

The Relationship between Leisure Time and Religious Beliefs and Women's Social Health

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ABSTRACT:

In recent years, social health has gained increasing prominence as a key dimension of overall health, alongside physical, psychological, and spiritual well-being. Health is no longer understood merely as the absence of physical and mental illness; rather, the quality of individuals' functioning in social relationships and their perceptions of society are now considered essential criteria for evaluating both individual and societal health. Accordingly, the present study aims to examine the relationship between leisure time and religious beliefs and the social health of women in Nurabad Mamasani County. In terms of purpose, this research is applied, and in terms of methodology, it adopts a descriptive-survey design. The statistical population consists of women aged 18–50 residing in Nurabad Mamasani County. Based on the latest census (2016) reported by the Statistical Center of Iran, this population comprises 27,996 individuals. The sample size was determined to be 384 participants using Cochran's formula. A researcher-developed questionnaire was employed to measure the study variables, and data analysis was conducted using SPSS version 22. The findings indicate a significant relationship between adherence to religious beliefs and women's social health in Nurabad Mamasani County. Furthermore, a significant relationship was found between the manner of spending leisure time and women's social health in the same population.

Keywords: *Women's social health; leisure time; religious beliefs.*

INTRODUCTION:

Women, as human capital in any society, play a prominent role in sustainable development and in ensuring the cultural and national continuity of that society. Securing and improving women's health requires serious attention to their health and rights. This health has different dimensions, some of which are the responsibility of society and some of which fall under the responsibility of the family. The issue of women's social health is so significant that societies, to protect themselves from the harms resulting from threats to and deterioration of social health, design and implement programs and measures that take into account cultural and social backgrounds and emphasize their implementation (Safavi et al., 2009).

In general, from a social health perspective, every individual is a member of a family and a larger society, and attention is focused on the individual's social and economic conditions and well-being within their social network. Social health has its roots in two positive material environments, namely financial and biological issues, and a positive human environment, which examines individuals' social networks (Mesdaghi Nia, 2012: 15). Although various theories can be used to

theoretically analyze social health each interpreting and explaining it from different aspects one of the most widely accepted interpretations belongs to Keyes' theory of social health. Keyes' work originates from both sociological and psychological principles. According to Keyes, a missing link in the history of studies on health, particularly mental health, is the question of whether it is possible to evaluate the quality of life and individual functioning without considering social criteria. Social health is a combination of several factors that collectively indicate how well a person functions in their social life, for example, as a neighbor, colleague, and citizen (Keyes & Shapiro, 2004: 5).

Keyes, through an extensive factor analysis, demonstrated that mental health has emotional, psychological, and social dimensions, and based on theoretical conceptualizations of social health, he presented a measurable five-dimensional model. According to these dimensions, a socially healthy individual performs well when they perceive society as a meaningful, understandable system with potential for growth and flourishing. They feel that they belong to social groups and consider themselves partners in society and its development. The content of his social

health scale reflects a positive spectrum of individuals' evaluations of their experiences in society.

On the other hand, according to functionalist theorists, religious rituals prepare individuals for social life by imposing discipline on the self and strengthening self-control. Religious ceremonies bring people together, reaffirm their shared bonds, and consequently strengthen social solidarity. The importance of religion and religious teachings is such that many consider the roots of human thought and ideas to be grounded in religion. Bonald attempted to show that the origins of language and categories of thought lie in primitive humans' reflections on God (Abazari, 1988: 1367).

Another factor influencing social health is the way leisure time is spent. Leisure time refers to activities that individuals choose based on their interests, motivation, and freedom of action. Despite their diversity, these activities in some way meet social needs. Individuals who spend more time on leisure activities tend to have higher levels of social health. Leisure activities can serve as an appropriate source for promoting health (Moghadassi Jafari et al., 2006).

In the county of Nurabad Mamasani, social problems such as unemployment, honor-related issues, poverty and deprivation, loneliness, cultural problems, family disorders and difficulties, stress and psychological pressures, mental illnesses, emotional deprivation in families, and economic and social problems threaten the social health of individuals, especially women in this region (News and Analytical Website of Nurabad Mamasani and Rostam, 2017). Therefore, it is important to examine influential components, such as social health and the social and cultural factors that affect it, which are less frequently addressed. On the other hand, since an essential condition for the growth and flourishing of any society is the presence of aware and creative individuals, and considering that social health plays a major role in the functioning of all individual, family, and social domains, it is evident that proper and comprehensive planning for ensuring the social health of members of society is necessary (Piran, 1997: 1).

Given that women's issues today are an unavoidable, important, and sensitive reality, and that existing research on women's social health has been insufficient, examining social health as an important and influential variable in women's lives is significant. Therefore, this study aims to examine the relationships among leisure time, religious beliefs, and women's social health.

Theoretical Foundations of the Research:

Social Health:

Social health refers to an individual's evaluation and perception of how they function in society and the quality of their relationships with other people, close contacts, and the social groups to which they belong (Keyes & Shapiro, 2004). Larsen (1996) defines social health as an individual's perception of the quality of their relationships with others, close contacts, and the social groups to which they belong. Social health is the

existence of relationships among individuals, or socialization. It includes enjoying being among friends and receiving support from family, relatives, and friends (Sam Aram, 2012: 26). From an empirical perspective, the concept of social health is rooted in sociological literature on social deviance and social alienation. Social health refers to the quality of the relationship between the individual and society, in which individuals are not absorbed into social frameworks, creating a favorable ground for the development of social deviations. In such a condition, an excessive form of individualism places personal demands in opposition to social life (Akbarian, Tabardarzi, & Khaki, 2010).

Components of Social Health:

1. Social Actualization (Social Flourishing): Social actualization refers to the belief that society is gradually evolving and possesses potential for positive transformations, and that the individual perceives the future of society as hopeful (Farsi Nejad, 2004: 88). Individuals who benefit from this dimension perceive society as a general and integrated system composed of diverse individuals and trust others as capable and kind beings, believing that people can be active and effective contributors (Keyes, 2004).
2. Social Integration: Social integration refers to the perception of the quality, organization, and functioning of the social world, equivalent to the concept of "environmental mastery," and involves viewing the world as logical, intelligent, understandable, and predictable (Keyes, 2004). Healthy individuals are interested in social structures and feel capable of understanding surrounding events. They do not deceive themselves by imagining a perfect world; instead, they deepen their understanding and perception of life.
3. Social Acceptance: Individuals who have a positive attitude toward their own personality and accept both the positive and negative aspects of life possess social and mental health. Social acceptance refers to an individual's perception of society based on others' characteristics. It includes acceptance of others, trust in people's inherent goodness, and a positive view of human nature, all of which help individuals feel comfortable in society. Those who accept others conclude that people are generally constructive. Just as mental health includes self-acceptance, acceptance of others in society can also lead to social health (Hezarjaribi & Arfaee Aindin, 2012: 315).
4. Social Cohesion: Social cohesion refers to the feeling of being part of society, the sense that one belongs to it, and the perception of shared participation and support within society. Thus, social cohesion is the degree to which people feel that there is something in common between themselves and those who constitute their social reality, such as their neighbors (Sam Aram, 2008: 7).

Cultural Factors Affecting Social Health:

1. Commitment to Religious Beliefs

One cultural factor influencing women's social health is religious beliefs. There is no doubt that religiosity is a

very important prerequisite for enhancing individuals' social health. Religion and religiosity are among the most influential factors affecting all dimensions of human existence, including the social dimension. Numerous examples exist in this regard. Many people turn to religious beliefs and institutions when facing crises to give meaning to life, create hope, and achieve health and well-being. The importance of religion and religious institutions in human life, both individual and social, is evident. Religion exists in various forms across every known culture and usually plays a central role in individuals' lives. In recent years, religion has been considered one of the most important variables influencing human behavior and psychological states by many behavioral scientists, to the extent that some regard religion as a fundamental factor in individual and social health (Sam Aram, 2012: 27).

Durkheim (1964) refers to the concept of the "cult of the individual," which does not mean narcissism but rather respect for the integrity of all individuals. In other words, the divinization of the individual leads to respect for human rights and their recognition. Health emerges within the inner content of the individual. According to religious teachings, in social interactions and behavior toward others, humans are not only producers of behavior but also receivers of their own actions. In the course of social life and in the perfection of the afterlife, humans ultimately sit at the table of their own deeds. This is a Qur'anic principle, and understanding it is key to achieving social health. Durkheim believed that religion prohibits certain actions for its followers, and committing such acts leads to punishment, blame, or at least public disapproval. Through engaging in forbidden acts, a person becomes sinful and must expect some form of punishment (from society or nature) (Zolfaghari, 2009: 69). Durkheim also believed that religion is not merely a set of beliefs but is usually accompanied by rituals and ceremonies that strengthen group solidarity and demonstrate the influence of the collective on the individual. Religion encompasses feeling, behavior, and thought simultaneously (Afroogh, 1994: 109–110).

Auguste Comte also believes that religion is the principle of unity that provides a common ground, and individual disorders tear society apart. Religion allows humans to overcome their disorders and selfish tendencies and, because of love for each other, he mentions religious social components and considers it the cornerstone of social order, which is the strong thread that binds the individuals of society to each other with a common creed and ideological system (Kozer, 2007: 34). Harry Alpert, a Durkheimian researcher, has classified four major functions of religion as social forces that discipline, integrate, give life and give happiness. Religious rituals prepare humans for social life through self-discipline and self-control. Religious rituals bring people together and reaffirm their common bonds, thereby strengthening social solidarity. Performing religious rituals revives the group's heritage and transmits its enduring values to future generations. It also has a happiness-giving function that counteracts

feelings of frustration and lack of faith by arousing a sense of happiness in believers and a sense of confidence in the essential legitimacy of the moral world of which they themselves are a part (Serajzadeh et al., 2013: 57). Religion is, in fact, the most important influential factor. It is the best and most effective method for organizing human society and compelling people to observe social laws more than any other method. The need for religion and the necessity of religiosity are for reforming individual and social relationships and creating and continuing a healthy human life. Religion is situated within human life and plays a vital role in the individual and social dimensions of human society (Mirza Mohammadi et al., 2013: 22).

2. Leisure Time Management:

Another cultural factor influencing women's social health is how they spend their leisure time. Leisure time includes activities that individuals choose based on their interests, motivation, and freedom of action. Despite their diversity and differences, these activities in some way fulfill social needs. There is a significant correlation between social health and the amount of time spent on leisure activities. Individuals who allocate more time to leisure activities tend to have higher levels of social health. Leisure activities can serve as an appropriate source for promoting health. Participation in sports competitions, as one form of leisure activity, enables individuals to maintain balance and equilibrium and to regulate their emotions. The health-promoting nature of leisure activities stems from the fact that when individuals engage in them, they perform tasks they can do well, which enhances their vitality and well-being. Leisure time provides relief from anger and tension and empowers individuals to expand their cognitive horizons (Jafari et al., 2006).

According to Agnew and Peterson (1989), sports as a form of leisure activity are considered an important form of social control and have many educational objectives. Keane, through a review and synthesis of more than 200 articles and studies on physical activities in schools, identified nine objectives, including moral development and the acquisition of social competencies, and emphasized their fundamental role in development and growth (Tabardarzi, 2007). Booth et al. (1999) showed that participation in leisure-time physical activities increases individuals' commitment and reduces opportunities to engage in antisocial behaviors such as delinquency and violence.

Research Method:

The present study is applied in terms of its objective and descriptive-survey methodology. The statistical population of this research consists of women aged 18–50 living in Nurabad, Mamasani County, according to the latest census (2016) from the Statistical Center of Iran, totaling 27,996 individuals. The sample size was determined using Cochran's formula and equals 384 participants.

The data collection instrument used in this study is a questionnaire. A researcher-made questionnaire was

used to measure the research variables. The questionnaire items were designed based on the study's theoretical framework, the concepts and variables used in the research hypotheses, and a review of similar studies conducted within and outside the country. After designing the questionnaire and before its final implementation, it was evaluated by several experts in the field. After addressing its shortcomings and deficiencies, the final version was prepared.

To determine reliability, Cronbach's alpha was calculated on a sample of 30 women. After extraction, the questionnaire scores were entered into SPSS and analyzed using Cronbach's alpha (Table 1).

Table 1: Cronbach's Alpha coefficients of research variables

Variable Name	Dimensions	Cronbach's Alpha
Religious beliefs	Cognitive	0.74
	Emotional	0.71
	Consequential	0.73
	Ritual	0.74
	Knowledge	0.71
Leisure time management		0.71
	Social flourishing	0.71
	Social acceptance	0.75
	Social adaptation	0.72
	Social cohesion	0.77
Total		0.81

Based on Table 1, the Cronbach's alpha values for all variables are at an acceptable level, indicating adequate reliability.

Research Hypotheses:

1. It seems that there is a significant relationship between commitment to religious beliefs and the social health of women in Nurabad Mamasani County.
2. It appears that there is a significant relationship between leisure-time management and the social health of women in Nurabad, Mamasani County.

Findings:

The results showed that the respondents in the sample group are aged 18-50, with an average age of 33.97. Also, of the 384 people whose information was examined, 35.2 percent were single, and 59.6 percent were married women. Divorced women and widowed women accounted for 1.3 percent and 1.2 percent of the total respondents, respectively. The Lor ethnicity with the highest frequency includes 61.2 percent of the total respondents. Respondents with the Fars ethnicity are in second place with 29.2 percent. The lowest frequency is associated with Turkish ethnicity, with 3.7 percent of respondents. Also, 3.2 percent of the respondents were

from other ethnicities. The educational status of the female respondents was divided into four educational levels. Women with an associate's degree or a bachelor's degree make up 50.5 percent of the total respondents. Women with a high school education and diploma account for 3.27 percent of the respondents. Also, 15.6 percent of women had a master's degree or higher, and only 6.5 percent of all respondents had primary or secondary education. The respondents' housing status was divided into four categories: owned, rented and mortgaged, institutional, and other. 61.5 percent of women owned their own homes. 34.1 percent lived in rented and mortgaged homes, and only 2.1 percent lived in institutional homes.

Table 2: Descriptive statistics of independent variables

Variable	Dimensions	Mean	Standard Deviation	Minimum	Maximum	Number of Observations
Commitment to religious beliefs	Cognitive	13.01	2.60	3	15	384
	Emotional	13.32	2.45	3	15	384
	Consequential	11.50	2.61	3	15	384
	Ritual	6.61	2.88	3	15	384
	Knowledge	8.32	2.89	3	15	384
Leisure time management	—	18.54	4.98	7	33	384

According to Table 2, the adherence to religious beliefs variable is divided into the following dimensions: belief, emotion, consequence, ritual, and knowledge. The mean of the belief dimension is 13.01, and its standard deviation is 2.60. The number of observations for this variable is 384, and there are no missing values. The minimum and maximum levels of the belief dimension are also obtained as 3 and 15, respectively. The mean of the emotional dimension is 13.32, and its standard deviation is 2.45. The number of observations for this variable is 384, and there are no missing values. The minimum and maximum levels of the emotional dimension are also obtained as 3 and 15, respectively. The mean of the consequential dimension is 11.50, and its standard deviation is 2.61. The number of observations for this variable is 384, and there are no missing values. The minimum and maximum levels of the consequence dimension are 3 and 15, respectively. The average of the ritual dimension is 6.61, and its

standard deviation is 2.88. The number of observations for this variable is 381 people, and there are no unanswered questions. The minimum and maximum levels of the ritual dimension are 3 and 15, respectively. The average of the knowledge dimension is 8.32, and its standard deviation is 2.89. The number of observations for this variable is 384 people, and there are no unanswered questions. The minimum and maximum levels of the knowledge dimension are 3 and 15, respectively.

The average of leisure time is 18.54, and its standard deviation is 4.98. The number of observations for this variable is 384, and there are no missing values. The minimum and maximum amounts of leisure time are 7 and 33, respectively.

Table 3: Descriptive statistics of social health and its dimensions

Statistics	Social Health	Social health dimensions			
		Social Flourishing	Social Integration	Social Acceptance	Social Cohesion
Number of observations	384	384	384	384	384
Mean	58.44	16.05	15.27	15.11	12.05
Standard deviation	8.67	2.74	3.45	3.38	2.25
Minimum	22	4	4	4	3
Maximum	75	20	20	20	15

Table 3 shows that the range of social health in the sample group is 22-75. In other words, the minimum level of social health among respondents is 22, and the maximum is 75. The average social health score for respondents is 58.44, and the standard deviation is 8.67. Also, considering that women's social health is divided into four dimensions of social flourishing, social adaptation, social acceptance, and social cohesion, the information required to describe these dimensions is given separately in Table 4- 11. As shown in this table, the averages for social flourishing, social adaptation, social acceptance, and social cohesion are 16.05, 15.27, 15.11, and 12.05, respectively. The standard deviations of these dimensions are 2.74, 3.45, 3.38, and 2.25, respectively. The minimum scores for social flourishing and social adaptation among respondents are 4. This value is 4 for social acceptance and 3 for social cohesion. Also, the maximum scores for social flourishing, social adaptation, social acceptance, and social cohesion among all respondents are 20, 20, 20, and 15, respectively. The aforementioned information indicates that respondents achieved the highest social health in the social flourishing dimension, with an average of 16.05, and the lowest in the social cohesion

dimension, with an average of 12.05. Descriptive statistics related to social health and its four dimensions are shown separately in the table below.

Table 4: Relationship between commitment to religious beliefs and women's social health

Variable Name	Pearson Correlation	Significance Level
Commitment to religious beliefs	0.374**	0.001

**p < 0.01

Table 4 shows the relationship between commitment to religious beliefs and women's social health. The obtained correlation coefficient is 0.374, and the significance level is 0.001. The results indicate a positive and significant relationship between commitment to religious beliefs and women's social health, and the hypothesis of a relationship between the two variables is accepted at a confidence level above 99 percent.

Table 5: Relationship between leisure time management and women's social health

Variable Name	Pearson Correlation	Significance Level
Leisure time management	0.111*	0.036

**P < 0.05

Table 5 shows the relationship between leisure time management and women's social health. The obtained correlation coefficient is 0.111, and the significance level is 0.036. The results indicate a positive and significant relationship between leisure time management and women's social health, and the hypothesis of a relationship between the two variables is accepted at a confidence level above 95 percent.

CONCLUSION:

The present study aims to investigate the relationships among leisure time, religious beliefs, and women's social health. The results showed that there is a relationship between adherence to religious beliefs and women's social health in Noorabad Mamasani County. Functionalists believe that religion has a serious impact on health. In explaining this, it can be said that religion creates a sense of community and collective protection among individuals, and its product is solidarity among them. In any case, religion and adherence to religious beliefs create a sense of solidarity, which can be directly or indirectly effective in improving the health of a community and neighborhood. Religious beliefs and other beliefs can be used effectively to promote social health. However, the important point is that these people differ greatly in their degree of faith and level of religiosity, and in their approach to religious issues, especially among young women, who may consider ways to improve health through modern methods while ignoring tradition. According to functionalist theories, which were proposed to explain the relationship between social health and religiosity, religion fosters a sense of community and social unity, thereby

strengthening group solidarity. Religion and adherence to it, by creating a collective spirit, religious enthusiasm, and the spread of universal feelings through collective rituals and ceremonies, can provide the necessary grounds for bonding between members and social cohesion. Religious rituals bring people together, thereby reaffirming their common bonds and, in turn, strengthening social solidarity. It is by relying on the functions of cohesion and strengthening social bonds that religion can be effective in expanding the bond between the individual and the community. According to this approach, on the one hand, religious teachings emphasizing extensive relationships and interactions with others make religious people more inclined to expand their social connections and provide social support, which in turn leads them to receive more social support from those around them. Thus, religion plays a positive role in promoting their social health by fostering their participation in the wider community and expanding their support networks. The results of this hypothesis are consistent with the research of Afshani (2016) and Serajzadeh et al. (2013).

The results indicated a relationship between how women spend their leisure time and their social health in Noorabad, Mamasani County. Eddington and Dumasier believe that leisure time has various positive functions that lead to the acquisition of mental and social health for individuals. The results of testing this hypothesis confirm the views of Eddington and Dumasier. The results of this study also confirm Larson's (1996) findings on the relationship between leisure participation and various dimensions of health among women. Leisure time, as one of the social, cultural and economic factors, if spent optimally in a way that brings satisfaction to the spending agent, can have a positive impact on the individual's views and perceptions of society, its conditions and future, and cause the individual to accept a positive impact from society, its conditions and future, and cause the individual to look at their society with a hopeful view, and this longing, cohesion and hope for society undoubtedly cause the individual to strive and strive for the society to achieve its goals and lead to the promotion of society and improvement of its economic and welfare status. The functionalist view of the positive role of leisure time in individual and social growth supports this claim. It also confirms the views of the systemic approach in the study of social health, which believes that in the study of social and human phenomena, all existing phenomena have a mutual effect on each other, and that leisure time, as one of the social phenomena, can have a mutual effect on social health and be affected by it. From another perspective, we can consider the social model of health. This view holds that health, in general and social health in particular, is not influenced by a single factor or source, and that it is not influenced by a single factor in absolute terms, but rather by various social, economic, cultural, and psychological factors. The results of this hypothesis are consistent with the research of Hezarjeribi et al. (2012) and Kadkhodaei et al. (2013).

Fear and distrust of such research by actors, frustration and avoidance of expressing real opinions for specific social and cultural reasons, as well as conservatism in providing honest answers, practically make it difficult to obtain real and accurate information and can complicate the results of any research.

Considering the significance of religious beliefs and social health, it is suggested that religious beliefs be respected and that freedom of religion be promoted before anything else, so that non-believers do not ridicule those who believe. Spreading this view has led to mutual respect, which will bring social health and a better life. Also, what will increase satisfaction with leisure time is investing in and creating appropriate facilities, spaces, and conditions, as well as cultural activities for all segments of society, especially young people. Surely, this investment will be beneficial for society, improve social health, and ultimately advance and develop society. These investments can be made through both the private and public sectors and cooperatives.

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