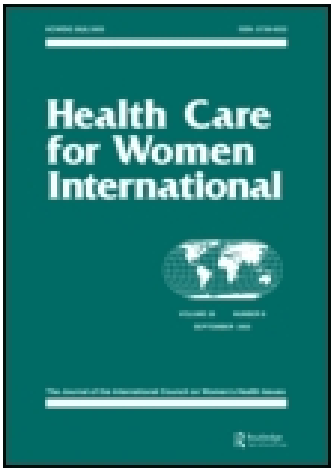

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Women's Health Bridges and Barriers: A Qualitative Study

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Women's Health Bridges and Barriers: A Qualitative Study

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The authors aimed to understand the social bridges and social barriers to women's health in Iran. We used a qualitative content analysis method and interviewed 22 women. The participants identified appropriate employment, physical exercise, and cultural and educational development as social bridges to women's health. Social barriers to women's health included gender inequalities, burden of responsibility, and financial difficulties. Based on the results of this study, we suggest an interdisciplinary approach to plan social-based health programs in order to improve women's health outcomes in the developing countries such as Iran.

Women's health is of crucial importance to family and social systems. In particular, mothers' health is fundamental to development and is associated with socioeconomic growth and prosperity. In many societies, women are the guarantors of future generations, and their importance remains often dimmed or hidden behind male management (MacKian, 2008).

Women's exposure to increasing risk factors such as smoking, job conflicts or job stress, AIDS, and cancer as well as social problems such as family

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violence, poverty, and sexual abuse makes the importance of research into the fields of women studies more relevant and necessary (Mazure, Espeland, Douglas, Champion, & Killien, 2000). Moreover, many women are engaged in low income jobs and face dangers that threaten their health and life as a result of their professions (Nelson et al., 1996).

Based on our review of the literature, we suggest that women are subjected to a variety of gender inequalities including sexual violence inside or outside of marriage, reproductive health difficulties, professional stress, and stresses arising from social factors, opportunity for physical exercise, and exposure to other high risk behaviors. Some examples of the literature from developing countries include a study investigating women's status among Egyptians where the authors revealed that 94% of women were illiterate and 97% were housewives. Women and girls encountered diseases more than their older male counterparts with higher rates of obesity among women compared with men (Kharboush et al., 2005).

In Pakistan, researchers explored women's perceptions and experiences of sexual violence using a qualitative approach noting that sexual coercion and nonconsensual sex were common and not limited to abusive relationships. Difficulties in negotiating safe sex resulted in unwanted pregnancies, some leading to unsafe abortions. Women reported escalation of violence during pregnancy to be common. Social norms prevented disclosure of sexual violence, leading to limited support or intervention or both (Hussain & Khan, 2008).

In the Far East, Tian, Li, Zhang, and Guest (2007) evaluated the status of reproductive health among the Chinese women through a qualitative method and concluded that men have more and better access to reproductive health care services. Incorrect diagnosis, overtreatment and IUD insertion with unsterilized tools contributed to the persistent high rate of reproductive tract infections (RTIs) in the study settings. Undesirable contraceptive devices, insufficient health information, a strong tendency for keeping male embryos and attempts to abort female embryos, and higher payments for baby boys compared with baby girls are reported as obvious examples of gender prejudice.

Investigators of the relationship between professional and family stress and the status of women's health in South Korea found a positive correlation between social support and health status, whereas they observed an inverse association between professional and family stress and state of health (Kim, Won, Chung, Lucy, & Kim, 2005).

Swedish researchers reported the results of a study evaluating the relationship between socioeconomic changes and health status of single mothers, concluding that low education was correlated with higher morbidity and mortality, poverty, unemployment, poor accommodation, and undesirable health behaviors with more violence and hospitalization among low income sectors of the society (Fritzell, Ringbäck, Weitoftb, Fritzell, & Burström, 2007).

In Iran, women are experiencing a developing transition. Educational improvement and improved social position have been reported in a national study by the Iranian Centre for Studies and Research on Women (2005). Ahmadnia (2003) in a study conducted on the effect of women's employment reported an increasing rate in women who are employed and who also maintain a family role. The combination of both roles was considered an important factor in women's health.

Goshtasebi, Vahdaninia, and Rahimi Foroshani (2009) studied the physical aspects of women's health and evaluated women's attitude and how it reconciled women's housekeeping with outside employment. The authors reported that a majority of women (60%) who worked in outside employment believed that a contradiction exists between outside employment and housekeeping. The informants preferred their traditional role as homemakers because of social obstacles.

In a population-based study of Iranian women, Goshtasebi et al. (2009) investigated the prevalence and potential risk factors for female sexual difficulties. They found that more than 52% of the participants had experienced at least one type of sexual difficulty. The greatest frequencies were observed for difficulty with orgasm (21.3%) and difficulty with lubrication (11.9%).

Based on the documents we found that the study of women's issues in Iran is important as there are few studies on Iranian women's social health and even fewer on women's perspectives on health using qualitative methodology (Ahmadnia, 2003; Goshtasebi et al., 2009; Iranian Centre for Studies and Research on Women, 2005; Khodadadpour & Deilamy, 2009).

Qualitative research is based on a naturalistic paradigm and is appropriate in understanding social and humanistic phenomena regarding context (Polit & Beck, 2006). Johansson, Huang, and Lindfors (2007) believe that the perception and discovery of the meaning of health could affect different areas of development programs for women's health. The potential of qualitative research in examining a diversity of social factors, depth of health phenomenon, women's vulnerability, the fundamental role of their health in family health and the reflection of women's health status in development indices are among the reasons that our team was encouraged to undertake a qualitative study on the effect of social factors on women's health.

METHOD

A qualitative approach was adopted to enable the research team to explore women's social perspectives on health. Qualitative methods focus on understanding the phenomena and are suitable for uncovering the nature of people's experiences, beliefs, feelings, or preconceptions (Macnee & McCabe, 2006). Using a qualitative method, the researcher can uncover social

processes and understand human experiences (Lobiodo-Wood & Haber, 2006).

We analyzed the data using a qualitative content analysis. This is a process of understanding, interpreting, and conceptualizing the meaning in qualitative data (Macnee & McCabe, 2006). The data are broken down into meaningful units and then developed into categories (Lobiodo-Wood & Haber, 2006) with the intention of identifying prominent themes and patterns among the themes (Polit & Beck, 2006).

Initially, we reviewed the products of verbal communications of all participants. The statements were transcribed from the tapes, and the nonverbal context of interviews was recorded. Next, we broke down the content into the smallest meaningful units, called themes or codes. Next, the codes assigned were reviewed many times and classified based on similarity of the meaning. Then they were categorized into categories and subcategories. Every time, we made the necessary changes regarding the number, content, and the name of categories. The participants, the research team members, and the peers revised some of the codes and final categories. They reached common agreement regarding the meaning of data as well as content and names of the categories (Krippendorff, 2004; Morgan, 1993).

Sampling and Data Collection Process

We collected and analyzed the required data simultaneously based on the content analysis method. Twenty-two women were recruited from a variety of places including sport clubs, homes, and parks in Tehran (capital of Iran). The inclusion criteria follow: being at reproductive age (postmenarch and premenopausal), being healthy (not suffering from any current illness at the time of research, not taking medication for any chronic diseases), and willingness to be interviewed about women's health and social factors.

One of the research team members approached the women to explain the research goals and the interview guide questions of the study. If they agreed to take part in the research, an appointment was made for the time and the place of interview. Since the research was a qualitative study, open-ended and semistructured interviews were conducted by employing interviewing skills. The guided questions follow: (a) How do you view your health as a woman regarding social factors?; (b) In your opinion, what social bridges and barriers affect women's health?; (c) Does society care about women's health?; and (d) If we had a minister of social affairs and if you were appointed for that position, what would you do for women's health?

Added points raised by the women helped the researchers to develop the interview guide over time. The interviews were conducted over one to two sessions, with an average of 60 minutes. They were audiotaped and transcribed as soon and as fully as possible.

We collected and analyzed the data during a 1-year period from mid 2006 until data saturation. This occurs when themes and categories in the data become repetitive and redundant, such that no new information can be obtained by further data collection (Polit & Beck, 2006).

Data Trustworthiness

We developed the conformability of the data (similar to reliability and validity in quantitative research) through multiple methods:

- Prolonged engagement, allocation of adequate time, and good communication;
- External check, review of the handwritten materials including codes and categories by five participants (member checking), five other women who did not participate, and with colleagues (peer checking); and
- Through maximum variation of sampling, the opportunity to participate was offered to women from different socioeconomic statuses as to explain different social factors that affect their health (Streubert & Carpenter, 2003).

Ethical Considerations

Ethical approval was obtained from the Nursing Faculty Research Committee affiliated with the Iran University of Medical Sciences. Two first authors (SP and KK) as interviewers informed of all the women of the purpose and design of the study, recording permission, and the voluntary participation with concern to confidentiality and anonymity. We also asked for both written and oral informed consent from the participants. To protect their privacy, the interviews were conducted separately with the participation of only the interviewer and the interviewee.

FINDINGS

Participants' Characteristics

The participants consisted of 22 women aged 20–50 years. Twelve participants (48%) were 20–30 years old, 6 (24%) were 31–40, and 7 (28%) were 41–50. In terms of education, 11 women (44%) were at high school level, 5 (20%) had completed primary and elementary level, and 9 (36%) had university education. Eleven women (44%) were housewives, and the rest had external employment. Eight participants (32%) were single, one was divorced, and the rest (64%) were married. The participants' demographic data are presented in Table 1.

Two main categories, each comprising three subcategories, emerged through the analysis. These are presented in Table 2.

TABLE 1 Participants' Demographic Data

Demographic characteristic	No.	%
Age		
20–30	11	50
31–40	5	23
41–50	6	27
Education		
Primary and elementary school	4	18
High school	10	45
University	8	37
Marital status		
Single	7	32
Married	14	64
Divorced	1	4
Occupation		
Housekeeper	10	45
Occupied	12	55
Total	22	100

Women's Social Bridges

Appropriate job. The importance of good career and employment opportunities were emphasized by most of the participants, including those who were employed and those who were housewives. To have a useful economical hobby, to be away from home tensions, to obtain independence, and to have a voice in society were revealed as useful reasons for women's employment. Based on the participants' views, having a job was reported as an important factor to women's independence, empowerment, and social participation. Employment was also reported as a shelter, a relaxation factor, or protecting women from their husbands' orders. The participants also emphasized the necessity of proper remuneration, the availability of child care facilities at the workplace, lower daily working hours, a reduction of total working years for retirement, and finally a healthy work environment for women.

TABLE 2 Main Categories and Subcategories

Main categories and their subcategories
• Social bridges of women's health
○ Good career
○ Women's physical exercises
○ Cultural and educational development
• Social barriers of women's health
○ Gender inequalities
○ Burden of responsibilities
○ Financial difficulties

The financial aspects of a job were considered less important than its social aspects. Some of the participants experienced a sense of limitation and sex discrimination, discomfort, and ill health when their husband or their father (for those who live with their parents) did not allow them to have employment.

Based on the participants' views, despite all useful outcomes, the women who had full-time jobs worried about neglecting their children and having role strain and employment tensions. A participant stated, "Employed women have more problems; they have the burden of both housework and job responsibilities. When they arrive home, their housework just starts."

According to our participants, in a socially health community women participants thought that they should have attained career equality based on their individual skills and characteristics, with fewer working hours and more services provided for their children by their employer such as kindergarten.

Physical exercises. Doing exercise is one of the main social factors the women noted as related to women's health. As one participant said, "Exercise is very important for women's health. Women experience lots of housework, pregnancy, and lactation, so they need it more."

Exercise provides a sense of freshness. New public protected areas for women's physical exercises have recently been developed, including women's clubs and women's parks; thus the women can be identified as equal citizens with men accordingly.

Our participants revealed that women need more female-only sports areas, more exercise classes, the increase of public exercise, and more knowledge and information about the benefits of exercise to their health. A participant said, "Today we have lots of places and facilities for women's exercise, but there are many women who even don't know about them. Some are too shy to participate in such physical activities especially in public places."

In contrast, another participant stated, "We, as women, sometimes are broadcasted by feminist propaganda, but it is like a fashion, a mode, it seems that now they (policymakers) are preparing for women to exercise" (Participant 11, aged 44).

Education and cultural growth. Education and cultural growth were identified as another important factor contributing to women's social health. Our participants confirmed that cultural growth is both a right and a prerequisite for women's development. A participant stated:

> Therefore, it is necessary to educate women, especially to a higher level as this will make them more aware and more careful about their rights. Now there are more women in close competition with men in higher education and in scientific Olympiads; this is a kind of improvement and equality.

One participant revealed the following: "They (women) are obtaining good academic positions, so they are increasingly being empowered more and more, they are attaining good positions." Another participant gave her perspective:

> In the past, women were under the pressure and authority of men; but everything has changed. With cultural growth they have achieved; now they are the center of attention and, with the financial independence and numerous social successes, they are no longer under the authority of men. (Participant 8, aged 38)

A participant stated that there is a direct relationship among income, literacy, and health in women, and that women need to learn how to manage their families, how to solve their problems, and how to live healthy.

Social Barriers to Women's Health

Gender inequalities. Some of the participants complained about gender inequality. This was a concept that was revealed by the participants in different and complex ways such as "negative/painful experiences," "becoming happier to have a male embryo, even during prenatal period," and "don't spend enough money on their wives after marriage." The participants from lower socioeconomic groups experienced more frequent and more negative experience of gender inequality. One of the participants said, "I am 47, I have four children, but I still have to ask for my husband's permission for every little thing, I have no freedom." Another participant explained the discrimination as follows: "When they want to curse somebody, they say, 'You are even more inferior than a woman'. It seems that being a female is a kind of curse."

Burden of responsibilities. Multiple and difficult duties were identified as another social barrier determining the women's health perceptions. The married women and those who had children experienced more responsibility and overload than singles and those with no children. The participants mentioned less marital satisfaction and less support from their husband, as one participant stated:

> Nobody cares for us (housewives); you are busy with cleaning, washing, and cooking at home from the very morning to night, but nobody appreciates you. I wish somebody cared about me, thought about me, listened to me, or even just said a small thankyou.

Overall, the women with multiple roles reported more negative health problems and less social support, and the single ones mainly complained of caring for their old sick parents.

Financial difficulties. Our participants described a wide variety of outcomes on both family health and women's health as a result of economic problems. Economic problems were often associated with marital conflict. It was commonly reported that women had a poor sense of well-being if the husband was in debt or was close to a loan repayment date or was experiencing high inflation rates resulting in financial pressure. They believed that these issues were associated with domestic violence among family members, especially between couples. A participant described her experiences: "I am hopeless, I think that everything is finished, we have lots of financial problems; we cannot tolerate it anymore." In contrast, single participants and those with jobs reported fewer economic problems.

DISCUSSION

Social Bridges of Iranian Women's Health

Social factors can create strong bridges or barriers to women's health. Recognizing the factors leading to health can improve the quality of life. Qualitative research can create a context-bound analysis regarding the participants' viewpoints. Our participants believed that social welfare and social factors were a prerequisite for women's health. Social facilities must be planned and developed according to the customers' (here women's) demands and viewpoints. In addition, it seems that the countries and people with similar culture and situations would have similar demands as well.

Employment

The perspective on outside employment is changing among women. Based on traditional views, outside employment was not considered good for women. Women were not used to working out of the house. Today, sociocultural changes have occurred such that more social security in available for women. Financial demands exist, and in many cases women are allowed to have outside employment. The negative view of employment for women has been modified. Our participants expressed having appropriate employment as a means of escape from family boredom and conflict and that it provides the possibility of fun and change particularly for those employed in higher positions. The participants put more emphasis on the human rather than financial aspects of employment. The social values of power and independence associated with employment were described as positive attributes toward women's sense of health and well-being. Such issues as employment-related stress and role conflict, however, were cited as the main drawbacks to employment. The women attribute positive qualities such as tranquility, peace of mind, authority, and independence to employment rather than only its income. Therefore, the cultural and social advantages of employment for women made them tolerate and cope with the job role strain.

In contrast to our findings, other researchers reported that financial reward was more important than the social ones for Iranian women (Johansson, Huang, & Lindfors, 2007). Nevertheless, Ketabi, Yazdkhasti, and Farrohki (2003) found that employed women of the Isfahan Province in Iran felt more empowered than unemployed women, which is consistent with the findings of this study of Iranian urban women. Similar to some of the participants in this research, Swedish women are less likely to be employed in professional roles. They mainly work in semiskilled employment and express that with higher academic attainment they could have more high status jobs with higher salaries (Johansson et al., 2007).

Although a study of South Korean women revealed intense psychosomatic stress and job stress associated with having multiple roles (Kim et al., 2005), there is a desirable, social change in Iran taking place with regard to women's employment. Iranian women now have increased access to the full range of higher education opportunities and the full range of employment opportunities, leading to a reduction in gender inequality (Iranian Centre for Studies and Researches on Women, 2005).

Women's Physical Exercises

The majority of our urban women participants believed that physical exercises were a path to health and well-being. From this study of urban Iranian women it appears that exercising in communal protected public places results in participants reporting a sense of self-worth and freedom. The Iranian Healthy People Program, which was programmed until 2010, values sport and physical activity also as determinants of health in common with other national and international organizations (Zurakowski, 2004). Evidence from Korea supported the effectiveness of aerobic exercise classes for Korean women as a health determinant and that exercise resulted in higher levels of self-efficacy and better health status in the intervention group (Chang et al., 2006). We expect similar outcomes in Iranian women, and there remains a need to popularize and advertise the exercise opportunities currently available for Iranian women in order to increase the uptake and access to this health intervention and so maximize community and individual benefits.

Educational and Cultural Growth

Our participants described that they were experiencing a transitional period and positive changes in the educational/cultural situation of Iranian women. Women are now excelling in academic and managerial positions and are gaining ever-greater achievements. Women's education and awareness are more than just obtaining knowledge through the achievement of an academic degree. There is also experiential learning that needs to be valued

and rewarded. The status of women's health and education may be better promoted in Iran than in some of the neighboring countries states, so it is not possible to generalize from these positive findings. For instance, in Pakistan access to education is reduced due to gender bias in enrollment. In addition, there are high drop-out rates among women at all levels of education resulting in lower literacy rates among Pakistani women (Rizvi & Nishtar, 2008).

The empowerment of women is closely associated with better knowledge of health issues and adoption of more responsibility for maintaining good health. Literacy is believed to be one of the significant indices of socioeconomic conditions and affects health and lifestyle more than other variables. Men and women use their knowledge differently to access the resources that affect health (Zajacova, 2006). Furthermore, higher education is known as an empowering factor among Iranian women for participation in development (Ketabi et al., 2003). Women play an important role in health, hygiene, and the educational progress of their children, so investment in educating women not only decreases the gender gap but also decreases levels of exploitation. On the other hand, it increases productivity and revenue (Zajacov, 2006).

In Iran, as a result of implementing the National Development Programs, according to the Iranian Centre for Studies and Researches on Women (2005), the gender gap in the area of education is narrowing as evidenced by an increase in the number of female admissions to a broader variety of subject areas and disciplines with successful outcomes. Higher education for women is synonymous with better employment opportunities and higher income and participation (Ketabi et al., 2003).

Although the value of globalization and transition is very important, it can sometimes be associated with some negative or ambivalent outcomes. The transitional phase being experienced in Iran has led some observers to note that there is a growing number of divorces, an increase in average age at marriage, and a lower fertility rate as a result of employment and education among women (Iranian Centre for Studies and Researches on Women, 2005).

Social Barriers of Women's Health

Gender inequalities. One of the most common complaints of our participants was that gender inequalities have affected various aspects of women's life. Similar to the participants in another Iranian study assessing health status in teenagers, the feeling of restriction as a result of social limitation was considered as one of the barriers to health (Parvizy & Nikbakht, 2002). Gender inequality is a global problem, and the adoption of gender equality for all women, the restriction on violence against women, and the empowerment of women to control their lives are a cornerstone

of development and population programs as highlighted in the United Nations' initiatives (Nelson et al., 1996). Research in Africa and Latin America have found that political development may coopt a broader gender equality agenda (Guang-zhen, 2007). In Pakistan, where there is marked gender inequality, there is lower access to women's health and well-being and, on average, women have poorer health status (Rizvi & Nishtar, 2008), though it is claimed that there is a unidirectional, linear process of change in the women's position in Pakistan from "traditional" women who lack "freedom and control" to "modern, autonomous women" (Mumtaz & Salway, 2005).

In a developing country such as Egypt, women have been shown to suffer from a high burden of socioeconomic disadvantage, gender inequality and illhealth (including obesity, gynecological problems, parasitic infections, and anemia; Kharboush et al., 2005).

Violence within the family is often considered a personal issue that is not discussed, but it frequently forms part of the individual woman's life, and women experiencing domestic violence are less likely to seek help. They often blame themselves and consider the problem as a personal matter (Hildingh et al., 2006). Our study showed that in a safe and secure environment, urban Iranian women are willing to discuss this issue and express their dissatisfaction. This suggests that with advocacy, this issue can be brought to the surface so that it can be appropriately addressed to reduce the suffering of the victims of domestic violence. With improvement in the general well-being of the society, the population becomes less tolerant of inequality including gender inequality. It seems that this is the right time in Iran to further address this agenda and that the positive developments should be shared in the wider region.

Burden of responsibilities. Burden of responsibilities was recognized as another aspect of the social barriers to women's health. The performance of different roles by women and the consequent pressure associated with it is a widespread topic in feminist literature. Women's health and health outcomes have attracted the attention of many researchers.

Indian women have been shown to experience a number of affective disorders such as depression associated with the differing responsibilities that they hold, feeling oppressed at home and also expectations resulting from the role of the mother-in-law in the Indian household (Pereirab et al., 2007). In this cultural context, oppression is perpetuated by women on women rather than men on women. In such a context, it may be more appropriate for education and antidiscrimination practice to be targeted at women from an early age to break this cycle.

Similar to our findings, Kim and colleagues (2005) described that, in recent years, women have played more diverse and complex roles and therefore experienced more stress in their personal and professional life. Hildingh and colleagues (2006) examined factors that predict a lack of female well-being and suggested that women who held more than four out of a list of

five roles (being a student, a mother, a sexual partner, an employee, and family head) had poorer health status as reflected by reporting more stress, experiencing more headaches and sleep disorder, and making more visits to physicians. We do not suggest that women should reduce the number of roles they undertake; rather, they need to explore including additional supports that may include participation in communal activities such as the sports activity initiative in Iran, which has shown a beneficial effect.

A study on Dutch women (Plaisiera et al., 2008) demonstrated that men benefited more from spousal support compared with women. While women suffer more depression and anxiety from multiple social roles, men tend to benefit from a diversity of social roles such as being an employee, husband, parent). Researchers in the field of women's studies need to further explore why men benefit from a diversity of social roles, while women's health suffer especially as women's health is considered to be the foundation of family health and of a healthy society.

Financial difficulties. Economic problems are sometimes the origin and, at times, the catalyst of family disputes and fights. Bonhomme (2007) reported that being a woman could increase the possibility of poverty, and this is reported in high-, medium-, and low-income countries. Pereirab and colleagues (2007) found that Indian women living in poor economic circumstances are more prone to depression, sleep disturbance, fatigue, and weakness. Low-income Egyptian women have also been shown to suffer from the high burdens of socioeconomic disadvantage, gender inequality, and ill health (Kharboush et al., 2005). This was also articulated by the women in our study and suggests that the social wider determinants of health have commonalities across cultures. In another developing country, Pakistan, women cite lack of control over their personal income and limited access to and control over economic resources as factors associated with poor well-being (Mumtaz & Salway, 2005). Taking all this into account, we agree with other researchers who note that gender equality is likely to result in both economic and political development (Guang-zhen, 2007).

Further Research

Further research is necessary to identify which of the wider social factors of health are most strongly associated with positive/negative health outcomes and well-being in women so that policymakers and governments can better allocate their resources in order to support women to get equal health benefits from multiple roles when compared with men. The role of religion and culture in developing countries such as Iran also needs to be explored in more detail so that the positive contribution of religion can be married with feminist principles in order to reduce the tension between the need to honor religious and cultural values and to honor the need for women's

development. Social researchers and scholars could study the life experiences of women engaged in social activities and in different job situations. Also a domestic model through the grounded theory method could be designed for women's social development in which the family structure and function is respected. Action researchers may also help to design and implement an interdisciplinary approach with the participation of a range of social workers and health care personnel for local decision making and problem solving for women in different social situations. Finally, social researchers can develop different tools for women's social health.

Study Limitations

Since this study was based on a small sample of women volunteers from the urban Tehran population, generalizability seems to be limited, though common human experiences, data trustworthiness, and rich and deep data through a qualitative perspective will compensate for this limitation. The characteristics and health perspectives of the women who were approached but refused to participate are unknown, which is in line with the ethical approval granted.

CONCLUSIONS

Women need more careful programming regarding social health aspects to prevent the adverse effects of development. To maintain the role of women in the family requires holistic and sustainable development. Academicians and policymakers have to explore potential consequences so that Iranian women can prepare to develop additional roles without compromising the fabric of family values. We recommend that social workers, health practitioners, and authorities use the data obtained from this study to gain a deep knowledge of the social challenges the women faced during their lives.

Furthermore, the knowledge achieved by this study can be a basis for other social research. An interdisciplinary approach, involving a range of social organizations that share the aim of enhancing social supports while harnessing the positive aspects of the religious and cultural context is likely to promote both a caring environment and the well-being of women, who are the custodians of the next generation. Removing gender discrimination, developing employment opportunities, supporting the practice of religious duties, and disseminating the public exercise programs will enhance women's health outcomes. The judiciary and legal system also needs to play a role in supporting women's health by developing just laws and enforcing the rule of law. Policymakers need to continue to promote economic development not just for women but also for the whole society. Culture is a dynamic phenomenon; social reforms need to continue. The provision of

increased access for women to higher education and higher status positions can remove the "glass ceiling" for women's progress, which ultimately will empower women.

With regard to the recent technological and communicational advances in everyday life, revision of social life skills is necessary. Public education programmers should consider the sociocultural factors related to the curricula and in the media and localize the social health process with respect to women's learning environment.

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