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Daughter-initiated health advice to mothers: perceptions of African–American and Latina daughters

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Abstract

The prevailing paradigm of health exchange within the family is for health advice to flow from parent to child. Consistent with this pattern of exchange, most research has focused on the one-directional influence of the parent on the child and there is thus an absence of literature that explores the ability of adolescents to influence their parents' health behaviors. This qualitative study addressed this gap by exploring the feasibility of daughters providing health advice to their mothers. Twelve focus groups were conducted with 78 African–American and Latina daughters between the ages of 12 and 17 from low-income neighborhoods in a Mid-Western city in the United States. This study utilized a grounded theory approach to examine the focus group data. The findings indicate that many daughters report that they are already giving their mothers a wide spectrum of advice, including health advice. Differences were found in the reported willingness of African–American daughters when compared to Latina daughters to provide their mothers with specific cancer advice. These data suggest that some of these daughters have the potential to be valuable health education conveyers in the family.

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The problem

The prevailing health promotion paradigm is that parents give their children advice about health. Consistent with this paradigm, most health promotion literature has focused on the one-directional influence of the parent on the child [1–3] and there is thus a notable absence of literature that focuses on the ability of young people to influence their parents' health behaviors. The purpose of this research is to examine the feasibility of utilizing adolescents to provide their mothers with health information.

That there is a critical need for general health promotion interventions that prioritize the family, particularly the low-income family, is undisputed. The unique set of stressors [4] and the documented poor health outcomes faced by many low-income families [5, 6] make this unit an ideal focal point for health promotion and specifically, cancer awareness. The context of the low-income family, in particular the necessary relational interdependencies, provides an important framework for the transmission of health information between adolescent and parent. The long-term focus of this research is to utilize the mother–daughter relationship for cancer prevention and control. Despite tremendous strides in addressing cancer disparities in the United States, the benefits of breast and cervical cancer screening for low-income women remain disproportionate [7]. Health disparities continue to plague women of ethnic minorities, such as African–Americans and Hispanics, who represent the two largest minority groups in this Mid-Western city [8]. African–American and Latina women have the highest incidence and mortality rates, respectively, of

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cervical cancer [9]. These disparities suggest that there is a dire need for culturally relevant interventions that focus on these communities effectively [10–14].

Background

The one-directional transmission of health information from parent to child has been well established and is the prevailing health promotion paradigm. Health outcomes for children are significantly improved through the positive relationship between parent and adolescent child [15, 16]. Several studies have successfully maximized the parent–child relationship as a vehicle for addressing sexual risk taking [17, 18], poor nutrition [19, 20], lack of exercise [21] and other risk behaviors confronting children, adolescents and young adults. However, both the changing nature of the family and educational opportunities for teenagers, which include a curriculum with general life skills and many health-related subjects [22–26], dictate the investigation of a more bidirectional flow of health information between parent and child.

The mother–daughter relationship is central to, and a fundamental unit for, the dissemination of nurturing and learning [27–29]. The bond between mothers and their children generally has been characterized as unique and fundamental to intergenerational learning and behavior modeling [30–33]. Mothers tend to be the most influential persons in the family network [34]. Studies of two-parent families show, for example, that children of both sexes are more likely to report discussing issues (including sex and sexuality) with mothers rather than with fathers, and are more satisfied after communicating with their mothers [35]. Daughters in particular have been noted to talk to their mothers about a variety of issues, including sensitive topics such as sexually transmitted disease prevention and topical microbicides [36].

There are several reasons why daughters in particular are uniquely positioned to be effective conveyers of health information in the family and, specifically, to their mothers. First, the changing nature of the family is such that many households, especially in low-income neighborhoods, are headed by women [8]; fathers are absent from the home for a variety of reasons; mothers have limited time [4], and mothers often work full time and sometimes even work at more than one job [4, 37]. These family dynamics suggest that daughters are faced with an array of familial responsibilities including some level of caretaking or support roles in the family. In these families, there may be higher levels of interdependency between parent and child because of economic need [38]. Second, in a substantial number of low-income families, children are closer in age to their parents and these 'age-condensed patterns' have implications not only for child rearing and parent–child relations [39, 40] but also for the dissemination of health information. Third, the expanded learning opportunities for youth now include a school curriculum with general life skills and many health-related subjects [22–26], as well as technology use.

Additionally, adolescents have a long history of demonstrating their effectiveness as health advocates. However, up to this point, the potential of adolescents as health advocates has mostly been utilized and explored in relation to their peers [41–44]. Many studies use the mother as the conduit for providing health promotion instead of considering the potential of daughters to influence their mothers. Other studies have demonstrated that mothers and their adolescent daughters will work together for health promotion purposes. In the Daughters and Mothers Exercising Together (DAMET) study, mothers and daughters were willing to collaborate on an exercise program [45].

Some studies, though, have illustrated the use of adolescents to educate or promote health with their parents. Researchers found that 90% of non-smoker adolescents would be willing to help a parent quit, and that female participants were more likely to be willing to take on this role [46]. Popular efforts in the United States, such as Children Helping and Motivating Parents to Stop Smoking [47] launched by Campaign for a Tobacco-Free America, illustrate the role children can play in impacting their parents' health behavior. The Colon Cancer Alliance urges children to talk to their parents about

colon cancer [48, 49] while other research indicates that children can influence their parents even in a health domain traditionally thought of as being the sole responsibility of adults, i.e. diet [50]. Furthermore, there is preliminary indication that despite an inevitable conflict between mother and teenage daughter, there is a willingness on the part of daughters to provide their mother with potentially life-saving cancer information [51].

This research examines the feasibility of utilizing adolescents to provide their mothers with health information. Studies have shown that race/ethnicity, cultural views, socioeconomic status and family dynamics all play a role in determining people's health behavior [52, 53]. Research findings are inconsistent as to whether the role of ethnicity is an exclusive factor in predicting health behavior. For purposes of this study, we are not examining ethnic differences but instead are trying to assess the feasibility of African–American and Latina daughters being willing to be conveyers of health advice to their mothers.

The research question, i.e. if daughters are willing and open to provide their mothers with health advice, is necessarily guided by the extensive family communication literature [54–59]. There are various theories about family dynamics that provide a useful framework for understanding why daughters might have influence on their mothers [59, 60]. However, this study is informed, in particular, by the interpersonal communication motives model [61] which provides a rationale for why daughters might be able to influence their mothers' health beliefs. This model takes into account the motivations for why girls might be inclined to provide health advice to their mothers as well as how certain characteristics of daughters might influence message credibility and the extent to which they might be able to influence their mothers.

This study makes a critical contribution to the literature on health promotion in that it has the potential to provide researchers and practitioners valuable insights into the conceptualization of innovative interventions specially geared at mother–daughter dyads. This is an innovative approach because it recognizes that daughters have continual access to their mothers and can provide them with health information and tangible assistance, such as child care, accompaniment to doctor's visits and emotional support. It provides a culturally intact resource to provide cancer education, similar to the latest approaches to increasing cancer screening in women that focus on culturally tailored interventions [62, 63].

Methods

Sample

Eligible participants were those girls between the ages of 12 and 17 who lived in the same house with their mother or the person whom they regarded as the mother figure. Criterion sampling [64] was used and participants were selected who lived in neighborhoods with income levels well below the poverty thresholds [65]. Neighborhoods reported median household incomes between $4401 and 19 698 [8]. We conducted 12 focus groups with 78 participants: six with African–American and six with Latina daughters. The research protocol was approved by the institutional review board of the MetroHealth Medical Center in Cleveland.

Recruitment

This study specifically recruited participants from low-income neighborhoods. This study focused on low-income African–Americans and Latinas because of the known disparities in cancer incidence, prevalence and mortality. Census data were used to identify some of the poorest neighborhoods in a mid-Western city that had large numbers of African–American and Latina residents. Most of the focus groups were conducted during the summer months and we, therefore, benefited from the availability of numerous youth programs. Participants were recruited from three recreational centers, two job training programs, three summer camps and two girl empowerment programs.

Data collection

This study used a focus group methodology to explore the perceptions, attitudes and experiences of adolescent daughters. This study examines, in particular, the (i) salient characteristics of the mother–daughter relationship; (ii) existing nature of general

health communication within this dyad and (iii) willingness to share cancer health information with her mother. This is an initial exploratory study and given the importance and merit of assessing the daughters' views independent of that of their mother, we only conducted focus groups with daughters. Future studies will explore the willingness of mothers to accept and act on their daughter's health advice.

Instruments

The focus group guide was reviewed by members of the community advisory board for clarity and cultural appropriateness. In particular, the domains of the focus group guide were further informed by previous research with mothers and daughters conducted in South Africa [51]. The focus group guide for the present study consisted of three major domains: (i) the mother–daughter relationship, (ii) advice given by the daughter and (iii) the potential of daughters to give their mothers cervical cancer advice.

Procedures

We first arranged a face-to-face visit with each program manager of the youth program, explained the background and goals of the research and inquired about the potential of approaching the program attendees to participate in the research. Once the eligible girls expressed an interest in learning more about the research, they met with the research staff for about 30 min. At this meeting, the daughters were informed about the research topic and the focus group methodology and had the opportunity to ask questions about their participation as well as the long-term goals of the study. There were ~8–10 girls present at each informational meeting. Of these attendees, at least 80% would continue to express an interest. They were given an informational letter and a consent form to take home to their parents. The majority of those at the informational meetings (80%) returned their signed consent form to the youth program manager. Research staff spoke with each parent who signed a consent form. Furthermore, daughters were asked to complete an assent form. All focus groups were held at the location where the group was recruited. Light refreshments were served prior to the start of the focus groups and a $10 department store gift certificate was provided as a stipend.

Data analysis

The data analysis process began within 24 hours after the moderators completed debriefing reports. These reports covered the logistics of the space, the group dynamics, the moderators' performance, the participants' comprehension, emerging themes and unanticipated findings [66]. The data analysis process for this study was guided by the principles of grounded theory [64]. Grounded theory is particularly suited to the analysis of this data in that the goal was to understand the issues that could serve as barriers or assets to the development of a daughter-initiated intervention. Because of potential confidentiality issues with respondent validation [67] and time demands [68,69], this study used several other methods of data analysis to ensure the rigor of the research. To ensure reliability, the analysis process involved three coders who read the transcripts and independently wrote a summary of the main issues that emerged for each of the domains. Coders were instructed to first make notes in the margins as to the main points and, thereafter, identify the main themes as understood by them for each of the questions. After they developed these summaries independently, the three coders met to discuss the emerging themes. Coders then reached consensus on the main themes. The agreed upon salient themes for each question were then combined into one final summary for each domain. Coders agreed 95% of the time with each other. When different interpretations arose, coders had extensive discussions until they agreed on a final interpretation. No computer software was used in this data analysis.

Results

The total sample was 51% Latina and 49% African–American. Of those self-reporting as Latina, 44% identified themselves as Puerto Rican, while the others reported a range of ethnic backgrounds including Dominican, Guatemalan, Peruvian, El

Salvadorian and Argentinean. The average age of the participants was 15 and their average grade in school was ninth. For study purposes, the use of the term 'mother' includes any female primary caretaker living in the home, regardless of her legal guardianship status. The mothers' average age was reported as 39 and most of the sample (85%) indicated that they lived with their biological mother. The remainder identified a stepmother, aunt, grandmother, cousin or sister as the primary female caretaker. Almost two-thirds (63%) of the sample reported that their father did not reside in the home. Of the 78 daughters, 13% reported having no siblings. The average number of siblings reported by participants was 2.24 (median = 2 and SD = 1.6) with a range from 1 to 7.

The mother–daughter relationship

Stressful environment

One of the overarching themes was the stressful lives of mothers. The majority of participants talked about their mothers' busy work schedule, the various difficulties mothers experience in their role as economic provider and how these issues limited time with the daughter. Many of the participants stated similar comments such as: 'My mom is a single parent, so she has two jobs … She leaves at 8 in the morning and won't come back home until 10 at night. So the days that she does have off, we go out and we'll have fun … You know, we don't spend enough time because I have younger brothers and sisters that I have to take care of and it doesn't leave me time to go out with my friends.'

Participants often remarked that their mother's life circumstances influence them. For example, one participant said: 'Like she (my mom) influences me to do better, because I know she's like struggling, like she's got all these jobs and stuff, and so like she influences me to work hard so I don't have to do all those jobs.' Other comments suggest that the stressful and difficult circumstances, in some cases, can foster a closeness, as captured in this response: 'Me and my mom have been through a lot of stuff, so we have a more open relationship and I'm able to tell her almost anything. She tells me stuff that happens to her on day to day occasions and so I'll try to help her out and she'll try to help me out in school with teachers that are getting on my nerves and stuff.'

Another important issue that emerged is how the mother's poor health may impact the daughters' anxiety about her own future, such as: 'Because my dad isn't there, and I feel like the only person I have right now is my mom. If I lose her, then I'm left with nobody, so I tell her like: ''you're [not] raising me without mother and father.'' If I lose you, then I won't have anybody.'

Mother as protector and friend

Several daughters viewed their mother as their friend and protector and expressed a strong emotional attachment. There were strong loyalty statements despite stories of conflict about the daughters' relationship with their mothers. Some of these quotes were: 'she's there for me,' 'we stick together' and 'she's got my back.' One participant talked about how their particular living conditions have made her mother protective. She says, 'My mother is protective, but in a good way. She tells me not to go in certain areas because of where certain killings have been happening …'

The 'mother as friend' theme was a particularly common theme. For example:

> Participant: 'Well the relationship with my mother is, I like that because she's still young, and she's like a little kid still.'
>
> Moderator: 'How old is she?'
>
> Participant: 'Thirty, and she like likes kids and she's into like everything that we're into, like the shoes and clothes and all of that, and I just like her.'

Learning opportunities

Several focus group participants suggested that their access to learning opportunities, especially at school, offered a reason for why their mothers would listen to them. For example, one participant said: 'Like sometimes she (mother) says I'm smarter than her, because like when she's about to make a big mistake,

I am like 'Mom' and 'don't do this because' and I give her all kinds of reasons. Like I persuade her not to do something, just like she does for me and she'll do it.' According to some, they often share what they learn with their mother. One participant said: 'Like when I learn something like helpful in school, like I want to hurry up and tell my mother so like she won't get it and she'll like be aware of it.' In some cases, daughters have skills that the mother does not have as illustrated in this comment: 'Just yesterday, we went to the mall. I drove her around. I always drive her everywhere, because she doesn't know how to drive, so I drive her everywhere' (see Table I).

The nature of daughter-initiated advice

Obstacles in communication

Focus group participants described incidences of advice giving to their mothers against a background of communication challenges and rewards. In every focus group, participants mentioned their mother's use of 'prescriptive talk'. Prescriptive talk refers to mothers talking to their daughters in ultimatum mode. For example, participants discussed how their mothers would often use phrases such as, 'You better not do what I did,' 'You better not do it,' 'I warn you' or 'You better do it'. Several daughters reported significant obstacles in communication with their mothers. One girl explained: 'Me and my mother, we're on different levels, and sometimes we get along and sometimes we don't but I still have her back and she'll still have mine, but it really isn't a relationship. We just do our own things, because we're different. I don't listen to her and she doesn't listen to me.'

Table I. *Percentage of daughters who have previously given advice to their mother*

Focus group	% of participants who have ever given 'general' advice to their mothers	% of participants who have ever given 'health' advice to their mothers
AA1[a]	75 (6/8)	100 (8/8)
AA2	82 (9/11)	73 (8/11)
AA3	57 (4/7)	71 (5/7)
AA4	75 (3/4)	50 (2/4)
AA5	66 (4/6)	83 (5/6)
AA6	100 (5/5)	100 (5/5)
L1[b]	100 (8/8)	87 (7/8)
L2	57 (4/7)	86 (6/7)
L3	100 (4/4)	75 (3/4)
L4	75 (4/6)	100 (6/6)
L5	80 (4/5)	80 (4/5)
L6	86 (6/7)	100 (7/7)

[a]AA = African–American.
[b]L = Latina.

General advice giving

We explored the daughter's experience of giving general advice to her mother. Among those who had no significant barriers in communication with their mother, the majority reported giving their mothers a range of advice from hairstyles and clothing styles to work and intimate relationships. Advice was both requested by the mother yet also unsolicited at times. There were several examples of advice about appearance: One participant said: 'Probably, like when she goes out in public, I'm like, ''Um umm, you better not wear that. That looks nasty,'' and stuff like that we do nowadays, that they shouldn't be doing, like saying certain stuff, playing certain music, around certain people …' There were many examples of giving relationship advice as the following comments illustrate: 'I gave her a lot of advice, like the dudes that she pick, as far as her boyfriend or whatever, I don't think they are the right ones, and I try to tell her, and she doesn't listen until something goes wrong' (see Table II).

Health advice

In each focus group, several of the participants indicated that they have given their mother health

Table II. *Percentage of daughters who agreed to share cervical cancer information with their mother (n = 78)*

African–American focus groups	Agree	Latina focus groups	Agree
AA1	4/8 = 50%	L1	8/8 = 100%
AA2	6/11 = 55%	L2	7/7 = 100%
AA3	7/7 = 100%	L3	4/4 = 100%
AA4	2/4 = 50%	L4	6/6 = 100%
AA5	3/6 = 50%	L5	5/5 = 100%
AA6	4/5 = 80%	L6	7/7 = 100%
Total	26/41 = 63%	Total	37/37 = 100%

advice in the past (see Table II). Furthermore, several participants reported providing their mothers' health advice that resulted in mothers obtaining medical care. One participant talked about encouraging her mother to obtain cancer screening. She said: 'When she (mother) goes to have a cancer screening, what can I say, she is scared, but I tell her that she can't go alone if it is a cancer screening. She always has to take someone with her and I support her. I tell her that even though she doesn't like to, but I tell her that she had to go because it is for her health, she has to know if she has something.' Even advice about birth control was not taboo. Another participant said 'My mom kept getting pissed off that she kept on having kids, so I was like ''go to the hospital and get your tubes tied. If not, I'll run down to the corner store and I'll get you some condoms or something.'' She was like, ''All right, I'll go get my tubes tied.'''

Several participants reported giving advice to mothers about diet and nutrition. For example, one participant said, 'Like my mom, she's a little bit fat. And I'm like ''mommy [go on a] diet.'' I tell her, ''mom you're going to feel better, healthier.'' She's like ''okay.'' She says, ''I'll take your advice and go on a diet.''' Illustrative of the fact that many of their mothers smoked cigarettes, participants reported giving their mothers regular advice about smoking. In fact, some indicated that they went beyond advice giving as illustrated by one participant, 'The advice I try to give to her [mother] about smoking and drinking, she's not a liquor drinker, but she's got to have a can of beer. Cigarettes are high. She's got to have a pack of cigarettes. And she'll ask me for some money, I'll tell her no, because I know she will buy cigarettes with it.' Other participants provided mothers' health advice about behavior changes needed to deal with a variety of chronic illnesses such as diabetes and asthma. One participant said: 'My mom's got diabetes and asthma and high cholesterol, so I always be on it. Like you know when you see a piece of chocolate and you want it, like I was telling her ''You know you can't be eating much of that, because your sugar is going up too high.'''

Willingness to provide mothers with cervical cancer advice

The major difference in responses between Latina and African–American daughters involved their willingness to provide their mothers with cancer advice (see Table II). The Latina daughters (100%) overwhelmingly responded that they would share cancer advice with their mother. One Latina participant said: 'I think you should. I know I do, because why not? You learn something in school and your mom probably doesn't know. You might as well share it with her so she can know it too. You already know and you should tell your mom so that you can protect that part too [referring to cervical cancer].'

The African–American daughters were more varied in their response to the same question, and only 63% reported that they would share cancer advice with their mother. We examined the reasons that African–American participants provided for being reluctant to give their mothers health advice. One participant thought her mother should already have access to this knowledge and that perhaps she was not the right person to tell her. She said: 'Because she should already know, unless it's something new, but I still wouldn't tell her. Somebody else would tell her.' Previous experience with giving mothers health advice seemed to also influence daughters' future willingness to provide cervical cancer advice. One participant said: 'She's hardheaded and doesn't listen and I don't feel like wasting my breath talking to her.'

Some of the participants expressed that although they may give their mother health advice, the mother would not necessarily act on that advice. An African–American participant, on telling her mother to stop smoking and drinking, said: 'She tells me ''Stay in a child's place.'''

In summary, the findings demonstrate that focus group participants have a multifaceted and dynamic relationship with their mothers and daughter-initiated knowledge transfer occurs regularly. The mother–daughter relationship within the low-income family seems to occur within the context of stressful and difficult personal circumstances. Nonetheless,

these adversities appear to foster closeness between mother and daughter which manifests itself in communication opportunities. Although several daughters reported significant obstacles in their communication with their mother, many others viewed their mother as their friend and protector.

Focus group participants indicated that they often had access to additional learning opportunities and skills that they tend to convey to their mothers, solicited and unsolicited. Daughters reported that they regularly give their mothers a wide range of advice mostly about appearance but also about managing relationships. In all the focus groups, participants indicated that they had given their mother health advice at least once. Although Latina and African–American daughters had similar responses to almost every focus group question, the one main difference involved is their willingness to provide their mothers with cancer advice. Latina daughters overwhelmingly reported that they would share cancer advice with their mothers. However, African–American daughters varied more so in their responses, believing that their mother should already know the information or previous experience with their mother indicated that she would not listen to the daughter's advice.

Discussion

This study examined the mother–daughter relationship and the potential for daughter-initiated health advice. Parents influence their children in a wide spectrum of activities and knowledge acquisition from television watching [70], driving style [71], diet and exercise [72–74] to HIV/AIDS education [75]. Nonetheless, there is a lack of research directly examining the potential of young people to influence their parents' health behaviors. In this study, the overarching themes to be considered for daughter-initiated health advice include stressful lives of mothers, mother as primary protector, closing age gap between mother and daughter and the daughter's ability to access new learning opportunities. These data suggest that these roles create a relationship in which certain communication boundaries may have shifted to include advice giving by adolescents as appropriate. Many of the focus group participants indicated that they are already providing their mothers with health advice. This finding is similar to previous research with low-income mothers and their adolescent daughters in South Africa [51].

The role of mother as a friend has important implications for daughter-initiated health education efforts. Adolescents, despite their young age, are often highly motivated to help others, especially peers, in health education programs [74,76–79]. Pinquart and Silberstein conducted a key study on adolescent-to-parent influence and value transmission [80]. They state that children are assumed to internalize the attitudes, rules and expectations of their parents. Their research suggests that this narrow view necessarily constrains research and fails to acknowledge that adolescents can influence their parents, thus providing the opportunity for mutual influence.

This study has generated several intriguing questions about the potential of daughter-initiated health advice. One of the most interesting findings includes the difference in responses between the African–American and Latina daughters. The Latina daughters all stated unequivocally, regardless of positive or negative feelings toward their mother, that they would give their mother health advice while the African–American daughters differed among themselves. Some of the hesitation to give mothers cancer advice involved how they thought their mother would perceive their advice, how they did not feel it was their place to give the mother advice and/or how they thought she should already know this information. Although these data suggest that there may be significant differences between African–American and Latina family dynamics in terms of daughter-initiated health advice, further in-depth exploration is necessary. In general, there are inconclusive findings on the role of ethnicity as the sole factor in determining health behavior. Ethnicity is one factor that by itself does not explain the perceptual differences between African–Americans and Latinas. The influence of cultural views, socioeconomic status and family structure is probably more indicative of daughters' behavior and their

potential to impact their mothers' health behavior than ethnicity alone.

Limitations

The interpretation of these findings must necessarily be mediated by the fact that focus group data by itself is exploratory and therefore no generalizations beyond these participants can be made. This data does, however, provide researchers and practitioners with some key domains that could be further explored. In this study, the emerging themes can possibly provide the basis for further in-depth study and quantification. On the other hand, while these data report on the perception and attitudes of daughters about their mother or mother figure, it needs to be interpreted with caution in that these perceptions may not correlate with that of their mothers or female caretakers. A limitation of this study includes the fact that we did not interview mother–daughter pairs and thus we cannot compare the responses of the daughters to that of their mothers. In fact, given the known discrepancies in perceptions of messages (both received and sent) in pair communication [81,82], it may be that daughters believe they are giving health advice but that their mothers do not perceive, interpret or accept it, at all, as health advice.

Future research

Further research is needed on the many cultural contextual factors which may affect health behavior and advice giving across and within ethnic groups. The most significant question about daughter-initiated health advice may be whether mothers will even listen and act on health advice from their daughters. However, before these questions can be answered, researchers need to establish whether mothers find it appropriate that their adolescent daughters give them health or cancer advice in particular. Future research also needs to examine the motives of both daughters and mothers for giving and being accepting of health advice.

Conclusions

Despite findings that daughter-initiated advice may already occur, it is also clear that not all mother–daughter relationships will be suitable candidates for such an intervention. As researchers continue to examine innovative and culturally appropriate ways to reduce health disparities among those who are low income, underserved and consequently lead extremely challenging lives, it is imperative that researchers recognize the assets that exist between mothers and daughters. Daughters are exposed to a wide range of educational opportunities, making them likely candidates to provide their mothers with health information. They have access to their mothers; they care about their mothers and often their mothers are all they have. It is critical that future research efforts to reduce health disparities explore this unique relationship and its potential for daughter-initiated health education.

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Conflict of interest statement

None declared.

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