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Mini review

Determinants of the Social Health of Rural Women in Ghale-Shahin Rural District in Kermanshah Province, Iran

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Abstract

Social health is essential to social development of rural communities, especially rural women, in order to promote their welfare as well as their human and social capital. The present research was applied in terms of objective, and it was implemented using different approaches to examine the social health of rural women and its determinants in Kermanshah Province, Iran. The research method was descriptive-correlational conducted based on documentary and field method (questionnaire was used as the research instrument). The statistical society consisted of rural women (N=5561) of Ghale Shahin County, which is located in the west of Kermanshah Province, out of which 209 women were selected by multistage sampling method. 209 questionnaires were distributed among the study population, and 187 complete questionnaires were analyzed. Return rate of the questionnaires was equal to 89%. The results showed that the majority of women had a moderate level of social health, communication skills, and social support. It was also found that there was a positive significant correlation between TV watching, the amount of leisure time, the level of communication, and social health of rural women. Results also showed that leisure time, TV watching, and communication skills altogether explained 49 percent of the social health variance of the rural women in the study area. As communication skills and social health of rural women were at the moderate level, and considering the results of the study, it is recommended that organizations in charge of social health of the rural women, such as rural women's social health bases, national youth organization, social affairs deputy of municipality and/or rural development agents as social worker, develop educational content of social health promotion courses with participation of rural women.

Keywords:
communication skills, social health, rural women, social development, social support

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INTRODUCTION

Throughout the human history, one of the most important and basic human needs, which nowadays is known as the human right and social goal, have been a health issue. Healthy people constitute the center of sustainable development. Human-centered approaches of development pay great attention to health and they believe that without health, individuals, families, communities, and nations cannot achieve economic and social goals (Fathi et al., 2012). World Health Organization's emphasis on social health has caused social health to be a common concern of sociologists and social planners in each society (Fathi et al., 2012). Therefore, social health, as one of the aspects of health, has found diverse roles and great importance. Health is not limited to physical and mental health, rather human performance in social relations and his thinking about society is considered as criteria of one's health evaluation at the macro level of society (Sam Aram, 2009). In fact, we say a person is socially healthy if he can fulfill his social roles at the usual and conventional level and make a link with society and social norms (Fadaee Mehrabani, 2007). In the rural society of Iran that has special cultural and social environment, norms, and ethics, there is no institutionalized social health, especially among villagers. Accordingly, the decline in social capital, insecurity, and lack of trust will be increased, leading the society towards degradation (Sharbatyan, 2014). Despite valuable status and the role of women in the rural areas, little attention has been paid to them in the rural development projects. Hence, it is essential to consider rural women who constitute a significant part of village populations. Women living in the rural societies have multiple experiences of discrimination and deprivation because they are responsible for economic activities that do not yield tangible income. This causes that they have a low social-economic position and access to limited resources (Kaur et al., 2005). However, little attention has been directed to the health issues of this population. In most parts of the world, women are more vulnerable than men and this vulnerability is relatively more in rural societies. Despite the participation of women in many activities in the rural regions, they are deprived of high social rank and status (Veysi & Badsar, 2005). Some personal characteristics of rural women that can be involved in their social isolation are their low self-esteem and poor social skills making it difficult to establish lasting relationships with others (Moradi & Zamani, 2013). This problem is more serious in our country, Iran, so that due to the poor economy, lack of efficient planning, and rising crime and deviations, social health situation is not at favorable level (Yahyazadeh & Ramezani, 2013). Rafiee et al (2010) considered six indicators: population growth, murder, poverty, unemployment, insurance coverage, and literacy in 2007. Their results showed that among the 30 provinces of Iran, Kermanshah was ranked 26th in terms of social health, and its score was very low. Now the question is, 'what factors have led the social health status to be in undesirable status?' It should be noted that these statistics include rural and urban societies, while the situation is worse in rural communities, especially among rural women. Hence, the researcher decided to conduct his study on rural women. For this purpose, we chose rural women of Ghale Shahin district as the study population (one woman in each family). Study site (Ghale Shahin) is one of the two parts of Sarpolezahab County located in the west of Kermanshah province. In this area, most people live in rural areas and are engaged in livestock and agriculture. Ghale Shahin consists of two rural districts of Sarab and Ghale Shahin that include 29 villages (8 villages located in Sarab, and 21 villages in Ghale Sahin). These districts have 2670 families and a population of 11,386.

The pilot study revealed that the local rural women had poor performance in establishing social communication because of unawareness and ignorance of the personal capabilities that refers to their social health. Therefore, the general objective of this study was to investigate the social health of rural women and factors affecting it in Ghale Shahin district. Hence, the following questions were addressed:

1. What is the social health level of rural

women in the study area?

2. What is the social support level of the rural women?

3. How much is the communication skills of the rural women?

4. Are there any correlations between individual variables (demographic characteristics, socioeconomic status, social support, and communication skills) and social health of the rural women?

5. What are the factors affecting the social health of the rural women?

The concept of social health is considered beside the physical and mental aspects of health. Keyes defines social health as a way of assessing and understanding an individual performance in the community and the quality of his relationships with other people, relatives and social groups that are members of them (Keyes, 2005).

public health is one's assessment of the quality of relationships with family, other people and social groups, and in fact, it contains inner responses of the person to stimuli and feelings, thoughts and behaviors that indicate satisfaction or dissatisfaction of life and the social environment.

The research aims to reflect the individual experience of rural women in relation to the society. Keyes's (1998) social health theory reflects one's assessment of the social experiences. He believes that literature related to the social health at the individual dimension is limited. In a factor analysis, he suggested that social health of people includes five components (Figure 1).

Therefore, in the current study, five components of Keyes's (1998) social health theory were used to assess the social health of rural women, each of which will be explained later.

a-Social prosperity: it includes assessment of potentials and tracking the evolution of the society and believing that society experiences a gradual evolution, and it has potential capabilities for positive change (Keyes & Shapiro, 2004). Social prosperity also means that there are conditions for growth and prosperity in one society and people can make use of the potentials that the society has provided for them and change the conditions for their interest (Abdullah Tabar et al., 2009).

b- Social conformity (solidarity): quality, organization, and functioning of the social world are considered in this aspect. A healthy rural person tries to obtain more information of his surrounding world so that he can adapt himself to other people living in the society. In fact, this aspect is called social adaptation too. It is believed that society is an understandable, logical and predictable phenomenon and in fact, it is the understanding that one has towards organizing the social world around himself (Keyes & Shapiro, 2004; Nickvarz, 2009).

c- Social acceptance: it is one's interpretation of society and properties of others. People who have this dimension of social health perceive the society as a set of different people and they accept others with all their positive and negative aspects and view them as kind and trustworthy people (Keyes & Shapiro, 2004). Those who accept others have realized that people are constructive and accepting others in society can lead to social health (Hezar Jaribi & Safari Shali, 2012).

d- Social participation: it reflects an individual's assessment of his social value. Those who have a desired level of this dimension believe that they are an important member of the society and they have valuable things to giv to others. Social participation reflects how and to what extent people feel that what they are doing in the world is important for society and it is regarded as social help (Keyes & Shapiro, 2004).

e- Social cohesion: Social cohesion is the extent to which people feel they have something in common with others and belong to one society and social groups. This concept is in contrast with Simon's alienation and social isolation and Marx's class awareness (Keyes, 1998). As men-

Figure 1. Keyes social health dimensions (Keyes, 1998).

tioned earlier, this study was conducted to examine the social health level of rural women and factors affecting it. In order to examine the level of social health, components of the Keyes theory were used, and social health of the rural women of women living in Ghale Shahin was measured using Keyes indices. It is also worth noting that in order to recognize the factors affecting the social health, literature was reviewed and accordingly, the factors affecting the social health were depicted within the conceptual framework.

Hosseini (2008) reported that the social health in the population was at the moderate level. A significant relationship was found between communication skills and social health, between religious beliefs and social health, and between socioeconomic status and social health. However, no significant relationship was observed between the way of spending leisure time and social health. Shiri (2011) examined social heath of people with low physical and movement capability and factors affecting it in Tehran. His findings indicated a significant relationship between communicative skills and social health of individuals. In addition, a significant relationship was found between received social support, level of social health, level of emotional supports received, and level of social health of individuals. In the meantime, it was found that there was a significant correlation between socioeconomic status and social health of individuals and between the way of spending leisure time and social health. In a study conducted by Amini Rarani et al. (2011) showed a significant relationship between the independent variables of socioeconomic status, communication skills, the way of spending leisure time and between life quality and the dependent variable of social well-being. In this regard, socioeconomic variables and communicative skills could explain the variance of social health of the young people. In addition, Hezar Jaribi and Arfaee Einodin (2011) examined the relationship between the way of spending the leisure time and social health and concluded that the amount of leisure time spending on social and physical activities affects the social health of people positively. Zare (2011)'s study showed that there was not a significant correlation between the variables of age, type of residence, the duration of the heading, and education level and total social health of women as the head of family. Yahyazadeh and Ramazani (2013) also examined the social health and social factors affecting the health of women as the head of family in Qorveh County. Their findings showed that there was a significant difference between the social health of head and non-head women. The results of Sharbatyan and Tavafi (2015) showed that social health level among youths was at the moderate level and that social health was significantly related to age and socioeconomic status. In addition, a significant difference was found between social health of married and unmarried young people, while a significant correlation was not found between social health of individuals in different age groups. Laurie and Christine (2015) referred to nine factors that explained social health, namely living in poverty, persistent unemployment, losing work, lack of transportation facilities, stress, feeling deprivation, need for social support, using drugs, and lack of health cares.

Braveman and Gottlieb (2014) in a study on factors determining social health claimed that factors such as academic achievement and high socioeconomic status are the social factors correlated with health and choosing a healthy lifestyle. In contrast, socioeconomic status disadvantages such as poverty, lack of access to health care, unhealthy physical environment, and material deprivation are social factors correlated with health inequalities. McDonald et al. (2013) showed that in the United States and China, workers who had higher social capital experienced fewer health problems and better professional status. Prince-Paul (2012)'s study showed a strong positive correlation between social and spiritual health, communication functions, and quality of life. Spiritual health explained significantly quality of life variance by 5%, while it was not statistically significant. Hunter et al. (2011) in study on the most important determinants of social health at the local level revealed that social participation, communication in society, poor housing, and poverty and unemployment are some of the factors affecting health at the

local level. Song and Zhang (2011) focused on Chinese students and showed that physical activity improved the social health of students significantly so that the higher the level of activity was, the better the social health was evaluated. In summary, factors affecting social health examined by researchers can be mentioned as below:

• Socioeconomic status: socioeconomic status is a composite index that reflects the person's work experience and socioeconomic position relative to other people in the society (Marmot, 2004). Socioeconomic status is effective on human health and for most of the world's people, health status is determined primarily with the level of socioeconomic development that is income per capita, level of education, nutrition, employment, housing, family size, the rate of population growth, etc. (Sajadi & Sadrossadat, 2004).

• Marital status: Marital status is important since people can choose the spouse who can provide support emotionally and morally in stress times (Hatami, 2010).

• Communication skills: Hatami (2010) stated that other processes affecting the social health that has a significant role in the lives of citizens is communication and interactive skills. Through social interaction, people form their personality and gain the collective life practices, and knowledge and skills needed. Matson (1990) cited by Hatami (2010) also believes that communication skills are behaviors whose improvement can affect the relationships between people and their social health on the one hand and useful and effective function in society on the other hand.

• Social support: Regardless of whether the individual is under the influence of stress and psychological pressure or not, social support makes the person avoid the negative experiences of life and this has beneficial health effects (Drentea et al., 2006).

According to the literature review and the investigation of the factors affecting public health, conceptual framework was formed as shown in Figure (2).

MATERIALS AND METHODS

The population of this descriptive correlational study included all 5,561 rural women in 2,670 families who were 15-60 years old living in Ghale-Shahin rural district. To determine the sample size of the study, the Bartlett et al. (2003) table was used. Considering the size of population (5,561women in 2,670 families), the sample size was determined to be 209 who were taken by the multi-stage sampling method. The main instrument of the study was a questionnaire. In order to assess public health (the dependent variable), the Keyes's (1998) social health questionnaire was used, and in order to assess the independent variables including demographic characteristics, socio-economic status, social support, and the communication skills, a self-designed questionnaire was applied. A total of 209 questionnaires were distributed among the study population, and 187 complete questionnaires were analyzed. Return rate of the questionnaire was 89%. The validity of the questionnaire was confirmed using the faculty members' viewpoint at Sociology and Rural Development and its reliability was confirmed using Cronbach's alpha coefficient (0.77). Descriptive statistics (frequency, percentage, mean and standard deviation) and inferential statistics (correlation coefficient and linear regression) were used to analyze the data. Data were analyzed (Descriptive statistics and inferential statistics) by $SPSS_{20}$ software package.

Figure 2. Conceptual framework of study

Table 1
Demographic Characteristics and Socio-Economic Status of Rural Women

Variable	Classes	Frequency	Percent	Mode
Education level	Illiterate	27	14.4	Bachelor's and higher
	Primary school	21	11.2	
	Intermediate school	17	9.1	
	High school (Diploma)	46	24.6	
	Associate degree	16	8.6	
	Bachelor's and higher	60	32.1	
Age (years)	15 to 27	63	33.7	27 to 39 years old
	27 to 39	67	35.8	
	39 to 51	35	18.7	
	51 to 63	22	11.8	
	Mean = 34.5			
Family monthly income (×1000 IRR*)	2000 to 7600	41	21.9	7600- 1320
	7600 to 13200	94	50.3	
	13200 to 18800	25	13.4	
	18800 to24400	23	12.3	
	24400 to 30000	4	2.1	
	Mean=1100160			
Occupation	Housekeeping	115	61.5	Housekeeping
	Agriculture	36	19.3	
	Hand crafts	30	16.1	
	School student	10	5.3	
	University student	13	7	
	Employee	14	7.5	
Leisure time and resting (hr/d)	< 5	128	68.4	Less than 5 hours per day
	5-10	50	26.7	
	10-15	7	3.7	
	15-20	2	1.1	
Watching TV (hr/d)	<2	85	45.5	<2 hr/d
	2-4	62	33.2	
	4-6	30	16	
	6-8	10	5.3	
Listen to radio (hr/d)	<1	169	90.4	<1 hr/d
	1-3	12	6.4	
	3-5	5	2.7	
	>5	1	0.5	None of them
Membership in rural organizations	Cooperative	8	4.3	
	Village administration and Islamic council	2	1.1	
	Rural management organization	42	22.5	
	Women's Micro-Credit Fund	4	2.1	
	None of them	131	70.1	
Family size (people)	1-3 people	33	17.6	3-6 people
	4-6 people	117	62.6	
	7-9 people	35	18.7	
	More than 9 people	2	1.1	
	Mean = 4.9		SD=1.82	

* 1 USD = 36,039 IRR (Iran's Rials)

RESULTS

Socio-economic and personal status of rural women

As Table 1 shows, most rural women (32.1%) were university graduates. Most of them (35.8%) were 27 to 39 years old. Results showed that the mean monthly income of respondents' family was 11,001,600 Iran's Rials (IRR). The results also showed that 61.5% of them were housekeeper and majority of them were not the head of the family (88.2%).

Table 2
Frequency of Respondents Based on Social Health

Level of social status	Frequency	Percent
Low	9	8.4
Moderate	162	86.6
High	16	8.6
Total	187	100

Scale: 1. Very low, 2. Low, 3. No idea, 4. High, 5. Very high
Mean= 3.157 SD=1.142

Table 3
Social Support Received from Supportive Sources

Item	Rank mean	SD
Emotional support of family	2.57	0.63
Material support of family	2.54	0.62
Information and advisory support of family	2.37	0.71
Emotional support of friends	1.93	0.71
Information and advisory support of friends	1.78	0.74
Material support of friends	1.54	0.76
Information support of social institutions	1.46	0.66
Emotional support of social institutions	1.34	0.60
Material support of social institutions	1.28	0.52

They had less than 5 hours of leisure time per day (68.4%). It is noteworthy that the majority of rural women (45.5%) watched television and 90.4 percent of them listened to radio less than one hour a day. The family size of study area was between 3 and 6 people. Also, the majority of them had no participation in the rural organizations (Table 1).

Social health status of rural women

The results of social health of rural women are summarized in Table 2. It shows the moderate level of social status of rural women (M = 3.157 and SD = 1.142). It is worth mentioning that in order to calculate the frequency distribution of subjects based on the level of social health, ISDM (Interval of Standard Deviation from the Mean) index was used. Results showed that most respondents (86.6%) were at the moderate level of social health (Table 2).

Social support of rural women

As shown in Table 3, the studied women had received the highest emotional, material, informational, and advisory support from their families. They had received moderate social support (M= 1.86 and SD=0.66) from family, friends, and social institutions. Therefore, according to the findings, the majority of participants (64.7 %) had moderate rate of social support. Among the dimensions of social support, most participants (58.3 percent) were provided with moderate emotional support and in the material and information support dimensions, most of the participants had low rate of material (62%) and informational support (47.1%) (see Table 4).

Table 4
Evaluated Indices and the Results of Testing the Third Hypothesis

Rate of support	Social support		Emotional support		Material support		Informational support	
	f	%	f	%	f	%	f	%
Low	59	31.60	63	33.70	116	62	88	47.10
Moderate	121	64.70	109	58.30	61	32.70	84	44.90
High	7	3.70	15	8	10	5.30	15	8
Total	187	100	187	100	187	100	187	100

Source: Research findings.

Table 5
Communicational Skill of Rural Women

Communication skills	Rank mean	SD
Self-esteem	3.91	0.97
Understanding non-verbal messages	3.81	0.95
Easily expressing the happiness	3.79	0.98
Understanding speech of others	3.77	1.02
Being unbiased to views and values of others	3.58	1.08
Easily expressing unhappiness	3.55	1.07
Acceptance of limitations	3.49	1.06
Recognizing your own feelings dealing with problems	3.43	1.01
Clearly expression of the objectives and intensions	3.4	1.09
Recognizing the negative feelings and expressing them	3.39	1.07
Accepting the positive feedbacks	3.36	1.09
Empathy	3.34	1.02
Recognizing the feeling of others dealing with problems	3.27	0.93
Expression of feelings	3.25	1.06
Not taking a stand against opposite views	3.05	1.02
Keeping the relaxation in stressful conditions	3.03	1.22
Accepting the personality of others	3.02	1.37

Scale: 1. Very low, 2. Low, 3. No idea, 4. High, 5. Very high Mean=3.00 SD= 1.065

Table 6
Frequency of Rural Women Based on Communication Skills

Level of communication skills	Frequency	Percent
Low	9	4.8
Moderate	99	52.9
High	79	42.3
Total	187	100

Communicational skills of rural women

Communicational skills of women are shown in Table 5. According to the results, all components of communicational skills of rural women were at more than moderate level. Additionally, after classification of skills into three groups of low, medium and high, frequency of rural women based on the status of communication skills showed that most of the women (52.9 percent) were classified at moderate level (Table 6).

Relationship between individual variables and social health of rural women

As shown in Table 7, there was a positive and significant correlation between watching TV ($r=0.18$, $p<0.05$), leisure time ($r=0.38$, $p<0.01$) and communication skills ($r=0.18$, $p<0.01$) and the social health of rural women at the 95% confidence level (5% error). However, there was no significant correlation of age, income, education level, family size, listening to the radio, and social support with social health.

The factors affecting social health of rural women

In order to investigate the factors affecting the social health of rural women, multiple regression was used. According to Table 8, regression model has been confirmed (see F, Durbin Watson, VIF and Tolerance).

As shown in Table 8, the relationship between the independent and dependent variables (R) is 0.7. This shows that independent variables (amount of leisure time, watching TV, communication skills) can explain 49 percent of the variance of social health of rural women ($R^2=0.49$), and just social support did not have a significant impact on social health. Additionally,

Table 7
Correlation Coefficients of Variables with Social Health

Variable	correlation coefficients	r	p-value
Age	Pearson	-0.50	0.45
Monthly income	Pearson	0.07	0.30
Education level	Spearman	-0.04	0.58
Family size	Pearson	-0.01	0.80
Leisure time	Pearson	0.18*	0.01
Watching TV	Pearson	0.10*	0.04
Listening to radio	Pearson	0.03	0.65
Social support	Spearman	0.20*	0. 52
Communication skills	Spearman	0.38*	0.00

* Significance level of 0.05

Table 8
Coefficients of Independent Variables

Independent variables	B value	Beta	t	p-value	VIF	Toleranc
Constant coefficient	67.72	-	9.3	0.00	--	--
Social support (X1)	0.29	0.36	0.81	0.41	1.50	0.66
Amount of leisure time(X2)	1.04	0.20	3.20	0.00	1.06	0.94
Amount of watching TV(X3)	1.54	0.17	2.73-	0.00	1.06	0.94
Communication skill(X4)	0.80	0.50	8.24	0.00	1.00	0.99
R^2_{Ad} = 0.47	R^2= 0.49	R= 0.70	27.69=F	p=0.000		DW=1.74

*p<0.05

according to the beta value, among the regression equation variables, communication skills, amount of leisure time, and watching television had the greatest impact on the dependent variable, respectively. Therefore, based on Table (9), linear regression equation of rural women's social health level in this study can be written as follows:

Y= 67.72+1.04 (X2) +1.54 (X3) + 0.804 (X4)

DISCUSSION AND CONCLUSION

As displayed in previous section, rural women stated that they receive the highest material, emotional, information and advisory supports from their family members rather than community. This could be due to declining importance of social relations and social capital in rural areas.

In addition, most of the women had received moderate social support and among the social support dimensions, most participants had received emotional support at moderate level and material and information support at low level. One the other hand, most rural women were housekeeper that is a hidden job without income and they were not member of any organization. Therefore, it is evident that they could not be supported in terms of information and material issues.

The results about communication skills of respondents also revealed that communication skills of most of them were at moderate level. If rural women had membership in rural organizations, they would be able to establish effective communications. As a result, rural women due to the lack of effective communication skills do not have the self-esteem required to start communication with the people living in the society. So, social communication has undergone undesired changes, as social health level of rural women indicated it.

The findings of the study on the factors affecting the level of rural women's social health showed that social communication skills, the amount of leisure time, and the amount of watching TV had the highest impact on the social health, respectively. In order to establish healthy relationships with others, it is essential to have communication skills. In addition, television plays a significant role as a communication channel to increase knowledge and awareness

of people in various areas, especially in social health. Having leisure time and watching television will further strengthen social health. Therefore, its impact on social health is undeniable. Having leisure time and watching TV would improve the social support. These findings are confirmed by Hezar Jaribi and Arfaee Einodin (2011) and Amini Rarani et al. (2011) who showed that communication skills could explain the social health of the young people.

We found a positive and significant relationship between rural women's social health and their communication skills, the amount of leisure time and watching TV. The current result confirms Hosseini (2008), Shiri (2011), Amini Rarani et al. (2011) and Hunter et al. (2011) who have reported that there is a significant correlation between students' communication skills and their social health.

The findings of the research showed no relationship between education, age, and social health of rural women. This is in agreement with Zare (2011) who showed no correlation between age, education and overall social health of women who were head of their families. However, it was inconsistent with the results of the study conducted by Sharbatyan and Tavafi (2015) who acknowledged that there was a significant relationship between the variables of age and socio-economic status and social health.

The findings showed that rural women's social health and their communication skills as well as the amount of support they received from the various sources were at the moderate level and needs to be improved. Therefore,

• It is recommended that rural women health-related organizations such as Social health Bases, Welfare Organization, National Youth Organization, Department of Social Affairs of Municipality, or Rural extension as a social client develop and implement educational content of communication skills and the ways to promote the social health with participation of rural women.

• It is recommended that social health-related organizations (including welfare organization) be involved in the field of social health and take steps in providing necessary educations to women by holding educational programs.

• According to the findings of the study, TV can be effective in promoting social health; it is recommended that in TV organization the channel of rural women's programs be established in the area of social health promotion and enhancing the communication skills.

• It is recommended to determine the social indices of health among rural women and to examine the preventive and progressive factors of social health with qualitative approaches.

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