

## II. BREAST-FEEDING SUPPORT PROGRAMS

WIC agencies are required by federal regulations to promote and support breast-feeding among their clients. This is accomplished through staff training, offering clients prenatal breast-feeding education (through classes and/or one-on-one contacts, and written materials and/or videos), informing clients about the food packages for breast-feeding mothers, and providing or referring to support services after the birth. Agencies receive targeted funding for these activities. They can also use either food funds or Nutrition Services and Administration (NSA) funds to purchase breast pumps to give or lend to breast-feeding mothers, and most agencies now have a breast pump program. In addition, many agencies have at least one lactation consultant (generally an International Board Certified Lactation Consultant, or IBCLC) on staff.

The breast-feeding support programs described in this chapter go beyond the required services. They have three main themes:

1. ***Peer Counseling.*** Peer counselors are generally current or former WIC clients who breast-fed their babies for a substantial period. Peer counselors may be volunteer or paid, part-time or full-time, and they may have different levels of training. Generally, the breast-feeding coordinator (who is a certified lactation consultant) trains and supervises them and provides backup support for unusual or high-risk situations.
2. ***Multifaceted Programs*** that emphasize individual assistance and outreach to health professionals. The programs profiled also provide a wide range of other services for breast-feeding mothers.
3. ***Programs for High-Risk Groups.*** Programs profiled are targeted at mothers of premature or seriously ill infants or teenage mothers.

## A. PEER COUNSELING

Over the past several years, peer counseling programs have become more common in the WIC program, although they are not yet standard. Because the FY 2004 appropriation for the WIC program provides funding for peer counselors, these programs are currently of considerable policy interest. USDA considers them to be a “best practice” in the Nutrition Support Standards, but the standards do not provide any guidance on what makes a good peer counseling program. Most programs require peer counselors to be current or former WIC participants who have breast-fed at least one child, generally for six months or more. However, the programs we studied varied in their service structure along the following dimensions:

- Training and quality control: the length of training varies, as does the frequency with which the peer counselor is monitored.
- Compensation—from unpaid to well-paid.
- Hours—from very part-time to full-time (4 to 40 hours per week).
- Services provided: responsibilities of peer counselors may include prenatal counseling, teaching or assisting with prenatal classes, hospital bedside counseling, telephone counseling, in-person counseling in clinics, administering pump programs, leading or assisting with support groups, and translating (if bilingual).

Sometimes, WIC agencies incorporate peer counselors into their services in part because they cannot afford more qualified staff, such as lactation consultants. Other agencies believe strongly that peer counselors are better able than professional staff to motivate mothers to breast-feed and to continue breast-feeding, as clients may feel more comfortable with discussing breast-feeding issues with someone “just like them.”

We profile three programs that illustrate some of this variation. Texas, a pioneer in peer counseling programs, runs statewide training in how to establish peer counseling programs and train peer counselors. At the same time, Texas allows a lot of local autonomy in defining the programs. The program in Berkeley, California, and the surrounding area receives substantial outside funding and pays peer counselors competitive wages. It uses peer counselors from diverse backgrounds to serve its multi-ethnic clientele. In contrast, the peer counseling program in Washington and Greene counties in southwestern Pennsylvania operated for 10 years with volunteer peer counselors who provided counseling by telephone out of their homes.<sup>1</sup>

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<sup>1</sup> Two of the comprehensive breast-feeding programs described in Section B (Sacramento and Miami) also use peer counselors.

## **BREAST-FEEDING PEER COUNSELOR PROGRAM<sup>2</sup> TEXAS**

### **OVERVIEW**

**Location:** Statewide, available in 61 of 80 local WIC agencies

**Start Date:** April 1991

**Target Population:** Pregnant and breast-feeding WIC clients are the primary targets for this initiative; however, non-WIC clients are served in hospitals.

**Purpose:** To improve infant health by increasing breast-feeding rates through breast-feeding promotion, education, support, and assistance.

**Services:** Peer counselor services vary at the local level, and can include one-on-one assistance in WIC clinics, hospitals, the home, or over the phone; breast-feeding and prenatal classes; breast pump programs; and referrals to other social services.

**Funding:** The Texas peer counselor program received \$1.3 million in U.S. Department of Agriculture (USDA) operational adjustment funds for fiscal year 2003.<sup>3</sup> Many local agencies also use a portion of their regular WIC funding to support their peer counselor programs.

**Why Program Was Chosen:** This program was one of the first Breastfeeding Peer Counselor (BFPC) Programs in the country, and it has been used as a model by other states. Moreover, through the Peer Dads Program, it has attempted to slowly expand into nontraditional venues. It can serve as a model for other agencies to enhance breast-feeding promotion efforts by implementing Texas' intensive breast-feeding trainings for program staff, WIC staff, and health professionals.

**Key Challenges:** Staff turnover has been a challenge at some WIC clinics. Counselors may leave, for example, because they can no longer bring their infants to work after their first birthday or because they need to find a full-time job. In addition, it is challenging for a statewide program to maintain quality control and ensure that peer counselors give consistent, good-quality services and accurate information to clients.

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<sup>2</sup> Telephone interview: April 1 and 7, 2003; site visit: September 16-17, 2003.

<sup>3</sup> Operational adjustment grants are awarded by Food and Nutrition Service (FNS) regional offices, often through a competitive process. FNS regional offices retain 10 percent of Nutrition Services and Administration (NSA) funds allocated to state agencies for these grants.

## BACKGROUND

**State Characteristics.** Texas, with over 21 million residents in 2001, is one of the largest states in the nation by land area and population. In 2002, 52 percent of the state was white and 12 percent was African American, lower than the national average. About 32 percent of the state's population is of Hispanic or Latino origin, compared to 13 percent for the U.S. as a whole. More than 31 percent of the population speaks a language other than English in the home. In 1999, over 15 percent of residents lived below the poverty line.<sup>4</sup>

**WIC Program Background.** The Texas WIC program is the second-largest program in the country, serving 800,000 to 850,000 clients a month in fiscal year 2003. In September 2003, 51 percent of clients were children, 25 percent infants, 11 percent pregnant women, 7 percent postpartum women, and 6 percent breast-feeding mothers. WIC clients in Texas all have access to basic WIC services, but supplemental services depend on the specific agency, with some offering free immunizations and the USDA's Farmer's Market Nutrition Program (FMNP).

According to program staff, there are multiple barriers to breast-feeding among the Texas WIC population. Some mothers believe common breast-feeding myths, including constant pain, the inability to go back to work or school, and lack of father-infant bonding. Breast-feeding while returning to work can be very difficult for WIC clients, as certain work environments are less flexible than others. For example, service jobs often do not have private space for breast-feeding mothers. Additional barriers include a lack of confidence and support, a family history of formula feeding, and receipt of inaccurate information from health professionals who may not have the expertise to support breast-feeding or who view formula feeding as a safety net.

**Program History and Objectives.** In 1989, when state WIC agencies were mandated to name a state Breastfeeding Coordinator, the Texas Breastfeeding Coordinator conducted a needs assessment of local WIC agencies to identify successful practices in promoting breast-feeding, concentrating particularly on those sites with the highest breast-feeding rates. Staff from two of the most successful agencies reported doing something that resembled peer counseling. For example, one agency paid a \$10 stipend to program participants to speak about their breast-feeding experiences with other clients.

Based on these findings, the BFPC Program was developed from the state level with input from the local La Leche League International chapter and has been operating since April 1991. The state Breastfeeding Coordinator (who later became the state Peer Counselor Coordinator) collaborated with a team leader from La Leche League to write the first proposal and develop training materials. Initially, the program was piloted in Travis County, Houston, and Harris County. Having successfully implemented and refined these pilot programs, program officials gained support from WIC stakeholders and were able to promote the initiative across the state.

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<sup>4</sup> Unless noted otherwise, state and county characteristics throughout this report are from *quickfacts.census.gov*.

The BFPC Program mission is to improve infant health by increasing breast-feeding rates. Goals include (1) increasing the number of WIC mothers who breast-feed, (2) providing follow-up support to mothers who start to breast-feed, and (3) creating long-term networks of breast-feeding support in low-income neighborhoods. The core philosophy of peer counseling is that WIC mothers with breast-feeding experience have a perspective to offer expectant and new mothers that health professionals do not. Building on their own experience, peer counselors incorporate current research and knowledge from breast-feeding experts into information they share with their clients. Another important element is having a network of specialists, such as WIC nutritionists and nurses, local breast-feeding coordinators, lactation consultants, and clients' physicians, to whom the peer counselor can refer the mother.

**Target Population.** WIC clients who are pregnant or breast-feeding are eligible to participate in the program. In addition, non-WIC women often receive BFPC services in local hospitals. In a few pilot sites, fathers of WIC infants can be counseled by "peer dads" (see box).

## **PROFILE OF INNOVATIVE PROGRAM**

**Services Provided.** Since WIC agencies have autonomy and flexibility in program implementation at the local level, services vary from agency to agency. At many agencies, peer counselors serve as role models by breast-feeding their infants (either during a private counseling session or in the waiting room) and discussing their experiences, often with women who have never seen a baby being breast-fed or talked to a mother who has breast-fed. One peer counselor remarked that peer counselors are "regular people, regular moms," which is different from having WIC staff convey the benefits of breast-feeding to clients.

In general, peer counselors teach or co-teach breast-feeding and pump classes, and facilitate or co-facilitate breast-feeding discussion and support groups.<sup>5</sup> In some agencies, they teach prenatal and general nutrition education classes.<sup>6</sup> Classes, which often rotate between English and Spanish, last for 30 minutes. Peer counselors might teach small or large classes, depending on the agency. For example, at one of the Houston clinics, classes are held in an auditorium that was formerly a movie theater. There, it is not unusual for a peer counselor to teach a class of 100 women. As of August 1, 2003, the state permits breast-feeding discussion groups in lieu of breast-feeding classes. Local staff must develop an objective, provide an evaluation component, and select a major topic for discussion. Some agencies open the event to non-WIC mothers.

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<sup>5</sup> The program has had limited success with support groups unless they are held as nutrition education encounters at the time of voucher issuance.

<sup>6</sup> Peer counselors must complete a set of modules in order to teach nutrition education classes other than breast-feeding.

## PEER DADS PROGRAM

The peer-counseling program for fathers (hereafter referred to as “peer dads”) started in fiscal year 2002 in four pilot sites (Austin, Brownsville, El Paso, Houston). State WIC officials were aware that WIC needed to better incorporate fathers into program services. Research also indicates that the father influences a mother’s decision to breast-feed (Peregrin 2002, Arora et al. 2000). Therefore, the Peer Dads Program was designed to arm fathers with information, education, and support, so that they have the skills and knowledge to help their partner breast-feed successfully.

To become a peer dad, a father must have a breast-fed baby who is currently enrolled or was previously enrolled in WIC. Local Breastfeeding Coordinators and their staff train the peer dads in an eight-hour workshop using the state agency developed WIC Father-to-Father Breastfeeding Support Training Manual, *Training Dads to Help Dads*, and *Becoming a Father: How to Nurture & Enjoy Your Family* (Sears, Gotsch, and Froelich 2003).

Peer dads’ schedules vary from 4 to 20 hours per week. Services can be conducted in the WIC clinics or over the telephone. Peer dads attend breast-feeding classes to inform prenatal and postpartum women about the program and to encourage their partners to seek counsel. They also approach fathers in the waiting room to see if they would be interested in talking about breast-feeding, and on occasion have attended health fairs. Common topics for discussion with fathers include the benefits of colostrum, the advantages of breast milk over formula, and ways fathers can be supportive of their baby’s mother during the breast-feeding experience. Sessions last about 20 minutes. If the peer dad is faced with a question that he cannot address, he refers the father to a peer counselor, nutritionist, lactation consultant, or WIC supervisor. The most frequent referral is to the peer counselor.

One pilot site has been very successful since beginning the initiative, with more WIC fathers coming to the clinic and receiving the services of the peer dads each month. Specifically, peer dad contacts increased from 2 in May 2002 to 89 by October 2002. In exit interviews, fathers have rated the services of the peer dad as “very important” and said the information they received from peer dads would help them support their babies’ mothers with breast-feeding and help them to be better fathers. Other peer dad pilot sites have so far met with limited success because of the low volume of males in the clinic and problems in recruiting and retaining peer dads. For example, the state Peer Counselor Coordinator noted difficulty in getting peer dads to plan time to come into clinics around their regular work schedule. Despite implementation challenges, local WIC agencies that sponsor peer dads are excited about the pilot. They like the concept of fathers helping fathers and are working hard to make the program work.

In addition, peer counselors provide one-on-one counseling and assistance to pregnant women and new mothers in hospitals, in WIC clinics, and over the telephone.<sup>7</sup> In some hospitals, there are staff contacts that identify potential clients for peer counselors to visit. Some hospitals provide peer counselors with a printout of breast-feeding clients, so that they know which rooms to visit. Typically, the local WIC clinic generates a monthly maternity list of expectant mothers. Peer counselors try to call the mother within three weeks of delivery to answer any questions about breast-feeding, offer encouragement, and remind the mother to call the clinic or peer counselor upon delivery with breast-feeding questions or concerns. If they cannot reach the mother by telephone, they send a letter to the home. Peer counselors will follow up with breast-feeding WIC mothers for as long as there is a need for individual assistance.

Some peer counselors issue breast pumps, answer local breast-feeding hotlines, answer a statewide toll-free hotline at Mom's Place in Austin (see box), make home visits, distribute pamphlets in WIC waiting rooms and hospitals, prepare bulletin boards, participate in health fairs, train WIC staff, make presentations to health care professionals, and perform other WIC duties. Some local agencies provide WIC certification services on site in the hospitals. There are often "reverse referrals" when a peer counselor connects with a mother in the hospital who is eligible for WIC but is not enrolled. At most hospitals, peer counselors simply call the local agency and make a certification appointment for the mother while she is in the hospital. Peer counselors also refer clients to local lactation consultants, Mom's Place, or other social services.

Clients often see a peer counselor for at least two breast-feeding contacts, including one breast-feeding class and one individual counseling session, which frequently takes place on the day the client is being certified. However, the number and length of contacts with a specific client vary. For example, one local agency requires its peer counselors who counsel mothers in hospitals to follow up with five telephone calls. Most issues that surface during one-on-one counseling, whether in person or over the phone, are common, such as latch-on challenges, sore nipples, and engorged breasts. Often non-breast-feeding issues arise, such as frustrations with a partner or the challenges of being a new mother. Complex breast-feeding issues are rarer, but if one does come up, peer counselors can refer WIC clients to a lactation consultant, a site supervisor, the Breastfeeding Coordinator, a nurse, a nutritionist, the mother's physician, or another designated health professional. Many local agencies have Internationally Board Certified Lactation Consultants (IBCLCs). In Austin and Central Texas, peer counselors often refer mothers who need extra attention to Mom's Place. Most hospitals have lactation consultants that see high-risk mothers or mothers with problems beyond the peer counselors' scope of practice or knowledge. Peer counselors are trained to make immediate referrals for

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<sup>7</sup> In WIC clinics, staff members refer clients to a peer counselor for breast-feeding assistance. Some WIC agencies have more funding than ever before, but not enough to meet peer counselor demand. As a solution, agencies have scheduled certification appointments and prenatal and breast-feeding classes when peer counselors are scheduled at the clinic, so that they can target WIC clients who would most likely benefit from peer counselor services. Some peer counselors have their own office space, while others do not. In many clinics, the breast-feeding room and the peer counselor's office are the same.

## **MOM'S PLACE**

Mom's Place is the Texas WIC Breastfeeding Resource Center. Located in the capital, Austin, this centralized resource center and WIC lactation clinic provides assistance through a statewide toll-free breast-feeding hotline (operating during regular business hours), individual assistance by appointment for complicated breast-feeding cases, and breast pumps. The director, who is an IBCLC and a nurse, as well as at least two peer counselors from the BFPC Program, staff the center. Mom's Place deals with complex issues relating to premature infants, infants in the neonatal intensive care unit, congenital abnormalities (such as cleft lip, cleft palate), digestive disorders, neurological disorders, mastitis, poor range of tongue motion, physical injury to mother, sore nipples, and failure to thrive. The peer counselors primarily answer routine breast-feeding questions on the hotline, issue breast pumps, and handle clerical tasks, whereas the director provides one-on-one assistance for mothers with more complex issues.

Generally, the three main sources of referrals are hospital lactation consultants, peer counselors, and other WIC staff. A WIC clinic is attached to Mom's Place, and sometimes staff bring walk-ins over to the center. In turn, Mom's Place staff often provide reverse referrals to clients who are probably eligible for but not enrolled in WIC. It is also common for former clients to refer friends and relatives to Mom's Place.

Aside from functioning as a central breast-feeding resource center, Mom's Place serves as a training facility for the Texas Department of Health's dietetic internship program. Pediatric residents also come to Mom's Place for one of their public health rotations, along with nursing students from the University of Texas, Austin Community College, and Baylor College of Medicine. Written into the Mom's Place grant is a continuing education stipend program requiring that 40 WIC staff receive three days of training at Mom's Place each year. In addition, the director conducts several in-services and trainings for the Texas Department of Health, local health departments, and community organizations.

The Mom's Place grant totaled \$189,000 in fiscal year 2003. This comprised the entire operating budget for the clinic, which employs a staff of four who worked a total of three FTEs. During fiscal year 2003, there were 2,104 telephone consultations through the hotline, 2,167 local calls, and 8 electronic mail messages. Of these 4,279 contacts, 2,402 were from WIC clients and 709 were from professionals requesting breast-feeding information. In addition, 39 medical and health students received brief training at Mom's Place. Forty-four WIC staff received training as well. As for clinic consultations, there were 1,124 appointments for 819 clients (801 were WIC clients). Of the mothers seen, 80 percent were still breast-feeding one month after the first clinic visit to Mom's Place.



problems outside the normal breast-feeding experience (for example, severe pain or failure to thrive), breast-feeding problems that are not resolved within 24 hours of the peer counselors' intervention, or problems in an area other than breast-feeding.

**Participation.** The BFPC Program is available statewide, but it is not mandatory that local agencies participate. There are 80 local agencies, with 61 offering the program. The majority of local WIC agencies without peer counselors are small. Peer counselors also work in 30 participating hospitals. At most hospitals, peer counselors do not try to differentiate between WIC and non-WIC mothers, because it would be too cumbersome and time-consuming to select specific mothers for peer counselors to visit.

**Coordination and Collaboration.** The La Leche League plays an important role in promoting the program, giving referrals to WIC clients, receiving referrals for non-WIC clients, and helping with staff training. Moreover, the organization assisted with initial program development. The state professional liaison of the local chapter formally gave her support for the initiative. To the state Peer Counselor Coordinator, this "stamp of approval" from a reputable breast-feeding advocacy group was beneficial in garnering support.

**Publicity and Outreach Efforts.** Program participants often have their first contact with the BFPC Program through a local WIC agency that offers these services. Ideally, a peer counselor connects with a client when she is pregnant and being certified for WIC services. While a client is waiting for vouchers, peer counselors often introduce themselves or have the WIC staff introduce them. In this way, they have time to work with the mother, addressing concerns and educating her about the benefits of breast-feeding well before delivery. Some clinics require that pregnant women meet with a peer counselor.

Local agencies have implemented a range of publicity strategies to promote the program, such as putting up displays in waiting rooms. Some peer counselors have spoken about breast-feeding on radio and television shows. In addition, to raise awareness about the program, they give presentations to health professionals and visit social service agencies and health fairs.

## **ORGANIZATION AND MANAGEMENT**

**Staff and Organizational Structure.** The state Peer Counselor Coordinator is the main contact for the BFPC Program, fielding questions that cannot be handled at the local level and facilitating the Peer Counselor Trainer Workshop. Local Breastfeeding Coordinators recruit, train, and supervise the peer counselors. Many of these coordinators have degrees in nutrition and are IBCLCs. About 300 peer counselors are employed in 123 full-time equivalent positions and work about 20,000 hours a month.

Local agencies have their own recruiting and hiring practices for peer counselors. Nevertheless, state BFPC policy requires that peer counselors be current or previous WIC participants, be successful in having breast-fed at least one infant, be enthusiastic about breast-feeding, and have access to a telephone and transportation. Some local agencies set other criteria, based on their own needs and hiring practices. For example, some agencies require that staff be bilingual in Spanish. However, this can become a problem when needy clients miss out

on services while the local agency waits for an appropriate bilingual applicant. Some agencies try to hire peer counselors whose ethnic and cultural background is similar to that of clients.

Peer counselors are often recruited through WIC staff, other peer counselors, or posters in the clinics. After completing an application and an interview, they are hired as regular employees, temporary employees, or contractors, depending on local policies. The state Peer Counselor Coordinator originally envisioned peer counselors working four hours a week so that they did not earn a salary that would make them ineligible for certain social service benefits. However, over the years, their hours of work have expanded. Some WIC agencies have full-time and/or part-time peer counselors working anywhere from 4 to 40 hours a week. Some part-time peer counselors have another part-time position, such as intake clerk, within the local health department or WIC agency.

As previously mentioned, agencies develop local policies on how their programs are structured. For example, at one agency, peer counselors may be allowed to work in hospitals, usually for longer hours, after gaining experience in the clinic for one year. At another agency, peer counselors might be required to attend additional state-sponsored training before working in the hospital. Other agencies might allow peer counselors to work in the hospitals immediately after the initial training program.

### **DESIGNING A PEER COUNSELOR PROGRAM**

The *Training Moms to Help Moms* manual provides answers to the following questions for WIC staff that want to begin a BFPC Program:

- How do you choose peer counselors?
- What are the responsibilities of the peer counselor?
- How many peer counselors do you need?
- How many peer counselors should you recruit and train?
- Why is peer counselor training required?
- Where will you hold the training?
- How will you schedule the training?
- How will you conduct the training?
- Do you need a graduation?
- What is the role of the lactation consultant?
- What are the costs?
- How are peer counselor costs funded?

**Training and Quality Assurance.** Training for the BFPC program occurs at two levels: training professionals to train the peer counselors, and training the peer counselors locally. The state Peer Counselor Coordinator collaborated with a La Leche League team leader—a nurse and IBCLC—to develop training manuals. They wrote the *WIC BFPC Training Manual—Moms Helping Moms* to train the peer counselors, along with *Training Moms to Help Moms* for the Peer Counselor Trainer Workshop.

The state Peer Counselor Coordinator and other staff usually facilitate the train-the-trainer workshop, which is held three times a year in Austin. Participants include local Breastfeeding Coordinators, lactation consultants and educators, nurses, WIC staff, La Leche League team leaders, teen-parent educators, health educators, and experienced peer counselors. The workshop gives an overview of the approaches to peer counseling, how to design a peer counselor program and advocate for one in their agency, and how to conduct effective peer counselor training (see box). The training also presents detailed lesson plans, including topics to be covered, handouts, videos and books needed, and questions to address with the class. Panels of local Breastfeeding Coordinators and peer counselors provide additional insight and guidance.

Local peer counselor training is designed to be five classes of four hours each. This schedule can be modified to meet trainer or participant needs, but the initial training should total 20 hours. Like other elements of the BFPC Program, the frequency of trainings varies from agency to agency. Travis County’s Breastfeeding Coordinator holds a training whenever there are 6 to 10 interested people, usually two or three times a year. Some agencies have little peer counselor turnover, so training sessions may occur less frequently. Program officials recommend holding training outside the clinic or after clinic hours to avoid interruptions, and to ask community advocates, peer counselors, or WIC staff to co-facilitate. Most agencies allow participants to bring their breast-feeding infants.

The content of the actual peer counselor training focuses on enabling peer counselors to help with routine breast-feeding issues (such as latch-on problems) and answer “real-life” questions. Specific topics include the advantages of breast-feeding, the amazing breast (anatomy, physiology), comparing breast milk with substitutes, the immunological qualities of breast milk, prenatal care, basic how-to’s of breast-feeding (such as latch-on and positioning), common concerns, starting solids, weaning, parenting skills, barriers to breast-feeding, cultural considerations, counseling techniques, including the father and family in the breast-feeding process, special circumstances, referrals, mother/infant separation, breast pumps, and peer counselors at work. Participants receive copies of *The La Leche League International Breastfeeding Answer Book* to use as a reference tool while working with clients (Mohrbacher and Stock 2003). The Texas BFPC Program has trained about 2,500 breast-feeding mothers as PCs since its inception in 1991.

The extent to which additional, on-the-job training is implemented varies from site to site as local agencies develop their own orientation and mentoring/training plans. For new staff, some agencies use a formal “Peer Counselor Skills Check-Off” list of the various observations and activities staff must perform before they are permitted to work on their own in counseling mothers or teaching classes. Other agencies have informal procedures but require similar activities. In Travis County, new peer counselors must observe the counseling, teaching, and documentation of other peer counselors. The new counselors, while being observed by WIC

staff or the Breastfeeding Coordinator, must also (1) counsel a prenatal mother, (2) co-teach or teach a breast-feeding class, (3) counsel a mother in person or over the phone, and (4) create or help design a bulletin board promoting breast-feeding or the peer-counseling services. Finally, the peer counselor in training must locate various resources in the clinics (such as pamphlets, breast pumps), weigh an infant, conduct an inventory of the breast pumps, visit Mom's Place, and meet with the local Breastfeeding Coordinator and WIC supervisors before qualifying to work independently.

Peer Counselors have the opportunity to attend other training sponsored by the agency, state, or community organization. For example, the program includes a monthly in-service session that lasts about an hour. Usually, local staff review and discuss actual case studies and/or peer counselors receive an update or training session on a breast-feeding topic from the agency's Breastfeeding Coordinator, the lactation consultant, or an invited speaker.

Many peer counselors also undergo the same state agency-sponsored training that breast-feeding staff and health care professionals receive. The Texas Department of Health Breastfeeding Promotion Section and the Texas Association of WIC Directors have coordinated a statewide effort to train professionals on breast-feeding information so that WIC clients are receiving consistent messages. Training courses include "Principles of Lactation Management" and "Counseling and Problem Solving." These two training sessions last for 15 hours over two full-day sessions. Other classes available by request for health care providers include "Mini Breastfeeding Management Program I and II" and the "Physicians' Breastfeeding Course."

For quality assurance, local Breastfeeding Coordinators frequently observe peer counselors, especially new hires, and provide feedback. They also rely on the site supervisor to monitor peer counselors. Annual audits require observations of WIC staff doing counseling, including peer counselors.

**Record Keeping and Data Systems.** In the WIC clinics, peer counselors fill out standardized tracking forms for individual counseling. These forms are flagged for any necessary followup and inserted into the client's chart. The Breastfeeding Counseling Form includes basic contact information, the reason for the call or visit, a series of questions about the infant and mother (frequency of feedings, number of wet diapers, positioning, milk supply, health problems), the peer counselor's response, pamphlets given, and any referrals made. The Prenatal Breastfeeding Counseling Form includes basic contact information, questions to prompt a discussion about breast-feeding (for example, Does the mother know anyone who is breast-feeding? Does she have a support system in place?), a checklist of topics discussed (for example, latch-on, positioning, engorgement), the peer counselor's response, and pamphlets given. Furthermore, at some agencies, peer counselors maintain class attendance and telephone logs. While counselors do not insert written documentation into the patient's charts in hospitals, they report verbally to the nurse in charge, who will document their comments.

**Funding.** In fiscal year 2003, the Texas BFPC Program received \$1.3 million in operational adjustment funds through USDA for a budget that includes the cost of the peer counselor salaries, staff training, and training materials. Many local agencies also use a portion of their regular WIC funding to support their peer counselor programs. Other sources of funding cover food and child care provided at the local and statewide training. In addition, one of the initial

pilots was funded through the Office of Childhood Services of the U.S. Department of Health and Human Services.

## ASSESSMENT AND LESSONS LEARNED

**Program Strengths.** Some research indicates that women are more likely to breast-feed after hospital discharge with the support of peer counselors, whether through phone calls or through individual counseling (Gross et al. 1999; and Shaw and Kaczorowski 1999). The peer counselor provides woman-to-woman support and is often seen as a friend, a personal cheerleader, or a sister. In Texas, breast-feeding rates have increased at all WIC agencies that have implemented peer counselor programs. Specifically, 98,338 infants born to WIC mothers were breast-fed in July 2001. By July 2002, the number was 106,250, and by July 2003, it was 112,691. The proportion of breast-feeding mothers to total infants was 7.5 percent in 1990, and over 20 percent in 2003. Texas uses a multifaceted approach to breast-feeding promotion, including peer counselor services, WIC staff training, and health professional training. Therefore, it is hard to say to what degree each component contributed to the increase, since the components were implemented simultaneously.

Success is also evident at the local level. For example, Travis County was a pilot site for the peer counselor program. The breast-feeding rate was 16.7 percent in April 1991, but by June 1992, a little over a year into the pilot, the rate was 21.2 percent. These percentages reflect the ratio of breastfeeding mothers to the total number of infants participating in the program. In fiscal year 2003 this ratio was 41 percent at the Travis County WIC Program.<sup>8</sup>

A secondary outcome is that peer counselors have gained the skills and self-esteem to pursue other employment. For many peer counselors, the program is their initial entrance into the workforce. Since 1991, local agencies have hired more than 200 peer counselors into other staff positions. Some have gone on to pursue higher education; several have passed the IBCLC exam and now work as lactation consultants. Many local agencies have instituted career ladders, so that an experienced peer counselor can become a senior peer counselor, then a Peer Counselor Coordinator, and eventually an assistant Breastfeeding Coordinator. Several smaller agencies have moved experienced peer counselors into Breastfeeding Coordinator positions.

Many hospital staff members see the value and success of having someone address breast-feeding needs upon delivery. Hospitals have even started to hire their own lactation consultants. Several hospitals have hired WIC peer counselors into Breastfeeding Counselor positions paid for by the hospital. While this structural change reduces the number of peer counselors needed at the hospital, another benefit is that hospitals are becoming “breast-feeding friendly.”

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<sup>8</sup> Over the years, Texas began to take a closer look at breastfeeding initiation rates among infants of mothers who were on the WIC Program during pregnancy and therefore available to receive breastfeeding information and encouragement from WIC. In September 1999 the breastfeeding initiation rate among infants born to a mother who had been served by WIC during pregnancy at the Austin/Travis WIC Program was 70.4 percent. By December 2003 the initiation rate at Austin/Travis had increased to 83 percent.

**Key Challenges.** Peer counselor turnover has affected the BFPC Program. Most agencies allow peer counselors to bring their breast-feeding infants to work up to 1 year of age. A prime time for peer counselors to resign is after this first year. Also, many peer counselors are from socioeconomic circumstances that may produce a higher-than-average incidence of family and financial issues that disrupt their ability to continue their job. With this in mind, local Breastfeeding Coordinators recommend recruiting more peer counselors than a local agency thinks it will need. Furthermore, there are pros and cons in allowing peer counselors to bring their breast-feeding infants to work. The main advantage is that peer counselors can model breast-feeding for clients. At the same time, even though the WIC clinics are full of infants and children under the age of 5 every day, some agencies may consider it a liability that an infant brought to work by his mother might become injured or ill.

All peer counselors have a unique style in how they interact with clients, which can be perceived as both a challenge and a benefit. Despite their preferences, personalities, and varying education backgrounds, they must provide consistent information, as well as document and communicate appropriately.<sup>9</sup> With a statewide program, achieving this level of quality control can be difficult. In particular, some bilingual peer counselors struggle with documentation because they have trouble expressing themselves in writing in either English or Spanish.

Peer counselors' schedules vary from 4 to 40 hours per week. When peer counselors are hired for part-time jobs, applicants must understand how their income could affect their eligibility for services and benefits. If their income is too high, they may lose benefits such as WIC and Medicaid. Some women must choose between having a reduced workload and losing benefits in order to pursue a valuable position within the WIC program.

**Lessons Learned.** To maximize the effectiveness of the BFPC Program for pregnant and postpartum women who choose to breast-feed, WIC staff must have a clear understanding, preferably gained in a meeting or training before the initiative begins, of the roles and responsibilities of peer counselors. This is especially important so that peer counselors are not pulled away from their service delivery duties to assist with regular WIC administrative tasks. One common misconception among WIC staff is that a peer counselor in the waiting room is "hanging out" and not working. However, she is actually modeling and discussing breast-feeding and gaining the trust of clients. Moreover, site coordinators should make it clear that peer counselors are in the clinics to provide breast-feeding support to WIC clients, not to take over WIC staff positions. Peer counselors actually decrease the workload and improve service delivery, since breast-feeding support can be time-intensive. WIC staff do not usually have time to provide routine breast-feeding support in the context of a busy clinic schedule.

Experience has demonstrated that the program works best when WIC staff (1) include peer counselors in staff meetings, (2) treat them like one of the team and recognize that the position is a "real job," (3) respect the work they are doing and acknowledge that it is different from what

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<sup>9</sup> Peer counselors have a wide range of educational credentials, ranging from high school to college degrees.

other staff do, and (4) mentor peer counselors. In addition, WIC staff are more likely to support the program when they assist in peer counselor recruitment and training and attend state agency-sponsored breast-feeding trainings. WIC staff also have greater confidence in the program when program officials regularly observe and monitor the activities of peer counselors to make sure they are providing textbook information rather than relying on personal experience alone.

Overall, the BFPC Program has rejuvenated the enthusiasm of WIC staff for promoting breast-feeding, and clinic staff appreciate the services that peer counselors provide. The state Peer Counselor Coordinator thinks that the program can be replicated, especially since the training manual walks interested stakeholders through program implementation step by step. In fact, the front section of the manual explains in detail how to design a peer-counseling program.

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**EXPANDED BREAST-FEEDING PEER COUNSELOR PROGRAM<sup>10</sup>**  
**ALAMEDA/CONTRA COSTA COUNTIES, CALIFORNIA**

**OVERVIEW**

**Location:** Northern Alameda County and parts of Contra Costa County (Berkeley and environs), California

**Start Date:** 2001

**Target Population:** WIC clients and other low-income women

**Purpose:** To increase breast-feeding initiation and duration rates by providing support and assistance to pregnant and postpartum women.

**Services:** Peer counselors (PCs) provide one-on-one assistance in hospitals, homes, and WIC clinics, as well as over the phone, to pregnant and breast-feeding women.

**Funding:** \$500,000 grant from the California Endowment, plus an additional 50 cents for every \$1 spent on the grant from the California Nutrition Network.<sup>11</sup> The WIC program provides some funding as well.

**Why Program Was Chosen:** This program provides services in the hospital immediately after delivery and over the telephone for one year, or until breast-feeding ceases. The program has also tried to meet the language and cultural needs of its diverse clientele, many of whom do not speak English, by hiring bilingual and multicultural staff members.

**Key Challenges:** It is a challenge for one lactation consultant to provide adequate supervision for the PCs. In addition, the program initially did not have office space, so many counselors worked from home, adding to the challenge of providing adequate supervision. Turnover has also been a concern.

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<sup>10</sup> Telephone interview, April 25, 2003.

<sup>11</sup> Founded in 1996, the California Endowment is a private health foundation that resulted from the creation by Blue Cross of California of the for-profit WellPoint Health Networks Corporation. With \$3 billion in assets, the organization provides grants to local community organizations in the state.

## BACKGROUND

**County Characteristics.** Alameda County has a population of 1.5 million, based on an estimate for 2001. In 2000, 41 percent of the population was white, 20 percent Asian, 20 percent Hispanic, and 15 percent African American; the last three figures are higher than the state average. Over one-third of the population speaks a language other than English in the home. Out of 58 counties in the state, Alameda ranks 46th in poverty and 45th in childhood poverty, with 11 percent of the population below the poverty level in 2000, compared to the state average of 14 percent (rankings from California Food Policy Advocates 2003).

Contra Costa County has a population of almost 1 million. In 2000, 58 percent of residents were white, 18 percent Hispanic, 11 percent Asian, and 9 percent African American. About 26 percent of the population speaks a language other than English in the home. About 8 percent of the county lives below poverty, lower than the state average.

**Program History and Objectives.** In 1989, the City of Berkeley WIC Director started a peer-counseling program (the precursor to the current program), after learning about the concept during a breast-feeding session at a National Association of WIC Directors conference. WIC mothers were identified as potential PCs if they had exclusively breast-fed an infant for at least seven months and had an interest in becoming a PC.<sup>12</sup> At that point, it seemed there would not be enough funding to pay the PCs, but women were interested anyway. At the start, 35 women voiced interest in the program, 15 attended the training, 10 completed the training, and 6 were hired on a temporary basis at an hourly wage. A small amount of funding came from the WIC budget and Chez Panisse, a Berkeley restaurant that gives the WIC program money for emergency food for clients. The restaurant agreed that some of these emergency food funds could be used to pay PCs. This program, targeting Berkeley WIC clients, operated for several years. However, WIC funding was reduced as WIC participation declined, and the program did not have enough funds to sustain itself.

Around the time the breast-feeding program was in danger of being eliminated due to reduced WIC funding, the WIC Director learned about grant funding through the California Endowment. In order to receive funding, however, she had to expand the peer-counseling program beyond the Berkeley WIC clientele into the community, including the hospitals. It took about a year to apply for and receive funding. In 2001, the City of Berkeley received \$500,000 to operate the expanded project until September 30, 2003.<sup>13</sup>

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<sup>12</sup> Exclusive breast-feeding is used here to mean giving no formula, but would include feeding solids as appropriate.

<sup>13</sup> This profile discusses activities prior to September 30, 2003, when the California Endowment grant formally ended. As of October 1, 2003, the program is continuing on a smaller scale. There is some unspent money from the California Endowment, which is funding the lactation consultant and two of the PCs. This money continues to be matched by the California Nutrition Network. Program officials anticipate that this money will last until funding from the \$15 million earmarked by the U.S. Department of Agriculture (USDA) for breast-feeding PC programs becomes available. In addition, three WIC Programs are paying for some of the PCs' time.

**Target Population.** As part of the grant, City of Berkeley PCs serve all WIC clients and low-income residents of northern Alameda County and some parts of Contra Costa County. PCs also provide services at Alta Bates Hospital, which is in Alameda County but serves non-county residents also.

**WIC Program Background.** Alameda County has seven WIC clinics, with a total monthly caseload of 33,650 participants. The county has one mobile outreach unit that provides WIC services at social service agencies, hospitals, and at private obstetricians' and pediatricians' offices throughout the county. The WIC program sponsors a Farmer's Market Nutrition Program (FMNP) for pregnant women. The program has also worked to increase the ethnic, gender, and language diversity of the staff. In addition, they have increased participation by providing Saturday services at the Hayward WIC site in the southern portion of the county.

In Alameda County's Berkeley program, 9 percent of participants are pregnant, 13 percent breast-feeding, 4 percent non-breast-feeding postpartum, 23 percent infants, and 50 percent children. The Berkeley program offers two breast-feeding classes to prenatal clients in English or Spanish. The first class covers the advantages of breast-feeding; the second discusses breast-feeding techniques. There is also a postpartum breast-feeding class. Clients have access to an electric pump loan program, a breast-feeding "warmline," and an incentive program for long-term breast-feeding.

The Contra Costa County WIC program has four clinics that provide basic WIC services in English, Spanish, Vietnamese, Laotian, Tagalog, and Igbo. The program serves 16,500 participants. Of these, 11 percent are prenatal, 12 percent breast-feeding, 6 percent non-breast-feeding postpartum, 25 percent infants, and 46 percent children. The program provides two prenatal breast-feeding classes and a Spanish-speaking support group. To promote long-term breast-feeding, there is an incentive program that recognizes mothers who breast-feed exclusively for 6 and 12 months. In addition, the program has an electric pump loan program and a toll-free warmline. The WIC program collaborates with the Child Abuse Prevention Council to provide discharge bags with gifts and information for breast-feeding moms in the hospital. Staff provide referrals to the PC program and in-person lactation assistance.

## **PROFILE OF INNOVATIVE PROGRAM**

**Services Provided.** PCs contact and counsel clients primarily in the hospital and over the telephone. They call from home or from the breast-feeding office when making telephone contacts. The PCs typically provide one-on-one counseling, referrals, some written material, and electric or manual pumps if needed. They address current breast-feeding status, combination feedings, common problems (such as engorgement, sore nipples), and length and frequency of feedings. They also discuss the mother's diet and the use of vitamin supplements. PCs use a protocol to refer complicated cases to a lactation consultant or other medical authority. The PCs distribute their home phone numbers and will identify the best time to call a client. Home visits and appointments at the WIC clinic are less common and are made when clients are having breast-feeding difficulties, in which case lactation consultants are responsible for the

consultation. However, the PCs are encouraged to be present at the consultations to increase their counseling skills.

All City of Berkeley prenatal WIC clients are enrolled in the program. Ideally, PCs contact Berkeley prenatal WIC clients during the seventh month of pregnancy. Other WIC clients and non-WIC clients are enrolled in the hospital, where PCs make rounds six days a week to identify and assist WIC clients or other low-income women. The latter can often be identified because they participate in MediCal. The hospital lactation consultant assists the PCs in targeting the appropriate women. Specifically, the PCs identify WIC and low-income clients from a list they receive of hospital patients.

In the hospitals, the PCs go from room to room explaining the program and checking whether the woman is eligible based on income and residence. If she is eligible and would like to participate, then she is enrolled in the program and given bedside assistance. The enrollment forms are returned to the WIC lactation office, and the WIC lactation consultant considers age, location, language, and ethnicity to match the client with a PC to provide followup. The hospital lactation consultant supervises the counselors while they are in the hospital. The PCs will refer clients who need additional assistance to the hospital lactation consultant. The two positions work together, and the PCs are considered part of the health care team.

After delivery, all clients are followed for one year or until they stop breast-feeding. The goal is to have contacts with breast-feeding clients at 2–3 days, 5–7 days, 10–14 days, 1 month, 3 months, 6 months, 9 months, and 1 year after delivery. These contacts are primarily over the telephone.

The grant requires that program staff include bilingual and multicultural PCs to meet the needs of clients from different cultures and of those who do not speak English. The program has PCs who speak Arabic, Spanish, and various dialects of Chinese, Vietnamese, and Korean. In the hospital, PCs try to identify monolingual women in need of assistance in their own language, regardless of their income.

**Participation.** The grant from the California Endowment specifies that 2,250 women a year should be served; however, the program has been averaging about 1,600 a year.

**Coordination and Collaboration.** The Alta Bates Hospital agreed to have PCs provide breast-feeding support and information to their patients.

**Publicity and Outreach Efforts.** A hospital lactation consultant and the PCs publicize the program by word of mouth and through handouts. Most of the physicians that see the Medi-Cal and low-income clients know about and refer patients to the program as well.

## ORGANIZATION AND MANAGEMENT

**Staff and Organizational Structure.** One lactation consultant and 17 PCs staff the program, including the 6 original PCs from 1989.<sup>14</sup> Of these, 15 are paid \$18 an hour and 2 volunteer their services. The PCs are temporary employees who have breast-fed their own children, have an interest in being a PC, and are flexible and willing to work evenings and weekends.<sup>15</sup> Potential candidates complete an application and are interviewed. Some are then selected to participate in the training, without compensation. After completing the training, candidates take an exam. The results are used, in part, to determine who is hired. The number of hours they work varies a great deal with their language abilities, as some languages are in demand more than others. Some of the PCs work other part-time or full-time jobs as well, sometimes even for the WIC peer-counseling programs of other counties.

**Training and Quality Assurance.** Initially, the program contracted with the La Leche League to conduct train-the-trainer sessions for lactation consultants, lactation educators, and WIC nutritionists. After trying this and using various training curricula, program officials developed their own PC training manual and curriculum. The WIC lactation consultant facilitates the 24-hour training, which addresses anatomy, common breast-feeding problems and how to help, cultural differences, and nutrition. Since receiving the California Endowment grant, there have been two trainings for PCs. In addition, PCs receive in-service training at a biweekly staff meeting. For quality assurance, the lactation consultant regularly observes PC activities and reviews charts.

**Record Keeping and Data Systems.** The WIC Director provides the California Endowment with program updates every six months, as the grant requires. PCs are expected to document every client contact. Standardized forms, in triplicate, are used. One copy goes to the hospital, one goes to the PC, and one is sent for centralized processing into the WIC computer system.

**Funding.** The California Endowment grant is for \$500,000. Since 2001, the California Nutrition Network has given 50 cents for every \$1 spent of the California Endowment funding, increasing the total by almost another 50 percent. Most salaries are covered in the grant, but two are paid with WIC funds. The main cost of the program is the salaries of the PCs.

## ASSESSMENT AND LESSONS LEARNED

**Program Strengths.** When the grant was submitted in 2001, the exclusively breast-feeding rate in Berkeley was 29 percent.<sup>16</sup> As of November 2003, it was 35 percent, which was the goal

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<sup>14</sup> In addition, an hourly lactation consultant is available when the full-time consultant is on vacation.

<sup>15</sup> In most cases, PCs have breast-fed a child for at least seven months, but program officials do make some exceptions.

<sup>16</sup> A PC program was already in place at this time in Berkeley.

outlined in the grant. The state rate was 10.8 percent in November 2003. These results are promising, although it is not possible to say definitively that this is attributable to the peer-counseling program. In addition, the WIC Director has noticed that exclusive breast-feeding almost always leads to breast-feeding for a year or more.

The program's success reflects the PCs and the support they receive from the lactation consultant. It is critical to have a full-time lactation consultant on-call after-hours to provide support and assistance to the PCs. It is also essential that breast-feeding education start early, even before a woman becomes pregnant. In general, clients give positive feedback about the program and look forward to receiving a call from their PC. In addition, PCs have an opportunity for career growth with the program. For example, one of the original PCs is now a supervising lactation consultant.

**Key Challenges.** Staffing was difficult at first, as many of the new PCs required significant support and training. In addition, there was only one lactation consultant to meet this need. Having two lactation consultants supervising the program would be ideal so that there would be more time to review the PCs' case notes, monitor and observe activities, and schedule individual meetings with the PCs. It is also a challenge to supervise a staff that works primarily from home, though biweekly PC staff meetings enhance communication. Staff turnover has been an issue as well. Some PCs have been terminated because they did not like to do paperwork or were providing inaccurate information. Others resigned because they felt "burned out" from being on the phone so much with clients, or they had personal issues to deal with. The WIC Director finds that her most stable PCs are married and have support at home to do this work.

Quality control and assurance has been a major challenge. PCs did not have office space until after the first year of implementation. During that time, PCs had no choice but to work from home without direct supervision. Some staff members took advantage of this system and were terminated. The WIC Director remarks that it is "extremely important" to have adequate space, telephones, furniture, and equipment in place before the PCs are hired, as well as to have the proper ratio of professional staff to PCs.

**Lessons Learned.** The WIC Director believes that this project can be replicated at other agencies, but she recommends that someone with experience in implementing a PC program be consulted. It is critical to get support and buy-in from the WIC agency and community stakeholders. The hospital component is very important, too, so that women can be contacted immediately after delivery, when establishing breast-feeding relationships is critical. The WIC Director also recommends paying the PCs a "decent" salary. Other counties that have started similar programs have lost PCs because the pay was inadequate. Finally, the WIC Director suggests following clients for six months after delivery and then providing them with contact information if they have questions or problems. It is difficult to follow clients for more than six months, especially as the PCs are busy enrolling new clients and so many old ones are becoming unreachable.

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**TELEPHONE PEER COUNSELING BY VOLUNTEERS<sup>17</sup>**  
**SOUTHWEST PENNSYLVANIA**

**OVERVIEW**

**Location:** Washington and Greene Counties, Pennsylvania

**Start Date:** 1993

**Target Population:** Pregnant and breast-feeding WIC participants

**Purpose:** To encourage mothers to breast-feed and provide them with regular breast-feeding support after they start.

**Services:** The program trained volunteer breast-feeding peer counselors (PCs) to contact WIC participants during pregnancy and after birth, and to continue regular followup as long as they are breast-feeding. They provide support, routine breast-feeding assistance, and referrals to other sources of care, with supervision and backup from a lactation consultant.

**Funding:** The program, which cost very little, was paid for out of WIC breast-feeding funds.

**Why Program Was Chosen:** This program is unusual in that, over a period of 10 years, breast-feeding peer counseling was conducted by volunteers only. The PCs were trained and supervised by a lactation consultant. All services were provided by telephone from the counselors' homes, so that PCs could integrate their work with their home responsibilities. Although this type of program seems a useful model for agencies with tight funding, the agency is now moving to the use of paid PCs, because of the challenges noted.

**Key Challenges:** It became increasingly difficult to recruit volunteers. The limited availability of volunteers and the limited number of hours they could work meant the program could not serve all breast-feeding clients and that PCs contacted pregnant women only once.

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<sup>17</sup> Telephone interview, May 24, 2003.

## **BACKGROUND**

**Community Characteristics.** Washington County is part of the Pittsburgh metropolitan area and adjoins Allegheny County. Its 2001 population was 200,000. Greene County is a rural (nonmetropolitan) county with a population of just over 40,000. It has a high poverty rate (15.9 percent in 1999 versus 11 percent for Pennsylvania as a whole). The populations of both counties are 95 percent white.

**WIC Program Background.** The WIC agency for Washington and Greene Counties is Community Action Southwest, a large community action agency that also sponsors Head Start and other family literacy programs, as well as the Child and Adult Care Food Program, among others. The program sponsors 13 WIC clinics throughout the area, one open 5 days a week, two open 3 days a week, two open 2 days a week, and others open less often (ranging from one day a week to once every two months). The less-frequent clinics are in locations like community centers and church basements. Fourteen full-time WIC staff and 3 part-time staff move around between the various locations. Each month the agency serves 4,800 WIC participants and has about 125 prenatal participants giving birth.

**Program History and Objectives.** The objectives of the Telephone Peer Counseling Program are to encourage breast-feeding initiation and duration by providing mothers with support from knowledgeable mothers in their own community. The program began in 1993, when the Breastfeeding Coordinator (who is now both the Breastfeeding Coordinator and the Nutrition Services Director [WIC local agency director]—hereafter, the Director) heard about the Texas peer-counseling program and, to save scarce WIC funds, decided to try something similar with volunteers. Before the peer-counseling program started, the Director saw mothers at the WIC clinics who needed help, took phone calls from mothers with breast-feeding questions, and worked with mothers with breast-feeding problems who were referred by WIC staff. She also tried to call prenatal participants soon before delivery to talk about breast-feeding and to provide support to mothers who breast-fed after birth, but she could not call everyone.

The Director led the development of the program. She attended the Texas Peer Counselor training, which gave her useful background. She developed the idea of volunteer PCs who were WIC mothers (or former WIC mothers) working out of their own homes. The program would provide a monthly stipend of \$25 to PCs to cover the cost of the phone and occasional trips to the WIC office for meetings. She also decided that PCs would serve only clients in their local calling areas, so they would not have to pay for toll calls.

She then recruited PCs. The original group was recruited through ads in the WIC program newsletter and recommendations from WIC staff—mostly the latter. The first training lasted three full days and was conducted in person. Ten women started the training, and six completed it and became PCs.

## **PROFILE OF INNOVATIVE PROGRAM**

**Services Provided.** PCs made an initial call to prenatal participants four to six weeks before their due date. Using open-ended questions, they asked the expectant mother how she felt about breast-feeding, and told her they were available to help if she decided to breast-feed. The

PCs gave pregnant women their home phone number. If a woman was adamant that she would not breast-feed, they did not call back, but if she wanted to breast-feed or was unsure, they tried to call as soon as possible after the birth. Sometimes, they heard of the delivery from WIC staff, but otherwise they tried calling around the due date to see how things were going, and called back if the mother had not yet delivered.

Although PCs gave out their home phone numbers, clients rarely called them. Instead, the PCs initiated most calls. The program's goal was that a PC would call a breast-feeding mother two or three times a week in the first month after birth, once a week in the second month, and about once a month thereafter, until weaning. However, they adjusted this schedule based on what worked for each mother—if she was experienced, she may have needed only occasional calls from the start; if she was having problems, she may have needed a call every day. Clients were often too overwhelmed to ask for help, but they were very appreciative when the PCs checked on them.

The PCs were also trained to give referrals and to alert mothers when a problem might be serious enough to require the doctor. PCs referred complex breast-feeding problems to the Director. They also made referrals to community agencies for services such as counseling for depression, women's shelters for domestic violence, help with getting a crib or diapers, and so forth. Each PC came to know the resources in her area well. If a mother was referred to a doctor in an emergency situation, the Coordinator was also notified—but this happened only a few times in 10 years.

**Coordination and Collaboration.** There was no formal collaboration between the volunteer program and other programs, but the community has become more supportive of breast-feeding over time. When the PC program started, the WIC Director was the only Internationally Board Certified Lactation Consultant (IBCLC) in the area. Hospitals did not have “rooming in” of babies with their mothers, and very little breast-feeding support was available. The

### **A PROGRAM IN TRANSITION**

Community Action Southwest has recently moved to paid PCs, with the hope that they can serve more mothers. The agency joined a consortium with two other local WIC agencies and received U.S. Department of Agriculture (USDA) funding for two PCs, who will each work 10 hours a week in an office setting. Two of the volunteer PCs were hired as the first paid PCs at the agency, so they needed minimal training. The PCs are now covered by a union contract and were hired under union rules.

Our interview with the Director took place one month before these changes went into effect. At that time, the Director expected to discontinue using the volunteer PCs, because of union rules and because the paid counselors may be able to handle the full caseload. She also hoped the paid PCs will be able to make more prenatal contacts, to try to increase breast-feeding initiation as well as duration.

level of support has changed a great deal in the past 10 years. All but one of the local hospitals have lactation consultants, all have rooming in, and a lot more support is available in the community.

**Participation.** The peer-counseling program reached about half of new mothers in the two counties (a little over 60 a month), largely because not all mothers were in the local calling areas of one of the PCs. The Director used to call expectant and breast-feeding mothers in areas without PCs, but she has not been able to since she became the Nutrition Services Director three years ago. Thus, the more rural areas, which are less likely to have PCs, tend to be underserved. About 30 percent of WIC mothers choose breast-feeding (about 20 a month among those contacted) and receive additional follow-up calls from the PCs as described above.

**Publicity/Outreach.** The agency has not done publicity or outreach for the peer-counseling program, because they have never had enough PCs to cover all WIC women giving birth. However, there is a brief description of the peer-counseling program on the WIC part of the Community Action Southwest Website.

## **ORGANIZATION AND MANAGEMENT**

**Staff and Organizational Structure.** The Director supervised the program; she recruited the PCs, trained them, and reviewed their work. In the volunteer program, there have generally been seven to nine PCs at a time. During the early years, PCs tended to stay 4 to 5 years (and one stayed 10 years), but now they stay about 2 years. In part, the shorter tenures reflect welfare reform and increased pressure to take a paid job. In addition, PC experience motivates some mothers to move into the workforce, particularly as their children get older. Some PCs, however, continue peer counseling after they start paid work, but handle fewer cases.

PCs must have breast-fed a child for at least 6 months (all the current PCs breast-fed over a year) and have children no younger than 6 months old. They have to be former or current WIC participants. Women interested in becoming PCs filled out an application form and a survey in which they described their breast-feeding experience. The PCs received a \$25 monthly stipend for months in which they worked at least five hours. The PCs set their own hours, with the stipulation that they should call clients only between 9:30 A.M. and 8 P.M., unless clients gave them permission to call at another time. Most worked 5 to 10 hours a month.

The WIC agency used the computer to assign prenatal clients who will deliver soon to PCs in their local calling area. Each PC was assigned 15 to 20 pregnant clients a month, of whom about 5 would breast-feed. The contact lists were mailed to the PCs.

**Training for Peer Counselors and Quality Control.** The Director developed the original training and has updated it regularly. Initially, it was based on the training materials of the Texas peer-counseling program. Later, she changed it to include the same breast-feeding material used in training WIC staff. The Director had helped develop this statewide curriculum. The training also covers issues related to confidentiality, material on maternal and child nutrition, and a section on making referrals: when to refer to the Director (who is an IBCLC), WIC staff, and community agencies, and especially when to tell the mother to call the doctor, with procedures for following up to make sure the doctor was contacted. The Director also does most of the training, but sometimes other WIC staff have delivered parts related to child nutrition or WIC

procedures. The training initially was in a small group, but has increasingly been one on one, as new counselors joined the program one at a time as previous counselors left.

When a new counselor joins the program, the training includes only 12 hours of in-person training, and then from 8 to 15 hours of telephone training, in which the Director role-plays being the client. The Director trains the new PCs on how to handle introductory calls (including what to do if people are rude or hang up), and on how to handle the most common breast-feeding problems. Practicing counseling over the telephone works much better than practicing in person, as the PCs are forced to practice giving explanations and instructions without visual aids—for example, explaining the proper way to get the baby to latch on to the breast.

The Director was in frequent contact with trainees during their first month—she was often on the phone with each of them for two to three hours a week. Afterwards, she found they needed little supervision; she just called them once a month to check in. She tried to meet with the PCs at least quarterly, but met with them less frequently in the past year, because of the press of her other duties.

The Director received contact forms (discussed below) from PCs when the baby was weaned. She called about six randomly selected mothers who had weaned each quarter and asked them how it was to work with the PC. This provided a form of quality control.

**Record Keeping.** The Director designed a contact sheet for counselors to fill out for each client. It had basic contact information on the mother, and a section in which to enter data on the baby after the birth. It also included a checklist for types of contacts and issues PCs often encounter. On the back was an infant assessment that the PCs reviewed with the mother to determine whether the baby was having any trouble. This assessment, which included questions such as how many wet diapers the baby had per day, was used during every call for the first two months after birth, and sometimes later if needed.<sup>18</sup> At the end of the form, the PCs attached notes on each contact. They mailed the form back to WIC when the baby was weaned.

**Funding.** The only concrete cost for the program (when operating as a volunteer program) was the PC stipends, which came to \$2,000 to \$3,000 a year. The stipends were funded out of WIC breast-feeding funds. (Some of the counselors worked fewer than 5 hours a month and thus did not get stipends.) The Director's time was not really an extra cost—she would have been calling mothers herself if she had not had PCs to do it. She spent only about one day a month checking in on PCs, except during training periods. If anything, the WIC agency may have saved money from having PCs, as they handled the more routine breast-feeding issues, so the Director did not have to.

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<sup>18</sup> The Director noted that the assessment was especially important when mothers did not see the pediatrician until two weeks after birth. Now, babies have a three-day checkup visit, which helps in catching early feeding problems.

## ASSESSMENT AND LESSONS LEARNED

**Program Strengths.** The program is interesting because it is an example of a successful peer-counseling program implemented in a largely rural area. In addition, it has been staffed by volunteers, which has kept the cost very low.

There is some evidence that the PCs have succeeded in improving the duration of breast-feeding among WIC mothers who initiated it, but they do not seem to have affected initiation rates. In particular, in the early years of the program, the Director monitored breast-feeding initiation and duration rates among clients in each clinic her agency ran. Average breast-feeding durations were much longer in clinics with PCs in the area than in clinics with no PCs (12 to 18 weeks versus 4 weeks), but initiation rates were no different (about 30 percent throughout the area). Lately, she has not monitored these rates, because of her additional responsibilities and because of a recent switch to a new computer system. Because the PCs have had the resources to make only one contact during pregnancy, the Director believes they have not affected initiation rates.

Clients are very positive about their PCs. When the director calls to get feedback on the PCs, she often hears comments from mothers such as that they could not have breast-fed as long without the support of the counselor. Other typical comments include how the counselor did not make them feel bad for weaning, but praised them for breast-feeding as long as they did.

Another positive outcome of the program was the PCs' increased self-confidence and new skills learned, which have helped them to pursue further education or to enter the workforce.

**Key Challenges.** The major challenges this program faced included the difficulty finding volunteers in the more rural parts of the counties and the limited hours that most volunteers were willing to work. These problems limited the ability of the program to serve all women giving birth in the two counties. They also meant that the program did not have the resources to contact pregnant women more than once. Now that they have a regular, paid staff, the WIC agency hopes to increase its contacts with pregnant women. Another issue has been the limited time available for the Director to supervise the program, as funding constraints have forced her to take responsibility for both the overall administration of the WIC program and for the coordination of breast-feeding promotion. Additional funding for WIC nutrition services or funding from other sources would alleviate these problems. (As noted, outside funding was received for the move to paid PCs.)

**Lessons Learned.** The WIC Director for Washington and Greene counties believes that volunteer breast-feeding PCs could be useful in an agency that is short of funding, but that they could not be expected to stay as long as her original group did. Her experience was that once the counselors were trained, she did not need to spend much time monitoring them.

The program is unusual in that it allows PCs to work out of their homes, but the results suggest that this model can work. Telephone counseling out of the home seems of particular value in a rural area, where transportation is not always available. The use of telephone training to help counselors prepare to provide assistance over the telephone may be of interest to other programs. The restriction of the PCs to local calls was a concern; other agencies might want to explore different options for telephone connections.

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## B. MULTIFACETED PROGRAMS WITH STRONG OUTREACH COMPONENTS

This section describes programs that include readily available individualized help, either by phone or in-person, complemented by extensive outreach to community health professionals to “sell” the idea that WIC supports breast-feeding and is not just a source for infant formula. Two of the programs (Riverside and Miami) provide the support largely through a hotline with in-person meetings as a backup, while one (Sacramento) provides support largely through clinic appointments with lactation consultants. These programs also include a wide range of other services, which are summarized in Table II.1.

TABLE II.1  
BREAST-FEEDING SUPPORT SERVICES AVAILABLE IN  
MIAMI, RIVERSIDE, AND SACRAMENTO

Services	Miami	Riverside	Sacramento
Training programs for WIC staff and/or other health professionals	X	X	X
Incentives for mothers	X	X	
Support groups	X	X	
In-hospital counseling and/or support to hospital staff	X	X	
In-person counseling in WIC clinics available daily		X	X
Breast pump program with a large stock of pumps available	X	X	X
Calling mothers at regular intervals	X	X	
24-hour helpline	X <sup>a</sup>	X	
Home visits			X
Peer counseling	X		X

<sup>a</sup>In Miami, the helpline is staffed during the day, and an answering machine is used at night and on weekends. The machine is only checked occasionally, so the helpline does not have full 24-hour coverage.

Two of these programs (in Riverside and Sacramento) have extensive outside funding. The Riverside program serves all women in the county, which clearly makes it a “WIC Plus” program for which outside funding is appropriate. The Miami program, which does not have non-WIC funding, is a good example of comprehensive services in a more constrained budgetary environment.



**LOVING SUPPORT BREAST-FEEDING PROGRAM<sup>19</sup>**  
**RIVERSIDE COUNTY, CALIFORNIA**

**OVERVIEW**

**Location:** Riverside County, California

**Start Date:** Breast-feeding services have been available since 1982 to WIC clients, a 24-hour telephone helpline began in 1997 for WIC clients, and helpline services were expanded to all Riverside County residents in 2000.

**Target Population:** All pregnant and breast-feeding women who live in Riverside County.

**Purpose:** To meet the Healthy People 2010 breast-feeding objectives by providing help and support to breast-feeding women and collaborating with the health professionals that care for them.

**Services:** 24-hour helpline, individual assistance, prenatal education, educational materials and incentives, breast pump program, outreach to the medical community, training of health professionals, outreach to employers.

**Funding:** \$480,000 from California's Proposition 10 Tobacco Tax Initiative, and several hundred thousand more in special grants from the state WIC agency, plus some smaller grants and in-kind contributions.

**Why Program Was Chosen:** This program offers breast-feeding support 24 hours a day, 7 days a week, 365 days a year to all county residents through a helpline. Focusing outreach on one key message, "contact the helpline if you need breast-feeding assistance," is one key to the program's success. In addition, Breastfeeding Representatives, who are responsible for a geographical territory, conduct outreach similar to that done by formula company representatives. The rich menu of services and extensive outreach and training offered to health care professionals work together, yet some subset may be useful to other agencies with less-generous funding.

**Key Challenges:** At first, it was challenging to convince community health professionals to refer patients to the breast-feeding helpline, but extensive outreach has largely overcome their reluctance. At this point, an important challenge is to keep a high level of services as the popularity of the program grows. The geographic dispersion of the county's population is also a challenge.

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<sup>19</sup> Telephone interview, May 13, 2003; site visit, August 12-13, 2003.

## **BACKGROUND**

**County Characteristics.** Riverside County is one of the fastest growing counties in the United States. In 2001, the population was 1.6 million, with a 5.9 percent increase between April 1, 2000, and July 1, 2001. The population is growing as people migrate to the county for the lower cost of housing and living. In addition, businesses are relocating from Los Angeles and San Diego to the county because of lower real estate costs. It is also a large county in land area, comprising 7,207 square miles, about half of which is desert, and extending from Orange County to the Arizona border. According to 2000 figures, 66 percent of the population is white and 19 percent report some other race, both of which are higher than the California average. In addition, about 6 percent of the population is African American and 4 percent is Asian; both figures are lower than the state average. Regardless of race, 36 percent are of Hispanic or Latino origin. In 1999, 14 percent of the population of both California and Riverside County lived below the poverty level, higher than the national average.

**WIC Program Background.** The Nutrition Services Branch of the Riverside County Department of Health (which is the local WIC agency) has a \$9.3 million annual budget and 170 staff, including 40 dietitians. Funding streams include the U.S. Department of Agriculture (USDA), Proposition 10, California Nutrition Network, California Health and Disability Prevention Program, and medical nutrition therapy insurance reimbursement. The department is responsible for WIC, Loving Support, and a range of other nutrition programs.

The caseload that Riverside WIC handles is larger than or comparable to that of some states. The WIC program serves 60,000 clients a month in 18 clinics. According to August 2003 figures, 75 percent of participants are Hispanic, 53 percent speak English, about 10 percent are prenatal women, and 5 percent are breast-feeding mothers. Monthly clinic census ranges from 800 in the smallest clinics to 10,000 in the larger ones. Proposition 10 funds allowed WIC to expand clinic hours to some evenings and weekends, and to serve an additional 3,000 clients each month. The WIC Customer Service Center is a centralized call center that answers a toll-free number for people inquiring about WIC or scheduling a clinic appointment. On average, the call center receives 10,000 to 14,000 calls a month.

**Program History and Objectives.** Since 1982, the Riverside WIC program has provided comprehensive prenatal education, lactation education, and breast-feeding support groups for WIC clients, as well as extensive staff training. However, WIC staff did not have the time to provide much individualized counseling and help with breast-feeding. The breast-feeding helpline began in 1997, but at that time, it was available only to WIC clients and operated only during regular business hours. The helpline came into being because WIC staff members saw that by the time women came to enroll their infant in WIC, it was too late to address breast-feeding problems, since many mothers, lacking support and assistance, had already stopped breast-feeding. In addition, women who were not enrolled in or eligible for WIC received limited, if any, information and support.

California voters passed the Proposition 10 Tobacco Tax Initiative, part of the Children and Families Act, in November 1998. The proposition increased tax on cigarettes and tobacco products to fund intervention services for young children and their families. The Nutrition Services Branch applied for and was awarded Proposition 10 funds from the First 5 Riverside

Commission to expand and enhance the existing breast-feeding services to all Riverside County residents, not just WIC participants. Upon receiving the funding in 2000, program officials classified all breast-feeding supportive services under the umbrella name “Loving Support Breastfeeding Program.”<sup>20</sup> The program also began extensive community outreach at this time, with both clients and health care professionals.

Loving Support is committed to meeting the Healthy People 2010 objectives pertaining to breast-feeding: (1) 75 percent of new mothers must leave the hospital breast-feeding after delivering their babies; (2) 50 percent of new mothers must continue to breast-feed their babies for the first six months of life; and (3) 25 percent of new mothers must continue to breast-feed their babies for at least one year.

To meet these goals, Loving Support developed five “Standards for Success”: (1) increased numbers of pregnant women will receive accurate and reliable information regarding the importance of and how to initiate breast-feeding; (2) increased numbers of newly delivered mothers will receive information, support, and help for breast-feeding in the immediate postpartum period; (3) increased numbers of women will be successful at breast-feeding their babies through at least the first year of life; (4) increased numbers of mothers will continue to breast-feed after returning to work or school; and (5) standardized reports using collected data will be generated on a quarterly basis to demonstrate the successes in the first four standards.

**Target Population.** Loving Support targets all pregnant and breast-feeding women in Riverside County. WIC also offers additional breast-feeding services only for WIC clients. The program also conducts substantial community outreach targeting health care providers and employers.

## **PROFILE OF INNOVATIVE PROGRAM**

Loving Support offers a wide range of breast-feeding services for all county residents, but the WIC clinics provide additional breast-feeding services to WIC clients. Although Loving Support and WIC are separate programs, they are very integrated. Because the line is difficult to draw, and the WIC services would at any rate be important in context, we discuss the full range of breast-feeding support services offered by the Riverside County Department of Public Health in this section, indicating when services differ for WIC clients and others.

### **Services Provided to Parents/Caregivers**

**Helpline.** A toll-free breast-feeding helpline is available to all Riverside County residents. Support, encouragement, and technical assistance are provided 24 hours a day, 7 days a week, 365 days a year. Two full-time Helpline Counselors, who are lactation educators, manage the calls during weekday business hours. The Breastfeeding Representatives and the Breastfeeding

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<sup>20</sup> The program purchased the rights to use the Loving Support logo and name from Best Start Social Marketing of Florida.

Coordinator rotate on-call after-hours duty for the helpline weekly.<sup>21</sup> After-hours calls are returned within 30 minutes.

The helpline addresses a variety of concerns: breast abrasions, infant thrush, medication safety, alcohol consumption, latch on, infant weight loss, jaundice, weaning, and pumping due to mother and infant separation. Some mothers receive so little support from family and friends that often they simply need a friendly voice to encourage rather than criticize them. The Helpline Counselors use the La Leche League International's *Breastfeeding Answer Book* protocols, which are available in English and Spanish and on CD-ROM (Mohrbacher and Stock 2003).

In addition to receiving incoming calls, Helpline Counselors call mothers who fill out and mail postage-paid postcards requesting enrollment in the Loving Support Program. WIC participants receive a postcard, included in a WIC Last Trimester Help Bag, during their last-trimester counseling session. To reach additional mothers, Certified Nurse Assistants and other medical staff members distribute these postcards to new mothers in hospitals after delivery. Riverside County Public Health Nurses, the Tobacco Free Families Health Education Program, and the Black Infant Health Program also distribute the postcards to pregnant women. These postcards include the mother's name, contact information, and a request to receive a call from a Helpline Counselor and join the program. Calls are made upon receipt and allow the Helpline Counselors to provide education, help, and support to new mothers to ensure that breast-feeding gets off to a good start. Helpline Counselors also do follow-up calls to all Loving Support Program mothers at critical milestones in the infant's development (3 weeks, 6 weeks, 3 months, 6 months, 9 months, and 12 months; or until weaning) in order to offer anticipatory guidance regarding growth spurts, returning to work, teething, introduction to solid foods, and weaning advice from family or friends.

In some situations, a Helpline Counselor is unable to provide over the telephone the assistance the mother needs. If a serious medical situation is apparent, the Helpline Counselor will suggest that the mother seek medical assistance from her physician or, in life-threatening situations, go directly to a hospital or call 911. Typically, however, the Helpline Counselor will refer a client to a Breastfeeding Representative in the client's geographical area.

The average number of calls and the average call length varies, but in a typical day, the Helpline Counselor will receive 20 calls and complete 30 follow-up calls. Call length can vary from a few minutes to an hour, depending on the need or the number of questions.

**Individual Assistance.** Breastfeeding Representatives provide individual assistance to mothers primarily in WIC clinics, hospitals, and over the telephone, and to a lesser extent in doctor's offices or in the home. When a Breastfeeding Representative receives a referral from the Helpline Counselor, she calls the client to discuss the problem or breast pump need over the

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<sup>21</sup> A bilingual Helpline Counselor is teamed with a Breastfeeding Representative for on-call duty, if the latter is not bilingual. Staff members are paid for 1 hour for every 8 hours on call but not active, and bank compensatory time-and-a-half for time spent responding to calls.

phone and, if needed, schedules a meeting time and place, often at a WIC clinic. Often a mother knows what to do but needs in-person reassurance that she is doing everything correctly. In other situations, a breast-feeding mother may have pain that warrants intensive assistance. Breastfeeding representatives can arrange to see mothers at WIC clinics; some have walk-in hours, and others require an appointment, which will be scheduled either the same day or the next day. As a standard procedure, after Breastfeeding Representatives provide individual assistance, the Helpline Counselors will conduct the follow-up calls. However, some Breastfeeding Representatives conduct their own follow-up calls. In general, immediate follow-up is provided to mothers having serious problems.

A goal of Loving Support is to help all the county's 14 hospitals become "baby-friendly," not only by having Breastfeeding Representatives provide bedside counseling to postpartum women, but also by training medical staff to provide such support. In general, the Breastfeeding Representative trains medical staff members to provide bedside assistance, and the Breastfeeding Representative counsels a patient only if a staff member feels it is necessary. In particular, the Riverside County Regional Medical Center (RCRMC) nurses in the neonatal intensive care unit (NICU) and Obstetrics, Labor, and Delivery unit work with the Breastfeeding Representative to ensure that all mothers receive bedside counseling and information on breast-feeding from either the Breastfeeding Representative or a nurse. For example, one week after an infant is discharged from the NICU, the Breastfeeding Representative and a NICU nurse assess the breast-feeding mother and infant. In addition, the hospital has collaborated with Loving Support to offer a weekly walk-in lactation clinic for any breast-feeding mother needing assistance.

**Prenatal Education.** Prenatal education classes are available only to WIC clients, and are facilitated by WIC staff members at the clinics. There are three components in the prenatal breast-feeding education efforts: (1) group education topic one month after prenatal enrollment: "What have you heard about breast-feeding?" (2) group education topic two months before delivery: "What to expect in the hospital," and (3) individualized consultation and distribution of the WIC Last Trimester Help Bags.

**Breast Pump Program.** Breast pumps are available on loan to women, including teenagers, who are working, going to school, or separated from their infants. Pumps can be obtained at WIC clinics, or a Breastfeeding Representative may deliver them to the hospital or home. Non-WIC mothers give a \$30 deposit, but attachments are given for free from Loving Support as part of the Proposition 10 funding. All mothers borrowing a pump sign a pump loan agreement. The completed agreements are mailed or faxed to the central Loving Support office for input into a pump distribution database. The hard copy of the agreement is kept at the clinic or hospital where the pump was distributed. A daily printout, entitled the "Breast Pump Availability Report," is generated and distributed to Loving Support staff to identify which clients and clinics have pumps. WIC mothers with breast pumps are flagged in the WIC Integrated Statewide Information System so that WIC staff members know to follow up.

**Support Groups.** Support groups are available each month at all WIC sites for WIC participants and weekly at two hospitals for anyone who is interested. Lactation educators who are located in the WIC clinics facilitate the WIC groups. Breastfeeding Representatives, along with hospital staff that have been trained by Loving Support, facilitate the hospital-based support groups. Topics for discussion include adjusting to parenthood, breast-feeding: a family

experience, returning to work, breast-feeding the older baby, weaning with love, and wearing your baby (that is, using a baby sling). Each group has about 20 people, and 2,500 people attend support groups each month.

**Materials and Incentives.** A Loving Support Prenatal Breastfeeding Education Package is sent to all pregnant women who call the helpline to enroll in the Loving Support Program. This package includes the pamphlets “Is Breastfeeding Right for Me?”; “Ten Healthy Habits While You Are Breastfeeding”; “Ten Ways to Relax While Breastfeeding”; “Ten Tips on How Dad Can Help with the Baby”; and “Eat 5 a Day the California Way.” A Loving Support introductory letter and refrigerator magnet with the helpline number is included.

WIC participants receive, to take to the hospital for delivery, a WIC Last Trimester Help Bag that contains a “Breastfeeding: The Best Start” pamphlet, a 10-day diaper log, a “Dear WIC, I had my baby...” postcard, a “Wear Your Love!” necklace flyer, a “No Bottles” sticker, and a Loving Support refrigerator magnet. In January 2003, Wear Your Love necklaces were added as an incentive for WIC participants to breast-feed exclusively and to attend monthly breast-feeding support or nutrition education sessions. The necklace has a baby head charm of the appropriate gender, race, and ethnicity, and mothers who breast-feed exclusively receive a bead for the necklace when they attend a support group or nutrition education session.

Loving Support mails inspirational cards to encourage, congratulate, and honor breast-feeding mothers at critical milestones in the baby’s development (3 weeks; 3, 6, 9, and 12 months). In addition, displays in physician’s offices include a “Take-Away” card that offers up-to-date breast-feeding information, helpful hints, and support resources.

### **Community Outreach to Medical Professionals**

Loving Support wants to ensure that health care providers have the knowledge and resources necessary to help their patients choose and continue to breast-feed. The seven Breastfeeding Representatives visit 300 prenatal, pediatric, and family practice care providers and 14 hospitals on a monthly or biweekly basis. During a visit, the Breastfeeding Representative will ask staff if they have any material or training needs, or any general questions about breast-feeding. The Breastfeeding Representatives will also restock educational materials, displays, and take-away cards at this time. There are different displays for the obstetricians’/gynecologists’ (OB/GYN) and pediatricians’/family practitioners’ offices. Both provide bilingual displays with a Loving Support business card, but the former also contains a pamphlet with more details on breast-feeding and Loving Support. Each office receives either the Loving Support Resource Guide for OB/GYNs or the Loving Support Resource Guide for Pediatricians/Family Practitioners. Both contain information on the Loving Support and WIC programs, the breast-feeding policy statement of the American Academy of Pediatrics and the Family Practice Association, resources, camera-ready patient handouts, and a section on current research. These guides, particularly the current research section, are updated on a monthly basis when Breastfeeding Representatives visit offices. In addition, a quarterly Baby-to-Breast newsletter is distributed to all partnering health professionals with up-to-date information and resources on breast-feeding. In addition, hospitals are provided Loving Support crib cards to replace the pharmaceutical companies’ crib cards.



## **Community Outreach to Employers**

In 2002, the Loving Support staff developed the “Breastfeeding Friendly Workplace” package to help local businesses comply with California’s AB1025-Lactation Accommodation Law, which imposes requirements upon employers concerning safety, work conditions, and time to accommodate employees who desire to express breast milk. Loving Support offers to come to the workplace and provide technical assistance.

## **Participation**

Loving Support wants to reach at least 50 percent of mothers who give birth in Riverside County, a challenge considering that there are more than 24,000 infants born each year in the county. In the first year of the program, the Loving Support program counseled 5,150 mothers between July 2001 and June 2002. Now, on average, Loving Support counsels 4,000 to 5,000 clients, and the helpline receives or returns 4,000 to 5,000 calls *each quarter*. Specifically, the helpline received or returned 4,412 total calls in April through June 2003. Of those calls, 1,730 were initial calls and 2,682 were follow-up or repeat calls, representing 2,724 individual mothers. During the quarter July–September 2003 the Helpline Counselors received or returned 4,743 total calls. Of those calls, 1,804 were initial calls and 2,939 were follow-up calls.

The typical helpline client varies, but the helpline receives many calls from first-time or young mothers who do not know much about breast-feeding. Most calls are from WIC participants, and many initial calls are from new mothers in the hospital who received literature or a referral from medical staff. Fathers or male partners will occasionally call on behalf of the mother, as will other relatives. It is also common for medical providers to call the helpline for information to assist their patients. About 3 percent of calls are from mothers who do not live in the county. Loving Support tries to help these mothers over the phone. If the caller needs in-person assistance, Loving Support either refers them elsewhere, if such help exists, or will try to meet them at a clinic.

## **Coordination and Collaboration**

Loving Support maintains extensive collaborations with agencies and organizations in the county, including area hospitals, doctor’s offices, and pharmacies. For example:

- Loving Support provides referrals to and receives referrals from the La Leche League so that breast-feeding mothers receive as much support as possible.
- Loving Support has worked with one pharmacy to display breast-feeding supplies in a special section and has supplied the reference book *Medications & Mothers’ Milk* (Hale 2002) to 18 pharmacies.
- In addition, Breastfeeding Representatives participate in and often organize regional breast-feeding networks and coalitions comprising professionals, mothers, and other interested persons.

These are only some of Loving Support’s extensive collaborations.

## **Publicity and Outreach Efforts**

The main message for all publicity efforts is simple: anyone in Riverside County can call the Loving Support Breastfeeding helpline 24 hours a day for breast-feeding assistance. The program uses multiple mediums to publicize this message, including displays in OB/GYN and pediatricians'/family practitioners' offices, the Baby-to-Breast newsletter, magnets, business cards, magazine and bus shelter advertisements, movie theater advertisements, public service announcements, Lunch and Learns, and prenatal education classes. World Breastfeeding Month in August provides additional exposure through press releases, health fairs, and a county proclamation. In addition, as discussed earlier, the program uses postcards at WIC and the hospitals, bags with magnets and other information, and outreach to health care providers to obtain referrals or calls to the helpline. According to program tracking forms, most clients called the helpline after receiving a magnet or business card at WIC or their doctor's office.

## **ORGANIZATION AND MANAGEMENT**

**Staff and Organizational Structure.** The Loving Support Program has 13 staff members: the Breastfeeding Coordinator who is the overall project coordinator, 8 Breastfeeding Representatives of which 1 is a Senior Nutritionist helping to oversee the project, 2 Helpline Counselors, 1 data entry clerk, and 1 clerical support clerk. While personal experience is not a requirement for a Loving Support position, all but one staff member have personal breast-feeding experience. The Chief of Nutrition Services and the WIC Director spend a limited amount of time on the program and are not funded through Proposition 10 funds. The Breastfeeding Coordinator supervises the Breastfeeding Representatives, Helpline Counselors, and clerks.

The Breastfeeding Representatives have varying backgrounds, but all need to be enthusiastic and passionate about breast-feeding. Some are registered dietitians, others public health professionals, WIC staff members, or teachers. The Breastfeeding Coordinator and two Breastfeeding Representatives are Internationally Board Certified Lactation Consultants (BCLCs). Breastfeeding Representatives are classified as Health Education Assistants, which requires a four-year degree or a two-year degree plus two years of experience. They have three primary responsibilities: direct client services (including pump distribution), outreach and technical assistance to the medical community, and training health professionals. The first two roles require a significant amount of travel. Breastfeeding Representatives are responsible for one to three hospitals, two to three WIC clinics, and all the OB/GYN and pediatricians'/family practitioners' offices in their geographical region.

The Helpline Counselors are classified as Health Service Assistants, a position that requires a high school degree. They must be bilingual and have an understanding of the community.

Although WIC staff members are not funded through the Loving Support program, each WIC clinic has a lead lactation educator responsible for teaching breast-feeding classes, facilitating support groups, and managing and distributing breast pumps for their clinic participants. When the clinic's Health Service Assistants, Health Education Assistants, or Nutritionists are unable to provide assistance to a breast-feeding mother, the lead lactation

educator will try to help the mother. However, if there is a challenging case that the lead lactation educator is unable to manage, a Breastfeeding Representative is contacted. The WIC clinic lactation educators report to the supervising nutritionist in each clinic. However, they also meet bimonthly with the Breastfeeding Coordinator.

**Training and Quality Assurance.** The Breastfeeding Coordinator developed and coordinates the Trained Lactation Counselor (TLC) training that takes place one or two times a year. The Breastfeeding Coordinator, guest speakers, and other Loving Support staff are the trainers. All new WIC employees, Helpline Counselors, WIC clinic lactation educators, and Breastfeeding Representatives attend this 40-hour training, but other health professionals can attend as well. WIC employees working at the Customer Service Center attend a modified one-day training.

Monthly in-services and staff meetings for Loving Support and WIC staff members provide additional training opportunities. Loving Support staff members and lead lactation educators often attend other trainings, including Birth and Beyond courses, the La Leche League annual conferences, Loma Linda University's Perinatal Services Network training, and courses offered at the Lactation Institute in Encino, California.

RCRMC is the only hospital in the county with a medical resident training program that includes Loving Support. As part of their family practice, obstetric, pediatric or physician assistant's rotation, all RCRMC residents, as well as area dietetic interns, participate in a mandatory three- to four-hour rotation in the walk-in help clinic, where they learn about helping mothers with latching on and other common problems from the Breastfeeding Representative assigned to RCRMC. They also observe bedside teaching.

The Obstetrics, Labor, and Delivery unit hosts a Skills Day once a year for its nursing staff members. Nurses receive a hands-on "refresher" on breast-feeding by spending 30 minutes with the Breastfeeding Representative. In addition, it is mandatory that all this unit's nurses receive training on bedside counseling; two nurses at a time spend a morning with the Breastfeeding Representative, and the bilingual Certified Nursing Assistant (CNAs) spend two full days with the Breastfeeding Representative. The Breastfeeding Representative assigned to RCRMC has also trained all NICU nurses.

Training of hospital staff members is limited because Loma Linda University has a successful Perinatal Services Network training program that trains hospital staff, primarily nurses, in breast-feeding. Loving Support collaborates and coordinates efforts with the Perinatal Services Network to ensure that they enhance rather than duplicate the work in the hospitals. Specifically, Loving Support has provided some nurses the opportunity to shadow the breast-feeding representatives in bedside counseling of new mothers. Loving Support also trains all county-employed Public Health and Clinic Nurses in breast-feeding support through a one-day new-employee training and an annual one-day update.

**Record Keeping and Data Systems.** The Loving Support initial call and program enrollment tracking form includes: name, contact information, language, infant's name, infant's birth date, where infant was born, breast-feeding or formula-feeding status, how they heard about Loving Support, and the type of consult (such as incoming call, called out, in-person contact).

The follow-up tracking form includes similar information as the initial tracking form, with the addition of inquiries regarding breast-feeding termination, combination feedings, and a section for notes. Helpline Counselors and Breastfeeding Representatives use these forms when providing individual help over the phone or in person. Breastfeeding Representatives send the original form to the central Loving Support office for processing, often after photocopying the form for their records.

**Funding.** For fiscal year (FY) 2002–2003, Proposition 10 provided \$480,000 to support, expand, and enhance the breast-feeding program for WIC participants and move beyond the WIC client base. As of November 2003, Loving Support was in its second two-year agreement with First 5 Riverside. This agency wants awardees like Loving Support to sustain the program on their own eventually. This is a challenge for Loving Support, as there is a growing need and an already insufficient amount of staff and community resources to meet the need. The WIC program currently funds one Helpline Counselor. Loving Support is considering having the Medi-Cal managed care program provide a Helpline Counselor, since many of the clients receiving services are also Medi-Cal clients. There is also a potential to bill Medi-Cal and insurance companies for Loving Support services in hospitals and outpatient clinics.

### **LUNCH AND LEARNS**

In 2003, Loving Support conducted about 198 Lunch and Learn sessions for 873 people working in OB/GYNs', pediatricians', or family practitioners' offices; hospitals; and other health clinics in the county. Funding was from a special grant from the state WIC program. A Breastfeeding Representative developed the Lunch and Learn facilitators' manual, and Breastfeeding Representatives facilitated the actual presentations, which could last anywhere from 15 to 90 minutes, depending on the audience's interest in breast-feeding and time constraints.

Temporary Office Assistants were hired for this project, and each was assigned to a Breastfeeding Representative to assist with logistical and clerical issues.

The Lunch and Learns discussed Loving Support services and how breast milk "stacks up" to formula. Regarding the latter, large colored Lego blocks, each representing a specific component of breast milk, were stacked to illustrate the difference in breast milk and formula. By the end of the demonstration, there was a tower several feet high for breast milk and a small stack of blocks for formula, which indicated that breast milk has more to offer than artificial human milk. Program officials note that the demonstration was important because at the same time, pharmaceutical representatives were visiting doctors' offices to inform them of the new "brain development" infant formula newly supplemented with "special" lipids. A healthy lunch is also provided to participants.

Loving Support is currently searching for funding to continue this well-received project.

In FY 2002–2003, Loving Support received \$250,000 in WIC funding, and \$133,000 from a WIC Best Practices Grant for the Lunch and Learns (see box). The Riverside County Children and Families Commission also provides funding for Loving Support. Many hospitals, clinics, and community groups offer office or meeting space at no cost.

## **ASSESSMENT AND LESSONS LEARNED**

**Program Strengths.** Program officials cite three significant successes. First, breast-feeding rates among WIC clients have increased. In 1999, the Riverside County WIC exclusively breast-feeding rate was 10 to 11 percent. The goal of Loving Support is to increase these rates by 1.5 percent each year so that by 2010, the Riverside County WIC exclusively breast-feeding rate is at 20 percent. In June 2003, the exclusively breast-feeding rate among the WIC population in Riverside County was 14.5 percent. It rose to 14.8 percent in August and 15.1 percent in September. Second, there is an increased awareness and augmented support from community health care providers who are communicating breast-feeding as the norm to their clients. Third, the helpline and comprehensive outreach program has increased awareness of breast-feeding among the WIC population and the general public. More people in the community are talking about breast-feeding, and it is becoming more common and accepted.

Families have been very appreciative of the Loving Support program's 24-hour service and follow-up calls. Clients often call and send thank-you letters to Loving Support staff members. Program officials repeatedly hear clients say, "I wish that you had been around years ago," or "I wish that I had known about this service with my first child." Many breast-feeding women remark, "If you were not here, I would have quit."

Health care providers appreciate the services of Loving Support as well. The resources, training, and helpline support allow them to better meet the needs of their breast-feeding clients. Many carry Loving Support business cards in their lab coat pockets so they can easily make referrals. They see the program as especially beneficial to young and first-time mothers. Furthermore, WIC staff members value the quality breast-feeding services since they cannot spend much time with their breast-feeding clients because of busy caseloads. WIC staff members also have greater knowledge and confidence in discussing breast-feeding because of the TLC training and frequent updates from the program.

In general, the Loving Support staff is energized and enthusiastic about what they do. They do whatever it takes to help a breast-feeding mother in need.

**Key Challenges.** Initially, it was difficult to convince doctors and other health care professionals to refer their patients to the Loving Support program, or to allow outreach materials to be displayed in their offices. At that point, the helpline was not widely known, and the Breastfeeding Representatives had not yet established a credible reputation with the wider community. However, now doctors enthusiastically refer patients to the program, because more of their patients have expressed an interest in breast-feeding over the past three or four years.

Further, it is challenging keeping up with the popularity of the program. Once a client is entered into the database, she will receive a series of phone calls from a Helpline Counselor.

Following up with as many as seven contacts (one prenatal and six postpartum) for every client throughout the baby's first year is time-consuming for staff members. Another large challenge is the geographic size of the county. Breastfeeding Representatives spend a significant amount of time traveling throughout their territories.

At a community level, overcoming the barriers to breast-feeding is a challenge for staff members and clients. These barriers include embarrassment to breast-feed in public, fear that not enough milk is produced, and challenges in going back to school or work. In addition, some in the Hispanic culture believe that the first week of breast milk is "dirty," and some Hispanic mothers think that formula is better because it costs more. Of greater concern is that many women do not have the support of their male partner, friends, or family to breast-feed.

**Lessons Learned.** The extensive services provided in Riverside are clearly beyond what most WIC agencies can contemplate, even with outside funding. If a WIC program has minimal breast-feeding services, Loving Support program officials suggests that the program implement a 24-hour helpline so that clients always have access to help. The helpline receives many calls from frantic mothers on Friday afternoons, on weekends, and in the middle of the night. However, if there was no helpline, or if the helpline was only available during business hours, the mother might resort to formula and give up on breast-feeding altogether. Targeting all outreach materials around a simple message, "Call the hotline if you need breast-feeding help," seems to be an important source of the program's success.

Another priority for program planners is to implement a system so mothers receive support in the hospital immediately after delivery and a supportive call during the first few days at home with the new baby. Providing services in the hospital or coordinating with hospital staff is critical to helping mothers initiate breast-feeding.

The idea of having "Breastfeeding Representatives" that do for breast-feeding what formula company representatives do to sell formula is a very creative part of the Riverside program, but may be more than agencies can afford without substantial outside funding. However, Riverside staff pointed out that a WIC agency could "get the word out" with limited funding and still produce an increase in enrollment rate or clients served. For example, Loving Support produced magnets. They were not very expensive, but many clients tell Loving Support staff members that they learned about the program because they picked up a magnet and put it on their refrigerator. Outreach to health professionals also is an important element of the Breastfeeding Representative's work that other agencies could (and do) adopt in a scaled-back form.

Riverside staff commented that communication skills, flexibility, and passion are important attributes to look for in staff members. Different strategies work for different people, but the key for breast-feeding success is not to give up and to seek out help and support.

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**LACTATION CONSULTANT SERVICES<sup>22</sup>**  
**SACRAMENTO COUNTY, CALIFORNIA**

**OVERVIEW**

**Location:** Sacramento County, California

**Start Date:** June 2002, a three-year pilot that will continue if funding is available

**Target Population:** WIC mothers within 10 days of giving birth, participants in the Birth and Beyond program, clients who receive county public health nursing services, and relevant health care professionals

**Purpose:** To reduce the number of WIC mothers who discontinue breast-feeding due to a lack of support by providing enhanced breast-feeding services and educating health care professionals about the benefits of breast-feeding.

**Services:** Full-time lactation consultants offer consultations in the WIC offices, technical assistance through a breast-feeding helpline, home visits, and a Spanish-speaking peer counselor. Another key component is training WIC staff, Birth and Beyond staff, Sacramento County Public Health Nursing Services, and community doctors and nurses about the importance of breast-feeding.

**Funding:** \$1,500,000 over three years from Proposition 10 tax revenues<sup>23</sup>

**Why Program Was Chosen:** Full-time professional lactation consultant services are available to WIC clients during office hours, along with home visits. The program also includes active collaboration with local organizations to promote awareness of the benefits of breast-feeding.

**Key Challenges:** The county would not allow the program to hire lactation consultants as regular employees with benefits. It was also a challenge to gain acceptance for the program among regular WIC staff and other health professionals. Finally, it could be difficult to arrange private space for the consultants to see clients at WIC clinics.

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<sup>22</sup> Telephone interview, April 28 and May 2, 2003.

<sup>23</sup> In 1998, California voters passed Proposition 10, which levied a tax on cigarettes to generate funding for children's health programs.

## BACKGROUND

**County Characteristics.** Sacramento County is the eighth-most-populated county in California, with 1,223,499 residents, 16 percent of whom are Hispanic or Latino in origin and 64 percent of whom are white (U.S. Census Bureau 2002). It encompasses approximately 994 square miles in the middle of the 400-mile-long Central Valley, the state's prime agricultural region. In 1997, 30 percent of the population aged 0 through 4 lived in poverty, and in 1999 an estimated 11,272 children aged 3 to 4 lived in poverty. The number of low-birth-weight infants declined slightly from 1997 to 1999—6.9 to 6.6 percent. Sacramento County's median household income in 2000 was \$42,329, and approximately 27.5 percent of kindergarteners and 18.9 percent of children (grades 1–8) were classified as English learners during the 1999–2000 school year.<sup>24</sup>

**WIC Program Background.** Sacramento County has two WIC agencies, but only one (the County Department of Health and Human Services) participates in the pilot. This agency has four clinics. Before the pilot, Sacramento County had two part-time lactation consultants who each worked 17 hours a week on a caseload of 21,000 women, infants, and children. The consultants were overwhelmed with cases and did not have adequate private space in the WIC clinics to deliver services. Except for one clinic that collaborated with the Birth and Beyond Program for a mini-grant through a United Way agency, WIC was not able to provide lactation consultations through home visits. In addition, the consultants delivered training to other WIC staff, including both nutrition assistants and registered dietitians, to teach them about basic breast-feeding skills and to encourage them to refer clients to the lactation consultants whenever possible.

**Program History and Objectives.** The pilot program seeks to make professional lactation services available through Internationally Board Certified Lactation Consultants (IBCLCs) to reduce the number of mothers who discontinue breast-feeding due to challenges (such as sore nipples) and/or a lack of support. According to the project director, health care professionals often do not have the time or training to understand or appreciate the benefits of breast-feeding, and thus fail to provide mothers with the support that they need to pursue it. In her opinion, nurses are more likely to use formula as the immediate solution to any problems that a new mother encounters when breast-feeding. While Sacramento County had lactation consulting services before the pilot began, WIC had only two part-time IBCLCs for a caseload of more than 20,000 clients. Program staff knew that more should be done to encourage and support breast-feeding among WIC clients.

To fund the pilot, county officials relied on Proposition 10 funding. The California WIC Association encouraged local agencies to develop ways that they could use the revenues in anticipation of a future request for proposal, which eventually was released in 2000. In writing the proposal for Sacramento County, the senior health program coordinator—who would become the project director—conferred with the county's breast-feeding coordinator to gauge the service

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<sup>24</sup> Unless indicated, all data are taken from the Sacramento County portion of *California Report Card 2001: Factors for School Success*, prepared by Children Now, a California children's advocacy group, November 2001.

needs in the WIC community. The coordinator stressed that increasing the number of professional lactation consultants would be the most effective use of additional resources. Before the pilot, it was difficult for WIC mothers to breast-feed successfully because they lacked a readily available, well-staffed support network. Thus, hiring additional IBCLCs became the core component of the county's grant proposal.

Between 1995 and 2000, the Sacramento WIC program used several peer counselors to offer general support to breast-feeding mothers or pregnant clients who expressed an interest in breast-feeding. However, program officials concluded that peer counselors required too much training and supervision, and that IBCLCs would be a better use of funding. Instead of referring a client to a lactation consultant when appropriate, sometimes a peer counselor tried to address the problem herself, often sharing inaccurate information. According to the project director, if a lactation professional is not available, it can be discouraging for clients and "set some of them up for failure." By the time the pilot began, most counselors had left WIC through attrition. The only peer counselor remaining travels to different clinics as needed to translate when a lactation consultant who does not speak Spanish has a Spanish-speaking client.

Program officials note that because it is easier to recruit bilingual counselors as opposed to IBCLCs, peer counselors serve as a critical link to Spanish-speaking clients. Furthermore, they can assume responsibility for tracking pumps, making follow-up telephone calls, and communicating with the rest of the clinic's staff, which grants the lactation consultants more time to provide technical assistance. The project director noted that, in an ideal world, there would be as many peer counselors as languages spoken among clients who need breast-feeding services.

**Target Population.** Program officials target services to WIC mothers within 10 days of the birth, the critical period when breast-feeding relationships are established. However, technical assistance is available at *any* time while a mother is breast-feeding. Participants in the Birth and Beyond program and those who receive assistance from Public Health Nursing Services through the county are also eligible.<sup>25</sup> Assistance from Public Health Nursing Services is available to parents of medically high-risk infants, such as premature and low-birth-weight infants. In addition, the pilot includes educating Birth and Beyond staff, Public Health Nursing Services nurses, and community doctors and nurses about the importance of breast-feeding so that mothers receive the critical support they need.

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<sup>25</sup> Birth and Beyond is a multidisciplinary home visitation program for families who have a pregnant woman or an infant with one or more specific factors, such as substance abuse, that put them at an increased risk of child abuse. It provides family support services to pregnant women and families with new babies up through three months of age, though families may continue to participate until their youngest child reaches age five. The program's goals are to help build strong families, meet the needs of developing infants, and ensure that every baby in the county receives medical care. Priority is given to teen mothers and single parents. There are nine Birth and Beyond sites in Sacramento County. A multidisciplinary team staffs each location, which houses a family resource center.

## PROFILE OF INNOVATIVE PROGRAM

**Services Provided.** The pilot has expanded lactation technical assistance in Sacramento County to reduce the number of women who discontinue breast-feeding. Instead of two part-time IBCLCs, all four participating clinics have consultants available 40 hours each week. One outlying clinic—with the smallest caseload—provides an IBCLC two or three days a week.<sup>26</sup> The Spanish-speaking peer counselor is available to translate at all clinics.

WIC clients can receive consultations from IBCLCs either in the clinics or at home. Three of the four clinics have private offices for one-on-one consultations, which typically last one hour; home visits last between one and two hours. To receive a home visit, WIC participants must enroll in the Birth and Beyond Program. In addition, there is a breast-feeding helpline answered by a recording, with messages returned by an IBCLC during regular office hours on the same or the next business day. Messages left after hours are returned the next business day, although messages that indicate a breast-feeding crisis late in the day on Friday or over the weekend are returned during the weekend.

The grant also paid for neonatal scales to measure how much breast milk infants consume, along with nursing bras. WIC staff do not distribute the bras as incentives, but rather as medical aids to help prevent breast infections. Frequently, clients who cannot afford to replace their ill-fitting under-wire bras are at a greater risk of developing plugged ducts that can lead to breast infection.

Occasionally, lactation consultants work with a client in the hospital, if the infant is sick and the mother needs support. Most of their work with the Birth and Beyond program occurs through home visits. An IBCLC accompanies a Birth and Beyond staff member on the first visit and can elect to conduct any follow-up visits by herself.

**Participation.** Only one of the two WIC agencies in Sacramento County participates in the enhanced lactation consultant services pilot. That agency's total monthly caseload is 21,000, of which women make up 25 percent, infants make up 25 percent, and children aged 1 to 4 make up 50 percent; the other agency has 12,000 clients. While the pilot is geared primarily toward WIC clients, women who are enrolled in the Birth and Beyond program or receive assistance from Public Health Nursing Services also have access to the lactation consultants (some women may be enrolled in multiple programs). Each month there are 5,000 births—25 percent of all births in Sacramento County—to mothers who participate in at least one of these three services (Sacramento County Public Health Advisory Board 2001).

In March 2003, there was a total of 900 contacts through WIC lactation consultants. Of these, 504 were telephone contacts, 204 were breast-feeding class contacts, 141 were individual clinic consultation sessions, 46 were home visits, and 4 were referrals from Public Health

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<sup>26</sup> If a mother at this outlying clinic needs immediate assistance, she can speak to one of the other lactation consultants. If she is willing to travel, she can get an appointment at one of the other sites by the next business day. A lactation consultant may be available on the schedule to make a home visit.

Nursing Services. These figures do not include contacts with the Spanish-speaking peer counselor—82 breast-feeding class contacts, 69 telephone contacts, 20 individual clinic sessions, and two Birth and Beyond Home visits. In April 2003, the project director observed that the demand for lactation consultants had “really skyrocketed.” The IBCLCs were not overwhelmed in April of 2003, but their caseloads have since reached a saturation point. According to the WIC program director, they have a need for 1 or 2 more lactation consultants and another bilingual peer counselor. An estimated 5 percent of total pilot participants who receive services are not enrolled in WIC.

**Coordination and Collaboration.** According to the breast-feeding promotion coordinator, the WIC program has developed good relationships with community organizations and agencies over the years. She noted that Birth and Beyond is an excellent collaborative partner. Since the pilot began, lactation assistance has become an integral part of the home visits through the Birth and Beyond program. The coordinator serves on its steering committee and attends its stakeholder meetings. The two programs share breast-feeding data and success stories, and consultants often attend trainings sponsored by Birth and Beyond, such as one on mandated reporting for child abuse.

In addition, the pilot enhances the overall collaboration between WIC, Birth and Beyond, and Public Health Nursing Services by making the lactation consultants a key part of the multidisciplinary team that becomes active during the prenatal period for any given client.<sup>27</sup> The team includes drug and alcohol counselors, social workers from Child Protective Services, child development specialists, Medi-Cal staff, Birth and Beyond home visitors and team leaders, and WIC lactation consultants. A different team serves each Birth and Beyond site and meets weekly to discuss specific cases and issues. Teams intervene with any client enrolled in Birth and Beyond, regardless of whether that client is on WIC. While the lactation consultants offer breast-feeding technical assistance, nurses visit the family to ensure that growth and development is progressing and that the family is receiving adequate medical care.

**Publicity and Outreach Efforts.** WIC clients and other eligible women learn about the lactation consulting services from within WIC and from outside organizations.<sup>28</sup> WIC staff inform their clients about the breast-feeding helpline when they enroll, and staff also refer clients who disclose problems with breast-feeding during their nutrition contact. If a lactation consultant is available, she can meet with the client immediately. Otherwise, the nutritionist delivers a message to the consultant, who then calls the client at home and counsels over the phone or schedules a clinic appointment. Staff also contact the lactation consultant if a client is

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<sup>27</sup> These teams fall under the oversight of the county Department of Health and Human Services.

<sup>28</sup> The WIC office conducted a survey with the University of California at Davis for a time utilization report. Of a sample of 316 clients who had received lactation consultation during six weeks in September and October 2002, 42 percent were self-referred (after receiving information from WIC counselors, prenatal classes), 28 percent were referred by WIC staff, 12 percent were referred from Birth and Beyond, 10 percent were contacted directly by a lactation consultant, and 7 percent were referred from community health care providers.

considering breast-feeding but is skeptical. The consultant will in turn call the client to discuss the decision. WIC staff inform clients about the enhanced lactation consultant services during breast-feeding classes, and the IBCLCs occasionally teach a prenatal or postpartum class.

Moreover, a lactation consultant tries to call all pregnant women enrolled in WIC to introduce herself, explain the support services that are available, and ask if they intend to breast-feed. This contact establishes a relationship between client and consultant, building a foundation of trust that can encourage the mother to consider breast milk carefully as an alternative to formula.

Apart from WIC, the pilot works to build the community's capacity to support breast-feeding by working with as many health staff as possible to increase their awareness of available resources and services to support breast-feeding mothers in Sacramento County. For example, private lactation consultants who work in local hospitals routinely refer patients to WIC for breast-feeding support. ALTA, the regional professional organization for IBCLCs, often sponsors booths at community events and distributes information about WIC's lactation consulting services.

## **ORGANIZATION AND MANAGEMENT**

**Staff and Organizational Structure.** Currently, an equivalent of five full-time IBCLCs provide lactation consultations. In addition, a bilingual peer counselor interprets and also provides direct services for Spanish-speaking WIC clients; she is equivalent to a nutrition education assistant in the county's salary rating system.<sup>29</sup> She also has responsibilities to support and translate for other WIC staff.

Day-to-day management of the pilot falls under the breast-feeding promotion coordinator (project coordinator), a WIC dietitian who obtained her IBCLC certification after developing an interest in breast-feeding. She oversees the six part-time lactation consultants and the peer counselor. The project coordinator also provides breast-feeding training for WIC staff, breast-feeding training for Birth and Beyond staff and public health nurses, and training to anyone in the community with an interest in learning about breast-feeding and lactation consultants, such as doctors and social workers (see training section below for more details). In addition, she oversees all WIC breast-feeding activities, teaches some classes, and assists with class design.

The pilot consumes nearly 10 percent of the coordinator's schedule. The project director oversees the project coordinator and general coordination of the pilot. She allocated most of her staff time to developing the pilot and securing Proposition 10 funding. Currently, about 5 percent of her schedule is set aside for the pilot.

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<sup>29</sup> There was a county hiring freeze at that time, and WIC was forced to eliminate one regular staff member (nutrition assistant) to accommodate the inclusion of a Spanish peer counselor for the pilot program.

**Training.** A training component supplements the services that lactation consultants provide. The project coordinator sent the lactation consultants to a “train-the-trainer” session. The consultants, in turn, train WIC staff, Birth and Beyond home visitor staff, public health nurses, and other community health care providers to enable them to support, refer, and problem-solve directly with mothers of newborns. Public nurse trainings take place approximately monthly, and members of the Birth and Beyond staff are offered sessions about 10 times a year. The project coordinator estimated that at least 130 people from WIC, Birth and Beyond, and Public Health Nursing Services have been trained since the pilot began in June 2002.

For the county’s public health nurses and Birth and Beyond staff, lactation consultants and the breast-feeding coordinator have delivered a three-day training on the basics of breast-feeding and when it is appropriate to refer patients to the lactation consultants. Specific topics include normal infant behavior, feeding cues, the consequences of giving bottles and pacifiers before the mother’s milk is established, sore nipples, insufficient milk supply, and helping mothers develop a back-to-school or back-to-work plan. In addition, once a year there is a follow-up training on “hot topics,” such as how to support a breast-feeding mother whose baby is jaundiced.

WIC staff have received similar breast-feeding trainings. For example, lactation consultants held an in-service day for WIC staff on breast-feeding premature infants. Trainers passed around dolls of varying weights so that WIC staff could compare growth stages. They presented a video tape and placed drops of breast milk in a test tube to illustrate a normal amount for a micro-preemie to drink during one feeding. It is important for WIC staff to share accurate information with their clients so that they are on the same page with the lactation consultants.

Breast-feeding education also extends to the wider community. The program coordinator is involved with the Breastfeeding Coalition for the Greater Sacramento Area. The coalition asked lactation consultants to conduct a one-day training session for a group of doctors and nurses on breast-feeding topics. WIC also collaborated with Pfizer to host a doctors’ dinner, for which the pharmaceutical company covered all costs.<sup>30</sup> WIC invited speakers from across the country, including a well-known neonatalist and expert on breast milk. Representatives from Pfizer were pleasantly surprised that 48 out of 50 slots were filled, an unusually high turnout for such an event, and they hope to host the doctors’ dinner annually.

**Funding.** The pilot provides \$500,000 annually for three years from Proposition 10 tax revenues. To receive such a large amount of outside funding for a WIC project is unusual. In the project director’s opinion, a WIC agency cannot provide adequate breast-feeding assistance unless it also receives outside funding to supplement its regular budget.

It is too soon for program officials to determine whether the enhanced lactation consultant services will extend beyond the pilot period. California is facing a severe budget shortfall, and the project director remarked that the county is proposing to relinquish its WIC contract back to the state, which would in turn contract for WIC services with a nonprofit agency.

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<sup>30</sup> WIC selected Pfizer because of an ethics clause stating that it can collaborate only with drug companies that do not produce baby formula.

The project coordinator is working on a project proposal that would enable her WIC agency to expand its lactation consultant services even further and link the IBCLCs more closely with peer counselors, perhaps “working in teams of two like a doctor and nurse.” The project would also fund one additional Spanish-speaking peer counselor to work in the outlying clinics.

## ASSESSMENT AND LESSONS LEARNED

**Program Strengths.** An indicator of success for the pilot has been higher breast-feeding rates. In the first nine months of the pilot, breast-feeding rates increased as follows:

	8 weeks	5 to 6 months	11 months
June 2002	46.6%	30.4%	24.3%
February 2003	50.7%	34.3%	25.6%

The project director thinks that the home visits can make a significant difference in raising breast-feeding rates. Many mothers find it difficult to transport their infants to the WIC clinic. Home visits are much more convenient for the mother and baby.

Lactation consultants distribute surveys to health care professionals three months after training to determine to what extent the professionals have altered their service delivery because of the breast-feeding training. Further, the project coordinator and the lactation consultants also have collected questionnaires after some of the training sessions. Another outcome indicator is the number of professionals and paraprofessionals who have received breast-feeding education.<sup>31</sup>

Since the pilot began, the project coordinator, each quarter, calls to get feedback from approximately 25 clients who met with lactation consultants. Responses are “glowing” and “there has not been one complaint.” Many WIC mothers have told the coordinator that they would not have been able to breast-feed without lactation consultant services in place. Learning how to hold a baby during feeding and how to latch on properly are common responses when she asks what information from the lactation consultants was most helpful.

The pilot seems to have had a significant impact on regular WIC staff. Before the pilot, staff were “timid” in promoting breast-feeding. Since limited lactation consultant services were available, staff were reluctant to encourage WIC mothers to breast-feed, because they did not have the technical knowledge to address problems that emerged if the lactation consultant was not available.<sup>32</sup> Before the pilot, WIC staff often struggled with questions like “Should I give

<sup>31</sup> In addition, the Proposition 10 Committee is coordinating a formal evaluation, which will be conducted by a local private company at the end of the pilot.

<sup>32</sup> In the outlying clinic, an IBCLC came on site only 4 hours each week.



this mother formula or not?” However, since enhanced lactation consultant services began, WIC staff actively promote breast-feeding, because there are professionals who can provide the necessary information and support when needed. Now, a lactation consultant can determine whether, for example, it would be appropriate to supplement with formula, lend out an electric pump, and see the mother for a lactation consultation. WIC staff are grateful that they no longer have to make tough decisions that they are not qualified to make.

Because of the training received by regular WIC staff, the staff has an enhanced sense of knowing what to say to their clients about breast-feeding, they are more likely to refer clients to the helpline and lactation consultants, and they are more aware of the health risks of using formula. According to the project director, WIC employees chose this profession because they enjoy helping people. Anything that enables them to do their job better—like receiving breast-feeding training—gives them self-esteem and gratification. The breast-feeding training, which is mandatory, is integral to the total training plan for all new and ongoing WIC staff.

Finally, one success of the pilot is the infants the IBCLCs save. Consultants are frequently the first people to see the mother after delivery and before her first postpartum doctor’s appointment. They may visit a WIC client at home two or three days after delivery and conclude that the infant is sick and needs immediate medical care. The lactation consultant contacts the doctor’s office to make an expedited appointment or helps transport the mother to the hospital. In 2003, there were three infants who were hospitalized the same day as the home visit. The breast-feeding coordinator noted that the babies could have died if they had not received immediate medical attention.

**Key Challenges.** Program staff encountered several challenges, both during the planning phase and during implementation. The project director encountered difficulties in obtaining approval from county officials for contracts for the IBCLCs. Ideally, she would have preferred to designate the consultants as regular county employees with full benefits, but officials were reluctant to grant a special job classification. Moreover, they insisted that the lactation consultants each purchase a \$1 million liability insurance policy.

In addition, the receipt of the Proposition 10 dollars was delayed. Although the First 5 Sacramento Commission<sup>33</sup> approved funding quickly, it took the Sacramento County Board of Supervisors almost a year to transfer the funding to the WIC program. The project director observed that the county can sometimes be resistant to procedural changes, and also is concerned about the possibility of legal challenges initiated by employee unions and the community at large that may arise from contracting out services. As a result of a lawsuit filed several years ago, the county cannot contract out for a service unless it can be demonstrated that county employees cannot provide it.

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<sup>33</sup> The First 5 Sacramento Commission is a quasi-county agency with political independence from the Board of Supervisors. It is responsible for distributing Proposition 10 funds. Members of the Commission include a member of the County Board of Supervisors, the Chief of the County Public Protection Agency, the Chief of the County Department of Health and Human Services, and a representative from a local school district. Each California county has such a commission.

Another challenge is that some WIC staff have been resistant to referring clients to the IBCLCs, especially those who used formula for their children. They may have feelings of guilt and resist the information that lactation consultants share. It is common for them to think, “If formula was good enough for my baby, it is fine for my clients.” Part of the training that the project coordinator developed distinguishes between guilt and regret. It is hoped that staff can embrace the latter so that they can “provide breast-feeding education with conviction” to their clients. Unfortunately, the project director thinks that some WIC staff members will “never be on the breast-feeding bandwagon.” Consequently, lactation consultants need to encourage those enthusiastic staff members who are committed to promoting breast-feeding.

Space for the consultants was another hurdle for the pilot. In some cases, clinics had extra space to offer the lactation consultant, and in others they had to “battle” for a private office. In the smallest clinic, the consultant must work in whatever space is available that day.

Though the pilot has augmented collaboration with other organizations and health professionals to promote breast-feeding, WIC still encountered challenges with community partners. Birth and Beyond staff were at the start not referring clients to lactation consultants. In the project coordinator’s opinion, Birth and Beyond home visitors thought that clients did not need help, when in fact clients needed the professional guidance of IBCLCs to breast-feed successfully. Birth and Beyond home visitation staff “were taking matters into their own hands” because they can be “protective of their clients’ families.” Eventually, WIC had to work with managers at Birth and Beyond to mandate that line staff refer all pregnant and postpartum mothers to lactation consultants, who would in turn determine whether they needed to make a home visit. The process now works very well.<sup>34</sup>

Similarly, the project director continues to be frustrated by the fact that not all stakeholders are on board with breast-feeding promotion and lactation assistance. In her opinion, some health care professionals are “fine with formula.” Nurses and doctors use formula as the “quick answer,” neglecting to try to determine exactly what might be causing the difficulty with breast-feeding. It is also difficult to get the general public to recognize the value of breast-feeding. In conjunction with this pilot, the project coordinator teaches a class to WIC and Birth and Beyond staff on the marketing strategies of formula companies. She discusses the marketing techniques of formula companies, the difference between guilt and regret for women who did not breast-feed, and the health risks of using formula. The latter topic is what usually “raises people’s eyebrows.” They are surprised that formula can (according to WIC staff) increase the risk of diabetes, cancer, obesity, and ear infections.

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<sup>34</sup> The project coordinator told a story about a mother who had lost three children to Child Protective Services. The Birth and Beyond home visitor was certain that this mother would fail at breast-feeding, but in fact she thrived under the guidance of the lactation consultant, pleasantly surprising the home visitor. Accomplishments like this are slowly overcoming the prejudices against lactation consultants (that is, the belief that lactation consultants are not needed). Having a policy in place that would allow the lactation consultants to be “seen in action” and to be seen as an asset to the Birth and Beyond program has helped.

**Lessons Learned.** Having an IBCLC who is available for private counseling sessions throughout the week and for home visits is sometimes the critical factor in successful breast-feeding. A survey conducted in a neighboring county asked 145 WIC mothers who had stopped breast-feeding, “What would have helped you to continue breast-feeding?” It found that 65 percent selected the option of “having a staff member provide assistance in their homes.” Program officials think that the pilot could be replicated, and that including home visits is an important component of any successful program. In fact, they would like to expand the program by adding lactation consultants for the other WIC agency and hiring more peer counselors so that they can work formally in teams.

Another key element for replication is outside funding sources. The project director noted that there would not have been enough funding in the general WIC budget to provide the right number of lactation consultants needed to support eligible breast-feeding mothers adequately in Sacramento. Before the pilot, two part-time lactation consultants paid for with WIC dollars were unable to meet service needs fully. Obtaining outside funding through Proposition 10 has been critical to expanding these services.

Program officials have realized that there is still resistance to breast-feeding from different stakeholders. They imagine that some professionals and paraprofessionals—whether they be doctors, nurses, or WIC staff—will never be “won over.” At this point, WIC “just tries to win them over one by one.” The project director hopes that the pilot, particularly by training community health care providers, can begin to change attitudes about breast-feeding. WIC staff encounter many clients who think that breast-feeding is a “nice idea” but is only for “the fortunate few”: stay-at-home mothers. Moreover, some people attach a stigma to breast-feeding in public, which may dissuade some clients from electing this instead of formula. Ideally, WIC officials want breast-feeding to be perceived by the general public as the norm, and as an appropriate practice for women of all socioeconomic levels.

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**BREAST-FEEDING PROMOTION AND SUPPORT PROGRAM<sup>35</sup>**  
**MIAMI-DADE COUNTY, FLORIDA**

**OVERVIEW**

**Location:** Miami-Dade County, Florida

**Start Date:** Selected services began in 1997<sup>36</sup>

**Target Population:** Current and potential WIC clients, along with health care professionals.

**Purpose:** To increase breast-feeding rates among WIC clients and to help them breast-feed successfully.

**Services:** Multifaceted services, including a breast-feeding helpline, lactation consultant services, peer counselors, a breast pump loan program, breast-feeding support groups, and baby showers.

**Funding:** \$400,875 for fiscal year (FY) 2002, which represents 14 percent of the total WIC budget.

**Why Program Was Chosen:** The Miami-Dade County Breastfeeding Promotion and Supportive Program (BPSP) is a comprehensive program that includes a community outreach component with technical assistance for local health care professionals as needed.

**Key Challenges:** Most obstacles have been related to peer counselor and staff recruitment and retention. First, program officials were unsure of the best way to recruit volunteers for the peer counselor program. Moreover, retention has been an ongoing issue. Because a small number of volunteers eventually moved into paid positions, many other volunteers left the program because they were unwilling to continue counseling services without compensation. In addition, low salaries for lactation consultants make it difficult to recruit and retain them, as many are attracted to higher-paying positions in private hospitals and clinics.

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<sup>35</sup> Telephone interview, April 8, 2003.

<sup>36</sup> Different program components had different start dates—breast-feeding helpline, lactation consultant services, and breast pump program (September 1997); peer counselor program (May 1998); and community outreach (October 1999).

## BACKGROUND

**County Characteristics.** Miami-Dade County is one of the most densely populated regions in Florida, with 2,289,683 inhabitants in 2001. Approximately 6.5 percent of the population are children under five. The majority (57.3 percent) of county residents classify themselves as Hispanic or Latino in origin, which is significantly higher than the state average of 16.8 percent. Almost 68 percent of households speak a language other than English at home, as compared to 23.1 percent statewide. In 1999, 18 percent of the county lived below the poverty line, and the median household income was \$35,966.

**WIC Program Background.** The Miami-Dade County WIC program has the third-largest local WIC agency in the country in terms of the numbers of participants and has the largest staff of all Florida WIC agencies. There are 23 clinics in the Miami-Dade County service area, as well as an administrative office and a central appointment office. The WIC program has 55,000-60,000 enrolled participants per month, including infants and young children; about 11,000-12,000 are pregnant and breast-feeding women.<sup>37</sup>

Until the BPSP began in 1997, the only breast-feeding promotion and services for WIC clients included breast-feeding classes taught by WIC nutritionists. Moreover, all women had received formula for their infants regardless of their breast-feeding patterns and preferences. The breast-feeding program administrator noted that most staff assumed clients would “feel like they were not getting something free if they did not receive formula.”

**Program History and Objectives.** Soon after starting her position in July 1997, the breast-feeding program administrator concluded that the county WIC clinics were falling short of what they could be doing to encourage and support clients to breast-feed. Consequently, with help from her staff, she developed a comprehensive set of support services for clients. By the late nineties, the Miami-Dade County BPSP had become a multifaceted program that sought (1) to assist WIC clients from pregnancy through year one postpartum with breast-feeding issues, and (2) to promote the WIC program as a source of breast-feeding assistance to doctors’ offices, hospitals, community organizations, and third-party insurers.

The program administrator decided to implement a breast-feeding helpline first, because it was easiest to establish. Within a few months, the WIC program began a breast pump loan program and lactation consultant services to further support clients in their efforts to breast-feed. In 1998, the administrator launched a peer counselor program, as the demand for breast-feeding support services—specifically culturally appropriate support—exceeded what the regular WIC staff could provide. Peer counselors would be more representative of the client population in terms of ethnicity and languages spoken, thus enabling WIC to offer effective breast-feeding support to a more diverse client base.

Finally, the breast-feeding program administrator decided to incorporate community outreach into the BPSP’s mission. She targeted local hospitals, health care professionals, and

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<sup>37</sup> Based on participation data supplied by the Miami-Dade County WIC program, December 3, 2003, covering the period October 2002 to October 2003.

third-party insurers to receive information on WIC's breast-feeding support services. In her opinion, a fundamental goal of community outreach is to "change the image of WIC," educate community stakeholders about WIC services, and encourage them to refer pregnant and postpartum women to lactation consultants and peer counselors. Specifically, the WIC program is shifting away from "where the formula is" to "WIC makes breast-feeding easy." In fact, the latter statement has been incorporated into the program logo, and all hospital and outreach personnel wear uniforms with this slogan on the front.

**Target Population.** WIC participants enrolled in a county WIC clinic are eligible for breast-feeding support services. Staff who work in the hospitals target low to moderate-income pregnant and postpartum women who are potentially eligible for WIC services in addition to current WIC clients. The BPSP also reaches out to community health care workers and other stakeholders to educate them about the benefits of breast-feeding and lactation support services available through WIC.

## **PROFILE OF INNOVATIVE PROGRAM**

**Services Provided.** WIC promotes breast-feeding education for pregnant and postpartum women through individual breast-feeding consultations with board-certified lactation consultants, peer counselors, breast-feeding support groups, a breast-feeding helpline, a breast pump loan program, and baby showers.

All 23 county clinics have a lactation consultant available, although at 7 of them, the Internationally Board Certified Lactation Consultant (IBCLC) comes in only once a week. Clients have access to individual lactation consultations, which typically last an hour but could be as long as two or three hours, depending on the mother's need. Sometimes WIC participants must wait one business day to see a consultant, and occasionally they must wait a few days, but they can often be seen within 24 hours. Clients always access the lactation consultants through the helpline. Common issues include (1) sore nipples that last more than 24 hours, (2) first attempt at breast-feeding a premature infant, (3) breast milk supply issues, (4) breast surgery, (5) cleft palate and/or lip, (6) metabolic disorders, (7) inverted nipples, (8) latch-on problems, and (9) concerns about the infant's weight gain.

Volunteer peer counselors supplement the support offered by lactation consultants. Volunteer peer counselors are available to assist primarily via telephone, while paid peer counselors (also known as outreach workers) work in hospital maternity wards promoting WIC and breast-feeding. Sometimes, they rotate to different clinics to assist with outreach events like health fairs. Currently, there are about 10 active volunteer peer counselors, and they volunteer no more than 5 hours a week. However, by December 2003, an additional 15 volunteer peer counselors will be trained and available.

The breast-feeding helpline is answered weekdays from 7 A.M. to 4 P.M. by two WIC staff members, one of whom is an IBCLC. An answering machine operates in the evenings and on weekends; messages are checked once during weekday evenings and twice a day over weekends. The helpline is not exclusively for WIC clients. Doctors and nurses frequently call the helpline if they have a question or concern about a breast-feeding patient or a patient who is interested in

breast-feeding. Program staff do *not* ask health care professionals if the question pertains to a WIC client. They simply answer any breast-feeding questions that they receive, which typically are on medication or specific diseases as they relate to breast-feeding. Approximately 800 women receive assistance through the helpline each month.

A breast pump loan program is another component of the BPSP. Staff distribute electric pumps only to mothers who have premature or sick infants, or who face long-term separation from their infants. Recipients of electric pumps must be breast-feeding full-time (except for mothers of premature or sick infants) and cannot receive formula through WIC. Program staff are more liberal with mini breast pumps and usually distribute them to mothers of older babies (4 to 6 months old) who work or attend school. Staff lend manual pumps to anyone who requests one, except that pumps are not given to mothers who complain about sore nipples or who do not want to put the baby to the breast. In these cases, someone from the WIC breast-feeding staff will first counsel the mother and see if there is an alternate solution. Frequently, mothers must wait for electric pumps, but usually only for a few days. Women who request manual pumps tend to wait two days or so, because pumps are delivered through interoffice mail or regular mail from a central office. In addition, the Miami-Dade County WIC program will soon start a pilot electric pump program for working mothers, who will receive a free pump upon agreeing to complete a survey at 3, 6, and 12 months on the pump's usefulness, degree of breast-feeding success, and overall satisfaction.

In addition, WIC sponsors breast-feeding support groups, two in English and two in Spanish. Classes are held monthly at a local clinic and are led by one of the paid peer counselors. The program also sponsors baby showers for breast-feeding mothers every two months at two centrally located clinics. Showers provide games, gifts, distribution of food vouchers, and discussions about creative recipes that clients can try with WIC food. Gifts items, all of which are donated by various community organizations and businesses, include baby bouncy seats, diapers, and portable snack containers.

**Participation.** During FY 2002, the program served 9,568 women through the helpline, lent 246 double pumps, and conducted 728 individual lactation consults. The breast-feeding program administrator thinks that the Spanish support group is more successful and better attended than the English one because "Latin women really appreciate the support." One Spanish support group held a birthday party for their babies and discussed the benefits of breast-feeding—all four of them had been breast-feeding for at least one year.

**Coordination and Collaboration.** The WIC program has incorporated community outreach into its breast-feeding promotion efforts, particularly outreach to local doctors and nurses. Staff believe that building relationships with these health care providers through education can only benefit those WIC clients served by these doctors and nurses.<sup>38</sup>

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<sup>38</sup> WIC staff used to conduct new-employee education sessions on breast-feeding for the Healthy Start program in Miami-Dade County. (Healthy Start is a Medicaid expansion program that provides free health insurance coverage to eligible pregnant women.) However, limited time and staff resources led them to stop doing this training.



**Publicity and Outreach Efforts.** Clients hear about the breast-feeding services from WIC staff, posters in the clinics, referrals, and outside agencies, as well as a breast-feeding helpline sticker on each WIC identification card. The sticker seems to be a very effective way to encourage women to access the support services. According to the breast-feeding program administrator, this tool is a “staple that they could not do without.” WIC receives referrals from hospitals, doctors, the La Leche League, and Healthy Start; it has a very good relationship with Healthy Start and receives many referrals from them.

Outreach staff conduct community outreach in various ways, both for clients outside the clinic and for health care professionals. Currently, staff members rotate to six local hospitals each week, and counselors are in any given hospital for 4 to 8 hours. They talk about breast-feeding services available through the WIC program to *all* patients, room to room, on the maternity ward. They distribute WIC applications and ask patients if they have any questions or would like more information on breast-feeding. Outreach staff also sponsor booths at health fairs and work closely with a local baby supply and clothing store, teaching classes for their customers and attending their baby fairs monthly or every other month to distribute information. Moreover, staff have presented at dinners insurance companies have sponsored for physicians, explaining current services available through WIC, with an emphasis on breast-feeding support. Three dinners have been held so far, with 10 to 20 physicians attending each event.

WIC breast-feeding staff have been planning to conduct outreach to physicians’ offices. Because staff is limited, however, they have hosted only a few sessions.<sup>39</sup> Generally, a WIC health educator cold-calls an obstetrician/gynecologist to introduce herself, talk briefly about the WIC program, and schedule a session. The educator meets with doctors and nurses at lunchtime to talk about the WIC program, the breast-feeding support services that it offers, and the ways WIC helps mothers succeed at breast-feeding. Visits last about 45 minutes. The educator also explains that WIC staff can help health care professionals with questions about non-WIC patients who breast-feed. She leaves several WIC applications, breast-feeding helpline posters, posters explaining how to enroll in WIC, and general breast-feeding materials for the health care providers. Staff also conduct followup with private doctors’ offices, because they do not want to get community stakeholders enthusiastic about breast-feeding and then “disappear.” Monthly followup typically includes calling someone at the obstetrician/gynecologist’s office to check how things are going.

## **ORGANIZATION AND MANAGEMENT**

**Staff and Organizational Structure.** The WIC breast-feeding program in Miami-Dade County has 12 employees (8 full-time and 4 part-time), although some play dual roles. These include a full-time bilingual telephone helpline operator, a full-time breast pump coordinator, five lactation consultants (three full-time share helpline coverage, and two half-time work only in the clinics), a full-time outreach coordinator, a part-time outreach worker for doctors and nurses,

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<sup>39</sup> An outreach staff member was hired in November 2003 and will begin to make calls to set up sessions. The program administrator expects that these outreach sessions will become much more routine.

full-time and part-time administrative assistants who coordinate the outreach schedule and perform clerical duties, and the breast-feeding program administrator, who oversees day-to-day operations and policy development. The breast-feeding program administrator noted that 95 percent of her staff started in the peer counseling program, and that peer counselors must have been enrolled at WIC at some point.

Breast-feeding support staff rotate to different clinics each week since there is not enough staff to have a permanent worker at each clinic. Seven large clinics have a lactation consultant who comes in one day each week; the remaining 16 clinics have a consultant available on-site less frequently. Of the lactation consultants, two work almost exclusively in the field (that is, rotate to different clinics), three also operate the telephone helpline, and one also assists with community outreach. Community outreach workers visit venues like hospitals and health fairs, and sometimes teach breast-feeding classes to local health professionals. Volunteer peer counselors are available primarily to assist via telephone—occasionally they will also assist with the helpline—while paid peer counselors work in hospital maternity wards promoting WIC and breast-feeding. Peer counselors also administer pumps and can teach breast-feeding classes at clinics as needed. They also lead the support groups. (WIC nutrition educators are responsible for teaching some breast-feeding classes, but these last only about 10 minutes. Classes taught by breast-feeding staff are an hour long.)

Aside from the administrative assistants and the administrator, official staff titles are either family support worker or health educator. Most lactation consultants have worked their way up from being peer counselors and have earned their IBCLC.<sup>40</sup>

**Training.** The Miami-Dade County WIC program provides some training opportunities for staff and community stakeholders to augment breast-feeding support services for clients. The program administrator offers a 26-hour training course for peer counselors, which she teaches along with another staff member. They meet once a week for 6 to 8 weeks, and two make-up sessions are permitted. The administrator organizes training schedules around participants' needs, and sometimes classes are offered at night to accommodate participants. Topics include anatomy and physiology of the breast, composition of breast milk, addressing cultural differences, communication skills, time management of breast-feeding, normal course of breast-feeding from infancy through toddlerhood, nutrition and breast-feeding, parenting skills, and general baby care. On average, each session starts with 15 students, and 8 graduate. Although the breast-feeding program administrator used to offer the peer counselor training three or four times each year, she now only offers it twice annually. She estimates that there is a waiting list of about 20 at any given time.

In addition, new health educators or family support workers receive 16 hours of new WIC employee training and a few hours of followup. The breast-feeding program administrator

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<sup>40</sup> The breast-feeding program administrator noted that only staff who conduct individual consultations are required to be certified. However, some peer counselors have obtained their IBCLC because they are “passionate about breast-feeding.” Since the program began, six peer counselors obtained their lactation certification.

conducts all trainings. Initial sessions cover basic breast-feeding management, when to refer clients to specialists, the breast pump program, anatomy and physiology of the breast, breast milk composition, the risks of artificial feeding, and proper positioning and latch-on techniques. Follow-up topics include fun ideas on teaching breast-feeding classes, service updates, and any policy updates.

As a supplemental training for peer counselors, WIC held its first all-day educational conference in 1998. Its purpose was to support, honor, and reinforce the knowledge of the peer counselors. The conference included parenting and breast-feeding panels, which addressed such topics as Teaching Your Client About Money, Motherhood Stress, Living on One Budget, Nutrition, Breast-feeding Basics, Cultural Differences, Choices in Education, Breast Pumps, and Making Breast-feeding Classes Fun. Peer counselors, local private practice nurses, and some WIC employees attended; it was open to health care providers in the community free of charge. The conference was so successful that the Miami-Dade County WIC office decided to host a yearly conference, and there have been educational conferences for the peer counselors and lactation consultants ever since.

**Record Keeping.** All breast-feeding staff, including peer counselor volunteers, submit monthly reports that indicate their number of (1) classes taught, (2) pumps distributed, (3) people served through individual counseling sessions, and (4) telephone helpline calls made and received. In addition, hospitals submit information on whether patients breast-feed or not, whether patients are enrolled in WIC or not, the number of patients admitted, and the number of times that patients were seen by a doctor or nurse. Client satisfaction surveys are conducted regularly among clients who have received “full” breast-feeding services.<sup>41</sup>

**Funding.** The WIC program allocates 14 percent of its total budget, or \$400,850 annually, for breast-feeding support services. This figure includes staff salaries. For incentive items for the baby showers, the program relies on donations from local companies, including children’s clothing stores, discount stores, caterers, bakeries, and restaurants. Doctors and other professionals have donated their time to speak at special events and conferences.

## ASSESSMENT AND LESSONS LEARNED

**Program Strengths.** The breast-feeding program administrator said that breast-feeding rates have increased by about 10 percent between 1997 and 2003, and have increased each year. She feels that the most important success of the BPSP is that staff have implemented an “all-encompassing, holistic approach,” rather than a “piecemeal” program. The breast-feeding helpline is key in this success, because it informs many participants about other breast-feeding services. It also provides breast-feeding technical assistance to health care professionals. Feedback from client surveys is almost always positive, and they would recommend the BPSP to friends and relatives (see the Lessons Learned section for survey details). Other WIC staff—

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<sup>41</sup> “Full” is defined as accessing the telephone helpline and using at least one individual consultation.

non-breast-feeding staff—are pleased that they have somewhere to refer clients who have breast-feeding questions or concerns.

Moreover, the program administrator remarked that there have been some inspirational stories from peer counselors. One homeless woman with three children volunteered as a peer counselor for a year, was hired for the breast-feeding helpline, and eventually earned her IBCLC. After operating it for five years, she passed her IBCLC boards and now works for the Miami-Dade County WIC program as a lactation consultant. The breast-feeding program administrator mentioned that 95 percent of her staff were once peer counselors, and 6 peer counselors have become IBCLCs, of whom 3 work as lactation consultants for the WIC program.

**Key Challenges.** Several challenges have emerged while these support services have been implemented. At first, they were not sure how to recruit for the peer counselor program. The program administrator obtained a list of WIC clients who had received a breast-feeding food package in the past few years and called them to gauge their interest. Skeptics in the community (local lactation consultants not affiliated with WIC) said that the program would never succeed, since low-income women would not be interested in volunteering. Nonetheless, many women expressed interest and the volunteer peer counseling program thrived. However, they found that volunteers must be routinely reminded to submit their monthly service reports.

More recently, the biggest challenge facing the BPSP has been staff retention. The breast-feeding program administrator does not feel that WIC has the capacity to serve all targeted women in the county who could benefit from breast-feeding services. It is especially difficult to keep volunteers interested in the BPSP now that some peer counselors are paid. When the peer counseling program began in 1998, it was fully staffed by 15 to 20 active volunteer peer counselors. Eventually, however, WIC secured funds to hire four counselors part-time (two full-time equivalents), and this decision changed the climate of the program. Initially, those peer counselors who were not hired no longer wanted to be counselors, and the volunteer program almost “collapsed.” The administrator is currently increasing the number of volunteers through the University of Miami and Jackson Hospital, but is also seeking ways to compensate them.

The breast-feeding program administrator noted also that the low salaries offered make it difficult to fill paid staff positions with people who are passionate about breast-feeding and have the capacity to support mothers. An additional barrier is attrition—lactation consultants are lured away by higher pay at private hospitals. Ideally, she would like to hire an additional 12 lactation consultants so that each clinic would have an IBCLC at a designated time every week.

**Lessons Learned.** For the breast-feeding program administrator, offering fully comprehensive breast-feeding services to WIC clients in a given service region can be hindered by a limited staff. This is also true particularly of outreach to private medical practices. Ideally, WIC would be able to reach more health care professionals, but her staff is small and the county covers a wide area. Community outreach sessions are time-consuming, each lasting about 45 minutes, not including monthly follow-up phone calls.

Though the community outreach to private medical practices has been slow, the breast-feeding program administrator plans to continue to make it a part of the BPSP’s mission. Ultimately, she hopes to change WIC’s image with health care providers and the wider

community to show that it is a place to get not just free infant formula but also information and technical assistance on breast-feeding and nutrition. The program administrator thinks that a breast-feeding telephone helpline is an easy, effective way to build lactation support services beyond traditional breast-feeding classes, not only to clients but also to community health care providers. She reported that many physicians appreciate the program because costs of breast-feeding support services through the private sector are high, and unaffordable to approximately 30 percent of patients. (Lactation consultations in the private sector are about \$90 and up for the first session, and \$50 for each additional one. To borrow a breast pump, patients pay \$45 per month, and the attachment pieces cost another \$45.)

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### **C. PROGRAMS FOR HIGH-RISK GROUPS**

Besharov and Germanis (2001) suggested that WIC should target more intensive services to groups that are at particularly high risk for adverse health outcomes. This section highlights some targeted breast-feeding support programs that seem useful approaches to serving two (sometimes overlapping) high-risk groups: (1) teenage mothers, and (2) mothers of premature or seriously ill infants.

Two of the three programs—in Arkansas and Hawaii—offer improved access to breast pumps for high-risk groups. Breast pumps are key tools in promoting breast-feeding initiation for mothers with ill or premature infants, or who otherwise must be separated from their infants. They can also be important tools for promoting a longer duration of breast-feeding for mothers returning to work or to school—and returning to school is particularly important for teen mothers. The third program—in the Toledo, Ohio, area—offers prenatal breast-feeding education classes tailored to meet the needs of pregnant teens.

All three of these programs are inexpensive and may save WIC funds over the long term, by reducing costs for special formulas. Furthermore, they may improve the health of these high-risk infants over time.





## BREAST PUMPS FOR MOTHERS OF PREMATURE OR SERIOUSLY ILL INFANTS<sup>42</sup> ARKANSAS

### OVERVIEW

**Location:** Statewide

**Start Date:** Spring 2000

**Target Population:** Arkansas WIC mothers of premature or seriously ill infants.

**Purpose:** To support breast-feeding and meet the breast-feeding needs of all Arkansas WIC mothers with premature or seriously ill infants by offering a low-cost, non-returnable breast pump.

**Services:** Receipt of free electric breast pumps to keep, expedited WIC appointments to get certified for breast-feeding, and a toll-free number for technical assistance.

**Funding:** Arkansas allocates WIC food dollars to purchase breast pumps at a bulk price of \$99 each; the pumps account for the majority of program expenses.

**Why Program Was Chosen:** The program ensures that these high-risk families receive breast pumps quickly, and it appears to save the state money spent on special formulas and tracking loaner pumps. Arkansas may be the only state that sponsors a breast pump program targeting premature infants and seriously ill infants. Facilitating long-distance certifications in a rural state that has just a few, centrally located neonatal intensive care units (NICUs) is also innovative.

**Key Challenges:** In the planning phase, challenges included developing and justifying the breast pump specifications and completing the state contract. In addition, it has sometimes been difficult for county health units with high caseload volume to expedite service for mothers who need to be certified as breast-feeding in order to receive a pump.

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<sup>42</sup> Telephone interview, April 2, 2003.

## BACKGROUND

**State Characteristics.** The population of Arkansas in 2000 was 2,673,400, 78.6 percent of which were white and not of Hispanic or Latino origin. African Americans made up the largest minority racial group, at 15.7 percent. Most state residents speak English as their first language. In 1999, 15.8 percent of the population lived below the poverty level, and the median household income was \$32,182. In 1997, one-quarter of children<sup>43</sup> lived in poverty. An average of 84,153 clients were enrolled in WIC each month during fiscal year (FY) 2002, approximately 3 percent of the total state population (U.S. Department of Agriculture 2003a).

**WIC Program Background.** The Arkansas WIC program is considered a single WIC agency, operated by the Arkansas Department of Health. The 75 county health departments—or units—serve as the WIC clinics. Most county health units are open Monday through Friday from 8 A.M. to 4:30 P.M. The average monthly caseload for FY 2003 was 85,468: 3,177 breast-feeding women, 12,737 pregnant women, 7,348 postpartum women, 23,784 infants, and 38,422 children. The average monthly breast-feeding rate was 13.3 percent.<sup>44</sup>

WIC offers lactation training for WIC staff and other health professionals, as well as services that promote breast-feeding and support clients who choose to breast-feed. Lactation specialists from the state office in Little Rock administer a toll-free breast-feeding helpline, in operation since 1990 and available weekdays from 8 A.M. to 4:30 P.M. Voicemail is available after regular office hours, on weekends, and during holidays, and calls are returned on the next business day. (The voicemail message includes phone numbers for other resources if immediate assistance is needed.) Mothers and health care professionals can ask questions about breast-feeding problems, medications, and related issues.

In addition to the special initiative described below, the Department of Health offers less expensive breast pumps for mothers returning to work or school (Double Delux Small Electric Pumps, \$45 each through a contractor or \$150 retail), and manual pumps for occasional or short-term pumping, particularly for stay-at-home mothers. A limited number of Lactina electric pumps are available on loan for short-term complications and medical problems. Specialized equipment and supplies, such as breast shields and sizing inserts, are also available.

**Program History and Objectives.** The Breast Pumps for Mothers of Premature or Seriously Ill Infants (BPMPSI) program was originally launched as a pilot to test the feasibility of providing non-returnable breast pumps (Pump In Style) to mothers of premature infants. Before then, the WIC division at the Department of Health had available for loan 200 reusable Lactina breast pumps, which are widely used in the United States and recommended by many

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<sup>43</sup> Data are from [www.barc.usda.gov/bhnrc/cnrg/state05.htm](http://www.barc.usda.gov/bhnrc/cnrg/state05.htm), accessed September 24, 2003.

<sup>44</sup> The breast-feeding rate is calculated using a formula required by the Southwest Regional WIC office—the number of breast-feeding WIC clients divided by the number of all infants.

health care professionals. However, demand for breast pumps far exceeded the supply, and mothers with premature infants were often placed on waiting lists.<sup>45</sup>

Not only did health officials fail to meet the demand for breast pumps, tracking and cleaning the reusable Lactina pumps were costly in terms of staff time and lost pumps. Frequently WIC staff encountered disconnected telephone numbers in trying to retrieve the pumps. Lactina pumps, which have a hospital-grade motor, cost \$600 in 2002.

In 1999, the U.S. Department of Agriculture (USDA) passed a regulation allowing WIC food funds to be used to purchase breast pumps. Before this pilot, the WIC program bought pumps with Nutrition Services and Administration (NSA) grants, which limited the number of pumps the program could purchase. With an additional funding stream available, the state WIC director—who was very committed to breast-feeding advocacy—approached the state breast-feeding coordinator and WIC breast-feeding nutrition consultant to explore what could be accomplished if more funding was allocated to breast-feeding initiatives.

After consulting with health care professionals at Little Rock’s four tertiary hospitals that serve most premature infants in the state, the WIC breast-feeding coordinator and WIC breast-feeding nutrition consultant suggested the Pump In Style breast pumps, which were reusable and less expensive.<sup>46</sup> Because mothers keep the pumps, WIC staff would not have to spend time cleaning or tracking them. Since the state could purchase pumps in greater quantities, it could secure a bulk price from a contractor (in the end, the state paid \$99 versus \$250 retail).

Importantly, WIC staff carefully researched various pump models to develop the specifications, undergoing a thorough study of the pumps on the market that might meet the needs of their clients. For example, it was critical that the breast pump convert from electric to manual to account for losses in electricity due to a delinquent payment of a utility bill or a storm. State officials first approached the pump program as a pilot to test the feasibility of the Pump In Style breast pumps, but since have instituted it as a permanent part of the WIC program because of its success.

**Target Population.** The Pump In Style breast pumps are available to Arkansas WIC mothers of premature or seriously ill infants. To receive a breast pump, a mother first must be certified as a WIC breast-feeding mother.

## **PROFILE OF INNOVATIVE PROGRAM**

**Services Provided.** WIC clients who have infants with special needs and are certified as breast-feeding are eligible to receive a free Pump In Style to keep. Some mothers contact the

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<sup>45</sup> County health units, which serve as WIC sites in Arkansas, generally stopped tracking the number of requests for pumps when a waiting list reached 50 clients, which it often did.

<sup>46</sup> Doctors and nurses were very supportive of the Pump In Style pumps because their private-pay patients had been using them for years and were very pleased.

helpline if they encounter a problem in getting a breast pump from their county health unit, but this rarely occurs.<sup>47</sup> Each county health unit still has at least one Lactina breast pump that they can lend for a week or two if the need arises. As of April 2003, Arkansas had ordered 2,000 Pump In Style pumps.

In addition, WIC field staff grant mothers of premature or seriously ill infants expedited appointments to become certified for breast-feeding. Moreover, WIC staff located in Little Rock must accommodate clients (of premature or seriously ill infants) who are post C-section or staying at a neonatal intensive care unit, and who have traveled to the capital city and are far from their “home” WIC clinic. These women receive WIC certification as breast-feeding mothers at a WIC clinic near the hospital and receive a pump on the same day. Because Arkansas has a statewide WIC agency and automated system, this long-distance certification was not too hard to implement. When the mother returns home, she goes to her “home” WIC agency to receive vouchers. The agency checks the computer to verify her certification and issues the vouchers. The home agency also calls or e-mails the Little Rock unit to obtain a copy of the record of the mother’s certification visit, which the Little Rock staff send by mail.

**Participation.** The Arkansas Department of Health originally intended to administer the pumps to premature infants only. Soon, however, program staff learned through surveys of the first pump recipients that local hospitals recognized that mothers of infants with serious medical conditions proved to be excellent candidates for the pump program and referred them as well. Still, most clients have premature infants. In the initial wave of pump recipients, 7 out of 318 infants had serious birth defects that interfered with breast-feeding. Though the babies were not premature, their mothers needed an effective pump for long-term use. The remaining babies had low birth weights.

**Coordination and Collaboration.** Before the state officially launched the pilot program, the state breast-feeding coordinator and the WIC breast-feeding nutrition consultant delivered brief presentations to postpartum and nursery staff at Little Rock’s hospitals with neonatal intensive care units: three tertiary hospitals and Children’s Hospital. The presentations included a description of the pilot and a demonstration of a Pump In Style pump. According to the state breast-feeding coordinator, staff were “eager and supportive.”

**Publicity and Outreach Efforts.** WIC clients generally hear about the BPMPSI program through health care professionals and through word of mouth from previous pump recipients. State officials distributed information on the program to all hospitals, clinics, and county health units in the state. The state breast-feeding coordinator also delivered presentations to postpartum and nursery staff at the main hospitals in the Little Rock area with neonatal intensive care units, which included a program overview and a demonstration of a Pump In Style pump. The three tertiary hospitals, along with the city’s Children’s Hospital, serve the majority of premature deliveries in the state and are where many WIC clients learn about the breast pumps. The coordinator observed that word of mouth is an effective and powerful means of marketing the

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<sup>47</sup> Each month, the hotline receives between 60 and 100 calls, of which up to 10 are related specifically to the specialized pumps. Most of these are inquiries about how to obtain a pump.

program. Using breast pumps to feed premature and seriously ill infants is a “novel” concept that “makes a splash” with health providers and mothers interested in breast-feeding.

By the spring of 2002, all WIC sites and hospitals statewide were familiar with the breast pumps for children with special needs. The state breast-feeding coordinator reported that health care professionals in all parts of the state inform new hospital staff about the BPMPSI initiative during their employee orientations, to ensure that the new staff inform interested mothers about the pump program. In addition, county health units, clinics, and hospitals display program brochures in waiting rooms, and the Department of Health posts information on its Website.

## **ORGANIZATION AND MANAGEMENT**

**Staff and Organizational Structure.** The state breast-feeding coordinator and the WIC breast-feeding nutrition consultant developed and administer the BPMPSI program at the state level. They also are responsible for educating the statewide health care community about this new resource for WIC mothers. During the planning and development phase, the state WIC director provided counsel as needed and approved the final state contract with a pump manufacturer. A computer programmer from the Department of Health designed a database and entered results from a survey of initial recipients of the Pump In Style pumps, and two part-time state WIC staff members monitored those who responded to the survey to collect data on breast-feeding and using the breast pumps. (See the evaluation section for a description of the survey.)

Program officials completed the contract with the manufacturer, distributed the first round of pumps to county health units, and developed a database for tracking outcomes, but, after these tasks were completed, little state staff time has been needed for the pump program. The state breast-feeding coordinator and the WIC breast-feeding nutrition consultant respond to occasional calls on the toll-free breast-feeding hotline, and they deliver short presentations on the program from time to time at health and nutrition workshops.

**Funding.** Most funding is used to purchase Pump In Style pumps; very little is allocated to staff time or outreach. WIC uses food dollars for these breast pumps and does not receive any outside funding. For its first contract, the state purchased 1,000 pumps for \$99 each, and the supply lasted about two years. An additional 1,000 have been ordered, some of which remain in the central supply warehouse in Little Rock, while others are stored at the county health units for immediate distribution. Breast pump expenditures for FY 2001 were \$90,490, which represented less than 1 percent of its annual WIC food funds. In FY 2002, the state spent about 1 percent of its annual food funding, or \$216,465. Because the state WIC director is a breast-feeding advocate and has prioritized this project, the pump program should continue as long as there is available federal funding.

## **ASSESSMENT AND LESSONS LEARNED**

**Evaluation and Outcomes.** State WIC officials used a written survey and follow-up telephone calls to gauge initial client experiences with the Pump In Style breast pumps. After the pumps arrived from the manufacturer, program staff inserted a survey into approximately 500 pumps and sent one pump to each county health unit in Arkansas. In order for health units

to receive additional breast pumps, officials required that the initial pump recipients complete the short survey that collected preliminary information for the phone survey, which local staff returned via fax. This approach ensured that the state office would receive immediate feedback, establishing a quality control mechanism that would reveal any design flaws that would require that the pumps be returned to the manufacturer. State officials received a total of 283 completed surveys. Data from the surveys included infants from 35 participating hospitals.

As a second monitoring component, two part-time state WIC employees called survey-completing mothers each month for as long as the mothers continued to pump breast milk. The follow-up calls included questions on product satisfaction, satisfaction with milk production, and breast-feeding duration rates. Most clients liked the Pump In Style pumps, noting that they were easy to use and produced adequate amounts of milk. Reasons for dissatisfaction among some mothers included (1) slow speed of the pump; (2) inadequate milk production; and (3) pain. The shortest breast-feeding duration was 4 weeks, and the longest was 83 weeks.

**Implementation Successes.** As a result of the BPMPSI program, the state no longer maintains waiting lists for breast pumps for mothers with premature or seriously ill infants. The

RESPONSES TO TELEPHONE FOLLOW-UP OF MOTHERS  
USING THE PUMP (PILOT PHASE)

	Number of Responses
<hr/>	
Satisfaction with the WIC Pump	
Very satisfied	520 <sup>a</sup>
Somewhat satisfied	45
Not satisfied	12
Satisfaction with the Amount of Milk Collected	
Very satisfied	337
Somewhat satisfied	155
Not satisfied	84
Was the Pump Helpful?	
Essential to the health of my baby	332
Helpful	212
Somewhat helpful	23
Not helpful	7
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<sup>a</sup>Total responses for a particular question exceed 283—the total number of clients who received follow-up phone calls—because staff asked the same questions from month to month and aggregated the data. Therefore, we cannot determine how responses changed, if at all, over time.

initiative ensures that mothers can receive a Pump In Style pump within a few days of delivery. Receiving a pump in a timely manner is crucial to initiating breast-feeding, since mothers may be more reluctant to begin once they have used formula.

Based on the survey distributed to initial program participants, WIC clients have been very thankful for being able to provide breast milk to their premature or seriously ill infants. According to the state breast-feeding coordinator, mothers “love” using the Pump In Style model because it is easy to use and “anyone could pick it up and figure out how to use it without reading any instructions.”<sup>48</sup> When asked if the breast pump made it possible for them to provide breast milk for their infants, clients overwhelmingly responded “yes.”

Program officials reported that physicians and hospital staff have expressed a renewed appreciation for the WIC program because they understand how it helps infants with special needs gain access to breast milk. Moreover, WIC field staff feel empowered and relieved by being able to meet the clients’ needs, instead of placing them on a waiting list for pumps. Because the Pump In Style pumps are non-returnable, staff no longer spend time cleaning breast pumps and can focus on other services. In addition, the pilot part of the study suggested that fewer infants were prescribed expensive special formulas, which saved money.

**Key Challenges.** Very few implementation challenges have been associated with the program. State program officials noted that the main hurdle during the planning phase was developing and justifying the pump specifications—such as ensuring that the pump could switch to manual mode in case of power outage—and finalizing the state contract. Arkansas officials cautioned that other states might not be able to use the Pump In Style if it is not approved for a state contract. They noted, however, that similar breast pumps might work just as well.

In addition, the state breast-feeding coordinator observed that, for a few county health units with a heavy client flow, it has been difficult at times for WIC staff to expedite cases for mothers who need to be certified as breast-feeding in order to receive a pump. While it is challenging to juggle this immediate demand along with their regular caseloads, staff manage because they understand that the BPMPSI program meets a critical need for these families. Since appointment “show rates” are rarely 100 percent—especially for appointment slots early in the day—it is generally not a problem to incorporate an urgent case into the schedule.

**Lessons Learned.** Program officials reported that a key element of the program’s success has been the support of hospital staff, particularly at Children’s Hospital in Little Rock, who serve as a primary source of referrals for the specialized pumps. Consequently, an agency implementing a similar program should know it is important to conduct outreach to area hospitals and health care professionals as early as possible to educate them about the breast pump program and encourage them to refer to WIC mothers who deliver premature or have seriously ill infants. If the hospitals in Little Rock were not so in favor of breast-feeding and did

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<sup>48</sup> The survey of initial recipients revealed that only 1 of 283 clients had trouble assembling the pump, and only a few experienced difficulty using it.

not have a history of collaborating with WIC, it may have required considerably more advocacy and education of health care professionals on the part of state officials.

The state breast-feeding coordinator noted that any state could implement a pump program for mothers with premature or seriously ill infants, provided that funding was available to purchase enough pumps. A significant factor that could influence replication is the degree to which a state WIC director supports breast-feeding and is willing to allocate food dollars for a specialized pump program. In Arkansas's experience, NSA dollars alone were not sufficient to eliminate waiting lists.

For mothers who are away from home because their infants are in an NICU on an emergency basis, a program to certify them so that they can receive a pump may be of interest to other states. The statewide WIC agency in Arkansas is unusual, so other states would have to consider the feasibility of implementing such procedures.

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**PUMPS IN THE SCHOOLS (PITS)<sup>49</sup>**  
**HAWAII**

**OVERVIEW**

**Location:** Piloted in two high schools on the island of Oahu; the program is now operating in 10 more schools.

**Start Date:** Fall 2001 for two pilot schools; fall 2003 for expanded implementation.

**Target Population:** Teenage mothers attending selected high schools and participating in the Graduation Reality and Dual-Role Skills (GRADS) program.

**Purpose:** To make it easier for teenage mothers to continue breast-feeding after they return to school, and thus to extend breast-feeding duration for this high-risk group.

**Services:** High-quality double pumps are made available in school, along with a private place to pump. Girls on WIC receive an attachment kit for free, while other girls receive one at a reduced price.

**Funding:** The original program in two schools was funded with WIC breast-feeding funds. Expansion is being funded through a WIC operational adjustment grant.

**Why the Program Was Chosen:** This program extends to the school setting services available from existing breast pump programs for WIC mothers, and targets a high-risk population (teenage mothers) by bringing the services to them. It would be replicable at modest cost.

**Key Challenges:** The program depends heavily on the GRADS teachers to encourage participation; building coalitions with these teachers is critical. Young mothers face many challenges, such as short breaks between classes, that make breast-feeding difficult.

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<sup>49</sup> Telephone interview, April 21, 2003.

## **BACKGROUND**

**State WIC Program Background.** In Hawaii, the WIC program serves 33,000 clients a month. About one-fourth are women (pregnant or postpartum). There are 16 local agencies and about 30 clinics. The breast-feeding initiation rate is 92 percent for the state and 75 to 94 percent for WIC participants, depending on the clinic and its demographics.

**Program History and Objectives.** Hawaii implemented a statewide pump program in January 2000. This program consists of giving away manual pumps and lending hospital-quality double electric pumps. Part-time working and schooling mothers, partial breast-feeders (receiving fewer than four cans of formula a month from WIC), and some mothers with transient medical needs are eligible for manual pumps. The pumps on loan are for exclusively breast-feeding high-risk infants and full-time working or schooling women. Mothers who borrow the electric pumps receive a free attachment kit to keep.

Returning to school is a primary barrier to breast-feeding duration among high school mothers, so the state's Contracted Breastfeeding Specialist developed the idea of keeping double electric pumps in schools for multiple girls to use between classes. Although a breast-feeding WIC teen qualifies for the pump program, most do not participate. The Breastfeeding Specialist was concerned about teenage mothers carrying around the double pumps along with all the other things they need to bring to school. In addition, she wanted to make it easier for teen mothers to continue breast-feeding once they returned to school, since many would start but then quit when they went back to school. The goal of the program is to increase the duration of breast-feeding among teenage mothers.

## **PROFILE OF INNOVATIVE PROGRAM**

**Services Provided.** Teen mothers at 12 public schools on Oahu, Hawaii, and Kauai are eligible to use the pumps. All teen mothers in the schools can use the pumps, even if they are not on WIC. Girls on WIC get the attachment kits for free. Girls who are not on WIC have to buy the kit, but are offered a reduced price by private vendors. The attachment kit can be converted to a manual pump for use on weekends and when the girls are not at school.

Any girl who is interested in using the pump just has to ask the GRADS teacher. The teacher gives the girl a form to bring to WIC saying that she attends one of the PITS schools and is a parenting teen. The girl can then go to WIC and get an attachment kit. This form is useful because some of the girls are not very articulate and would have difficulty explaining their situation at the WIC clinic.

The teachers set up special areas where the girls come to use the pump. In one pilot school, the area is a corner of a room that is partitioned. There is a chair, a stool, and some posters. In the other pilot school, the pump is in a separate room that used to be a storage room, while at another school it is in the health room. The key is to have a comfortable place for the girl to sit. They usually pump for the 10 minutes between classes, although it takes 20 minutes to pump fully—that is all the time they have. They are also welcome to come in at recess and lunch times. Sometimes two girls pump at the same time. In one of the pilot schools, the non-GRADS teachers have been very supportive of this program. If a mother in this school is late to class due

to feeding or pumping, she is given a permission slip with no questions asked, as long as she lets the teacher know she will be late; this communication is handled teacher-to-teacher via cell phones.

The teen mothers on WIC who breast-feed usually also get formula from WIC, but they still have access to the breast-pumps. In Hawaii, women generally cannot borrow an electric breast pump if they are using formula. Pumps are usually available only to exclusively breast-feeding women. However, the WIC program makes an exception for teens, because their circumstances are such that they cannot always use breast milk exclusively. For example, the mother may not be able to nurse exclusively because the baby may be with the father's family at times, or she may need to leave the baby at child care while she works or attends school. In addition, because teen mothers have only 10 minutes between classes to pump, pumping may not be enough to feed the baby breast milk all the time. Furthermore, their lives are hectic, and they may have difficulty handling the planning needed to have pumped breast milk available at all times.

**Coordination and Collaboration.** The key collaboration for this program is with the schools—specifically, between the teachers in the GRADS program and the nearest local WIC agency. GRADS is a support program for pregnant and parenting teens in school. It is designed to teach them life skills and help them succeed in school so they can graduate and further their educations. The schools in PITS each have a designated GRADS teacher. These teachers took on the task of getting the school principals to agree to the program. In addition, they spread the word about the pumps and found and decorated private spaces for pumping. The local WIC director or breast-feeding coordinator is asked to visit the schools with the state breast-feeding specialist to get to know the teachers and the students, and to establish ongoing collaboration.

**Participation.** The State Breastfeeding Contractor did not have precise figures on the number of teen mothers who used the pumps during the pilot phase, and had even less sense of participation levels at the new schools. Nonetheless, based on her own interactions with the girls, she thought that, at the smaller pilot school, about 12 girls consistently pumped during the last year. Overall, because of the small numbers involved at each school, teacher reports of participation, although anecdotal, seem likely to be fairly accurate.

Preliminary surveys and teacher interviews indicate that teen breast-feeding rates have become much higher since the program was implemented. Furthermore, teachers in the pilot project reported that breast-feeding durations have increased. Teachers reported that the program has increased breast-feeding durations from an average two to four weeks of partial breast-feeding postpartum, to about 80 percent breast-feeding upon return to school, which generally happens at six weeks postpartum. Some young mothers are now breast-feeding for six months to one year or longer. In one participating school, there is now only one formula-feeding parent, while the eight others are exclusively breast-feeding.

Interestingly, the program is more successful when child care is available at the school. In fact, one Kauai high school has put the pump in the child care room, so that even if the infant is sleeping, the mother can pump while being near her baby, or she can pump one breast while the infant feeds on the other. This may also help increase “let down” and improve maternal milk supply. Presence of a child care center at the school also provides an indication of a supportive environment for teen mothers.

The teen mothers who participate in PITS are of various ages and some have more than one child. Most have a boyfriend, and most come from families who do not believe in abortion. Staff report that many are normal teenagers, with a lot of pressure on them, but some are fairly high-risk. Like most teens, they are concerned about their image. The students involved in the program are from many ethnic groups: Hawaiian, Filipino, Micronesian, Caucasian, and African American.

**Outreach.** The girls in GRADS hear about the pumps from their local WIC agency, the teachers, and other girls; some also see the pumping areas that have been set apart. The Breastfeeding Specialist also reported the program has helped change the “culture” in the schools. Now, students and teachers accept that pumping is what mothers do in these schools. Pumping and breast-feeding used to be the exception, but now have become “the thing to do.”

**Expansion Plans.** The program is expanding to 10 additional schools throughout Hawaii during the 2003–2004 school year. The Breast-feeding Specialist will go to each site’s WIC agency and train the local Breastfeeding Coordinator and other staff on how to link with the schools to provide attachment kits to the girls. She is meeting with the GRADS teachers and the girls at the schools to get the program started. She expects the local Breastfeeding Coordinators to become involved and help keep the program running.

## ORGANIZATION AND MANAGEMENT

**Staff and Organizational Structure.** The State Breastfeeding Contractor conceived the program and got it up and running. She conducts periodic surveys and comes to talk to the girls. The local WIC clinics provide attachment kits to the girls as part of their regular services. However, the GRADS teachers run PITS on a day-to-day basis.

One important feature in how the program was set up is that WIC staff dealt with each school directly, rather than going through the state Department of Education. The GRADS teachers initially talked to the principals to obtain their agreement. Then the State Breastfeeding Consultant helped negotiate a Memorandum of Agreement between WIC and each school, which specifies the responsibilities of each party. For example, WIC is responsible for servicing the pumps, but if a pump is stolen or vandalized, it is the school’s responsibility.

**Funding.** For the first two years, costs were covered by regular WIC breast-feeding funds. The Breastfeeding Specialist charged her time as usual to WIC. The teachers are employed by the school, so there is no cost to WIC for their time. WIC already had the pumps, which were purchased with food funds. To expand the program to 10 more schools, the state received a WIC Operational Assistance Fund Grant of \$49,500.

In the long run, the Breastfeeding Specialist thinks that PITS probably saves WIC money, because it provides a way to use one or two breast pumps for multiple clients, with minimal staff involvement and less likelihood of theft.

## ASSESSMENT AND LESSONS LEARNED

**Program Strengths.** This program is straightforward to implement, has minimal costs, and may in fact save WIC money by reducing formula expenditures. It also offers the opportunity to increase breast-feeding durations for teenage mothers, whose infants are often at high risk.

As noted above, the impressions of the teachers and the Breastfeeding Specialist are that usage of the pumps has been substantial. The GRADS teachers believe that PITS has improved breast-feeding rates and durations, decreased illnesses among the babies, and thus decreased absenteeism among the girls.

Even after PITS implementation, most teen mothers introduce formula at two to four weeks postpartum. Nonetheless, breast-feeding duration is longer among teen mothers after PITS implementation in their schools. More teen mothers breast-feed exclusively or feed a combination of breast milk and formula, rather than ceasing breast-feeding completely. Because of the time constraints on pumping between classes, local WIC staff have been encouraged to work with these young mothers to encourage as much breast-feeding as possible, while still being flexible about providing formula. This change in attitude, along with the availability of the pumps, has proven to be effective in lengthening the breast-feeding relationship, while supporting the young mothers based on their needs and the realities of their day. Post-intervention student surveys in the pilot schools show that students view both WIC and their schools as much more supportive of breast-feeding than before the implementation of PITS.

Hawaii WIC has developed new surveys for the new sites this year—they will do a “pre” survey before the program starts, and then a “post” survey after it has been going awhile. These surveys will provide a stronger basis for evaluating the program’s outcomes.

**Key Challenges.** The program is very dependent on the GRADS teachers and their enthusiasm for encouraging participation. The Contracted Breastfeeding Specialist hopes, with the new grant funding, to be able to spend more time in the schools sharing information and assisting young mothers with any breast-feeding problems.

**Lessons Learned.** The Contracted Breastfeeding Specialist advises others interested in starting a similar program to work closely with the teachers in school-based programs for teen parents and make sure they are committed to the breast pump program. They know the teen mothers and the realities that they face. She also recommends taking the teachers’ advice on how the program should work in their school.

The initiative for the program in this case came from the state WIC agency, but they worked with the local schools, rather than with upper levels of the school bureaucracy, to obtain access to the young mothers. This type of coalition seems important in reaching teen parents, as they have difficulty finding time and transportation to visit the WIC agency.

An important caveat is that the high use of the in-school breast pumps by Hawaii's teen mothers may be harder to achieve in other places. Breast-feeding rates in Hawaii are very high in general, and the local culture is very supportive of breast-feeding.<sup>50</sup>

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<sup>50</sup> In contrast, we spoke with a local WIC agency that operated a similar program in a state with low breast-feeding rates. They found that the pumps available in the schools were hardly used, although other WIC services were appreciated.

**INFANT-FEEDING CLASSES FOR TEENS<sup>51</sup>**  
**LUCAS COUNTY, OHIO**

**OVERVIEW**

**Location:** Lucas County, Ohio (Toledo and environs)

**Start Date:** 2000

**Target Population:** Pregnant teenagers on WIC or in school programs for pregnant teens.

**Purpose:** To provide breast-feeding education for pregnant teenagers that is targeted at their needs and concerns and thus encourages them to breast-feed their babies.

**Services:** WIC staff run, for pregnant teens on WIC, a class that presents information and includes open-ended discussion of infant feeding from the point of view of teenagers, a video on breast-feeding designed for teens, information on other resources, and “goody” bags with incentives and informational brochures. In addition, in-depth classes are offered in local high schools as part of school programs for pregnant teens.

**Funding:** Staff time is funded from WIC breast-feeding funds. Food and incentives were originally funded through small grants from the March of Dimes (MOD) and local hospital foundations, but the WIC agency is taking over these costs after obtaining a special waiver from the state agency.

**Why Program Was Chosen:** The WIC class seems a good example of breast-feeding education targeted to a particularly high-risk group—pregnant teens—and it would be replicable in a range of settings at modest cost. The partnership with the schools is also of interest.

**Key Challenges:** Convincing teenage mothers to breast-feed is an ongoing challenge, and it is difficult to affect their decisions through one class. In addition, only 15 to 20 percent attend. Additional contacts in the schools and in the hospital around the time of the birth are used to reinforce the message.

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<sup>51</sup> Telephone interview, May 30, 2003.

## BACKGROUND

**Community Characteristics.** Lucas County, Ohio, contains the city of Toledo and its immediate environs. It is located in the northwest corner of the state, bordering Lake Erie and Michigan. The 2001 population of this urban county was just over 450,000. The county is 17 percent African American, compared to 12 percent in the state as a whole, and 5 percent Hispanic, compared to 2 percent in the state as a whole. The 1999 poverty rate was 14 percent in Lucas County, much higher than the 11 percent rate in the state overall. Lucas County has the second-highest teen pregnancy rate in the state, and it used to have the highest rate.

**WIC Program Background.** The WIC agency is part of the Toledo-Lucas County Health Department, which operates eight WIC clinics, three or four of which are in local hospitals. The agency enrolls about 12,000 WIC clients a year in all categories.

In addition to the infant-feeding classes that are the focus of this profile, the Toledo-Lucas WIC program offers a range of other services for breast-feeding women:

- They can schedule appointments with the breast-feeding staff at the central WIC office if they need breast-feeding help; if transportation is a problem, breast-feeding staff will travel to other WIC clinics.
- If pregnant WIC participants attend infant-feeding classes or otherwise express interest in breast-feeding, WIC staff attempt to telephone them right after the birth. If the mothers are having any problems, staff encourage them to bring the baby in to see the lactation consultants. The main WIC clinic has a very accurate scale that gauges the amount of milk ingested when the baby is weighed before and after nursing.
- WIC lactation consultants coordinate with the hospital lactation consultants—the hospital consultants work with mothers while they are in the hospital, and WIC staff take over after discharge.
- WIC has electric pumps to lend out and manual pumps to give out: (1) Lactina pumps are targeted at mothers with babies in the hospital, but there is a waiting list; (2) other, less-expensive electric pumps are provided for mothers returning to work or to school, with some models on loan and some that mothers can keep.

**Program History and Objectives.** The breast-feeding coordinator started separate classes for teen mothers in 2000. When conducting breast-feeding education classes for pregnant women that included both adults and teenagers, the coordinator noticed that the needs and concerns of teenagers were very different from those of older women, and she thought it would be more effective to offer classes targeted at teens. She wanted to present the benefits of breast-feeding in a way more meaningful to teens, and also to hold the class at a time when it would be easier for them to come.

Soon after the Health Department started offering the teen classes, the breast-feeding coordinator received calls from the teachers of the Graduation Reality and Dual-Role Skills (GRADS) programs (special programs for pregnant or parenting teens) in local high schools,



expressing interest in the infant-feeding classes, but also some concern that girls would skip school to attend them. The coordinator offered to present classes in their programs, which they were very happy to have. She began to visit the three area high schools regularly and give classes on breast-feeding—these classes have been opportunities for the teachers also to learn, and she reaches some girls who will not come to the WIC class (and some who are not eligible for WIC).

## PROFILE OF INNOVATIVE PROGRAM

**Services Provided.** The breast-feeding class WIC runs is for pregnant teens on WIC. They all receive a postcard around their seventh month of pregnancy inviting them to the next class. The postcard refers to the class as an “infant-feeding class” (mention of breast-feeding may discourage attendance) and notes that pizza will be served. Sometimes, the postcards mention some of the other incentives available (described below). The WIC class is offered every six weeks at a local church, on Wednesday at 3:30 P.M., so teens can come after school. (At the church, more parking is available than at the WIC clinic; they hold classes for older mothers there, too, but at 10 A.M.) The class, which usually lasts from 60 to 75 minutes, counts as a WIC nutrition education class. The girls sign in and give their WIC case number.

The class is intended to get out a few key messages:

- Breast-feeding is best for both mother and baby.
- WIC staff will help. They make sure the expectant mothers know how to get in touch with the breast-feeding coordinator and her staff.
- Pumps and an enhanced food package are available.
- It is possible to breast-feed and to go back to school. The breast-feeding coordinator has arranged private rooms for pumping at all the local high schools and colleges.

As the teens arrive, music from one of the radio stations popular with teens plays at a low volume. At the start of the class, they serve pizza and drinks—it is a draw and helps to break the ice. Next, the coordinator shows a video that shows teens breast-feeding and talking about why breast-feeding is best. She shows this first partly because “teenagers tend to be late.”

At times, the breast-feeding coordinator invites various speakers from other health department programs. For example, a staff member who offers smoking cessation classes may talk about these classes (as many pregnant teens also smoke), or another staffer may talk about the “Help Me Grow” program, which offers up to two home visits from a nurse after the baby is born.

The most useful way to get the pregnant teens to consider breast-feeding is to have a breast-feeding teen attend the class with her baby—this has more impact than any information from the staff, as the breast-feeding teen can tell those in the class how breast-feeding works for her. In addition, the breast-feeding coordinator sometimes brings the “peer helper” who works with her

at the WIC agency. She is a mother who is now 30 but who had her first child as a teen and has been on WIC, and she shares her experiences.

Next, the coordinator gives out the “goody bags” that she puts together for the girls and goes over what they contain. The contents vary somewhat, but they tend to include:

- Handouts with information and resources—for example, brochures on whom to call if they are breast-feeding and having problems, how to store breastmilk, how to know if the baby is getting enough milk; flyers from other organizations; and information from the MOD on folic acid (required as part of a MOD grant—see the discussion of funding).
- Condoms—the coordinator discusses birth control and what works best while nursing.
- “Onesies”—baby underwear purchased with the MOD grant.
- Free toiletries and the *American Baby* magazine.
- Magnets with numbers for the breast-feeding coordinator’s office (for breast-feeding help), magnets with a “Breastmilk Storage Guide,” and pens with the WIC office phone number.
- A voucher for a half-price car seat if they attend a car seat class.

The breast-feeding coordinator shows the girls different breast-feeding aids and points out that they can suggest them as presents to family or friends who may want to buy a gift for the baby; examples include breast-feeding pillows. She also discusses breast pumps, including which pumps are available through WIC, and which types of pumps are better than others. Many of the girls are interested in this information.

Next, there is an open-ended discussion. The breast-feeding coordinator passes out a series of questions on laminated paper. She asks for volunteers to read the questions (as not all the girls can read). For example, questions include:

- Can you breast-feed and go back to school?
- Can you smoke and breast-feed?

She tries to get a group discussion going, letting them express what they believe and offering more information. She tries to focus on the issues that concern teens, recognizing their immaturity, such as “Will my breasts sag if I breast-feed?” or “Can I still go out with my friends?” The coordinator discusses the benefits of breast-feeding from the teen mother’s point of view, such as: the baby is easier to take care of, she can get more sleep at night with nursing in bed, she does not need to take bottles when out, and she will have larger breasts.

The coordinator is flexible in leading the discussion and will focus on what seems to be of most concern to the girls attending. The discussion lasts 50 minutes to 1 hour. She also encourages the girls to bond with each other; some exchange phone numbers at the end. In addition, there is a drawing for a baby quilt (made and donated by local volunteers) at the end of each class, which is another incentive for the girls to attend.

The breast-feeding coordinator also gave classes at three local high schools in GRADS, their special program for pregnant/parenting teens, every six weeks. In fall 2003, the school district moved all pregnant and recently delivered teens to a separate school; the school has a satellite WIC clinic on site every three to four weeks, and she offers classes at that time. In the school setting, she sees the same girls repeatedly, so she covers different information each time. For example, one class may focus on positioning the baby on the breast, and another class may focus on what to do if the baby is premature (not uncommon for teen mothers). She always brings a few of the goody bags in case the class contains girls who are close to delivery. In spring 2003, there were about 10 to 15 girls in the program at each of the three high schools.

**Coordination and Collaboration.** In addition to the collaboration with the schools, WIC staff also work with the hospitals to help teenagers. The hospitals have lactation consultants on staff, and they will refer mothers to WIC when appropriate. In addition, the local hospitals offer a Teen Lamaze class, and the WIC breast-feeding coordinator works closely with the people who run this class. She refers WIC teens to the Lamaze class as appropriate, and the hospital staff in turn provide information about WIC services, including WIC's teen classes.

**Participation.** In general, about 15 girls attend each WIC class. Many are brought by someone else—their mother, boyfriend, or other relative—since they need a ride. Thus, 20 or more people typically attend.

About 15 to 20 percent of those invited attend each class, a participation rate that is typical for WIC classes. Some girls may come after a second invitation, or the breast-feeding coordinator may reach them in the classes she gives in the schools. In a few cases, young women come after they have had their baby, as some deliver before the next available class. The coordinator told a story of a girl who came to the class with a three-day-old baby and stayed after to ask, “Can I still breast-feed?” She hadn't realized how important it was. The staff stayed at the clinic and worked with her until she was successful in getting started.

The classes in the schools reach a potentially wider audience—all pregnant teens in the school parenting programs, including some who may not qualify for WIC. However, the WIC classes may attract some girls who are not in school.

**Publicity/Outreach.** Most WIC teens are recruited through the postcards described above or their contacts with WIC staff. In addition, the local hospitals and doctors offices have information on the breast-feeding help available through WIC to offer their patients. The breast-feeding coordinator also visits the high schools and tells teens who do not know about WIC how to enroll, and offers classes there as described above.

## ORGANIZATION AND MANAGEMENT

**Staff and Organizational Structure.** The breast-feeding coordinator for the agency developed and runs the classes. She is a nurse and an Internationally Board Certified Lactation Consultant (IBCLC). Toledo-Lucas County WIC also employs two other lactation consultants and a peer helper who work part-time—they sometimes help with the teen classes. They recently hired three more peer helpers, as they have abundant funding for breast-feeding services right now.

**Funding.** Staff time is funded from WIC breast-feeding promotion funds. The coordinator also obtained a grant from the MOD, and small grants from other local hospital foundations. These grants ranged from \$500 to a few thousand dollars. They also take advantage of some free materials from manufacturers and donated space at the church where the WIC classes are held.

The MOD funding helped pay for incentives for the girls and for the food at the classes. As part of the grant, they asked the WIC agency to include MOD material on folic acid in the informational packets offered to the girls, which the agency was glad to do. The coordinator also tries to offer a snack high in folic acid for the class.

When we spoke with the breast-feeding coordinator in May, the MOD funding was about to run out, but the WIC agency director had added funds to the WIC budget for the incentives the grant had paid for. The agency received permission from the state agency to pay for these incentives, because the program is seen as successful.

## ASSESSMENT AND LESSONS LEARNED

**Program Strengths.** There is little direct evidence concerning program outcomes for the teen classes, but the Toledo-Lucas County breast-feeding program overall shows signs of success. The breast-feeding coordinator reported that since she started at the agency six years ago, breast-feeding initiation rates have increased from around 20 percent to 39 percent. Unfortunately, they do not track breast-feeding rates separately for teens.

The coordinator reports the teens react pretty positively. Some of the mothers of the teens say, “I wish you had been around when I had my kids.” She bonds even more with the girls in the school programs, as she sees them repeatedly during their pregnancy. These girls gave a luncheon for her and other speakers who came in to talk to them at the end of the school year. Most of these girls, she says, breast-feed at least for a short while, often until they return to school.

**Key Challenges.** It is an ongoing challenge for the WIC program to find ways to persuade pregnant teenagers to breast-feed. The special class for pregnant teens seems to be a step in the right direction. The classes offered through the schools and related work to build support for breast-feeding in the schools are even stronger steps. The breast-feeding coordinator felt it was more useful to reach the young women repeatedly with the message of breast-feeding than to provide the information only once. Nonetheless, even the single class seems a useful way to open more young women to the idea of breast-feeding, particularly if the hospital lactation consultants and WIC staff can then follow up at the time of the birth.

**Lessons Learned.** The classes described above were developed and operate at minimal cost and it seems like they could easily be replicated, particularly by staff experienced in working with teenagers. The key idea is to try to reach teenagers about breast-feeding in terms that relate to their interests and concerns.

## **CONTACT INFORMATION**

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