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The Reflections of Childhood Poverty on Women's Health in Adulthood: A Qualitative Study

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Abstract

Objectives: The aim of this study is to determine the reflections of childhood poverty on women's health in adulthood.

Methods: This study was a qualitative study conducted using a grounded-theory approach. Eleven women who were identified by the purposeful sampling method were interviewed. The data were collected by interviewing women with a personal information form and a semi-structured interview form. The data were analyzed using the content analysis method and themes were created. The ages of the women were between 32 and 49 years, eight had undergraduate level education, nine were married and seven had income equal to their expenses.

Results: Two main themes were identified in the study as deprivation (habit, social exclusion, neglect) and resilience (coping effort, skill).

Conclusion: As a result, the poverty experienced in childhood is reflected in the healthy lifestyle behaviors of women. In this context, more research, education, advocacy and cooperation should be done by health professionals to form the basis for actions and policies regarding poverty, which is an important social determinant of health.

Keywords: Adulthood, Childhood Poverty, Women's Health, Qualitative Study

Öz

Çocukluk Çağı Yoksulluğunun Yetişkinlikte Kadın Sağlığına Yansımaları: Nitel Bir Çalışma

Amaç: Bu araştırmanın amacı, çocukluk çağı yoksulluğunun yetişkinlik döneminde kadın sağlığı üzerindeki yansımalarını belirlemektir.

Yöntem: Bu çalışma, temellendirilmiş teori yaklaşım yöntemi kullanılarak yürütülen nitel bir çalışmadır. Amaçlı örnekleme yöntemi ile belirlenen on bir kadınla görüşülmüştür. Veriler, kişisel bilgi formu ve yarı yapılandırılmış görüşme formu kullanılarak kadınlarla görüşülerek toplanmıştır. Veriler, içerik analizi yöntemi kullanılarak analiz edilmiş ve temalar oluşturulmuştur. Kadınların yaşları 32-49 arasında olup, 8'i lisans düzeyinde eğitime sahip, 9'u evliydi ve 7'sinin geliri giderlerine eşitti.

Bulgular: Çalışmada yoksunluk (alışkanlık, sosyal dışlanma, ihmal) ve dayanıklılık (başa çıkma çabası, beceri) olmak üzere iki ana tema belirlenmiştir.

Sonuç: Sonuç olarak, çocukluk çağında yaşanan yoksulluk, kadınların sağlıklarına yansımıştır. Bu bağlamda, sağlık profesyonelleri tarafından sağlık açısından önemli bir sosyal belirleyici olan yoksullukla ilgili eylem ve politikaların temelini oluşturmak için daha fazla araştırma, eğitim, savunuculuk ve iş birliği yapılmalıdır.

Anahtar Kelimeler: Çocukluk Çağı Yoksulluğu, Kadın Sağlığı, Yetişkinlik, Nitel Çalışma

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INTRODUCTION

Childhood poverty is an important global public health problem. Children are deprived of shelter, education, nutrition, water or health services because of poverty. These unmet basic needs often result in serious health problems later in life (UNICEF, 2020; UNICEF, 2023). Adult health is shaped throughout life, but childhood has a special importance in this respect. This is because childhood is a key stage for the formation of health-related behaviors that form the basis of future health and development (Gupta et al., 2007; Umeda et al., 2015; Wise, 2016). In the literature, children's early experiences with poverty have been shown to affect adult health in physical, mental, and social domains (Dufford et al., 2020; Hughes & Tucker, 2018).

In many societies, poverty mostly affects women and children and causes problems especially for healthy living behaviors (Ngoma & Myimbo, 2017; UN Women, 2021). Poverty is also associated with women's health problems such as cardiovascular disease, diabetes, obesity and high risk of death (Jonshon, 2020; Nguyen et al., 2022; Rafael, 2011), depression, suicide risk, and stress (Seponski et al., 2019; Smith et al., 2021). In addition, poverty has been stated to cause intergenerational transmission (Hernandez & Pressler, 2014; WHO, 2025). In this context, adverse experiences such as childhood poverty negatively affect not only women's own health but also the health of their families and children, while also influencing healthy lifestyle behaviors. Such behaviors include maintaining a balanced diet, engaging in regular physical activity, getting adequate sleep, adopting stress management strategies, and avoiding harmful habits such as smoking and alcohol consumption. Within the scope of women's health, regular medical checkups, prenatal care, and preventive measures for children's health are also considered important healthy lifestyle behaviors (Cavenagh & Simerson, 2022; Nguyen et al., 2022). It is also anticipated that this research can guide policymakers in preventing or alleviating poverty in the general population, thereby strengthening the connection between evidence and policy in public health (O'Donnell, 2024). Health professionals have important potential in the fight against poverty. Health professionals are responsible for being resources for health education, implementing health promotion programs, conducting research and designing specific and targeted public health interventions to understand the health effects of poverty (Price et al., 2018).

The literature has shown that childhood poverty is associated with an increased risk of chronic diseases and mental health problems in women during adulthood (Lee et al., 2021; Ortiz-Llorens et al., 2022). Moreover, it has been demonstrated that this situation negatively affects family health through intergenerational transmission (Houweling & Grünberger, 2024). These studies generally focus on physical/mental health problems and social inequalities. This study, however, directly links childhood poverty to women's health outcomes, addressing a significant gap in the literature. The main purpose of this research is to examine in depth the reflections of childhood poverty on women's health. The results obtained will contribute to the protection of the health of women with childhood poverty experiences in the long term, the prevention of health problems in these women, and the determination of early treatment methods for their problems.

Research Questions

What are the reflections of childhood poverty on women's health?

METHODS

Study Design

This research is a qualitative study that uses a grounded theory approach to determine the reflections of childhood poverty on women's health.

Participants and Setting

The universe of the research consisted of women living in a province of Nevşehir in 2022. Participants were found and contacted by the snowball method. First of all, the three participants included in the preliminary application were selected from among those who applied to the health unit of a university. The interview form was applied to these participants as a pilot application and necessary corrections were made based on the feedback received from them. Three participants who participated in the pilot application were not included in the study. However, other participants who met the inclusion criteria were reached through the participants in the ten main interviews conducted after the pilot interviews. During the data collection process, participants were women who declared that they lived in poor regions and households during childhood, although their current socio-economic level was moderate or good.

The sample for the study was determined by the purposeful sampling method, and consisted of 11 participants who experienced childhood poverty and agreed to participate in the research. The age of the participants in the study ranged from 32 to 49 years, eight had undergraduate level education and three had postgraduate education. Two of the participants were single, nine were married, four women stated their income was higher than their expenses and seven stated their income was equal to their expenses. While nine of the women stated that their family type was nuclear family, two stated it was an extended family. Participants had three or more siblings and almost all of them had children.

Participant selection

The study included women aged 18 and over who reported experiencing childhood poverty and reported difficulties meeting basic needs or accessing healthcare during this period. This was assessed based on participant self-reports. Individuals with a diagnosis of mental illness and individuals who did not volunteer to participate in the study were not included in the study, as having a mental illness would affect the results of the study. There were no participants who withdrew from the study. Participants were informed that participation was not compulsory and they could leave the study whenever they wanted.

Data Collection Tools

Various measures were taken to ensure the validity and reliability of the data collection tools. First, the semi-structured interview form was comprehensively prepared regarding childhood poverty and women's health, and it was submitted to three experts in qualitative research and public health for content validity evaluation. To test the clarity, comprehensibility, and appropriateness of the form, a pilot study was conducted with three women who met the inclusion criteria, and necessary adjustments were made based on participant feedback. To ensure reliability, all interviews were audio-recorded, and the recordings were transcribed verbatim. The transcribed texts were independently reviewed and coded by two researchers, ensuring consistency and minimizing potential biases. These steps are in line with standard practices for ensuring the validity and reliability of qualitative data collection tools (Creswell & Poth, 2018; Tong et al., 2007). Data collection tools consist of two parts, an "Information Form" with descriptive information about women and the semi-structured "Interview Form".

Information Form: This form consists of questions about the demographic characteristics of women such as age, education level, marital status, number of siblings, income status, family structure, and place of residence.

Semi-structured Interview Form: This consists of open-ended questions evaluating the impact of childhood poverty on women's health. (Table 1). This form comprised seven structured questions. During the interviews, the questions were posed in a predetermined order, and supplementary explanations or clarifications were provided whenever necessary to ensure participants' full understanding and to facilitate richer, more detailed responses.

Table 1. Semi-structured interview questions

1.	What do you think about poverty?
2.	What do you think about childhood poverty?
3.	How did it feel to experience poverty as a child?
4.	What did being poor as a child mean to you?
5.	How do you think poverty has affected your childhood life?
6.	How do you think poverty affects your current life/health?
7.	Is there anything important that wasn't asked and that you want to add?

Data Collection

In this study, data were collected between April and June 2022 using a semi-structured interview method. The interviews were conducted by a psychiatric nurse experienced in qualitative research, which ensured effective communication with the participants and that the questions were asked clearly and comprehensibly. During the interviews, the researcher took detailed notes of the participants' responses and also observed and recorded their body language, facial expressions, and gestures. Data collection continued until data saturation was reached. All interviews were audio-recorded, and no participant objected to this. The recordings were transcribed within 24–72 hours, and the transcripts were verified for accuracy by two other researchers. The interviews lasted an average of 45–50 minutes and were conducted in quiet, and uninterrupted environments (e.g., a room in a house or a garden) where participants could communicate comfortably. This process ensured that both participants' verbal responses and non-verbal cues were fully captured, supporting the reliable collection of data.

Data Analysis and Interpretation

This study followed the COREQ (Consolidated Criteria for Reporting Qualitative Research) checklist to ensure methodological rigor. In the research, which used the grounded theory approach one of the qualitative research methods, the collection of research data and the analysis of the data were carried out simultaneously. The data analysis process was carried out with a systematic and inductive approach. Evaluation of the data, coding and analysis of the data were carried out manually by the researchers without using any tools. Raw data were obtained by documenting voice recordings within 24-72 hours of interviewing each participant. A total of 331 pages of interview text were created and used as raw data. The data analysis process in the research was carried out step-by-step: organizing the data for analysis, reading and taking short notes, describing the data within codes and themes,

classifying the data within codes and themes, interpreting the data and presenting the data. As data arrived from the participants, the data were analyzed, and comparisons were constantly made with the initial data. After data were collected, data files were organized. The data were read as a whole several times before being segmented. Notes and reminder notes were created during the readings. Data analysis was carried out in three steps: open, axial and selective coding. In the open coding step, researchers examined the text for salient categories of information and then used a constant comparison approach. The researchers searched for examples that represented the category and continued searching with axial coding until they yielded no more new information for the category. In the final coding stage, the researchers carried out the selective coding process by creating expressions related to the categories. The themes and sub-themes were formed by revealing the relationships between the categories. Themes were supplemented with direct quotations when necessary.

Reflexivity

The self-reflective information of the researchers in this study is as follows: the first researcher (Associate Professor) completed their doctorate in public health nursing, and the second researcher (Associate Professor) completed their doctorate in psychiatric mental health nursing.

The researchers have scientific research experience in mental health and illness, women's health, public health, and qualitative research. In addition, the researchers have experience in providing health services and counseling to poor families within the scope of community health studies. The fact that the researcher conducting the interviews was a psychiatric nurse ensured the sustainability of effective communication and interviews with the participants.

Credibility and Trustworthiness of Qualitative Data

To ensure the credibility and trustworthiness of the qualitative data in this study, multiple strategies were applied throughout the research process. Long-duration, in-depth interviews were conducted by a psychiatric nurse who has expertise in qualitative research and effective communication techniques. The researcher not only asked the semi-structured interview questions but also carefully observed and documented participants' non-verbal cues, including facial expressions, gestures, and body language, taking detailed notes during each session. This allowed for a richer, more nuanced understanding of participants' experiences.

Before the interviews, explanations were provided to establish secure and trusting communication between the researcher and participants. Data were collected at prearranged, comfortable locations, such as private rooms in participants' homes or gardens, ensuring minimal distraction and optimal interaction. A voice recorder was used for all interviews to ensure accurate data capture, and no participant refused recording. Each interview lasted approximately 45–50 minutes, and a one-to-one transcription was completed within 24–72 hours of each interview. Another researcher subsequently reviewed the transcriptions to verify accuracy, ensuring confirmability and reducing potential bias.

Participant confirmation was applied to enhance credibility. At the end of each interview, the researcher summarized the key points back to the participant, who was asked to provide feedback on the accuracy of the summary and to add any further clarifications. Participants were also invited to review the full transcripts and preliminary findings to confirm consistency and ensure their perspectives were accurately represented.

Expert opinion was sought at two critical stages: these experts were from the fields of public health nursing and mental health nursing and have experience in qualitative research. First, during the development of the interview form to ensure the clarity and relevance of questions, and second, during theme development to validate the analytical interpretations. Researcher triangulation was employed throughout the analysis, with multiple researchers reviewing codes, categories, and themes to ensure reliability and minimize subjective bias.

Finally, the study design, including research questions, data collection procedures, and data analysis steps, was described in detail. All raw data, including audio recordings, transcriptions, and field notes, were systematically organized, read multiple times, and analyzed using open, axial, and selective coding in a manual, systematic, and inductive approach. This transparency allows readers to follow the research process clearly and supports the transferability of findings. The results of this study can thus be applied to similar populations in different contexts, meeting the standards for consistency, reliability, and trustworthiness in qualitative research.

Ethical Considerations

This study was approved by the Hacı Bektaş Veli University Non-Interventional Clinical Research and Publication Ethics Committee (Date: 28.03.2022, Decision no:28). The purpose of the research was explained to the participants individually and approval was obtained from the participants for participation in the research. The names of the participants were kept confidential, and participant numbers were used in the statements instead of the names.

RESULTS

Two main themes and five sub-themes emerged regarding the reflections of poverty experienced in childhood in

the health of women. Themes and sub-themes were deprivation (habit, social exclusion, neglect) and resilience (coping effort, skill). The themes and sub-themes obtained in the research are presented in Table 2.

Theme 1. Deprivation

All of the participants stated that poverty experienced in childhood was reflected in their lives, healthy lifestyles that they could not learn in childhood were actually a habit, poverty caused social exclusion and they neglected themselves because these situations were reflected in adulthood.

Habit

Almost all of the participants stated that poverty affects many healthy lifestyle habits, especially nutritional habits, activity status and hobbies. The participants stated that they could not practice a healthy lifestyle in adulthood, because they did not learn it in childhood, and that their family life was also affected in this sense.

> *"Poverty affects the past, the present, the future; in short, the whole life. Things that were engraved in my mind and identity in childhood… I reflect these on myself, my family, my child, unfortunately!" (Participant 3)*

> *"Although it is a good meat dish, I prefer pastry. I know it's not healthy. I know it makes you gain weight, but it's the taste, maybe it's a habit… Actually, the name of this taste is the taste of the past. I can say it's a magical taste. For example, phyllo… I think eating phyllo is related to my childhood poverty." (Participant 6)*

> *"When we were kids, we always had a responsibility. We'd say eat quickly and do business. That's why I eat fast now. I never learned to eat slowly…" (Participant 5)*

Social Exclusion

All of the participants stated that their participation in social environments was restricted due to economic inadequacies, they were excluded due to poverty, this situation affected their whole life/health and their interpersonal relations remained weak. They also stated that poverty left a permanent mark on their minds and that this permanent mark was accompanied by negative emotions such as being sad, being excluded, resentment and unhappiness. They emphasized that these emotions affect mental health in adulthood.

> *"We grew up in poverty, there was no money anyway… Therefore, there were no swimming lessons, sports, activities, etc.... We couldn't even go to a folklore course. We couldn't go to the places where we were supposed to be with our friends." (Participant 7)*

> *"I was ostracized because I was poor. My first trauma was when my primary school teacher ostracized me because I was poor. Years have passed, but I remember the wound it inflicted on my soul like it was yesterday." (Participant 9)*

> *"... Simply, when you can't get an ice cream, it can stay in your mind for years. When an outfit, shoe, buckle or ribbon cannot be bought, it can leave a mark on the child for years. Even if we can get it now, it doesn't make sense." (Participant 11)*

Neglect

The women in this study emphasized that their physiological, psychosocial and safety needs were not met in childhood, and that all of these are reflected in adulthood, causing them to neglect themselves (such as delaying their own needs, not applying to health institutions). Participants stated that they were traumatized in childhood, felt helpless and could not express their feelings.

> *"For example, when we were little, we couldn't go to the doctor much because my father did not have health insurance. Therefore, when we had health problems as children, my father would immediately get angry or upset. I remember this. It has become so ingrained in my mind that illness is now a luxury for me. If my knee hurts, I don't go to the doctor, if my eye hurts, I don't go to the doctor." (Participant 2)*

> *"You haven't played volleyball for years, you haven't been to the theater. It does not exist in my current life because I did not learn, see or do! We don't even know what activities we like, what our hobbies are..." (Participant 4)*

> *"I am always ugly, always tired, always inadequate… So this affects my self-confidence. For example, my plans for the future are like this, I don't always see myself in a good place. Always medium, always medium." (Participant 1)*

Theme 2. Resilience

The majority of the participants stated that they tried to cope with problems related to poverty and that they came out of the negative situations they experienced in this coping process unscathed, and even gained some skills by learning from their trauma.

Coping Effort

Some of the participants stated that their mother (creative, solution-producing, loving, etc.) was a very important factor in poverty, that they normalized many problems in childhood to fight poverty and that they tried to cope with it.

> *"Some people are agitated about poverty. I don't think so, I'm glad I lived those days. Poverty has been very instructive for me. I can say that the formation of my present personality was thanks to poverty." (Participant 8)*

> *"I mean, when I say it like that, I feel sad, but now I see that it has made me very strong… For example, when I want to buy something that I can't get, my childhood comes to mind" (Participant 10)*

> *"The moment I complain in my life, I think of my mother… My mother was a woman who tried to make pies for us with a handful of flour at home, even when the bailiffs came to the house. If we didn't have such a strong mother,*

most of us would be women who lost. Since my mother was a multicultural woman, I used to read world classics by the side of the fields. Maybe they brought me up." (Participant 1)

Skill

Participants stated that they took on heavy burdens in the process of coping with poverty, deprivation (food, clothing, hobby, etc.) forced them to develop skills and these skills are reflected in adulthood.

"Yes, why would a child hide the bread and cheese (so that it would not run out)…or wait to see if their father bought meat. A child should not experience these things like this" (Participant 3)

"Managing, collecting, covering, hiding… I had such responsibilities. So I matured long before my peers. Sometimes I was a caretaker for my brother, sometimes a domestic worker, sometimes a servant to neighbors and relatives... I had to plan my time to play the game. That's why I can manage my time very well at work." (Smiling) (Participant 9)

DISCUSSION

In this study, women's views on the reflections of childhood poverty on their health were gathered under the themes of deprivation and resilience. The findings show that poverty experienced in childhood affects women's physical, mental, and social health, with particularly profound consequences for mental health. Childhood poverty causes multiple deprivations in areas such as health, education, and living standards, demonstrating that access not only to basic needs but also to education, health care, safety, and nutrition is essential for healthy adulthood (Ge & Ngai, 2020). Women often bear the greatest burden of poverty, which creates serious negative impacts on women's health. Another outcome of poverty is the concept of resilience, which is debated in terms of its advantages, measurability, and whether it stems from personal characteristics or can be learned (Atkinson & Martin, 2009; Bene et al., 2014; Friedli, 2009). Lister (2006) emphasized that resilience emerged as a concept to define personal resources used in the struggle for survival. In this study, deprivation and resilience were found to be interrelated; in particular, deprivation was often masked by resilience, and this masking had negative reflections on women's health.

Poverty leads to negative outcomes such as high unemployment, low educational attainment, irregular diet, obesity, and financial barriers to physical activity (Knight et al., 2018; Round & Longlands, 2020; Singh et al., 2021). As emphasized in the literature, poverty and health problems are transmitted across generations, resulting in increased health expenditures, poorer health outcomes, and restricted social life (Sapkota et al., 2020). The habit sub-theme identified in this current study supports these findings. Participants stated that, due to poverty in childhood, they lacked opportunities to develop healthy eating, regular physical activity, and hobbies; therefore, they could not maintain a healthy lifestyle in adulthood. Moreover, their statements that this situation was also reflected in their children are consistent with the intergenerational transmission highlighted by Sapkota et al. (2020).

Childhood poverty creates significant barriers to accessing healthy nutrition and is associated with malnutrition (da Fonseca et al., 2014; Min et al., 2018; Żukiewicz-Sobczak et al., 2014; Umeda et al., 2015; Vilar-Compte et al., 2021). Poverty is linked not only to physical problems such as hunger, poor-quality food, and obesity but also to psychosocial problems such as eating disorders and social exclusion (Knight et al., 2018; Olson & Miller, 2007). In this study, women emphasized that poverty negatively affected their eating habits; behaviors such as eating quickly and consuming carbohydrates instead of healthy foods were childhood habits that became permanent in adulthood. These findings highlight the impact of food deprivation on attitudes and behaviors towards nutrition in adulthood and point to the risk of intergenerational transmission.

Social exclusion directly affects health and creates a vicious cycle with economic, social, and cultural inequalities (WHO, 2010). It hinders full participation in society and is particularly important to assess in vulnerable groups (O'Donnell et al., 2021). Children experiencing poverty and exclusion are more likely to face mental health problems (González et al., 2021), and studies show that exclusion increases mental health symptoms, reduces social trust, and heightens isolation (Saasa et al., 2021). In this study, the social exclusion sub-theme under deprivation was striking. Participants reported being excluded due to childhood poverty, which negatively affected their mental health, weakened relationships, and limited participation in social life. These findings highlight the need for services that protect and promote health in the face of poverty, deprivation, and exclusion.

Resilience, defined as adapting to difficulties (Ungar & Lienbenberg, 2011), often develops in children from poor families (De France et al., 2022). While they may show academic success and self-control, this can coincide with neglect of physical health (Hostinar & Miller, 2019). Consistent with the literature, participants in this study gained some coping skills from childhood poverty but could not develop healthy lifestyle behaviors such as proper nutrition, exercise, or healthcare use. Many also sought to counter social exclusion through activities like reading. However, as Lister (2006) notes, portraying resilience too positively risks ignoring the burden of poverty, which leaves many women overwhelmed by hopelessness and lack of control. Thus, although resilience may bring limited gains, its negative effects on women's health appear

deeper and longer-lasting, making the interaction between deprivation and resilience a critical issue.

The family environment can help reduce the impact of poverty (González et al., 2021). Mothers' mental health, in particular, strongly influences children's mental health in poor families, and this effect grows as children age (Radey & McWey, 2021; Radey et al., 2022; Smith et al., 2021). In this study, participants emphasized that a strong, creative, and loving mother was a key factor in coping with poverty and in fostering self-improvement. Family figures, cognitive schemas, and role changes contributed to resilience. Resilience is generally supported by a loving, consistent, and reliable environment in childhood (Southwick et al., 2016). These findings support the literature on the meaning of growing up in poverty. However, resilience must also be viewed critically, as parents often deepen their own deprivation by allocating scarce resources (food, shelter, money, health) to their children. Using the iceberg metaphor, resilience and deprivation appear visible at the surface, while the more destructive and wide-ranging effects of deprivation remain hidden below.

Limitations

This study has some methodological limitations inherent to qualitative research. First, the study did not employ software-assisted qualitative data analysis (e.g., NVivo, MAXQDA), and all coding and analysis were performed manually, which might have introduced subjective bias despite researcher triangulation. Second, the sample was limited to 11 women from a specific geographic region, which may restrict the transferability of findings to other populations.

CONCLUSION

Experiences of childhood poverty prevent women from developing healthy lifestyle behaviors. This situation creates a risk for the health of women, children, families, and society. In this study, poverty experienced by women in childhood was reflected in their health behaviors in adulthood, and negatively affected their own and their families' health in terms of physical, mental and social aspects. In addition, although they developed resilience to the deprivation they were exposed to, the negative effects on health are more devastating.

Protecting, sustaining and promoting women's health is a potentially important intervention point for child, family and community health. For this reason, interventions should be made to eliminate poverty, which is an important social determinant of women's health. In this context, more research, education, advocacy and cooperation should be performed to form the basis of actions and policies. It is also recommended that professionals working in this field conduct research that gives more insight into what poverty means for women.

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REFERENCES

Atkinson, P. A., Martin, C. R., & Rankin, J. (2009). Resilience revisited. *Journal of Psychiatric and Mental Health Nursing,* 16(2), 137–145. https://doi.org/10.1111/j.1365-2850.2008.01341.x

Béné, C., Newsham, A., Davies, M., Ulrichs, M., & Godfrey Wood, R. (2014). Resilience, poverty and development. *Journal of International Development*, 26(5), 598–623. https://doi.org/10.1002/jid.2992

Campbell, J. A., Walker, R. J., & Egede, L. E. (2016). Associations between adverse childhood experiences, high-risk behaviors, and morbidity in adulthood. *American Journal of Preventive Medicine,* 50(3), 344–352. https://doi.org/10.1016/j.amepre.2015.07.022

Cavenagh, Y., & Simerson, D. (2022). A Lifestyle intervention program to improve knowledge and health behaviors in women. *Nursing for Women's Health*, 26(1), 51-62. https://doi.org/10.1016/j.nwh.2021.11.002

Cohen, B. E., & Reutter, L. (2007). Development of the role of public health nurses in addressing child and family poverty: A framework for action. *Journal of Advanced Nursing,* 60(1), 96–107. https://doi.org/10.1111/j.1365-2648.2006.04154.x

Creswell, J., & Poth, C. (2018). Qualitative inquiry & research design: Choosing among five approaches (4th ed.). Sage Publications

Fonseca, M. A. (2014). Eat or heat? The effects of poverty on children's behavior. *Pediatric Dentistry,* 36(2), 132–137.

De France, K., Evans, G. W., Brody, G. H., & Doan, S. N. (2022). Cost of resilience: Childhood poverty, mental health, and chronic physiological stress. *Psychoneuroendocrinology,* 144, Article 105872. https://doi.org/10.1016/j.psyneuen.2022.105872

Dufford, A. J., Kim, P., & Evans, G. W. (2020). The impact of childhood poverty on brain health: Emerging evidence from neuroimaging across the lifespan. *International Review of Neurobiology,* 150, 77–105. https://doi.org/10.1016/bs.irn.2019.12.001

Friedli, L. (2009). Mental health, resilience and inequalities.

World Health Organization. https://apps.who.int/iris/bitstream/handle/10665/107925/E92227.pdf

Ge, T., & Ngai, S. S. Y. (2020). Three pathways to promote poverty resilience: The effects of poverty on children's educational and behavioral performance under multisystems in China. *Children and Youth Services Review*, 113, Article 104962. https://doi.org/10.1016/j.childyouth.2020.104962

González, L., Estarlich, M., Murcia, M., Barreto-Zarza, F., Santa-Marina, L., Simó, S., Larrañaga, M. I., Ruiz-Palomino, E., Ibarluzea, J., & Rebagliato, M. (2023). Poverty, social exclusion, and mental health: The role of the family context in children aged 7–11 years. *European Child & Adolescent Psychiatry*, 32(2), 235–248. https://doi.org/10.1007/s00787.021.01848-w

Gupta, R. P., de Wit, M. L., & McKeown, D. (2007). The impact of poverty on the current and future health status of children. *Paediatrics & Child Health*, *12*(8), 667–672. https://doi.org/10.1093/pch/12.8.667

Hernandez, D. C., & Pressler, E. (2014). Accumulation of childhood poverty on young adult overweight or obese status: Race/ethnicity and gender disparities. *Journal of Epidemiology & Community Health*, 68(5), 478–484. https://doi.org/10.1136/jech-2013-203062

Hostinar, C. E., & Miller, G. E. (2019). Protective factors for youth confronting economic hardship: Current challenges and future avenues in resilience research. *American Psychologist*, 74(6), 641–652. https://doi.org/10.1037/amp0000520

Houweling, T. A. J., & Grünberger, I. (2024). Intergenerational transmission of health inequalities: research agenda for a life course approach to socioeconomic inequalities in health. *Journal of Epidemiology and Community Health*, *78*(10), 650–653. https://doi.org/10.1136/jech-2022-220163

Hughes, M., & Tucker, W. (2018). Poverty as an adverse childhood experience. *North Carolina Medical Journal*, 79(2), 124–126. https://doi.org/10.18043/ncm.79.2.124

International Council of Nurses (ICN). (2017). Nurses' role in achieving the Sustainable Development Goals. https://www.icnvoicetolead.com/wp-content/uploads/2017/04/ICN_AVoiceToLead_guidancePack-9.pdf

Johnson, S., & Raphael, D. (2020). Poverty in Canada: Implications for health and quality of life. In D. Raphael (Ed.), *Poverty and Health* (pp. 228–269). Canadian Scholars.

Knight, A., O'Connell, R., & Brannen, J. (2018). Eating with friends, family or not at all: Young people's experiences of food poverty in the UK. *Children & Society*, 32(3), 185–194.

Kyngäs, H., Mikkonen, K., & Kääriäinen, M. (2019). The application of content analysis in nursing science research. In H. Kyngäs, K. Mikkonen, & M. Kääriäinen (Eds.), *The Application of Content Analysis in Nursing Science Research* (pp. 3–11). Springer Nature.

Lee, H., Slack, K. S., Berger, L. M., Mather, R. S., & Murray, R. K. (2021). Childhood poverty, adverse childhood experiences, and adult health outcomes. *Health & Social Work*, *46*(3), 159–170. https://doi.org/10.1093/hsw/hlab018

Lister, R. (2006). Poverty, material insecurity, and income vulnerability: The role of savings. In S. Sodha & R. Lister (Eds.), *The Saving Gateway: From Principles to Practice* (pp. 8–33). IPPR.

Min, J., Xue, H., & Wang, Y. (2018). Association between household poverty dynamics and childhood overweight risk and health behaviours in the United States: An 8-year nationally representative longitudinal study of 16,800 children. *Pediatric Obesity*, 13(10), 590–597. https://doi.org/10.1111/ijpo.12292

Ngoma, C., & Mayimbo, S. (2017). The negative impact of poverty on the health of women and children. *Annals of Medical and Health Sciences Research, 7*(6), 442–446.

Nguyen, T. T. P., Phan, H. T., Vu, T. M. T., Tran, P. Q., Do, H. T., Vu, L. G., Doan, L. P., Do, H. P., Latkin, C. A., & Ho, C. S. H. (2022). Physical activity and social support are associated with quality of life in middle-aged women. *PLoS ONE, 17*(5), e0268135. https://doi.org/10.1371/journal.pone.0268135

Nikulina, V., & Widom, C. S. (2014). Do race, neglect, and childhood poverty predict physical health in adulthood? A multilevel prospective analysis. Child Abuse & Neglect, 38(3), 414–424. https://doi.org/10.1016/j.chiabu.2013.09.007

O'Donnell, Owen. (2024). *Health and health system effects on poverty: A narrative review of global evidence*. Health Policy, 142, 105018. https://doi.org/10.1016/j.healthpol.2024.105018

Olson, C. M., Bove, C. F., & Miller, E. O. (2007). Growing up poor: Long-term implications for eating patterns and body weight. *Appetite*, 49(1), 198–207. https://doi.org/10.1016/j.appet.2007.01.012

O'Donnell, P., Moran, L., Geelen, S., O'Donovan, D., van den Muijsenbergh, M., & Elmusharaf, K. (2021). "There is people like us and there is people like them, and we are not like them." Understanding social exclusion–A qualitative study. *PLOS ONE*, 16(6), e0253575. https://doi.org/10.1371/journal.pone.0253575

Ortiz-Llorens, M., Cabib, I., & Bambs, C. (2022). Childhood socioeconomic position and cardiovascular disease among older women and men: The moderating role of parenthood onset. *International Journal of Public Health*, *67*, 1604884. https://doi.org/10.3389/ijph.2022.160.4884

Price, J. H., Khubchandani, J., & Webb, F. J. (2018). Poverty and health disparities: What can public health professionals Do?. *Health Promotion Practice*, *19*(2), 170–174. https://doi.org/10.1177/152.483.9918755143

Radey, M., & McWey, L. M. (2021). Safety nets, maternal mental health, and child mental health outcomes among mothers living in poverty. *Journal of Child and Family Studies*, 30(3), 687–698. https://doi.org/10.1007/s10826.021.01909-3

Radey, M., Ledermann, T., & McWey, L. (2022). Informal support and obligation contribute to fewer child behavior problems over time. *Family Relations, 71*(3), 1004–1017. https://doi.org/10.1111/fare.12659

Raphael, D. (2011). Poverty in childhood and adverse health outcomes in adulthood. Maturitas, 69(1), 22–26. https://doi.org/10.1016/j.maturitas.2011.02.011

Round, A., & Longlands, S. (2020). *Child poverty and devolution in North East England* (pp. 8–39). IPPR North.

Saasa, S., Okech, D., Choi, Y. J., Nackerud, L., & Littleton, T. (2021). *Social exclusion, mental health, and social well-being among African immigrants in the United States. International Social Work, 64*(2), 249–263. https://doi.org/10.1177/002.087.2820963425

Sapkota, T., Houkes, I., & Bosma, H. (2021). Vicious cycle of

chronic disease and poverty: a qualitative study in present day Nepal. *International Health*, *13*(1), 30–38. https://doi.org/10.1093/inthealth/ihaa016

Seponski, D. M., Somo, C. M., Kao, S., Lahar, C. J., Khann, S., & Schunert, T. (2019). Family, health, and poverty factors impacting suicide attempts in Cambodian women: A qualitative analysis from a randomly selected national sample. *Crisis*, 40(2), 141–145. https://doi.org/10.1027/0227-5910/a000548

Singh, G., Zhu, H., & Cheung, C. R. (2021). Public health for paediatricians: Fifteen-minute consultation on addressing child poverty in clinical practice. *Archives of Disease in Childhood. Education and Practice Edition*, *106*(6), 326–332. https://doi.org/10.1136/archdischild-2020-319636

Smith, M. V., & Mazure, C. M. (2021). Mental health and wealth: Depression, gender, poverty, and parenting. *Annual Review of Clinical Psychology*, *17*, 181–205. https://doi.org/10.1146/annurev-clinpsy-071.219.022710

Southwick, S. M., Sippel, L., Krystal, J., Charney, D., Mayes, L., & Pietrzak, R. (2016). Why are some individuals more resilient than others: the role of social support. *World psychiatry, 15*(1), 77–79. https://doi.org/10.1002/wps.20282

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International journal for quality in health care, 19*(6), 349–357. https://doi.org/10.1093/intqhc/mzm042

Umeda, M., Oshio, T., & Fujii, M. (2015). The impact of the experience of childhood poverty on adult health-risk behaviors in Japan: A mediation analysis. *International Journal for Equity in Health*, *14*, 145. https://doi.org/10.1186/s12939.015.0278-4

Ungar, M., & Liebenberg, L. (2011). Assessing resilience across cultures using mixed methods: Construction of the child and youth resilience measure. *Journal of Mixed Methods Research*, *5*(2), 126-149. https://doi.org/10.1177/155.868.9811400607

UNICEF. (2020). *Child poverty: For a child, poverty can last a lifetime.* https://data.unicef.org/topic/child-poverty/overview/

UN Women. (2021). *Economic empowerment: Four facts you need to know about gender and poverty today.* https://data.unwomen.org/features/four-facts-you-need-know-about-gender-and-poverty-today

Van Duin, L., Bevaart, F., Zijlmans, J., Luijks, M. J. A., Doreleijers, T. A., Wierdsma, A. I., & Popma, A. (2019). The role of adverse childhood experiences and mental health care use in psychological dysfunction of male multi-problem young adults. *European Child & Adolescent Psychiatry*, 28(8), 1065–1078. https://doi.org/10.1007/s00787.018.1263-4

Vilar-Compte, M., Burrola-Méndez, S., Lozano-Marrufo, A., Ferré-Eguiluz, I., Flores, D., Gaitán-Rossi, P., Teruel, G., & Pérez-Escamilla, R. (2021). Urban poverty and nutrition challenges associated with accessibility to a healthy diet: a global systematic literature review. *International Journal for Equity in Health*, *20*(1), 40. https://doi.org/10.1186/s12939.020.01330-0

Yuchs, K. C., & Bonham, C. E. (2022). Caring for the poor: Analysis of nurses' attitudes toward the culture of poverty. *Journal of Christian Nursing: 39*(1), 28–35. https://doi.org/10.1097/CNJ.000.000.0000000772

Żukiewicz-Sobczak, W., Wróblewska, P., Zwoliński, J., Chmielewska-Badora, J., Adamczuk, P., Krasowska, E., Zagórski, J., Oniszczuk, A., Piątek, J., & Silny, W. (2014). Obesity and poverty paradox in developed countries. *Annals of Agricultural and Environmental Medicine, 21*(3), 590–594. https://doi.org/10.5604/12321.966.1120608

Wise P. H. (2016). Child poverty and the promise of human capacity: Childhood as a foundation for healthy aging. *Academic Pediatrics*, *16*(3 Suppl), S37–S45. https://doi.org/10.1016/j.acap.2016.01.014

World Health Organization (WHO). (2010). *Poverty, social exclusion and health systems in the WHO European Region.* WHO Regional Office for Europe.

World Health Organization (WHO). (2025). *World report on social determinants of health equity.* WHO. https://www.who.int/publications/i/item/978.924.0107588