

## Social Health Status and Health Literacy in Non-Medical Students of Islamic Azad University

### ABSTRACT

**Background and Objective:** Social health refers to the evaluation and recognition of an individual's performance in society and the quality of his or her relationships with others, relatives, and social groups. On the other hand, health literacy enables people to play an active role in changing environments to influence health and it is considered a determinant of health. The present study was conducted to investigate the status of social health and health literacy in non-medical students.

**Materials and Methods:** This study was conducted by survey method with descriptive-correlation approach on 200 non-medical students of Islamic Azad University, Rasht Branch in the academic year of 2018-2019. The subjects were selected by quota sampling. An adult health literacy questionnaire (HELIA) was used to collect information. The dimensions of access, reading skills, comprehension, evaluation, decision making and use of health information and Keyes social health questionnaire were analyzed using version 23 of SPSS software and analyzed using descriptive statistics, correlation and chi-square test.

**Results:** The mean score of health literacy and social health was  $120.38 \pm 16.26$  and  $109.87 \pm 11.09$ , respectively. The highest mean score (76.61) was related to comprehension and perception. The majority of people had adequate health literacy and their social health status was moderate. In social health components, the lowest score was obtained in the dimension of social participation and the highest was related to the dimension of social cohesion. There was no significant statistical correlation between students' health literacy and social health scores ( $p = 90$ .)

**Conclusion:** In the present study, a significant percentage of students had inadequate health literacy levels. Also, the low dimensions of admission and social participation in students can affect their social and interpersonal relationships and also affect other aspects of their health.

**Paper Type:** Research Article

**Keywords:** Health Literacy, Social Health, Students

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## Introduction

Health is a very dynamic concept that is increasing in its scope and dimensions day by day. Studies have shown that different dimensions of health can interact with each other; for example, the social dimension of health has preventive effects on both physical and mental dimensions (1). Block & Berslow (1972) first considered the concept of social health in a study and equated it with performance degree of community members. In their efforts, they created the index of social health and determined the level of activity and performance of the individual in society by asking various questions in the physical, mental and social dimensions of individual health (2). According to Keyes, social health is operated by the individual's perception of participation in society, acceptance by others, predictability of society and social events, sense of participation in society and the potential and growth of society (3). Therefore, it can be expressed that the social dimension of health is the most complex and controversial dimension of health, which definitions are summarized in three approaches; social health as an aspect of individual health along with physical and mental health, social health as social determinants of health, and social health as a healthy society (4).

The World Health Organization emphasizes that despite the importance of health services in diagnosing and improving serious diseases, the economic and social conditions that make people sick, are more important to people's health. The importance of this issue is such that the organization formed a special group called commission for social determinants of health (CSDH) in 2005, which its final report was published in 2008 after extensive and comprehensive studies and evaluations (5).

In general view, the social determinants of health are those economic and social conditions

in which individuals are born, grow, live, work and get old (6). In a report, the World Health Organization introduces health literacy as one of the greatest determinants of communities' health (7) and defines it as "cognitive and social skills and the ability of individuals to understand and use the information available to promote and maintain good health" (8, 9). Health literacy consists of different components including the skills of reading, listening and analyzing, decision-making and the ability to use these skills for prevention and treatment purposes in the field of personal and social health and it is not necessarily referred to years of study or general reading ability (10). Health literacy refers to an individual's capacity to access, interpret, and understand the necessary information for needed services and to make appropriate health decisions. These capacities are relatively stable over time, although they may progress with training programs or decrease with increasing the age and pathological processes that affect cognitive function (10, 11)

Today, health literacy is recognized as an important and vital indicator affecting the results and costs of health care, and having high health literacy is required by the health care system (11). Health literacy affects health-related behaviors and the use of health services and also affects health outcomes in the community (12). Studies show that people with low health literacy confront with more problems such as; arbitrary and uncontrolled use of drugs, failure to follow the doctor's instructions, poor control of blood sugar status, low health knowledge and lack of expression of health and hygiene concerns, as well as inappropriate communication with physicians (10-13) and on the other hand increase health literacy can affect well-being, increase health and reduce health inequalities (14). A

person's health literacy may vary depending on the medical problem under treatment, the health care provider, and the care delivery system (11). Gender, level of education, place of residence and economic status have been the most important factors that have been considered in different studies and on different population groups, and in most studies, the level of education and economic status have been mentioned as two factors affecting health literacy (12,13, 15).

Azimi et.al, in a study entitled "Comparison of Health Literacy of Medical and Non-Medical Students of Shahid Beheshti Universities in 1394", concluded that 26.4% of medical students had inadequate health literacy and 31.2% had adequate health literacy. Also, 44.8% of non-medical students had inadequate health literacy (16).

In Sajjadi's study on non-medical students in Isfahan, the findings showed that 2.4% of students had inadequate health literacy and 3.8% of them had not-enough health literacy (17).

Students were selected as the study population due to their age and educability.

The objectives of the present study include the study of social health status and level of health literacy in non-medical students. With regard to the importance of the role of health literacy in promoting community health, the necessity of doing studies in this area to use an effective strategy to improve health status and especially for students who are the future of this community is evident. The concept of social health, along with the physical and mental dimensions of health and its social aspect, is assessed by focusing on the individual and in relation to interpersonal interactions and their social participation (2). Most of the studies conducted in the country have examined the relationship between health literacy and general health and its mental dimension, and not much attention has been paid to the social dimension

of health, which present study intends to address this issue.

## Materials and Methods

The present study is a correlational survey study which conducted in the academic year of 1397-1398. The statistical population was all students studying in non-medical fields of Islamic Azad University, Rasht branch (faculty of humanities and technical sciences). The sample size was estimated based on Krejcie and Morgan table which corresponds to Cochran's formula and ratio formula in estimating the sample size. In cases where we do not have the population variance or error percentage, we can use this table to estimate the sample size in survey studies. Based on this, for the present study, a sample size of was obtained 196 people, which finally 200 people were studied. Sampling was proportional quota method which was calculated based on the number of students in each faculty (127 students of humanities sciences and 73 students of agriculture faculty). Inclination criteria included studying at the Islamic Azad University of Rasht at the time of conducting the study, lack of educational background in fields related to medical sciences, satisfaction with participating in the study. Also, previous educational background in medical sciences groups and incomplete completion of the questionnaire were among the exclusion criteria. The instruments used included two sections, demographic information and two questionnaires of adult health literacy and Keys social health.

Adult Health Literacy Questionnaire (HELIA<sup>1</sup>)

This questionnaire, which was designed by Montazeri et.al and its reliability and validity has been confirmed (9), includes 33 phrases which evaluate health literacy in 5 dimensions of access (6 items), reading skill (4 items), comprehension

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1. Health Literacy for Iranian Adults

(7 items) measurement (4 items), decision making, and the use of health information (12 items). It should be noted that this tool is not dedicated to a specific stratum, occupation, education and age group and can be used for different population groups (12-14).

The scoring criteria to items is done using the 5-point Likert scale. Therefore, the “not at all”, “never” and “absolutely hard” options get a score of one, and the “always” and “totally easy” options get a full score of five. In this study, the level of health literacy of the participants, with regard to the scores obtained based on the cut points of 50, 66, and 84 were divided into four categories; insufficient (0 to 50), not enough (50/1 to 66), sufficient (66/1 to 84) and excellent (84/1 to 100) (8). The raw scores of each person in each sub-measurement are obtained from the algebraic sum of the scores, then the following formula is used to convert it to the 0-100 spectrum:

$$\frac{\text{Minimum possible raw score} - \text{Obtained raw score}}{\text{Minimum possible score} - \text{Maximum possible score}} \times 100$$

To obtain the total score, we divide the total scores calculated for each subscale by 5 (18). To perform the chi-square test, the sum of the scores of the two categories “not enough” and “insufficient” was limited to the category of health literacy and the sum of the two categories “excellent” and “sufficient” was reported as the category of desired health literacy.

### Keyes Social Health Questionnaire

In the present study, Keyes social health 33-items scale was used to examine the social health status and its components (19). This questionnaire, which is self-report one, was translated into Persian by Saffarinia and Tabrizi (1391) and then the Persian version was translated into English and consists of 33 items and 5 subscales of “social adaptation”, “social cohesion”, “social participation”, “social prosperity” and “social

acceptance” (2). The component of social adaptation means believing that society is understandable, logical and predictable, knowing and being interested in society and its related concepts; which consists of six questionnaire questions. Social cohesion means to feel being part of society and thinking that person belongs to society, feeling supported through society and having a share in it; this component also has seven questions. Social participation means the feeling that people have valuable things to offer to the community and thinking that their daily activities are valued by the community; this component consists of six questions. Social prosperity means knowing and believing that society is growing positively, which includes seven questions of the questionnaire, and ultimately social acceptance means having a positive attitude towards people, acknowledging others, and generally accepting people in spite of some of their confusing and complex behaviors. This component has seven questions (1, 4).

The answers are based on a 5-point Likert scale (strongly agree, agree, have no opinion, disagree and strongly disagree) and each option is assigned a score of 5, 4, 3, 2 and 1, respectively. The lowest possible score in social health is 33 and the highest possible score is 165 and the range of obtained scores is divided into three groups of: low social health (score 33-77), average social health (score 78-121) and high social health (score 122-165) (1). It should be noted that 18 items of this questionnaire (items 29, 32-11, 13-16, 24-26, 5) are scored reversely (20). The validity and reliability of this instrument have been confirmed in various studies conducted in the country (21-23). In the study of Hashemi et al. (1393) which aimed to determine the psychometric properties of the short form of this questionnaire, the obtained Cronbach’s alpha was reported equal to 0.81 (23). Babapour et

al. (1388) used internal consistency to evaluate the reliability of this tool and reported that the obtained alpha for the whole scale was 0.78, and it was 0.74 for social participation, 0.74 for social acceptance, 0.71 for social correlation, 0.70 for social prosperity and 0.77 for social cohesion for each of the subscales, respectively, which shows that this tool has a good reliability. The content validity of this questionnaire has also been confirmed (24). All questionnaires were completed by the individuals themselves after obtaining their informed consent. The information record of the individuals was anonymous and all students were assured that the information received from them would be kept confidential and used only for research and if they wish, they can be informed of the results of the

research. Finally, the data were analyzed with SPSS software version 23. To analyze the data, descriptive statistics (frequency distribution, mean and standard deviation) and analytical statistics (Chi-square and Pearson correlation coefficient) were used in which confidence coefficient was considered 95% and the significance level was considered  $p < 0.05$ .

## Results

The present study was aimed to investigate the status of health literacy and social health and their correlation in non-medical students. The mean age of the students was  $6.36 \pm 25.28$  years and ranged from 18 to 45 years; and the majority of them were under the age group of 25 years (Table 1).

**Table 1- Frequency of health literacy status in students in terms of demographic variables in them**

Chi-square test	Health Literacy				%	N	Demographic variables	
	Enough		Not Enough					
	%	N	%	N				
0.26	69.2	90	61.4	43	65.5	133	Female	Gender
	30.8	40	38.6	27	33.5	67	Male	
0.45	81.5	106	85.7	60	83	166	Student	Job
	18.5	24	14.3	10	17	34	Employed	
0.56	62.3	81	68.6	48	64.5	129	Less than 25	Age (years)
	18.5	24	12.9	9	16.5	33	25-30	
	19.2	25	18.6	13	19	38	Above 30	
0.26	17.7	23	20	14	18.5	37	Associate Degree	Level of Education
	60	78	67.1	47	62.5	125	BSc	
	22.3	29	12.9	9	19	38	MSc& Ph.D.	
0.74	15.4	20	11.4	8	14	28	Weak	Income status
	19.2	25	20	14	19.5	39	Medium	
	65.4	85	66.6	48	66.5	133	Good	
0.62	78.5	102	81.4	57	79.5	159	Single	Marital status
	21.5	28	18.6	13	20.5	41	Married	

One –hundred thirty-three participants (66.5%) were women and the largest number of them (62.5%) were studying at the undergraduate level. The mean and standard deviation of health

literacy score in the individuals was 100 scores ( $12.96 \pm 69.59$ ). Also, the minimum score was 30.8 and the maximum score was 98.3. Six percent of students (12 students) had inadequate health

literacy, 29% (58 students) had not-enough health literacy, 51.5% (103 students) had adequate health literacy and 13.5% (27 students) had excellent health literacy. The highest mean

score (76.61) was related to comprehension and understanding. The mean raw and standardized scores for the dimensions of health literacy are given in Table 2.

**Table 2: Frequency of student scores based on Health Literacy dimensions**

Dimensions of Health Literacy	Raw Mean (SD)	Standardized Mean	Minimum score	Maximum score
Reading skills	14.59(3.42)	66.16	4	20
Access	23.20(3.94)	71.65	9	30
Understanding	28.45(4.48)	76.61	13	35
Assessment	15.22(2.54)	70.13	6	20
Decision Making behaviour	42.44(7.95)	63.42	18	60
Total Health Literacy	120.38(16.26)	69.59	68	157

The mean and standard deviation of the social health score was  $11.09 \pm 109.87$  and the minimum score was 78 and the maximum was 147. The results showed that the social health status of 85.5% of students was at average level and 14.5% of them were at high level. It should be noted that in the present study, none of the individuals were low in terms of social health. Also, in relation to social components,

the mean score of individuals in the component of social cohesion was 24.45, social prosperity was 21.34, social acceptance was 20.61, social participation was 19.61 and in the component of social adaptation was 23.86. Therefore, the lowest score was obtained in the dimension of social participation and the highest was related to the dimension of social cohesion (table 3).

**Table 3: Frequency of student scores based on social health dimensions**

Dimensions of social health	Mean	SD	Minimum score	Maximum score
social solidarity	24.45	4.13	11	35
Social flourishing	21.34	3.84	13	31
social acceptance	20.61	3.02	12	28
social participation	19.61	3.52	10	29
Social adaptation	23.86	3.11	15	34
Total score of social health	109.76	11.02	78	147

The results of chi-square test did not show a statistically significant relationship between any of the demographic variables examined in this study (age, gender, education level, income status and marital status) with health literacy in students (table 1). Also, there was no statistically significant relationship between demographic

variables and social health status of students (table 4).

Other findings of the present study showed that there was a statistically significant correlation between the variables of individuals' age and their social health score ( $p = 0.02$ ,  $r = 0.165$ ), but this correlation was not significant for

health literacy score ( $p = 0.5$ ,  $r = 0.04$ ); but in examining the dimensions of social health, there was a significant correlation only between the dimensions of social cohesion ( $p = 0.02$ ,  $r = 0.162$ ) and social acceptance ( $p = 0.004$ ,  $r = 0.205$ )

with the age of students. It was not observed any statistically significant correlation between social health scores and health literacy of the students ( $p = 0.44$ ,  $r = 0.05$ ).

**Table 4: Frequency of social health status in students in terms of demographic variables**

Chi-square test	Social Health				N	Demographic variables	
	Good		Medium				
	%	N	%	N			
0.58	62.1	18	67.3	115	133	Female	Gender
	37.9	11	32.7	56	67	Male	
0.61	86.2	25	82.5	141	166	Student	Job
	13.8	4	17.5	30	34	Employed	
0.41	55.2	16	66.1	113	129	Less than 25	Age (years)
	17.2	5	16.4	28	33	25-30	
	27.6	8	17.5	30	38	Above 30	
0.38	17.2	5	18.7	32	37	Associate Degree	Level of Education
	72.4	21	60.8	104	125	BSc	
	10.3	3	20.5	35	38	MSc& Ph.D.	
0.41	6.9	2	15.2	26	28	Weak	Income status
	17.2	5	19.9	34	39	Medium	
	75.9	22	64.9	111	133	Good	
0.60	75.9	22	80.1	137	159	Single	Marital status
	24.1	7	19.9	34	41	Married	

## Discussion

As the results of the study show, 35% of the surveyed students had insufficient or not enough health literacy. Findings of Saatchi et al.'s study showed that 35% of the individuals had not-enough health literacy, 18.21% had adequate health literacy, 12.29% had inadequate health literacy and 7.14% had excellent health literacy (15). In the study of Zareban, on the female population of 7 cities in Baluchistan region, the majority of the individuals under studied had insufficient or borderline health literacy and individuals with higher health literacy level assessed their general health status better (25).

The results of Mahmoudi's study on non-medical graduate students of Ferdowsi University

of Mashhad also showed that 25% of these students had inadequate health literacy, 38.31% had borderline health literacy and 36.69% had adequate health literacy (26). Relatively, it can be said that the surveyed students in the present study are in a better position in terms of health literacy than similar studies. Such a situation can be expected regarding that the dimension of access to health information is appropriate and the dimensions of understanding and decision-making of behavior are also reported high in them. Individuals must be able to understand and use sufficient information provided to them in specific health settings to make appropriate health decisions (25). Tavousi et.al in a study examining

the national health literacy of Iranian adults by helping the questionnaire of the present study, showed that the areas of access and evaluation in the field of health literacy had lower scores than other areas and the highest frequency of desirable health literacy was reported in understanding and comprehension dimension (69.5) and the lowest of it was reported access rate dimension (44.6) (27).

The findings of Ahmadi's study on students of Farhangian University also indicate that the highest mean score was related to understanding and comprehension dimension and the lowest was related to the decision making and behavior dimension (12). In his study, Mohammadpour concluded that health literacy, especially in terms of understanding, comprehension and ability to extract information and consequently achieving a correct understanding of the basic concepts of diet, correct implementation of medication program, physical activity, has positive and significant relationship with improving the patient's clinical condition (28).

The results of the present study related to the social health status of non-medical students in Rasht branch showed that the majority of them were in the average level and the highest mean score was related to the social cohesion dimension and the lowest was related to the social participation dimension. Omidy in his study reported social health in students higher than average (29); which shows a better status than the students studied in the present study. Various factors such as socio-economic conditions, sampling method and even the studied major (educational field) can be related to creating these differences. In a Javadi's study conducted on medical students in Gilan, the results of the mean scores obtained in various dimensions of social health showed that the highest means were related to the social cohesion dimension

and then the social prosperity dimension and the lowest related to the social adaptation dimension (20). Keyes believes that people with higher social cohesion try to maintain their cohesion when confront with unpredictable events, and in fact, this dimension of social health shows the individual's understanding of the quality of his social world and how it is organized and operated (30). Social adaptation is the understanding of the quality, organization, and function of one's social world. A socially healthy person tries to know more about the world around him. In general, social adaptation is equivalent to the concept of seeing the world in a logical, intelligent, understandable and predictable way (31).

Social acceptance is also a social example of self-acceptance (one of the dimensions of mental health). In self-acceptance, a person has a positive attitude about himself and his past life, and despite his weaknesses and disabilities, he accepts all aspects of his life. In social acceptance, on a larger scale, the individual believes in and accepts society and its people with all its defects and positive and negative aspects (4); which this dimension of social health and following that, the dimension of social participation in our individuals was lower than other dimensions of social health. It should be acknowledged that when people in society can communicate easily and without tension, and maintain stable relationships with others, they will achieve their goals more easily, and this affects other aspects of their health (29).

The results of various studies indicate that social health in individuals increases with increasing the age (4, 31), which is consistent with the results of the present study. One of the important results of the present study was that their social health increased with increasing the age. Keyes also found in his study that social health generally increases with increasing the age and



believed that skills, resources, and experiences increase with increasing the age and help people cope better with social challenges (29).

Although, no correlation was observed between social health and health literacy in the findings of the present study, but the results show that health literacy empowers people to play an active role in changing environments to affect health and considers as a capital for social capital development and accountability to the health inequalities as well as a key component for the health of populations (11).

The results of various studies indicate this matter that health policy makers should consider health literacy as one of the most important tools for improving self-care to formulate and design implementable programs and patterns in the community. It seems that one of the important ways to promote health literacy in people is to access appropriate information. Service providers must be aware of the abilities of individuals to process health information in order to improve their health, and they must also be able to transfer information to people with different levels of health literacy. Therefore, one of the important approaches in this field is the training of health system staff in this field. On the other hand, health education programs which offered through various media, should also have a greater focus on health literacy issue. One of the most cost-effective tools for promoting health literacy is cyberspace and the internet, which can be a good background for the growth and increase of health literacy due to ease of access.

One of the limitations of the present study is that the questionnaires completion was done in a self-reporting manner, which it may not have the necessary accuracy, although the necessary explanations were given to individuals regarding the confidentiality of the answers.

Also, the sampling method in this study was non-probability method and the number of men was lower than the women under study, which may affect the results obtained, so it is suggested that in future studies, sampling should be done randomly and with a more appropriate sample size of students' gender.

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### References

1. Haery M, Tehrani H, Olyaeimanesh AR, Nedjat S. Factors influencing the social health of employees of the ministry of health and medical education in Iran. *Iran J Health Educ Health Promot.* Winter 2016;3(4): 311-318.
2. Saffarinia, M. Social factors of Health psychology in Iran. *Quarterly journal of health psychology,* 2014; 3(11): 102-119.
3. Zamankhani F, Abachizadeh K, Omidnia S, Abadi A, Hiedarnia M.A. Social Health Situation Analysis of all Provinces of Islamic Republic of Iran. *Community Health* 2016; 3 (3): 181-89.
4. Zahedi asl M, Pilevari A. A Meta- Analysis of Social Health Studies. *Social Development & Welfare Planning,* 2015; 5(19): 71-107.
5. WHO. Commission on Social Determinants of Health-final report. (2008). [https://www.who.int/social\\_determinants/thecommission/finalreport/en/](https://www.who.int/social_determinants/thecommission/finalreport/en/).
6. Tavakol M. Social health: dimensions, components, and indicators in Iranian and world Studies. *Bioethics journal,*2014;14(4):115-135.
7. Marmot M, Friel S, Bell R, Houweling TA, Taylor S, & Commission on Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health. *The lancet.*2008; 372(9650), 1661-1669. [https://doi.org/10.1016/S0140-6736\(08\)61690-6](https://doi.org/10.1016/S0140-6736(08)61690-6)
8. Javadzade SH, Sharifirad G, Reisi M, Tavassoli E, Rajati F. Health literacy among adults in Isfahan, Iran. *J Health Syst Res* 2013; 9(5): 540-9
9. Esna ashari F, Pirdehghan A, Rajabi F, Sayarifard A, Ghaderian L, Rostami N, Pirdehghan M. The study of health literacy of staff about risk factors of chronic diseases in2014. *Avicenna journal of clinical medicine.*2015;22(3):248-254.
10. Afshari M, Khazaei S, Bahrami M, Merati H. Investigating Adult Health Literacy in Tuysarkan

- City. *J Educ Community Health*. 2014; 1 (2):48-55. <https://doi.org/10.20286/jech-010248>
11. Panahi R, Ebrahimi G, Ahmadi A. Health Literacy: A Key Component of Controlling Social Determinants of Health. *J Educ Community Health*. 2018; 5 (1):1-3. <https://doi.org/10.21859/jech.5.1.1> <https://doi.org/10.21859/jech.5.3.1>
  12. Ahmadi FZ, Mehr-Mohammadi M, Talaee E, Fardanesh H, Paknahad M, Taghizadeh S, et al. Health Literacy among students of Farhangian University. *Payesh*. 2018; 17 (3):257-266.
  13. Reisi, M. Mostafavi, F. Hasanzadeh, A. & Sharifirad, G. The relationship between health Literacy, health status and healthy behaviors among elderly in Isfahan. *Health System Research*,2011;7(4). 469-480.
  14. Lee YM, Yu HY, You MA, Son YJ. Impact of health literacy on medication adherence in older people with chronic diseases. *Collegian* 2017;24(1):11-8. <https://doi.org/10.1016/j.collegn.2015.08.003> PMID:29218957
  15. Saatchi M, Panahi M, Ashraf Mozafari A, Sahebkar M, Azarpakan A, Baigi V et al. Health Literacy and Its Associated Factors: A Population-Based Study, Hormuz Island. *irje*. 2017; 13 (2):136-144
  16. Azimi S, Ramezankhani A, Rakhshani F, Ghaffari M, Ghanbari S. Comparison of health literacy between medical and non-medical students in Shahid Beheshti Universities in the academic year 92-93. *Pejouhandeh* 2015; 20(2): 78-85.
  17. Sajadi F A, Sajadi H S, Panahi R. Health Literacy of University Students and its Influential Factors: A Case Study at Isfahan University. *J Educ Community Health*. 2020; 7 (1):23-28. <https://doi.org/10.29252/jech.7.1.23>
  18. Montazeri A, Tavousi M, Rakhshani F, et al. Health Literacy for Iranian Adults (HELIA): development and psychometric properties. *Payesh* 2014; 13:589-599.
  19. Keyes CL, Annas J. Feeling good and functioning well: Distinctive concepts in ancient philosophy and contemporary science. *The journal of positive psychology*. 2009 May 1;4(3):197-201. <https://doi.org/10.1080/17439760902844228>
  20. Javadi N, Darvishpour A, Khalili M, Barari F. The survey of social wellbeing and related factors in students of Guilan Medical University in 2015. *Research in Medicine*. 2017; 40 (4):197-203.
  21. Heidari GH H, Ghanaei Z. The normalization of well-being social inventory. *Andishah va Raftar*. 2008; 2(7): 31- 40.
  22. Zaki M A, Khoshouei M. Factors affecting social well-being of the city of Isfahan. *Urban studies*.2013; 3(8): 79-108.
  23. Hashemi T, Hekmati I, Vahedi SH, Babapour J. Psychometric properties of short-form social well-being questionnaire. *Journal of Behavioral Sciences*. 2014; 8(1):11-19
  24. Babapour Khair al-Din J, TusiF, Hekmati I. Investigating the role of determinants in students' social health University of Tabriz. *Scientific-Research Quarterly Journal of Psychology*. 2009;16:8-26.
  25. Zareban, I. Izadirad, H. Jadjal, K. Evaluation of health literacy, health status and health services utilization in women in Baluchistan region of Iran. *Journal of Health Literacy*, 2016; 1(2): 71-82. doi: 10.22038/jhl.2016.10852 <https://doi.org/10.20286/jech-02036>
  26. Mahmoudi H, Taheri A. relation between information literacy and health literacy of students in Ferdowsi university of Mashhad. *Human information interaction*.2015;2(2):31-41.
  27. Tavousi M, Haeri MA, RafiefAR S, Solimani A, Sarbandi F, Ardestani M, et al. Health literacy in Iran: findings from a national study. *Payesh* 2016;15(1):95-102.
  28. Mohammadpour M, Zarifinezhad E, Armand R. A Study of Correlation between Applied Health Literacy and Self-Care Behaviors in Hypertensive Patients of Gachsaran City, 2016 (Iran). *Qom Univ Med Sci J*. 2018; 12 (10):55-65 <https://doi.org/10.29252/qums.12.10.55>
  29. Keyes, C. L. M. & Shapiro, A. D. Social Well-Being in the United States: A Descriptive Epidemiology. In O. G. Brim, C. D. Ryff, & R. C. Kessler (Eds.), *The John D. and Catherine T. MacArthur foundation series on mental health and development. Studies on successful midlife development. How healthy are we? A national study of well-being at midlife* (p. 350-372). 2004, University of Chicago Press.
  30. Rezaei O, Noghani Dokht M. The social well-being of university students and factors affecting it. *Journal of Social Sciences*,2016; 14(2): 9-13.
  31. Fathi M, Ajamnejad R, Khakrangin M. Factors Contributing to Social Health among Teachers of Maragheh City. *Social Welfare Quarterly*. 2013; 12(47): 225-243.

