Social well-being of women in reproductive ages and its related factors in Zanjan, 2016

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Abstract

Background: Social well-being is one of the main health dimensions that needs to be assessed.

Objectives: As there are few studies on the social well-being dimensions, the current study aimed to determine the social well-being of women of reproductive age and the related factors in Zanjan, Iran.

Methods: This cross-sectional study was conducted on 382 women of reproductive age (10-49 years), referred to the Health Centers of Zanjan, Iran. Samples were selected using the stratified cluster sampling method, according to the socioeconomic status. Data were collected, using the Keyes social well-being questionnaire as a tool with good validity and reliability. Data were analyzed through SPSS software using descriptive and analytical tests (Kruskal-Wallis, Pearson Correlation, and Multiple regressions). The statistical significance level was considered as $p<0.05$.

Results: In total, 382 women were assessed, and their social well-being total mean score was 64.7 ± 6.5. The domains of Social contribution (16.8) and Social integration (10.8) had the highest and the lowest mean score, respectively. Those women and their husbands' who had a higher educational level ($p<0.001$, $P=0.03$) and were employed ($P=0.003$, $p=0,004$) were more likely to have better social well-being. A significant association was found between the social well-being and socio-economic level ($P<0.001$). No significant association was found among age groups and marital status with social well-being. The educational level and sufficient income were found significant as independent variables associated with social well-being in the multiple linear Regression models.

Conclusion: The majority of women had a moderate level of social well-being. When planning for improving social well-being, education and income should be considered. Further research to improve the dimensions of social well-being in women in reproductive age is recommended.

Keywords: *social well-being, women, reproductive age*

Introduction

Health, as one of the most dynamic phenomena around the world, has different scopes and dimensions that are developed over time. The World Health Organization (WHO) defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" [1]. Health dimensions have interactive effects so that the social dimension of health has preventive effects on both physical and mental dimensions. Social well-being is defined as the person's evaluation of his/her performance in the community and his/her attitude toward other people in society. Undoubtedly, the way people deal with their issues influences their attitude towards other people and social groups [2]. The social dimension of health includes levels of social skills, social function, and the ability of each person to recognize him/herself as a member of a larger community. The Person's relationship in the social network is considered to

measure social health [3]. Evidence supports that women with higher social health levels might have better communication skills, be more capable of making decisions, and have higher self-efficacy [4].

Moreover, social health is an important index of social development. The concept of social health encompasses the dimensions of social actualization, social cohesion, social integration, social acceptance, and social contribution. The quality of life and personal performance cannot be assessed without considering the social criteria, as a high quality of life is not only associated with physical, emotional, and psychological health, but also depends on the social function of individuals [5]. Today, social well-being, along with physical, psychological, and mental health, has become an important aspect of health, and a person's social relations and views about the community are considered as health measures at the community level. Inattention to the social aspect of health in the communication era can increase the vulnerability of individuals to psychological disorders and social problems [6]. Physical health besides proper functioning, physical health can influence mental health and facilitates communications with the society, leading to an adequate level of social well-being [7].

The evidence supports the effects of social well-being on different aspects of health. Globally, little is known about the social well-being, compared to the physical and mental health, because of unclear effects of medical services on social well-being [7]. Since women have a key role in the health of family and community, conducting further research on women's social well-being is essential [8]. Women's health, particularly maternal health, is one of the underlying concepts in social development and, consequently, socio-economic well-being. Also, women have the responsibility of the next generation and have an influencing role for the development of the community [8], whose role often remains behind the masculine leadership [9]. Secretary-General António Guterres, on the 25th anniversary of the International Conference on Population and Development (ICPD) told "Many women and girls still face enormous challenges to their health, well-being, and human rights". He concluded that while some progress has been achieved in women's rights over the past 25 years, which reduced poverty among women and improved their education and health, globally, there is a need for pushback on women's rights, including reproductive rights and vital health services [8].Almost 50% of health is influenced by social determinants of health such as poverty, illiteracy, occupation, and respect for women's rights; while only 25% of health is influenced by the health system, 15% by genetic factors, and 10% by the environmental factors, indicating the important role of social determinants in improving the health [10]. Employment, gender discrimination, maternity and spousal roles, poverty, violence, education, and properties are some of social factors that vary among different societies and cultures [10]. There exist a large body of evidence about the social well-being status of students [11-16], labor children [17], teachers [18], employed people [6,19], and families [20] in Iran. Apart from a systematic review focused on women in Iran generally [21], few studies have provided special data on women in reproductive ages. The promotion of the social health of women, as one of the most important and vulnerable social groups, who has a significant contribution to the sustainable development of societies, can improve public and social health [2]. As little is known about women's social well-being status in reproductive ages, it is important to conduct applied research in this field. Therefore, due to the lack of information on these issues in Zanjan, the current study aimed to determine the social well-being status of women in reproductive ages and its related factors in Zanjan, 2016.

Methods
This cross-sectional, analytical study was conducted on 382 women of reproductive age reproductive age (10-49 years), who were referred to the health centers of Zanjan, Iran, in 2015. This research is registered with grant number A-11-147-3 and is approved by the ethics committee of the Vice Chancellor for Research of the Zanjan University of Medical Sciences (ZUMS.REC.1394.52). The sample size was determined using former studies [22,15]. As well, to get the maximum sample size, a prevalence of 50% was assumed in the population. At first, six health centers were selected for sampling

using the cluster sampling method considering the three socio-economic status (i.e, affluent, semi-affluent, and deprived regions). Then a simple random sample of age groups (with 10 years interval) according to the Zanjan population was recruited in the study until to achieve the required sample size. Demographic data (e.g, age, marital status, educational level, employment status, residence area, income), and social well-being status were collected using appropriate questionnaires. Social well-being status was measured by a questionnaire developed (20 items) by Keyes in 5 dimensions including social actualization, social cohesion, social integration, social acceptance, and social contribution which each dimension is measured by four items.

The social well-being questionnaire has different versions with various number of items (e.g. 15,20,21,26,28,and 33 items). The validity or internal consistency of these questionnaires are assessed and approved in different studies in Iran [15,11,19,20,16,13,14,18,26,17,22]. The psychometric properties (validity and reliability) of the short form of the whole questionnaire (15 items) are investigated and approved by a large body of evidence in Iran [17,22,23,24,and 25]. The 20 items social well-being questionnaire has been used and approved with a good level of internal consistency (Cronbach's Coefficient α=0.80) in some studies Iran [18,26]. First, the purpose of the study was explained in detail for all participants, and their informed consent was obtained. The eligible participants were asked to indicate their agreement with 20 statements [18,26] about their social well-being on a five-point Likert scale (from strongly disagree [1] to strongly agree [5]). According to the questionnaire guideline for measurement of the social well-being, the total score of the questionnaire was 100. A score from 20 to 46 was considered as a low level of social well-being, indicating that fundamental planning is needed to promote the social well-being. A score ranging from 47to 74 and 75- 100 was considered as a moderate and a high level of social well-being, respectively. A score ranging from 47to 74 (moderate level) shows that social well-being is improving, although it should be strengthened. Scores higher than 75 indicate a good social well-being level and the process should be continued. Data were analyzed using SPSS version 21 and descriptive and analytic statistical tests were used. To evaluate the normality of the data, the Kolmogorov–Smirnov test was used. As data were normally distributed, Kruskal-Wallis, Spearman's correlation coefficient, and multivariate linear regression model (forward stepwise method) were used to test the hypothesis. In the regression model, the social well-being was considered as a constant variable, and age, education, marital status, employment, income sufficiency, husband's employment, husband's education, and socio-economic region were considered as predictive variables.

Results

In total 382 women in reproductive age were assessed. Most of the participants (30.9%) were in the 20- 29 age group, 39.2% had no formal qualification (under diploma), and 86.6% were married. Around 50% of participants reported insufficient income, and 73% of them were housewives. More than half of women's husbands (53.4%) were working in the private sector and 49.7% of them had no formal qualification.

The results showed that the mean total score of women's social well-being was 64.6±6.56, which indicates a moderate level of social well-being. Only two participants (0.5%) were in a low level of social well-being, 94%(N=359) were at the moderate level, and 5.5%(N=21) women had a high level of social well-being. As presented in Table 1, among the five dimensions of social well-being, the lowest score (10.8±1.8) was related to social integration, whereas the highest score (16.8±3.64) was attributed to social contribution (Table 1).

Table 1: The mean score of social well-being status and its dimension

Social well-being dimensions(N=382)	Mean Score	SD
Total Social Well-being	64.7	6.56
Social Actualization	11.07	1.99
Social Integration	10.08	1.98
Social Coherence	12.26	2.09
Social Acceptance	13.73	2.7
Social Contribution	16.82	3.64

The distribution of demographic variables and their association with social well-being are presented in Table 2. The results showed a significant positive association between the mean score of social well-being and women's education (P<0.001), spouse's education (P=0.03), women's employment (P=0.003), spouse's employment (P=0.004), and socio-economic status (P<0.001). In other words, the higher education of both women and their husbands, employment of both women and their husbands, and living in an affluent area were associated with higher levels of social well-being. However, no significant association was found between the mean score of social well-being and women's age group or marital status (Table 2).

Table 2: Association between demographic variables and social well-being

Variable	Groups	Frequency (%)	Social well-being Mean ± SD	χ^2	P-value*
Age (N=382)	10-19	87(22.8)	63.6± 6.5	4.08	0.2
	20-29	118 (30.9)	64.5±6.7		
	30-39	106 (27.7)	65.3±6.7		
	40-49	71 (18.6)	65.4±6.07		
Education (N=380)	Illiterate	9 (2.4)	60.0±3.7	23.20	< 0.001
	No formal qualification	149 (39.2)	63.5±6.6		
	Diploma	113 (29.7)	64.6±7.1		
	Academic Education	109 (28.7)	66.7±5.5		
Marital Status (N=381)	Single	47 (12.3)	63.7±7.7	2.68	0.4
	Married	330 (86.6)	64.8±6.3		
	Divorce	2 (0.5)	58.5±3.5		
	Widow	2 (0.5)	66.0±4.2		
Employment (N=377)	Housewife	278 (73)	64.1±6.7	17.98	0.003
	Public job	37 (9.7)	67.5±4.7		
	Private job	6 (1.6)	71.5±7.8		
	Student	52 (13.6)	65.4±5.7		
	Unemployed	4 (1.0)	60.2±7.7		
	Other	4 (1.0)	61.7±4.2		
Income sufficiency (N=324)	Sufficient	38 (11.7)	65.7±7.02	3.76	0.15
	Fairly sufficient	124 (38.3)	65.2±6.1		
	Insufficient	162 (50.0)	63.9±6.5		
Husband's employment (N=328)	Public job	53 (16.2)	65.9±5.9	17.52	0.004
	Private job	175 (53.4)	65.7±6.5		
	Worker/ labor	54 (16.5)	62.6±6.3		
	Retired	2 (0.6)	55.5±7.7		
	Unemployed	3 (0.9)	61.6±6.1		
	Other	41 (12.5)	62.9±5.4		
Husbands' Education (N=330)	Illiterate	8 (2.4)	61.8±6.9	8.87	0.03
	Under Diploma	164 (49.7)	63.9±6.02		
	Diploma	86 (26.1)	65.4±6.9		
	Academic Education	72 (21.8)	66.3±6.2		
Socio-economic region (N=382)	Affluent	126 (33.0)	65.6±6.3	9.45	0.009
	Semi affluent	128 (33.5)	65.2±6.8		
	Poor	128 (33.5)	63.3±6.3		

*Kruskal-Wallis Test

The results of the multiple linear regression model regarding the factors influencing social well-being, after adjusting for confounding variables, are presented in Table 3.

Table 3: Adjusted factors influencing social well-being using Multiple Linear Regression Model

Factors	Beta	T	P-value
Age	0.064	1.09	0.2
Education	0.206	21.54	0.01*
Marital status	0.079	1.31	0.1
Employment	- 0.035	- 0.56	0.5
Income sufficiency	- 0.117	- 1.97	0.04*
Husband's employment	- 0.103	- 1.64	0.1
Husband's Education	- 0.046	- 0.56	0.57
Socio-economic region	- 0.053	- 0.78	0.4

*Statistical Significance

The variables of education and income were identified as independent factors for social well-being (P=0.01 and P=0.04, respectively). In other words, women with higher education levels and more income were more likely to have higher levels of social well-being. The social contribution dimension showed the highest positive correlation (P<0.001) with social well-being. The results showed that increased participation in social activities is correlated with higher social well-being (Table 4).

Table 4: Correlation among different dimensions of social well-being with total social well-being

Social well-being Dimensions (N=382)	R*	P- value
Social Actualization	0.204	0.001
Social integration	0.272	0.001
Social coherence	0.58	0.001
Social acceptance	0.557	0.001
Social contribution	0.710	0.001

*Spearman's correlation coefficient

The current study revealed a significant association between age and social actualization and social integration, education and social actualization, social and social coherence; marital status and social actualization; employment of spouses and social actualization; and social cohesion with social contribution.

Discussion

In this study, most women had a moderate level of social well-being, which is inconsistent with the study conducted on the social well-being level of the staff of the Ministry of Health and Medical Education [6], employed women in Tehran [19], teachers [18], and students [27,11,14,22,15,16,28,29]. According to the findings, social integration and social contribution had the lowest and the highest scores among other dimensions of social well-being, respectively. Inconsistent with the results of the current study, some studies on teachers and the staff of the Ministry of Health and Medical Education ranked the social contribution as the domain with the highest mean score, while the social acceptance domain was ranked as the lowest [18,6]. In another study on employed women in Tehran [19], the social cohesion and the social acceptance dimensions had the highest and the lowest mean score, respectively [19]. This difference might be due to the various characteristics of participants in the different cultural context and their job classification. So that in all recent studies, all participants were employed, indicating that employment could influence the social acceptance for employed women while in the current study, 73% of women were housewives, which social integration is more important for them than social acceptance. Also, no significant difference was observed between the total score of social well-being and different age groups, which is by the results reported by some of the previous studies [18,6,17], while is not by the findings of another study which reported a positive direct association between age (+30 years) and social well-being [16]. A positive association was found between the level of education and social well-being in the current study, which is consistent with other studies [6,17,22,14,15]. However, a study

reported no association between education level and social well-being level among teachers of elementary level [18]. A systematic review of social well-being among Iranian women revealed a direct correlation between the level of education and social well-being, indicating that people with a lower level of education were more likely to have poorer social health [21]. Due to the importance of education level for social well-being as well as the relationship between education and socio-economic status (and subsequently, healthy lifestyle), it is important to explore the role of lifestyle in health and social well-being. Some studies conducted on a large number of women in reproductive age in Ahwaz and Tehran have emphasized on the importance of the women's education level as one of the important influencing factors on lifestyle [30-31]. In the present study, husband's education and employment were reported as the factors that affect social well-being. This suggests that higher education and employment of husbands can increase the social well-being of wives through affording the living costs and needs, making a spirit of commitment, and creating a stable network of relationships between spouses, and a positive attitude toward social affairs and relationships. The husband's employment leads to the continuity of the individual's connection with the community and meeting economic, social, and psychological needs, and consequently, results in the improvement of the family's social well-being. Some studies reported that the education level of women in reproductive age was related to their nutrition, self-actualization, spiritual development, health responsibility, interpersonal communication, and stress management [30-31]. The higher level of education in men can be an important factor to guide the women of reproductive age to undertake healthy behaviors. Not only the education status of women but also the education status of their husbands are associated with health outcomes through influencing lifestyle behaviors (e.g, nutrition, exercise), values, and problem-solving capacity [32]. Inconsistent with the findings of other studies [6,22], the present study found that women's employment is associated with higher scores of social well-being, which is in accordance with some of the previous studies [18,19,15]. It can be attributed to the different socio-economic characteristics and cultures of participants. A systematic review of Iranian women's social well-being reported an association between social well-being and employment [21]. Given the strong association between employment, income, and better health [21,33], women's employment should be considered in strategic planning by managers and policymakers. In some other studies, employment of wives and husbands are reported as influencing factors on the health-promoting lifestyle, which emphasizes the effect of the economic situation of the family on health. Which means that employed women and women who their spouse are working have better access to health care services and are affluent for providing appropriate housing and nutrition and living in a safer place. Therefore, they have a better chance of undertaking health-promoting behaviors [24,27]. In this study, no significant difference was found between the total score of social well-being among different marital groups, which is consistent with the results of some of the previously conducted studies [6,16] and inconsistent with other studies [11,15,28]. Evidence support inequalities in health and health behaviors between the couple and lone mothers, indicating that lone mothers are more likely to report a higher prevalence of poor self-perceived health and being smoker compared with couple mothers [34]. Nevertheless, it seems that married life leads to a positive attitude toward social affairs and consequently improves the level of social well-being through fulfilling various needs, creating commitment, and creating a stable network of relationships [6]. In the current study, a significant association was found between income adequacy and social well-being, which is in line with some other studies [17,21]. There is a close link between income and health and meeting the health needs of people, but there is no direct relationship between income and health. However, healthier people are not necessarily affluent, as some high-income people do not know how they can have good nutrition or how to comply with health recommendations. Meanwhile, the proportion of income in which is spent on education and health has a direct relationship with health [35]. Social health is an important factor in accepting social norms that enable individuals to balance positively and avoid adverse responses [7,4]. People with high levels

of social well-being can face and cope with the challenges of social life and have better social performance. Since women's health is a priority in all societies, designing high-quality research in women's health filed is very important to provide appropriate strategies for maintaining and improving women's health.

The current study had limitations. First, there were problems for data collection as people were not interested in participating in the current study, so the researchers had to replace people with new participants. Second, there is the likelihood of selection bias because the recruitment of participants was restricted to women who were referring to health centers. Therefore, the findings of this study are not generalizable to the general population of Zanjan. Using the self-report questionnaire is also another limitation of this study.

The current study benefits from its large sample size and low information loss rate. It also was the first study that was conducted to assess the social well-being of women in reproductive age in Zanjan. Selecting participants from different socio-economic areas and various age groups according to the population of each age group in Zanjan city is one of the strengths of this study.

Conclusion

The results of this study showed that the social well-being of most women was at a moderate level. The highest and the lowest scores were attributed to the dimensions of social integration and social contribution, respectively. The socioeconomic status, education, and employment of women and their husbands were recognized as influential factors in social well-being. Among the five dimensions of social well-being, social contribution showed the greatest correlation with social well-being. Also, significant associations were found between the following variables: age and dimensions of social actualization and social integration; education and social actualization; social well-being and social coherence; marital status and social actualization; spouse's employment and social actualization; and social cohesion and social contribution. However, further research is needed to reach a better understanding of social well-being in all social groups and to design appropriate plans for

improving this phenomenon as one of the main components of health.

Conflict of interest
The authors declare that they have no conflict of interests.

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