The Qualitative Report

Volume 27 | Number 12 Article 8

12-9-2022

A Qualitative Analysis of Personal Health Care Challenges Experienced by Iranian Divorcees

Farzaneh Golboni
Qazvin University of Medical Sciences, farzanehgolboni@gmail.com

Zainab Alimoradi
Qazvin University of Medical Sciences, zainabalimoradi@yahoo.com

Bengt Fridlund
Linnaeus University, beppe.fridlund@gmail.com

Liselott Årestedt
Linnaeus University, Liselott.arestedt@lnu.se

Mark Griffiths
Nottingham Trent University, mark.griffiths@ntu.ac.uk

See next page for additional authors

Recommended APA Citation

Golboni, F., Alimoradi, Z., Fridlund, B., Årestedt, L., Griffiths, M., Broström, A., & Pakpour, A. h. (2022). A Qualitative Analysis of Personal Health Care Challenges Experienced by Iranian Divorcees. *The Qualitative Report*, *27*(12), 2783-2800. https://doi.org/10.46743/2160-3715/2022.5152

A Qualitative Analysis of Personal Health Care Challenges Experienced by Iranian Divorcees

Abstract

Divorce, nowadays an increasingly more prevalent life event in Iran, can create poor general health among Iranian women, possibly due to bigger challenges for health-related behaviors. The aim was to explore challenges to achieve health-related behaviors as experienced by divorced Iranian women acting as household-heads. An inductive exploratory design based on qualitative content analysis was utilized. Twenty strategically selected divorced women acting as household-heads in Tehran were interviewed between September 2019 and January 2020. The divorced women experienced individual-centered and social and environmental-centered challenges concerning their health-related behaviors. Lack of competence, lack of personal control, and lack of emotional support were described as individual-centered barriers. Lack of community-based support, lack of financial support, and lack of labor market support were described as social and environmental challenges to health-related behaviors. A wide range of individual, social, and environmental-centered factors hindered divorced women acting as household-heads to engage in health-related behaviors. Therefore, person-centered interventions are necessary alongside efforts to develop appropriate policies and amend protection laws to increase the welfare and health of divorced women acting as household-heads.

Keywords

divorced women, household-heads, health, health barriers, qualitative analysis

Acknowledgements

All of the participants who participated in this study are thanked. The Vice-chancellor (Research) of Qazvin University of Medical Sciences has provided financial support to this project. The funding body had no role in the design of the study, collection, analysis, interpretation of data and writing the manuscript.

Authors

Farzaneh Golboni, Zainab Alimoradi, Bengt Fridlund, Liselott Årestedt, Mark Griffiths, Anders Broström, and Amir hajiagha Pakpour AHP

The Qualitative Report 2022 Volume 27, Number 12, 2783-2800
https://doi.org/10.46743/2160-3715/2022.5152

A Qualitative Analysis of Personal Health Care Challenges Experienced by Iranian Divorcees

Farzaneh Golboni[1], *Zainab Alimoradi[2], Bengt Fridlund[3], Liselott Årestedt[4], Mark D. Griffiths[5], Anders Broström[6,7], and *Amir H. Pakpour[2,6]

[1] Student Research Committee, Qazvin University of Medical Sciences, Qazvin, Iran
[2] Social Determinants of Health Research Center, Research Institute for Prevention of Non-Communicable Diseases, Qazvin University of Medical Sciences, Qazvin, Iran.
[3] Centre for Interprofessional Collaboration within Emergency Care (CICE), Linnaeus University, Växjö, Sweden
[4] Department of Health and Caring Sciences, Faculty of Health and Life Sciences, Linnaeus University, Kalmar, Sweden
[5] International Gaming Research Unit, Psychology Department, Nottingham Trent University, Nottingham, UK.
[6] Department of Nursing, School of Health and Welfare, Jönköping University, Jönköping, Sweden
[7] Department of Clinical Neurophysiology, Linköping University Hospital, Linköping, Sweden

Divorce, nowadays an increasingly more prevalent life event in Iran, can create poor general health among Iranian women, possibly due to bigger challenges for health-related behaviors. The aim was to explore challenges to achieve health-related behaviors as experienced by divorced Iranian women acting as household-heads. An inductive exploratory design based on qualitative content analysis was utilized. Twenty strategically selected divorced women acting as household-heads in Tehran were interviewed between September 2019 and January 2020. The divorced women experienced individual-centered and social and environmental-centered challenges concerning their health-related behaviors. Lack of competence, lack of personal control, and lack of emotional support were described as individual-centered barriers. Lack of community-based support, lack of financial support, and lack of labor market support were described as social and environmental challenges to health-related behaviors. A wide range of individual, social, and environmental-centered factors hindered divorced women acting as household-heads to engage in health-related behaviors. Therefore, person-centered interventions are necessary alongside efforts to develop appropriate policies and amend protection laws to increase the welfare and health of divorced women acting as household-heads.

Keywords: divorced women, household-heads, health, health barriers, qualitative analysis

Introduction

Health is a relative concept with different meanings and manifestations in different cultures (Svalastog et al., 2017). For each individual, health has different physical, psychological, and social dimensions and meanings that are influenced by demographic,

* Zainab Alimoradi and Amir H. Pakpour are co-corresponding authors of this paper.

socio-economic and psychological factors (Parvizi & Hamzehgardeshi, 2014). Among demographic factors, gender is one of the factors affecting the health status of individuals in communities. Gender entails a set of socially formed characteristics such as norms, roles, and relationships between groups of women and men that vary from one society to another. These gender-based social factors also affect access to and use of healthcare services which in the long run can impact negatively on health (Magar et al., 2019), which raises the need for separate gender-based studies examining health and its determinants. Health, especially among women, can be influenced by family and social conditions (Magar et al., 2019; Mariani et al., 2017). Therefore, aspects influencing health need to be carefully studied, because in many countries women's health is more vulnerable than men's due to discrimination rooted in socio-cultural factors (Mariani et al., 2017). In most countries, women have a higher life expectancy than men, even if they often suffer from greater social and psychological problems compared to men (WHO, 2011). One of these social problems with various consequences on physical and mental health for women is the evolution of family structure in different parts of the world, which has been accompanied by an increase in the population of women acting as the head of the household due to divorce (Pieters, 2011).

Divorce, one of the most stressful life events in adulthood, might have several negative impacts on health. An epidemiological study from the US reported that two years after divorce alcohol consumption and chronic depressive disorder increase in both women and men (Williams & Dunne-Bryant, 2006). Some short-term consequences appear to be similar for women and men, but long-term effects may differ because divorce (both directly and indirectly) has negative impacts among divorced women engaging in health-promoting behavior programs (Overbeek et al., 2006). In Iran, the growing number of female-headed households has increased markedly over the past 15 years. According to the most recent population and housing census, female-headed households constitute over three million households, an increase of 58% female-headed households over the past decade (Nourolahi et al., 2016). The number of Iranian divorces was at its highest in 2016 which has subsequently increased the number of female household-heads. The consequences of divorce are influenced by factors such as financial status, gender differences, quality of relationship prior to marriage, social support, and children (Hetherington & Kelly, 2003). It is important to note that 71% of divorced Iranian women have children, 90% of these women do not remarry, and the living problems in this group is much more severe than in other female-headed households (Nourolahi et al., 2016). Historically, in many countries and cultures, the responsibility of providing financial family support has been placed upon men, and the male is the head of the family. However, looking after the family often falls on the woman when relationships end. An Iranian woman who has previously played the role of wife and mother must then take on the role as head of the household and "breadwinner." Consequently, a divorced woman assuming the role of head of a family may experience difficult situations (Kwon & Kim, 2020). Playing multiple roles that are sometimes in conflict with each other can cause mental and physical fatigue. Poverty and disability, especially in managing the family's economic affairs, can also damage Iranian women's self-esteem and mental health and culminate in depression and other mental disorders (Nazoktabar & Veysi, 2008). A recent systematic review on health of female-headed households in different countries identified the role of social capital and social support, but also highlighted that divorced women are exposed to serious harm due to their dual role in the family, female gender, and consequent deprivation of primary sources of livelihood (Khazaeian et al., 2017). Another study showed that single mothers with little to no perceived social support from family experienced a 33% increase in the relative risk of a late rent payment (Martin-West, 2019).Those who indicated little to no social support from other community resources

experienced a 68% greater risk of a late rent payment compared with two-parent families (Martin-West, 2019).

Some previous Iranian studies (Enayatifar et al., 2018; Gholipour & Rahimian, 2011; Shahbazi et al., 2015) examining the physical and mental health status of female-headed households show that female heads of households have poorer physical and mental health than other women. A variety of mental health illnesses, such as anxiety, depression, aggression, isolationism, and obsessions, as well as psychosomatic physical pain were reported (Gholipour & Rahimian, 2011). Only ten percent of the Iranian women acting as household-heads had good mental health (Enayatifar et al., 2018), and eight out of ten reported very poor general health (Shahbazi et al., 2015). Post-divorce, and despite much effort, women may often fail to provide family financial security (Qamar & Faizan, 2021). Also, due to the difficulty of managing their living economy and cultural issues such as the negative view by other individuals, Iranian women can suffer from social isolation, and their relationships with others can be limited, leading to mistrust of other individuals (Newton-Levinson et al., 2014). Moreover, female household-heads can experience adverse quality of life, especially in terms of physical health and mental health (Solhi et al., 2015; Veisani et al., 2015), greater social isolation, addiction, and delinquency (Khani, Khezri, & Yari, 2018), as well as several family- and social-challenges (Lebni et al., 2020). (Nikbakht et al., 2016) emphasized that divorced Iranian women experience social vulnerabilities which led to the use of protective mechanisms to adapt to new conditions. In addition, negative emotions and psychological problems are among the consequences (Davarinejad et al., 2020), and some women have difficulties in rebuilding their lives after the divorce due to a loss in their self-confidence (Hayati & Soleymani, 2019). The combination of having an increased lack of confidence and lowered self-esteem in themselves and a negative self-perception can lead to emotions such as loneliness, inferiority, and failure, as well being perceived as victims of guilt, hatred, and remorse (Hayati & Soleymani, 2019). In the Iranian society, women's lives after divorce are often faced with ambiguities and dangers, including child custody battles, economic problems, and living alone with depression and despair, as well as having to face Iranian society's negative attitude towards divorced women. Their ex-husbands often cause them many problems (e.g., in relation to social activities) also after the divorce (Sadeghi & Agadjanian, 2019).

Purpose of the Study

The World Health Organization defines health as a "state of complete physical, mental and social wellbeing, not just the absence of disease or infirmity" (Yazdi Feyzabadi et al., 2018). However, a knowledge gap exists regarding how Iranian women acting as household-heads experience barriers to engaging in their own health-related behaviors. One study showed that residual resources (i.e., residual money, time, and energy) and underlying factors (i.e., individual and socio-economic characteristics) are important aspects in health promotion (Seyedfatemi et al., 2015). Unfortunately, divorced mothers often engage in health promotion behaviors only after meeting the needs of their children and resolving other life issues. This leaves limited resources and they may put their personal health at risk (Amato, 2000). An explanation of complex situations rooted in a cultural and social context, and the recognition of its dimensions and factors affecting health promotion behaviors among female household-heads, requires a qualitative methodology to be fully understood. Qualitative methods can provide a deep insight into individual's perspectives (Bansal et al., 2018). However, no previous study has examined the challenges of health-related behaviors, as experienced by divorced woman acting as household-heads in Iran. The aim of the present

study was to explore challenges to achieve health-related behaviors as experienced by divorced Iranian women acting as household-heads in Tehran.

Role of Researchers

The first author was a Ph.D. candidate in health promotion when the study was designed. With a B.Sc. and M.Sc. in Midwifery, and several years of clinical practice, she had an extensive experience of women's health before becoming a Ph.D. student. During recent years she noted a growing number of Iranian divorces. Most of the divorced women acted as household-heads with children, and she perceived their responsibilities as very demanding. This new situation might put a lot of divorced Iranian women in difficult situations. Playing multiple roles, sometimes in conflict with each other, can cause mental and physical fatigue. Poverty and disability, especially in managing the family's economic affairs, can also damage women's self-esteem and mental health and culminate in depression and other mental disorders. Based on this clinical experience, she understood that she lacked knowledge of how divorced women, especially those who acted as household-heads, described challenges for health-related behaviors. Due to the importance of the topic, she conducted an extensive literature search. The review showed lack of studies regarding challenges of health-related behaviors among divorced Iranian women acting as household-heads. Accordingly, she designed a study to explore this as part of her Doctoral thesis. The other research team members are academic members and researchers at various medical, health and/or psychology departments at (i) Qazvin University, Iran, (ii) University of Jönköping, Sweden, (iii) Linnaeus University, Sweden, and Nottingham Trent University, United Kingdom.

Methods

Design and Setting

An inductive qualitative content analysis (Elo & Kyngäs, 2008) was used with an analysis according to Graneheim and Lundman (2004). The qualitative content analysis goes beyond the mere extraction of objective content, and is also flexible and systematic in identifying individuals' patterns and relationships between factors or within a specific context (Given, 2008). Difficulties for divorced women to engage in health-related behaviors might be due to a variety of physical, psychological and social aspects, including attitudes, values and motivation (Payne & Payne, 2004; Yazdi Feyzabadi et al., 2018). To collect in-depth information on these areas, qualitative content analysis was deemed as the most suitable method. Tehran has a special geographical and cultural position as the capital city of Iran. It is the key metropolis of Iran in terms of population with many ethnic groups living in the city. So, Tehran was selected as the research city to reach participants with maximum diversity in terms of ethnic, cultural, economic, and social status.

Participants

One-to-one semi-structured interviews were conducted with 20 strategically selected divorced women who were household-heads. The women were identified from lists provided to the researchers by the Welfare Organization in Tehran. To obtain a strategic sampling, women living in Teheran with diverse socio-economic and demographic characteristics were invited to participate (i.e., women of different ages, divorce duration [less than 5 years, 5-10 years, and more than 10 years], number of children, different levels of education [high

school, diploma or academic] and residence [tenant or landlord], as well as having different occupations [governmental/private employment, unemployed]). The first author scrutinized the lists and conducted the strategic sampling, as well as contacting the women and informing them about the study. This process was continued until a satisfactory variation regarding socio-economic and demographic characteristics was reached. Overall participants varied greatly in age (between 25 to 58 years) and with mean divorce duration of 6.5 years. They had different educational levels and different jobs (e.g., servant, secretary, hairdresser, chef, worker, peddler, and teacher).

Data Collection

Semi-structured interviews were used to collect data. All interviews were carried out by the first author, who was the same sex as the participants to facilitate the collecting of in-depth data. All interviews, which were tape recorded and field noted, were done individually and face-to-face in a suitable place chosen based on the participants' preference. In most cases, this was a private room in the Welfare Organization premises in Tehran.

The researcher began the interview by explaining the procedure in a friendly and open way to gain trust and establish a situation which facilitated the interview. The interview began with the following open-ended question to set the scene: "How do you, as a divorced woman and head of the household, explain the concept of health?" Then two questions followed: "What are the challenges of healthy behaviors for you?" and "What can help you to improve your health?" The interview continued in an open-minded way with suitable probing questions, depending on the women's responses, guiding them through the interview, helping them to explain their experiences regarding potential challenges for engaging in health-related behaviors. The duration of the interviews varied from 40 to 60 minutes.

Data Analysis

The analytical process was performed according to Graneheim and Lundman's structure (Graneheim & Lundman, 2004). Consequently, interviews were transcribed verbatim within 24 hours after each interview. Transcriptions were checked for accuracy and read several times for achieving a general feel for the data by the first author. Specified semantic units were highlighted and specified as the transcripts were scrutinized line-by-line. Meaning units were condensed and labeled as codes to maintain the essential content. The identified meaning units labeled as codes were compared and organized in clusters based on their shared content. Codes with similar shared content formed subcategories and categories reflecting the main manifests and their relationships regarding the study aim. The number of women who expressed experiences regarding challenges to achieve health-related behaviors was not of interest in the analysis. According to Graneheim and Lundman's structure (2004) an experience phrased by one or a few women were given the same space or meaning as one expressed by all women when creating the category system. Finally, the underlying meaning in the categories formed themes that constituted the latent content presented in Table 1 and Table 2. MAXQDA 10 was applied to data organization and to analyze the content of interviews. The data analysis process led to 465 primary codes, 30 main codes, 18 subcategories, six categories, and two themes.

Table 1
Content Description of the Theme "Individual-Centred Barriers to the Health-Related Behaviors of Divorced Women Acting as Household Heads" and Associated Categories and Dubcategories

Theme	Category	Subcategory
Individual-centered challenges to health-related behaviors	Lack of competence	Ignorance of healthy habits
		Absence of exercise
		Inappropriate hygiene routines
		Misunderstanding of transfer and development of diseases
	Lack of personal control	Strenuous parenthood
		Strenuous working conditions
		Stressful economic situation
	Lack of emotional support	Affective consequences of past marital life
		Offensive personal stigmatizing

Table 2
Content Description of the Theme "Social and Environmental Challenges to Health-Related Behaviors of Divorced Women Acting as Household Heads" and Associated Categories and Subcategories

Theme	Category	Subcategory
Social and environmental-centered challenges to health-related behaviors	Lack of community-based support	Harassment in their living locality
		Inability to find proper housing
		Absence of consulting services at school
	Lack of financial support	Absence of specific insurance for divorced women
		Inadequate allowance from responsible centres
		Absence of child support
	Lack of labour market support	Absence of suitable job
		Uncertain employment conditions at private workplaces
		Harassment at work

To ensure the rigor of the data analysis, the proposed criteria of Guba and Lincoln including credibility, dependability, confirmability, and transferability were used (Lincoln & Guba, 1986). For this purpose, requisite time was allocated to perform interviews. The

researchers focused on dependability (with all interviews conducted by the same researcher) and credibility (with the interviewer being the same sex as all the participants). Transcriptions of the interviews were checked for confirmability and read repeatedly to reach an in-depth understanding of the data. The interview text, as well as the codes, subcategories, categories, and themes extracted from the interviews were carefully peer checked by the members of the research team with knowledge of the Iranian language. Additionally, external audit and code-recode methods were used during the data analysis, all such measures to ensure the dependability. The strategic selection from the Welfare Organization in Tehran provided women of diverse ages, different divorce durations, and various number of children, but also different levels of education, residences, and occupations bringing not only good credibility but also good transferability possibilities.

Ethical Considerations

The study was approved by institutional review board and the Ethics Committee of Qazvin University of Medical Sciences (IR.QUMS.REC.1398.044). Necessary correspondence was carried out in conjunction with the Welfare Organization in Tehran. When inviting women for interviews, oral and written information was provided about the purpose of the study, the need to record interviews, and the confidentiality of information. The women were assured that their interview narratives would not be reflected anywhere and would only be presented in the form of anonymous comments. All interviews were performed with a prior arrangement after explaining the study aim and obtaining the consent for participation and tape-recording the interviews.

Results

The women described lack of competence, lack of personal control and lack of emotional support as their individual-centered challenges to engage in health-related behaviors. Also, the lack of community-based support, lack of financial support, lack of labor market support emerged as social and environmental-centered challenges to their health-related behaviors. Therefore, the women failed to achieve healthy behavior due to the interaction of individual-centered along with social and environmental-centered challenges.

Individual-Centered Challenges to Engaging in Health-Related Behaviors

The women described not having the competence in maintaining health-related behaviors, that they ignored healthy habits, did not exercise, had inappropriate hygiene routines, misunderstood transfer, and development of diseases, and did not adhere to healthcare regimes. Experiencing strenuous parenthood, strenuous working conditions, and stressful economic situations led to feelings that they lacked personal control. Also, affective consequences of past marital life alongside offensive personal stigmatizing made participants feel that they lacked emotional support. An overview of individual-centered challenges to engaging in health-related behaviors for divorced women acting as household-heads are presented in Table 1.

Lack of Competence

Lack of competence led to ignorance of healthy habits, absence of exercise, inappropriate hygiene routines and a misunderstanding for transfer and development of diseases.

Ignorance of Healthy Habits. Ignorance of several healthy habits were described by the women due to their ignorance and indifference to these habits and lack of understanding of their impact on their health. Unhealthy eating behaviors, such as high salt and fat intake, high sugar intake, and fast-food consumption, were described due to lack of money. “Eating healthy costs, a lot, but fast food is affordable, so I eat more of it” (Participant 3). The women also described that they not only ate lots of fast-food but ate only one meal a day. “Many times, I don’t eat lunch at all or just eat some sandwiches quickly to go to work” (Participant 2). Other descriptions included smoking plenty of cigarettes, high alcohol consumption, and having unprotected sex. “I did not drink until last year, I prayed, but the stress was so high that I started to drink at a party with my friend, now I consume it almost daily” (Participant 12).

Absence of Exercise. The women seldom exercised, even on holidays. If they had free leisure time from work, they preferred to rest other than to exercise. “I prefer to rest on vacation and not do some exercise” (Participant 10). Also, another woman mentioned that “I must work hard six days a week, and I need one day to rest. I have no extra time to do exercises” (Participant 18).

Inappropriate hygiene routines were the other issue that might jeopardize their health. Most of them mentioned that they do not have hygiene routines. Non-frequent change of underwear, not washing clothes and hands, both in general and before meals, were examples of inappropriate hygiene routines that the women described. “I go home late, sometimes I only go to the bathroom once in a day when I get home! I do not change my underwear everyday” (Participant 18).

The other point was their misunderstanding of transfer and development of diseases. The women were unaware of how sexually transmitted diseases were passed on, what the breast cancer risks were, and how to examine their own breasts as described by the women. "I never thought I should examine my own breasts and I did not know the danger at all” (Participant 14). The lack of accessibility to free medical care centers and adherence to follow-up of cancer screening test results were also told. The women described that not adhering to treatment for physical problems such as genital warts, urinary tract infections, and breast mass varied depending on the problem, and was either due to lack of accessibility, lack of time, or misunderstandings. “My chest hurts, and I feel my left breast is stiff, but I did not go to the follow-up” (Participant 18).

Lack of Personal Control

Several of the participants thought that they have no personal control. This sense of lack of personal control, often due to strenuous parenthood, strenuous working conditions, and a stressful economic situation affected engagement in health-related behaviors. The women described being stressed due to the difficult conditions of playing the role of parents alone, difficult working conditions and stressful economic conditions. Over time, these stresses lead to physical symptoms such as palpitations, insomnia, anxiety symptoms, and depression. Also, in terms of time and financial capacity, they did not have the necessary conditions to take care of their health.

Strenuous Parenthood. Lack of personal control was common and had its ground usually in a strenuous parenthood. The women described that their health-related behaviors were affected by chronic pessimism, anxiety, and stress due to their role as household-head. They also mentioned several physiological symptoms, such as heart palpitations and insomnia, but worries about their children's current (and future) health were also described. “I

only think about the fate of my children, I wish their luck will not be like mine" (Participant 16). Self-blame, constant panic, and highlighting their role in life events were also evidence of self-blame among the women. "I always tell myself that if you were educated, you had a personal income, you would not have this end" (Participant 3). The women described constant grief with references to crying, being depressed about their life situation as a single mother, and constantly being in a state of unhappiness. "I talk to myself from morning till night and cry" (Participant 5).

Strenuous Working Conditions. The women described that they were not able to control their working situation due to their role as household-head. This led to strenuous working conditions, including long hours, late shifts, and longer shifts than normal. This caused fatigue, insomnia, and various mental health concerns which prevented healthy leisure time activities. "When I get home from work, I have no more energy, I'm exhausted, I just sleep" (Participant 17).

Stressful Economic Situation. The other issue mentioned by almost all of participants was their stressful economic situation. They described that due to their low income as household-heads in combination with high expenses, they had poor control over their own and the family's financial situation. This caused them stress and negatively affected decisions on buying healthy food alternatives. It also made it difficult or impossible to afford pursuing various healthcare treatments including doctor visits, buying medicines, having health tests. "I could not afford to buy medicine for my stomach [problems]. Instead, I went to a herbalist that were cheaper" (Participant 9).

Lack of Emotional Support

Lack of emotional support was described by the women as a challenge for social health and being related to affective consequences of past marital life and offensive personal harassment related to the disruption of the social health dimension of life.

Affective Consequences of Past Marital Life. The women described that they were feeling alone and emotionally affected by their past marital life. They recounted bad marital memories, a strong need to attract attention, their children's sense of hatred of their father and described how alone and depressed they were. "When I wake up in the morning, I always remember how oppressed I am" (Participant 7). The women also described aggression and anger when dealing with others. Showing anger, shouting at work or at home, hitting their children, and even suicide attempts were examples of negative affective consequences. "I get nervous, I cannot stand it like before, I fight with anyone who lies or oppresses" (Participant 20).

Offensive Personal Stigmatizing. The other issue experienced was offensive personal stigmatizing. The women described that being divorced was considered negative in society and this social stereotype of divorced stigma created great tension and stress in their lives. As a result, they had to hide their divorce at work, school, family, and forcing children and families to lie about their living conditions, and just escaping reality. "I am afraid to say I got divorced, because people look at a widow negatively" (Participant 7). The women asserted that society had a stigmatizing view of their divorce and that members of society considered widows to have a moral problem in attracting men. There was a kind of suspicion of them being a concubine or in an illegitimate relationship. The women described individuals in society thought that widows provided easy sexual access for men, that there

was no barrier for them to be in relationships with men, and that most widows had been in relationships with multiple men. This stigma limited their social health and created a lonely life. "In fact, being a widow or prostitute is the same from society viewpoint. I am afraid to disclose that I am widowed" (Participant 12).

Social and Environmental-Centered Challenges to Health-Related Behaviors

Besides individual centered challenges, participants faced social and environmental-centered challenges to achieve health-related behaviors. Experiencing harassment at their place of living, inability to find proper housing, and absence of consulting services at school led women to feel a lack of community-based support which limited their health-related behaviors. The women also described a lack of financial support because there was no specific insurance for them. Financial help and allowances from government and charitable organization responsible centers were inadequate and they did not receive financial support for their child. In addition to the lack of community-based and financial support, the women also felt a lack of support from the labor market. They were not able to find suitable jobs after being divorced, experienced uncertain employment conditions at private workplaces, and experienced harassment at work. An overview of social and environmental-centered challenges to health-related behaviors for divorced women acting as household-heads is presented in Table 2.

Lack of Community-Based Support

The participants explained that they do not receive any support from their community. Lack of community-based support, including harassment in their living locality, inability to find proper housing, and absence of consulting services at school was described as a challenge. The women acknowledged that poor living conditions in terms of home and neighborhood affected their health-related behaviors by affecting their physical, mental, and social dimensions of health. The described that these unfavorable conditions caused a constant feeling of stress, anxiety, and depression, which caused other problems, such as insomnia, aggressive behaviors with family members, and neglect of their own physical health.

The women described being harassed in their living locality. Shopkeepers' verbal taunts about the absence of a husband, not renting an apartment to a widow, and the family's distancing from the woman were described as harassment that affected their social health. "Every real estate agent I go to does not rent a house to me as soon as they find out I am a divorcee" (Participant 8).

Besides experiencing harassment in their living locality, it was difficult to find proper housing. The women described severe problems in finding suitable housing because the cost of adequate housing was very high due to the high cost of both mortgages and rent. They described the unsuitability of housing, having to live in small apartments without bathrooms and windows, often in bad neighborhoods because they had little money to spend for renting a house/flat. The challenges in finding proper housing, or paying for existing housing, led to poor choices regarding own health-related behaviors. "The house I bought does not have a bathroom. I did not have more money to get a better place. Not having a bathroom has made it really difficult to maintain personal hygiene" (Participant 14).

Absence of Counseling Consulting Services at School. Another point mentioned was lack of community-based support and absence of counseling services at their children's school. They described that there were no counseling services for their children, which meant

that the children lacked a mentor in life, at school, university, or at other centers (e.g., sport clubs). Not receiving any kind of support from counseling services made the women stressed and angry because they had to raise their children themselves:

> Why no one cares about our children, believe me I regret it, I told the school I take care of my children alone. Because not only does not help at all, but from time to time the teacher calls my daughter and asks about our lives. This makes me very sad and puts a lot of stress on me. (Participant 15)

Lack of Financial Support

Lack of financial support was described as absence of specific insurance for the women, inadequate allowance from responsible centers, and absence of child support which limited choices regarding health-related behaviors. They received very little and limited financial support from their ex-husbands which was not enough to make a living.

Absence of Specific Insurance for Divorced Women. One of the issues that participants complained about was absence of specific insurance for divorced women. There are different forms of basic insurance in Iran, and some include very low coverage for health costs. Most of participants had this kind of insurance, which coverage was not effective, and they had problem affording their medical costs. The women described that there was no special insurance with specific conditions for women who were household-heads "Really, our insurance should be like for the rest of society. Do we not have the same financial rights?" (Participant 13). The health insurance companies had contracts with a limited number of health/medical centers and other insurance companies (e.g., Iran Health Insurance) also paid a small amount of money, which their insurance did not. There was no supplementary insurance for the women, which limited their ability to pay for health procedures such as dentistry and mammography. "My tooth decayed. I went with a health insurance booklet, but it was not accepted. Finally, I went to an experimental practical denturist and had it removed" (Participant 10).

Inadequate Allowance from Responsible Centers. The other point was inadequate allowance considered for these women from responsible centers. The women described the subsidies that they received by government agencies were insignificant. Two US dollars from the Emdad Committee for Islamic Charity and another two UD dollars government subsidy, as well as the lack of a separate support package were examples of the very small allowances in responsible centers. "The money they give as subsidies is really low compared to the expenses I have" (Participant 11). The women also described that financial support was difficult to get and provided via a very complex and cumbersome process, which was described to double the inefficiency of the support system. The women stressed that there were a limited number of options for them to obtain loans to cover their basic needs, as the banks required a need for official employee guarantors and a payroll deduction for loans below 200 USD to pay the loan, making it difficult to get a loan. "I struggled for a loan of 20 million IRR [80 USD]. God knows how much I was bothered" (Participant 9).

Absence of child support was another issue which troubled these women. The women described lack of various support for their children at educational facilities, school, and university. They also stressed that the purchasing power of their income and absence of child support had decreased due to increasing costs, and as a result, made buying healthy alternatives of daily necessities (meat, dairy products, fruit, etc.), and paying for their children's schooling difficult. The cost of school services for children, the purchase of school

uniforms and warm winter clothes, and the purchase of wedding gifts and accessories for children had to be avoided. “I went to school and argued with my daughter's school principal over two US dollars she had asked for, so that I broke everything on her desk” (Participant 15).

Lack of Labor Market Support

The participants experienced lack of labor market support. They described that as divorcee, they could not find suitable job, employment conditions are uncertain at private workplaces, and harassment at work affected the women’s social health. The women described that they had severe problems in finding suitable jobs because there were no specific places to support the self-employment of women acting as household-heads. Hand selling on sidewalks and in inappropriate places, and municipal fines for peddlers were described as examples of self-employment. Street peddles in metro stations, washing many carpets in carpet cleaning services, doing hard physical work at home, and nursing severely sick elderly individuals were jobs possible to get, but described as not suitable for a woman, either based on the physical challenges, or lack of specific skills which limited their possibilities to achieve health-related behaviors either by being fatigued or by lack of money. “I have been nursing a paralyzed man for two years and this is not really in my ability” (Participant 5).

The other issue for participants was uncertain employment conditions at private workplaces. In private offices there was security for work, which was an obstacle to their healthy behaviors. They received proposals to establish an illegal relationship with their employer or to become a concubine. If they rejected such a proposal, the women stressed fear of losing their job and not being able to afford living in general including not being able to pay for health care services. “I got a job as a secretary in a private company, and its salary was not bad either. One month later, the boss said that if you want to stay, you should start a relationship with me” (Participant 19).

Harassment at work was an important problem experienced by the women. The women described that they were verbally and non-verbally harassed at work. Insults to their personalities in the workplace, abuse of their working conditions and needs, and verbal and non-verbal profanity were types of harassments described: “I am tired of male colleagues talking badly in the workplace. They speak disrespectfully to me” (Participant 7). The behavior of their employers in the workplace was inappropriate and the women described being paid unequal wages compared to other employees and their insurance was not guaranteed: “My employer pays me half the overtime and threatens to fire me when I object” (Participant 5).

Discussion

The aim of the present study was to explore challenges to achieve health-related behaviors as experienced by divorced Iranian women acting as household-heads in Tehran. The discussion will be structured according to the two themes; individual-centered barriers and social and environmental-centered barriers, that we identified as challenges for engaging in health-related behaviors among the women.

Individual-Centered Challenges to Health-Related Behaviors

Lack of competence, lack of personal control, and lack of emotional support were described as individual-centered barriers to engaging in healthy practices. This was expressed

as ignorance of healthy habits, absence of exercise, inappropriate hygiene routines, and misunderstanding of transfer and development of diseases. These findings are consistent with results from two other Iranian studies (Ahmadi & Mansoorian, 2013; Yazdi Feyzabadi et al., 2018) which found that divorced women did not pay attention to their health, ignored symptoms of poor health, had irregular food and sleep habits, and did not exercise due to lack of time. In the present study, the women were responsible for their family as household-head. Being a female household-head can cause lack of personal control, strenuous working conditions, and a stressful economic situation (Ahmadi & Mansoorian, 2013). They also found that multiple mental conflicts concerning various issues, such as economic issues and physical and mental fatigue due to multiple responsibilities, decreased the physical and mental energy levels of divorced women. These problems were also described in the present study and caused mental disorders, sleep disorders, and failure to perform health-promoting behaviors, such as exercise and healthy eating.

Lack of emotional support was described as other individual-centered barriers for engaging in health-related behaviors. The women described that their current living conditions were still affected by their past marital life and offensive personal stigmatizing occurred due to their divorce. They experienced negative emotions and social stereotypes that created great tension and stress in their lives. According to Afrasiabi and Jahangiri (2016), many Iranian women acting as household-heads show violent reactions to problems, which also harms themselves. Afrasiabi and Jahangiri mean that in the context of widowhood, they were not safe from the words and stigmas of those around them and were faced with all kinds of negative behaviors including slander and rumors, and became pessimistic about themselves and were rejected by their relatives (Afrasiabi & Jahangiri, 2016).

Social and Environmental-Centered Challenges to Health-Related Behaviors

The women described the lack of community-based support, lack of financial support, and lack of labor market support as social and environmental challenges to maintaining engagement in health-related behaviors. Ahmadi and Mansoorian (2013) noted that financial problems caused Iranian women acting as household-heads to choose between their own health and that of their children. The problem of providing living expenses, irrespective of the role of "breadwinner," or a mother who did not have a basic role of breadwinner, becomes more obvious for women, and many of these women had severe maternal problems, especially at the beginning of widowhood, to the point that they were unable to meet basic needs (Ahmadi & Mansoorian, 2013). In another Iranian study (Afrasiabi & Jahangiri, 2016), most of the female-headed households participating had difficulty in meeting basic living needs such as food, clothing, and housing, as well as the cost of education for themselves or their children. The divorced women in the present study also believed that they were harassed in their community, which could be an obstacle to their health. Moreover, the behavior of employers in the workplace was inappropriate and they were verbally and non-verbally harassed at work and within the locality in which they lived. This issue can appear in different social areas such as public spaces, workplaces, school, and in various forms (e.g., telephone harassment, requesting undesirable marriages and without suitable conditions, and requests to be a concubine). The feeling and experience of sexual insecurity was an integral part of life for the women, which has been described in previous studies (Hosseini et al., 2019; Newton-Levinson et al., 2014).

The women had problems finding suitable jobs, along with uncertain employment conditions at private workplaces and experienced harassment at work. These conditions led them to experience lack of labor market support, another barrier experienced to prevent healthy behaviors. The women were forced to take jobs that were disproportionate to their

physical condition or lacked moral and social security in the private sector. Ahmadi and Mansoorian (2013) also found that Iranian women who were doing hard and heavy work at home and/or outside their home to earn money also described negative effects on their health. The lack of funding and lack of a dignified life and employment in low-status jobs are among many problems that has been described (Islam, 2017). The women in the present study experienced harassment at work due to being divorced. According to (Ahmadi & Mansoorian, 2013), the social behaviors experienced after the death of a husband make these women realize that they are widows and life without the support of their husbands is difficult.

Another challenge to health-related behaviors in the present study was the lack of adequate insurance coverage for divorced women, inadequate allowance from responsible center, and absence of child support. Poor social support was one of the most important barriers to engaging in healthy behaviors among the women here, which has been confirmed in several previous studies (Adams et al., 2017; Afrasiabi & Jahangiri, 2016; Misra et al., 2000). The subsidies paid to the responsible government organization were very small, and the financial support provided by a very complex system doubles the inefficiency of this support. Non-governmental organizations, especially religious and charitable organizations, including churches, are important for providing financial support to disadvantaged women (Tang & Chen, 2002). Studies have shown that divorced women are often more likely to be uninsured (i.e., two times more) than married women (Johnson, 2004; Jovanovic et al., 2003). In Iran, marriage can be a good source of insurance coverage for women, as they are often covered by their spouses who are employed (Meyer & Pavalko, 1996). Not only in Iran, but in other developing countries, female household-heads are at greater risk of poverty. Poverty and lack of health insurance coverage can lead to further deprivation for these women from health and medical services. Because the high cost of health services generally accounts for more than 40% of household income, this threatens the standard of living in the short-term and long-term (Raiz, 2006). For example, in the United States, female household-heads and their children have less insurance coverage than couples, which can seriously damage their own health and their children's health (Oswald et al., 2005; Schoen et al., 2008). Similar to Ahmadnia and Kamel (2017), women in the present study were not covered by any insurance, even health insurance. (Afrasiabi & Jahangiri, 2016) also described low income, lack of insurance, and long working hours as problems faced by female household-heads.

The causes of poor health-related behaviors and poor health status of divorced women can be reflected from the perspective of two models (i.e., the crisis model and the source model). In the crisis model, the emergence of mental conditions after divorce, which is itself the result of conflicts between couples can threaten their mental and physical health (Amato, 2010; Williams & Umberson, 2004). However, in the source model, marriage provides support for women, providing emotional and financial support to the individual (Hughes & Waite, 2009; Liu, 2012). This support can reduce psychological distress and increase access to health. Married people are dependent on their spouses. It is common that spouses have jobs and are covered by health insurance. Most health insurance coverage for employed people is also good. Therefore, a woman at the time of marriage has the resources of financial, emotional and psychological support, etc. of her husband and also benefits from her husband's insurance. Consequently, according to the source model, married women are likely to experience a healthier lifestyle compared to unmarried women (Koball et al., 2010; Lavelle et al., 2012).

From the divorced women's own perspective acting as household-heads, a wide range of individual as well as social and environmental barriers to engaging in health-related behaviors. Therefore, in addition to designing person-centered interventions, the results here demonstrate the need for policy interventions in terms of legislation or reform of welfare protection laws for female household-heads.

References

Adams, M. H., Bowden, A. G., Humphrey, D. S., & McAdams, L. B. (2017). Social support and health promotion lifestyles of rural women. *Online Journal of Rural Nursing and Health Care, 1*(1), 43-65.

Afrasiabi, H., & Jahangiri, S. (2016). Problems of social interactions of women head of household (Qualitative study amongst Shahin-Shahr women). *Women in Development & Politics, 14*(4), 431-450. DOI: 10.22059/jwdp.2016.60963

Ahmadi, F., & Mansoorian, M. R. (2013). The experience of widowed head of the family during role transition: A qualitative study. *Journal of Qualitative Research in Health Sciences, 2*(1), 62-75.

Ahmadnia, S., & Kamel, G. A. (2017). Women-headed households in Tehran: A qualitative study of their experiences, challenges and capacities. *Social Welfare Quarterly, 17*(65).

Amato, P. R. (2000). The consequences of divorce for adults and children. *Journal of Marriage and Family, 62*(4), 1269-1287.

Bansal, P., Smith, W. K., & Vaara, E. (2018). New ways of seeing through qualitative research. *Academy of Management Journal, 61*(4), 1189-1195. DOI:10.5465/AMJ.2018.4004

Davarinejad, O., Ghasemi, A., Hall, S. S., Meyers, L., Shirzadifar, M., Shirzadi, M., Brand, S., & Shahi, H. (2020). Emotionally stable, extraverted, conscientious, and unambivalent: Iranian women successfully navigating divorce adjustment. *Journal of Family Issues, 42*, 2181-2206.

Elo, S., & Kyngäs, H. (2008) The qualitative content analysis process. *Journal of Advanced Nursing, 62*(1), 107–115.

Enayatifar, E., Miri, M., Norozi, E., Hosseini, T., & Malaki Moghadam, H. (2018). A study on mental health status and coping skills in female household heads in Birjand. *Daneshvar, 25*(2), 11-18.

Gholipour, A., & Rahimian, A. (2011). Economic, cultural, and educational factors related to empowerment of head-of-household women. *Social Welfare Quarterly, 11*(40), 29-62.

Given, L. M. (Ed.). (2008). *The Sage encyclopedia of qualitative research methods*. Sage Publications.

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today, 24*(2), 105-112. DOI: 10.1016/j.nedt.2003.10.001

Hayati, M., & Soleymani, S. (2019). The consequences of divorce for the divorced person: A qualitative study. *Rooyesh-e-Ravanshenasi Journal (RRJ), 7*(11), 273-288.

Hetherington, E. M., & Kelly, J. (2003). *For better or for worse: Divorce reconsidered*. WW Norton & Company.

Hosseini, M. R., Khazaie, S., & Golami, F. (2019). The experience of living divorced women from the feeling of insecurity in everyday life. *Women Studies, 10*(30), 25-52.

Hughes, M. E., & Waite, L. J. (2009). Marital biography and health at mid-life. *Journal of Health and Social Behavior, 50*(3), 344-358. DOI: 10.1177/002214650905000307

Islam, H. (2017). Economic problems confronted by divorced women and its impact on their children. *Journal of Sociology, 1*(1), 77-86.

Johnson, N. E. (2004). *Critical issues in rural health*. Blackwell Press.

Jovanovic, Z., Lin, C. J., & Chang, C. C. (2003). Uninsured vs. insured population: Variations among nonelderly Americans. *Journal of Health and Social Policy, 17*(3), 71-85. DOI: 10.1300/j045v17n03_05

Khani, S., Khezri, F., & Yari, K. (2018). A study of social vulnerability among female-headed households and headed women in Soltan-Abad District, Tehran. *Women in Development and Politics, 15*(4), 597-620.

Khazaeian, S., Kariman, N., Ebadi, A., & Nasiri, M. (2017). The impact of social capital and social support on the health of female-headed households: A systematic review. *Electronic Physician, 9*(12), 6027-6034.

Koball, H. L., Moiduddin, E., Henderson, J., Goesling, B., & Besculides, M. (2010). *What do we know about the link between marriage and health?* Sage Publications.

Kwon, M., & Kim, H. (2020). Psychological well-being of female-headed households based on age stratification: A nationwide cross-sectional study in South Korea. *International Journal of Environmental Research and Public Health, 17*(18), 6445.

Lavelle, B., Lorenz, F. O., & Wickrama, K. A. S. (2012). What explains divorced women's poorer health?: The mediating role of health insurance and access to health care in a rural Iowan sample(*). *Rural Sociology, 77*(4), 601-625. DOI: 10.1111/j.1549-0831.2012.00091.x

Lebni, J. Y., Gharehghani, M. A. M., Soofizad, G., & Irandoost, S. F. (2020). Challenges and opportunities confronting female-headed households in Iran: A qualitative study. *BMC Women's Health, 20*(1), 1-11.

Lincoln, Y. S., & Guba, E. G. (1986). But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. *New Directions for Program Evaluation, 1986*(30), 73-84.

Liu, H. (2012). Marital dissolution and self-rated health: Age trajectories and birth cohort variations. *Social Science & Medicine, 74*(7), 1107-1116. DOI: 10.1016/j.socscimed.2011.11.037

Magar, V., Heidari, S., Zamora, G., Coates, A., Simelela, P. N., & Swaminathan, S. (2019). Gender mainstreaming within WHO: Not without equity and human rights. *Lancet, 393*(10182), 1678-1679. DOI: 10.1016/s0140-6736(19)30763-9.

Mariani, G., Kasznia-Brown, J., Paez, D., Mikhail, M. N., H Salama, D., Bhatla, N., Erba, P. A., & Kashyap, R. (2017). Improving women's health in low-income and middle-income countries. Part I: challenges and priorities. *Nuclear Medicine Communications, 38*(12), 1019–1023. https://doi.org/10.1097/MNM.0000000000000751

Martin-West, S. (2019). The role of social support as a moderator of housing instability in single mother and two-parent households. *Social Work Research, 43*(1), 31-42. DOI: 10.1093/swr/svy028

Meyer, M. H., & Pavalko, E. K. (1996). Family, work, and access to health insurance among mature women. *Journal of Health and Social Behavior, 37*(4), 311-325.

Misra, R., Patel, T., Davies, D., & Russo, T. (2000). Health promotion behaviors of Gujurati Asian Indian immigrants in the United States. *Journal of Immigrant Health, 2*(4), 223-230.

Nazoktabar, H., & Veysi, R. (2008). Socio-economic and cultural condition of women-headed households in Mazandaran province. *Social Welfare, 7*(27), 95-113.

Newton-Levinson, A., Winskell, K., Abdela, B., Rubardt, M., & Stephenson, R. (2014). 'People insult her as a sexy woman': Sexuality, stigma and vulnerability among widowed and divorced women in Oromiya, Ethiopia. *Culture, Health & Sexuality, 16*(8), 916-930.

Nikbakht, A., Pashaei Sabet, F., & Bastami, A. (2016). Life of women after divorce. *Iranian Journal of Psychiatric Nursing, 4*(3), 66-74.

Nourolahi, T., Ghaemi, Z., Goodarzi, H. M., Naeneeni, O., Jafari, S., Ghaderi, S., . . . Tadaion, P. (2016). *The Iranian population and housing census: The technical report*. Statistical Center of Iran.

Oswald, D. P., Bodurtha, J. N., Broadus, C. H., Willis, J. H., Tlusty, S. M., Bellin, M. H., & McCall, B. R. (2005). Defining underinsurance among children with special health care needs: A Virginia sample. *Maternal and Child Health Journal, 9*, S67-S74.

Overbeek, G., Vollebergh, W., de Graaf, R., Scholte, R., de Kemp, R., & Engels, R. (2006). Longitudinal associations of marital quality and marital dissolution with the incidence of DSM-III-R disorders. *Journal of Family Psychology, 20*(2), 284-291.

Parvizi, S., & Hamzehgardeshi, Z. (2014). Adolescents' view of health concept and its risk factors: A literature review. *International Journal of Adolescent Medicine and Health, 26*(3), 351-359.

Payne, G., & Payne, J. (2004). *Key concepts in social research*. Sage.

Pieters, J. (2011). Education and household inequality change: A decomposition analysis for India. *Journal of Development Studies, 47*(12), 1909-1924.

Qamar, A. H., & Faizan, H. F. (2021). Reasons, impact, and post-divorce adjustment: Lived experience of divorced women in Pakistan. *Journal of Divorce & Remarriage*, 1-26.

Raiz, L. (2006). Health care poverty. *The Journal of Sociology & Social Welfare, 33*(4), 87.

Sadeghi, R., & Agadjanian, V. (2019). Attitude and propensity to divorce in Iran: Structural and ideational determinants. *Journal of Divorce & Remarriage, 60*(6), 479-500. DOI: 10.1080/10502556.2019.1586228

Schoen, C., Collins, S. R., Kriss, J. L., & Doty, M. M. (2008). How many are underinsured? Trends among U.S. adults, 2003 and 2007. *Health Affairs (Millwood), 27*(4), w298-309. DOI: 10.1377/hlthaff.27.4.w298

Seyedfatemi, N., Rafii, F., Rezaei, M., & Hezaveh, M. S. (2015). Factors influencing the health promotion in female-headed households: Golden triangle of money, time and energy *Journal of Knowledge & Health, 10*(4), 13-22. DOI: 10.22100/jkh.v10i4.792

Shahbazi, N., Veisani, Y., Delpisheh, A., Sayehmiri, K., Naderi, Z., Sohrabnejad, A., & Mami, S. (2015). Relationship between socioeconomic status and general health in the female-headed households. *Scientific Journal of Ilam University of Medical Sciences, 23*(1), 56-62.

Solhi, M., Shabani Hamedan, M., & Salehi, M. (2015). Quality of life of women heading household covered by Tehran Welfare Organization. *Rahavard Salamat Journal, 1*(1), 1-10.

Svalastog, A. L., Donev, D., Kristoffersen, N. J., & Gajović, S. (2017). Concepts and definitions of health and health-related values in the knowledge landscapes of the digital society. *Croatian Medical Journal, 58*(6), 431–435.

Tang, Y.-Y., & Chen, S.-P. (2002). Health promotion behaviors in Chinese family caregivers of patients with stroke. *Health Promotion International, 17*(4), 329-339.

Veisani, Y., Delpisheh, A., & Sayehmiri, K. (2015). Health related quality of life in the female-headed households. *International Journal of Epidemiologic Research, 2*(4), 178-183.

World Health Organization (WHO). (2011). *10 facts about women's life*. https://www.who.int/features/factfiles/women/en/#

Williams, K., & Dunne-Bryant, A. (2006). Divorce and adult psychological well-being: Clarifying the role of gender and child age. *Journal of Marriage and Family, 68*(5), 1178-1196.

Williams, K., & Umberson, D. (2004). Marital status, marital transitions, and health: A gendered life course perspective. *Journal of Health and Social Behavior, 45*, 81-98.

Yazdi Feyzabadi, V., Seyfaddini, R., Ghandi, M., & Mehrolhasani, M. (2018). The world health organization's definition of health: A short review of critiques and necessity of a shifting paradigm. *Iranian Journal of Epidemiology, 13*, 155-165.

Author Note

Farzaneh Golboni is a Ph.D. candidate in health promotion when the study was designed. With a B.Sc. and M.Sc. in Midwifery, and several years of clinical practice. This manuscript is related to her dissertation.

Dr. Zainab Alimoradi (Co-Corresponding Author) is Associate Professor of Midwifery and Reproductive Health in Qazvin University of Medical Sciences. She is supervisor and advisor of several thesis in midwifery counseling. Also, she is director of Social Determinants of Health Research Center. She is interested in sexual and reproductive health, Adolescent's health and social determinants of health with 80 related peer-reviewed research papers. She has contributed as an author in 9 books. Please direct correspondence to zainabalimoradi@yahoo.com.

Dr. Bengt Fridlund RNAN, RNT, BSc in Pedagogy, PhD, is a senior professor in emergency care as well as in cardiovascular care.

Dr. Liselott Årestedt RN, PhD, is Deputy Head of Department of Health and Caring Sciences, Faculty of Health and Life Sciences, Linnaeus University.

Dr. Mark Griffiths is a Chartered Psychologist and Distinguished Professor of Behavioural Addiction at the Nottingham Trent University, and Director of the International Gaming Research Unit. He is internationally known for his work in behavioral addictions. He has published over 1300 peer-reviewed research papers, six books, and over 180 book chapters. He has won 24 national and international awards for his research.

Dr. Anders Broström RN, MSc in Nursing, PhD, is a professor in nursing as well as in Health and Care Science, Jönköping University, Jönköping, Sweden and holds a position as senior researcher at the Department of Clinical Neurophysiology, Linköping University Hospital, Linköping, Sweden.

Dr. Amir H. Pakpour (Co-Corresponding Author) is professor of health psychology working in Jönköping University, Jönköping, Sweden. Please direct correspondence to amir.pakpour@gmail.com.

Acknowledgements: All the participants who participated in this study are thanked.

Funding: The Vice-chancellor (Research) of Qazvin University of Medical Sciences has provided financial support to this project. The funding body had no role in the design of the study, collection, analysis, interpretation of data and writing the manuscript.

Authors' Contributions: All authors contributed to all the stages. All authors revised the manuscript, agreed to be fully accountable for ensuring the integrity and accuracy of the study, and read and approved the final version of the manuscript to be published. All the authors met the criteria for authorship, and they are listed as co-authors on the title page.

Article Citation

Golboni, F., Alimoradi, Z., Fridlund, B., Årestedt, L., Griffiths, M. D., Broström, A., & Pakpour, A. H. (2022). A qualitative analysis of personal health care challenges experienced by Iranian divorcees. *The Qualitative Report, 27*(12), 2783-2800. https://doi.org/10.46743/2160-3715/2022.5152