

Development and Implementation of a Women's Health Promotion Program: The Moms for Moms Approach

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Abstract:

The Moms for Moms (M4M) program provides mothers the arena necessary to explore new ideas and definitions about mothering as well as skills and strategies concerning parenting, family management, and healthy habits. A participatory approach has been used to understand the development and implementation of the program from the perspective of the participants and community agency staff in an urban city. This approach provides detailed descriptions and interpretations of the shared beliefs, behaviors, and values of the participants as well as how these attributes are shaped by involvement in M4M. The findings from a needs assessment and program feasibility study conducted from August 2006 to June 2008 are used to inform a recently launched Healthy Lifestyles Initiative at a community-based agency for women, to determine if M4M fits within the culture of the organization and to determine the relevance of participatory methods to engage mothers and community agencies in creating health promotion programming.

Keywords: women's health promotion programming | mothers | program development | program implementation | stress | social support | participatory approaches

Article:

The purpose of this article is to describe the development and implementation of a community based women's health promotion program, Moms for Moms (M4M). The M4M program is designed to reduce mothers' experience of stress by creating social support and networking systems as well as providing a participatory experience in the development of health programming for women who are actively mothering. Mothers are the primary health care agents for their families (Denham, 1999) and still provide the majority of the physical and emotional caretaking within families (Kushner, 2007). Mothering is often done in the context of additional responsibilities such as paid work, volunteerism, and caring for other family members, including

elderly parents. Juggling the daily tasks for these responsibilities creates stress and leaves women little time or emotional energy to care for themselves. Although support groups exist for specialized groups of mothers, such as new mothers and mothers of special needs children, few programs exist for mothers of older children struggling with daily stressors.

The M4M program is being developed in conjunction with a local women's support agency and with participants as a way to create a program that is relevant to the everyday needs of mothers as well as fits into the culture and existing structure of programming at the community agency. Using participatory methods, this article describes the development of the M4M program and its implementation in a feasibility pilot study. We discuss strategies learned and implications for launching similar programming for women on a full scale.

BACKGROUND

Stress, a mental or emotional strain or tension resulting from adverse or demanding circumstances, plays a direct role in negative health outcomes (Schneider, 2006). In addition, recent national data show approximately 9% of adults with children to have serious psychological distress, with higher rates existing among parents who are women, younger (18-44), are low income, and/or receive Medicaid (Herman-Stahl et al., 2007). Risk factors for stress can include a multitude of triggers, including unfavorable working conditions and increased family responsibilities.

Studies have shown that social support may influence the incidence and prevalence of many health outcomes through protection from the adverse consequences of stress (Heaney & Israel, 2002). In fact, social networks have been found to be strongly associated with health status at the individual level (Schneider, 2006). At the community level, Heaney and Israel (2002) argue that strong social networks and active social support render communities able to take advantage of local resources and solve problems. It is important that public health programming recognize stress as a serious health problem and that programs and interventions are developed to help people reduce and cope with stress.

Using various methods, studies have addressed the need for social support among women who are caregivers. A study conducted by Parker, Schulz, Israel, and Hollis (1998) used female lay health advisors to identify stressors and protective factors experienced by women in an east-side Detroit community. The advisors provided one-on-one support and helped organize community activities focused on women, children, and family health (Farquhar, Parker, Schulz, & Israel, 2006). Another study analyzed data from an online social support network to assess changes in the level of parenting stress and found that mothers who participated regularly were more likely to report a decrease in parenting stress following the intervention (Dunham et al., 1998). A third study compared outcomes of a parent education and a parent support group. Both groups reduced social isolation and parenting stress among mothers (Telleen, Herzog, & Kilbane, 1989). These interventions demonstrate that providing social support to mothers in various forms can reduce

stress. The methods used suggest that programmers should use creative methods to address the needs of mothers while providing a way to communicate with other mothers.

RESEARCH DESIGN

The purpose of the larger study is to (a) evaluate the development and implementation of a community based health promotion program targeting women who are actively mothering, (b) assess the program's effectiveness at providing social support and reducing stress, and (c) evaluate potential for sustainability within a community agency. This article describes the first part of the larger project. The primary research questions addressed in this article are, What are the specific needs of mothers, both as women and caregivers, and how can a community-based health promotion program meet them? To answer these questions a needs assessment was conducted using a series of participatory and qualitative methods (focus groups, in-depth interviews, and experience sampling methods). The needs assessment was conducted with women who were clients of the agency partner as well as women from the community served by the agency. The community partner assists women in accessing information about available community resources. The agency offers programs and services such as legal advice, career and resume enhancement, and self-esteem building with the aim of increasing women's self-reliance.

METHOD

Needs Assessment

To fully understand the health concerns of mothers and the type of programs they feel would be most helpful, we conducted a needs assessment by analyzing qualitative data collected on a series of pilot studies. All three studies examined health perceptions and practices of working-class and low-income mothers, the majority of whom were clients at the community organization. Participation in these studies gave mothers the opportunity to disclose their most intimate health concerns about being a mother and provide insight on how to best deal with those concerns. Specifics of each substudy are described below.

Mothers' focus group study. We conducted focus groups ($n = 3$) to explore mother's health-related needs and experiences and how the context of their daily lives shapes their health and is shaped by their caregiving roles. We asked mothers to discuss the types of health programs they would like to participate in at the community agency as well as the logistics of these programs. Focus groups consisted of eight individuals in total (two participants in groups 1 and 2 and four in focus group 3). An experienced moderator conducted each focus group using a focus group guide and was supported by at least one assistant moderator, who took extensive notes and audio-recorded the sessions.

Mother-daughter study. We conducted in-depth interviews with mothers and their adolescent daughters to assess issues relating to perceived health, health concerns, and quality of mother-daughter relationships. Only the mothers' ($n = 6$) interviews were used for the needs assessment.

Interviews lasted approximately 1 hr and were tape-recorded. Relevant sections of the semistructured interview guide focused on mothers' perceptions of their personal health, their family's health, positive and negative health habits and activities in their lives, and ideas for health promotion programming.

Experience Sampling Methodology study. The Experience Sampling Methodology (ESM) study was designed to provide insight into the everyday occurrences and health concerns of mothers. ESM allows participants to record behaviors, emotions, and attitudes in real time, thereby providing a snapshot into their daily lives. A strength of this methodology is the ability to avoid recall bias as participants record events as they happen instead of at follow-up (Kahneman, Krueger, Schkade, Schwarz, & Stone, 2004). Mothers ($n = 10$) responded to a randomly programmed survey three times per day for 10 days on a personal digital assistant (PDA). The survey covered daily habits about diet, exercise, and sleep and mothers reported on their emotions, stress levels, and time pressure. Open-ended questions allowed mothers to provide in-depth reflections concerning perceptions of family health and identity and to identify topics of conversations they held with their children. Mothers were also interviewed before and after the PDA survey by a trained interviewer about their day-to-day-experiences using a semistructured interview guide. Mothers were asked to describe their everyday experiences and at follow-up to describe how and if these experiences had changed. Mothers' perceptions of health, their health concerns, and their thoughts on potential health promotion programming were also discussed. Interviews took approximately 1 hr and were tape-recorded.

Community presentation. Preliminary results were presented to clients at the community agency, including participants in the study. Patton (2002) describes review by participants as a way to check results and conclusions for accurate and complete descriptions. By presenting conclusions from the research, women were able to provide feedback and suggestions for the pilot program. Notes from the ensuing discussion were incorporated into the needs assessment.

Participants. Across the three pilot studies, participants were English-speaking women actively engaged in mothering (have a child living in their home for whom they are responsible). All participants were clients and/or volunteers of the community partner, and recruitment occurred through distribution of flyers, brochures, and verbal referrals via agency staff after screening for women's status as active mothers or caregivers. The study design allowed for variation by race and ethnicity, social class, age, and gender of children (except for the mother– daughter study), number of children, and working status. This variation allowed for identification of themes common across diverse groups of mothers and suggestion of differences that may need to be taken into account when designing programs.

Twenty-one mothers participated, with two mothers participating in more than one substudy. Participants included women from low-income and working-class backgrounds of varied races and ethnicities, although the predominant racial and ethnic group was African American. Participants are representative of the community in which the agency is located and the majority

attended at least one agency workshop or program. The agency primarily serves low-income and working-class women. Although data on socioeconomic position were not collected from participants in all substudies, 8 of the 10 participants in the largest study (ESM) reported annual family incomes less than \$30,000 per year. Participants in this substudy were representative of participants in all substudies. Table 1 displays participant data and a summary of study characteristics.

Data Analyses

The primary analyses for the needs assessment came from the focus group data that was conducted specifically with the goal of assessing clients’ needs for health programming within the community agency. We reviewed and incorporated data from the other substudies to gain a better understanding of the population, specifically their health concerns and needs that might best be addressed through programming. We reviewed audiotapes of the focus groups along with notes taken by the assistant moderators during the focus groups. We created a matrix to plot participants’ responses to mothering challenges, benefits, health concerns, and program suggestions across the three focus groups.

TABLE 1. Sources of Data and Participant Characteristics for Needs Assessment

	<i>Mothers’ Focus Group Study</i>	<i>Mother– Daughter Study</i>	<i>Experience Sampling Methodology (ESM) Study</i>	<i>Community Presentation</i>
<i>n</i>	3 Groups (8 participants)	6	10	7
Recruitment criteria	Female clients and volunteers of community agency with at least one child living at home for whom they are the primary caregiver	Female clients of community agency with at least one adolescent daughter (age 11-17) living at home for whom they are the primary caregiver	Female clients and volunteers of community agency with at least one child living at home for whom they are the primary caregiver	Female clients and volunteers of community agency with at least one child living at home for whom they are the primary caregiver; some were participants in one of the substudies
Demographics	Black (<i>n</i> = 7) White (<i>n</i> = 1) Family size: range 2-4; mode = 3	Black (<i>n</i> = 6) Family size: range 3-8; mode = 4 Annual income: 10-20k (<i>n</i> = 4) 20-30k (<i>n</i> = 4)	Black (<i>n</i> = 7) White (<i>n</i> = 3)	Demographics not collected Marital status: Single (<i>n</i> = 3) Married or partnered (<i>n</i> = 7)

		30-40k (n = 1) 40-50k (n = 1) Marital status: Single (n = 5) Married (n = 1)		
Content covered	Desired health programs, health-related needs and experiences	Perceived health, health concerns, mother–daughter relationships	Daily life, health concerns, identity, family health, relationships with children, changes in daily life since study completion	Preliminary findings from focus groups, ESM study, and mother–daughter studies, next steps for pilot study

We transcribed interview recordings verbatim and coded using ATLAS.ti 5.0, a software program that allows for organization and categorization of text. Two coders (the authors) reviewed and coded transcripts for themes based on the research questions, and a codebook was created. To ensure reliability, coders selected two transcripts to code in overlap. Discussions were entered directly into ATLAS.ti for future analyses. We also independently coded and then compared open-ended responses to questions on the PDA survey. We discussed, addressed, and resolved disagreements for each step of analysis in meetings. For each participant in the ESM study ($n = 10$), there were 30 possible observation points. An analysis of missing data showed a total of 167 observation points for the sample. We then calculated and reviewed simple descriptive statistics across the available observation points.

RESULTS AND IMPLICATIONS FOR PROGRAMMING

Through analyses of focus group, interview, and PDA survey data, we identified challenges and benefits to mothering, health concerns, and desired programming of this group of mothers.

Challenges and Benefits to Mothering

Primary challenges included scheduling of time and issues around lack of time to complete tasks, finding time for self, issues of employment, navigating and securing community and financial resources, and parenting. Mothers also reported issues specific to raising children, including providing consistent discipline, communication with children, especially older children and teenagers, and preparing children to be leaders and not followers. Although challenging, participants saw mothering as a resource. Benefits of mothering included emotional support, motivation for personal growth, pride and joy in children, and tangible support from children, including help with household chores.

Health Concerns

Mothers expressed a variety of health concerns in focus groups and interviews. They used a holistic definition of health to include physical, mental, social, and spiritual components. They believed that mental health was equally important as physical health and contributed to their overall health status. Their main health concerns focused on physical and mental health such as exercise, healthy balanced diets, and reducing the feelings and causes of chronic stress. They reported a number of health issues both for themselves and in their family history, including alcoholism, depression, obesity, diabetes, hypertension, and cancer. Although mothers had a number of personal health concerns, they consistently put their children's health before their own. This issue triggered an animated discussion during one of the focus group sessions, resulting in one mother pulling out her daily calendar and showing the group her doctor appointments. She said, "Actions speak louder than words," and showed the group the days she scheduled appointments for both herself and her children. She told the group she had to learn to put her health first in order to be there for her children. She encouraged other mothers to realize that if mothers are not healthy, they cannot be there for their children and keep them healthy. Although the rest of the group agreed with the sentiment, they felt it was difficult advice to follow.

Related to health concerns was the issue of support. Many mothers reported they did not have a social network that provided adequate support. At most, social support was realized through immediate family, including partners or spouses, parents, and children. These networks were also viewed as draining resources as much if not more often than they provided support. One mother said it was possible to be a single mother even when a spouse or partner lived in the home.

Health Practices

Interviews with mothers that focused on their daily health practices showed that most of the mothers had eating habits they perceived as being unhealthy—consisting of snacks, fast-food purchases, sweets, or skipping meals altogether. Mothers who worked and/or attended school often cited time pressure as a primary reason for their eating habits, making statements such as, "Oh, I'll just grab something." Likewise mothers reported not engaging in consistent exercise and either getting too little or poor sleep at night. When asked by her daughter if she wanted to exercise using a video, one mother replied, "Girl, are you crazy?" Only three mothers in the study smoked cigarettes. Mothers reported prayer, reading, engaging in meaningful conversations with family and friends, and spending quality time with their families as healthy practices that they engaged on a regular basis.

A preliminary examination of the ESM data verified these reported health practices. Examining responses across all observation points ($n = 167$), we found that only 40% of the responses consisted of having eaten a pretty or somewhat healthy meal or snack. Likewise 46% of the responses reported mothers were sitting or standing, only 21% of responses included moderate exercise and there were no instances of vigorous exercise reported.

Preferred Program Content

Mothers desired programs that offer support in the form of mentoring and networking, offer parenting skills and strategies, address interpersonal skills and relationships, and that focus on physical health. Overall, these workshops should set up a system in which the mothers are provided lasting support in the form of buddies and peer groups to keep them from regressing and to send positive messages to their children.

Preferred Program Logistics

Mothers stressed the importance of their active involvement in planning and administering the program. They felt the program leader should be a woman similar to them (with respect to experiences) who does not necessarily have specialized training but can teach the participants to become program leaders themselves. Specific programs should be interactive and combine topics into ongoing weekly sessions so that women can work on more than one goal each week. Not surprisingly, mothers raised the need for childcare although the manner in which childcare could be provided was flexible. A pooling of childcare resources was often suggested as a solution. Mothers also provided insight into the materials and incentives to be used in programs. The use of technology for providing support (i.e., text messages) was highly desired as were visual materials.

Less support was given to printed materials, although several mothers mentioned they collect brochures on health topics to share with their children. Gift bags and small prizes or rewards were viewed as helpful incentives for mothers as were visible advertisements for the group to be worn on T-shirts and hats.

Conceptual Framework

The conceptual development of the M4M program incorporated findings from the needs assessment along with previously used strategies found in the literature and theories from varying disciplines. We used a feminist participatory model as presented by O'Connor, Denton, Hajdukowski-Ahmed, Zeytinoglu, and Williams (1999) to include women in a collaborative knowledge making process whereby their voices become instrumental in gathering and interpreting knowledge. This form of research is essential to ensure that the lives of women are improved through research and through processes that eliminate structures that are oppressive to women. Using the feminist participatory model, M4M incorporates women's ways of knowing and problem solving to give women, specifically mothers, a voice concerning their own health.

As a means of facilitating the empowerment of participants, research findings are produced directly by the experts, that is, those who have directly experienced the concept of interest (O'Connor et al., 1999). Women help uncover findings and explain to researchers the meaning of mothering in the context of daily life. This type of reciprocal collaboration puts mothers in a

position in which they can become confident in working with researchers and in enhancing their lives and the lives of others in their community.

In applying this feminist participatory model to the development of a health promotion program for women who are actively mothering, we relied heavily on the experiences of the women themselves and their definitions of health and well-being. Experiences of isolation and stress were expressed by all of the women across the needs assessment studies. In addition, women described health as a holistic experience, citing physical, mental, social, and spiritual components to their experiences of health and wellness. The women's definitions of health most closely matched a wellness model (Larson, 1999), which was incorporated into an existing model of social support.

Heaney and Israel (2002) describe a conceptual model that highlights the multiple ways that social support and social networks can influence health. Although their model shows how social support and social networks directly influence stress, health behaviors, and thus health, it also allows for potential reciprocal influences between the constructs. Figure 1 shows an adaptation of the Heaney and Israel (2002) model. In the revised model, societal influences such as organizational and community resources, societal expectations, and stressors influence an individual's perception of stress. Perceived (or experienced) stress then influences the individual's coping resources, definitions or understanding of health, as well as their health behaviors, which all ultimately affect individual health outcomes. The revised model also allows for potential reciprocal influences of individual-level factors on the experience of stress as well as between societal factors and individual factors.

The model also demonstrates how the M4M program can influence health outcomes by its affect on mothers' experience of stress and individual coping resources as well as on community empowerment and competence. Theoretically, participation in the M4M program can alter mothers' experience of societal stressors by providing a supportive social network as well as through the use of stress relief techniques. Through the sharing of advice and information, and the renorming of personal expectations of motherhood as well as learning new parenting and health skills, mothers' individual coping skills can also be affected. Over time, this approach may increase community resources by empowering women to organize and create change at the community level.

Feasibility Pilot Test

Drawing from the needs assessment, literature review, and conceptual frameworks of support, empowerment, and participatory approaches, we developed M4M to implement a health-related program in which mothers are able to share advice concerning family management and stress reduction. The M4M program serves as a venue in which mothers can develop positive relationships and support one another as they navigate the daily tasks of caregiving. The community agency does not currently offer classes or workshops of this format for its clients.

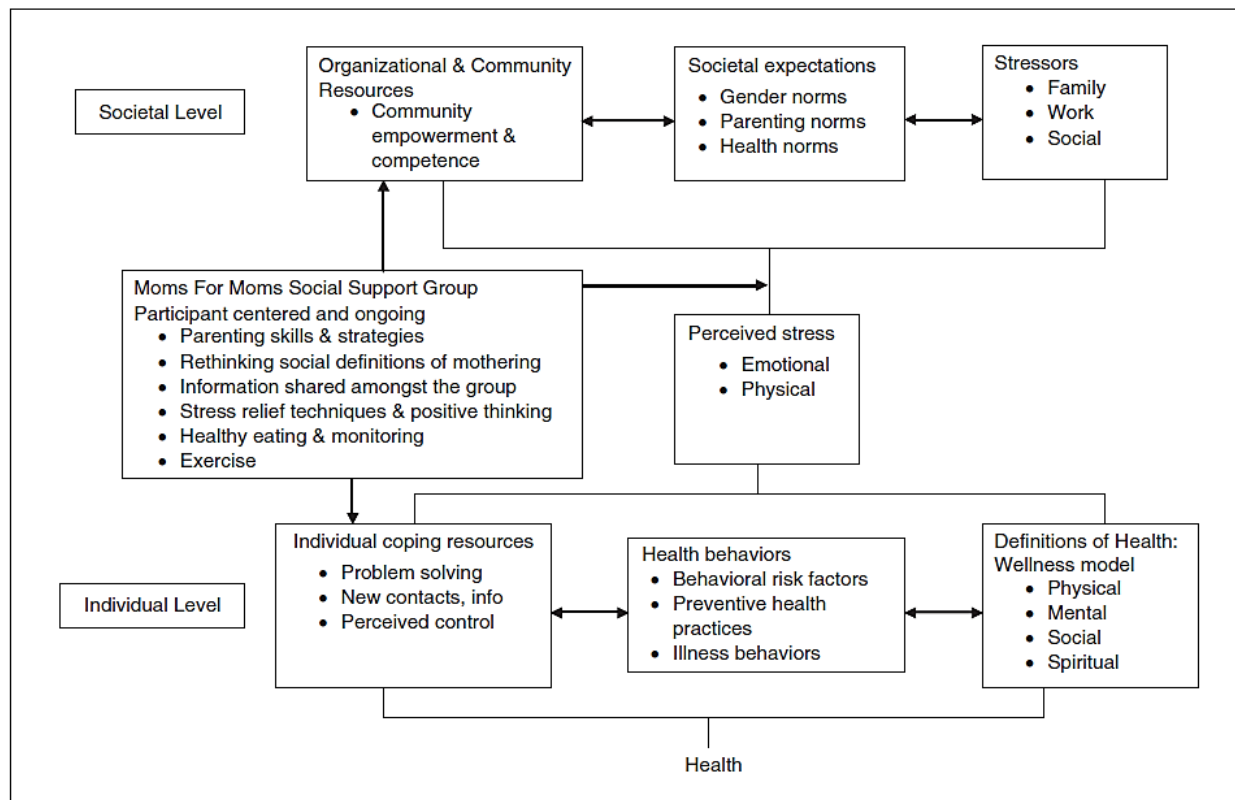


FIGURE 1 Conceptual Model

In direct response to the needs assessment, a program of biweekly meetings was designed for mothers. This group served two purposes: (a) a support group for women who are actively mothering and (b) a planning group for health promotion efforts targeting the larger community of mothers at the agency and in the county. Participants from the needs assessment studies were invited to participate in the M4M group, and four participated in at least one session. Similar to the recruitment strategy for the needs assessment studies, flyers and brochures were posted within the community agency and referrals and recommendations were made within ongoing programs and workshops at the agency. The total number of participants in the biweekly group meetings was nine; however, a core group of women ($n = 3$) participated in every session. These activities were open to the entire community and surrounding cities.

Mothers were instrumental in planning the meetings and session topics as well as taking responsibility for their growth and change throughout the program. Project staff facilitated the biweekly M4M sessions and served as a resource for the group, assisting where needed to find resources and materials for weekly sessions and larger community-wide events. Graduate and undergraduate students at a local university also assisted with implementation of the program as part of a credited course. Sample topics covered in the sessions included stress reduction techniques, mission and vision statement formulation, resource guide creation, positive

affirmation therapy and journal-keeping, and effective parent–child communication. Mothers also participated in a walking group as the weather permitted.

The group fulfilled its second purpose by allowing mothers the opportunity to assist in the planning and implementation of health-related workshops for the larger community of mothers. During the feasibility pilot program, M4M sponsored two events for the local community and surrounding areas: Spa Day and Real Talk! Spa Day was created in direct response to requests from participants in the needs assessment. Held at a local church, Spa Day was a way in which mothers could take a break and relax together while receiving services to pamper and destress. Refreshments were provided along with face, hand, and foot care, energy therapy combined with gentle touch and massage, positive affirmation therapy, and Chi Gung (a series of stretches and poses). Attendance for the event consisted of approximately 20 mothers and 3 adolescent daughters. Of these, 2 women attended the biweekly support meetings. During the event, mothers were invited to attend M4M sessions, if they did not already do so, and were provided with health education brochures on topics of importance to women. Women were also given small take-home gifts, such as tea lights, hand lotion, and relaxing music, to recreate their own spa day experience at home.

Real Talk! focused on mother–adolescent communication. The event featured a facilitated panel discussion between three community mothers and three community adolescents as well as a prerecorded video of teens talking about their efforts to communicate with their mothers. The panel discussion and the video highlighted barriers and benefits to healthy communication as well as parenting issues and successful mother–adolescent relationships. Attendance at this event consisted of 15 participants. Participants’ status in terms of active mothering was not assessed. *Real Talk!* was held at the community agency and included a take-home activity in which all participants were provided an envelope and a card with the prompt: “In the next month I will talk to my child/mother about . . .” Each participant completed this sentence and addressed it to his or her child or mother to be mailed in one month. Participants were encouraged to try any form of communication they learned at the panel within the next month.

DISCUSSION AND FUTURE DIRECTIONS

The feasibility trial allowed for implementation of the intervention on a small scale to receive feedback concerning successful and problematic areas for intervention refinement before implementing it in larger groups and subpopulations in full-scale trials. Input received from participants was fed back into the program as a way to include the voices of marginalized women. However, building a social support network using participatory methods is difficult because of the time commitment required to establish rapport with participants and community members. Participants are willing to get involved when they believe researchers are in the community for the right reasons and when they can trust the community will experience positive change. Program facilitators should spend as much time as possible in the community learning about the resources currently available and getting to know the people who call it home.

Participation can be elicited via intensive recruitment through local groups and agencies as a way to benefit from existing social networks. Methods used to increase participation in this study included distribution of flyers and brochures, verbal referrals from agency staff, word-of-mouth referrals, and weekly phone calls to participants. Participation was low despite these efforts. This may have been due to the nature of the programming at the community agency, as many clients visit the agency for specific reasons such as financial counseling, legal information, or resume-building workshops and may not return until a new need arises. Building a social support group may work better in more defined community spaces such as schools and extra-curricular programming, where mothers may have more opportunity to interact with each other because of increased opportunity for engagement. Using the community agency however served as a venue to hold weekly sessions in which mothers were comfortable and familiar with their surroundings.

As the M4M program moves forward, weekly activities and assignments that mothers can share with friends and family will be incorporated to keep them engaged until they return to the group. Constant communication is key to reinforce the importance of building and maintaining interest in the group. Systems need to be established that allow for contact with group members and to serve as reminders for members to contact one another for support and encouragement.

The implementation of the program was limited because of financial constraints as well as constraints imposed by the structure and purpose of the community agency. For example, although women felt strongly that technological advances such as text messaging could help reduce their feelings of isolation and increase the support component of the program, financial constraints did not allow us to pursue this avenue. Future programs may want to incorporate technology as a means to overcome the barrier of time constraints identified by mothers.

The results of this pilot program may not be generalizable to mothers from other communities. Women who participated in M4M attended workshops at the community agency because of the services provided, which were primarily geared toward financial and legal independence. The needs of mothers in other community agencies may differ based on the services and/or function of the agency.¹ In addition, the needs of individuals and their communities may change over time and should be incorporated into health promotion programming. The basic ideas and methods of this study can be used when creating health promotion programming for a wide variety of audiences. What makes this type of program development key is that it is responsive to the needs of those involved and results in a tailored program that is salient to the everyday lives of the participants. Participatory approaches provide women a voice and the space to create change. Preliminary analyses from the larger study show that although the major criticism against the program was the participation rates, women did feel the program activities and process were helpful. One participant expressed these feelings in a follow-up interview when she said, "I'm speaking out a lot more today . . . I used to think I didn't have a voice, I wasn't being heard."

CONCLUSIONS

This article highlights the potential a participatory process holds for developing effective and salient family-based health promotion programs to increase healthy practices and reduce stress among mothers. Women are the primary health care providers and decision makers for their families, yet their own health needs often go unrecognized. Programs targeting the health needs of mothers have the potential to effect change among women as well as families. This project has not only produced an intervention in which mothers receive social support as a means to reduce stress but highlights the importance of understanding women's lives as mothers and health care providers by including their voices and ideas for action. The information obtained from this study can be used to inform current and future programming of community-based organizations. The findings also have the potential to stimulate women's health research and bring attention to the importance of feminist participatory methods' ability to provide women a venue to discuss issues salient to them and to bring about action in their own communities.

NOTE

1. Additional interviews were conducted with mothers through other agencies in New York City. Although not included in this article, results indicate similar definitions of health, barriers and challenges to health, and perceived needs for programming.

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