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Investigating the Relationship between Religiosity and Social Health in Shoush

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Abstract

The aim of this study is to determine the relationship between religiosity and social health among women in Shoush city. The present study is a cross-sectional survey according to the objectives, nature and manner of work. The statistical population of the present study includes the number of women aged 18-55 years in the city. According to available information, their number is equal to 25,000 people. The statistical sample of the present study was obtained using the Cochran's formula of 378 people. The data collection tool and measurement of variables in this study is a researcher-made self-made questionnaire. Findings from Pearson correlation coefficient showed that there is a significant direct relationship between religiosity and its dimensions (belief, ritual) with social health and ritual dimension has a greater impact on social health. The results of bivariate regression analysis between religiosity and social health showed that the value of the coefficient of determination is equal to 0.131 and indicates that 13.1% of the changes in social health are related to the independent variable of religiosity.

Keywords: Religiosity, Social Health, Women,Shoush city.

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1. Introduction

Today, due to technological advances and the development of new information-communication technologies and their direct impact on the quality of human life, the issue of health in all its dimensions, including physical, mental and social health and the factors affecting it has become particularly important; Many social thinkers, especially medical sociologists, believe that social factors and conditions have a significant impact on maintaining and promoting human health, and medical, biological andEven psychology is not sufficient and satisfactory due to the lack of attention to the important role of social and cultural factors on patterns of health and disease (Sajjadi and Sadr al-Sadat, 2004, p. 247).

Keys (2004) assesses a person's social health by knowing how he or she functions in the community and the quality of his or her relationships with other people, relatives, and the social groups of which he or she is a member. According to him and Shapiro, what makes life richer and more meaningful are relatives, relationships and shared experiences. Hence, he calls the ability of the individual to interact effectively with others and the community in order to establish satisfying personal relationships and fulfill social roles, the title of social health (Keys and Shapiro, 2004). According to Hendry et al., (2006), social health is not the absence of mental illness, or even the absence of negative emotion, which in a given context can be considered a constructive response; Rather, it is the ability to perform social maps effectively and efficiently without harming others (Raymond, 2004; quoted by Babapour, Tusi and Hekmati, 2009, p. 11). In fact, we consider a person to have social health when he can express his social activities and plans in a normal way and feel connected with society and social norms (Fadaei-Mehrabani, 2007, p. 8). Social health is one of the important and effective factors in the promotion and development of human beings and desirable interaction with the environment and others, especially among women. Women are one of the most sensitive groups in society and their health ensures the health of the family and consequently the health of society. Therefore, addressing women's health issues (physical, mental and social) can directly and indirectly play an important role in ensuring the general health of society.

Therefore, the healthy future of our society will depend on the necessary attention to the overall health of women and mothers. Women who have social health can more successfully cope with the challenges of social role-playing and participate more in group activities, so it can be expected that they will be more in line with social norms. (Fathi et al., 2010, pp. 228-227). In the meantime, countless factors can affect social health. One of these factors is religiosity. Religion can often be a powerful factor in determining social phenomena, shaping institutions, influencing values, and influencing relationships (Zuckerman, 2005, p. 175). Heden (1983) believes that religiosity is a fundamental factor in socialization and intellectual, practical and orientation in solving problems, phenomena and social problems (Nazkatbar et al., 2006, p. 234). In general, religious beliefs are related to the individual and social health of individuals in a society (Dai, 2009).

Due to its consequences and functions at the individual and social level, religion has always been one of the most determining factors in shaping and directing human societies and has played an important role in creating and maintaining social structures and human social life (Rad, 2015, p. 140). In our society, the situation of quantitative variables has improved compared to previous years, but qualitative variables such as social health are always challenged. We see a bolder face. Therefore, the main purpose of this study is to identify the relationship between religiosity and social health among women in Shousha and seeks to answer these questions, what is the degree of religiosity and social health of women? And what is the relationship between women's religiosity and social health?

2. Review of Literature

Afshani and Mohammadabadi (2016) investigated the relationship between religiosity and social health of women in Yazd. Findings from Pearson correlation coefficient showed that there is a significant and direct relationship between religiosity and social health and with increasing religiosity, social health also increases. Kafashi (2015) investigated the relationship between the components of religiosity and the components of students' social health. The results showed that the most direct effect can be expressed as the direct effect

of religious religiosity in the components of religiosity on the social cohesion variable in the components of social health.

Cheraghi and molavi (2015) in a study entitled Religion and Social Health showed that there is a significant relationship between religiosity and social health of students as well as religiosity and dimensions of social health.Firooz Rad et al., (2015) investigated the relationship between religiosity and social health among students of Payame Noor of Marand University. Findings from Pearson correlation coefficient showed that there is a significant and direct relationship between religiosity and students' social health as well as between religiosity and social health dimensions (integration, acceptance, participation, cohesion and social prosperity). And is the least correlated with the dimension of social prosperity. There is a significant difference in students' social health according to their gender; But this difference with other demographic variables is not significant. Also, there is no significant relationship between age and social health. The results of bivariate regression analysis also showed that the variable of religiosity has a 27.3 effect on students' social health.

Serajzadeh et al. (2013) studied the effect of religiosity on health among students of Tabriz University. Findings showed that the variables of religiosity, lifestyle-centered health and social support explain 36.8 of changes in total health, 16.6 of changes in physical health, 31.2 in mental health and 32.6 in social health. Statistically, religiosity has a significant direct and indirect effect on overall health, but in different dimensions of health, the impact of religiosity is shown in different ways. Religiosity indirectly affects physical health through the variable of lifestyle health centered. The effect of religiosity on social health is indirect and through social support. The impact of religiosity on mental health is confirmed both directly and indirectly (through social support). These findings confirm the implications of functionalist theories about the positive effect of religiosity on health-centered lifestyle, social support and health, especially mental health and social health.

Mohammadi et al., (2011) examined the role of religious teachings in individual and social health and its preventive effect on physical, mental and social health and types of health from the perspective of Islamic and Western thinkers and the effects of religious teachings and spiritual curricula. The

results showed that different dimensions of religiosity and spirituality have a positive relationship with physical, mental and social health, so that religious beliefs can lead a person to perfection and excellence and thus mental and physical health and ultimately social health. Poursta, Hekmati (2010) predicted social health based on religious beliefs among female students. The results showed that acceptance and social participation with all dimensions of practice of religious beliefs and social integration and cohesion with some dimensions of practice to religious beliefs have a significant relationship, but there is no significant relationship between social prosperity and the practice of religious beliefs. The results of simultaneous multivariate regression analysis showed that performing religious duties and activities predict social integration. It also provides for the fulfillment and obligations of social acceptance and social participation. Mustahabs, religious activities and decision-making and choice have the ability to predict social prosperity, social cohesion and the overall score of social health.

Dai (2010) regarding the study of the role of religious practices and rituals on individual and social health of individuals showed that there is a significant relationship between religious practices and individual and social health of individuals. Francis et al., (2004) showed in their research that differences in religious attitudes, more important than religious practices, can predict people's health. In fact, many health variables are explained by religious beliefs. Cobb and O'Connor (2003), Koenig (2004) and Desutter and Hatsbutt (2006) believe that there is no negative or inverse relationship between Dindra and health.

A review of social health research suggests that each of the studies examined social health from a particular perspective and examined it in relation to a particular variable or variables. Or has been studied in a specific sample such as students and young people. In relation to the female community and the ages of 18 to 55 years are less common. One of the most important differences between this research and other researches is the localization of Keys social health questionnaire according to the research population, and the measurement of social health with indigenous items. On the other hand, with a deeper look at the external background, it can be seen that research that has reached a negative relationship between religiosity and social health or lack of

relationship is more than a positive relationship. This issue can be analyzed with the view that the religion of Islam has a more social character than the religions of Christianity and other religions, and it can be seen in the positive relationship between religiosity and social health. This can be seen in the more social presence of the religion of Islam and its meaning and sanctification in the dimensions of its material and social life, and that Islam in this way gives a divine color and smell to daily life and work, and thus by solving the problem. Lack of meaning in life contributes to the mental and social health of individuals and society.

2.1. Religiosity

Religion is a collective phenomenon and is interrelated with other social units; In a way that both affects and is influenced by other institutions of society. Many sociologists have tried to explain the different aspects of religiosity. Among them, the most famous category belongs to Glarg and Stark. They believe that despite the differences between different religions, fixed principles can be considered for them, which include the Beliefand rituals and emotional dimensions, religious knowledge, and consequences (Rabbani and Beheshti, 2011, pp.89-90). The doctrinal dimension includes the beliefs that the followers of that religion are expected to believe. The ritual dimension includes specific religious practices such as worship, prayer, participation in specific sacred rituals, etc. that followers of any religion are expected to perform. The empirical or emotional dimension includes the ideas and feelings associated with establishing a sacred relationship or existence. The dimension of religious knowledge includes basic information and knowledge about the principles of religious beliefs and scriptures that followers are expected to know. Consequential dimension; Includes the consequences of belief, practice, experience and religious knowledge in the daily life of a believer and his relationships with other people (Tavassoli and Morshedi, 2006: 104-103;Quoted from Serajzadeh et al., 2004, p. 125).

In the present study, according to the purpose of the research, two dimensions of belief and ritual variables of religiosity, which are more tangible items for the statistical population of this study in relation to social health, were

used. As a result, other dimensions of the variable that had a lower level of reliability in the relevant research were omitted.

Table 1: Glark-Stark model (Sirajzadeh, 2004: 62)

General Dimensions of Religious Commitment	Early Scales
Belief	Basic beliefs, ultimate beliefs, underlying beliefs
Rituals	worship, prayer, participation in special sacred rituals
Experimental	attention, cognition, faith, fear
Consequences	effects of religious belief, practice, experience and knowledge in daily life

2.2. Social health

Goldsmith defines social health as "assessing a person's significant positive and negative behaviors in relation to others" and identifies it as one of the most fundamental indicators of health in any country that leads to the efficiency of the individual in society. According to Larson, social health is an assessment of the quality of one's relationships with family, others, and social groups and, in fact, includes one's internal responses to stimuli and feelings, thoughts, and behaviors that indicate one's satisfaction or dissatisfaction with life and social environment. Larson, 1933, p. 285). According to Keys, social health is "valuing an individual's condition and performance in society, which is a positive reflection of social health" (Keys, 1998, p. 122).

2.3. Keyes Social Health Theory

Keys (2004) defines social health as a report of the quality of a person's relationships with other people, relatives, and social groups of which he or she is a member. Thought and behavior), which indicate the satisfaction or dissatisfaction of a person with his life and social environment. According to Keys, a person's life and personal performance cannot be evaluated without considering social criteria. Good performance in life is more than mental health, it also takes into account social tasks and challenges. A socially healthy person performs better when he or she sees the community as a meaningful, understandable, and potential set for growth and prosperity, and feels that he or she belongs to a social group and contributes to the community and its development. Keys has proposed five dimensions for social health based on the social dimension and level of individual analysis. He discusses the dimensions

of social health by considering the model of health.In fact, Keys' multidimensional model of socialhealth includes five aspects, which are:

A) Social prosperity

Social prosperity means knowing and believing that society is growing positively, and believing that society is in control of its own destiny and that it is in control of its potential to control its own evolution" (Keys, 2004, pp. 9, 10). "People with the desired levels of this dimension of social health are more hopeful than the current situation and the comprehensive future and believe that the world will become a better place for each other" (Farsinejad, 2004, p. 88).

B) Social adaptation

Social adaptation is knowing and being interested in society and the concepts that society is understandable, rational and predictable. Healthy and social people are aware of social issues and feel that they can understand what is happening around them (Keys and Shapiro, 2004, p. 7). People who are socially elderly, not only about the nature of the world in which they live; They are also interested in what is happening around them and feel able to understand what is happening around them. This concept is the opposite of meaninglessness in life and, in fact, the individual's perception of the quality, organization and management of the social world around him (Keys, 1998, p. 7).

C) Social acceptance

In social acceptance, the individual believes in and accepts the positive and negative aspects and disadvantages of society and people. People who are healthy in this way understand the community as a whole and are made up of different people and trust others as capable and kind people. People believe that people can be diligent and effective. These people have a favorable view of human nature and feel comfortable with others ”(Keys and Shapiro, 2004, p. 22).

D) Social contribution (participation)

Contribution is a social belief according to which an individual considers himself a vital member of society and thinks he has something valuable to offer

to the world and his community. These people try to feel loved and to share in a world that values them just because they are human. Social participation is parallel to the goal dimension in life on the scale of mental health ”(Hosseini 2008, p. 34). Social participation in general means whether and to what extent the individual feels that what he or she is doing in the world is valued by society and is effective in public welfare.

E) Social cohesion

Cohesion, or social solidarity, means feeling part of society, thinking that one belongs to society. Feeling supported by the community and having a share in it. Thus, social cohesion is the degree to which people feel that there is something in common between them and those who make up their social reality, like their neighbors ”(Samaram, 2013, p. 13).

Although this theory had five dimensions, it is an embedded model. But since in the localization of theories and the application of theories to specific socio-cultural conditions, not necessarily many of the dimensions and characteristics of that theory are applied, we have done the same with Keys' theory. Two indicators of this theory, such as social adaptation and cohesion in our society, are conceptually found to some extent by social acceptance or participation, and conceptual adaptation or propositional adaptation, which could not be used among the researcher's statistical clothing. Initially, the Keys questionnaire was measured in all dimensions, but the statistical population studied is not educated women or young people, but all women.

The items of these two were not known and tangible to the statistical population of the researcher in a small town with a traditional context after the Keys questionnaire; As a result, we came across many unanswered statements. Inevitably, in consultation with the professors, these two dimensions were abandoned and the three most important dimensions of social health, which were more tangible among the statistical population of the researcher, were used. But since a more important indicator of many social behaviors, including their social health, can play a role in our society is the issue of social trust. We included social trust in two dimensions (personal, institutional) as a main indicator along with the main indicator of social health variable. Because of the study and cognition obtained by researchers in the pre-test, we concluded that

the dimension of social trust can play a more important role in social health among women. For example, can a woman who cannot trust a neighbor, friend, or other social institution be said to be socially healthy or to have more scientific health than social health? Absolutely not. Another important point is the issue

The overlap of social trust with other dimensions of social health has been solved by using completely separate examples when designing the questionnaire.

F. Social trust

Giddens divides trust into two types: He considers the first type of trust to be trust between individuals. The second type of trust he mentions is trust in institutions. In institutional trust, there is no need to confront the officials of the systems. But he takes into account that in many cases non-specialist actors are confronted by systemic officials. He calls this connection and the attitude of the people with the actors in the system as access points. The access points of the abstract systems provide the ground for the interaction of the named and the signified and the anonymous and the signified actors. In other words, non-specialist actors encounter the institution's specialists at access points. Giddens attributes his theory of the nature of modern institutions to mechanisms of trust in abstract systems, especially systems of specialization. Takes. That is, non-specialist actors trust specialized systems (Giddens, 2001).

According to the above theories, it can be explained that a person with social health can be considered when he / she can express his / her activities and social plans in a normal way, feel connection and solidarity with society and social norms, does not consider his / her peers as rivals and enemies. To do social work without harming others, to engage in social participation among individuals. Therefore, according to the above reasons, it can be determined that social trust is the next of social health, the absence of which in a person leads to a disorder in a person's social health. Based on the above theoretical framework, the analytical model of the research is presented in Figure (1) and tested:

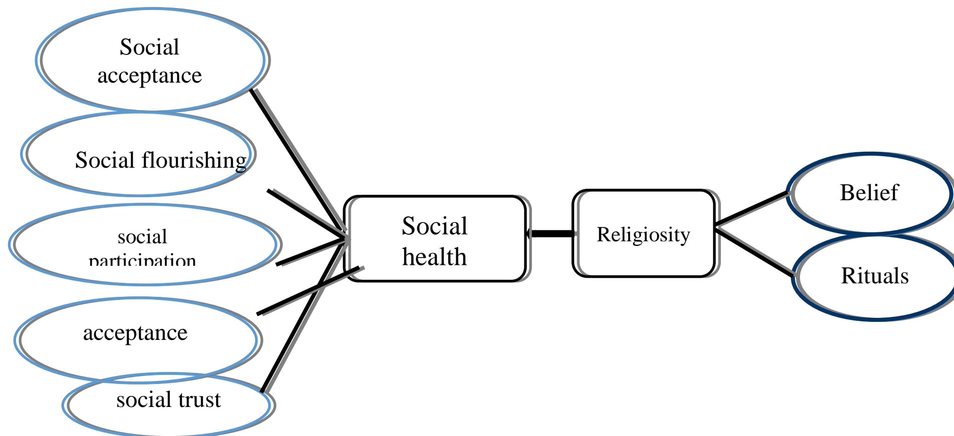

Figure 1: Analytical model of research

2.4. Hypotheses

1. There is a significant relationship between religiosity and women's social health.

2. There is a significant relationship between the ritual dimension (religiosity) and women's social health.

3. There is a significant relationship between the belief dimension (religiosity) and women's social health.

3. Methodology

The present study is an applied study in terms of purpose, a cross-sectional study in terms of time, and a survey in terms of data collection. The statistical population in this study is all women (18-55 years) in the city of Shoush city, which using the Cochran's formula, the statistical sample size of 378 people has been calculated. The data collection tool in this study is a questionnaire. In this study, a researcher-made questionnaire was used to measure variables. Findings were analyzed using descriptive statistics and inferential statistics by SPSS. To prepare the validity of the questionnaire, first the questionnaire was prepared and given to a number of experts, and after extracting their opinions, the questionnaire was finalized. Finally, to evaluate the reliability of the questionnaire from Cronbach's alpha, which was obtained through pre-test, it was found that all variables have a reliability above 0.7, so the questionnaire has a good internal reliability.

In this study, Glark and Stark's religiosity model has been used to practice and measure the degree of religiosity. According to this model, religiosity has five dimensions: belief, ritual, empirical, emotional and consequential. In the present study, based on two doctrinal dimensions, a ritual of 9 items was considered to measure religiosity, each item was measured at the level of distance measurement by Likert scale.

In this study, Keys social health model has been used to make the measurement of social health practical. According to this model, social health has five dimensions of social cohesion, social acceptance, social participation, social prosperity and social adaptation. In the present study, based on the three dimensions of social acceptance, social prosperity, social participation (Keys) and social trust (which was added based on the researcher-made index), 60 items were considered for measuring social health, each item at the measurement level. Distance is measured by the Likert spectrum.

Table 2. Reliability coefficientof religiosity and social health indicators based on Cronbach's alpha

Reliability coefficient (ritual and belief)		Number of items	Indicator		Variable
Post-test	pre-test	5		Social flourishing	Social health
0.93	0.89	7		social acceptance	
		23	Personal	social trust	
		17	Institutional		
		8		social participation	
		60		Collection	
071	0.71	4	Belief		Religiosity
		5	Rituals		
		9	Collection		

4. Findings

The independent variable of religiosity was measured using nine items that people answered based on the Likert scale. In general, among about 8.2, the level of religiosity was very low, about 14.6 was low, about 30.2% was moderate, about 34.7 was high and about 11.4 The level of religiosity is very high. The average level of religiosity is 3.65, which is higher than the average.

Among about 77.2 of women, the doctrinal dimension of religiosity is very high, but the ritual dimension of religiosity is moderate among the women of Susa. The average doctrinal dimension of religiosity is 4.41 and the average

ritual dimension is 3.23. Therefore, women in the city of Susa pay more attention to the doctrinal dimension of religion than to the ritual dimension.

Table 3. Distribution number of respondents according to the degree of religiosity

RitualistikDimension		Belief Dimension		The degree of religiosity		Degree
Percent	Abundance	Percent	Abundance	Percent	Abundance	
6.9	26	77.2	292	11.4	43	very much
32.5	123	10.8	41	34.7	131	Much
36	136	5	19	30.2	114	medium
17.7	67	4.5	17	14.6	13	Low
5.8	22	2.4	9	8.2		very little
1.1	4	0	0	1.1	4	Unanswered
3.23		4.41		3.65		Average
100	378	100	378	100	378	Total

The dependent variable of women's social health was measured using four dimensions of social acceptance, social prosperity, social participation and social trust, to which individuals responded based on the Likert scale. In total, about 1.3of women have very little social health. About 16.1have a low level, about 41.8 have a moderate level, about 23.5 have a high level and about 3.2have a very high level of social health.The average social health of women is above average and is higher than three, which is the average (average 3.23). Among the four dimensions of women's social health, the social acceptance dimension with an average of 3.46 had the best situation and the social participation dimension with an average of 2.67 had an unfavorable situation. In other words, women's social participation in Susa is low and even below the median index (number 3), but women are in a better position in terms of social acceptance and social trust.

Table 4. Frequency distribution of respondents in items of social health indicators

Variables	social trust		. Social Contribution		Social Acceptance		Social flourishing		Social health	
	N	%	N	%	N	%	N	%	N	%
very much	49	13	55	6.14	45	9.11	22	8.5	12	2.3
Much	122	3	48	7.12	87	23	85	5.22	89	5.23
medium	127	6.33	78	6.20	113	9.29	162	9.42	158	8.41
Low	40	6.10	95	1.25	77	4.20	78	6.20	61	1.16
very little	3	8.0	89	5.23	44	6.13	26	9.6	5	3.1
Unanswered	37	8.9	13	4.3	12	2.3	5	3.1	53	14
Average	3.43		2.67		3.46		3.02		3.23	
sum	100	378	100	378	100	378	100	378	100	378

Pearson correlation coefficient between the religious dimension of religiosity and social health is equal to 0.217 and Pearson correlation coefficient between the ritual dimension of religiosity and social health is equal to 0.318 and its level of significance is zero. Due to the fact that the level of significance in the correlation coefficient is less than five percent, so there is a positive and significant relationship between the dimensions of religiosity and social health. The ritual dimension has shown more correlation with the dependent variable than the belief dimension.

Table 5. Pearson correlation coefficient between religiosity and social health

Result	Sig	Pearson	Variable
Significant positive correlation and rejection 0 H.	0.000	0.363	The degree of religiosity
Significant positive correlation and rejection 0 H.	0.000	0.217	Belief Dimension
Significant positive correlation and rejection 0 H.	0.000	0.318	RitualistikDimension

According to Table (6), the religiosity variable of 0.363 is correlated with women's social health. In fact, this correlation shows a moderate and significant relationship between these two variables. On the other hand, the value of the coefficient of determination is equal to 0.131, which shows that 13.1 of the dependent variable changes (social health rate) is explained by the independent variable (religiosity rate) and the rest of the dependent variable changes occur by other variables. These studies have not been reviewed.

Table 6. Bivariate regression between religiosity and women's social health

Sig	T	Beta	B	Sig	F	DW	R^2adj	R^2	R	dependent variable	independent variable
0.000	6.969	0.363	0.421	0.000	48.57	1.740	0.129	0.131	0.363	Social health	Religiosity

According to the standard impact factor (Beta), the religiosity variable has an effect of about 36.3% on women's social health, ie by increasing a standard deviation in the religiosity variable, women's social health increases by 0.363 standard deviation.

Table 7. Bivariate regression between the variables of religious belief and social health

Sig	T	Beta	B	Sig	F	R^2adj	R^2	R	dependent variable	independent variable
0.000 0.000	3.95 3	0.215	4.18	0.000	15.63	0.043	0.04 6	0.21 5	Social health	Belief Dimension

According to Table (7), the religious dimension of religiosity is 0.215 correlated with women's social health. In fact, there is a weak and significant relationship between these two variables. Also, the value of the coefficient of determination is equal to 0.46, which shows that the independent variable (religious dimension of religiosity) explains only 4.6% of the changes of the dependent variable (social health rate). In other words, 4.6 of the changes in social health are due to the religious dimension of religiosity and 95.4 of the remaining changes are due to factors and variables that have not been considered in the present study. According to the standard impact factor (Beta), the religious dimension of religiosity has an effect of about 21.5 on women's social health, ie by increasing a standard deviation in the religious belief dimension variable, women's social health increases by 21.5 standard deviation

Table 8. Bivariate regression between the ritual dimension of religiosity and women's social health

Sig	T	Beta	B	Sig	F	R^2adj	R^2	R	dependent variable	independent variable
0.000	5.95 7	0.316	3.00 1	0.000	35.49	0.097	0.10	0.31 6	Social health	RitualistikD imension

According to Table (8), the ritual dimension of religiosity in the amount of 0.316 is correlated with women's social health. This correlation is moderate and significant. The coefficient of determination is equal to 0.10, which shows that the independent variable (religious ritual dimension) explains 10 of the changes of the dependent variable (social health rate). In other words, 10% of the changes in social health are due to the ritual dimension of religiosity and the remaining 90% of the changes are due to factors and variables that were not considered in the present study. According to the standard impact factor (Beta), the ritual variable of religiosity has an effect of about 31.6 on women's social

health, that is, by increasing a standard deviation in the ritual variable of religiosity, women's social health increases by 31.6 standard deviation.

5. Conclusion

The aim of this study was to investigate the relationship between religiosity and social health among 18-55 women in Shoush. The independent variable of this research is religiosity. In the present study, two dimensions of belief and ritual were examined. Descriptive findings show that the degree of religiosity, the average doctrinal dimension of religiosity is equal to 4.41 and the average ritual dimension is equal to 3.23. Therefore, women in the city of Susa pay more attention to the doctrinal dimension of religion than to the ritual dimension.

The dependent variable of this research is social health. The average social health of women is above average and is higher than the number three, which is the average (average 3.23). Among the four dimensions of women's social health, the social acceptance dimension with an average of 3.46 is the best situation and the social participation dimension with an average of 2.67 is in an unfavorable situation. In other words, women's social participation in Susa is low and even lower than the average index (number 3), but women are in a better position in terms of social acceptance and social trust.According to the findings, the level of women's social health in the four dimensions of social prosperity, social participation, social acceptance, and social trust is above average.

The results of the analytical test of the main hypotheses of the research show that there is a significant relationship between the two variables of religiosity and social health and the direction of this relationship is positive and direct; That is, with the increase of religiosity among women, their social health also increases. This research finding is consistent with the results of Afshani and Mohammadabadi (2015), Cheraghi and Molavi (2015), Firoozrad et al. (2013), Pourstahkamati (2010), Dai (2010).

The results of the bivariate regression equation showed that the coefficient of determination that the independent variable of the study explains about 0.131 of the variance of the students' social health; In other words, 13.1 of the

changes in social health were due to religiosity, which had a significant relationship with students' social health. 4.6 of changes in social health were due to religious beliefs, and 0.10 were changes in. Social health is due to the ritual dimension of religiosity. The results of the present study indicates that there is an interrelationship between religiosity and social health. Religious rites and rituals, despite the differences, bring people closer to each other by creating intellectual and doctrinal harmony and increase the solidarity and social cohesion of individuals, as well as the role of religious teachings in establishing extensive communication and interaction with others in Expanding the network of social relations (communication and social interactions) of individuals and their membership in extensive social networks, paves the way for people to enjoy more social support, which plays an effective role in promoting women's social health. Accordingly, it is suggested that religiosity as an important and effective indicator in health in general and social health in particular should be given more attention by scientific circles and social policy makers. Therefore, according to the results of the present study, it is suggested that a favorable environment be created in order to increase the level of religiosity among women by increasing belief indicators, rituals that each in turn will be effective in increasing women's social health.

Also, according to the results of the study, 13.1 of the changes in social health are due to religiosity and 86.9 of the remaining changes are due to factors and variables that were not considered in the present study. Other researchers are suggested to pay attention to other effective factors to increase the social health of women in Shoush city and to study those factors scientifically. As a result, proper planning can be achieved to improve and enhance social health. With high social health among women, we will see a healthy family, and with a healthy family, we will pursue a healthy society, a society that will face development and progress in the future with far fewer challenges.

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