Perceptions of Health and Well-Being Among Women in a Work-Based Welfare Program

Eugenie Hildebrandt and Sheryl T. Kelber

ABSTRACT Women who are single parents, poor, and employed in low-paying jobs have little choice about being dependent on public assistance programs to meet basic personal and family needs. Objective: To explore women’s perceptions of their health and well-being while enrolled in a work-based welfare program. This is the second in a series of articles about Temporary Assistance for Needy Families. Design and Sample: Qualitative interviews and quantitative survey methods were used to explore perceptions of health and well-being in a purposive sample of mothers (n = 34) enrolled in a work-based welfare program in a city in the U.S. Midwest. Methods: Instruments used were a semistructured interview guide, a demographic data form, and the General Well-Being Schedule (i.e., a survey tool developed for the U.S. Health and Nutrition Examination Survey). Data collection was completed in June 2000. The data were triangulated; using both quantitative and qualitative data added to the in-depth understanding of the subjects. Results: Distress levels reported by participants were significantly higher than in the general U.S. population. Conclusions: Results of this study suggest that current policies do not effectively support health and well-being of single mothers enrolled in work-based welfare programs. Key words: community health, poverty, primary health care, vulnerable populations, women.

In the United States, more than half of the women with children work away from home and can readily attest to the stresses of holding a job, being a parent, taking care of a home, and taking care of themselves. But what of poor women who are single parents and employed in low-paying jobs with little chance of advancement? Their efforts to stay healthy and safe are often ineffective because of the severe constraints of their life situations, which leave them little choice about being dependent on assistance programs to meet basic family needs (Carney, 1992; Dodson, Manuel, & Bravo, 2002; Fergerson, 2001; Lens, 2002; Olson, Muhammad, Rodgers, & Karim, 2000; Pearlmuter & Bartle, 2000). People who cope with multiple health and social risks are particularly vulnerable. In the words of one single mother in this study:

I had my son prematurely. He was born at 25 weeks. He only weighed a pound and seven ounces. I couldn’t work. I needed to be at home with him for a whole year. He had asthma, bronchitis, his lungs were filled, and he had some disabilities for his motor skills. That is why I am on welfare [TANF]. [Edna, age 35]

Background

Welfare supports

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 replaced the welfare program, Aid to Families with Dependent Children (AFDC)—a Federal and State assistance program that for over 60 years provided basic financial support for adults, usually women, who were
responsible for dependent children. PRWORA replaced AFDC with Temporary Assistance for Needy Families (TANF). The outcome sought was that welfare-dependent people, mostly women, would join the workforce to be eligible for income supplements (U.S. Department of Health & Human Services [USDHHS], 1999; Wisconsin Department of Workforce Development [DWD], 2001). This policy change had a significant impact on family life and health (Kneipp, 2000).

To remain eligible for federal funds for their disadvantaged citizens, states aligned their programs to meet TANF criteria. Services or supports offered through work-based welfare in one Midwestern state, Wisconsin, are job training, earned income credit, job access loans, case management and assistance with public housing, child care, and transportation. Food stamps and health care through Medicaid are programs separate from work-based welfare. There is a 5-year lifetime limit for cash assistance for families. Employment options and TANF criteria are reported elsewhere (Hildebrandt, 2002).

Earning power and access to health care are linked to each other and to the health of individuals and families at all income levels (Anderson, Halter, & Gryzlak, 2004; USDHHS, 2000). Former welfare recipients and women who have been enrolled in work-based welfare programs have only limited prospects for moving up to better jobs that provide health benefits, or moving to better, safer neighborhoods. Data about employment outcomes after people leave welfare have indicated that most leavers in several states were working (51–72%), but usually at low-wage jobs with average earnings below the poverty line (Cancian & Meyer, 2000; Lerman, 2001; Loprest, 1999; Romero, Chavkin, Wise, Smith, & Wood, 2002).

Hildebrandt (2002) and Pearlmutter and Bartle (2000) also found that women on welfare were stressed by their inability to get jobs that paid well enough for them to support their families. This problem was also illustrated by Cancian and Meyer (2000) who found that over a 5-year period only 10% of young women who left welfare earned enough to be above the poverty line. Health is a major issue in this failure to achieve independence. TANF recipients are less healthy, less educated, and poorer than impoverished women who have never been on welfare; they experience higher levels of depression and domestic violence than women in the general population (Wood et al., 2002). In a large three-city study, “87% of the mothers reported mental health problems based on a diagnoses by a mental health professional, and 52% of the families reported concurrent mental and physical health problems in both the primary caregiver and at least one of the children” (Burton, Lein, & Kolak, 2005, p. 5). This emerging population of TANF participants deserves the attention and intervention of public health professionals at all levels of prevention. We must incorporate the thinking and language of public health into the economics language of TANF and advocate for broadening the scope of welfare reform to better attend to the role health plays in work.

The purpose of this study was to explore women’s perceptions of their health and well-being while enrolled in a work-based welfare program. This is important because such a significant change in policy can be expected to have unintended effects as well as anticipated results for these vulnerable women and their families. The knowledge gained from these data will inform political, social, and health professionals about the human costs and benefits of this policy and help shape future policy.

The data reported here are the findings that have been triangulated using both quantitative and qualitative data, thus supporting a greater depth of understanding of the participants (Polit & Hungler, 2001). This use of quantitative and qualitative data sets is still as exceptional in qualitative research, as the use of case-oriented strategies is innovative to quantitative research (Ragin, 1999; Richards & Richards, 2003).

The research questions that guided the data analysis reported here were:

1. What positive and negative perceptions do women have about their health and well-being while enrolled in a work-based welfare program?
2. How do women from this vulnerable population, who are enrolled in work-based welfare, compare with the general population on self-reported parameters of health and well-being?

**Methods**

**Design, sample, and setting**

This was a community-based, descriptive study of women participating in the TANF program. The
study was approved by the University Institutional Review Board for the Protection of Human Subjects. Case-oriented strategies were used (those that use modest numbers of cases, usually fewer than 50) to make facts understandable, rather than variable-oriented strategies that use large samples designed to predict and generalize (Ragin, 1999). The participants were a purposive sample of 34 women who lived in disadvantaged neighborhoods in a Wisconsin city of 600,000 and were enrolled in a work-based welfare program. There were 31 African American, one Caucasian, and two Hispanic women; ages ranged from 21 to 47 years with a mean age of 32 years. All of the participants had children. Thirty-five percent of the women had been enrolled in Wisconsin’s work-based TANF welfare program (W-2) for a year or less, and 65% had been enrolled for more than a year and up to 2 years. The interview settings were an inner-city church, an adult education center, an inner-city community center, and a community nursing center located in a large subsidized housing development.

**Instruments**

A data collection form was used to obtain demographic data that included child-care arrangements and welfare services that were used by participants. An interview guide was used to gather narrative, qualitative data. Data were also gathered using the General Well-Being (GWB) schedule, a self-administered, 18-item survey tool used in the U.S. Health and Nutrition Examination Survey (HANES) (Dupuy, 1977, 1978).

The GWB schedule is a brief, well-designed tool useful for measuring sense of well-being and for quality-of-life research. Norms were established using the HANES database of over 6,900 people (Fazio, 1977; Dupuy, 1984). The 18 items of the GWB schedule were grouped into six subscales. The alpha coefficients of the tool, among studies, have ranged from 0.88 to 0.95. Test-retest reliability is adequate for assessing groups (Edwards, Yarvis, Mueller, Zingale, & Wagman, 1978; Fazio, 1977; Himmelfarb & Murrell, 1983). Fazio (1977) correlated the GWB schedule with the Minnesota Multiphasic Personality Inventory (MMPI), Zung Self-Rating Depression Scale, College Health Questionnaires (CHQ) for current depression, CHQ for past depression, Psychiatric Symptoms Scale, Personal Feelings Inventory, and interviewer rating. Responses for the GWB schedule are based on a six-point scale for 14 of the questions and a 10-point scale for four of the questions. The total GWB score is computed by summing the scores of the 18 items and subtracting 14. The scoring range for the GWB schedule is 14–110, with higher scores indicating a higher perception of health and well-being (Dupuy, 1978). The Cronbach alpha for the GWB schedule in this study was 0.82.

**Procedure**

Network or snowball sampling was used to achieve a sample of 34 women. Inclusion criteria were adults who were enrolled in the work-based welfare program for 2 years or less. The women responded to word-of-mouth information and fliers posted in the community. This resulted in a homogeneous, self-selected sample adequate for the level of qualitative analysis used. Participants filled out the demographic data form, were interviewed, and completed the GWB survey. The interview was approximately 1 hr long and took place at a site convenient to the interviewee. Subjects were paid an incentive of $20 to cover costs such as their time, child care, and transportation.

The GWB survey data were entered into SPSS-PC for Windows® software to facilitate analysis. The responses to the 18 questions were coded so that for all questions, high scores indicated positive health and well-being. Interview narratives were transcribed and entered into NVIVO® software to facilitate coding and analysis of these qualitative data (Qualitative Solutions & Research [QSR], 1999). Interview narratives were coded by the researcher. As a measure of consistency in coding, a research assistant also coded 30% of the narratives, with coding agreement between coders ranging from 88 to 96% agreement.

**Analysis**

Descriptive statistics appropriate for the level of data were used to summarize the demographic data. The responses to the GWB schedule were scored to compute a distress score for each subject. Subscale scores were compared with the U.S. reference figures established for the GWB schedule. The six GWB subscale labels of anxiety, depression, positive well-being, self-control, vitality, and general health were used as coding themes for the qualitative data. This
facilitated the linking of the quantitative GWB data with the qualitative interview data of the women’s descriptions of their health, well-being, and experiences during their enrollment in work-based welfare. This methodological triangulation using the GWB, interview, and demographic data contributed to the in-depth understanding of the data.

Results

The mean number of years of education for this sample was 10.9 (SD = 1.1). Sixty-five percent of the women had not finished high school; 26 percent of the women had 10 or fewer years of education. Of the total study sample, 64.7% were in jobs or job training, designed to get them job-ready for entry-level jobs, 17.7% were in unsubsidized jobs or trial jobs (closest to job readiness), and 17.6% were not employed or were engaged in job searches.

The number of children per family ranged from one to seven with 64% of the women having three or more children. Thirty-five percent of the women had children less than 5 years of age. Of the women who were currently working, 61% used daycare services. Only 65% of the respondents indicated they had Medicaid health care coverage.

The responses to the 18-item GWB schedule were compared with the U.S. national reference standards (Dupuy, 1978). These reference standards categorize respondent states into severe distress (score of 0–60), moderate distress (score of 61–72), and positive well-being (score of 73–110). There was a significantly higher level of distress in the study sample than in the U.S. population ($\chi^2 = 76.84$, df = 2, $p < 0.001$). The GWB scores for the women indicated that 61.8% of all respondents fell within the range of severe distress as compared with 13.5% in the U.S. reference sample, 32.4% fell within the range of moderate distress compared with 15.5%, and 5.9% fell within the range of positive well-being as compared with 60% in the reference sample. The mean GWB score for the sample indicated severe distress ($M = 56.38$, $SD = 15.61$) with 62% of the women scoring less than 60. The findings related to the subscales of GWB for the study cohort were approximately the opposite of the national reference standards of the U.S. population. (Fig. 1).

The subscales of the GWB instrument represent six constructs: self-control, vitality, anxiety, depression, positive well-being and general health. Responses to the individual questions were coded as positive or negative responses and are summarized in Table 1, grouped by the six subscales. This item analysis was presented to look more closely at the responses to each question. Even though most of the women were classified as distressed by the total score and did not always feel economically stable and sure of themselves, most (73.5%) felt in firm control of their thoughts, emotions, and feelings. While most reported feeling tired, worn out, or exhausted, when waking up the majority (61.8%) felt fresh and rested. Almost all of the women felt their daily lives were full of things that were interesting (Table 1).

**Narrative interview data relative to gwb data**

Data from the GWB instrument identified the perceived level of well-being as well as distress (lack of well-being) perceived by the women. The interview data provided information about the daily life events that were most stressful or what interventions would be most effective.

Narrative comments from the interviews were coded into the six GWB constructs, and these data were examined concurrently with the results from the quantitative analysis (Ragin, 1999). Table 2 summarizes the percent of woman whose comments, during the interview, were perceived as representing positive endorsement, negative endorsement, or both for each of these constructs. High negative and positive scores for the same construct suggest there is both stress in losing the security of traditional welfare and positive feeling associated with independence and work—a “mixed blessing.”
TABLE 1. Responses to General Well-Being Questionnaire

<table>
<thead>
<tr>
<th></th>
<th>Positive(^a)</th>
<th>Negative(^b)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td><strong>Self-control</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you been feeling emotionally stable and sure of yourself?</td>
<td>12</td>
<td>35.3</td>
</tr>
<tr>
<td>Been in firm control of your behavior, thoughts, emotions, or feelings?</td>
<td>25</td>
<td>73.5</td>
</tr>
<tr>
<td>Losing your mind, or control over the way you act, talk, think, feel, or your memory?</td>
<td>29</td>
<td>85.3</td>
</tr>
<tr>
<td><strong>Vitality</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you felt tired, worn out, used-up, or exhausted?</td>
<td>13</td>
<td>38.2</td>
</tr>
<tr>
<td>Have you been waking up fresh and rested?</td>
<td>21</td>
<td>61.8</td>
</tr>
<tr>
<td>How much energy, pep, or vitality have you felt? (during the last month)</td>
<td>24</td>
<td>70.6</td>
</tr>
<tr>
<td><strong>Anxiety</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you been anxious, worried, or upset?</td>
<td>13</td>
<td>38.2</td>
</tr>
<tr>
<td>Have you been bothered by nervousness or your “nerves”?</td>
<td>14</td>
<td>41.2</td>
</tr>
<tr>
<td>Been under or felt you were under any strain, stress, or pressure?</td>
<td>16</td>
<td>47.1</td>
</tr>
<tr>
<td>How relaxed or tense have you been? (during the last month)</td>
<td>14</td>
<td>38.2</td>
</tr>
<tr>
<td><strong>Depression</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you felt down-hearted and blue?</td>
<td>12</td>
<td>35.3</td>
</tr>
<tr>
<td>Felt so sad, discouraged, hopeless, or had so many problems that you wondered if anything was worthwhile?</td>
<td>16</td>
<td>47.1</td>
</tr>
<tr>
<td>How depressed or cheerful have you been (during the last month)</td>
<td>19</td>
<td>55.9</td>
</tr>
<tr>
<td><strong>Positive well-being</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How satisfied or pleased have you been with your personal life?</td>
<td>17</td>
<td>50.0</td>
</tr>
<tr>
<td>Has daily life been full of things that were interesting to you?</td>
<td>31</td>
<td>91.2</td>
</tr>
<tr>
<td><strong>General health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bothered by any illness, bodily disorder, pains, or fears about your health?</td>
<td>8</td>
<td>23.5</td>
</tr>
<tr>
<td>How concerned or worried about your health have you been?</td>
<td>6</td>
<td>17.6</td>
</tr>
</tbody>
</table>

\(^a\)Positive indicates the responses to items that would reflect positive well-being.

\(^b\)Negative indicates the responses to items that would reflect negative well-being.

**Well-Being**

GWB scores indicated 94.2% of the subjects felt severe or moderate distress, compared with the interviews in which 91.2% indicated a high level of distress. During the interviews 76.5% \((n = 26)\) of the women made statements reflecting both low and high levels of well-being and 14.7% \((n = 5)\) made statements reflecting only low levels of well-being. Many of the reasons given for perceived lack of well-being were out of the control of the participants. One mother of five children, who had managed to provide for her family before the “rules changed,” expressed her lack of a sense of well-being in the following way:

I am constantly moving. On work-based welfare I have been in and out of shelters and I am tired of that. I just want a stable roof over my head and be able to pay my own bills instead of my Dad spending money every month…. These are my kids and I am supposed to be taking care of them. [Olanda, age 31]

The mothers wondered about the relative worth of the meager wages they were able to earn compared with the importance of their role as single parents. One said:

How are you supposed to take care of your kids with $5.15 an hour that you are working for? and the

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TABLE 2. Narrative Data: Women’s Perceptions of the Effect of Work-Based Welfare, By Percent \((N = 34)\)

<table>
<thead>
<tr>
<th>GWB subscales into which narrative data were coded</th>
<th>Negative effects of work-based welfare ((% \text{ of women}))</th>
<th>Positive effects of work-based welfare ((% \text{ of women}))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>97</td>
<td>0</td>
</tr>
<tr>
<td>Well-being</td>
<td>91</td>
<td>82</td>
</tr>
<tr>
<td>General health</td>
<td>82.4</td>
<td>32</td>
</tr>
<tr>
<td>Depression</td>
<td>50</td>
<td>0</td>
</tr>
<tr>
<td>Self-control</td>
<td>38</td>
<td>76</td>
</tr>
<tr>
<td>Vitality</td>
<td>26</td>
<td>62</td>
</tr>
</tbody>
</table>
oldest one’s got to raise the rest of them … Where are the fathers at? [Grace, age 28]

A positive comment was:

I always wanted my GED. God gave me a second chance and I am going to use it. Work-based welfare pushed me in a way, and I had to get on it. I always wanted to be clean and stop using drugs and drinking. [Nadeen, age 23]

Health
The respondents were asked to rate their concern about their health on the GWB on a zero to 10 scale with anchored zero representing not concerned at all and 10 representing very concerned. Eighty-one percent of the women ranked their level of concern 5 or greater with 10 (30%) of these women indicating they were bothered by illness all of the time and only two of the 34 women indicating no concern at all (M = 6.44, SD = 3.09). This is consistent with the interview data where 82% of the women said there were negative effects on their health while on work-based welfare.

Many of the women verbalized that their health problems were chronic problems and represented recalcitrant barriers. The problems were exacerbated by the demands of working away from home, and managing their family needs within their limited resources. Asthma was cited by 21% of the respondents. An example of this comes from Inez, age 40.

Either I am wheezing or coughing really bad or I have a tension headache. I have high blood pressure. They got me on all kinds of medication. It could be a side-effect from taking all different kinds of medicine from my high blood pressure.

Anxiety
Four items on the GWB instrument measured anxiety: nervousness; stress, strain or pressure; anxiousness; and tension. The responses of most participants indicated severe to moderate difficulties in regard to questions about these four items (Table 1). When asked to rate their ability to relax on a zero to 10 scale with anchored zero representing very relaxed and 10 representing very tense, 88.2% of the respondents rated their level of tension as 5 or greater (M = 6.35, SD = 1.87). This is consistent with the responses from the interviews where all the women expressed anxiety about their life situations during the interviews. The following quotations are examples of the stress being placed on their lives:

Well, if I am working an eight hour shift I need an hour before and an hour after work to get back and forth and my children need to be cared for. My mother is not a resource. She is a very sick lady. I chose not to use her. If anything was to happen, they would look back at me. I had a very hard time getting day care. A very hard time. [Rhonda, age 30]

A frequently cited concern for these women in entry-level jobs that had few benefits was that women lost wages when they took off time to care for sick children or took their children to health care providers for immunizations and well-child care or sought health care for themselves.

Depression
In response to the GWB questions related to depression, women indicated that they felt down-hearted and blue (64%) and sad and discouraged (53%). When asked to rate their depression on a zero to 10 scale, with zero indicating very depressed and 10 meaning very cheerful, 44% of the respondents rated their depression score at 5 or below (M = 6.18, SD = 2.34). During the interviews in the qualitative part of the study, half of the 34 subjects indicated feelings of depression while enrolled in TANF.

Self-Control and vitality
The women responded positively on the GWB schedule in regard to their perception of self-control and vitality. Ninety-one percent of the respondents found their daily life interesting and 61 percent felt rested when waking up. When asked to rank their energy on a scale of zero to 10 anchored with zero indicating no energy and 10 indicating very energetic, 71% ranked their energy as 5 or higher (M = 5.09, SD = 2.09). This was also reflected in the qualitative interview data where a larger percent of women expressed positive effects than negative effects (Table 2).

Women were thrown into very new experiences by the new work-based welfare expectations. Their lives changed dramatically and some women saw it as a challenge while others were overwhelmed. The following is the comment of a young Hispanic
woman who did not feel she could rise to the challenge:

Well, right now it is kind of hard because I don’t know how to use the bus. But now for different places to apply for jobs, I don’t even know how to do it. I don’t know how to get to places. They give you a bus route, but I can’t read that. I don’t know how to read that. [Josephine, age 25]

Another woman who expressed a sense of control or empowerment said:

The last year been hard, but it is getting better because now I am depending on myself more and I am more determined now than I was before. The good things about my life is me being more self-confident, having my self-esteem up. I am more determined now to have a job than sitting around the house not doing nothing. [Helen, age 25]

Discussion

The study framework of primary health care and personal and community competency building is useful in discussing work-based welfare policy and the perceptions of the women enrolled in the program. The responses to the questions on the GWB schedule and the findings from the qualitative interview data were consistent with each other. This triangulation of data supports the adequacy of the findings.

What positive and negative perceptions do women have about their health and well-being while enrolled in a work-based welfare program?

The women perceived themselves as having a high level of distress in both the quantitative and qualitative data sets (94 and 91%, respectively). These stressors were quantified using the GWB questions. Economic stress, education, new roles, work schedules, transportation, housing, and child care were among the stressors cited in the interviews, and 76.5% of the women expressed both negative and positive effects within their lives since their enrollment in work-based welfare.

The women’s inability to earn sustainable incomes was a concern. Lack of a high-school education has been recognized as a barrier to obtaining jobs and to moving up to better jobs (Cancian & Meyer, 2000). The state’s education standard to obtain most women work-ready has been a high-school diploma or GED, which leads to entry-level jobs with limited benefits and limited advancement opportunity. This translates to jobs that are less likely to offer flexibility or pay enough for single-parent, single-earner families to become or stay economically stable.

The multiple roles the women had to play as parents and also bread winners in the workforce were barriers. Once these women are launched into the work world, they will lose work time and wages if they have to stay home from work because they or their children are ill or need health care. Issues such as these become economically destabilizing.

Health benefits were another source of distress. Although Medicaid continues to be available to eligible women in low-paying jobs, it has been uncoupled from TANF welfare. This barrier added to their confusion about their eligibility and may be partially responsible for the finding that only 65% of the women in this study indicated they were enrolled in Medicaid. Women often just did without preventive health care.

How do women from this vulnerable population, who are enrolled in work-based welfare, compare with the general population on parameters of health and well-being?

There is a marked difference between this cohort of work-based welfare mothers and the National Reference Standards derived by Dupuy (1978) for adult populations. The GWB data illustrate that the marginalized working mothers in this sample perceived themselves as having high distress levels and low levels of well-being while on work-based welfare. The data regarding health and well-being are inverted compared with the U.S. population. The finding that 94.1% of the study sample meets the criterion for moderate or severe distress (Fig. 1) bodes ill for the mental and physical health of the
women and their successful transition into the workplace.

The subjects also identified some positive effects on their health and well-being. Achieving at least a basic education and being perceived by others as a person with work skills gave many of them a sense of being empowered. Current legislation and policy do not address the needs of many female heads of households who are working to support their families. One such instance was the woman quoted in the opening paragraphs of this article; she needed to quit work for a year to care for her one pound, seven ounce baby boy. Offering her a cash grant in exchange for attending classes to have her “job-ready” missed the point. If this baby had been born at the end of her 5-year lifetime maximum time allowable on work-based welfare, she would have had to work. Could she have cared for him? Unless she were granted an exception to the legislative rules requiring her to work, this child could not have been expected to survive. With a lifetime of work ahead of her and the episodic crises she can anticipate in raising this frail child, even the maximum of a 5-year limit of support must frighten her and should be a sobering thought to the health care providers who touch her life.

Limitations
The purpose of this qualitative study was to describe the levels of health and general well-being of the participants all of whom were enrolled in a workfare program. The participants were selected to achieve an information-rich sample. These data do not imply causality, and the study was not designed to support generalization of the findings. The women were not surveyed before being enrolled in W-2, and therefore there is no comparison data to indicate their level of distress before W-2. These design choices direct how the findings can be used. They do not limit the strength of the data about women’s perceptions of current distress while on work-based welfare.

Recommendations and Conclusions
The following considerations relate to the support of women’s health and well-being and the mitigation of the negative or unintended effects of work-based welfare.

1. Work-based welfare policy goals are focused on reducing the number of people on welfare. Given the data from this study, higher level goals are recommended that would address the immediate and longer term mental, physical, and psychosocial health and well-being of workfare participants.

2. Programs focusing on well-being can be designed to build on the self-care competence identified by the participants in this study.

3. Policy revisions and program evaluation can be implemented to mitigate and monitor the high distress levels and low levels of health and well-being such as those identified by participants.

The ability of single-parent, low-income women to care for themselves and their families and also earn a living wage is compromised by impaired health and well-being. A higher standard of health and psychosocial support for the vulnerable populations of this country will make it more likely that we will achieve our 2010 goals for the nation.

Acknowledgments
This study was funded by the Center for Urban Initiatives and Research of the University of Wisconsin-Milwaukee.

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