

Study on the Role of Social Capital in Student's Health at Kermanshah University of Medical Sciences: The Role of Demographic Variables

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ABSTRACT

Introduction: The concept of social capital is associated with almost all human, social and health issues due to its nature and content. Social capital represents the characteristics of social life, networks, norms and trust that enable participants to work together towards common goals, and it is recognised as an important determinant of health.

Aim: The present study aimed to study the role of social capital in students' health at Kermanshah University of Medical Sciences and the role of demographic variables in 2017.

Materials and Methods: In this descriptive and analytical study, the statistical population consisted of 450 students at the Medicine, Dentistry and Pharmaceuticals Schools at Kermanshah University of Medical Sciences in 2017. The sample size was determined through the Cochran's sample size formula, and 450 students were selected through simple random sampling. Further, for data collection, a demographic questionnaire and

the Onyx and Bullen's social capital scale were employed. Then, data were analysed through the descriptive (percentage, mean, and standard deviation) and inferential statistics (ANOVA and t-test) in the SPSS Statistics Software Version 23.0.

Results: In the present study, the mean score and standard deviation of students' social capital measured 2.81 ± 0.45 . In addition, it was shown that the dimensions of the communication with family members and friends and feeling security and trust had the highest and lowest means, respectively. Also, the results demonstrated that there was a significant relationship between the students' social capital and each of gender, age, marital status, education, faculty, and residence ($p < 0.05$).

Conclusion: The results revealed that the students' social capital correlated with each of gender, age, marital status, education, faculty, and residence. Therefore, promotion of the social capital of university students requires holding workshops and training courses by planners.

Keywords: Demographic factors, Medical students, Social health

INTRODUCTION

Today, social capital is seen as one of the social determinants of health, which has attracted a lot of attention [1]. The term "social capital" was used for the first time by Hanifan in 1916 [2]. The concept of this idiom was refined by sociologists, psychologists, economists, and social theorists during a century [3,4]. This was done to develop an understanding of living in social construct [5]. Social capital is defined as a series of norms and networks leading to the development of public activities based on social science principles. In particular, social capital is developed by social relations and resource mobilisation, thereby encouraging poor people to support the social norms and helps decrease their vulnerability. For example, the most significant social capital at the workplace depends on how poor people interact socially in the absence of conventional mechanisms including insurance and financial resources; thus, it is considered as an essential factor to protect them against the hazards and their own vulnerability [6].

Social capital has three dimensions: structural, relational and cognitive. The relational aspect describes a kind of personal relationship that a person has with others due to the history of their interactions. Boosting this aspect leads to increased trust, identity, compliance with norms, and doing what should be done [7]. Moreover, the structural aspect refers to the general pattern of contacts between individuals. In other words, the structural aspect means to whom about one has access and how this access is defined [8]. Finally, the cognitive dimension is related to the sources that provide expressions, interpretations and semantic meanings between groups [7].

Despite the importance of social capital [3,9] and its predictable role in health and welfare of people in rich and developed societies, few studies have been conducted in developing countries [9]. Alternatively, the association of social capital with health is confirmed by different studies, conducted at different time and locations [10], in sociology, economics, politics, public health [9], computer sciences [11], management, and leadership [12]. Various investigations [13]; have supported the role of social capital as an important health determinant [10,13,14]; however, there is no concise information available [2,10]. Nevertheless, social capital is defined as a series of norm, networks, trust, and social participation, which may help to facilitate and promote the activities to conduct effective measures in a society [15]. Simultaneously, there is a profound connection between personal and social levels of social capital and good health, trust, and social participation. Furthermore, similar relation is observed between the dimensions of social capital and health [14-16].

Social trust, social participation, social relations and relationships, as components of social capital, have beneficial effects on growth and development. In addition, the profits of investment in physical and human capitals are increased by social capital. In societies enjoying higher social capitals, the collaboration between its members and organisations is easier [17].

Moreover, social capital and social issues are inextricably intertwined [18]. Health has social and individual aspects, all of which can be linked to social capital [19]. Along with the physical, welfare and environmental components, social characteristics such as social capital plays essential roles in promoting health [20]. Social capital affects health through the following ways: dissemination of health information, probability of increasing health-related norms and

behaviours, social control of risk behaviours of health (efficiency, collective), increasing access to facilities and local services, and mental processes such as effective support [21].

Sociologists believe that social capital, in the form of social trust, which is one of the most basic structures ensures flourishing the personal health, and social trust. Social capital can distribute justice in the field of health and distribution of health resources at national geographic levels [22]. The societies in which there are high levels of trust and social capital are supposed to have a kind of solidarity and consensus, whereby justice develops in terms of the distribution of health resources [16].

Research shows that the presence of social capital develops a kind of social support for individuals, thereby resulting in their financial, informational, practical and emotional support. Of these outcomes, the emotional support provides them with more noticeable assistance [23]. Giddens (1999) also argues that this emotional support is a protective shell, whereby all ordinary people find themselves protected in the face of everyday life situations [24].

Universities are organisations that attract a significant number of young people each year. These students make up more than half of the human resources that contribute to the development of human societies. More to the point, since the new generation has seen unprecedented technological and social changes, increasing the diversity of values and attitudes in different social fields along with the plurality of lifestyles and individualist pressures on students due to their specific characteristics have caused concerns, and since society cannot survive without having healthy people, university students are considered one of the main elements of educational systems that play major roles in different environments, whereby the groundwork is laid for social and cultural exchanges [21, 25]. Besides, the medical students have special prestige in societies because they are employed in positions that are concerned with the health of people, and the health of this stratum depends on the effective services provided by them. Despite the previous research on social capital, no studies have been conducted about the social capital of students at Kermanshah University of Medical Sciences. Therefore, the present study aimed to study the role of social capital in students' health at Kermanshah University of Medical Sciences and the role of demographic variables in 2017.

MATERIALS AND METHODS

In this descriptive and analytical study, the statistical population consisted of 450 students at the Medicine, Dentistry and Pharmaceuticals Schools at Kermanshah University of Medical Sciences in the first semester of the academic year 2017 for six months (from September of 2017 to February 2018). The sample size was determined through the Cochran's sample size formula [26] ($n=350$). This number was multiplied by 1.5 (design effect), and 450 subjects (525 subject were included in the sample population. Moreover, 75 questionnaires were excluded from the study because of being defaced, incomplete answers of the respondents, and not returning of the questionnaires) were identified as the final sample. Further, for data collection, a demographic questionnaire and the Onyx and Bullen's social capital scale were employed.

Demographic Questionnaire: It comprised six items: gender, age, marital status, education, faculty, and residence.

Social Capital Scale: This 36-item questionnaire was developed by Onyx and Bullen., [27] to evaluate and measure the social capital. This scale comprises eight dimensions: participation in local communities (seven questions), pioneering in social activities (Six questions), feeling security and trust (Five questions), communication with neighbors (Five questions), communication with family members and friends (Three questions), tolerance of differences (Three questions), life value (Three questions), and working communications (Four questions). Not to mention, the reliability and validity of the questionnaire were confirmed by Yari A et al., ($\alpha=0.79$) [28]. Additionally, the questions were scored with four-point Likert scaling (1=very low, 2= low, 3=

high, 4= very high). Since the number of questions in each dimension were different, all dimensions were measured using a scale of 100 after calculating the average of each dimension [29]. Besides, the validity and reliability of the questionnaire were assessed by Onyx & Bullen in 2000 in a survey on 1,200 people in five Australian states. The factor analysis conducted using the Varimax Method showed a correlation coefficient of 0.52-0.87 and a reliability coefficient of 0.84 [27]. The results of assessing the reliability of this questionnaire demonstrated that the Cronbach's alpha measured 0.81. It should be noted that the maximum and minimum scores were 144 and 36, respectively.

Further, the ethical principles employed in the present study included obtaining the necessary permits, retaining the rights for the schools under study to either accept or reject to participate in the study, and ensuring the confidentiality and non disclosure of the personal information of samples. Then questionnaires were distributed among the target sample. To this end, the objectives of the present study were explained to the target subjects'. Informed consent was obtained from all participants before the study began. The inclusion criteria were the right to choose the courses freely, while incomplete questionnaires were excluded from the study. Further, the participants were assured of the confidentiality of the collected information and lack of disclosure of their personal information. Then, data were analysed through the descriptive (percentage, mean, and standard deviation) and inferential statistics (ANOVA and t-test) in the SPSS Statistics Software Version 23.0. Furthermore, the significance level was set at $p<0.05$ in all tests.

RESULTS

In this study, of the whole 450 subjects under study, the male population accounted for 48.9% (220 subjects), and the rest (230 subjects or 51.1%) were female. The mean age of students was 20.72 ± 2.85 years, and the majority of students (304 subjects or 67.6%) were under 20 and the majority of subjects were single (425 subjects or 94.4%). Furthermore, 232 subjects (51.6%) were doing bachelor's degrees, and the subjects in the medicine school accounted for 40.7% (183 subjects). Moreover, in terms of the residence, there were 243 students (54%) in dormitories [Table/Fig-1].

The mean and standard deviation of students' social capital measured 2.81 ± 0.45 . In addition, in terms of the dimensions of the social capital of students, the results revealed that the communication with family members and friends (3.34 ± 0.67) and feeling security and trust (2.31 ± 0.64) had the highest and lowest means, respectively [Table/Fig-2].

The results also indicated that there was not a significant difference between both genders in terms of the means of students' social capital. It should be noted that male students had higher levels of

Variables	(%) Frequency	Groups
Gender	220 (48.9%)	Male
	230 (51.1%)	Female
Marital Status	425 (94.4%)	Single
	25 (5.6%)	Married
Age (in years)	304 (67.6%)	≥ 20
	146 (32.4%)	≤ 20
Faculty	183 (40.7%)	Medicine
	153 (34%)	Dentistry
	114 (25.3%)	Pharmaceutical Sciences
Education	232 (51.6%)	Bachelor's Degree
	163 (36.2%)	Master's Degree
	55 (12.2%)	PhD
Residence	243 (54%)	Dormitories
	174 (38.7%)	Rental
	33 (7.3%)	Personal Housing

[Table/Fig-1]: The personal characteristics of the samples under study (n=450).

Components of Social Capital	SD±Mean
Communication with Family Members and Friends	3.34±0.67
Pioneering in Social Activities	3.32±0.75
Tolerance of Differences	3.03±0.63
Life Value	3.02±0.75
Participation in Local Communities	2.60±0.59
Communication with Neighbours	2.53±0.58
Working Communications	2.32±0.60
Feeling Security and Trust	2.31±0.64
Total Social Capital	2.81±0.45

[Table/Fig-2]: The mean and standard deviation of the components of social capital in the population under study mean±std. deviation.

social capital compared to the female students (2.85 versus 2.77, respectively). The results of comparing the means of students' social capital were also indicative of the significant difference between the subjects in terms of each of age, marital status, education, faculty, and residence ($p < 0.05$) [Table/Fig-3].

Variables	Groups	Mean±SD	Sig.(2-tailed)
Gender	Male	2.85±0.47	t=1.733 p=0.048
	Female	2.77±0.43	
Marital Status	Single	2.83±0.42	t=2.942 p=0.007
	Married	2.45±0.64	
Age	20 ≥	2.85±0.40	t=3.059 p=0.006
	20 ≤	2.72±0.52	
Faculty	Medicine	2.79±0.46	F=4.785 p=0.045
	Dentistry	2.79±0.42	
	Pharmaceutical Sciences	2.85±0.45	
Education	Bachelor's Degree	2.78±0.45	F=2.069 p=0.012
	Master's Degree	2.87±0.46	
	PhD	2.76±0.35	
Residence	Dormitories	2.91±0.39	F=16.807 p<0.001
	Rental	2.66±0.49	
	Personal Housing	2.80±0.40	

[Table/Fig-3]: The results of comparing the components of social capital in terms of the demographic characteristics of the samples under study.

p-value<0.05 is significant; F=Analysis of Variance (ANOVA) test; t=Independent sample t-test

DISCUSSION

The present study aimed to study the role of social capital in students' health at Kermanshah University of Medical Sciences and the role of demographic variables in 2017. The results of the present study indicated that the social capital score was moderate, which was consistent with the results of a study done by Rezakhani Moghaddam H et al., and Asadi A et al., showed that the social capital of the majority of students at Islamic Azad University of Khalkhal and Ardabil Universities of Medical Sciences was average [30,31]. Likewise, Rezaei F et al., and Afghani Moghaddam F et al., concluded that the students at Jahrom and Sabzevar Universities of Medical Sciences had desirable levels of social capital [32,33]. In a study done by Moradian Sorkhkalae M et al., it was shown that the social capital of students at Tehran University of Medical Sciences was average [13].

This point implies the need for more efforts by policy makers and planners in universities to lay the proper groundwork towards growing the students' social capital. If universities can develop social capital as a social course, they will be able to work better and more efficiently, thereby resulting in creation of an atmosphere of public trust and confidence in societies.

It was shown that the dimensions of communication with family members and friends and feeling security and trust had the highest and lowest means, respectively. The results of a study conducted by Moradian Sorkhkalae M et al., indicated that the dimensions of participation in local communities and communication with family

members and friends had the lowest and highest mean scores [13]. In contrast, Rezaei F et al., concluded that communication with family members and friends and participation in local communities had the highest and lowest mean scores [32].

The results of the present study demonstrated that there was a significant difference between the social capital of students and gender. In other words, the social capital of male students was higher than that of female students. One of the reasons for the higher social capital score in male students can be their higher social communications and their lower limitations compared to the female students. This finding was concurrent with the results of studies conducted by Moradian Sorkhkalae M et al., Asadi A et al., Rezakhani Moghaddam H et al., and Karimian J et al., [13,31,34,35]. To further explicate the matter, it can be expressed that differences in the social capital of girls and boys can be due to various factors such as differences in their personality characteristics, interpersonal relationships, the social fabric of the samples under study, and their different socio-economic classes.

The results of the present study also showed that there was a significant relationship between the social capital of students and their age. This finding was consistent with the results of studies performed by Moradian Sorkhkalae M et al., Rezakhani Moghaddam H et al., and Rezaei F et al., [13,30,32]. Similarly, Salehi Amiri R et al., concluded that there was a direct relationship between social capital and age. To further explicate the matter, it can be stated that however one gets older, his/her experience will grow more, thereby leading to the adaptability of individuals to the conditions of their communities [36].

In the present study, it was shown that the marital status and social capital significantly correlated, and the single population had the highest mean score, which was consistent with the results of studies performed by Moradian Sorkhkalae M et al., Asadi A et al., and Rezaei F et al., [13,31,32]. Similarly, Bagheri Yazdi H reported that there was a significant difference between the social capital of single and married students [37]. The results of their study also indicated that the single students had higher levels of life value compared to the married students. Married people are likely to have lower average life value because of the responsibilities they undertake while studying.

In the present study, there was a significant difference between the education and the social capital of students, so that master's students had the highest average social capital score. This finding was consistent with the results of studies performed by Rezaei F et al., and Esmaeili Shahmirzadi S et al., [32,38]. In contrast, Salehi Amiri R et al., reported that the bachelor's students had the highest average social capital score [36]. Moreover, Montazeri N et al., and Abdelah Tabar H et al., expressed that the higher one's education, the better his/her condition will be in terms of general and mental health and the ability to deal with emotional problems [39,40].

The results of the present study showed that the students' social capital and faculty significantly correlated, so that the students of pharmaceutical sciences had the highest levels of social capital, which was consistent with the results of study conducted by Karimian J et al., [35]. This finding was due to the type and nature of the specialised courses passed by students, whereby leading to learning coping strategies and affecting their social behaviour. On the other hand, given the theoretical courses offered in social health fields, the social capital of students is affected somehow.

In the present study, there was a significant relationship between the students' residence and their social capital. In addition, the majority of students were living in dormitories, and their satisfaction with dormitory facilities resulted in their significant social capital. This result was concurrent with the results of studies conducted by Moradian Sorkhkalae M et al., Rezaei F et al., Foladian A and Sam Aram E et al., [13,32,41,42]. Given the results of the present study, the higher mean score of students living in dormitories can be attributed to students' living alone far from their family members and the necessity of performing all of their personal activities by themselves. Therefore, some measures should be taken to facilitate and improve the social health in dormitories.

LIMITATION

The present study had some limitations. First, the data were collected through a self-reporting method, possibly affecting the accuracy of the results. Second, because the sample consisted of doctoral students in the for-profit Schools of Medicine, Dentistry and Pharmaceuticals in Kermanshah University of Medical Sciences, the results could not be generalised to students in other medical schools. Finally, it is suggested that further studies be conducted in this respect to draw comparisons towards reaching a consensus on this matter.

CONCLUSION

Overall, the results of the present study were indicative of the relatively favourable social capital among the students at Kermanshah University of Medical Sciences. The results revealed that the students' social capital correlated with each of gender, age, marital status, education, faculty, and residence. Therefore, promotion of the social capital of university students requires holding workshops and training courses by planners.

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