Georgia Department of Public Health

Georgia WIC Program
Peer Counselor Observation Checklist

Peer Counselor: _____ **Clinic:** _____ **Month/Quarter:** _____

WIC ID #: _____ **Prenatal Participant:** ☐ **Postpartum Participant:** ☐

Observation Type: Face-to-Face ☐ Phone ☐ *Peers should have one face to face and one phone observation completed quarterly.

BREASTFEEDING COUNSELING	RATING			COMMENTS
Personalizes session by using participant's name & background information	Y☐	N☐	N/A☐	
Prioritizes topics to discuss	Y☐	N☐	N/A☐	
Asks open-ended questions	Y☐	N☐	N/A☐	**Rating Scale:** Frequently Rarely Never
Probes using appropriate questions to assess mother's situation	Y☐	N☐	N/A☐	
Uses counseling skills such as reflective listening and affirmation of feelings appropriately	Y☐	N☐	N/A☐	
Education was based on participant responses	Y☐	N☐	N/A☐	
Counseling: Accurate information provided	Y☐	N☐	N/A☐	
Counseling: Culturally appropriate information provided	Y☐	N☐	N/A☐	
Gave Handouts related to participant needs and interests (if applicable)	Y☐	N☐	N/A☐	
Uses breast models, dolls when appropriate	Y☐	N☐	N/A☐	
Reviews previous infant feeding experiences and/or that of other family or friends	Y☐	N☐	N/A☐	
Explores mother's current and future feeding plan for her infant	Y☐	N☐	N/A☐	
Explores participant's thoughts of information shared during counseling session	Y☐	N☐	N/A☐	
Explores participant's thoughts and feelings about breastfeeding	Y☐	N☐	N/A☐	

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Ends the counseling session on a positive note and offers appropriate follow-up and referrals as needed	Y☐	N☐	N/A☐	
Properly referred to the Designated Breastfeeding Expert (DBE)	Y☐	N☐	N/A☐	
WHAT WENT WELL				
WHAT CAN BE DONE DIFFERENTLY				
WHAT I WILL WORK ON - Improvement Goal(s)				

Peer Counselor (Print Name): _____ Date: _____

Peer Counselor Signature: _____ Date: _____

Reviewer Signature: _____ Date: _____