

# Appendix B: Peer Counselor Background Questionnaire

## Breastfeeding Peer Counselor Questionnaire

As part of the WIC Breastfeeding Peer Counseling Study for the U.S. Department of Agriculture, Food and Nutrition Service (FNS), we are asking Peer Counselors participating in the study to complete this short questionnaire. The purpose of this questionnaire is to learn about the characteristics of breastfeeding peer counselors who work with WIC participants. We estimate that it will take you 15 minutes to complete this questionnaire.

You and your WIC agency's name and location will not be identified in reports prepared for this study or in data files provided to FNS. None of your responses will be released in a form that identifies you or any staff member at your agency by name, except as required by law. Please note that this study is not part of an audit or management review of WIC.

Your participation in this questionnaire is completely voluntary. You are not required to complete this questionnaire and no one at your WIC agency will penalize you if you decide not to answer these questions. To help us protect your privacy, please read and follow the instructions below.

### INSTRUCTIONS

1. Please read and sign the WHITE copy of the Consent Form on the next page before answering any items on this questionnaire. If you do not wish to participate, do not sign the consent form.
2. When you finish please put the WHITE copy of the Consent Form and the questionnaire in the Study Envelope.
3. Seal the envelope closed and then give it to your supervisor. If you prefer, you may drop it in any U.S. Postal Service mailbox. No postage is required.

OMB Clearance Number: 0584-0548

Expiration Date: mm/dd/20xx

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this collection is 0584-0548. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collected.



# Consent Form

## Peer Counselor Questionnaire for the WIC Breastfeeding Peer Counseling Study

**Your participation in this questionnaire is completely voluntary.** You are not required to complete this questionnaire. If you if you decide not to answer these questions, there will be no adverse consequences for you. You may leave blank any questions you do not wish to answer.

**The purpose of this questionnaire is to learn about the characteristics of breastfeeding peer counselors who work with WIC participants.** If you choose to participate, the risk of any harm to you is minimal. You may not benefit directly by answering these questions. However, you may help the Food and Nutrition Service (FNS) learn more about how WIC can best support breastfeeding among WIC participants.

**You and your WIC agency’s name and location will not be identified in reports prepared for this study or in data files provided to FNS.** Your responses will be used for statistical purposes. None of your responses will be released in a form that identifies you or any staff member at your agency by name, except as required by law. Please note that this study is not part of an audit or management review of WIC. **To protect your privacy,** we will separate your questionnaire from other materials that have your name. We will store your consent form and questionnaire in two separate locations that are secure. We will keep track of your responses using a study identification number (study ID) and not your name. We will enter your responses and your study ID number into a computer database. Your name will not be stored in the same database with your responses.

This questionnaire and the WIC Breastfeeding Peer Counseling study have been reviewed and approved by Abt Associates’ Institutional Review Board (IRB) for research with human participants. The IRB study approval number is xxxx. If you have questions about your rights as a research participant, please contact [IRB@abtassoc.com](mailto:IRB@abtassoc.com), or call the IRB Administrator (toll-free) at (xxx) xxx-xxxx.

I have read and understood the above information and I agree to participate in completing the enclosed Peer Counselor Questionnaire for the WIC Breastfeeding Peer Counseling Study.

Signature: \_\_\_\_\_

Print your name: \_\_\_\_\_

Date: \_\_\_\_\_

**RETURN THIS COPY (White copy) with your Questionnaire**

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**You and your WIC agency's name and location will not be identified in reports prepared for this study or in data files provided to FNS.** Your responses will be used for statistical purposes. None of your responses will be released in a form that identifies you or any staff member at your agency by name, except as required by law. Please note that this study is not part of an audit or management review of WIC. **To protect your privacy**, we will separate your questionnaire from other materials that have your name. We will store your consent form and questionnaire in two separate locations that are secure. We will keep track of your responses using a study identification number (study ID) and not your name. We will enter your responses and your study ID number into a computer database. Your name will not be stored in the same database with your responses.

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**KEEP THIS COPY (Yellow copy) for your records**

**Section A. Your role as a Breastfeeding Peer Counselor**

1. Did you sign the Consent Form on the previous page? *Mark one answer.*

<sub>1</sub> YES *Go to Question 2.*

<sub>2</sub> NO *Please sign the Consent Form before marking any answers below.*

2. What is today's date?

Month   Day   Year

3. How long have you been a Breastfeeding Peer Counselor?

Year(s). *If less than 1 year, how many months?*   
←  
 Months

4. Are you paid to work as a Breastfeeding Peer Counselor? (Pay includes wages or a salary for work that you do.) *Mark one answer.*

<sub>1</sub> YES

<sub>2</sub> NO

5. Thinking about last month, about how many hours per week, on average, did you work as a breastfeeding peer counselor?

Hours per week, on average, last month

**Section B. Languages you speak**

**6. Do you speak any languages other than English? Mark one answer.**

- <sub>1</sub> YES Go to QUESTION 7.
- <sub>2</sub> NO SKIP to QUESTION 9 on PAGE 3.

**7. What other language(s) do you speak? Mark YES or NO for each.**

YES

NO

- <sub>1</sub> <sub>2</sub> Spanish
- <sub>1</sub> <sub>2</sub> Chinese (Mandarin, Cantonese, or other Chinese dialect)
- <sub>1</sub> <sub>2</sub> Tagalog
- <sub>1</sub> <sub>2</sub> French
- <sub>1</sub> <sub>2</sub> Vietnamese
- <sub>1</sub> <sub>2</sub> Other - Specify →

\_\_\_\_\_

Source: American Community Survey, 2005

**8. How well do you speak English? Mark one response.**

- |                 | Very Well                             | Well                                  | Not Well                              | Not at all                            |
|-----------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| I speak English | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> | <input type="checkbox"/> <sub>4</sub> |


Source: American Community Survey, 2005

### Section C. Your education and training

9. Do you have any of the following certifications? Mark YES or NO for each.

YES

NO

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Certified Breastfeeding Counselor (CBC)  |
| <input type="checkbox"/> | <input type="checkbox"/> | Certified Lactation Counselor (CLC)  |
| <input type="checkbox"/> | <input type="checkbox"/> | Certified Lactation Educator (CLE)   |
| <input type="checkbox"/> | <input type="checkbox"/> | Registered Lactation Consultant (RLC); that is, certification from the International Board of Lactation Consultant Examiners (IBLCE)         |
| <input type="checkbox"/> | <input type="checkbox"/> | Other breastfeeding or lactation certification - Specify  |

\_\_\_\_\_

10. Do you have a nursing degree, certification, or license? Mark all that apply.

- Certified nursing assistant (CNA) or nursing diploma
- Licensed practical nursing degree (LPN) or licensed vocational nursing degree (LVN)
- Associate's degree in nursing (ADN), usually a 2-year degree
- Bachelor of science in nursing (BSN), usually a 4-year degree
- Registered nurse (RN) license
- Nurse practitioner (NP) or clinical nurse specialist (CNS)
- Nurse-midwife (CNM)

11. What is the highest grade or level of school you completed? Mark one answer.

- Some high school
- High school diploma or GED
- Some college
- 2-year college degree (e.g., Associate's degree)
- 4-year college degree (e.g., Bachelor's degree)
- More than 4-year college degree (e.g., some graduate school, Master's degree)

**Section D. Demographic Information**

**12. What is your ethnicity?** *Mark one answer.*

- <sub>1</sub> Hispanic or Latino
- <sub>2</sub> Not Hispanic or Latino

**13. What is your race?** *Check one or more.*

- <sub>1</sub> American Indian or Alaska native
- <sub>1</sub> Asian
- <sub>1</sub> Black or African American
- <sub>1</sub> Native Hawaiian or other Pacific Islander
- <sub>1</sub> White

**14. Where were you born?** *Mark one answer.*

- <sub>1</sub> In the United States (one of the 50 states or the District of Columbia)
- <sub>2</sub> In one of the the U.S. Territories (*Puerto Rico, Guam, American Samoa, US Virgin Islands, Mariana Islands or Solomon Islands*)
- <sub>3</sub> In another country

**15. When were you born?**

Month   Day   Year

**16. Including yourself, how many people live in your household?**

Total number of people, including self, in your household

**17. How many of these people living in your household are:**

|                      |                      |  |
|----------------------|----------------------|--|
| <input type="text"/> | <input type="text"/> | Adults aged 18 and older?              |
| <input type="text"/> | <input type="text"/> | Children between the ages of 6 and 18? |
| <input type="text"/> | <input type="text"/> | Children under 6 years of age?         |



**18. What is your total household income?** *Mark one answer.*

- <sub>1</sub> Less than \$10,000
- <sub>2</sub> Between \$10,001 - \$15,000
- <sub>3</sub> Between \$15,001 - \$20,000
- <sub>4</sub> Between \$20,001 - \$25,000
- <sub>5</sub> Between \$25,001 - \$30,000
- <sub>6</sub> Between \$30,001 - \$35,000
- <sub>7</sub> Between \$35,001 - \$40,000
- <sub>8</sub> More than \$40,000

**19. Have you ever received any of the following?** *Check all that apply.*

- <sub>1</sub> SNAP Benefits (formerly Food Stamps)
- <sub>1</sub> TANF or cash assistance
- <sub>1</sub> Medicaid
- <sub>1</sub> Welfare
- <sub>1</sub> Not sure/don't know

**Thank you - we appreciate your participation.**

**Remember to do the following:**

- A. If you answered any questions, please check to make sure you signed the WHITE Consent Form. Return the WHITE copy and keep the yellow copy.
- B. Place the WHITE consent form and the questionnaire in the envelope provided. (You may keep the yellow copy of the consent form. It has information about how to contact us if you have questions about the study.)
- C. Be sure to seal the envelope closed and then return it to your supervisor at your local WIC agency. If you prefer, you may drop the sealed envelope in any US post office mailbox.

Thank you.