeding incidence and duration, and referrals.*

Types of organizations that use peer counselors trained by this organization include agencies in which medical care and social service programs intersect, health family programs, large hospital and maternity centers, or home visiting programs. Often the social service arm of an agency serves as the administrative home for the peer counselor program. Peer counselor coordinators are provided for the local hospital and maternity center. This is a long-standing partnership that continues to work well.

Peer counselors in this system are required to have a command of the English language and be bilingual or bicultural in order to work with monolingual clients.

*The peer counselor is sort of a bridge person who helps to advocate for her clients, and if the client is monolingual she needs someone to help translate both the language and the system to her.*

They also recommend that peer counselors come from the community in which they will practice.

*In general if you've got someone who has come from the same socioeconomic background as the women being served but can serve as a role model because she has been successful in getting an education, getting a job, assuming a leadership position in her community, those are the people that are really successful. Those are the mentors. They may have achieved middle class status in that process, and that doesn't necessarily disqualify them...So you are not just serving a woman who gets all her information from you, but you are a symbol of someone who has moved from that community into a position of leadership so that other people believe that they can do it too.*

Liability issues are handled through the employing agency. General professional liability policies cover peer counselors as well. Risk is limited through good training and supervision, with liability coverage as a back up. There is also a back-up system that links peer counselors with clinicians so that referral options are readily available to address issues outside the peer counselor practice parameters.

Recommendations to start-up programs focus on the importance of having a strong commitment from the central administration. Peer counseling needs to be a central priority of the statewide WIC organization. They feel it takes commitment from the State organization and the local agency. There needs to be a system for listening to peer counselors to understand how the program is working. Maintaining referrals into the peer counseling system, assuring that there is appropriate work space, conducting program evaluation, and maintaining a stipend or salary structure for peer counselors are all recommended. Ongoing support and supervision of peer counselors after the initial training are also recommended.

The second program uses a training curriculum distributed by a international breastfeeding support organization. This program does not administer the peer counseling programs, but provides training in breastfeeding basics and communication skills for any agencies in need of peer counselors. Trainers conduct trainings throughout the country and fees are charged for trainings.

*Everyone needs the same basic breastfeeding information but it's how you present that information and how you go about doing the mother-to-mother support that makes the real difference. It's not about the curriculum. It's not about the program. It's about assessing and adapting to each individual set of people that you are training as peer counselors so that you get a peer counselor who can talk to the women of her community.*

The program is sustained by grants from private sources and by the purchase of training materials by the contracting agencies.

Peer counselors must have breastfed their own babies for at least 6 months. At times those with less experience or no personal experience can be trained to function as a peer counselor but the ideal is to be a mother who has breastfed for 6 months. Counselors must have sufficient language skills to communicate with other women about breastfeeding. They must understand the benefits of breastfeeding for the mother and the baby. Peer counselors must be reliable and responsible given that they are required to schedule support meetings for new mothers, facilitate those meetings, and generally provide grassroots breastfeeding support in their own community.

Peer counselors also need to understand the importance of continuing breastfeeding. Leadership qualities are favored among the women who may be recruited to be peer counselors. In this system a peer counselor must have a personality that is open and a nonjudgmental in order to be an effective counselor and educator.

Peer counselors trained in this program have many different parameters of work. Most of them work in WIC but they may also conduct outreach through other means. Phone counseling, hospital visits, home visits, and private clinics may be venues for conducting outreach. Some peer counselors manage phone lines and hot lines around the country. They may facilitate local support groups in homes or churches or at WIC. Some of these women work in white-collar businesses and corporations. Peer counselors are, in fact, trained to work with women in all walks of society.

The third program is similar to program number two and in fact uses that program's training system as a guide for their own training efforts. The training provided by this group is targeting the African American population in the United States and emphasizes a training component that encourages the peer counselor to improve her educational and employment status. Trainees are encouraged to keep track of their lactation support hours and to prepare to "sit" for the IBCLC exam. They connect trained peer counselors with lactation consultants as mentors.

The training includes segments on promoting breastfeeding to the men and grandmothers of the community. The training emphasizes that once the fathers or grandmothers are educated about breastfeeding, they become supportive of and encourage breastfeeding in their families. These educational contacts are most effective in the prenatal period.

The philosophical view of a peer counselor trainee is quite different for this group. In this training approach personal breastfeeding experience isn't the main requirement. Being part of the culture group and the community is more highly valued. As a result many of these peer counselors have never had babies or breastfed.

*I think it cuts out a large amount of time that could be spent trying to get trust established when they are part of the same cultural group.*

The program maintains a helpline. Some people come to participate in training as a supplement to existing jobs. Others participate to enhance their abilities to help mothers. This program also sends trainers across the country to train agencies that target this same population group.

Peer counselors in this group are trained to keep minimal records of contacts, breastfeeding problems they encounter, and hours they work. They are currently initiating an evaluation component in the organization so that record keeping is becoming more important.

This group also runs a national coalition of breastfeeding advocates who are dedicated to promoting breastfeeding in this culture group.

## PEER COUNSELING CURRICULUM ASSESSMENTS

A total of 17 WIC curriculum programs were assessed, including 13 strictly WIC program curricula, two non-WIC curricula, and two WIC/Cooperative Extension Service collaborative programs. One of the WIC curricula assessed was from an Indian Tribal Organization.

### **Management Curricula**

Among the total curriculum programs assessed, 10 provide information for program managers or peer counseling program trainers. Very few actually provide dedicated training for managers; only three provide a separate training manual specifically for program managers. Most provide a chapter or a few pages of "notes" within the peer counseling training manual for managers. Many of the curriculum programs for managers simply provide speaker's notes to guide a trainer in delivering the peer counseling training to newly hired staff. All of the curricula with information for program managers or trainers are designed to be read by the staff rather than delivered in a formal presentation. None of the modules or information includes presentation overheads or other visuals designed for a formal training setting.

Among those curricula providing either a dedicated training module or information for trainers/program managers, the following was most frequently covered:

### **Program Administration**

Most include brief information on general program administration, including:

#### *Determining Staffing Needs*

Most provide guidance on hiring criteria for breastfeeding peer counselors, brief suggestions for where to recruit qualified peer counselors, and an application form. The non-WIC programs all include sample flyers to recruit peer counselors in the community. Many of the WIC Programs also provide official State-level contracts used in hiring contractual staff. Very few of the WIC materials provide details on how to determine the number of staff or full-time equivalents (FTEs), or appropriate caseload for a peer counselor. It is noteworthy that all of the non-WIC curriculum programs did provide this type of information for program managers. Retention of staff is only briefly mentioned in one or two of the programs. The non-WIC curricula are more likely to include this type of information, as well as guidance on mentoring and supporting peer counselors through their life circumstances.

#### *Supervision and Monitoring*

Very little is communicated about program supervision, other than to whom the peer counselor might report. Most States allow local agencies to determine lines of supervision. Several of the curricula providing program information include suggestions for program monitoring. Nearly all provide weekly and monthly reporting forms for staff to report hours worked, travel charged, and statistical information about number of clients served, age of infant at weaning, etc.

#### *Funding*

Very few modules provide information on ways to fund a peer counseling program. Some provide guidelines on salary requirements for peer counselors. One provides information on evaluating the need for a peer counseling program, and ways to structure it.

### *Job Management*

All curricula providing information or modules for program managers include job descriptions for peer counselors, as well as information on the general roles of the peer counselor. Some curricula also provide qualifications for and job duties of peer counseling program trainers and supervisors. Very few of the management curricula provide information on practice parameters or contact frequency recommended, although this information is included in the peer counseling curricula in nearly all cases.

### *Liability Issues*

Only a few of the training curricula address liability issues. None deals with actual legal coverage, but address, instead, the need for peer counselors to stay within practice parameters for their best protection.

### *Program Protocols*

Most curricula materials for program managers and supervisors provide copies of documentation and reporting forms. Rarely are agency policies and protocols for the program included, although it is anticipated that this information might be available in other agency materials such as policy and procedure manuals. One program provides relevant pages copied out of their State policy and procedure manual in the curriculum for managers.

### *Training of Staff*

Many of the curriculum programs include notes for the trainer, including guidelines on visuals, activities, handouts, and discussion questions. A few also provide trainers with information on adult learning theory and styles, and hierarchy of needs.

### *Program Promotion*

A few of the programs provide very brief information on the importance of peer counseling, although research data documenting proven benefits of peer counseling are not apparent in any of the programs. One non-WIC program provides a section on "Success Stories" of peer counseling with anecdotal stories of ways peer counselors have made a difference in the lives of new mothers. None of the curriculum programs provides information on promoting the program with WIC staff. The programs only briefly touch on building program support internally. The non-WIC programs are more likely to include limited information on partners within the local community.

## **Peer Counseling Training Curricula**

The peer counselor training curricula assessed provide numerous common elements. It should be noted that many WIC Program curricula provide similar materials and handouts, and it appears many have been adapted from the Texas WIC curriculum. Very few of the curricula, however, actually credit Texas WIC for the handouts and materials used, and some credit other programs for the same materials. It is unclear exactly where some of these pieces may have originated.

### *Training and Curriculum Format*

Nearly all of the curriculum materials are divided into a series of short classes, although there is no consistency in the number or length of classes. Most range from four to six classes of

approximately two to three hours each, although some provide for a series of up to 10 classes. Some are set up as one- or two-day training events; one is designed as a one-day training plus a ½ day workshop on the Best Start 3-Step Counseling Strategy©. Some programs include a graduation program at the end of the training, although very few actually provide details on how to set up a graduation, who to invite, etc. One program provides sample flyers.

All curricula assessed are packaged in three-ring binders, with tabs to separate individual class lessons. Most provide handout masters that can also be used as originals for transparencies. A few actually provide transparencies. Only one curriculum assessed provides a Power Point handout, although the actual electronic floppy disk is not included.

One program provides user-friendly single-page handouts on each topic area for later review and referral by the peer counselors. These handouts include counseling tips and questions to ask the mother in each of the topic areas. Handouts are also divided into easy-to-follow charts showing "symptoms" and "causes" to guide the peer counselor in providing appropriate education.

Most training programs tend to be primarily didactic in nature, designed as lecture programs, with occasional discussion questions interspersed throughout. Very few are interactive in focus other than demonstration or practice of breastfeeding positioning with a demonstration doll, or manual breast expression practice using a cloth breast model. Role plays are included in the counseling section in nearly all of the programs. Many use videos to demonstrate positioning and latch. Some programs require that peer counselors read the *Womanly Art of Breastfeeding* (La Leche League) as part of their independent study. Only one of the training programs includes observation of a mother-infant dyad, or encourages peer counselors to shadow another peer counselor, lactation consultant, or WIC nutritionist.

Some training programs include such things as pre-tests and post-tests, training evaluation forms, and reference bibliography. A small number of curricula also provide a glossary of terms after each chapter or at the end of the peer counselor's training manual.

#### *Breastfeeding Technique and Management Topic Areas*

Most training curricula include many key common elements:

##### *Promotion and Support of Breastfeeding*

- Benefits of breastfeeding (to infant, mother, family, and society)
- Constituents of human milk (comparison of human milk to artificial baby milks, components of breast milk, anti-infective properties of human milk, and milk composition at various stages)
- Contraindications to breastfeeding
- Addressing barriers of mothers, including myths/facts about breastfeeding
- Gaining support from family members (particularly the father)
- Breastfeeding trends, including national and state level breastfeeding rates

### *Basic Breastfeeding Technique*

- Anatomy and physiology of lactation (breast function, hormones of lactation, and the milk producing process)
- Prenatal preparation for breastfeeding (breast assessment/nipple types, things to avoid during pregnancy, and ways to prepare for breastfeeding)
- Basic positioning and latch of the infant at the breast (one program provides an observation form to guide appropriate assessment of positioning and latch)
- Tips for early success (things to avoid in the early days, adjusting to a new baby, working with hospital staff to achieve appropriate breastfeeding practices)

### *Prevention and Management of Common Maternal Breastfeeding Problems*

- Sore nipples, nipple thrush
- Engorgement and leaking
- Plugged ducts and mastitis
- Low milk supply (although this is not dealt with very thoroughly in most programs)
- Basic mother care (breast care, maternal nutrition, avoiding harmful products, family planning, and adjusting to a newborn)

### *Prevention and Management of Common Infant Breastfeeding Problems*

- Types of infants (sucking styles of infants, fussy babies, sleepy babies)
- Feeding frequency and duration
- Signs of adequate intake
- Slow weight gain
- Jaundice, hypoglycemia, and birth defects
- Preterm infants
- Sick babies

### *Special Situations*

- Breastfeeding multiples
- Tandem nursing and breastfeeding while pregnant (dealt with in some programs)
- Separation of mother and infant, including returning to work strategies
- Milk expression techniques/storage and handling of human milk

### *Infant Growth and Development/Parenting Issues*

- Normal infant growth, and appetite or growth spurts
- Starting solid foods
- Nursing strikes
- Weaning

(Some programs provide information on other parenting issues such as sleeping through the night, discipline, and dealing with siblings. Some programs also include information on teething and biting.)

### *Counseling Techniques*

All curriculum programs assessed include at least some discussion of appropriate counseling techniques. Many provide information and examples of counseling techniques from the Best Start 3-Step Counseling Strategy©, or the "LOVE" counseling method. All include at least some type of active listening technique as part of their counseling methods.

Most programs at least briefly mention telephone counseling skills, although some provide more detail with practice examples and handouts.

Many programs also deal with cultural sensitivity issues, although in varied ways. A few only deal with common issues such as comfort zones and language issues. Some provide charts with commonly held cultural beliefs of Hispanic, African American, Native American, and Asian families. The non-WIC curricula are more likely to encourage peer counselors to assess each mother individually for her unique beliefs and provide appropriate support.

Two programs include discussion of grief in their program. Only two programs include specific strategies on counseling teens, although others do allude to issues of teens in role plays and group discussion scenarios.

### *WIC Program Information*

Many programs mention the importance of WIC, and a few provide details about such things as WIC benefits, food packages for breastfeeding mothers, WIC eligibility criteria, and certification procedures. None describes the various roles of WIC staff, although this could be included in the training in another way. A few discuss the role of WIC in promoting and supporting breastfeeding, and one provides the National WIC Association breastfeeding promotion guidelines as handouts.

### *Referrals*

All programs mention that peer counselors should refer problems outside their area of expertise to a WIC Program supervisor or breastfeeding consultant. Only one discusses referrals to other public health programs, or community agencies and partners. Some also includes "red flags" to watch for in the mother and the infant that warrant referring a mother to her physician; however, this is not a standard feature of most programs. One program created a short video, "The Peer

Counselor: A Loving Link in a Caring Team," with interviews of peer counselors regarding their comfort level staying within practice parameters. The video focuses on the key types of referrals peer counselors most often make, including referrals to medical professionals, WIC, lactation professionals, and social service programs.

#### *Peer Counselor Role and Job Responsibilities*

All programs include at least basic information about the role of the peer counselor, including job description and basic expectations, although practice parameters are not clearly spelled out in many of the training program materials. Some include contact frequency expectations, although this is not a standard feature of all programs. Very few include organizational skills, such as how to set up a tickler card system, or appropriate follow-up methods. None of the programs addresses issues of working at home or professional expectations. Very few include information on how to work with WIC staff or strategies for becoming part of the WIC team. A limited number of programs provide information on appropriate procedures in making home or hospital visits.

#### *Documentation*

All training programs assessed provide standard reporting forms and documentation procedures. These include:

- Client contact checklist
- Reporting form to record hours charged, travel incurred, etc.
- Monthly reporting form to report caseload of mothers followed the previous month
- Confidentiality agreement
- Monthly reporting form to report caseload of mothers followed the previous month

Other documentation forms found in a few programs include group class logs, training checklists, breast pump tracking form, referral forms that can be used by WIC staff to assign WIC clients to peer counselors, and, in one program, a peer counselor "self evaluation" form to track her growth and progress in her job.

#### *Resources*

Most curriculum programs provide information on breastfeeding resources. Most focus on resources available through the WIC Program, and many also include information on community resources such as lactation consultants, breastfeeding coalitions, and health providers. Some also include national resources such as materials available through commercial and non-profit organizations. Locations for accessing breast pumps are also included in the resources for some programs.

#### *Other Areas Covered*

The non-WIC programs set up as collaborative efforts with the State's Cooperative Extension Program include much more information on maternal and infant nutrition, with great detail given to assessing appropriate diet, the Food Guide Pyramid, and special nutrition issues of the mother such as diabetes, overweight, and other issues.

All of the non-WIC and one of the WIC training programs also include information on teaching classes or leading support groups, although only brief information is provided. This is interesting in light of the fact that teaching classes is considered part of the routine job responsibilities for peer counselors in most programs.

Some States with breastfeeding legislation also discuss the laws in their State, ramifications, and how to communicate the laws to mothers. A few also include information on the World Health Organization Code of Marketing of Breast Milk Substitutes, and marketing practices of infant formula companies.

#### *Areas Not Covered*

Although nearly all programs include discussion of barriers or myths about breastfeeding, very few actually seem to provide strategies for such things as going out in public, dealing with other issues that may cause embarrassment, and gaining support of female relatives. It is also noteworthy that although real or perceived low milk supply is a common reported reason for supplementing and for weaning, strong emphasis on teaching peer counselors how to help mothers maintain and build milk supply is not apparent. Emphasis on supporting mothers during critical weaning periods is also not specifically addressed in any of the training curricula.

## CONCLUSION

The use of peer counseling initiatives in public health programs is a widely used technique to target behavior change. Breastfeeding peer counseling employs a wide array of activities to improve initiation and duration rates among women in a range of settings. The Department of Agriculture's Food and Nutrition Service contracted with Best Start Social Marketing to develop a breastfeeding peer counseling program model, "Using Loving Support to Implement Best Practices in Peer Counseling."

Interviews were conducted with WIC Program administrators and staff who work among three assigned categories of WIC Programs: programs with current peer counseling programs, programs that once utilized peer counseling but have discontinued, and programs that have never attempted to implement peer counseling. Peer counselors currently serving WIC mothers were also interviewed. Interviews were also conducted with non-WIC organizations that employ peer counseling. In addition, a limited number of peer counseling curricula were screened and assessed to ascertain the common components shared by the respective curricula.

The findings indicated that difficulties experienced and anticipated were similar across all interviewed programs. There were many barriers to successful program implementation and maintenance.

Several significant issues arose from the upper administrative level of peer counseling programs. Legislative, regulatory, and policy mandates for peer counseling are inadequate or non-existent. Additionally, there is a lack of support from multiple levels of public health administration.

Financial obstacles complicate the initiation, implementation, and maintenance of peer counseling programs. Insufficient resources for program initiation and discontinuity of funding streams provide an ongoing challenge to these programs. Compensation for peer counselors is regarded as either lacking or inadequate.

The lack of a standardized approach or guidelines for peer counseling programs is evident in the issues faced by programs. There is a lack of consistency in peer counseling administration and program structure. Inexperienced program developers and the lack of program models inhibit program implementation. There is no WIC specific breastfeeding peer counseling model. Additionally, there is a lack of a standardized training model.

Related to the role of peer counselors, there is a lack of science-based peer counselor practice parameters leading to inconsistencies in peer counselor responsibilities. Supervision of peer counselors is inadequate and likewise inconsistent. High turnover rates among peer counselors are a reoccurring problem among all programs. The high turnover appeared to be associated with several factors, including inadequate compensation. On the contrary, high turnover also seems linked to the benefits of peer counseling for the peer counselor. Programs acknowledge that peer counseling provides increased self-esteem and skills, and peer counselors often leave their position to further their education and obtain higher-level positions.

Peer counselors serve as the frontline of the peer counseling program, and thus offer unique insights into the program. Their experience is a positive one, and many view their job as an opportunity to help mothers by guiding them through successful breastfeeding experiences. Just as programs acknowledge the added benefit of the program to peer counselors, peer counselors also value the knowledge and training they receive. For some it provides empowerment to move on to higher paying jobs and to further their education.

Peer counselors identified inadequacies mirroring those indicated by the programs themselves. They would like to see increased monetary compensation and continuity of funding, improved access to and availability of ongoing training, better working relationships with hospitals, and an enhanced role of their supervisors in providing support and encouragement in their work.

Recommendations for effective peer counseling programs are similar among staff and administrators from the various programs. A major recommendation is the need for a flexible program structure that provides a baseline of quality standards, providing each state and/or the local agencies the ability to tailor and implement programs that are appropriate for their respective situations and settings. Training for peer counselors should be based on a model that has consistency, continuity, and is scientifically based. Additionally, peer counselors should have defined practice parameters and job descriptions. Their role should be a compensated position within the WIC human resources system. Lastly, the peer counseling program should be a service mandate within WIC.

These issues with which WIC must contend in order to build a successful, sustainable breastfeeding peer counseling program are significant challenges. However, they do not provide a complete picture. Underlying these challenges is a strong foundation built of two ingredients: a strong belief in the value and power of peer counseling and a desire to construct the necessary programs for institutionalizing peer counseling as a permanent WIC service offering.

Staff and administrators want peer counseling in their agencies. Funding constraints are the key impediments. The will to implement peer counseling is strong.

And peer counselors are a passionate “sales force”. They believe in the mission of breastfeeding and peer counseling. This passion, this desire to make a difference, to help their clients improve their lives, overcomes most barriers to successful peer counseling. Again, financial constraints restrict their capacity to deliver fully the consistent attention to their clients that they know is required.

This, then, is the good fortune. The most significant barrier, financial constraint, is already being addressed. Significant resources have been committed to peer counseling in the WIC program. A programmatic juncture has been reached in which sustainable funding is being provided to address the multiple logistics barriers. This dovetails with the emotional climate among WIC staff and peer counselors to expand their support for breastfeeding and families through strengthened peer counseling programs throughout the WIC community.

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# **APPENDIX A**

## Assessment Form Peer Counseling Program Curriculum

Name of Curriculum \_\_\_\_\_

Organization \_\_\_\_\_ State \_\_\_\_\_

Audience: WIC \_\_\_\_\_ Non-WIC \_\_\_\_\_ Designed for: Peer Counselors \_\_\_\_\_ Managers \_\_\_\_\_

Peer Counseling Curriculum CONTENT	Topic Areas	Mark (X)	Describe
Promotion and Support	Benefits of breastfeeding		
	Addressing barriers to breastfeeding		
	Gaining support from family members		
	Returning to work or school		
	Other:		
Breastfeeding Management	How the breast makes milk		
	Prenatal breast assessment		
	Basic positioning and latch		
	Tips for early success		
	Growth spurts		
	Assessment of breastfeeding		
	Common problems (i.e., sore nipples, engorgement, fussy baby, mastitis)		
	Managing more complicated problems (jaundice, low milk supply, suck difficulties, infant or maternal illness)		

	Increasing milk supply		
	Working with mothers of preterm infants		
	Using a breast pump		
	Other:		
Other Infant Issues	Teething		
	Starting solid foods		
	Fussy baby		
	Nursing strikes		
	Weaning		
	Other:		
Counseling	Basic counseling techniques		
	Telephone counseling skills		
	Cultural sensitivity		
	Confidentiality issues		
	Other:		
Outreach	Teaching breastfeeding classes		
	Leading breastfeeding support groups		
	Other:		
Referrals	WIC information		
	Public health programs		
	Referring to IBCLCs		
	Working with medical professionals		
Documentation	Basic documentation principles		
	Setting up tickler card or follow-up system		
	Other:		

Job Skills	Working at home		
	Professional standards		
	Organizing materials		
	Payroll reporting procedures		
	Other:		
Job Protocols	Practice parameters		
	Job description		
	Procedures for making referrals		
	Working in settings outside WIC		
	Documentation		
	Reporting		
	Contact frequency of mothers		
	Other:		
Forms	Documentation log		
	Client contact checklists		
	Assessment form		
	Reporting forms		
	Other:		

<b>Peer Counseling Curriculum FORMAT</b>		<b>Mark (X)</b>	<b>Describe</b>
Style of presentation	Lecture with slides/overheads		
	Interactive components		
	Small or larger group activities		
	Role play		
	Discussion		
	Videos		
	Independent study		
	Observation of another peer counselor		
	Other:		
Visuals included	Overhead transparencies		
	Power Point		
	Handout masters		
Other materials	Promotional brochure for peer counselors		
	Certificates for training completion		
	Other:		

Managing PC Curriculum CONTENT	Topic Areas	Mark (X)	Describe
Program administration	Recruiting and hiring peer counselors		
	Supervision		
	Funding		
	Monitoring peer counselors		
	Other:		
Job Management	Job descriptions for peer counselors		
	Practice parameters		
	Contact frequency		
	Other:		
Protocols	Agency policies and procedures		
	Documentation and reporting		
	Other:		
Training	Initial training options		
	Ongoing training		
	Staff meetings		
	Other:		
Promotion	Strategies for promoting the program with local WIC staff		
	Promoting the program with partnering organizations in the community		
	Impact of peer counseling		

<b>Managing PC Curriculum FORMAT</b>	<b>Topic Areas</b>	<b>Mark (X)</b>	<b>Describe</b>
Style of presentation	Lecture with slides/overheads		
	Interactive components		
	Small or larger group activities		
	Role play		
	Discussion		
	Videos		
	Independent study		
	Observation of another peer counselor		
	Other:		
Visuals included	Overhead transparencies		
	Power Point		
	Handout masters		
Other materials	Promotional materials		
	Recruitment flyers		



## **APPENDIX B**

# Current Peer Counseling Program In-depth Interview Guide

## Introduction

Hello, I'm \_\_\_\_\_ with Best Start Social Marketing. We are working with the USDA's Food and Nutrition Service in order to learn more about effective ways to manage and sustain peer counseling programs in WIC agencies.

We are conducting interviews in a number of States with about ninety-four staff and peer counselors. We are interviewing several different types of staff...State and local WIC Directors, Nutrition Education Coordinators, Breastfeeding Coordinators, local clinic staff, and peer counselors, so that we may get a broad picture of the different perspectives of each group.

Our goal is to understand your experiences and ideas regarding peer counseling; to learn what you think is going well, what you would like to see changed, and what you believe are the best approaches to peer counseling.

Thank you for agreeing to help us with this project. I would like to tape record our discussion so that I will be able to focus on our conversation rather than worrying about taking notes. May I turn it on now and ask you to confirm that it is okay to record this? Thanks.

This discussion is about you, your program, and your experiences and concerns. The information that we learn during our time together will be reported in a confidential manner. No individual or agency will be identified. The analysis of the data that we collect will be reported as a combined set of data from among all of the interviews that are conducted.

Thanks for taking the time out of your busy schedule to speak with us. Your assistance is very important in helping us to better understand how peer counseling works in your area. The interview will take approximately one hour.

*Before we start, do you have any questions?*

## Opening Questions

If you could use one word to describe what 'peer counseling' means to you, what word would you use?

Probe: tell me what you mean by \_\_\_\_\_(use word used by participant)

## Introductory Questions - (Program Initiation)

Tell me about when you began a peer counseling program in your State (or community)?

Describe how your program operates.

How many people work in the program?

What positions are staffed? (part/full-time positions?)

How many clients use the program?

If certain areas (districts) only, how did you decide the areas in your State (or community) that would receive peer counseling services?

### **Program Coordination**

Who coordinates the program?

How are staffing needs coordinated?

Probe: Who hires peer counselors?

Who supervises them?

How is supervision structured? (Regularly supervised sessions? How often,

How long? What kinds of issues are dealt with by the supervisor?)

What works well about this arrangement?

What doesn't work so well?

### **Program Funding**

How is the program funded?

What does it take to maintain the program funding? (Reports, proposals, etc.) Who does this?

How are your peer counselors compensated?

What parts of your compensation approach works well? (use participants' terms)?

What doesn't work so well?

If you could make any changes you want, how would you compensate peer counselors?

### **Peer Counselors**

Could you describe or define in your own words what a peer counselor is?

What criteria do you believe are most important in recruiting peer counselors?

How important do you feel it is for the peer counselors to share similarities with the population they serve? Which similarities do you feel are most important? Why?

### **How the Program Works**

What are the practice parameters (job responsibilities) for your peer counselors?

Probe: basic breastfeeding benefits and counseling?  
dealing with basic problems in the early days of breastfeeding?  
dealing with more challenging breastfeeding problems?  
helping mothers with ongoing issues of breastfeeding?

What is the range of outreach activities and settings for your peer counselors?

Probe: telephone calls?  
hospital visits?  
home visits?  
private clinics?  
WIC clinics?  
community settings? If so, be specific about which settings.

Which of these practice settings do you believe are most effective?

Are there other settings that are not being utilized that would be appropriate?

At what point are peer counselors advised to refer a mother to professional staff for follow-up?

Probe: What is the standard realm of expertise expected for your peer counselors?  
How is that determined?  
Who provides that follow-up beyond the peer counselor level of expertise?  
How is that referral process structured?

What is the typical caseload for peer counselors?

How often do peer counselors make contacts with clients?

Probe: When are they available to clients (i.e., 24/7? weekdays only?)

How often do you believe peer counselors should contact WIC clients?

Probe: If your peer counselors are currently not providing those kinds of contacts, what are the barriers to doing that? What would make it easier to do that?

What kind of documentation are peer counselors required to collect and record from their clients?

What documentation is ideal?

How long does a typical peer counselor continue to provide peer counseling to the client? (6 months, 1 year, etc.)

What kind of support do you think peer counselors need to do their job well?

Is liability protection provided to staff who have direct contact with clients?

Probe: Is that true for all staff or just professional staff?

How does that apply to peer counselors?

Do you feel peer counselors should have liability protection?

How is the performance of peer counselors monitored?

### **Training of Peer Counselors**

How qualified do you think peer counselors are to do their job?

Describe the training curriculum you currently use.

Probe: Developed your own?

Use one acquired from outside your organization? If so, where?

What about this training curriculum appeals to you?

What would you change?

How is the training delivered? (Days, time, delivery methods, etc) How important do you think those factors are?

What topic areas do you include in your training?

Probe: breastfeeding benefits  
addressing barriers  
basic positioning and latching  
dealing with common problems  
starting solid foods  
weaning issues  
returning to work or school  
dealing with lack of social support  
teaching classes/support groups  
counseling skills

Describe the core values of your peer counselor training. (What are the most important values that you want to convey in your peer counselor training?) How do you do this?

How do you prepare peer counselors to deal with cultural sensitivity and diversity issues?

What training needs do you believe are most important for peer counselors to have initially?

Probe: breastfeeding management (be specific...basics only? More in-depth problem solving?)  
counseling/addressing breastfeeding barriers  
when and how to make referrals  
WIC Program  
other public health programs  
being part of the healthcare team  
cultural diversity  
job management  
working at home  
other

What types of continuing education (ongoing training) do you believe peer counselors need?

Who provides training to PC's in your program?

What are the ideal qualifications for trainers?

Probe: a lactation consultant in the community?  
State WIC Breastfeeding Coordinator?  
another WIC program manager?  
nutritionist?

experience with breastfeeding?  
credential requirements?  
experiential requirements?

The USDA is developing a curriculum for State WIC personnel to use in training peer counselors. How should this curriculum be packaged to be most useful to you?

What types of reproducible tools/resources would help you in training your staff and managing your program?

Probes: Documentation log? Contact frequency schedule? Peer Counselor guide for initial calls? Referral cards? Training certificates? Curriculum handouts or slides?

### **Partnerships**

Tell us about any community groups or organizations with which you currently partner in your peer counseling program.

Probe: local hospitals or birthing centers?  
local physician offices/clinics?  
community organizations, such as Early Head Start, Cooperative Extension, child care centers, etc.  
other public health programs?  
worksites? other community groups?

What roles do community partners play in your program?

Probe: funding?  
providing housing for classes, support group meetings, etc.?  
making referrals of new moms who need follow-up?  
providing training for staff?  
providing lactation consultants?

How do you teach peer counselors about these programs and how to make referrals?

\*(not just breastfeeding referrals but community services and resources)

If you work with hospitals for giving and/or receiving referrals, how does that work?

If you could design the ideal referral system with local hospitals for early postpartum follow-up of new mothers, how would you do it?

### **WIC and Peer Counseling**

What is the relationship among peer counselors, WIC nutritionists and support staff?  
What would the ideal relationship be?

How involved are peer counselors in your breast pump program?

Tell me how WIC clients who have been followed by a peer counselor feel about the program?

### **Program Implementation**

When you first implemented the peer counseling program in your State what were the obstacles?

Probe: what type of support did you have?  
financial?  
space?  
administrative cooperation?  
shared value for peer counseling among staff?

How have you overcome the obstacles?

What information do you wish someone had told you when you first implemented your program?

### **Program Strengths and Weaknesses**

What factors do you think are most important in your program's success?

Probe: What works best about the way your peer counseling program is set up?

If you could change anything about the way your program is set up, what would you change? Why?

### **Program Sustainability**

What factors support program sustainability in your State?

What factors make it difficult to sustain a peer counseling program in your State?

Probe: How have you overcome these obstacles?

**Closing**

What recommendations do you have for USDA in designing the ideal peer counseling program?

What recommendations do you have for other States that might be interested in beginning a breastfeeding peer counseling program?

**Expression of Appreciation**

Thanks again for taking the time out of your busy schedule to speak with us. Thank you for your comments and suggestions, and please remember to let me know if you think of anything else you would like us to know.

**Ask for the following information:**

1. Peer Counseling training manual
2. Copies of documentation logs used to document client contacts
3. Copies of payroll documentation forms used
4. Job descriptions for staff
5. Any other information on your program that will help us with this project, (newsletter? pamphlets? video?)

## **APPENDIX C**

# **Discontinued Peer Counseling Program In-depth Interview Guide**

## **Introduction**

Hello, I'm \_\_\_\_\_ with Best Start Social Marketing. We are working with the USDA's Food and Nutrition Service in order to learn more about effective ways to manage and sustain peer counseling programs in WIC agencies. Our goal is to understand your experiences and ideas regarding peer counseling; to learn what you think works well and what you believe are the best approaches to peer counseling. We are conducting interviews in (add number) States with about ninety-four staff and peer counselors.

Thank you for agreeing to help us with this project. I would like to tape record our discussion so that I will be able to focus on our conversation rather than worrying about taking notes. May I turn it on now and ask you to confirm that it is okay to record this? Thanks.

This discussion is about you, your program, and your experiences and concerns. The information that we learn during our time together will be reported in a confidential manner. No individual or agency will be identified. The analysis of the data that we collect will be reported as a combined set of data set from among all of the interviews that are conducted.

Thank you for taking the time out of your busy schedule to speak with us. Your assistance is very important in helping us better understand how peer counseling works in your area. The interview will take approximately one hour.

Before we start, do you have any questions?

## **Opening Questions**

If you could use one word to describe what 'peer counseling' means to you, what word would you use?

Probe: Tell me what you mean by \_\_\_\_\_ (use word used by participant)

## **Introductory Questions (Program Initiation)**

Tell me about when you began a peer counseling in your State? Or community? How long did it remain in place?

Describe how your program operated.

How many people worked in the program?

What positions were staffed? (part-time versus full-time)

How many clients used the program?

If certain areas only, how did you decide the areas in your State that would receive peer counseling services?

**Program Coordination**

Who coordinated the program?

How were staffing needs coordinated?

Who hired peer counselors?

Who supervised them?

How was supervision structured? (Regularly supervised sessions? How often, how long?)

What kinds of issues are dealt with by the supervisor?)

What worked well about this arrangement?

What didn't work so well?

**Program Funding**

How was the program funded?

What did it take to maintain the program funding? (reports, proposals, etc.) Who did it?

How were peer counselors compensated?

What part of your compensation approach worked well?

What didn't work so well?

If you could have made any changes you wanted, how would you have compensated peer counselors?

**Peer Counselors**

Could you describe or define in your own words what a peer counselor is?

What criteria do you believe are most important in recruiting peer counselors?

How important do you feel it is for the peer counselors to share similarities with the population they serve? Which similarities do you feel are most important? Why?

## **How the Program Works**

What were the practice parameters (job responsibilities) for your peer counselors?

Probe: basic breastfeeding benefits and counseling?  
dealing with basic problems in the early days of breastfeeding?  
dealing with more challenging breastfeeding problems?  
helping mothers with ongoing issues of breastfeeding?

What was the range of outreach activities and settings for your peer counselors?

Probe: telephone calls?  
hospital visits?  
home visits?  
private clinics?  
WIC clinics?  
community settings?

Which of these practice settings do you believe are/were most effective?

Are there other areas that are not being utilized that would be appropriate?

At what point were peer counselors advised to refer a mother to professional staff for follow-up?

Probe: What was the standard realm of expertise expected for your peer counselors?  
How was that determined?  
Who provided that follow-up beyond the peer counselors' level of expertise?  
How was that referral process structured?

What was the typical caseload for peer counselors?

How often did peer counselors make contact with clients?

Probe: When were they available to clients? (i.e. 24/7? weekdays only?)

How often do you believe peer counselors should contact WIC clients?

Probe: If your peer counselors were not providing those kinds of contacts, what were the barriers in doing that? What would have made it easier?

What kind of documentation were peer counselors required to collect and record from their clients?

What documentation is ideal?

How long did a typical peer counselor continue to provide peer counseling? (6 months, 1 year, etc.)

What kind of support do you think peer counselors need to do their job well?

Is liability protection provided to staff who have direct contact with clients?

Probe: Is that true for all staff or just professional staff?

How does that apply to peer counselors?

Do you feel peer counselors should have liability protection?

How was the performance of peer counselors monitored?

### **Training of Peer Counselors**

How qualified do you think peer counselors are to do their job?

What type of training curriculum did you use?

Probe: Developed you own?

Use one acquired from outside your organization?

What about this training appealed to you?

What would you have changed or improved?

How would you describe the style or process of your training? How important do you think those factors are?

What topic areas did you include in your training?

Probe: breastfeeding benefits

addressing barriers

basic positioning and latching

dealing with common problems

starting solid foods

weaning issues

returning to work or school  
dealing with lack of social support  
teaching classes/support groups  
counseling skills

How did you prepare peer counselors to deal with cultural sensitivity and diversity issues?

Describe the core values of your peer counselor training. (What are the most important values that you want to convey in your peer counselor training?) How do you do this?

What training needs do you believe are most important for peer counselors to have initially?

Probe: breastfeeding management (be specific...basics only? more in-depth problem solving?)  
counseling/addressing breastfeeding barriers  
when and how to make referrals  
WIC Program  
other public health programs  
being part of the healthcare team  
cultural diversity  
job management  
working at home  
other

What types of continuing education (ongoing training) do you believe peer counselors need?

Who provided training to PC's in your program?

What are the ideal qualifications for trainers?

Probe: a lactation consultant in the community?  
State WIC Breastfeeding Coordinator?  
another WIC program manager?  
nutritionist?  
experience with breastfeeding?  
credential requirements?  
experiential requirements?

The USDA is developing a curriculum for State WIC personnel to use in training peer counselors. How should this curriculum be packaged to be most useful to you?

What types of reproducible tools/resources would help you in training your staff and managing your program?

Probe: documentation logs? contact frequency schedule? peer counseling guide for initial calls? referral cards? training certificates? curriculum handouts or slides?

### **Partnerships**

Tell us about any community groups or organizations you partnered with in your peer counseling program.

Probe: local hospitals  
local physician offices/clinics  
community organizations, such as Early Head Start, Cooperative Extension, child care centers, etc.  
other public health organizations? worksites? other community groups?

What roles did community partners play in your program?

Probe: funding?  
providing housing for classes, support group meetings, etc.?  
making referrals of new moms who need follow-up?  
providing training for staff?  
providing lactation consultants?

If you worked with hospitals for giving and/or receiving referrals, how did that work?

If you could design the ideal referral system with local hospitals for early postpartum follow-up of new mothers, how would you do it?

How do you teach your peer counselors about these programs and how to make referrals?

### **WIC and Peer Counseling**

Describe the level of support you feel your peer counseling program received in your agency (both state level and on the local clinic level).

How could support levels have been improved in your estimation? What things might have positively contributed to improved support?

What was the relationship among peer counselors, WIC nutritionists, and support staff?  
What would the ideal relationship be?

What steps could another State take to encourage support of staff?

How involved are peer counselors in your breast pump program?

Tell me how WIC clients who were followed by a peer counselor felt about the program?

### **Program Implementation**

When you first implemented the peer counseling program in your State what made it hard/difficult?

Probe: what were the obstacles?  
what type of support did you have?  
financial?  
space?  
administrative cooperation?  
shared value for peer counseling among staff?

How did you try to overcome some of these obstacles?

What information do you wish someone had told you when you first implemented your program?

### **Program Strengths and Weaknesses**

Describe the program's relative level of success.

What factors helped to make your program successful?

Probe: what worked best about the way your peer counseling program was set up?

If you could change anything about the way your program was set up, what would you change? Why?

**Program's Demise**

Tell me how your program ended?

Probe: What factors contributed to the demise of your program?

What efforts were made to keep it going?

If you could do it all over again, what changes would you make in the management of the program?

Probe: What information would you have found helpful then to sustain and improve your peer counseling program?

What repercussions did your State experience when the program ended?

What factors support program sustainability?

**Reinstating Program**

What would make it possible for you to consider reinstating a peer counseling program?

What would be the primary obstacles you would have to face in reinstating a peer counseling program?

What information would you find helpful now if you were to reinstate your peer counseling program?

**Closing**

What recommendations do you have for USDA in designing the ideal peer counseling program?

What recommendations do you have for other States that might be interested in beginning a breastfeeding peer counseling program?

**Expression of Appreciation**

Thanks again for taking the time out of your busy schedule to speak with us. Thank you for your comments and suggestions, and please remember to let me know if you think of anything else you would like us to know.

**Ask for the following information:**

1. Peer Counseling training manual
2. Copies of documentation logs used to document client contacts
3. Copies of payroll documentation forms used
4. Job descriptions for staff
5. Any other information on your program that will help us with this project (newsletter?pamphlets?video?)

## **APPENDIX D**

# Never Initiated Peer Programs Telephone Interview Guide

## INTRODUCTION

Hello, I'm \_\_\_\_\_ with Best Start Social Marketing. We are working with the USDA's Food and Nutrition Services in order to help WIC agencies implement, manage and sustain peer counseling programs.

We are conducting interviews in (add number here) States with about ninety-four staff and peer counselors. We are doing these interviews with several different types of staff...State and local WIC Directors, Nutrition Education Coordinators, Breastfeeding Coordinators, local clinic staff, and peer counselors, so that we may get a broad picture of the different perspectives of each group.

Our goal is to understand your experiences and ideas; to learn what you think would work well, and what you believe might be the best approaches to peer counseling.

Thank you for agreeing to help us with this project. I would like to tape record our discussion so that I will be able to focus on our conversation rather than worrying about taking notes. May I turn it on now and ask you to confirm that it is okay to record this? Thanks.

This discussion is about you, your program, and your experiences and concerns. The information that we learn during our time together will be reported in a confidential manner. No individual or agency will be identified. The analysis of the data that we collect will be reported as a combined data set from among all of the interviews that are conducted.

Thank you for taking the time out of your busy schedule to speak with us. Your assistance is very important in helping us better understand how peer counseling works in your area. The interview will take approximately one hour.

Before we start, do you have any questions?

### Opening Questions

If you could use one word to describe what 'peer counseling' means to you, what word would you use?

Probe: tell me what you mean by \_\_\_\_\_(use word used by participant)

### Introduction Questions:

Tell me what you have heard about peer counseling?

Could you describe or define in your own words what a peer counselor is?

What is the first thing that comes to your mind when you think of beginning a breastfeeding peer counseling program in your State? Why?

Have you ever thought about (or has anyone ever approached you about) starting a peer counseling program? If so, what factors stood in the way of pursuing it?

What advantages do you believe a peer counseling program could bring to your WIC program?

What benefits do you believe a peer counseling program could provide WIC clients in your State?

**Starting a Peer Counseling Program\*\*\***

If you were to begin a peer counseling program in your State, what issues would be the primary things your State would need to consider first?

Probe: (probe on the issues mentioned....)

funding/payroll policies?

getting the program approved through State channels?

coordination/management of the program?

hiring/training of peer counselors?

liability issues?

If you were to choose NOT to start a peer counselor program in your state, what would be your reasons?

**\*\*\*INTERVIEWER MUST BE READY TO EXPLORE and PROBE THE ISSUES IDENTIFIED BY THE PARTICIPANT at this point of the interview.**

In your opinion, what would be the best way to handle \_\_\_\_\_(use issue mentioned by participant)?

**Potential Partnerships**

Describe the possible partnerships you believe could be drawn upon in your community for support of a peer counseling program.

How difficult would it be to initiate a partnership with your local hospital to gain referrals of new WIC mothers upon discharge?

What issues would need to be considered in working out a referral system with partners such as hospitals, physician offices, and other groups?

### **Program Implementation**

What would make it easier for you to want to implement a peer counseling program?

What would make it difficult to implement a peer counseling program?

### **Program Sustainability**

Describe the factors that are needed to sustain a peer counseling program?

What factors would make it hard to sustain a peer counseling program in your State?

What factors do you THINK might be most important to ensure success of a peer counseling program in your State?

### **WIC and Peer Counseling**

We've already talked about the issues regarding starting a new program, I like to explore those further...

How important would the support of WIC clinic staff be in the success of your peer counseling program?

How would you incorporate the peer counseling program into your WIC Program?

Whose support would you need most?

What kind of information would be most helpful to you?

What kind of training do you feel your staff might need to begin a program? How would you want this training packaged/structured?

### **Closing**

What recommendations do you have for USDA in designing the ideal peer counseling program?

### **Expression of Appreciation**

Thanks again for taking the time out of your busy schedule to speak with us. Thank you for your comments and suggestions, and please remember to let me know if you think of anything else you wish us to know.

## **APPENDIX E**

## **PEER COUNSELOR Telephone Interview Guide**

Hello, I'm \_\_\_\_\_ with Best Start Social Marketing. We are working with the WIC Program in order to learn more about effective ways to manage and sustain peer counseling programs among WIC agencies. Our goal is to understand your experiences and ideas regarding peer counseling, to learn what you think is going well, what you would like to see changed, and what you believe are the best approaches to peer counseling. We are conducting interviews in (add number here) States with about ninety-four staff and peer counselors.

Thank you for agreeing to help us with this project. I would like to tape record our discussion so that I will be able to focus on our conversation rather than worrying about taking notes. May I turn it on now and ask you to confirm that it is okay to record this? Thanks.

This discussion is about you, your program, and your experiences and concerns. The information that we learn during our time together will be reported in a confidential manner. No individual or agency will be identified. The analysis of the data that we collect will be reported as a combined set of data from among all of the interviews that are conducted.

Before we start, do you have any questions?

### **Opening Questions**

If you could use one word to describe what 'peer counseling' means to you, what word would you use?

Probe: tell me what you mean by \_\_\_\_\_(use word used by participant)

What about one word to describe your experiences with your own peer counseling program?

Probe: tell me what you mean by \_\_\_\_\_(use word used by participant)

### **Introduction Questions**

Tell me about your job as a peer counselor.

How long have you been working as a peer counselor?

What first attracted you to the position of peer counselor?

What did you hope you would get out of this job?

What part of your job has become most rewarding to you?

### **Hiring Process**

Tell me about your hiring process. How did you learn about the position? Application, interview?

Why do you think you were chosen for this position?

Are peer counselor paid?

What works about this system?

What would you improve if you could?

### **Job Description**

What are your job responsibilities?

*Probe:* telephone contacts?  
home visits?  
hospital visits?  
documentation? How?  
teach classes?  
lead support group meetings?  
loan breast pumps?  
other duties?

What is your current caseload of WIC clients?

How many hours do you work?

What is the ideal caseload in your opinion?

What part of your job do you enjoy the most?

What part of your job is most challenging?

Describe how your job influences or affects your home demands.

Tell me how your family members and friends have reacted to your job?

If you could change any part of your job, what would it be?

## **Training**

What type of training did you receive before becoming a peer counselor?

Probe: formal training sessions?

observation of another peer counselor or lactation consultant?

personal study (books? videos? study modules?)

Formal training sessions – Can you describe what the experience of training was like?

What did you like best about the training?

What part about your training has been **most** helpful to you?

How effective do you feel your training was in preparing you to take on the role of being a peer counselor?

What part about your training has been **least** helpful to you?

What kinds of ongoing training have you had since you were first trained?

What type of information would you like to learn about that would help improve your ability to be an effective peer counselor?

Probe: what type of training do you feel would benefit you now?

## **Supervision**

Tell us about your supervisor...his/her position? What does your supervisor do to supervise you?

What would you change about how you are supervised if you could?

What kinds of supervision and support do you think peer counselors need to be effective in their roles?

How accepting of your work are the WIC staff in the local clinics?

What would be the ideal relationship among peer counselors and WIC staff?

## **Partnerships**

Tell us about any community groups or organizations you currently partner with in your peer counseling program.

Probes: local hospitals  
local physician offices/clinics  
community organizations, such as Early Head Start, Cooperative Extension, child care centers, etc.  
other programs?

What roles do community partners play in your program?

*Probe:* funding?  
providing housing for classes, support group meetings, etc.?  
making referrals of new moms who need follow-up?  
providing training for staff?

Describe any obstacles you had in setting up relationships with community groups. How did you overcome those obstacles? If you could do things differently, what would you change?

In the ideal breastfeeding peer counseling program, what partners do you wish you could be working with?

## **Referrals**

How do you obtain the names of WIC clients to follow with?

Who makes referrals to you?

How does that referral system work?

What improvements could be made in the current referral system?

If you work with hospitals for giving and/or receiving referrals, how does that work?

If you could design the ideal referral system with local hospitals for early postpartum follow-up of new mothers, how would you do it?

When you make referrals:

What programs or individuals do YOU make referrals to?

If a WIC client is experiencing problems you are not comfortable handling, who do you turn to for help?

What recommendations do you have for improving this referral system?

**Program Strengths and Weaknesses:**

What factors do you think are most important in your program's success?

Tell me about the feedback you've received from WIC clients you have followed up with as a peer counselor?

What works best about the way your peer counseling program is set up?

If you could change anything about the way your program is set up, what would you change? Why?

**Closing**

What recommendations do you have for other States that might be interested in beginning a breastfeeding peer counseling program?

**Ask for the following information:**

1. Peer Counseling training manual
2. Copies of documentation logs used to document client contacts
3. Copies of payroll documentation forms used
4. Job descriptions for staff
5. Any other information on your program that will help us with this project  
(newsletter?pamphlets?video?)