Social Support in the "Fourth Trimester": A Qualitative Analysis of Women at 1 Month and 3 Months Postpartum

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ABSTRACT

Social support is essential in the postpartum period when support is positively associated with infant care and maternal adaptation and its absence is associated with postpartum depression. The aim of this qualitative study was to explore how postpartum women experience social support and variations in the type and quantity received. Researchers conducted two semistructured interviews with a convenience sample of 22 participants at approximately one month and three months postpartum. Social support varied in quality and quantity. Respondents indicated that the presence of support made the postpartum period easier, less stressful, and more enjoyable. Efforts to help women plan for postpartum social support during pregnancy should focus on relationships and social networks as well as individual behaviors and community services.

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A newborn's arrival brings joy, but also change and challenge. As mothers adjust to caring for the infant and the accompanied fatigue and stress (Nagata, Nagai, Sobajima, Ando, & Honjo, 2004), help from her partner and extended family is vital (Bost, Cox, Burchinal, & Payne, 2002). This help, termed "social support," is defined as the help received from our contact with others. It can be delivered in four forms: emotional (displays of caring, trust, and empathy), instrumental (concrete help and service), informational (advice, suggestions, and information), and appraisal (information that is useful for self-evaluation) (Cohen & Wills, 1985). Social support is given voluntarily and prompts an immediate or delayed positive response in the recipient (Hupcey, 1998).

In the four decades since Cassell's then-groundbreaking findings connecting the social environment and health outcomes, researchers have connected health to the social environment

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in dozens of ways ranging from the decreased likelihood of catching a cold to the reduction of overall mortality; conversely, poor social environments have been connected to a wide range of risks including decreased immune function, higher blood pressure, and higher rates of depression, pain, and fatigue (Cassel, 1976; Chen & Feeley, 2014; Holt-Lunstad, Smith, & Layton, 2010; Holt-Lunstad & Uchino, 2015; Schnall, Harber, Stefanucci, & Proffitt, 2008). Specific to postpartum women, the presence of social support has significant positive correlations with outcomes including breastfeeding, infant care, and maternal adaptation, while a lack of social support is strongly related to the presence of stress and postpartum depression (PPD; Hung & Chung, 2001; Ni & Siew Lin, 2011). Thus, for the well-being of both the infant and mother, social support during the postpartum period is essential (Emmanuel, St John, & Sun, 2012).

While attention is often lavished on pregnant women, to prevent PPD, the provision of social support needs to be focused after birth, not before. In a sample of more than 6,000 Canadian mothers, Kim, Connolly, and Tamim (2014) found that mothers with low levels of social support after birth were more than five times more likely to experience PPD; however, levels of social support during pregnancy did not predict PPD. This is consistent with Liabsuetrakul, Vittayanont, and Pitanupong's (2007) findings that social support in the postpartum period, but not pregnancy, was associated with lower PPD in Thai women. According to Dennis, 2014, the risk of PPD is higher when the following are present in postpartum women: (a) lacking someone who has shared a similar experience to openly talk with, (b) lacking an intimate confidant or friend, (c) needing to ask for support in order to receive it, and (d) feeling socially isolated.

Some interventions that work to address one or more of these characteristics have shown that bolstering peer support can reduce PPD (Pilkington, Whelan, & Milne, 2015). Elliott et al. (2000) utilized group classes (5 antenatal and 6 postnatal) to help mothers who reported marital dissatisfaction to strengthen and utilize their social support networks and adjust to postpartum life. The intervention reduced primiparas' risk for depression at 3 months postpartum; no effect was seen in multiparas. Milgrom, Schembri, Ericksen, Ross, and Gemmill (2011) investigated the use of a self–help workbook plus telephone support in women with elevated EPDS (Edinburgh Postnatal Depression Scale) scores. Compared to routine care, mothers completing the intervention were significantly less likely to experience PPD at 12 weeks postpartum. Finally, in a randomized controlled trial, Dennis et al. (2009) evaluated the effectiveness of telephone-based mother-to-mother volunteers. Community volunteers contacted mothers at high risk of PPD by telephone a minimum of four times beginning within 72 hours of their entering the program. At 12 weeks postpartum, half as many women in the intervention group (13.5% vs. 24.8%) had EPDS scores greater than 12 compared to the control group.

The reduction in PPD when social support is present is theorized to be due to social support acting as a buffer, mediating the stressors associated with the transition into parenthood (Bilszta, Gu, Meyer, & Buist, 2008; Don & Mickelson, 2012). Some common stressors in the first few weeks include breastfeeding challenges, the logistics of newborns (e.g., outings, people visiting), and learning to understand the tears and rhythms of the baby (Razurel, Bruchon-Schweitzer, Dupanloup, Irion, & Epiney, 2011). These stressful events in the postpartum period occur with great frequency and are experienced with a high degree of intensity. Thus, even large amounts of social support often do not adequately match the great need for social support experienced (consciously or subconsciously) by postpartum women (Razurel et al., 2011).

While many studies have explored the relationship between social support and PPD, far fewer have focused on the social support network and provision of the support itself (Razurel et al., 2011) and few studies have examined the differences in delivery of the different types of social support in postpartum women's lives. The aim

of the present study was to explore how women in the "fourth trimester" experience social support, specifically (a) types received; (b) types desired, but not received; (c) sources of social support; and (d) the variance between soon after birth (1 month postpartum) and later (3 months postpartum).

METHODS

Institutional Review Board (IRB) approval was obtained from the authors' academic institution prior to the initiation of any data collection. Pregnant women ages 18 and older were initially eligible for inclusion. Women were excluded if they gave birth before 37 weeks, their baby died, or their baby had a life-threatening medical condition or congenital anomaly. Recruitment of potential participants occurred via convenience sampling in a midwifery and obstetric clinic, then via snowball sampling on social media. In the clinic setting, potential participants were identified by providers at their routine prenatal care visit at approximately 32 weeks or 36 weeks' gestation. On social media, pregnant women in the last trimester of pregnancy were invited to take part. In both the clinic setting and via social media, potential participants were provided with information about the study and directed to an online questionnaire to register. The registration questionnaire included informed consent, demographic questions, and contact information.

Researchers used text messaging to contact registered participants for confirmation of participation and to schedule interviews. Researchers conducted two semistructured interviews with each participant at approximately one month and three months postpartum. The researchers developed the interview guide and conducted key informant interviews with a convenience sample of four women who had given birth in the last 2 years to determine the acceptability of the questions. Key informants did not suggest any changes to the interview guide. The interview guide began with researcher introductions, an outline of what to expect from the interview, a review of the voluntary nature of the interview, and rapport- and trust-building questions about the respondents and their baby. It then proceeded to a series of open-ended questions regarding challenges they had experienced, people who had been supportive, examples of support they had received, support they would have liked to have more of, and what advice they would give to pregnant women regarding the postpartum period.

In addition, the interview guide contained a series of closed-ended questions in which respondents were asked to specify whether they *always*, *sometimes*, or *never* had people in their lives who provided different forms of the four types of social support. Respondents were asked to answer about social support in their lives at the time of the interviews in general and specific to the postpartum experience. These included five items regarding the presence of emotional support, two regarding informational support, three regarding instrumental support, and two regarding appraisal support. Example statements included "someone you can count on to listen to you when you need to talk," "someone to give you information to help you during this time," "someone you trust to watch your baby," "someone who shows you love and affection," and "someone who makes you feel capable." The same statements were included in the 1- and 3-month interviews.

Interviews were conducted via telephone, audio-recorded, and transcribed for analysis word-for-word. To ensure accurate transcription, a third researcher read all transcripts to verify the accuracy compared to the recordings. Each interview lasted approximately 30 minutes. Participants received one $10 gift card to a local gas station upon completion of each interview (up to $20 total, per participant). Recruitment and interviewing occurred on a rolling basis between April and December 2016.

The analysis approach followed a qualitative, data-driven process (Boyatzis, 1998). After initial readings of the transcripts by two researchers, codes were developed and used to establish intercoder reliability. Sixteen transcripts were selected at random and coded by both researchers; through subjective assessment the two researchers reached consensus regarding how to code the transcripts (Guest, MacQueen, & Namey, 2012). The remaining transcripts were equally split between the two researchers for coding. Instances of social support were categorized according to the types of social support defined above (informational, instrumental, emotional, appraisal, or "other"). "Other" was utilized when support was mentioned but was not

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described as a specific type of support. For each instance of social support mentioned by respondents, the source of support was recorded, and the instance was coded as either positive (support that was actually provided and received) or negative (support that was lacking, wished for, offered but never given, etc.) in a coding matrix. Analysis compared responses from the first and second interviews to look for differences in social support experiences. Quotes were lightly edited for clarity as needed, but every effort was made to maintain the participant's meaning. Words added for explanation by the authors are contained in block parenthesis.

In any qualitative study there is potential for bias due to the nature of using the researchers as human instruments for data collection and analysis. Bias may extend to the way the interviews are conducted and the way comments are interpreted. Bracketing is a method of acknowledging potential research bias (Tufford & Newman, 2012). Both researchers working on the present study were mothers who had given birth within the past 10 years and each had both positive and negative experiences of social support in the postpartum period. The researchers did not have any preconceived expectations regarding the respondents or their responses, primarily because their own experiences were so varied. The researchers agreed to bracket their own personal experiences and allow differences to emerge.

RESULTS

Respondents

Of the 26 women who registered for the study during the recruitment period, one was ineligible due to complications with the pregnancy, one could not be reached for interviews, and two declined to participate. In total, 22 women took part in the study and were each interviewed twice (once at 1 month postpartum and once at 3 months postpartum) for a total of 44 interviews.

Participants ranged in age from 24 to 36 years (mean 28.3 years). Regarding type of provider usually seen during prenatal visits, 12 reported receiving care from a doctor and 10 reported receiving care from a midwife. Regarding health insurance, 18 participants reported carrying private insurance, three carried Medicaid, and one did not report insurance. For nine participants, this was their first baby. Respondents raised their own examples of instrumental, informational, and emotional support but did not discuss appraisal support at any time other than when specifically asked in the closed-ended question series.

Instrumental Support

Respondents mentioned 220 instances of instrumental support. Of these, 115 (96 positive and 19 negative) were mentioned at the 1-month interviews and 105 (85 positive and 20 negative) were mentioned at the 3-month interviews. Instrumental support was primarily received by respondents from partners/spouses, close family members, friends, or via purchased services such as housecleaning services or meal/grocery delivery services. Instrumental support most often took the form of providing meals, childcare for the baby or older children, housework, help with groceries, or other day-to-day tasks that were a source of potential stress. In her 1-month interview, one respondent summed up the relief of having meals ready to go:

> *Respondent A, 1 month: We had a lot of friends bring us food. Some friends gave us a whole week of meals, which is great because it has been stressful and we don't have a lot of time.*

Partners played an important role in the provision of instrumental support for many respondents. This was expressed in varying degrees. One respondent stated in her 3-month interview:

> *Respondent B, 3 month: My husband, if I have to work late, he just handles everything and doesn't ask a lot of questions. That's probably the most helpful. Like he just gets it and does it and I don't have to stress about it. I can just be at work and not feel worse about it than I already do for not being at home and helping.*

Extended family also played an important role in the provision of instrumental support:

Respondent C, 3 month: My brother and his wife live close by. They are always willing to help out however they can and take my toddler overnight, watch her for a couple of hours, whatever they can do to help.

When this type of support was discussed in the negative context as missing or lacking, respondents reported that partners or family members had not been as helpful during the postpartum period as they had hoped or expected, although those hopes and expectations were rarely described as having been planned or concretely laid out ahead of time. In her 3-month interview, one respondent noted that although plans were made for instrumental support ahead of time, the plans fell through:

Respondent D, 3 month: I really thought that [my husband's mom] was going to help watch [the baby] for most of the day and then [my husband] could actually continue his day job, but that didn't turn out that way.

Another respondent noted in her 1-month interview that instrumental support was not provided to the same degree with subsequent children as with the first birth.

Respondent E, 1 month: There's less support, I think people think once you have a second, third, or fourth, you just don't need anything. And yeah, we don't need physical things, we don't need clothes or things like that...but it was meals galore for the first one when we actually had someone who could have made a meal because there was only one kid.

For some respondents, partners returned to work earlier than expected. As one respondent stated in her 1-month interview:

Respondent F, 1 month: It would have been really nice if [my husband] could have taken a few weeks off and just been a part of those early weeks when I was trying to figure out breastfeeding and getting into a routine and even simple stuff, like holding her while I took a shower.

For others, they had no family nearby and lacked a local support infrastructure (this impacted the presence of instrumental support as well as emotional support). Although some of these respondents acknowledged that friends were available to provide instrumental support if needed, they reported that the close relationship with family made it psychologically easier to ask for help from those individuals than from friends or acquaintances. As one respondent stated in her 1-month interview, having to ask for help can compound the stress of needing the help in the first place:

Respondent E, 1 month: Laundry. That's about the only thing that's been a little [stressful], like boxes and boxes of clothes that just need attention, but I don't really want to ask anyone to do that crappy job.

A lack of instrumental support led some respondents to feel resentment toward people in their social network. As one respondent stated in her 1-month interview:

Respondent C, 1 month: I feel like I should be keeping a very clean house and I should be the maid, and then I get bitter and resentful and I am like, "When did I agree to being the maid around here? Why am I the only one who sweeps the floor?" And I am.

Emotional Support

Respondents mentioned 77 instances of emotional support. Of these, 41 (32 positive and 9 negative) were mentioned at the 1-month interviews and 36 (24 positive and 12 negative) were mentioned at the 3-month interviews. Emotional support was received from partners/spouses, family, and friends. In addition, however, emotional support was received from less "tangible" sources such as social media groups and "mom groups" comprised of other mothers of infants and young children that met virtually or in person. For example, a respondent in her first month since the birth of her baby said:

Respondent E, 1 month: My closest friends are eight women who met in a breastfeeding support group when my first [child] was born. We've done date nights and play dates and that's been great.

Other respondents mentioned the peace of mind found through connections with other moms. These "mom networks" provided informational and emotional support. For example, one respondent stated in her 3-month interview:

Respondent C, 3 month: Some of my best friends, who are also moms, I can shoot a text to and say,

Respondents cited examples of emotional support such as having "adult time" with friends or family, just "hanging out," and other instances when another adult made the respondents feel loved, cared for, and important.

"This is what's happening today." and they'll just kind of commiserate and say, "I hate that, that happens here too." Even just being able to do that makes me feel better. I feel more normal.

Online groups were discussed with more ambivalence, as one respondent summarized in her 3-month interview:

Respondent B, 3 month: Support groups would be nice, but not snooty, stupid support groups of moms who do everything and talk about how awesome they are.

Respondents cited examples of emotional support such as having "adult time" with friends or family, just "hanging out," and other instances when another adult made the respondents feel loved, cared for, and important. For example,

Respondent G, 1 month: My dad drives by my house to and from work. Sometimes he just stops to see how I am doing and see if I need anything. My mom, once a week, all 3 of the kids and I go over there, generally when the baby is sleeping, so I can have an adult conversation with my mom because the most adult conversation I get is with a 7-year-old during the day. That's enough support, just to be able to talk to somebody who is not going to try to talk to me about dinosaurs or "Paw Patrol."

When emotional support was discussed in the negative context of lacking or missing, respondents were often clear about the presence of instrumental support (things people were doing for them) but that they missed emotional connectedness. One respondent spoke about the fact that her friendships changed after her baby was born, impacting her emotional support:

Respondent H, 3 month: It's really difficult because a lot of people who were there during my pregnancy weren't there [for me] after. And that is just really hard, especially when they've been really close friends.

Another respondent described the feeling of taking the backseat role to the new baby in her 1-month interview:

Respondent C, 1 month: I wish I would have had more just emotional support, people checking in to see how I'm doing. Obviously, people want to know about the baby, and I am happy to share, but I don't feel like I was getting checked in on for me as much.

Another lamented an emotional disconnection with her mom:

Respondent I, 3 month: I thought my mom would be more involved, but she's hardly there. It's a real big disappointment. (Interviewer: What are you not getting from her that you want?) *Just plain old like conversation. Actually taking an interest and wanting to communicate.*

For respondents without a local support infrastructure because family lived far away, the lack of emotional support compounded the stress of not having instrumental support present. One respondent with family and friends far away after a cross-country move talked about that connection.

Respondent J, 3 month: I think just the stress of feeling cooped up means that when I don't feel like I am being perfectly supported, I really don't respond well to that, it feels really not good.

Conversely, the presence of instrumental support made respondents feel emotionally bolstered. As two separate respondents remarked in their 1-month interviews:

Respondent K, 1 month: I knew I was going to have people to help me, just talk to me and be an adult around me, so it wasn't just me and the kids all day long and nobody, no adult to talk to.

Respondent L, 1 month: Our immediate family has been awesome with stopping by. My parents will say, "If you need to nap that's okay. If you want to nap while we are here, go for it." They just want to love on him and make sure we are doing okay too.

Informational Support

Respondents mentioned 73 instances of informational support. Of these, 44 (39 positive and 5 negative) were mentioned at the 1-month interviews and 29 (27 positive and 2 negative) were mentioned at the 3-month interviews. Respondents reported

that they received informational support from health-care providers, lactation consultants, family, friends, Internet sources, social media groups, and "mom groups" (either virtual or in-person). Personal contact with health-care providers was especially reassuring, as described by a respondent during her 1-month interview:

Respondent L, 1 month: I have an excellent pediatrician who gave me his card, so I do feel like if I need help and can't find [information] by looking online, I do feel like I have some support in that way.

Specific examples of informational support for respondents included health information (regarding either their own health or the health of their baby) or problem-solving for infant or personal care. In the 3-month interview, one respondent reflected on the help she received from a program at her local hospital:

Respondent K, 3 month: A...program at our hospital, it is run by a lactation consultant, so she is a nurse too, so whenever I go there, I can pop off a couple quick questions, so I take him there more when I have a question than to have them weighed because I can tell he is growing fine.

Informational support was not discussed by respondents as missing or lacking, but the topic of whether information could be trusted was raised by respondents. Specifically, respondents reported uncertainty regarding the credibility of Internet sources or virtual "mom groups" on social media; respondents raised questions about what sources of informational support were best and some exhibited dissonance in terms of what sources they claimed to trust and what sources they used themselves. As one respondent stated in her 1-month interview:

Respondent C, 1 month: Sometimes it is hard to find credible sources, depending on what you are looking for. You can find a blog that gives you info on anything, you can find it to support whatever you want it to support. I would say in general, it is pretty easy to find the information I need, whether it is just on the Internet searching myself, or talking to people I know who would be able to point me in the right direction. But more obscure/controversial topics, like the vaccine debate, can be a little challenging to find credible sources, I think.

Respondents reported that they received informational support from health-care providers, lactation consultants, family, friends, Internet sources, social media groups, and "mom groups" (either virtual or in-person).

Quantitative Ratings of Support

When asked to rate the frequency with which they experienced specific types of support, respondents generally stated that most examples of support were "always" present in their lives. Very few respondents stated that they "rarely" or "never" had people in their lives to fill specific support roles. Zero respondents stated that they "rarely" or "never" had people to fill emotional, informational, or appraisal support roles; this did not change from the first to second round of interviews. Three respondents stated that they "rarely" or "never" had people to fill instrumental support roles, however. One of these three mentioned this lack of support in the first month postpartum and the other two mentioned it in the third month postpartum.

CONCLUSIONS

The results of this study should be placed in the context of the study limitations. The participants were a convenience sample. Those who volunteered may have had a more extreme experience and thus been more willing to share their thoughts and experiences. Some of the participants were recruited using social media, and thus their comments related to social media may not be representative. The data were not systematically examined to assess differences between primiparous and multiparous women; the social support experiences of these two groups may be different. Finally, due to the presence of self-report bias in any interviewing situation, we cannot verify participants' responses or confirm their experiences.

This study provides useful insights into the social support provision for postpartum mothers for health-care providers and childbirth educators to consider. Social support in the form of instrumental, informational, or emotional support was evidenced in all participants' postpartum periods, although it varied in quality and quantity. It was also subjective and perceived differently

by different respondents. While some respondents reported at the three month interview that the amount of support had waned as compared to at their one month interview, the sources and forms of support remained relatively constant from the one month to three month interviews. Consistently, respondents indicated that the presence of instrumental, emotional, and informational support made the postpartum period easier, less stressful, and more enjoyable.

Given the benefits of social support both for improvement of the postpartum experience and long-term health, it is disconcerting how respondents consistently talked about social support in a passive way; social support was, for most respondents, something that appeared or did not appear, rather than something that was actively planned in advance or even sought out as needed. The exception to a lack of planned social support was that some respondents noted that friends/family had prepared "freezer meals" to lessen the meal prep burden after the birth and some respondents had made child care plans for the new infant or older children. When social support was needed, guilt was frequently associated with asking for help, resulting in their either not asking at all or experiencing stress about asking.

The discrepancy between the consistent high scores on the quantitative ratings of support and the respondents' comments regarding the lack of support appear to demonstrate the difference between having a person in your life who can do things for you and that person actually providing the needed support with or without being asked. This discrepancy highlights the challenges women face when reaching out for help and their feelings of neglect compared to the attention paid to the infant. Many cultures have traditions to prevent this; for example, in many Latin American countries, a custom called *la cuarentena* ("quarantine") allows for a 40-day period after birth during which mothers recuperate from labor and bond with their babies. New mothers do not cook or clean; they rest while others care for them. Similarly, in many Asian countries, a custom known as "doing the month," allows new mothers to rest and as they are intensely cared for by their female friends and family members. Masley hypothesizes a link between these types of rituals and the so-called "Latina paradox," which refers to the surprisingly good birth outcomes (relative to socioeconomic levels) enjoyed by Latina mothers in the United States (Kolker, 2013; Tuhus-Dubrow, 2011).

In the absence of these traditions, to help women prepare for the challenges of the postpartum period, we strongly encourage health-care providers and childbirth educators to discuss active planning for social support with pregnant patients as part of their prenatal care. Active planning necessitates the presence of specific answers to questions about how to tap into their social support network in times of need. Surface level questions, such as "Do you have someone to call?" do not provide the opportunity for women to say that although those individuals are present in their lives, they do not always get what they need. Requesting and receiving promises of help while still pregnant may reduce the need for asking or ease the guilt associated with these requests after the baby's arrival. Unfortunately, few tools to assist with this planning exist. One option is the Doulas of North America's Postpartum Planning Guide which encourages women to identify resource people before birth, such as people who could babysit, provide information about breastfeeding, or bring meals (Doulas of North America, 2005). Further research should explore the advantages and disadvantages of different modalities for organizing social support, including paper checklists, provider- or clinic-based interventions, Web-based or mobile interventions, or community interventions addressing postpartum needs of child care for the baby and any older children, meals, housekeeping, information about baby care, and emotional support.

Future research is warranted into the potential for differences in perception of social support between primiparous and multiparous women. It is possible that previous postpartum experiences change the way women perceive social support in subsequent pregnancies. In addition, future research should examine differences between emotional and appraisal support. While appraisal support may have been present for the women interviewed in this study, it is difficult to tease out the difference between appraisal and emotional support in participant comments because responses relating to their emotions triggered by appraisal may lead those experiences to look like emotional support.

IMPLICATIONS FOR PRACTICE

The concept of planning for social support is new to the postpartum literature. Literature searches find the concept of "planned social support" only related to reducing recidivism in sex offenders and relapse in substance abuse recovery (Whittaker, Tracy, Overstreet, Mooradian, & Kapp, 1994; Willis & Grace, 2009; Willis, 2010). If social support is known to have significant positive correlations with breastfeeding and infant care and negative correlations with the levels of stress and PPD, why wouldn't we want to help women plan for it? Indeed, related to substance abuse recovery, the idea of choosing a "sponsor" is one that could translate to the postpartum experience, particularly if the first postpartum experience helps women learn to navigate the social support landscape in subsequent pregnancies. This idea is supported by Dennis et al.'s (2009) findings with mother-to-mother telephone support. Prenatal providers and childbirth educators have a unique opportunity to encourage women reach out to members of their social support circle, to identify women with postpartum experience, to plan for this important time in advance. This is a time for women to ask not for the gifts and presents which are so ubiquitous, but to ask friends and family for the gift of their presence for emotional support, companionship, information, a listening ear, child care, and help with household tasks, providing mom more time for sleeping, nursing, and healing. This gift of their presence may allow for a calmer bonding experience and better emotional stability for the mother, improving the health of mother and baby alike.

Social support appears to be cumulative rather than a series of isolated incidents; respondents reflected upon ways in which emotional support made everyday stressors seem easier. They also at times described instrumental support that made them feel loved and cared for. The benefits of having supportive relationships were felt at the individual level. Community interventions to enhance the health of mothers, infants, and families, such as screening for social support during the prenatal period to identify women who lack strong social networks and the delivery of interventions to bolster social support, should focus on relationships and social networks as well as individual behaviors and services. Such community interventions could strengthen relationships, improve the health of individuals, and have the potential to improve community health and social norms to support healthy pregnancies and healthy families.

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