Role of Religion in Women's Social Health in Iran

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Abstract

The article investigates the impact of religion on social wellbeing among women. According to related theories, impact of being religious, interpersonal networks and relations and social support were analyzed. The research uses survey methods. Research census is women in the city of Kashan. Predictors of interpersonal networks and relations (e.g. religion) explains 7/6 percent of its variance; predictors of social support (e.g. religion and interpersonal networks) explain 89 percent of its variance; and predictors of social wellbeing (e.g. religion, interpersonal networks and social support) explain 13/79 percent of its variance. Fitness of theoretical model of research was confirmed with structural model analysis (path analysis) of structural equation modeling using Amos software.

Key words: Social wellbeing;
Religiousness;
Interpersonal networks and relations;
Social support.

Introduction

In recent centuries, Iranian society has moved from a traditional society towards a society with new structures. This movement, along with many other changes, has brought women to the public domain, but has not yet replaced structures to provide a secure public environment for their activity. The barriers and problems that have limited the opportunities for women's participation in various aspects of social life and development, and the inadequate functioning of economic, political and social institutions has also led to problems in society which indicate vulnerable conditions. On the other hand, study on problems and injuries and health have different aspects, and women as half of the population have more barriers and more vulnerability than men in facing social problems. These problems for women have many dimensions, and without considering them they cannot be properly understood, their inequitable and subordinate conditions in social situations against social participation, education and socialization, and the predefined situations, makes them less susceptible to social health and so many data confirm this analysis in this country. Women in society are less involved in social activities, and one of the most active cases that can create an interpersonal and social network in society is religious ceremonies. The research intends to answer the question: Does participation in religious ceremonies and in general religiosity have an impact on the level of social health of women or not?What is this effect? Which other variables affect this relationship? In 1995, McArthur conducted a study to evaluate the epidemiology of social health in the United States. The aim of this study was to achieve the prevalence of high and low level social health and the distribution of social health in the population with regard to variables such

as age, sex, marital status and occupational status. The results showed that almost 40% of adults aged from 25 to 74 years old had high scores in three social health scales. But 60% of adults had not achieved a high score on any of the social health scales. Also, 10% of the people in three or more of the three social health scales allocated a high score to themselves. The data showed that the majority of adults in the United States have a medium to high level of social health. But a significant proportion of the population had a very low social health, which, in terms of social indicators, could be considered as socially unhealthy.

Idler (2014) conducted research entitled Religion as a social determinant of public health. He points out in this research that religious institutions and public health institutions are trying to improve the health of the community. He tries to connect these two social institutions for the first time. He states that while social researchers have studied factors such as education, income inequality and discrimination experience in social health, they are less aware of the great influence of religion on health. He attempts to demonstrate with interdisciplinary approach that religiousness has a great impact as a social factor on the health of individual;, the effect that has so far being regarded as a negligible social factor in health.

Marks (2005) has conducted research on the impact of religion on health. In this work, he attempts to link three dimensions of religious experiences, including religious practices, spiritual beliefs, and faith with three dimensions of health, namely biological, psychological, and social, by a conceptual model of the research. He considers this model as a framework for studying findings in relation to religion and health and provides a wider survey in this regard.

Historically, the right to be healthy is one of the oldest rights that has been stated in the constitution of many countries of the world. Internationally, Article 25 of the Universal Declaration of Human Rights has resolutely stated that "everyone has the right to have adequate living standards in terms of health and welfare for himself and his family ..." In the introduction to the constitution of the World Health Organization, it has confirmed that health is one of the basic rights of every human being to enjoy the highest accessible standard of health (Park & Park, 1997: 26). The concept of social health is a concept that has been considered alongside physical and mental health aspects. Belloc and Breslow in 1972 first addressed the concept of social health. They synonymized the concept of social health with the "degree of society members' performance" and built the social health index. They tried to reach the level of activity and function of the individual through a variety of questions about physical, psychological and social health of the individual (Belloc and Breslow, 1971). This concept was raised a few years later by McDowell et al in 1978 and they argued that health is beyond the reporting of disease symptoms or disease amount, and future functional capabilities. They believed that individual welfare and comfort is a distinct thing in physical and mental health. Based on their perception, social health is, in fact, part of the health status pillar and can also be a function of it. Measuring social health content since the beginning was measured by focusing on the "individual" and on interpersonal interactions (for example, meeting friends) and social participation (such as membership in groups), and in measuring it, the objective elements (for example, the number of friends) and the subjective (such as the quality of friendly relationships) were all considered in the definition.

Larson (1992) in his study equates social health and social healthy and points out that there is no conceptual difference between these two in the literature discussed. McDowell & Newell point out that social health and healthy are less familiar to us than physical or mental health. Social health refers to society as a whole and its factors, such as the distribution of wealth or the social health of individuals; they define social health in individuals as follows: " that dimension of health of individuals, that involves how to communicate with others, how to respond to other people and how the person interacts with the social institutions and customs of the community." Durkheim (1951) states that among the potential benefits of plural life, social solidarity and coherence, feeling of belonging and interdependence, feeling of plural awareness and shared destiny. Keyes (1998) states that these benefits of plural life, are fundamental and basic for the definition of social health and defines social health as a status of the quality and function of an individual in society. The social health field, from 1995 onwards, in addition to a general and public attitude on the quality of health among all people, in industrialized countries began a specific tendency in the two dimensions of mental health and social health.

Kingsley Davis in his book Human Sociology presents the positive functions of religion and considers religion as the cohesion factor in society. He categorizes the meta-experimental activities into three modes of subjective (calm), high goals (immortality) and creatures and great beings (God), by distinguishing between the holy and unholy issue., He believes that individuals make intangible phenomena in the form of rules that are necessary for social order. In fact, the realities of the meta-experimental for achieving social cohesion link the group's goals with one's actions. He also adds that individuals increase their affiliation to group goals through participation in religious ceremonies, in this way; the unity of the people of the community is strengthened together (Hamilton, 1998: 210). Researchers who study the relationship between religion and health may agree on a number of points. First, most studies have found a positive relationship between participation in religious affairs and health of individuals. Witter and colleagues (1985) conducted a meta-analysis of 28 studies and concluded that in most of these studies, religion was positively correlated with health. Recent research studies emphasize on these findings (Ellison and Levin, 1998). Secondly, other research concluded that there is a significant relationship between religion and health (Inglehart, 2010; Myers, 2000; Witter et al., 1985). Witter et al. (1985) have estimated that the net cause of religious participation in health is between 2% and 6%. Lim Putnam (2010) stated that compared to some other factors, religion has less effect on health and loneliness, but its effect is equal to or greater than the factors of

education, marital status, social activity, age, gender, and race. Ellison, Gay, and Glass (1989) also point out that religious participation has an equal or greater effect on income. Ferriss (2002) explains that the number attending religious ceremonies is most closely related to health and social health; although some studies have found that the internal or spiritual dimensions of religion are related to health (Ellison, 1991; Greeley and Hout, 2006, Krause 2003).

Despite this general consensus, some of issues should be further evaluated. Firstly, most evidence about the religiousness effect on health comes from cross-sectional studies. While these studies control the critical factors affecting health, some people may be questioned casually about the interrelationship between religion and health (Regnerus and Smith, 2005). A slight or unobservable difference between religiousness and non-religiousness could explain this relationship. Self-choice is another important issue: healthy people choose religion to raise their spiritual health. On the other hand, those who find happiness in religion are more likely to be more religious than others. This is the self-imposed obstacle between people who come to a religion and those who are religious.

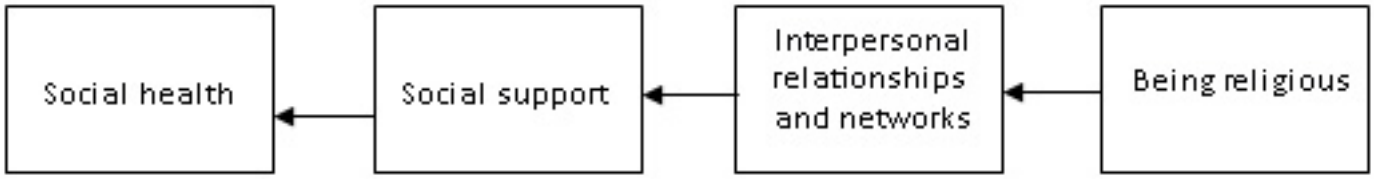
Although most religious studies and health studies use cross-sectional data, a number of longitudinal studies have also evaluated the causal effect of religiousness very carefully. Levin and Taylor (1998), using panel data collected from the National sample of African Americans, found that the general aspect and the private aspect of religiousness that had been measured at the first wave of their evaluation has significant relationship by health that had been evaluated in the second wave. Cross (2006) in a study on elderly Christians concluded that people who have been more skeptical about their religious beliefs show lower levels of health. Krueger et al. (2009), using a representative national sample, concluded that when people engage in religious activities, they experience higher levels of positive emotions. Many studies have been conducted to answer the question of why people who claim to be religious and regularly attend religious ceremonies are socially healthy and, ultimately, more satisfied with life. An important explanation for this question is that religion provides individuals with personal and social networks that result in social support for the individual. This is referring to classical sociologists such as Durkheim and Simmel, who considered the social dimension of religion as the foundation and essence of religion (Durkheim, 1951; Simmel 1997; also Cross, 2008). According to this discussion, religious participation increases social health because religious organizations create opportunities for social interaction between like-minded people and create friendships and social connections.

Although this interpretation is acceptable, many studies failed to find empirical evidence to support it. In the meantime, some studies found that the relationship between religious participation and health is positive and strong, and is shaped by social resources, such as the frequency of social activities and the size of the friendship network. Most research focuses on social networks and forms of support without distinction between religious and secular social resources. This is based on the assumption that social resources that exist in religious organizations are no different from those found in secular societies. However, if social resources provided by religious organizations have qualities that do not provide secular social networks, then the measurements used on social resources by this research cannot show the impact of religious social networks. In fact, some studies show that religious social resources have distinct qualities. For example, Ellison and George (1994) state that those who go to church have a better sense of comfort with those who are of their religion, because they have similar beliefs about the ways and means of helping another. Psychology literature on social identity and social support provides a similar path to the debate; these studies show that social support is more intentional in thought, understanding and interpretation, when it comes from one person with whom he or she shares a sense of social identity, (Haslam et al., 2009: 11). In addition, Cross and Wulff (2005) suggested that church-centered friendship can create a sense of belonging and increase this mental and physical health. In another study, Cross (2008) found a positive relationship between social participation and friendship with a person in a church with social health.

Lim and Putnam (2010) state social resources are related to religious participation and social health. They state that religious social resources have an independent impact on public social resources and social networks of religious increase attendance at religious activities and events, and social health. Some other research, rather than focusing on public and participatory religious aspects, focus on the mental and private dimensions of religion as potential intermediaries, which relate to religious meaning and intention rather than religious affiliation. Some researchers argue that religious beliefs increase health by providing a conceptual framework for interpreting world events that lead to rise in cosmopolitan assurance, and a sense of meaning and purpose in life (in an inoperable world) (Emmons et al., 1998; Inglehart, 2010). Other research also suggest that strong religious beliefs and personal spiritual experiences can enhance health by enhancing self-esteem and self-efficacy (Ellison, 1991).

Other researches emphasize feelings of closeness and convergence with God instead of emphasizing personal spiritual experiences and religious practices in the influence of religion on health and satisfaction with life. For example, Greeley and Hut (2006) combine sensation of closeness with God with other criteria of religious sensation (such as the feeling of love for God and the feeling of deep harmony and inner peace) and concluded that there is a positive relationship between them and happiness. Pullner (1989) uses similar criteria to construct a mark that is positively correlated with health and then compares the relationship between holy relationship with God and social relationships with others and the impact of these relationships on health.

Figure 1: Theoretical Research Model



Methodology

The methodology is survey and the data collection tool is a questionnaire. The statistical population of this study is women and girls aged between 19 and 39 years old in Kashan city. Based on the results of the census of the general population and housing population in 2011, their number is about 33,740. According to Cochran formula, 380 women were evaluated.

Religiousness: Lim and Putnam (2010) use several factor groups and dimension to measure religiousness amount. These dimensions include doing religious practices such as worshipping and reading the Holy book, the significance of self-declaration of religion in various dimensions of life, spiritual and religious experiences, such as the feeling of the presence and love of God throughout life and religious beliefs such as religious conservatism. (Like without lapse and error). The present study uses these dimensions to measure religiousness. According to the different dimensions of religious activities, the religiously significant self-importance of various aspects of spiritual, religious, and divine beliefs with 5, 4, 3, and 4 items are considered. Cronbach's Alpha followed by religious practices of 0.85, the significance of self-declaration of religion in various aspects of life equal to 0.86, spiritual and religious experiences equal to 0.85 and dimension of religious beliefs and divine values has been obtained equal to 0.86.

Interpersonal relationships and networks: In accordance with Garthoeffner, Henry & Robinson (1993), this variable in five dimensions of Self-disclosure (with four terms), the dimension of Genuineness (with four terms), Empathy dimension (with four terms), Comfort dimension (with six items) and communication dimension (with three items) was measured. Cronbach's alpha of dimension of Self-disclosure equal to 0.84, the Genuineness equal to 0.85, the dimension of Empathy equal to 0.85, the comfort dimension equal to 0.83 and the communication dimension is equal to 0.85.

Social support: Zimet, Dahlem, Zimet & Farley (1988) divide this variable into three dimensions: Family social support, social support for friends and significant other. They have used each of the 4 items to measure. The research, in accordance with them, considers the perceived social support in 3 dimensions and each dimension with 4 items. Cronbach's alpha for social support dimension of the family equal to 0.85, social support of friends equal to 0.84 and significant other dimension was obtained equal to 0.85.

Social health: These five dimensions were measured according to Keyes's scale (1998). Dimensions of social cohesion, social acceptance, social realization, social support, and social conjunction are each measured with 3 items. Cronbach's alpha of social cohesion dimension equal to 0.78, social acceptance equal to 0.77, social realization equal to 0.77, social support equal to 0.78, and social conjunction has been obtained equal to 0.75.

Findings

Table 1 (next page) shows the average dimensions of each of the variables based on the scale of 0 to 100. As it is seen, the dimension of significance of the self-declaration of religion has the highest average (94.8) and dimension of the social conjunction has the lowest average (466.45).

As shown in Table 2, the three theoretical paths of the theoretical model of research are significant at the level of $p < 0.001$. Also, the interpersonal relationships, social support, and social health increase by 0.66%, 50.9%, and 0.254% unit, respectively when religion, interpersonal relationships, and social support increase by one unit.

Table 3 shows the standardized effects of the entire causal paths. The interpersonal network, social support and social health increase by 0.276, 0.261, and 0.96 standard deviation unit when religion is increased 1 standard deviation unit, respectively. When interpersonal relationships increase by 1 standard deviation unit, social support and social health increase by 0.494 and 0.350 standard deviation units, respectively. When social support increases by 1 unit of standard deviation, social health increases by 37.1% of standard deviation unit.

In Table 4, multiple square correlations have been calculated. The predictor of the variable between interpersonal relationships, that is, the religious variable, has explained about 6.7% of its variance; in other words, the variance of the variable error of interpersonal relationship is approximately equal to 92.35% of the variance of interpersonal relationships. Variable predictors of social support (religion and interpersonal relationships) explain the 167/89% of its variance, which is significant, the variance of social support error is 10.833% of the social support variance. Variable predictors of social health (i.e. religion, interpersonal relationships, and social support) explain the 79.13% of its variance; the variance of social health error is equal to 203.86% of the social health variance.

Theoretical analysis of the research

In this section, the results of the fitting path analysis (Structural Modeling in Structural Equation Modeling), the theoretical model of the research, are evaluated by different

Table 1: The mean of different dimensions of the research variables based on the scale of 0 to 100

Sympathy of interpersonal relationships dimension	Honesty of interpersonal relationships dimension	self-disclosure of interpersonal relationships dimension	religious and divine beliefs being religious dimension	spiritual experience of being religious	significance dimension of the self-proclaiming of being religious	dimension of doing religious acts	Being religious
61.868	60.816	70.628	75.016	80.202	94.818	82,448	

social acceptance dimension Social health	Social cohesion dimension Social health	social support dimension Another important thing	support dimension Social Friends	support dimension Social Family	The relational dimension Interpersonal relationships	Comfortable dimension interpersonal relationships
66.904	56.217	59.423	66.936	64.167	71.027	70.056

social cohesion dimension Social health	Social support dimension Social health	social realization dimension Social health
45.466	55.85	57.335

Table 2: Regression weights of different paths of the theoretical model

Direction	Estimation	Sd	Significant level
Religion to interpersonal relationships	0.267	0.047	***
Interpersonal relationships to social support	0.509	0.009	***
Social support to social healthy	0.254	0.032	***

Table 3: Total Standardized Effects

Direction	Religion	Interpersonal relationships	Social support
Interpersonal relationships	0.276		
Social support	0.261	0.944	
Social health	0.096	0.350	0.371

Table 4: Multidimensional square correlations

	Estimation
Interpersonal relationships	0.076
Social support	0.891
Social health	0.137

tests (using the Amos software). The value of CMIN / DF (Chi-square divided by the degrees of freedom) is equal to1.553, because it is between 1 and 2, so we conclude that in terms of this indicator, the matching of experimental data with the theoretical model is confirmed in the sample (Cramines & McIver, 1981); the value of p is also equal to 0.198; however, it can be concluded that the model has acceptable adaptation in terms of both the amount of Chi-square and its surface covered. On the other hand, Browne, M.W, Cudeck, and R (1993) point out that if the RMSEA value is equal to or less than 0.05, the model has a good fit; the RMSEA test value is equal to 0.073. In the case of CFI, it should be noted that one can vote for the conceptual model of research, which is higher than 0.9 (McDonald, R.P & Marsh, H.W, 1990); this value is 0.998 in this research. If the TLI index is higher than 0.9, then it can be concluded that the model is fit (Bentler, P.M & Bonnet, D.G., 1980); the test value is equal to 0.996. Joreskog & Sorbom (1984) state that the GFI value is equal to and less than 1, and if this value is greater than 0.90, the fit of the model is appropriate; the value of this index is equal to 0.994. The values which are close to one represent the suitability of the model in the AGFI index (Tanaka, J.S & Huba, G.J, 1985); this value in this research is equal to 0.980. Bentler and Bonnet (1980) also explain that if the NFI value is more than 90%, the model has a good fit; the value of this test is more than 0.90 and equal to 0.995. Bollen (1989) suggests that the suitability of IFI and RFI tests is close to 1; the values of these tests are 0.998 and 0.990, respectively, which indicates that the model is acceptable in these two tests. As you can see, all of these indicators have high fitting in the sample of this study and show that the theoretical model of research has a high degree of resilience among the statistical population of the research.

Conclusion

This article seeks to evaluate the impact of religion on women's social health. Social health refers to the degree of participation and activity in affairs and relationships in society. One of the things about attending the community and participating in social networks and the formation of interpersonal relationships is to attend religious ceremonies; this is more important regarding women. Women in a traditional and people-centered society have fewer opportunities to participate in social activities. The purpose of this article was to evaluate the religiousness effect of women in their social health.

After evaluating different theories and designing the theoretical model, statistical tests showed that the religion and religious beliefs of women have a significant effect on their social health. This result is also shaped by the effect of two other variables, means, interpersonal relationships and networks, and social support and the creation of a mechanism. For women who do not have many opportunities to create interpersonal relationships and social networking one of the best options for them is to attend religious ceremonies. Also, religiousness is also effective in creating health; more people associate with those who are equal in terms of intellectual and mental features. These findings are consistent with other studies, in particular by Lim and Putnam (2010).

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