

Research Article**The Association between General Health and Religiosity among
Citizens in Yazd, Iran (2016)**

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ABSTRACT

In defining human existential dimensions, the World Health Organization (WHO) refers to physical, psychological, social and spiritual dimensions. Considering that one of the factors affecting mental health is spirituality and religiosity. This study aimed to assess the relationship between general health and religiosity among citizens in Yazd, Iran (2016). This descriptive analytical and correlation type study was undertaken on 383 citizens in Yazd using two stages cluster sampling in 2016. Data collection tools were three questionnaires; citizen's demographic characteristics, General Health Questionnaire (GHQ-28) and Religion Assessment Questionnaire (RAQ). Data were analyzed using descriptive and analytical statistics (Pearson's correlation coefficient, t-test, ANOVA and Regression) through SPSS 21 software. Significant level was performed as 0.05. Findings showed that the mean age of the participants (n=383) in this study was (38.66±11.40) years old. The mean of general health and religiosity scores of the participants was 27.22±16.31 and 97.35±19.21. The highest and lowest scores at (GHQ-28) and (RAQ) were related to anxiety/insomnia 8.11±4.87 and depression symptoms 4.22±4.96 and belief dimensions 30/43±6/08 and consequences dimensions 19/39±4/84 respectively. A negative meaningful statistical correlation was observed between mean of score of general health and score of religion ($r=-0.152$, $p=0.003$). According to the results of this study, level of mental health was more desirable in individuals with religious attitudes. Religion and spirituality, through the establishment of a suitable and ideal observational system, provide the condition for mental relaxation and it is considered as an important source of support for physical and mental health improvement; it is proposed to strengthen religion and spirituality as a factor in prevention of mental problems.

Keywords: Mental Health, GHQ-28, Religiosity, Citizens, Yazd

INTRODUCTION

Health and wellbeing are one of the great blessings in human life (1). Mental disorders are very evident in human societies, and many people in life can suffer from mental illnesses, and in other words, there are fewer people who are

immune to mental illnesses. The main goal of mental health is to prevent discomforts and maintain mental health in order to create a healthy and suitable social and individual environment (2). Psychologists believe that the only way that

can remove or neutralize pain and discomfort from the human body is to believe in God, and to believe in a source of truth and a superhuman power (3). Religion, medical science and health care have been interlinked in all demographic groups since the beginning of the recorded history (4). Nowadays, the importance of spirituality and religious attitudes in humans is of great interest to many mental health professionals (5). Many scholars consider the existence of religious beliefs and tenets as an effective factor in the health of individuals that can be effectively used in the treatment and prevention of mental disorders, and on enhance the ability of individuals to adapt and counteract with diseases (6). Also, religiosity helps to cope with a wide range of diseases or various stressful conditions such as chronic pain (7), cancer (8) and general stress (9). Religion includes transcendental beliefs, procedures and practices, where it is The Almighty God or the superior power in Western religious traditions, or it is an organized system of beliefs, practices and symbols, which are designed to strengthen the understanding of the relationship and responsibility with others in communal life in a community (4). In fact, religion is a psychological force that gives a new attitude regarding the world to human and changes his attitude toward himself, creation and surrounding events; the devoted person sees himself under the full-scale support and grace of God, and thus feel feels comfort and a deep spiritual pleasure (10). These people go through the distresses with more comfort by relying on their beliefs and beliefs; they are less likely to experience stress and anxiety (11). Religious beliefs, ceremonies and commitments are related to positive outcomes such as the improvement of quality, better life, well-being, physical and mental health, marital satisfaction, sustainable life and positive performance (12). The use of spirituality can be effective in promoting social supports, adaptation and compliance in health-related issues, alleviating miseries and reducing disappointment in life, increasing tolerance and so on (13). In the Islamic perspective, commemoration of God is the pacifier and immunizer of hearts (14). A 2011

study by AliBakhshi concluded that trust in God can play an effective role in increasing mental health as a coping strategy (15). The results of the research conducted by Cheraghi and Molavi in 2006 showed that there is a significant relationship between general religiosity and general health, and there is a significant relationship between three dimensions of religiosity that includes religious beliefs, emotional and religious rituals with different subscales of health. On the other hand, the consequential dimension of religion is not related to any other the subscales of general health (16). The results Lawler "the role of religion and spirituality over the health, satisfaction and well-being of the elderly people" showed that spirituality is a good prognosticator of the health of psyche, physical and mental health, as well as the reduction of depression (17). Despite the history of religious beliefs, experts in the field of psychology of religion at the theoretical level have discussed contradict points of view about the effects of religious beliefs on mental health (18). In 2000 study by Maltby stated that no evidence can be found that indicate the positive effect of religion on mental health (19). Freud and Ellis have had a kind of negative evaluation about the role and effect of religion on mental health, but scholars such as James, Jung, Allport, Maslow, Adler and Fromm spoke with positive attitude about the consequences of religious orientation on mental health (20). Considering the different results that are reported about the effects of religious orientation on health, also considering the socio-cultural context of the Iranian society and the existence of religious government (theocracy), and the scarcity of research backgrounds in this field, the aim of this study was to investigate the association between general health and religiosity among citizens in Yazd, Iran (2016) so through this way, a step can be taken to improve the health of the community.

MATERIAL & METHODS

Society and statistical sample

The present study was a cross-sectional and descriptive-comparative of correlation type. Study

population was all citizens 20 years old and above in the city of Yazd which based on the 2011 census, they were about 582,682 people. Based on two stage cluster sampling, 383 individuals were calculated via the Cochran sampling formula, (21). Based on using cluster sampling method for the neighborhoods of Yazd and simple systematic sampling through the postal code of homes for citizen selection, trained questioners after reassuring the participants about the confidentiality of information and explanation about necessity and importance of the research started their work for filling the questionnaires. Inclusion criteria were at least 1 year of living in that neighborhood and being over 20 years old, willingness to participate in the study and Exclusion criteria were unwillingness to participate in the study.

Tool of Measurement

To collect data, three questionnaires were used. The first questionnaire was a demographic data of the citizens; the second questionnaire was a 28-item questionnaire general health questionnaire (GHQ-28) and the third questionnaire was religion assessment questionnaire (RAQ) in order to measure religiosity.

Demographics Questionnaire

Demographic data of the citizens included age, sex, education level, marital status, job, type of housing, monthly income and socioeconomic status.

General Health Questionnaire

The General Health Questionnaire (GHQ-28) was developed by Goldberg in 1978 and is a test with a multiple and self-administration nature designed to assess discrete non-mental disorders, which can be found in different conditions of a society. The main questionnaire has 60 questions, but 30, 28 and 12- question short forms are used in different studies (the study uses the 28-question form) and since then it has been translated into 38 languages (22). In Iran, The GHQ-28 has been translated into Persian by Taghavi and colleagues (23). The questions of this four-choice questionnaire have four sub-scales as follows: 1- Somatic symptoms (items 1 to 7), 2- Anxiety/insomnia (items 8 to 14), 3- Social dysfunction (items 15 to 21) and 4-

Depression (items 22 to 28) (24). All items are assessed using four-point Likert scale (0–1–2–3). Therefore, the respondents' general health could be scored between 0-84, which is divided into 3 scales (a healthy score of 0-23, a score of 24-37 suspected of having a mental disorder and a score of 38-84 suffer from mental disorder). In each subscale (a healthy score of 0-6, a score of 7-14 suspected of having a mental disorder and a score of 15-21 suffer from mental disorder) was considered. The mental health status is inversely related to the score of this questionnaire, that is, by improving the mental health of individuals, the score of this questionnaire is decreased. The cut-off point of the score for the diagnosis of mental disorders in Iranian society is 23, and for each of the areas are 6. Noorbala et al. obtained the (validity) and (reliability) values of this questionnaire at its best cut-off point, which is 23, respectively students 74.5% to 92.3% (25).

Religion Assessment Questionnaire (RAQ)

Religion Assessment Questionnaire (RAQ) was adapted by Serajzadeh 1998 based on model Stark and Glock (1968) measure religious, religiosity attitudes, beliefs and became adjusted with Islam, especially Shia Islam (26, 27). The criterion of religiosity of Muslims that has 26 propositions and measures 4 dimensions of religiosity, respectively are as follows: 1-Religious Belief (items 1-7), 2-Experience (items 8-13), 3-Rituals (items 14-19) and 4-Consequences (items 20-26). Scoring method was based on the Likert 5-point scale (from strongly agree: 5 to strongly disagree: 1) and also scoring the statements 7, 14, 16, 17, 19 has been done in reverse order. Total score of 26-51 indicates a weak religiosity, the scores of 52-104 indicate average religiosity, and 105-130 scores are an expression of a strong religiosity. In the religious belief and ritual dimensions scores 7-13 represent the weak religiosity, the scores of 14-28 represent average religiosity and the scores of 29-35 indicate strong religiosity. In experience and consequences dimensions scores 6-11 represent the weak religiosity, the scores of 12-24 represent average religiosity and the scores of 25-30 indicate strong religiosity. In Sharifi's research (2005), the validity of this test was calculated by

correlating the scores of this test with the scores of the religious attitude test done by Khodayarifard. The calculated reliability coefficient was 0.45 at the $p < 0.001$ level of significance. The reliability coefficient of this test, which was calculated by Cronbach's alpha, is as follows: religious beliefs dimension: ($\alpha=0.62$), experience dimension: ($\alpha=0.56$), dimension of rituals: ($\alpha=0.79$), dimension of the consequences ($\alpha=0.66$) and total validity ($\alpha=0.78$) (28).

STATISTICAL ANALYSIS

The data after gathering were entered into SPSS version 21 software and analyzed by descriptive (frequency distribution, mean and standard deviation) and analytical statistics (Pearson's correlation coefficient, T-test, ANOVA and Regression). $P < 0.05$ was considered statistically significant.

RESULTS

Table 1 shows that out of 383 respondents of this research 217 (56.7%) male and 166 (43.3%) female participated in this study. The mean age of participants was 38.66 ± 11.44 . The highest frequency (41.3%) was related to 30-44 years age group. Single participants accounted for 80 (20.9%) and the remainder 303 (79.1%) were married. Most of them (47.8%) had monthly income of 1,000,000 to 2,000,000 Iranian

Currency toman. With regards to the education levels, diploma (12 grades education) and lower than diploma were held by 42.0% of the participants, 44.1% had associate degree and Bachelor, and 13.8% had master's and doctoral degrees. The majority of the participants 201 (52.5%) were Self-employed, and minority of them 60 (15.7%) were laborer. Fifty-eight percent of the participants were property owners and 42.0% were inhabitants of rental housing and had mortgages. With regard to socioeconomic status, 123 (32.1%) of participants were considered poor, 178 (46.5%) were at average status, and 82 (21.4%) were wealthy.

There was significant difference between general health and age ($p=0.011$), sex ($p=0.000$), education level ($p=0.002$), Job ($p=0.015$) and socioeconomic status ($p=0.017$) and there was no significant difference between the general health score and marital status ($p=0.163$), monthly income ($p=0.373$), type of housing ($P = 0.535$) and neighborhood ($p=0.136$). Also there was a statistically significant difference between religiosity and age ($p=0.000$), sex ($p=0.000$), marital status ($p=0.000$), education level ($p=0.000$), monthly income ($p=0.025$), job ($p=0.011$), neighborhood ($p=0.001$), socioeconomic status ($p=0.014$) and there was no significant difference between the religiosity score and type of housing ($p=0.223$).

Table1- Frequency and Relationship between the General Health Mean Scores and Religion Mean Scores with Demographic Characteristics among Citizens of Yazd in 2016

Demographic Characteristics	Categories	Frequency, No. (%)	Mental Health, Mean \pm SD	P value	Religion, Mean \pm SD	P value
Age group (year)	20-29	102(26.6%)	24.04 \pm 16.14	0.011	90.88 \pm 25.10	0.000
	30-44	158(41.3%)	26.74 \pm 15.75		99.08 \pm 15.46	
	45-69	123(32.1%)	30.48 \pm 16.70		100.50 \pm 16.65	
Sex	men	217(56.7%)	24.29 \pm 14.43	0.000	94.12 \pm 21.75	0.000
	women	166(43.3%)	31.06 \pm 17.82		101.57 \pm 14.25	
Marital status	single	80(20.9%)	24.96 \pm 14.09	0.163	89.81 \pm 25.78	0.000
	Married	303(79.1%)	27.82 \pm 16.82		99.34 \pm 16.55	
Education levels	diploma graduates and lower	161(42.0%)	28.65 \pm 16.44	0.002	100.54 \pm 15.38	0.000
	associate degree and Bachelor	169(44.1%)	28.11 \pm 15.72		97.53 \pm 19.21	
	master's and doctoral degrees	53(13.8%)	20.05 \pm 16.21		87.11 \pm 25.54	
Monthly Income	Less than 1 million	97(25.3%)	27.40 \pm 16.80	0.373	101.86 \pm 13.73	0.025
	Between 1 and 2	183(47.8%)	28.18 \pm 16.38		96.23 \pm 20.22	

	million				
	More than 2 million	103(26.9%)	25.36±15.71		95.10±21.17
Job	Retired	27(7.0%)	32.07±15.63	0.015	106.44±11.12
	housewives	38(9.9%)	22.60±17.44		100.97±11.85
	Self employed	201(52.5%)	27.35±15.83		96.99±19.70
	government employee	57(14.9%)	23.36±15.17		97.98±15.83
	laborer	60(15.7%)	31.23±17.37		91.61±24.76
Socio Economic Status	Weak	123(32.1%)	28.14±15.52	0.017	100.58±16.16
	average	178(46.5%)	28.67±16.91		97.32±18.94
	Strong	82(21.4%)	22.71±15.52		92.59±22.90

Mean of the score of general health of citizens was (27.22 ± 16.31). The findings of this study revealed that the highest and lowest scores among the mental health indexes were related to anxiety /insomnia 8.11±4.87 and depression symptoms 4.22±4.96. The obtained score of religiosity of citizens of Yazd was 97.35 out of 130. The average of the various dimensions of religiosity shows that the level of religiosity both in religious beliefs 30.43±6.08 and experience dimensions 25.28±5.15 were higher than in consequential 19.39±4.84 and ritual dimensions 22.24±6.13 (Table 2).

Table2- Mean and Standard deviation of General Health and Religion and its Dimensions among Citizens of Yazd in 2016

	Mean ± SD	Minimum	Maximum
General health	27.22±16.31	2.00	77.00
Somatic symptoms	7.05±4.88	.00	21.00
Anxiety/insomnia	8.11±4.87	.00	20.00
Social dysfunction	7.77±4.00	.00	21.00
Depression	4.22±4.96	.00	20.00
Religion	97.35±19.21	27.00	126.00
Belief	30.43±6.08	7.00	35.00
Experience	25.28±5.15	6.00	30.00
Rituals	22.24±6.13	7.00	35.00
Consequences	19.39±4.84	6.00	30.00

The findings of this study revealed a high prevalence of psychiatric disorders among citizens of Yazd, in total, 173 (45.2%) were healthy, 130 (33.9%) were suspected of having mental disorders, and 80 (20.9%) had mental disorders. The overall rate of the respondents' mental health (54.8%) was higher than the cut-off points 23. With regard to somatic symptoms, 52.7% of the subjects had healthy somatic habits and 9.9% had disorders. In the anxiety sub-scale, 46.7% of the participants were suspected of having disorders and 11.5% had disorders; in the social dysfunction sub-scale, 57.4% of the participants were suspected of having disorders and 6.3% had disorders; and in the depression sub-scale, 75.2% of participants were healthy and 5.5% had disorders.

Altogether, the religiosity level of 148(38.6%) people was strong; the religiosity of 204 (53.3%) people was average; and the religiosity of 31 (8.1%) of them was weak. In other words, the religiosity of (91.9%) people was average and higher than average that indicates a desirable level of religiosity in Yazd (Table 3).

Table3-The Frequency distribution of Status of General Health and Religion with its Dimensions among Citizens of Yazd in 2016

	GHQ	Somatic symptoms, No. (%)	Anxiety/insomnia, No. (%)	Social dysfunction, No. (%)	Depression, No. (%)
Health	173(45.2)	202(52.8)	160(41.8)	139(36.3)	288(75.2)
Suspected	130(33.9)	143(37.3)	179(46.7)	220(57.4)	74(19.3)
With disorder	80(20.9)	38(9.9)	44(11.5)	24(6.3)	21(5.5)
	Religion	Belief, No. (%)	Experience, No. (%)	Rituals, No. (%)	Consequences, No. (%)

Weak	31(8.1)	17(4.4)	19(5.0)	34(8.9)	26(6.8)
Average	204(53.3)	71(18.5)	93(24.3)	294(76.7)	302(78.8)
Strong	148(38.6)	295(77.1)	271(70.7)	55(14.4)	55(14.4)

As the table 4, demonstrates, there was a reverse negative correlation ($r=-0.152^{**}$, $p=0.003$) between general health and religion. All of the general health dimensions had association with religion, except the depression dimension ($p=0.074$, $r=-0.092$). Most correlations were significant at <0.05 . The highest correlation was related to social dysfunction with religion ($p=0.001$, $r=-0.166$) and then the relation of anxiety/insomnia with religion ($p=0.001$, $r=-0.164$).

In order to predict the components of general health of components of religiosity, stepwise regression analysis was used. Four factors of belief, experience, rituals and consequences were considered as predictive variables and four variables of somatic symptoms, anxiety/insomnia, social dysfunction and depression as criterion variables. The regression model with a correlation between general health score and dimension of belief of $p = 0.008$ was significant. In the belief dimension, both constant number and regression coefficients were significant. The other dimensions experimental ($p = 0.763$), rituals ($p = 0.203$) and consequence ($p = 0.223$) were not an appropriate predictor of general health score.

Table4- Pearson correlation between General Health and Religion and its Dimensions

General Health	Statistical Indicator	Religion				
		Belief	Experience	Rituals	Consequences	Total
Somatic symptoms	Pearson coefficient	-.119*	-.094	-.119*	-.116*	-.130*
	p-value	.020	.066	.020	.023	.011
Anxiety/insomnia	Pearson coefficient	-.148**	-.153**	-.157**	-.105*	-.164**
	p-value	.004	.003	.002	.040	.001
Social dysfunction	Pearson coefficient	-.137**	-.133**	-.155**	-.148**	-.166**
	p-value	.007	.009	.002	.004	.001
Depression	Pearson coefficient	-.079	-.061	-.061	-.121*	-.092
	p-value	.121	.231	.237	.018	.074
Total	Pearson coefficient	-.135**	-.122*	-.135**	-.134**	-.152**
	p-value	.008	.017	.008	.009	.003

* $p < 0.05$, ** $p < 0.01$

DISCUSSION

The aim of the present study was to evaluate the association between general health and religiosity among citizens in Yazd, Iran (2016). The mean score for the general health of citizens was 27.22 ± 16.31 . The results of this study were comparable to studies conducted by Niazi et al., (2016) to assessing the association between social participation and general health among women in Ilam (29). In the present study the mean scores for all mental health sub-scales, except depression, were greater than the cut-off point of 6. Similar to most of the other studies, anxiety disorder, had a greater prevalence, which is consistent with the studies by Noorbala (2017) (30). The World Health Organization (WHO) has reported anxiety as the most common psychiatric disorder (31). The findings of this study revealed 54.8% of the

respondents' mental health was higher than the cut-off points 23. Rates of mental disorders reported in a study by Najafi (2013) was the same as of our study 50.2% (32), and in the study of Noorbala et al (2009) in Tehran-Iran such rate was less than of our study (25). In general, the prevalence rate of mental disorder in the present study was higher than the prevalence rate of most of studies conducted, using GHQ-28 method. The difference in results implies that mental health is subject to a set of factors that should be explored from the point of view of psychosocial researches, since the cultural, economical and social characteristics of each region differ from others. The prevalence of suspicious of having mental disorders noticeably increased with increment of age. The findings of the present study are consistent with the findings of the studies

conducted by Noorbala et al (30). The general health score for males was better than the score for females. The general health findings in the present study were similar to a study by Noorbala et al in 2017 in Tehran and at study by Najafi (2013), in other words, women seem to have a greater potential for developing mental disorders. This can be attributed to the patterns of socialization and the relatively low status of women in most professional situations, their multiple roles in the family, and limited sources of satisfaction, as well as environmental stress, family problems, marital life, and the related biological factors affecting women (30, 32). The average scores obtained in the different educational groups indicate that the risk for mental disorders decrease with higher levels of education, also Noorbala's study suggest the positive role of education in increased general health (30). It seems that individuals with higher education levels make use of their greater knowledge and can better find effective ways to cope with factors that cause stress, control life conditions and adapt to prevailing situations. In our study, no association was found between general health and monthly income, type of housing, or neighborhood ($P > 0.05$). Descriptive findings of present study showed that religiosity of citizens of Yazd is above the average level and it is near the level of favorable. The mean of the score of religiosity in the study of Sharifi were in line with the findings of the present study (28). Inglehart states that in general, the importance of religion has declined in developed countries, but in countries, which suffer from economic recession and political instability, religion has still remained strong (33). The average of the various dimensions of religiosity showed that the level of religiosity both in religious beliefs and experience dimensions was higher than in consequences dimensions and ritual dimensions and the subjects received lower consequences compared to other dimensions (Table 1). The tendency to inner and individual religiosity was more than social religiosity. In this context Hamilton believes that religious beliefs and attitudes can respond to a genuine mental need of human (34). Therefore, it

seems that the religious beliefs are more prevalent relating to religious practices that has external and social manifestations, consequentially, people may believe in some religious faiths, but not enact these practices that are socially accepted Hamilton. The findings of the present study on the higher the level of religious beliefs, in comparison with other dimensions and signs of religiosity among citizens in Yazd, were similar to Karamollahi 2013 (35). There was a statistically significant difference between religiosity and age ($p=0.000$), the findings of the study were consistent with research findings by Adhami 2011 (36). The score of religiosity women was far better than men and also the obtained results suggest that married people were more religious than single people that were similar to Adhami study in 2011(36). The results obtained from the table indicate that the groups with diploma graduates and lower were most religious than other groups. Also there was a significant relationship between socio-economic-status with religiosity.

In this study, it was found out that there was a negative significant relationship between general health disorder and religion. In this regard, the findings of the study were consistent with study of Kézdy (2010) (37), but at study O'Connor (2003) no association were found between scores on the religiosity with the GHQ-30 (38). All of the general health dimensions had association with religion somatic symptoms, anxiety/insomnia and social dysfunction, except the depression dimension. There was a negative significant relationship belief, experience, rituals and consequences dimensions with general health disorder. This finding is in accordance with the theoretical discussions of Odi, Dorkim and Berger that in their intellectual system, religion has been interpreted as a factor for the relaxation of human, which, by identifying the purpose of life to man, gives him a particular course of movement and behavioral pattern that gives meaning to the human life and ultimately, this function brings mental relaxation into family, group and society (39). It was also found that there was a negative correlation between religion and somatic symptoms. Religion has a positive effect on the

mental and physical health. Religious scriptures in other faith traditions also emphasize the person's responsibility to care for and nourish their physical body. On the one hand, pain and other distressing somatic symptoms can motivate people to seek solace in religion through activities such as prayer or scripture study. Finally, Religion promotes better health behaviors, and is associated with less alcohol and drug use, less cigarette smoking, more physical activity and exercise and better diet. Living a healthier lifestyle will result in better physical health and greater longevity. Research findings by Lucchetti (2011) and Shri (2017) were consistent with the results of this research in this regard (40, 41). There was a negative correlation between religion and anxiety/insomnia among citizens in Yazd. Actually seemed to cope better with life stress, recover more quickly from experience less anxiety and other negative emotions than those who were less religious (42). This result is not compatible with study of Salehi 2015 (43). There was a negative significant relationship between religion and social dysfunction among citizens in Yazd. Religion also promotes human virtues such as honesty, forgiveness, gratefulness, patience, and dependability, which help to maintain and enhance social relationships. Religion provides social cohesion, the sense of belonging to a caring group, continuity in relationships with friends and family and other support groups. In addition, by persuading people to respect ethical principles, plays an important role in improving human relationships of individuals and social function (44). In this study, there was not a significant relationship between religion and depression.

CONCLUSION

Mental disorders are very evident in human societies, and many people in their lives are susceptible to mental illness. Religions and beliefs are factors that can change perspective of individuals in understanding the problems of life and in many cases make it easier for people to cross them. The religious attitude of individuals can affect their health and can be used effectively in treatment and prevention of mental disorders.

According to the results of this study, level of mental health was more desirable in individuals with religious attitudes. In this regard, it is necessary to pay more attention to the teaching of theoretical and practical religious principles and it seems a necessity to create deep and personal beliefs in the citizens.

ETHICAL APPROVAL

This study was approved by the Ethics Committee of Yazd Medical Sciences University with No. 4877 IR.SSU.STH.REC.1395.36. All participants were aware about the purpose of the study, completely voluntary filled out an informed consent form. Researcher pledged to complete questionnaire without any name of subjects also they were sure about the confidentiality of their personal information.

ACKNOWLEDGMENTS

This research is derived from PhD thesis of Maryam Alagheband and was financially supported by ShahidSadoughi University of Medical Sciences, Yazd-Iran. The authors would like to thank the all of Yazd citizens who participated in the study for their cooperation.

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