

# Breastfeeding Program Sample Evaluation Forms

## INTRODUCTION

This resource is a collection of sample evaluation forms that have been used in various breastfeeding programs and initiatives across Ontario. They will provide organizations with ideas and templates for evaluating breastfeeding programs, services, and resources. Organizations are welcome to adapt these sample evaluation forms to fit their specific community, services, population, and purpose.

The sample evaluation forms have been grouped under a number of topics. Within each topic, the sample evaluation forms are grouped according to the intended audience (i.e., mothers, volunteers, and/or service providers). Not all topics have sample forms relating to each audience.

The sample evaluation forms have been shared with permission. Identifying information has been removed.

## RECOGNITION

The Best Start Resource Centre thanks the individuals, and organizations, who gave their consent to share their forms as provided in this resource.

## FUNDING

This document has been prepared with funds provided by the Government of Ontario. The information herein reflects the views of the authors and is not officially endorsed by the Government of Ontario. The resources and programs cited throughout this resource are not necessarily endorsed by the Best Start Resource Centre.

For more information or comments contact the Best Start Resource Centre at [beststart@healthnexus.ca](mailto:beststart@healthnexus.ca).  
[www.beststart.org](http://www.beststart.org) – [www.healthnexus.ca](http://www.healthnexus.ca)

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**████████ Café**

Welcome to the ██████████ Café! This café has recently been expanded to new locations in ██████████. As a result, the ██████████ Community Health Centre and ██████████ Public Health are working together to collect feedback on the ██████████ Cafés so that we can provide better service to you.

We would like to collect information about the ██████████ Cafés and about the people who attend the cafés. We invite you to participate by filling out a survey. The survey will take about five minutes to fill out. You do not have to fill out this survey and you can choose not to answer specific questions or give your name if you do not feel comfortable. We will keep your information confidential and only ██████████ Public Health staff will have access to this information. Your answers will not affect the services you receive at the ██████████ Community Health Centre and ██████████ Public Health.

If you need help answering the questions, please ask the facilitator. If you have any questions about the research, please contact ██████████ at xxx-xxx-xxxx extension xx or by email at ██████████.

**Thank you for coming today and for sharing this information!**

## CONSENT FORM

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### Why are you doing this project and what is expected of me?

We are doing this project to learn more about the breastfeeding experiences of local women who also have low income. This information will help us improve services and care for women in the future.

A facilitator will ask you, as part of a small group of women, one or more questions about your experiences with breastfeeding. At the end of the discussion, you will be asked to fill out a short survey about yourself and your breastfeeding experience. The focus group and survey will take about 60 – 90 minutes.

A secretary with special equipment will take notes of the discussion, and a voice recording will be made of the session.

Child care, snacks, and transportation to and from the focus group location will be provided if needed. You will receive a \$30 grocery store gift card for participating.

### What if I change my mind?

Taking part is voluntary. You can refuse to answer questions, and you can withdraw at any time.

Anyone who attends a focus group will receive a gift card, even if they leave early or decide not to share any information.

### Are there any risks to me?

Sometimes women feel upset when they discuss their experiences with breastfeeding. If you want to leave, you can. A Registered Nurse will be available to talk to you during and after the group if you want.

### In a focus group, we cannot guarantee your confidentiality or anonymity.

It is possible that other participants may recognize you, and could share your name or comments outside of the focus group. We will ask all participants not to share names or comments outside the group, however, we cannot guarantee this.

### What will happen to my information?

The information we collect from the focus group and the survey will be reviewed to see if there are themes (common ideas or experiences) that emerge. These themes will be used to educate agency workers that provide services to breastfeeding women, and to create materials that promote breastfeeding (such as posters).

We will also share these themes with other communities around the province and the funding agency.

### What about my privacy or confidentiality?

The project team will never use your name or any identifying information about you in presentations, project materials, or reports. Your recorded comments and answers to the survey will not be linked to your name. As discussed above, we cannot guarantee that other participants in the focus group will not share your name or comments outside the group.

**What about data storage?**

Voice recordings will be stored in a locked cabinet at [REDACTED] and deleted once the discussion has been transcribed (i.e., typed in print). The transcribed files will be stored on a secure computer at [REDACTED] and destroyed no later than [REDACTED]. Data will be encrypted (i.e., coded) and password protected when using portable devices such as laptops.

**Who is involved in this project?**

The agencies and individuals involved in this work are:

Name	Agency	Contact
[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]

I, \_\_\_\_\_, understand that this project had been approved by the [REDACTED], and agree that I am fully informed and freely give my consent to participate.

---

Signature

Date

**Title of the Study:** [REDACTED]

Study conducted by:

[REDACTED]

- Position title
- telephone: xxx xxx-xxxx extension xxx
- email: [REDACTED]

[REDACTED]

- Position title
- telephone: xxx xxx-xxxx extension xxx
- email: [REDACTED]

[REDACTED]

- Position title
- telephone: xxx xxx-xxxx extension xxx
- email: [REDACTED]

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**Invitation to Participate:** I am invited to participate in the research study conducted by [REDACTED], [REDACTED], and [REDACTED]. This project is funded by a grant from Best Start Resource Centre for a community breastfeeding project.

**Purpose of the Study:** The purpose of this study is to get a youth perspective regarding information about starting and continuing breastfeeding as well the ideal format for a mom-to-mom breastfeeding support group.

**Participation:** My participation will consist of attending one group discussion lasting approximately one hour. During the discussion group, I will have a chance to share my ideas about the information that young women need to know to start and continue breastfeeding. I will also be able to share my ideas about what a mom-to-mom breastfeeding support group should be like. I understand that the group discussions will be scheduled on a day when most participants are already attending a program at [REDACTED]. I will also be asked to complete a short survey of my personal information (e.g., my age, number of children, etc.).

**Risks:** My participation in this study means that I will share my plans for infant feeding (if I am pregnant) and/or my personal experiences with breastfeeding or formula feeding (if my baby is already born). My participation may cause me to feel some discomfort if I had challenges in the past or have different ideas than the other women in the group. I have received assurance from the researchers that every effort will be made to minimize these risks including the following: I do not have to answer any questions that make me feel uncomfortable, or I can choose to write down the information and speak with the research assistant after the group discussion.

**Benefits:** My participation in this study will mean that I will have the opportunity to contribute to the development of a breastfeeding program and mom-to-mom support program at [REDACTED]. As someone who currently attends programs at [REDACTED], I may have some good ideas about information that might help other young mothers to start and continue breastfeeding. I can also provide information about the format of a mom-to-mom breastfeeding support program. There are no other programs like this in Canada, and I may feel empowered knowing that I have contributed to the development of this exciting program.

**Confidentiality and Anonymity:** I have received assurance from the researchers that the information I will share will remain strictly confidential. As a member of the group discussion, the other members will know who I am and will hear the information that I share. I understand that the discussion will be audio recorded and that the recording will be used only by the research team. I understand that when sharing the results of this study, [REDACTED] will be identified, but the researchers will protect my personal anonymity by not revealing my name when sharing the results of the group discussion with others (my name will be replaced with a number or fake name).

**Conservation of Data:** All the data collected (audio recording and transcripts of group discussion, consent forms, personal information sheets, etc.) will be kept in [REDACTED] locked office at [REDACTED]. Only the researchers ([REDACTED] and [REDACTED]) and the research assistant ([REDACTED]) will have access to this data. It will be stored for five years and then permanently deleted and/or destroyed.

**Compensation:** I will receive a \$10 gift certificate for participating in the group discussion. If I choose to stop participating or leave early from the group discussion, I will still receive this gift.

**Voluntary Participation:** I understand I have the choice to participate or not. Even if I do choose to participate, I can stop at any time and/or refuse to answer any questions without suffering any negative consequences. If I choose to withdraw from the study, the information that I provided up until my withdrawal will be used as part of the study. The reason for this is that the focus group involves a group discussion. Since names will not be collected, it will not be possible to retrace individual comments within the group discussion. I am under no obligation to continue sharing information or continue staying with the group.

**Acceptance:** I, \_\_\_\_\_, agree to participate in the above research study conducted by [REDACTED], [REDACTED], and [REDACTED].

If I have any questions about the study, I may contact the research assistant, [REDACTED] at xxx xxx-xxxx. I can also contact [REDACTED] or [REDACTED] (their contact information is on page 1 of this consent form).

If I have any questions regarding the ethical conduct of this study, I may contact:

[REDACTED]

telephone: xxx xxx-xxxx extension xxx

email: [REDACTED]

---

There are two copies of the consent form, one of which is mine to keep.

---

Participant's signature

Date

---

Researcher's signature

Date

**██████████ Workshop**

Welcome to the ██████████ Workshop! This workshop has recently been expanded to new locations in ██████████. As a result, the ██████████ Community Health Centre and ██████████ Public Health are working together to collect feedback about the ██████████ Workshop so that we can provide better service to you. We would like to collect information about the ██████████ Workshop and about the people who attend the workshop.

We invite you to fill out a survey before the workshop and one after the workshop. Each survey will take about five minutes to fill out. You do not have to fill out this survey and you can choose not to answer specific questions or give your name if you do not feel comfortable. We will keep your information confidential and only ██████████ Public Health staff will have access to this information. Your answers will not affect the services you receive at the ██████████ Community Health Centre and ██████████ Public Health. If you need help answering the questions, please ask the facilitator. If you have any questions about the research, please contact ██████████ at xxx-xxx-xxxx extension xx or by email at ██████████.

**Thank you for coming today and for sharing this information**



## [REDACTED] Breastfeeding Café: Participant Information

Please provide us with the following information that will help us evaluate this pilot program.

Your information will be kept anonymous and confidential.

Date: \_\_\_\_\_ Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

1. How did you hear about the [REDACTED] Breastfeeding Café? (please check all that apply)
 

<input type="checkbox"/> Family/Friend	<input type="checkbox"/> [REDACTED] Health Centre Team
<input type="checkbox"/> Midwife	<input type="checkbox"/> Pamphlet/Flyer <span style="float: right;"><input type="checkbox"/> Media</span>
<input type="checkbox"/> Other (please specify) _____	
  
2. I came to the Breastfeeding Café because: (please check all that apply)
 

<input type="checkbox"/> I want more information about breastfeeding
<input type="checkbox"/> I need help with breastfeeding problems
<input type="checkbox"/> I want to connect with other breastfeeding mothers for social and emotional support around breastfeeding
<input type="checkbox"/> Other (please specify) _____
  
3. We would like to know if we are reaching families who are part of the [REDACTED] Health Centre's priority populations. (please check all that apply)
 

<input type="checkbox"/> Living on limited income
<input type="checkbox"/> Living in unstable housing
<input type="checkbox"/> Recent immigrant with language barriers
<input type="checkbox"/> Lack of parenting social supports (e.g. family, friends, neighbours, community groups)
<input type="checkbox"/> Living with disabilities that affect health and wellness
  
4. What is your age?
 

<input type="checkbox"/> 15 – 20	<input type="checkbox"/> 21 – 25	<input type="checkbox"/> 26 – 30	<input type="checkbox"/> 31 – 35	<input type="checkbox"/> 36 – 40	<input type="checkbox"/> 40+
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5. What is your highest level of formal education?
 

<input type="checkbox"/> Grade 9 – 12	<input type="checkbox"/> College	<input type="checkbox"/> University
---------------------------------------	----------------------------------	-------------------------------------
  
6. What is your family composition?
 

<input type="checkbox"/> Two-parent family	<input type="checkbox"/> Single-parent family
<input type="checkbox"/> Other family members live me (e.g., parent, aunt, uncle, etc.)	
  
7. This pilot program needs to be evaluated to determine if it will continue.  
 May we contact you in the future to participate in an evaluation? ☐ Yes ☐ No

**Thank you for coming today and for sharing this information!**

**Demographic Data****Personal Information**

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NameAge

---

Please check your responses to the below questions.

1. I am currently pregnant:

☐ YES☐ NO (go to question #5)

2. If you are pregnant:

How many weeks are you? \_\_\_\_\_

3. If you are pregnant:

Have you made a decision about feeding your baby?

☐ YES☐ NO (go to question #5)

4. If you have made a decision about feeding your baby:

How will you feed your baby?

☐ Breastfeed☐ Formula☐ Combination (breastfeed and formula)

5. I have children:

☐ YES☐ NO (go to question #10)

6. If you have children:

How old are each of your children?

---

## Breastfeeding Program Sample Evaluation Forms

### Demographics (Mothers): General 1

7. Did you breastfeed your youngest child for any amount of time?

☐ YES

☐ NO

If yes, how long did you breastfeed your youngest child? \_\_\_\_\_

8. Were you discharged home from the hospital together with your youngest child?

☐ YES

☐ NO

If no, why? (example: baby kept in hospital; baby stayed with foster parent, etc.)

---

9. If you have other children, did you breastfeed them for any amount of time?

☐ YES

☐ NO

If yes, how long? \_\_\_\_\_

10. What is your relationship status? (please check one).

☐ Single

☐ Dating

☐ Married or common law

☐ Other (describe) \_\_\_\_\_

11. What is your level of education? (please check one)

☐ No high school

☐ Some high school

☐ High school completed

☐ Some college and/or university courses taken

☐ College diploma and/or university degree completed

12. Where do you live?

☐ [REDACTED]

☐ With parent(s)

☐ In own apartment or house

☐ With partner (boyfriend, fiancé)

13. With how many people do you live?

---

14. How many people that you live with are 18 years or older?

---

**THANK YOU!**

**Demographic Data**

NOTE: This Demographic Data Form is designed as a pop-up survey to evaluate an online resource.

1. In what year were you born? \_\_\_\_\_
  2. How many adults live in your household? \_\_\_\_\_
  3. What was your total household income before taxes last year?
    - ☐ Less than \$19,999
    - ☐ \$20,000 to \$39,999
    - ☐ \$40,000 to \$59,999
    - ☐ \$60,000 to \$79,999
    - ☐ \$80,000 to \$99,999
    - ☐ \$100,000 or more
  4. What is the highest level of education you achieved?
    - ☐ No high school
    - ☐ Some high school
    - ☐ High school completed
    - ☐ Some college and/or university courses taken
    - ☐ College diploma and/or university degree completed
  5. How old is your baby? \_\_\_\_\_ months
  6. How are you feeding your baby?
    - ☐ Breastfeeding
    - ☐ Formula
    - ☐ Combination of breastfeeding and formula
  7. [REDACTED] helped me to find out about breastfeeding resources in [REDACTED].
    - ☐ Strongly Agree
    - ☐ Agree
    - ☐ Neutral
    - ☐ Disagree
    - ☐ Strongly Disagree
  8. [REDACTED] was easy to use.
    - ☐ Agree
    - ☐ Neutral
    - ☐ Disagree
    - ☐ Strongly Disagree
  9. I would recommend [REDACTED] to my family/friends.
    - ☐ Agree
    - ☐ Neutral
    - ☐ Disagree
    - ☐ Strongly Disagree
  10. Any other comments or feedback about [REDACTED] ? \_\_\_\_\_
-

## Focus Group Questions

### Introduction

Thank you for your interest in joining this group discussion. I am looking at ways to help young mothers start or continue breastfeeding. Your ideas, thoughts, and/or information can be helpful for other mothers. I am also interested in your ideas about a mom-to-mom breastfeeding support group.

Participate as you would like. You do not have to answer any questions that you do not feel comfortable answering. I have some paper here if you would like to write down your ideas – you can speak to me after the group discussion. There are no right or wrong ideas; we value everyone's opinion and ideas. Please be respectful to each other even if you have a different idea.

The information you share will be confidential within this group and within the study. When we share information learned from these group discussions your name or identifying information will not be revealed.

To thank you for participating, you will receive a \$10 gift certificate. Are there any questions before we get started?  
[participants to sign consent form]

### Questions

#### Clients who are postpartum and/or have previous breastfeeding experience:

1. Tell me about your breastfeeding experiences?  
*(Prompt: How long did you breastfeed? What do you enjoy about breastfeeding? What did you least enjoy about breastfeeding?)*
2. What do you wish you had known about breastfeeding before your baby was born?  
*(Prompt: What information should be covered in prenatal classes?)*
3. What is a critical time of support for breastfeeding youth?  
*(Prompt: If your baby weaned, what would have helped you continue breastfeeding?)*
4. If you had questions or encountered challenges, who or what did you turn to for support or answers?  
*(Prompt: What helped you during difficult times?)*
5. What is the best way to promote breastfeeding programs to youth?  
*(Prompt: Prenatal breastfeeding classes, mom-to-mom breastfeeding support groups?)*
6. If a mom-to-mom breastfeeding support program was developed, what should it look like?

#### Clients who are pregnant:

1. Have you heard about breastfeeding?  
*(Prompt: From whom? From what resource?)*
2. What are your thoughts on breastfeeding?
3. Where do you get your information about breastfeeding?
4. Have you made any decision about breastfeeding?
5. What is your exposure to breastfeeding?  
*(Prompt: Your mother, family, friend, other)*

#### All clients:

We are planning to design a program about breastfeeding for young adults, and we are looking for your advice/input as to what this should look like.

1. What do you think we should include?
2. How many sessions?
3. How should we deliver the information?  
*(Prompt: How would you like to learn the information: Class? Peer? Family? Social media? Other?)*
4. What are the challenges of breastfeeding?
  - a. How can these be improved before delivery, in the hospital, once home?  
*(Prompt: What are some potential solutions?)*
5. From your perspective what are the benefits of breastfeeding?

**Thank you**

## Focus Group Questions

### Introduction

- Welcome, and thank participants.
- Introduce facilitator and project members.
- Housekeeping.  
Review locations of amenities, food/snacks, childcare, breastfeeding friendly area, etc.).
- Consent.
- Review the participant information sheet.  
Read the participant information sheet aloud.
- Discuss confidentiality and risk.
- Discuss **duty to report**.
- Invite questions from participants.
- Outline format for the session  
The format is a discussion followed by a questionnaire.

### Primary Question

- Tell me about your experience with breastfeeding.

### Prompting Questions

- The facilitator will use open-ended prompting techniques to elicit responses to the following questions:
  - What factors or people were helpful to you in your experience with breastfeeding?
  - What factors or people were not helpful to you in your experience with breastfeeding?
  - What changes can this community make so that women have better breastfeeding experiences?

**██████████: Evaluation****Thank you for attending the ██████████!**

Please take some time to fill out the following evaluation. The information we collect will help us better understand who is using our services and will help us evaluate the café so we can provide better service to you.

1. How did you hear about ██████████? (please check all that apply):
 

<input type="checkbox"/> Family/Friend	<input type="checkbox"/> Ontario Early Years Centre
<input type="checkbox"/> ██████████ website	<input type="checkbox"/> ██████████ Hospital
<input type="checkbox"/> Midwife	<input type="checkbox"/> Doctor/Nurse Practitioner
<input type="checkbox"/> Pamphlet/Flyer	<input type="checkbox"/> Other (please specify) _____
2. Are you currently pregnant?
 

<input type="checkbox"/> Yes	<input type="checkbox"/> No
------------------------------	-----------------------------
3. Are you currently breastfeeding?
 

<input type="checkbox"/> Yes	<input type="checkbox"/> No
------------------------------	-----------------------------
4. Please check why you came to the ██████████: (check all that apply)
 

<input type="checkbox"/> I wanted more information about breastfeeding.
<input type="checkbox"/> I needed help with breastfeeding problems.
<input type="checkbox"/> I wanted to meet and learn from other breastfeeding mothers.
<input type="checkbox"/> I was looking for more breastfeeding resources in the community.
<input type="checkbox"/> Other (please specify) _____
5. We would like to know who we are reaching with our café. (Check all that apply to you).
 

<input type="checkbox"/> I am living on a limited income (i.e., I have had to visit a food bank; I sometimes don't have money for rent).
<input type="checkbox"/> I am living in unstable housing (i.e., I am on a waiting list for housing and/or I have stayed at a shelter).
<input type="checkbox"/> I am new to Canada (i.e., I have lived in Canada for 10 years or less).
<input type="checkbox"/> English is my second language. What language do you speak most often at home? _____
<input type="checkbox"/> I don't have many social supports (e.g., family, friends, neighbours, and/or community groups).
6. What is your age:
 

<input type="checkbox"/> 15 – 20	<input type="checkbox"/> 21 – 25	<input type="checkbox"/> 26 – 30	<input type="checkbox"/> 31 – 35	<input type="checkbox"/> 36 – 40	<input type="checkbox"/> 41 and over
----------------------------------	----------------------------------	----------------------------------	----------------------------------	----------------------------------	--------------------------------------
7. What is your highest level of education completed?
 

<input type="checkbox"/> High school	<input type="checkbox"/> College	<input type="checkbox"/> University	<input type="checkbox"/> Other
--------------------------------------	----------------------------------	-------------------------------------	--------------------------------
8. What is your postal code? \_\_\_\_\_
9. Do you currently smoke?
 

<input type="checkbox"/> Yes	<input type="checkbox"/> No
------------------------------	-----------------------------
10. What does your family look like?
 

<input type="checkbox"/> Two-parent family	<input type="checkbox"/> Other family members live with me (e.g., parent, aunt, uncle, etc.)
<input type="checkbox"/> Single-parent family	<input type="checkbox"/> Other (please specify) _____



# Breastfeeding Program Sample Evaluation Forms

## Groups & Cafés (Mothers): Café Evaluation 1

11. Please indicate (✓) your level of agreement with the following questions:

Questions	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Does Not Apply
I felt welcome and accepted at the café.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The peer volunteers treated me and what I said with respect.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The peer volunteers were knowledgeable about breastfeeding.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My breastfeeding questions were answered by the peer volunteers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I would recommend this café to friends or family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. Please indicate (✓) your level of confidence with the following statements:

Statements	Yes	Same as Before	No
Since coming to this café, are you more confident in your knowledge about breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Since coming to this café, are you more confident in your ability to breastfeed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Since coming to this café, are you more confident in your ability to prevent/solve breastfeeding problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Since coming to this café, are you more aware of the community services and resources available for breastfeeding support?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. Please indicate (✓) your level of confidence with the following statements:

Statements	Yes	Same as Before	No
Since coming to this café, are you more comfortable breastfeeding your baby?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Since coming to this café, would you be more comfortable breastfeeding your baby in public (e.g., mall, car, park, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. Additional comments: \_\_\_\_\_

**Thank you for coming today and for sharing this information!**

**Breastfeeding Café Check-In**

Please tell us what you think of the café and any ideas to make it better – we want to make it the best it can be!  
(Your information will be kept anonymous and confidential and used only to evaluate this program.)

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

Today's café provided me:

- With the information I needed.

- ☐ strongly agree
- ☐ somewhat agree
- ☐ not sure
- ☐ disagree
- ☐ strongly disagree

Comments: \_\_\_\_\_

- With the social support I needed.

- ☐ strongly agree
- ☐ somewhat agree
- ☐ not sure
- ☐ disagree
- ☐ strongly disagree

Comments: \_\_\_\_\_

- With the additional skills I needed.

- ☐ strongly agree
- ☐ somewhat agree
- ☐ not sure
- ☐ disagree
- ☐ strongly disagree

Comments: \_\_\_\_\_

1. The most valuable part of today's café for me was: \_\_\_\_\_

\_\_\_\_\_

2. One thing I would change is: \_\_\_\_\_

\_\_\_\_\_

**Thank you for your input!**

**██████████: Breastfeeding Group Meeting Evaluation**

1. Welcome! Is this your first time at ██████████?

☐ Yes

☐ No

2. If this was your first meeting, did the meeting cover the kind of information you expected and needed?

☐ Yes

☐ No

Comments? \_\_\_\_\_

3. If you have attended more than one meeting, have the meetings covered the kind of information you expected and needed?

☐ Yes

☐ No

Comments? \_\_\_\_\_

4. Tell us how the meeting helped you.

Please rate each response below: 1 (no help at all) . . 2 . . 3 . . 4 . . 5 (very helpful)

\_\_\_ The meeting gave me support from other breastfeeding mothers.

\_\_\_ The meeting gave me breastfeeding information I did not have.

\_\_\_ The meeting gave me a safe place to ask questions.

\_\_\_ The meeting helped me understand where to get more breastfeeding information.

\_\_\_ other? Explain: \_\_\_\_\_

5. Before attending ██████████ meetings, how long did you think you would breastfeed?

Please check (✓) one response:

☐ 0 – 3 months

☐ 4 – 6 months

☐ 7 months – 1 year

☐ Over 1 year

6. Now, having attended meetings, how long do you hope to breastfeed?

Please check (✓) one response:

☐ Same as before OR

☐ 3 – 6 months

☐ 6 months – 1 year

☐ Over 1 year

7. Please list one new thing you learned about breastfeeding today:

\_\_\_\_\_

8. We would like to know if we are reaching ██████████ CHC's/██████████ priority populations.

Please check (✓) all that apply to you:

☐ I am living on a limited income.

☐ I am living in unstable housing (on a waiting list for housing or staying at a shelter).

☐ I am new to Canada (10 years or less).

☐ I am a single parent.

☐ I lack social supports (not enough friends, family, or helpful neighbours).

☐ I am living with disabilities that affect my health and wellness.

## Breastfeeding Program Sample Evaluation Forms

### Groups & Cafés (Mothers): Group Evaluation 1

9. Which languages do you speak at home?

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10. What is the highest level of school you completed?

---

11. What is one thing you would change about this meeting or group?

---

**Thank YOU!**

## Breastfeeding Program Sample Evaluation Forms

### Groups & Cafés (Mothers): Group Evaluation 2A

**Thank you for coming to [REDACTED]!**

[REDACTED] is interested in learning how you feel about breastfeeding. Please take a few minutes to complete this survey. Your answers will be kept private.

Today's date: \_\_\_\_\_

Please tell us how you feel about each of the following statements.

<b>Breastfeeding Statements:</b>	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
I am confident that I can use different strategies to have a positive breastfeeding experience.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know when to seek help for a breastfeeding problem.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am confident that I could access in-person breastfeeding support through [REDACTED].	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know where to go for trustworthy breastfeeding information.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can confidently talk about breastfeeding with my friends or family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Thank you!**

# Breastfeeding Program Sample Evaluation Forms

## Groups & Cafés (Mothers): Group Evaluation 2B

**Thank you for attending [REDACTED]!**

[REDACTED] is interested in learning about your experience with [REDACTED]. Please take a few minutes to complete this survey. Your answers will be kept private.

How many [REDACTED] sessions did you attend? \_\_\_\_\_

Please tell us how you feel about each of the following statements.

<b>Breastfeeding Statements:</b>	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
I am confident that I can use different strategies to have a positive breastfeeding experience.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know when to seek help for a breastfeeding problem.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am confident that I could access in-person breastfeeding support through [REDACTED].	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know where to go for trustworthy breastfeeding information.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can confidently talk about breastfeeding with my friends or family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Since attending [REDACTED], I feel more supported in my breastfeeding journey.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Since attending [REDACTED], I feel more confident breastfeeding my child.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Overall, I found the [REDACTED] group to be:

☐ Poor ☐ Fair ☐ Good ☐ Excellent

What is the most important thing you have learned throughout [REDACTED]?

---

---

What can be improved for future [REDACTED] sessions?

---

---

**Thank you**

## Breastfeeding Group Support

### **██████████ Postnatal and Breastfeeding Support Group**

1. Have you been to ██████████ Postnatal and Breastfeeding Support Group?

Please check one box.

- ☐ Yes.  
☐ No.  
☐ Not yet, but I plan to go.

2. What did you like most about ██████████ Postnatal and Breastfeeding Support Group?

Please check one box.

- ☐ Information from an expert (example, public health nurse, lactation consultant, etc.).  
☐ Traditional teaching (example, elder).  
☐ Talking with other mothers.  
☐ Traditional opening (smudge, drumming, and prayer).  
☐ Handouts (example, flyers, resource kits, etc.).  
☐ Food provided.  
☐ Other (please describe). \_\_\_\_\_

3. The group provides some breastfeeding information and support. Which statement do you agree with?

Please check one box.

- ☐ Too much breastfeeding information or support.  
☐ The right amount of breastfeeding information or support.  
☐ Not enough breastfeeding information or support.

4. Please let us know how we can give better breastfeeding support.

\_\_\_\_\_

5. How much did ██████████ Postnatal and Breastfeeding Support Group change your confidence in your ability to breastfeed?

Please check one box.

- ☐ Increased my confidence a lot.  
☐ Increased my confidence a little.  
☐ No change.  
☐ Decreased my confidence a little.  
☐ Decreased my confidence a lot.

**Thank you**

## Breastfeeding Group Support

**Pregnancy Circle**

1. Did you participate in the  Pregnancy Circle? Please check one box.

☐ Yes.

☐ No.

2. At the  Pregnancy Circle, breastfeeding information was given in several presentation styles. Please let us know how helpful you found each presentation style. Please check one circle beside each statement.

<b>Presentation Style:</b>	<b>Very helpful</b>	<b>Somewhat helpful</b>	<b>Not very helpful</b>	<b>Not at all helpful</b>
Information provided by the public health nurse.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Traditional teaching.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Breastfeeding demonstration.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Handouts (example, handouts, pamphlets, etc.).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other presentation style (specify): _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. How can we improve the way we give breastfeeding information at the  Pregnancy Circle?

Please check all statements that you agree with.

☐ I liked the way it was done, don't change a thing.

☐ I would have liked more videos.

☐ I would have liked more hands-on practice (example, a baby doll for practicing breastfeeding positions).

☐ I would have liked more traditional teachings.

☐ I would have liked more live demonstrations with mothers and babies.

☐ I would have liked more group discussions.

☐ I would have liked more games or group activities.

☐ Other (please describe). \_\_\_\_\_

4. How much did the  Pregnancy Circle change your confidence in your ability to breastfeed?

Please check one box.

☐ Increased my confidence a lot.

☐ Increased my confidence a little.

☐ No change.

☐ Decreased my confidence a little.

☐ Decreased my confidence a lot.

5. Do you plan to breastfeed? Please check the box beside the statement that is most true about your plans.

☐ No.

☐ Maybe.

☐ Yes, I plan to breastfeed.

☐ Yes, and I am already breastfeeding.

**Thank you**



## **Breastfeeding Support Group at [REDACTED] Pilot Project Final Evaluation**

### **Introduction**

Thank you for participating in this very successful pilot project for our breastfeeding support group. Your assistance in filling out the client feedback forms on a regular basis has been beneficial in helping us examine the success of this program.

The focus of today's session is to ask you a few questions about how you like the program and how we could make it better. The goal of this evaluation is to give us information that will help us sustain the breastfeeding support group.

#### **1. Promotion**

- How did you hear about the program?
- Do you have any other ideas of how we can better promote the program?
- Where do you frequently visit in the community that we should promote/advertise the program?
- Was the way we promoted the program adequate?
- Was the program advertised in the right language and mode?  
(e.g., Do we need to advertise with different content, different language, and/or different methods?)

#### **2. Process:**

- How did you find the registration/greeting when you first entered the meeting room each week?
- Do you have suggestions to make registration/greeting process better?
- How did you find the weekly group facilitation/process?
- How did you find guest speakers?
- Do you have suggestions for other guest speaker/topics?
- Is there anything you would like to add to the program? Is there anything you think could be done differently in the program?
- Did you use the one-on-one breastfeeding support/counselling?
- If you used the one-on-one breastfeeding support/counselling:
  - How was this experience for you?
  - What would you recommend to make it better?
- Were you referred to other community resources?
- If you referred to other community resources:
  - Which community resource were you referred to?
  - Did you attend the community resource?
- How did you find the weekly snacks, and do you have recommendations about the weekly snacks?
- Did you use the available interpretation services?
- If you used the interpretation services:
  - How was this experience for you?
  - Were you able to actively participate in the group discussions each week?

#### 3. Outcome

This question will help us to measure breastfeeding confidence/knowledge, increased initiation, increased exclusivity, and increased duration.

- Do you feel more confident/knowledgeable to breastfeed as a result of attending the group?
  - Please explain why or why not. What makes you feel more confident?
- Have you been breastfeeding longer than initially planned as a result of attending this group?
- Do you plan to continue to breastfeed for longer than initially expected as a result of attending this group?
- Do you think that you are more likely to exclusively (only) breastfeed your child/children as a result of attending this group? Why or why not?
- What are some tips/suggestions that you would like to share with other mothers who have not attended the Breastfeeding Support Group?

- Breastfeeding Café: Weekly Log

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

Topics Addressed	Notes/Discussions
<input type="checkbox"/> Benefits of Breastfeeding	
<input type="checkbox"/> Biting/Teething	
<input type="checkbox"/> Birth Experience	
<input type="checkbox"/> Breastfeeding in Public	
<input type="checkbox"/> Co-sleeping/Sleeping Patterns	
<input type="checkbox"/> Diet (maternal)	
<input type="checkbox"/> Duration (How long should I BF?)	
<input type="checkbox"/> Emotional Concerns (PPD, anxiety)	
<input type="checkbox"/> Expressing/Storage of Human Milk	
<input type="checkbox"/> Fatigue (maternal)	
<input type="checkbox"/> Feeding Patterns/Norms	
<input type="checkbox"/> Fussy Baby/Colic	
<input type="checkbox"/> Milk Supply	
<input type="checkbox"/> Nursing Strike/Breast Refusal	
<input type="checkbox"/> Position and Latch	
<input type="checkbox"/> Pregnancy	
<input type="checkbox"/> Return to Work/School	
<input type="checkbox"/> Siblings	
<input type="checkbox"/> Sleepy Baby (how to wake)	
<input type="checkbox"/> Sore Nipples (care of)	
<input type="checkbox"/> Sore Breasts	
<input type="checkbox"/> Solid Foods (baby)	
<input type="checkbox"/> Soothers/Thumb sucking	
<input type="checkbox"/> Supplementation	
<input type="checkbox"/> Support/Stress	
<input type="checkbox"/> Tandem Feeding	
<input type="checkbox"/> Weaning	
<input type="checkbox"/> Other	

## Breastfeeding Program Sample Evaluation Forms

### Groups & Cafés (Volunteers): Café Evaluation 1

1. Links/referrals to community resources: \_\_\_\_\_  
\_\_\_\_\_
2. Follow up: \_\_\_\_\_  
\_\_\_\_\_
3. Resources distributed: \_\_\_\_\_  
\_\_\_\_\_
4. Requests/ideas for future topics: \_\_\_\_\_  
\_\_\_\_\_
5. Facilitator comments (what worked, what didn't, changes needed, comments for next week's facilitators, etc.):  
\_\_\_\_\_
6. Log completed by: \_\_\_\_\_

# Breastfeeding Program Sample Evaluation Forms

Groups & Cafés (Volunteers): Group Attendance 1

## ██████████: SIGN-IN SHEET

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

Thank you for completing this form which provides ██████████ with statistics that are used only for service planning purposes.  
All information is kept confidential.

	Adult (PRINT first & last names)	Infant/Child (If attending with more than one child, please list one name per line)	CHECK (√) IF THIS IS YOUR FIRST VISIT (Fill Registration Form)	Age of Infant/Child	Pregnant? Due Date
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					

# Breastfeeding Program Sample Evaluation Forms

## Peer Support Programs (Mothers): Group Evaluation 1

### **[REDACTED]: Evaluation**

**Thank you for taking time to evaluate the [REDACTED] program!**

The information we collect here will help us better understand who is using our services and will help us evaluate the [REDACTED] program so we can provide better service to you.

1. How did you hear about the [REDACTED] program?

Please check all that apply:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Family/friend       | <input type="checkbox"/> Doctor/Nurse Practitioner  | <input type="checkbox"/> Midwife              |
| <input type="checkbox"/> [REDACTED] website  | <input type="checkbox"/> Ontario Early Years Centre | <input type="checkbox"/> [REDACTED] volunteer |
| <input type="checkbox"/> [REDACTED] Hospital | <input type="checkbox"/> Pamphlet/flyer             | <input type="checkbox"/> Other: _____         |

2. Why did you become involved with the [REDACTED] program?

Please check all that apply:

- ☐ I wanted more information about breastfeeding.  
☐ I needed help with breastfeeding problems.  
☐ I wanted to meet and learn from other breastfeeding mothers.  
☐ I was looking for more breastfeeding resources in the community.  
☐ Other: \_\_\_\_\_

3. We would like to know who we are reaching with the [REDACTED] program.

Please check all that apply:

- ☐ I am living on a limited income (i.e., I have used the food bank and/or paying bills is sometimes hard).  
☐ I am living in unstable housing (i.e., I am on a waiting list for housing and/or I have stayed at a shelter).  
☐ I am new to Canada (i.e., I have lived in Canada for 10 years or less).  
☐ English is my second language.

What language do you speak most often at home? \_\_\_\_\_

- ☐ I do not have many social supports (e.g., family, friends, neighbours, and/or community groups).  
☐ None of the above apply to me.

4. What is your age?

Please check one:

- |                                  |                                  |                                      |
|----------------------------------|----------------------------------|--------------------------------------|
| <input type="checkbox"/> 15 – 20 | <input type="checkbox"/> 21 – 25 | <input type="checkbox"/> 26 – 30     |
| <input type="checkbox"/> 31 – 35 | <input type="checkbox"/> 36 – 40 | <input type="checkbox"/> 41 or older |

5. What is your highest level of education completed?

Please check one:

- ☐ High School  
☐ College  
☐ University  
☐ Other: \_\_\_\_\_

6. What is your postal code? \_\_\_\_\_

7. What does your family look like?

Please check one:

- ☐ Two-parent family  
☐ Single-parent family  
☐ Other: \_\_\_\_\_

## 8. Are you currently breastfeeding?

Please check one:

- ☐ Yes (My baby is receiving only breastmilk).  
☐ Yes (My baby receives breastmilk and also some formula/other).  
☐ No (I stopped breastfeeding when my baby was \_\_\_\_\_ months old).

## 9. Please indicate (✓) your level of agreement with the following statements:

Statements	Yes	No	Comments (optional)
I feel/felt comfortable talking with the [REDACTED] volunteer.	<input type="checkbox"/>	<input type="checkbox"/>	
The [REDACTED] volunteer treated me and what I said with respect.	<input type="checkbox"/>	<input type="checkbox"/>	
The [REDACTED] volunteer was knowledgeable about breastfeeding.	<input type="checkbox"/>	<input type="checkbox"/>	
My breastfeeding questions were answered by the [REDACTED] volunteer.	<input type="checkbox"/>	<input type="checkbox"/>	
I would recommend this breastfeeding support to friends or family.	<input type="checkbox"/>	<input type="checkbox"/>	
Overall, I felt supported by my [REDACTED] volunteer.	<input type="checkbox"/>	<input type="checkbox"/>	

## 10. Please indicate (✓) your level of confidence with the following questions:

Questions	Yes	No
Do you feel more confident in your knowledge about breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel more confident in your ability to breastfeed?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel more confident in your ability to prevent or solve breastfeeding problems?	<input type="checkbox"/>	<input type="checkbox"/>
Are you more aware of the community services and resources available for breastfeeding support?	<input type="checkbox"/>	<input type="checkbox"/>

## 11. Please indicate (✓) your level of comfort with the following questions:

Questions	Yes	No
Do you feel more comfortable breastfeeding your baby?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel more comfortable breastfeeding your baby in public (i.e., mall, groups, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>

## 12. Additional comments: \_\_\_\_\_

**Thank you for sharing your [REDACTED] experiences.**

**Your input will help us to shape our breastfeeding program for future mothers during their breastfeeding journey!**

# Breastfeeding Program Sample Evaluation Forms

## Peer Support Programs (Mothers): Workshop Evaluation 2A

### Workshop

#### Mother Pre-Evaluation

Date

Family Number

Welcome to the Workshop.

Please take some time to fill out the following form before the workshop begins. The information we collect will help us better understand who is using our services and will help us evaluate the workshop so that we can provide better service to you. After the workshop, you will be given an opportunity to provide feedback on the event.

1. How did you hear about the Workshop? Please check all that apply.

<input type="checkbox"/> Family/friend	<input type="checkbox"/> Ontario Early Years Centre
<input type="checkbox"/> website	<input type="checkbox"/> Hospital
<input type="checkbox"/> Midwife	<input type="checkbox"/> Doctor/Nurse Practitioner
<input type="checkbox"/> Pamphlet/flyer	<input type="checkbox"/> Other _____
2. Tell us why you came to the Workshop. Please check all that apply.

<input type="checkbox"/> I want more information about breastfeeding.
<input type="checkbox"/> I need help with breastfeeding problems.
<input type="checkbox"/> I want to meet and learn from other breastfeeding mothers.
<input type="checkbox"/> I am looking for more breastfeeding resources in the community.
<input type="checkbox"/> Other (please specify) _____
3. Who did you attend the workshop with today? Please check all that apply.

<input type="checkbox"/> Partner	<input type="checkbox"/> Friend
<input type="checkbox"/> Parent	<input type="checkbox"/> Other _____
<input type="checkbox"/> Relative	<input type="checkbox"/> I didn't bring anyone
4. What trimester of pregnancy are you currently in? Please check only one box.

<input type="checkbox"/> 1 <sup>st</sup> trimester	<input type="checkbox"/> 2 <sup>nd</sup> trimester	<input type="checkbox"/> 3 <sup>rd</sup> trimester
--	--	--
5. What health care provider do you see most often during your pregnancy? Please check all that apply.

<input type="checkbox"/> Doctor	<input type="checkbox"/> Obstetrician
<input type="checkbox"/> Midwife	<input type="checkbox"/> Other _____
6. We would like to know who we are reaching with our workshops. Please check all that apply to you.

<input type="checkbox"/> I am living on a limited income (e.g., I have had to visit a food bank; I sometimes don't have money for rent).
<input type="checkbox"/> I am living in unstable housing (e.g., I am on a waiting list for housing; I have stayed at a shelter).
<input type="checkbox"/> I am new to Canada (i.e., I have lived in Canada for 10 years or less).
<input type="checkbox"/> English is my second language. What language do you speak most often at home? _____
<input type="checkbox"/> I don't have many social supports (e.g., family, friends, neighbours, community groups).
7. What is your age? Please check only one box.

<input type="checkbox"/> 15 – 20	<input type="checkbox"/> 21 – 25	<input type="checkbox"/> 26 – 30
<input type="checkbox"/> 31 – 35	<input type="checkbox"/> 36 – 39	<input type="checkbox"/> 40 or older



# Breastfeeding Program Sample Evaluation Forms

## Peer Support Programs (Mothers): Workshop Evaluation 2A

8. What is your highest level of school completed? Please check only one box.

☐ High school

☐ College

☐ University

☐ Other \_\_\_\_\_

9. What is your postal code?

\_\_\_\_\_

10. Do you currently smoke? Please check only one box.

☐ Yes

☐ No

11. What is your family composition (i.e., who makes up your family)? Please check only one box.

☐ Two-parent family

☐ Single-parent family

☐ Other family members live with me (e.g., parent, aunt, uncle, etc.)

☐ Other \_\_\_\_\_

12. Have you breastfed a child before? Please check only one box.

☐ Yes (for how long) \_\_\_\_\_

☐ No

13. Do you plan to breastfeed? Please check only one box.

☐ Yes

☐ No

☐ Unsure

14. Please indicate your level of agreement with the following statements. Check only one box for each statement.

STATEMENT	Strongly Agree	Agree	Disagree	Strongly Disagree
I am confident in my knowledge about breastfeeding.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am confident in my ability to breastfeed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am confident in my ability to prevent/solve breastfeeding problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15. Please indicate your level of comfort with the following questions. Check only one box for each question.

QUESTION	Very Comfortable	Comfortable	A little Comfortable	Not Comfortable
How comfortable are/would you be breastfeeding your baby?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How comfortable are/would you be breastfeeding your baby in public (e.g., mall, restaurant, park, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. Do you know where to go for breastfeeding support/resources in the community? Please check only one box.

☐ Yes

☐ No

☐ Unsure

17. What are your concerns about breastfeeding?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Thank you for coming today and for sharing this information!**

# Breastfeeding Program Sample Evaluation Forms

## Peer Support Programs (Mothers): Workshop Evaluation 2B

### **Workshop** Mother Post-Evaluation

Date	Family Number
Facilitator(s)	Demo Mother

Thank you for participating in the **Workshop**.

We are gathering information to look at ways to improve our workshop and would appreciate your feedback. Please take a few minutes to fill out this feedback form.

Your opinion is important to us and will help us provide better service to you in the future.

1. Please indicate your level of agreement with the following statements. Check only one box for each statement.

STATEMENT	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Does Not Apply
I felt welcome and accepted at the workshop.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The facilitators treated my partner (if applicable) and me as well as what we said with respect.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There were opportunities for me to participate in the workshop.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My breastfeeding questions were answered by the facilitators.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The facilitators were knowledgeable about breastfeeding.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I would recommend this workshop to friends or family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. The workshop had many different activities. We would like to know what activities you found the most helpful. Please indicate how you feel about the following activities. Check only one box for each activity.

ACTIVITY	Helpful	Not Helpful	Neutral	Comments
Talking about/brainstorming breastfeeding myths and why breastfeeding is normal.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Practice latching with demonstration dolls.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Talking about the first seven days after birth.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Matching breastfeeding problems to solutions (using activity cards).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Live breastfeeding demonstration.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

## Breastfeeding Program Sample Evaluation Forms

### Peer Support Programs (Mothers): Workshop Evaluation 2B

3. Since coming to this workshop, do you plan to breastfeed? Please check only one box.
- ☐ Yes ☐ No ☐ Unsure

4. Since coming to this workshop, do you know where to go for breastfeeding support/resources in the community? Please check only one box.
- ☐ Yes ☐ No ☐ Unsure

5. Please indicate your level of agreement with the following statements. Check only one box for each statement.

STATEMENT	Strongly Agree	Agree	Disagree	Strongly Disagree
Since coming to this workshop, I am confident in my knowledge about breastfeeding.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Since coming to this workshop, I am confident in my ability to breastfeed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Since coming to this workshop, I am confident in my ability to prevent/solve breastfeeding problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Please indicate your level of comfort with the following questions: Check only one box for each question.

QUESTION	Very Comfortable	Comfortable	A little Comfortable	Not Comfortable
Since coming to this workshop, how comfortable are/would you be breastfeeding your baby?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Since coming to this workshop, how comfortable are/would you be breastfeeding your baby in public (e.g., mall, restaurant, park, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Two new things I learned in this workshop are:

---



---

8. Would you be interested in a FREE follow-up workshop (to discuss specific problems, introduction of solid foods, etc.) once you have had your baby? Please check only one box.

☐ Interested ☐ Not Interested ☐ Unsure

9. Things I wish we had learned more about are:

---



---

10. Do you have other comments or suggestions?

---



---



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**Thank you for coming today and for sharing this information!**

# Breastfeeding Program Sample Evaluation Forms

## Peer Support Programs (Mothers): Workshop Evaluation 2C

### **Workshop** Partner/Parent/Relative/Friend Pre-Evaluation

Date

Family Number

Welcome to the **Workshop**.

Please take some time to fill out the following form before the workshop begins. The information we collect will help us better understand who is using our services and will help us evaluate the workshop so that we can provide better service to you. After the workshop, you will be given an opportunity to provide feedback on the event.

1. Who did you attend the workshop with today? Please check all that apply.

- ☐ Partner  
☐ Child  
☐ Relative

- ☐ Friend  
☐ Other

2. Please indicate your level of agreement with the following statements. Check only one box for each statement.

STATEMENT	Strongly Agree	Agree	Disagree	Strongly Disagree
I am confident in my knowledge about breastfeeding.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am confident in my ability to support my partner/child/relative/friend with breastfeeding.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Please indicate your level of comfort with the following question. Check only one box.

QUESTION	Very Comfortable	Comfortable	A little Comfortable	Not Comfortable
How comfortable would you be if your partner/child/relative/friend breastfed their baby in public (e.g., mall, restaurant, park, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Do you know where to go for breastfeeding support/resources in the community? Please check only one box.

- ☐ Yes ☐ No ☐ Unsure

5. What are your concerns about breastfeeding?

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**Thank you for coming today and for sharing this information!**

# Breastfeeding Program Sample Evaluation Forms

## Peer Support Programs (Mothers): Workshop Evaluation 2D

### **Workshop** Partner/Parent/Relative/Friend Post-Evaluation

Date	Family Number
Facilitator(s)	Demo Mother

Thank you for participating in the **Workshop**.

We are gathering information to look at ways to improve our workshop and would appreciate your feedback. Please take a few minutes to fill out this feedback form.

Your opinion is important to us and will help us provide better service to you in the future.

1. Please indicate your level of agreement with the following statements. Check only one box for each statement.

STATEMENT	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Does Not Apply
I felt welcome and accepted at the workshop.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The facilitators treated my partner (if applicable) and me as well as what we said with respect.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There were opportunities for me to participate in the workshop.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My breastfeeding questions were answered by the facilitators.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The facilitators were knowledgeable about breastfeeding.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I would recommend this workshop to friends or family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. The workshop had many different activities. We would like to know what activities you found the most helpful. Please indicate how you feel about the following activities. Check only one box for each activity.

ACTIVITY	Helpful	Not Helpful	Neutral	Comments
Talking about/brainstorming breastfeeding myths and why breastfeeding is normal.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Practice latching with demonstration dolls.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Talking about the first seven days after birth.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Matching breastfeeding problems to solutions (using activity cards).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Live breastfeeding demonstration.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

## Breastfeeding Program Sample Evaluation Forms

### Peer Support Programs (Mothers): Workshop Evaluation 2D

3. Since coming to this workshop, do you know where to go for breastfeeding support/resources in the community? Please check only one box.

☐ Yes

☐ No

☐ Unsure

4. Please indicate your level of agreement with the following statements. Check only one box for each statement.

STATEMENT	Strongly Agree	Agree	Disagree	Strongly Disagree
Since coming to this workshop, I am confident in my knowledge about breastfeeding.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Since coming to this workshop, I am confident in my ability to support my partner/child/relative/friend with breastfeeding.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Please indicate your level of comfort with the following question. Check only one box.

QUESTION	Very Comfortable	Comfortable	A little Comfortable	Not Comfortable
Since coming to this workshop, how comfortable would you be if your partner/child/relative/friend breastfed their baby in public (e.g., mall, restaurant, park, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Two new things I learned in this workshop are:

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7. Would you be interested in a FREE follow-up workshop (to discuss specific problems, introduction of solid foods, etc.) once you have had your baby? Please check only one box.

☐ Interested

☐ Not Interested

☐ Unsure

8. Things I wish we had learned more about are:

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9. Do you have other comments or suggestions?

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**Thank you for coming today and for sharing this information!**

# Breastfeeding Program Sample Evaluation Forms

## Peer Support Programs (Volunteers): Application Form 1

**Program Application Form**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone (home): \_\_\_\_\_

Phone (mobile): \_\_\_\_\_

Phone (work): \_\_\_\_\_

Email: \_\_\_\_\_

1. Please describe your experience with breastfeeding. Include information about how many babies you have had, how long you breastfed each baby, breastfeeding help you received, your overall feeling about your breastfeeding experiences, etc. If necessary, use the back of this page.


## Breastfeeding Program Sample Evaluation Forms

### Peer Support Programs (Volunteers): Application Form 1

2. Please tell us a bit about yourself and why you think you would be a good breastfeeding peer support volunteer at [REDACTED].


3. Please provide us with the names of two references.

Name: \_\_\_\_\_

Phone (home/mobile): \_\_\_\_\_

Name: \_\_\_\_\_

Phone (home/mobile): \_\_\_\_\_



**Breastfeeding Group**

# Peer Volunteer Application Package

Thank you for your interest in becoming a peer volunteer with the [REDACTED] Breastfeeding Group at [REDACTED]. There are three steps to follow to become a peer volunteer.

1. Complete the attached peer volunteer form.
2. Get a Police Records Check. Information for the Police Records check is provided separately.
3. Attend two training sessions (see the last page for dates & times).

**Note: Childcare and transportation are available.**

For more information, contact:

[REDACTED], program coordinator at

Return completed applications to [REDACTED] reception desk.

## Breastfeeding Program Sample Evaluation Forms

### Peer Support Programs (Volunteers): Application Form 2

#### Peer Volunteer Application Form

Name:

Address:

Phone (home):

Phone (mobile):

☐ I prefer texts

☐ I prefer phone calls/voice mail

Phone (work):

Email:

Please indicate (✓) whether you have one child or more than one child.

If you have more than one child, please fill in the blank with the number of children you have.

☐ I have one child.

☐ I have \_\_\_\_ children

If you have one child, how old is your child?

If you have more than one child, how old are your children?

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If you have one child, how long did you breastfeed your child?

If you have more than one child, how long did you breastfeed your children?

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What are your reasons for wanting to be a peer volunteer with [REDACTED] Breastfeeding Group?

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## Breastfeeding Program Sample Evaluation Forms

### Peer Support Programs (Volunteers): Application Form 2

#### Peer Volunteer Training

Date:

Time:

Place:

I will need childcare.

☐ Yes

☐ No

I will need transportation.

☐ Yes

☐ No

**Thank you**

**We look forward to seeing you at the training!**

**[REDACTED] – Volunteer Job Description**

Position Title: [REDACTED]

Status: Volunteer

**Training:**

- Attend a comprehensive training session before placement.

**Time Commitment:**

- One to four hours per week for a duration of one year.
- Time commitment may vary according to the peer volunteer's availability and choice of partnership.

**Qualifications:**

- Individual with a positive attitude and approach toward breastfeeding.
- Personal experience and breastfeeding success with a minimum six months of breastfeeding.
- Self-motivated, caring, open, and non-judgmental.
- Awareness of some of the barriers to breastfeeding (e.g., lack of breastfeeding support, young age, socially isolated, low-income, cultural barriers). Lived experience of any the barriers to breastfeeding can be an asset.
- Comfortable interacting with people from diverse backgrounds.
- Skillful with communication and outreach.
- Ability to work independently and as part of a team.

**Responsibilities:**

- Initiate contact with a pregnant or breastfeeding mother either through referral or informal community contact.
- Establish, with a pregnant or breastfeeding mother, a mutually agreeable:
  - Schedule of contact.
  - Method of contact (e.g., telephone, email, in person).
  - Place of contact (e.g. Ontario Early Years Centre, breastfeeding café, etc.).
- Provide a pregnant or breastfeeding mother with the support and information necessary to help establish and/or maintain a positive breastfeeding experience.
- Encourage a pregnant or breastfeeding mother to participate in existing community supports and resources.
- Maintain a contact log and submit monthly online data form, including course of action and/or information shared.
- Know when, and to whom, a pregnant or breastfeeding mother should be referred if her concern(s) are not within the peer volunteer's scope of training.
- Maintain contact with the with [REDACTED] coordinator and regularly attend with [REDACTED] staff meetings.
- May also provide support at a community site or event.
- May also teach a breastfeeding workshop.

**Boundaries:**

- Stay within the limits of this job description, the scope of training, and own personal/lived experiences.
- Keep information about a pregnant or breastfeeding mother and/or her family in confidence (unless required by law to report a problem).
- [REDACTED] is designed to be a telephone and/or community-site program. Home visiting is not within the scope of the peer volunteer's role.
- Practice self-care to avoid burnout from over-involvement (both emotional and time-wise)
- Keep personal and family well-being as a prime priority.


## Breastfeeding Program Sample Evaluation Forms

### Peer Support Programs (Volunteers): Job Description 1


#### Benefits to Volunteer:

- Increase breastfeeding knowledge.
- In-depth training (i.e., a 20-hour lactation management course).
- Share experiences of mothering and breastfeeding.
- Contribute to outreach project in your community.
- Meet interesting and diverse women who share breastfeeding enthusiasm.
- Expand view of the breastfeeding experience.
- Gain valuable volunteer experience.
- Develop experience toward Lactation Consultant Certification (IBCLC) or other related programs.
- Obtain a letter of reference.
- Receive satisfaction from contributing to both individual and community health.

Note: Training is Free. Details will be provided at Peer Volunteer Interview.

Application to be submitted by: 

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Training Dates: 

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#### CONTACT

Name:

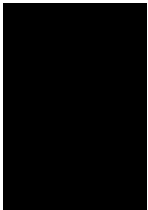
Title:

Organization:

Address:

Phone:

Email:



**Peer Leader Evaluation/Reflections**

**Training**

1. Thinking back to your peer leader training, what was the most beneficial part of your training? Should we keep this when training new peer leaders? *(Consider: topic content, time spent on topics, training format, etc.).*

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2. Thinking back to your peer leader training, what was the least beneficial part of your training? Should we keep this when training new peer leaders? *(Consider: topic content, time spent on topics, training format, etc.).*

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**Group**

1. From your perspective as a peer leader, what worked well during the Group sessions? *(Consider: What topics were participants most engaged in discussing, etc.?)*

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2. What would you change about the Group sessions to make them better? *(Consider: Uncomfortable topics? Additional topics? Format changes?)*

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3. Was it a challenge to feel connected with the participants at the Group? If so, what made it challenging?

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## Breastfeeding Program Sample Evaluation Forms

### Peer Support Programs (Volunteers): Role Evaluation Form 1

4. What type(s) of support from other organizations were most helpful to you in leading the [REDACTED] Group?

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5. What type(s) of support from other organizations could there have been more of to help you lead the [REDACTED] Group?

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6. What did you, as a peer leader, gain from this experience?

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#### Facebook

1. What works well on the Facebook page?

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2. What doesn't work well on the Facebook page?

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Would you like to be a peer leader again? Why or why not?

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**Thank you for your input!**

# Breastfeeding Program Sample Evaluation Forms

## Peer Support Programs (Volunteers): Role Evaluation Form 2

### **[REDACTED]: Evaluation**

**Thank you for evaluating the [REDACTED] program and your role as peer volunteer!**

The information we collect here will help us better understand the experiences of our peer volunteers and will help us improve our breastfeeding support services to our clients.

1. Have you been able to support your assigned breastfeeding mother?  
Please check only one box. Please add a comment to help us understand your experience.  
☐ Yes ☐ No  
Comment: \_\_\_\_\_  
\_\_\_\_\_
2. Did you feel that you could support your assigned breastfeeding mother with her breastfeeding experience?  
Please check only one box. Please add a comment to help us understand your experience.  
☐ Yes ☐ No  
Comment: \_\_\_\_\_  
\_\_\_\_\_
3. Do you feel that you were supported by the [REDACTED] staff when questions or concerns came up while providing breastfeeding support to your assigned breastfeeding mother?  
Please check only one box. Please add a comment to help us understand your experience.  
☐ Yes ☐ No  
Comment: \_\_\_\_\_  
\_\_\_\_\_
4. Has volunteering with the [REDACTED] program improved your sense of wellbeing either emotionally, mentally, and/or socially?  
Please check only one box. Please add a comment to help us understand your experience.  
☐ Yes ☐ No  
Comment: \_\_\_\_\_  
\_\_\_\_\_
5. Please share with us any thoughts or suggestions on how the [REDACTED] Community Health Centre could improve and support your role as a peer volunteer.  
Comment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
6. What is your postal code?  
\_\_\_\_\_

Thank you for sharing your peer volunteer experiences.

Your input will help shape the [REDACTED] program for other mothers during their breastfeeding journey!



# Breastfeeding Program Sample Evaluation Forms

## Peer Support Programs (Volunteers): Training Evaluation Form 1

### **██████████ Breastfeeding Training Evaluation**

1. How did you hear about the ██████████ Breastfeeding Training?

☐ Breastfeeding Café

☐ Breastfeeding Café

☐ Breastfeeding Café

☐ Other \_\_\_\_\_

2. What motivated you to come to the ██████████ Breastfeeding Training?

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3. Please provide a comment and a score (from 1 to 10 with 1 being the lowest score possible and 10 the highest score) for the following aspects of the ██████████ Breastfeeding Training.

Course Aspect	Comment	Score/10
Content		
Presentation		
Facilitation		
Resources		
Venue		
Food		
Child care		
Confidence and readiness to provide mom-to-mom breastfeeding support		

## Breastfeeding Program Sample Evaluation Forms

### Peer Support Programs (Volunteers): Training Evaluation Form 1

4. What did you like most about the training?

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5. What did you like least about the training?

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6. What was your most important learning?

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7. What else would you like to learn that would help you provide peer breastfeeding support?

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8. Other comments.

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**Thank you for completing this evaluation.**

**Your comments will be kept confidential and used to plan future training**

# Breastfeeding Program Sample Evaluation Forms

## Peer Support Programs (Volunteers): Training Evaluation Form 2

Your initials \_\_\_\_\_

### Training Survey – Day 1 (page 1)

Beside each question/statement, please put a check mark (✓) to indicate the rating that best fits your experience.

QUESTION/STATEMENT	RATING SCALE				
	1 Not Very	2	3 Neutral	4	5 Very
<b>Topic: The Value of Breastfeeding</b>					
After today's training, how familiar are you with the value of breastfeeding?					
Right now, how confident would you feel talking about the value of breastfeeding with a mother?					
After today's training, how applicable do you think this topic is to your role as a [redacted]?					
The presentation of this information was thorough and easy to follow.					
<b>Topic: The Importance of Peer Support</b>	1 Not Very	2	3 Neutral	4	5 Very
After today's training, how familiar are you with the importance of peer support?					
Right now, how confident would you feel talking with a mother about the importance of peer support?					
After today's training, how applicable do you think this topic is to your role as a [redacted]?					
The presentation of this information was thorough and easy to follow.					
<b>Topic: The Miracle of Human Milk</b>	1 Not Very	2	3 Neutral	4	5 Very
After today's training, how familiar are you with the facts about human milk?					
Right now, how confident would you feel talking with a mother about the facts of human milk?					
After today's training, how applicable do you think this topic is to your role as a [redacted]?					
The presentation of this information was thorough and easy to follow.					
<b>Topic: Getting Started</b>	1 Not Very	2	3 Neutral	4	5 Very
After today's training, how familiar are you with what you need to do to get started as a [redacted]?					
Right now, how confident do you feel getting started in your role as a [redacted]?					
How applicable do you think this topic is to your role as a [redacted]?					
The presentation of this information was thorough and easy to follow.					
<b>Topic: Facilitator</b>	1 Not Very	2	3 Neutral	4	5 Very
The facilitator was knowledgeable and well organized.					
The facilitator allowed for questions and discussion.					
The facilitator was engaging and able to keep my attention					

## Breastfeeding Program Sample Evaluation Forms

### Peer Support Programs (Volunteers): Training Evaluation Form 2

Your initials \_\_\_\_\_

#### **██████████ Training Survey – Day 1 (page 2)**

If something was missing about one of the topics presented today, what would you like more information about?

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What topics would you like to cover in upcoming ██████████ meetings?

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# Breastfeeding Program Sample Evaluation Forms

## Peer Support Programs (Volunteers): Training Evaluation Form 2

Your initials \_\_\_\_\_

### Training Survey – Day 2 (page 1)

Beside each question/statement, please put a check mark (✓) to indicate the rating that best fits your experience.

QUESTION/STATEMENT	RATING SCALE				
	1 Not Very	2	3 Neutral	4	5 Very
<b>Topic: Supporting the Breastfeeding Mother</b>					
After today's training, how familiar are you with aspects related to supporting a breastfeeding mother?					
At this time, how confident would you feel talking with a mother about what supporting her in breastfeeding involves?					
After today's training, how applicable do you think this topic is to your role as a [redacted]?					
The presentation of this information was thorough and easy to follow.					
<b>Topic: Common Challenges</b>	1 Not Very	2	3 Neutral	4	5 Very
After today's training, how familiar are you with the common challenges of breastfeeding?					
Right now, how confident would you feel talking with a mother about the common challenges of breastfeeding?					
After today's training, how applicable do you think this topic is to your role as a [redacted]?					
The presentation of this information was thorough and easy to follow.					
<b>Topic: Babies Learning to Breastfeed</b>	1 Not Very	2	3 Neutral	4	5 Very
After today's training, how familiar are you with how babies learn to breastfeed?					
Right now, how confident would you feel talking with a mother about their baby learning to breastfeed?					
After today's training, how applicable do you think this topic is to your role as a [redacted]?					
The presentation of this information was thorough and easy to follow.					
<b>Topic: Facilitator</b>	1 Not Very	2	3 Neutral	4	5 Very
The facilitator was knowledgeable and well organized.					
The facilitator allowed for questions and discussion.					
The facilitator was engaging and able to keep my attention					

## Breastfeeding Program Sample Evaluation Forms

### Peer Support Programs (Volunteers): Training Evaluation Form 2

Your initials \_\_\_\_\_

#### **██████████ Training Survey – Day 2 (page 2)**

If something was missing about one of the topics presented today, what would you like more information about?

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What topics would you like to cover in upcoming ██████████ meetings?

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# Breastfeeding Program Sample Evaluation Forms

## Peer Support Programs (Volunteers): Training Evaluation Form 2

Your initials \_\_\_\_\_

### Training Survey – Day 3 (page 1)

Beside each question/statement, please put a check mark (✓) to indicate the rating that best fits your experience.

QUESTION/STATEMENT	RATING SCALE				
	1 Not Very	2	3 Neutral	4	5 Very
<b>Topic: When a Mother or Baby is Sick</b>					
After today's training, how familiar are you with issues that can come up when a mother or baby is sick?					
Right now, how confident would you feel talking with a mother about issues that can come up when a mother or baby is sick?					
After today's training, how applicable do you think this topic is to your role as a [redacted]?					
The presentation of this information was thorough and easy to follow.					
<b>Topic: Complementary Feeding</b>	1 Not Very	2	3 Neutral	4	5 Very
After today's training, how familiar are you with complementary feeding?					
Right now, how confident would you feel talking with a mother about complementary feeding?					
After today's training, how applicable do you think this topic is to your role as a [redacted]?					
The presentation of this information was thorough and easy to follow.					
<b>Topic: Baby-Friendly Initiative &amp; the WHO Code</b>	1 Not Very	2	3 Neutral	4	5 Very
After today's training, how familiar are you with the Baby-Friendly Initiative and the WHO Code?					
Right now, how confident would you feel talking with a mother about the Baby-Friendly Initiative and the WHO Code?					
After today's training, how applicable do you think this topic is to your role as a [redacted]?					
The presentation of this information was thorough and easy to follow.					
<b>Topic: Milk Sharing</b>	1 Not Very	2	3 Neutral	4	5 Very
After today's training, how familiar are you with milk sharing?					
Right now, how confident would you feel talking with a mother about milk sharing?					
After today's training, how applicable do you think this topic is to your role as a [redacted]?					
The presentation of this information was thorough and easy to follow.					

# Breastfeeding Program Sample Evaluation Forms

## Peer Support Programs (Volunteers): Training Evaluation Form 2

Your initials \_\_\_\_\_

### Training Survey – Day 3 (page 2)

Beside each question/statement, please put a check mark (✓) to indicate the rating that best fits your experience.

QUESTION/STATEMENT	RATING SCALE				
	1 Not Very	2	3 Neutral	4	5 Very
<b>Topic: Accessing Resources</b>					
After today's training, how aware are you of resources in the community that would be helpful in your role as a [redacted]?					
Right now, how comfortable would you feel accessing or referring a mother to resources in the community and from the training?					
How much do you think the resources from the training will help you in your role as a [redacted]?					
<b>Topic: Facilitator</b>					
The facilitator was knowledgeable and well organized.					
The facilitator allowed for questions and discussion.					
The facilitator was engaging and able to keep my attention					
<b>Topic: Overall Experience</b>					
Overall, the training was well organized and there was a good flow between the topics.					
After this training, I feel more confident in my ability to support breastfeeding mothers.					
The venue was comfortable and accommodating.					
The childcare providers were helpful and reliable.					
The food/snacks met my needs.					
The length of the training was appropriate.					

What topics would you like to cover in upcoming [redacted] meetings?

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**Canada Prenatal Nutrition Program:**

**Client Survey on Skin-to-Skin Practices**

Thank you for participating in our skin-to-skin client survey. As a member of the Canada Prenatal Nutrition Program: [REDACTED], you attended a presentation on the benefits of skin-to-skin contact with your newborn baby and how to use wraps to help you practice skin-to-skin. You may have also received a skin-to-skin wrap to use at home in the first few weeks after giving birth.

We are asking you to help us by answering some questions about your experiences practicing skin-to-skin and breastfeeding. We are looking for feedback to help us have a better understanding of the relationship between skin-to-skin and breastfeeding. It is your choice to participate in this survey. Please note, your answers will be kept confidential. The staff from the Canada Prenatal Nutrition Program: [REDACTED] are available if you need help filling in the following form.

*We would like to have some information about your experience practicing skin-to-skin contact with your baby.*

1. Did you receive information on skin-to-skin contact before giving birth?

Please check one box only.

☐ Yes

☐ No

2. If you did receive information on skin-to-skin contact before giving birth, what did you learn about skin-to-skin contact that helped you the most after your baby was born?

Comment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Were you able to practice skin-to-skin contact within two minutes of your baby being born?

Please check one box only.

☐ Yes

☐ No

Comment: \_\_\_\_\_

\_\_\_\_\_

4. If you **were able** to practice skin-to-skin contact within two minutes of your baby being born, how long was the skin-to-skin contact?

Please check one box only.

☐ Less than 10 minutes

☐ 10 – 29 minutes

☐ 30 – 60 minutes

☐ Between one and three hours

☐ Longer than three hours

☐ I do not know/remember

5. If you **were not able** to practice skin-to-skin contact within two minutes of your baby being born, how long were you and baby separated?

Please check one box only.

☐ Less than 10 minutes

☐ 10 – 29 minutes

☐ 30 – 60 minutes

☐ Between one and three hours

☐ Longer than three hours

☐ I do not know/remember

## Breastfeeding Program Sample Evaluation Forms

### Educational Events (Mothers): Event Outcome Survey 1

6. Did you practice skin-to-skin contact during your hospital stay?

Please check one box only.

☐ Yes

☐ No

Comment: \_\_\_\_\_

7. Did the staff at the hospital encourage you to practice skin-to-skin contact during your hospital stay?

Please check one box only.

☐ Yes

☐ No

Comment: \_\_\_\_\_

8. Did you practice skin-to-skin contact after your hospital stay?

Please check one box only.

☐ Yes

☐ No

Comment: \_\_\_\_\_

9. Did anyone else among your family or friends practice skin-to-skin contact with your baby?

Please check one box only.

☐ Yes

☐ No

Comment: \_\_\_\_\_

10. Please pick two words to describe your skin-to-skin practice experience so far.

1. \_\_\_\_\_

2. \_\_\_\_\_

11. Who provided you with information and support for skin-to-skin contact?

Please check all boxes that apply.

☐ Canada Prenatal Nutrition Program: [REDACTED].

☐ Doctor.

☐ Nurse Practitioner.

☐ Nurse.

☐ Family.

☐ Friend(s).

☐ Other: \_\_\_\_\_.

## Breastfeeding Program Sample Evaluation Forms

### Educational Events (Mothers): Event Outcome Survey 1

***We would like to have some information about your experience breastfeeding your baby.***

1. Before your baby was born, did you plan to breastfeed?

Please check one box only.

☐ Yes

☐ No

2. Did your baby receive anything other than your breastmilk in the hospital?

Please check one box only.

☐ Yes

☐ No

3. If your baby received anything other than your breastmilk in the hospital, what was your baby given?

Please check all boxes that apply.

☐ Breastmilk from a Milk Bank.

☐ Formula.

☐ Sugar water and/or glucose.

☐ A combination of: \_\_\_\_\_.

☐ Other: \_\_\_\_\_.

☐ I do not know/remember.

4. What breastfeeding supports have you accessed in the community since your baby was born?

Please check all boxes that apply.

☐ \_\_\_\_\_.

☐ \_\_\_\_\_.

☐ Public Health Nurse.

☐ Lactation Consultant.

☐ Community Health Centre.

☐ Other: \_\_\_\_\_.

5. Did you go to a breastfeeding support drop-in the first week after having your baby?

Please check one box only.

☐ Yes

☐ No

Comment: \_\_\_\_\_

6. Has your baby received anything other than your breastmilk since you came home?

Please check one box only.

☐ Yes

☐ No

Comment: \_\_\_\_\_

7. Has your baby received anything other than your breastmilk in the last two weeks?

Please check one box only.

☐ Yes

☐ No

Comment: \_\_\_\_\_

## Breastfeeding Program Sample Evaluation Forms

### Educational Events (Mothers): Event Outcome Survey 1

8. If your baby has received **anything along with or in place of your breastmilk** in the last two weeks, please rate your confidence to continue to breastfeed until your baby is six months old.

Check the one box that best represents your confidence level.

Not confident at all

☐

1

☐

2

☐

3

☐

4

☐

5

☐

Very confident

☐

Comment: \_\_\_\_\_

9. If your baby has received **only your breastmilk** in the last two weeks, please rate your confidence to exclusively breastfeed with your own breastmilk and nothing else until your baby is six months old.

Check the one box that best represents your confidence level.

Not confident at all

☐

1

☐

2

☐

3

☐

4

☐

5

☐

Very confident

☐

Comment: \_\_\_\_\_

10. To what age do you plan to breastfeed your child?

Please check one box only.

- ☐ Up to six months of age.
- ☐ Between six and 12 months of age.
- ☐ Between 13 and 18 months of age.
- ☐ Between 19 and 24 months of age.
- ☐ Over 25 months of age.

11. Is there anything else you would like to say about your breastfeeding experience?

Comment: \_\_\_\_\_

**Thank you for participating in our survey.**

### Breastfeeding Educational Survey

1. Are you a resident of the [REDACTED] area?

Please check one box only.

☐ Yes

☐ No

2. Are you pregnant?

Please check one box only.

☐ Yes

☐ No

3. If you are pregnant, are you planning on breastfeeding your baby?

Please check one box only.

☐ Yes

☐ No

Comment:

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4. How can we provide breastfeeding support in our community in a friendly and inclusive manner?

Please share your ideas.

Comment:

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5. What would you like to know more about regarding breastfeeding and peer support?

Please share your ideas.

Comment:

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6. Identify the benefits of breastfeeding for a baby that you are already aware of.

Please check all boxes that apply.

☐ Decreased risk of ear infections, respiratory infections, and gastroenteritis.

☐ Decreased risk of Sudden Infant Death Syndrome.

☐ Decreased risk of type 2 diabetes.

☐ Decreased risk of asthma, obesity, type 1 diabetes and leukemia.

☐ All of the above.

7. Identify the benefits of breastfeeding for a mother that you are already aware of.

Please check all boxes that apply.

☐ Decreased risk of ovarian cancer.

☐ Decreased risk of breast cancer.

☐ Decreased risk of developing postpartum bleeding.

☐ All of the above.

**Thank you very much!**

## Breastfeeding Program Sample Evaluation Forms

### Educational Event (Service Providers): Class Evaluation 1A

#### Breastfeeding Education

##### Initial Questionnaire

Please circle the response that is most applicable to you.

1. How important do you think it is for a mother to breastfeed her baby?

1	2	3	4	5
Not at all important	Slightly important	Important	Fairly important	Very important

2. How important to do you think it is that all staff members at a health care office provide the same message about breastfeeding to patients?

1	2	3	4	5
Not at all important	Slightly important	Important	Fairly important	Very important

3. How confident are you with providing patients with information about breastfeeding?

1	2	3	4	5
Not at all Confident	Slightly Confident	Confident	Fairly Confident	Very Confident

4. How important do you think it is that mothers are provided with information about infant feeding options that is based on evidence and research?

1	2	3	4	5
Not at all important	Slightly important	Important	Fairly important	Very important

**Thank you very much!**

## Breastfeeding Education

### Follow-up Questionnaire

#### Part 1

Please circle the response that is most applicable to you.

1. How important do you think it is for a mother to breastfeed her baby?

1	2	3	4	5
Not at all important	Slightly important	Important	Fairly important	Very important

2. How important do you think it is that all staff members at a health care office provide the same message about breastfeeding to patients?

1	2	3	4	5
Not at all important	Slightly important	Important	Fairly important	Very important

3. How confident are you with providing patients with information about breastfeeding?

1	2	3	4	5
Not at all Confident	Slightly Confident	Confident	Fairly Confident	Very Confident

4. How important do you think it is that mothers are provided with information about infant feeding options that is based on evidence and research?

1	2	3	4	5
Not at all important	Slightly important	Important	Fairly important	Very important

#### Part 2

Please check (✓) the response that is most applicable to you.

1. I would rate the education I received today as:

☐ Poor ☐ Good ☐ Excellent

2. My breastfeeding knowledge has increased after today's session.

☐ True ☐ False

3. My skills for providing breastfeeding support have increased after today's session:

☐ True ☐ False

**Thank you very much!**

# Breastfeeding Program Sample Evaluation Forms

## Educational Events (Service Providers): Workshop Evaluation 1A

### Workshop Evaluation

#### Pre-Workshop

Please complete the following survey in support of our Breastfeeding Community Project. All information will be kept confidential, and only aggregated data will be shared. Your comments are very important and will help us to make improvements to the program.

Please indicate how your current level of knowledge/confidence on the following topics.

Rating legend:

<b>1</b> Not at all knowledgeable/confident	<b>2</b> Somewhat knowledgeable/confident	<b>3</b> Knowledgeable/confident	<b>4</b> Very knowledgeable/confident
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For each topic check one box only.

<b>TOPIC</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
The Canadian Paediatric Society's recommendation for exclusive breastfeeding.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The importance of skin-to-skin contact immediately after birth.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The potential harm in supplementing a newborn with formula.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The key elements of informed decision-making around infant feeding.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The importance of breastfeeding for both mother and baby.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The International Code of Marketing of Breastmilk Substitutes (WHO Code).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The difference between mother-led and baby-led positioning and latching.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How to access local community breastfeeding supports.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The principles and practices of the Baby Friendly Initiative.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How to help a breastfeeding mother who may be having challenges.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The basic principles of breastfeeding.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:



# Breastfeeding Program Sample Evaluation Forms

## Educational Events (Service Providers): Workshop Evaluation 1B

### **Workshop Evaluation**

#### Post-Workshop

Please complete the following survey in support of our Breastfeeding Community Project. All information will be kept confidential, and only aggregated data will be shared. Your comments are very important and will help us to make improvements to the program.

1. Please provide an overall rating of this event.

Check one box only.

☐ Excellent

☐ Good

☐ Fair

☐ Poor

Comment:

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2. Having completed this workshop, please indicate how your knowledge relating to breastfeeding has changed.

Check one box only.

☐ Increased greatly

☐ Increased a little

☐ Not changed

Comment:

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3. Having completed this workshop, please indicate how your skills relating to supporting breastfeeding women has changed.

Check one box only.

☐ Increased greatly

☐ Increased a little

☐ Not changed

Comment:

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## Breastfeeding Program Sample Evaluation Forms

### Educational Events (Service Providers): Workshop Evaluation 1B

4. For each of the following statements, please indicate how your level of knowledge/confidence has changed as a result of today's workshop.

For each statement check one box only.

STATEMENT	Increased greatly	Increased a little	Not changed
My knowledge of the Canadian Paediatric Society's recommendation for exclusive breastfeeding has:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My knowledge of the importance of skin-to-skin contact immediately after birth has:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My knowledge about the potential harm in supplementing a newborn with formula has:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My knowledge regarding the key elements of informed decision-making around infant feeding has:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My knowledge of the importance of breastfeeding for both mother and baby has:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My knowledge of the International Code of the Marketing of Breastmilk Substitutes (WHO Code) has:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My knowledge of the difference between mother-led and baby-led positioning and latching has:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My knowledge of how to access local community breastfeeding supports has:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My knowledge regarding the principles and practices of the Baby Friendly Initiative has:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My confidence to help a breastfeeding mother who may be having challenges has:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My knowledge related to basic principles of breastfeeding has:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Breastfeeding Program Sample Evaluation Forms

### Educational Events (Service Providers): Workshop Evaluation 1B

5. Will you be able to implement what you have learned into your current practice?

Check one box only.

☐ Yes

☐ No (If no, please give comment)

☐ Unsure

Comment:

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6. What might be the barriers to implementing what you have learned into your practice (e.g., funding, human resources, policies, personal attitudes)?

Comment:

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7. Did the workshop adequately support your learning-style needs?

Check one box only.

☐ Yes

☐ No (If no, please give comment)

☐ N/A

Comment:

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8. Did this course meet your professional development needs regarding breastfeeding support and lactation management?

Check one box only.

☐ Yes

☐ No (If no, please give comment)

☐ N/A

Comment:

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Additional Comments:

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**Thank you for your responses!**

# Breastfeeding Program Sample Evaluation Forms

Resources (Mothers): Kit Evaluation 1

## Resource Kit Evaluation

1. Who gave you the resource kit?

Please check one box only.

- ☐ clinic staff.  
☐ group staff/volunteer.  
☐ Postnatal and Breastfeeding Support Group leader.  
☐ Program Coordinator.  
☐ Family member.  
☐ Friend.  
☐ Other (please explain): \_\_\_\_\_

2. Have you had your baby?

Please check one box only.

- ☐ Yes.  
☐ No.

3. How much of the kit have you read?

Please check one box only.

- ☐ Whole kit.  
☐ Only the parts that answered my question(s).  
☐ Only parts that I could relate with.  
☐ None (please let us know why): \_\_\_\_\_

4. Please tell us how much you agree with the following statements.

For each statement, check one box only.

STATEMENTS	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	I'm not sure
The kit has the information I was looking for.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The information in the kit is easy to understand.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The kit had information that I used or plan to use.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The kit has details about where I can find more help or support with breastfeeding.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I think other pregnant women or new mothers would benefit from the information in this kit.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. What part of the kit did you like best, and why? \_\_\_\_\_

6. Which part of the kit was the least useful, and why? \_\_\_\_\_

7. Please describe any information you looked for in the kit, but could not find: \_\_\_\_\_

8. Do you have any other suggestions or comments about how we could improve this resource? \_\_\_\_\_

**Thank you for taking the time to answer these questions!**  
**Your input is important to us and will be used to improve the resource kit.**

**Video Evaluation Form**

Please watch the video [REDACTED] on YouTube at [REDACTED]. Thank you.

Today's Date: \_\_\_\_\_

I am a:

Please check one box only.

- ☐ Mother  
☐ Father  
☐ Grandparent  
☐ Friend  
☐ Other (please explain): \_\_\_\_\_

Please indicate your impressions of the statements listed below:

For each statement, check one box only.

The video ([REDACTED]):	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
was easy to follow.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
sections were easy to move between.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
helped me understand how to use a breast pump.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
helped me understand how to hand express.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
helped me know how to do breast massage.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
helped me understand how much milk to expect.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
helped me understand how to safely store and transport breast milk.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
taught me who to ask for more help.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
was a video that I would recommend to other mothers/families.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**THANK YOU FOR YOUR PARTICIPATION!**