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Sociological study of structural and capital factors affecting the health-oriented lifestyle of over 15 year old citizens in Shiraz

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ABSTRACT

In the past two or three decades, the concept of lifestyle in general and health-oriented lifestyle in particular have received the attention of many Social intellectuals, health researchers and medical sociologists. At a closer look, health-oriented lifestyle as a Multifactorial, multi-dimensional and multi-indication phenomenon, is associated with the collective patterns of behavior that deal with issues threatening the health of people, in order to guarantee the health of people. A close look at the literature shows that some researchers seek to explain health behavior patterns, while others seek to explain the factors such as individual choices. These choices are not made in a social, political, or cultural vacuums, and a variety of underlying determinants such as gender, social class and marital status affect them. By adopting a similar approach and relying on medical sociology background, the present article seeks to survey the health-oriented lifestyle as well as capital and underlying determinants among over 15 year old citizens in the city of Shiraz. To this end, 384 citizens were selected through classified random sampling and the required data were collected through appropriate questionnaire techniques. The findings showed that health-oriented lifestyle of citizens vary depending on their sex, age and marital status and that there is a significant correlation between different forms of human capital (social, economic and cultural) and health-oriented lifestyle.

Keyword:
Health-oriented lifestyle, social capital, cultural capital, economic capital, health-related behaviors, medical sociology

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INTRODUCTION

Introduction and Statement of the problem:

Cultural theorists, philosophers, and sociologists have shown interest in health and other factors associated with that, and different discussions in this field has led to development of a wide range of views. These discussions include discrimination of healthy body from non-healthy body and provision of a clear definition for these concepts. The question of "What is" Health and illness are placed in the core of philosophical research on health and terms such as "illness" and "sickness" are also covered in this field (Seedhuse, 2001, quoted by Taghavi; 2008: 112).

It seems that health and illness can fit into various semantic and interpretive systems, such that illness reports and responses are largely determined by social and cultural factors. Accordingly, every individual follows specific patterns and rules that allow them recognize when they or others are sick, what is the cause and nature of the illness, or what they should do to relieve and treat the illness. In other words, the culture in which we grow, will help us recognize and interpret the changes that occur in our body or in the body of others over time, distinguish healthy body from non-healthy body and describe discomfort and unnatural feelings.

In 1946, the World Health Organization (WHO) tried to provide a definition of health that also covered "complete physical, mental and social well-being, in addition to absence of disease, disability and maim". In this definition, the physical notion of health is outside the framework of physical body. And health and well-being are not necessarily limited to physical behaviors but cover environmental areas. Although this definition has repeatedly been criticized because of being overly idealistic, it emphasizes that health is an implied achievement, i.e. people become sick not merely because their body does not have the desired practices, but their attitude towards the forces in their body, he attitudes (as well as their spiritual and psychic abilities) also play a role in development of their disease (Norris et al. 2007: 113).

On the other hand, the attitude of people toward body and their perception of health and illness among differ from one strata of society to another. Several studies have shown the attitudes and mental images of different social groups. In this light, "Luc Boltanski" found that people who belong to rich families, are more likely to see a doctor, are closer to him due to class homogeneity, and are highly knowledgeable, therefore, they internalize the concepts of medical knowledge much better (Adam, 2005: 95). Based on these studies, the most important difference between people was in their attitude towards health. In addition, concepts of health and illness may be linked closely to the concepts of normality and morality. A good and moral life may mean a healthy life. Routine and common descriptions of health and disease may be deeply rooted in the social areas and cultural meanings. Therefore, It seems that the concepts of health and disease are not merely related to physical conditions. The meanings of these concepts may also cover conflicts associated with thongs that are normal, good, moral and socially accepted (Dixit, 2005: 2).

According to Turner "the concepts of health and disease are in the core of the human society social values, because they explain many of our notions and assumptions about the meaning of life and death, " (Turner, 2001, quoted by Dixit, 2005). Therefore, health and disease boundaries may differ from one individual to another, depending on their knowledge and beliefs of the universe and life, and different social, cultural, economic and ... factors are involved in determination of their scope. Therefore, the meaning of health and disease are understood, interpreted and described in different groups in every society. Therefore, illness can be understood as a social construction. Accordingly, empirical and positivistic approaches are not sufficient for understanding this is concept. Health and disease cannot be regarded as entities that can only be explained by natural sciences, but comprehension of the historical – social contexts is an important aspect of disease conceptualization.

In this vein, many studies have been conducted on the socio-demographic characteristics of people who use medical services; For example, it has been proved that women usually see doctors more frequently than men do, while children and the elderly usually see doctors more frequently than young and middle-aged people do. Other potential factors in this field include social classes, ethnic origin, family status and household size that are related to the frequency of consultations and meetings with physicians. It is worth noting that the present study will mainly let us know "who use the service and who do not use them, rather than letting us know why they use and why they do not use services." To answer the question of why some people seek high or low technical assistance, the theoretical behavior of patients should be explained (Keyvanara, 2007: 184).

Foreign Studies

The studies that focus on the public beliefs about health, can be traced back to 1960s and 1970s. In these studies, attempts are mainly made to define health as a state consisting of factors more than absence of disease. These views have been mentioned in more than one study. Herzlich is a pioneer in this field. In his studies on 80 adult middle-class French people, he discovered three types of health and disease perception during interviews. Herzlich concluded that health is defined as an internal factor with three different dimensions:

1. Health as the absence of illness (health in a vacuum);
2. Health is determined by the nature, heredity and temperament of human beings;
3. Health is a state of well-being and balance in the human body (Keyvanara, 2007: 180).

Herzlich believe that the relationship between the individual and community as well as disease and health is reflected in the social representations. In this relationship, the dichotomy between the individual and society is vital for building the framework of social representations and subjective experiences of health help individuals to be in harmony with society in terms of their social role. On the other hand, in some cases, diseases lead to destructive consequences in society. Therefore, social behavior plays a vital role in defining health and disease. Based on his findings, disease may be labeled as a form of deviance and this labeling mechanism is an important feature of the social representation practices. According to him, the

representation of health and disease Require a complex psychological explanation in the sense that each person experiences as well as the common values and information prevailing in a society are integrated into a meaningful impression (Dixit, 2005: 5).

Subsequent studies have yielded similar results. Pill and Scott (1982) interviewed with some working-class women with young children. The definitions deducted from interviews were based on the fact that health is the absence of illness. Another definition of health was also common among them. it was a functional definition that involved the ability to perform an action and the capacity to adapt to natural roles they were dealing with. The definition of health provided by Pill and Scott, Just like the one provided by Herzlich, was associated with joy and interest and passion for doing a work or related activities (Keyvanara, 2007: 180).

In another study conducted by Cockeram, Esnad and Diwali (1998) on the health-oriented lifestyle in Russia, The population, which consisted of 18 and over 18 year old individuals, were investigated through a survey and interviews. The findings showed that Men drink alcohol 21.2 times more than women do. As for smoking, the results showed that Men smoke 16 times more than women do. The results also showed that men are more likely to exercise and that the young, unmarried, educated, unemployed people as well as those who earn a high income those with high income, are more likely to test their medical well-being (Cockerham et al., 2002: 48-51).

Domestic studies

Sociology and medical anthropology are younger than other social sciences in Iran and the studies conducted in this field are relatively limited and don't have any significant diversity. However, increasing attempts have been made to develop the literature in this area in recent years.

The domestic studies conducted in this field include "investigation of health priorities from the perspective of people and experts in the Kerman population Research Center 2007)". This article is the result of a field study by Reza Abbasi, Mohammad Reza Aflatoonian, and Leila Ranjbar that was published in the Iranian Journal of Epidemiology, Volume 5, No. 4.

Population Research Centers have put simple community-based participatory research on their agenda with the aim of empowering people. Likewise, the present study that is conducted in the Kerman population research center, is an attempt to determine and compare the health priorities from the public and expert perspectives. In this study, the public views are collected from 20 clusters of 20 households by 10 two-membered trained teams. The views of about 1289 people from 324 households have been recorded in this study. The collected data in this study were analyzed using SPSS software and descriptive statistics.

The present study is a community based participatory research (CBPR) in which the problem is both stated and solved by people and the data policies are derived through consensus, reaction, dialogue and experience; in other words, The matters to be discussed in this project were raised with the participation of public activists and in the presence of diseases and environmental health experts. In this project, the environmental health experts raised some questions about regional problems based on the complaints made by households and using some environmental health checklists. Other social problems were also raised by the public during several meetings and led to development of a questionnaire that covered the views of both experts and people.

The strengths of this research include: being a community-based participatory research that allows The people living in the population research center regions get to know about the research method and participate in selection of subject matters. Secondly, interviewers had a more powerful sense of responsibility during the data collection process due to being familiar with people and communicating with them more easily. The above-mentioned strength increase the accuracy of data and help the researchers fully understand the social, economic and health problems in the region. Moreover, involvement of people in this process develops a sense of responsibility in them, in other words, the brainstorming provokes the region population to prioritize local problems and solve them if possible. The results of this study have shown that the priorities defined by people are significantly different from the priorities identified by experts. This indicates that the work plans for environmental health should be revised and special attention should be paid to the priorities determined by people.

Study of such research projects carried out on health and illness in the field of medical sociology and social medicine, shows that although these projects deal with the characteristics of population and environment, the extensive scope of the studied field causes the project executors, Colleagues and researchers to be quite unfamiliar with the society they study, and this has caused these studies to lack the necessary depth.

In this light, we hope that the expansion of studies in this field can provide the ground for development of necessary local research literature associated with health in the field of social sciences.

Theoretical Framework:

With an emphasis on the phenomenon of consumption, Analysts and theorists of social sciences attempt to explain and understand different aspects of the contemporary social life. In the meantime emphasis on the lifestyle concept has paved the path for many new analyses in this field. Since the time of its inception, this concept has been theorized by many experts. However, considering the research topic, we only focus on people who have been able to directly or indirectly affect the medical social studies.

Max Weber

Although lifestyle has not been coherently theorized by Max Weber, the impact of his ideas on the development of this concept has always been evident, and since in his social analysis, he transforms Marx's class concept into the concept of status, he seems to have been gradually forming the concept of lifestyle.

According to Weber, social status is the common memberships and group awareness that can be the constituent of groups with increasingly similar behavioral practices, so that these similarities can distinguish them from the rest of society members (Khademian; 2009: 72). If Marx focuses on the index of "production" in development of the class concept, Weber ideas of status recognition is based on similar consumption patterns. Therefore, the common behavioral practices in status groups indicate a type of consumption that they have in common. In the meantime, according to him, consumption is a process that

involves different social and cultural practices that reflect the differences between social groups, and doesn't results from economic factors alone (fazeli; 2003: 28).

However, According to Weber the lifestyle selection mechanism is a Dialectical contrast between the concepts of "choice" and "chance". In his view, people can choose their own lifestyle, but they should know that these choices are not entirely free and they will be pressed by their social status. Therefore, a permanent dialectic is established between choices and chances, in other words, if any of these two factors can destroy the other, it can affect the lifestyle results (Keyvanara2007: 65 and 66).

Giddens

In his explanation of class, Giddens stays away from economy and employment, and emphasizes on cultural factors. These factors that represent themselves in the form of concepts like "consumption patterns" and "lifestyle", are increasingly related to the characteristics of modern society. In modern society, according to Giddens, "symbols and signs associated with consumption play an increasing role in daily life." (Giddens, 2008: 429) and consumption, first corresponds to individual choices. Therefore, personal identity largely pivots around the lifestyle choices.

On the other hand, in his explanation of modern society, he points out to the formation of a society in which National governments strengthen over time and contribute to development of modern information society (Giddens, 2008: 186). The new information society leads to formation of new types of communications that provide the ground for development of new lifestyles that never existed before and due to the openness of social life today, plurality of grounds for action and the number of more powerful lifestyle choice sources for development of personal identity and conduction of daily activities become increasingly important" (Giddens, 2000: 88).

In Giddens' view, lifestyle can be regarded as a more or less comprehensive set of functions that are applied by individuals. These functions not only meet their current needs, but represents the certain narrative that they picks for their identity. Lifestyle is a relatively coherent set of behaviors and activities of a certain person in the course of everyday life "(Giddens, 1998: 120).

Bourdieu

Pierre Bourdieu is one of the most influential theorists whose works have been a useful redefinition of sociology and anthropology, and have managed to provide a comprehensive theoretical analysis of consumption and lifestyle concepts in the contemporary era. He emphasizes on how people's actions are influenced by the structure of their social world and how these actions reproduce that structure again.

Of all of his works, most suitable for medical sociologists is a book entitled "Distinction" in which he systematically investigates the patterns of consumer culture to define talent among different social classes in the French society. In this analytical work, he has used dietary and exercise habits, which shows how mental structures pivoting around a class, form specific aspects of healthy lifestyle (Keyvanara, 2006: 73).

According to Bourdieu, society is represented as a social space that is a fierce and endless competition Stand. In his view, during these competitions some differences emerge that provide the matter and the framework of social existence. He believes that society is a non-integrated entity that includes small distinct models of rules, regulations and forms of power that are referred to as field. Field is an arena for competition to gain a stand in the power hierarchy (Fazli, 2003: 37). Vakvant believes that field is in the first place a constructionist space of stands. (Acetone, 2002: 338). Each field or area provides its actors and agents with an atmosphere of facilities that that coordinate the creators (Bourdieu 2001: 81). Therefore, field reflects the social conditions of Actors, and plays a major role in explaining social structures in Bourdieu's genetic structuralism (Khademian, 2009: 97).

Bourdieu defines social space based on different forms of capital, including economic, social and cultural capital and believes that these forms of capital make field meaningful and their combination will determine the position of people in the hierarchy.

Bourdieu's concept of structure is also formed of field and capital; in other words, structure is a set of stands that are comparable due to the volume and composition of capital contained in them. (Fazli, 2003: 38). In his book (distinction) Bourdieu somehow reviews Weber's theory, or revives the conflict between Stand and class. He agrees with Weber in terms of individuals stand in the superior-inferior hierarchy, but does not look at a individuals stand only from the perspective of economic relations and believes that individuals' stand is a symbolic aspect of class structure that is not reducible to economic relations alone. According to Bourdieu, the relationship between state and class is not accidental, but there must be some kind of equality and homology between people so that they can occupy the same position and stand. He defines this congruence by means of "Queen" or "Habitus "(Khademian, 2002: 43). This concept forms the central core of his explanation for human action. He defines Habitus as a system of durable and transposable dispositions that generate structured and objectively embodied actions (Bourdieu, 1381: 2). According to Bourdieu Habitus is the product of individuals' objective and historical tendencies and can explain the perceptual limitations resulting from composition of different capitals, as well as the consumption features in each social class (Fazli, 2002: 39).

Habitus in Bourdieu's structural system is both the "the structuring structure" that is the structure which forms the social world and the "structured structure" that is built by the social world. It is also a set of dispositions for the semi-known and semi-unknown agents, as well as norms and values that form actions in the same way socialization processes do. In fact, Habitus forms knowledge (Chavoshian, 2001: 43). Thus Bourdieu links social practices to culture, structure, and power through the concept of habitus and mental structure.

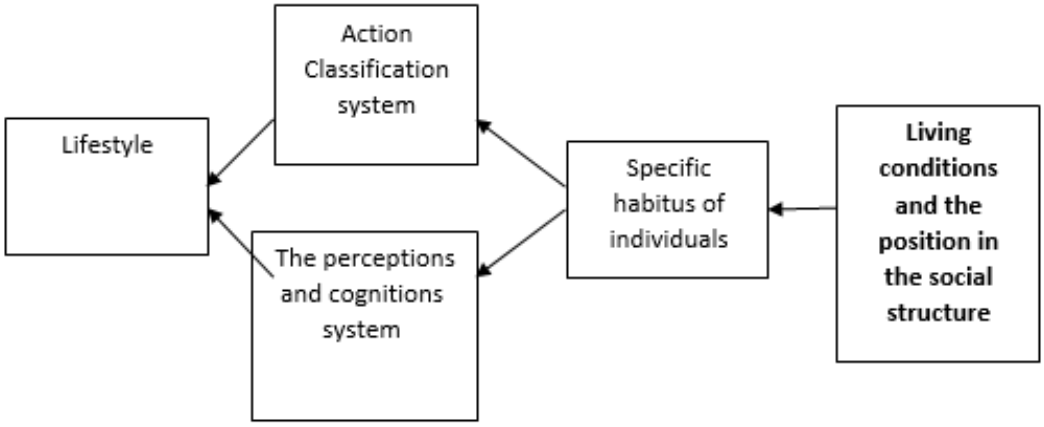
Following the set of concepts he uses, Pierre Bourdieu refers to the concept of talent and defines it as the "capacity of employing a group of objects and actions in a symbolic and material way in sense of a set of distinctive preferences", he believes that talent is the product of habitus and the basis of arbitration about the value of different

experiences that affects The type and amount of consumption

And represents the link between some products and consumers in a classified social space (Fazli, 2003: 42).

Thus, drawing on the concepts of economic and cultural capital, and using the concept of habitus that is defined as patterns of thought, understanding, consumption and lifestyle, Bourdieu developed a Model for class structure and reproducing that structure, and believed that people internalize their class position and express it through their cultural choices (Khademian, 2008: 101). Thanks to these concepts, he sought to provide a coherent theory about the formation of lifestyles. According to Bourdieu's model of lifestyle, objective conditions of life and the position of individuals in the social structure leads to development of specific habitudes that generate two systems, namely the action classification system and the perceptual and cognitive system. In fact, lifestyle is the interaction of these two systems. According to him, lifestyle is a non-accidental pattern that is classified in nature. In fact, lifestyle refers to the same actions and tasks that are classified in a particular manner and result from certain perceptions. He believes that lifestyle is the result of habitudes and embodied preferences of people that have developed into actions and are visible (Fazli, 2002: 45). Khademian has mapped out Bourdieu's analysis as follows:

Chart 1-2: Bourdieu's lifestyle model



Cockerham

William Cockerham is another individuals who has developed the concept of health-oriented lifestyle in recent years. He justified the need for theory of "health 'lifestyle" by drawing on the fact that many everyday lifestyle habits are associated with health outcomes, he also emphasized that in modern times, unlike previous historical times, health is considered as an achievement due to changes in disease, modernity and social identity patterns. This is what people feel obliged to achieve by improving their quality of life, because they would otherwise suffer an early death or chronic diseases. In this light, Giddens (1991) and Turner (1992) emphasize on the same point and assert that the lifestyle choices in the late modern era, have made people more responsible for their health and their body in general.

Cockerham's model of health lifestyle has been affected by Weber, Giddens and Bourdieu's lifestyle models. In a field study, he used the Bourdieu's theory framework and asserted that negative lifestyles as basic social imperatives in the late twentieth century in Russia and Eastern Europe led to decline of life expectancy. According to his research findings, the group who were more likely to experience declined life expectancy mainly consisted of middle-aged, working class men. Their Poor living conditions and relatively low position in the social structure, gave rise to some habits that were based on unsanitary practices (Such as heavy drinking, smoking, being heedless to diet, and avoiding exercise). This type of lifestyle increased the rate of heart disease, accidents and other health problems, and ultimately shortened life span. These behaviors were norms created through group interaction that had developed as a result of opportunities they had, and had been internalized by this mental structure. The daily life structure also limits the relevant health choices and directs people towards specific lifestyles that lead to sudden death (Keyvanara, 2006: 73).

William Cockerham uses the agency- structure discussion as a framework for developing the healthy life style theory and believes that the contemporary theoretical perspective does not deny the importance of agency and structure, but theoretical discussions in this field are focused on the superiority of one over the other. In other words, the advocates of the structure focus on the role of structural positions in mapping out the tendencies and individual behavior. However the advocates of agency stress on the capacity of individual actors in choosing their behavior, regardless of the structure impacts on them. Therefore, according to Cockerham, discussions related to the cooperation and relative interaction between agency and structure constitute an important but underdeveloped area in the theoretical discourse of medical sociology.

According to Cockerham, health lifestyle as collective patterns related to health, is defined based on the choices made from among options available to people, that correspond to their life chances and when this concept is used, The question is whether people's decisions about diet, exercise, smoking and… are only a matter of personal choice Or they are basically formed by the structural positions such as social class, or gender position? (Cockerham, 2005: 51) This definition includes the dialectical relationship between life chances offered by Weber's lifestyle concept. In this field, life choices serve as representatives of agency and life chances serve as a form of

structure that basically reflect the social class status, and both undermine and limit Options, While health and other lifestyle choices are optional (ibid: 55).

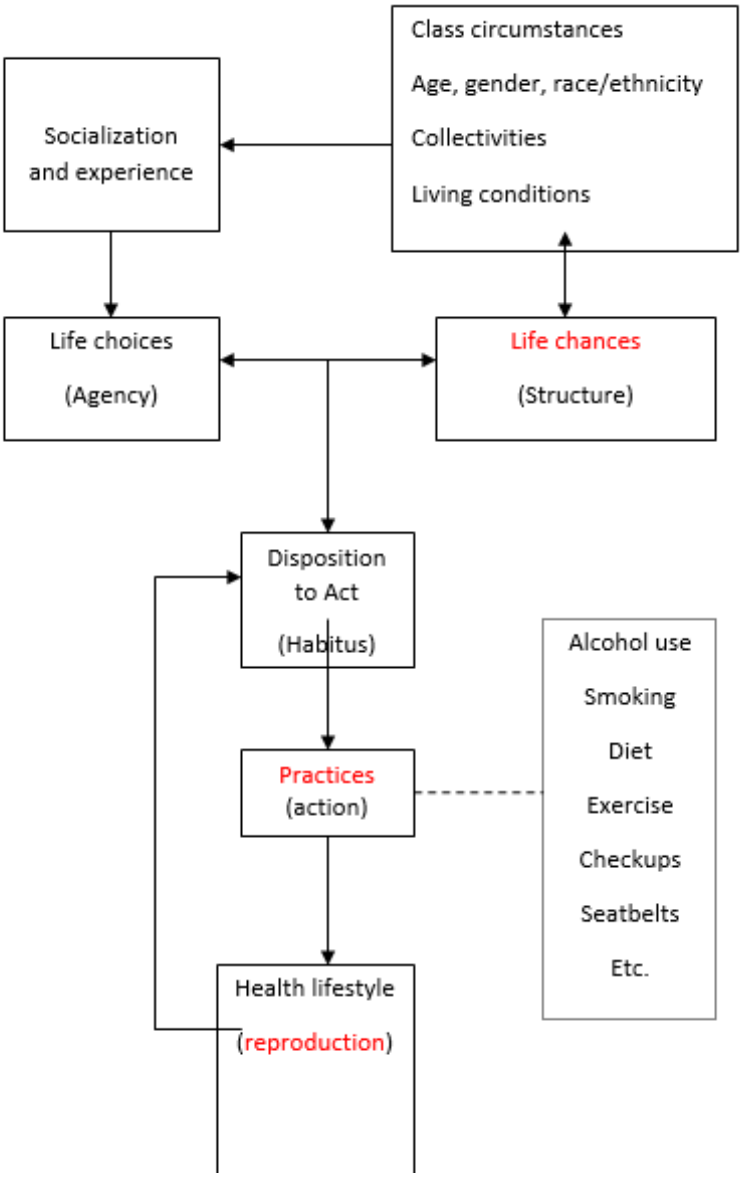
Weber links lifestyles but to status groups rather than individuals, and thereby shows that they are essentially a mass social phenomenon. Status groups are some sets of people masses that have similar conditions and class backgrounds and result from having a share in similar lifestyles. Thus, people who want to be part of specific status groups, need to adopt an appropriate lifestyle. Their status groups are classified based on their Consumption patterns; patterns that not only establish significant differences between groups, but reflect the differences that already exist in that area (ibid: 55).

Health lifestyles are collective patterns of health-related behavior that rely on choice made from among options that are available to people according to their life chances (Keon Ara; 2006: 66). In addition, health lifestyles are supported by an extensive range of goods and services in the health and wellness industry.

in his article titled "Theory of health Lifestyle and convergence of agency and structure" Cockerham points out to Vickers eta l. (1990) study on the lifestyle of American military personnel. They found that positive health behaviors are classified into two categories: 1- insisting on appropriate behaviors.2- avoiding risk. Other studies on health lifestyle have provided strong evidence that show non-healthy practices are more common among lower socio-economic groups. A significant part of these studies show that more positive functions of lifestyle are associated with women and higher social strata, and that the most negative functions are related to the practices and behavior of men and lower social classes (Cockerham, 2005: 56).

Therefore, it seems that health lifestyles are not inconsistent behaviors of single individuals, But are personal habits that have transformed into mass forms that represent certain classes and groups. The health lifestyle pattern which has been proposed by Cockerham is shown in the following figure:

Figure 2-2: Cockerham's health life style pattern



The first category of structural variables is class circumstances, which is likely the most powerful influence on lifestyle forms. The close connection between class and lifestyles has been observed in the works of Marx, Veblen and Weber. In his book entitled "distinction" Bourdieu regards class as the most decisive variable in the lifestyle forms and assesses different preferences of upper-middle class people

And the French working class in terms of exercise and eating habits. Bourdieu found the working class to be more attentive to the strength of the male body than to its shape and to favor food that is both cheap and nutritious; in contrast, the professional class prefers food that is tasty, healthy, light, and low in calories (ibid, 56)

Cockerham also refers to the results of Blaxter studies in the UK. He found that important differences in health lifestyles persisted between classes, with the upper and upper-middle classes taking better care of their health than the working and lower classes. Blaxter concluded that socioeconomic circumstances and environment determined the extent to which health lifestyles were practiced effectively (ibid, 56).

Therefore, all studies confirm that the professional classes have the highest participation in leisure-time sports and exercise, healthier diets, moderate drinking, little smoking, more physical checkups by physicians, and greater opportunities for rest, relaxation, and coping with stress

Cockerham also emphasizes that the upper and upper-middle classes are also the first to have knowledge of new health risks and, because of greater resources, are most able to adopt new health strategies and practices effectively (ibid, 58).

On the other hand, contemporary empirical studies show that these variables influence health lifestyles. Age affects health lifestyles because people tend to take better care of their health as they grow older. In addition, Based on these studies women tend to have a healthier lifestyle than men. However, there are different conditions about the impact of race and ethnicity on health and lifestyle. The studies that are conducted on ethnicity and race mainly deal with general level of health rather than health lifestyle and behaviors associated with that.

In the Cockerham's model of healthy lifestyle, "collectivities" and "social networks" are among other structural factors affecting health lifestyle. According to Cockerham, Collectivities are collections of actors linked together through particular social relationships, such as kinship, work, religion, and politics. Their shared norms, values, ideals, and social perspectives constitute inter-subjective "thought communities" beyond individual subjectivity that reflect a particular collective world view (ibid, 59). In this case, religion and ideology could be examples of collective views that point to health lifestyle choices.

"living conditions" is the last structural variable that Cockerham refers to in his study of health lifestyle ". Living conditions are a category of structural variables pertaining to differences in the quality of housing and access to basic utilities (e.g., electricity, gas, heating, sewers, indoor plumbing, safe piped water, and hot water), neighborhood facilities (e.g., grocery stores, parks, recreation), and personal safety. In this regard, Blaxter (1990) found in her nation- wide British survey that the conditions within which a person lives has important implications for health-related behavior. Health lifestyles were most effective in positive circumstances and least effective under negative conditions.

According to the Cockerham's healthy lifestyle model, different variables of structural factors create "life chances" on the one hand, and provide individuals with the ground for "socialization" and "experience" on the other hand. This is consistent with Bourdieu's view that dispositions are made based on experience and socialization and the social status of people provides the necessary social conditions for this process.

The type of Experiences and socialization processes provide a capacity for "life choices" according to which people choose and evaluate their course of action. The term "life choices" was introduced by Weber. He argues that people that have the people are able to interpret their conditions, make deliberate choices, and set their actions based on their subjective meanings. Therefore, in his opinion all the social practices occur in areas that refer to limitations and chances. He also believes that the

Actors interpretive understanding of the situation, will guide their behavioral choices (ibid: 60).

Cockerham's model shows that that the interaction of life choices and life chances produce individual dispositions toward action, these dispositions constitute a habitus. The notion of habitus originates with Edmund Husserl who used the term to describe habitual action that is intuitively followed and anticipated. The concept has been expanded by Bourdieu to serve as his core explanation for the agency-structure relationship in lifestyle dispositions. Bourdieu defines habitus as "systems of durable, transposable dispositions, structured structures predisposed to operate as structuring structures. In other words, habitus are used as a cognitive map or a set of perceptions that typically assesse and guide the choices and options of individuals (ibid: 61). Therefore, the habitus that have been formed in such a process, Form the activities and actions of people in various fields and finally lead to lifestyles.

In this connection, as already mentioned, research on structure and collectivist actions serve as the main axis of lifestyle studies, this theory seeks to answer this question: what conditions make a subjective experience possible. According to Bourdieu, the world we're living in is not the same for all residents and argues that an appropriate theory of action is bound to attentive to the representation conditions that serve as the foundation of Realistic interpretation (Chavoshian, 1381: 55).

According to Bourdieu, dialectic internalization of structural conditions of facilities and exploitation of these facilities by actors can only be achieved through a very important concept known as habitus. As mentioned before, he defined habitus as" a system of durable and transposable dispositions that generate structured and objectively embodied actions". Habitus is a conceptual framework for describing the conceptual prism which includes those different social dispositions that draw on its own logic and make cultural classification of social world possible (Chavoshian, 1381 quoted by Lee, 1993: 31). For Bourdieu, this concept serves as a vital link between objective social reality and the subjective experience whereby the objective requirements of cultural order are inducted to people as predictable action currents. In fact, habitus is the source of this set of dynamics that are objectively organized as

strategies without being the product of true strategic intentions (Chavoshian, 2001: 57). Thus, Bourdieu draws on the concept of habitus that is referred to as patterns of thought, understanding, consumption and lifestyle, to link mental structure of social practices to culture, structure and power.

Therefore, the following hypothesis can be provided:

1. There seems to be a relationship between social capital and health-oriented lifestyle.
2. There seems to be a relationship between cultural capital and health-oriented lifestyle.
3. There seems to be a relationship between economic capital and health-oriented lifestyle.

The health-oriented lifestyle mean differs based on underlying variables (gender, marital status and social class).

- Methodology

This is an applied study, it means that in this study attempts are made to collect data and knowledge about the health-oriented lifestyle of citizens, in order to provide practical techniques for its promotion. The study is conducted through a survey, and data are collected through questionnaire. Documentary (library) methods or the available sources are used to develop a conceptual and experimental framework. The unit of analysis in this study is individual. In this study, survey is used to achieve maximum generalizability of findings. The population consists of all the above 15 year old citizens in Shiraz. After collecting the respondents' responses, the data are analyzed by spss software at the descriptive and inferential statistics levels. The survey was conducted in 1394.

Population, sampling method and sample size

The population consists of a set of units that have one or several features in common (Sarayi, 1384: 5). Sarookhani has also defined population as the community from which a representative sample is obtained (sarookhani, 2003: 157). Therefore, in this study population refers to all the people to whom the survey results can be generalized. Population in this study includes all citizens above the age of 15 years. The population is sampled through cluster sampling. Considering the large size of the population, a sample size of 384 individuals was obtained through Cochran's formula:

The descriptive findings

A 54 -item 5-point likert scale questionnaire was designed to evaluate health-oriented lifestyle variable that is the dependent variable in this study. The score of 384 represents the highest level of health oriented lifestyle. The variable's mean is equal to 294.30 for citizens of Shiraz which shows the citizens of this city have high levels of health-oriented behavior. The mean score of health-oriented lifestyle dimensions are provided in the table below.

Respondents rating in terms of mean score	The mean score of respondents	variation range	dimensions of health-oriented lifestyle
high	44.6	9-54	following medical advices
Relatively high	19.63	5-30	Knowledge of the physical condition
low to occasionally,	18.41	5-30	exercise
Relatively high-high	85.17	4-24	Mental health
high	16.14	3-18	Shopping health
high	16.5	3-18	Driving safety
Relatively high	13.67	3-18	Daily mobility
Relatively low	18.11	5-30	Suitable nutrition
high	28.75	5-30	Alcohol use and smoking
healthy	16.04	3-18	Daily dietary habits
medium	25.37	3-36	Unhealthy diet
Relatively high	18.11	4-24	Self-protection
Relatively low	6.72	2-12	Safety against sunlight
Relatively good	17.62	4-24	Sleeping habits
Relatively good	13.58	3-18	Environmental health

Descriptive Results of independent variables

Social Capital: 15 items were used to measure social capital. The score of 18 and 108 indicated lack of social capital and high social capital respectively. The obtained social capita mean in this case was equal to 76.89 that shows the social capital of Shirazi citizens is at a medium level.

Cultural capital: the cultural capital was one of the independent variables of the study and 14 items were used to measure this variable. The score of 30 and 180 indicated lack of cultural capital and high social capital levels respectively. The obtained cultural capital mean in this case was equal to 70.9 that shows the level of cultural capital among Shirazi citizens is very low.

Economic Capital: Economic capital was one of the independent variables of the study and 4 items were used to measure it. As the items included 6 options, the first option covered nonpossession of car, home and other properties, and the score of zero was considered for them. However, as everyone has a minimum income, income was scored from 1 to 6. In this case, score of 1 and 21 represent the minimum and maximum economic capital respectively. The obtained economic capital mean in this case was equal to 6.17 that shows the level of economic capital among Shirazi citizens is Lower than average.

Human capital and health-oriented lifestyle

Pearson's correlation test was used to test the relationship between human capital and health-oriented lifestyle, and the

results show that the significance of the relationship between the three types of capital and health-oriented lifestyle is equal to zero which indicates a significant relationship between health-oriented lifestyle and human capital. The Correlation coefficients obtained for the relationship between social capital and health-oriented lifestyle is equal to 0.472 that shows a moderate correlation between these variables. In addition, the correlation coefficient obtained for the relationship between cultural capital and health-oriented lifestyle is equal to 0.271. That reflects a weak correlation between these variables. Finally, the weakest correlation was obtained for the relationship between economic capital and health-oriented lifestyle (0.133). The test results show that there is a direct correlation between human capital and health-oriented lifestyle. I.e. With any increase in the level of human capital, the lifestyle of citizens will become healthier. Table 4 shows the obtained results:

Number of observations	Correlation coefficient	Sig level	
597	0.474	0.0000	Social capital and health-oriented lifestyle
507	0.271	0.0000	Cultural capital and health-oriented lifestyle
653	0.133	0.001	Economic capital and health-oriented lifestyle

Health-oriented lifestyle and structural variables

Gender

In this study, the mean difference test was used to assess the relationship between gender and health-oriented lifestyle. Since gender is a dual mode nominal variable and health lifestyle is a distance variable, t-test is the most appropriate procedure. The results obtained based on the quantity of f and significance level, showed that there is a significant difference between the mean obtained for men and women. In other words, women have a more health-oriented lifestyle compared to men. The noteworthy point in this case is that the health-oriented lifestyle mean obtained for women is more than the obtained for men in all fields, except for the field of sports, in which men have proved to be more health-oriented. The following table shows the tests results.

Significance level	The value of t	Degree of freedom	mean	gender	variable
0.036	-2.102	697	292.286 296.52	Man woman	Health-oriented lifestyle
0.000	-5.339	736.685	13.11 14.26	Man woman	Daily mobility
0.005	-2.793	748	17.87 18.38	Man woman	Suitable diet
0.000	-6.526	695.557	28.5 29.4	Man woman	Alcohol use and smoking
0.036	-2.097	738.746	13.3 13.9	Man woman	Environmental health
0.016	-2.347	744	24.94 25.84	Man woman	Unhealthy nutrition
0.000	3.985	745	19.27 17.51	Man woman	exercise

Age

Pearson correlation test was used to test the relationship between age and health-oriented lifestyle. The Results show that the significance level is equal to 0.002 that represents a significant relationship between health-oriented lifestyle and age. The correlation coefficient obtained for the relationship between these two variables is equal to 0.115, which represents a direct and insignificant correlation between the variables. This means that as people grow older, their lifestyle will become healthier. The following table shows the results.

Correlation coefficient	Sig level	
0.115	0.002	Age and health-oriented lifestyle

Marital status

Marital status is proposed as a nominal variable in three modes (single, married or divorced) and health-oriented lifestyle is a distance variable. Therefore, the ANOVA test or F test is the most appropriate method to test the differences between the means of health-oriented lifestyle groups in terms of marital status. According to the descriptive results, the health-oriented lifestyle mean is equal to 290.34 for singles, 296.46 for the married individuals and 285.67 for the divorced individuals. The ANOVA test results, with significance level of 0.010 that is lower than Cronbach's alpha significance level (0.05) indicates the significance of mean difference. The test results are provided in the table below.

total	**divorced**		married		single	means
Significance level	f	Mean Square	Degree of freedom	Sum of squares	The source of variations	variable
0.010	4.655	3295.457 707.98	2 690 692	659.91 488505.9 495096.8	Intergroup Intragroup Total	Health-oriented lifestyle

Social class

Social class as an independent variable, is one of the variables that was measured by the participants using a 5-

point likert scale. In other words, the respondents were asked to put themselves in one of the 5 classes. The ANOVA test was used to test the mean difference in the health-oriented lifestyle according to the five classes. The descriptive results of the study indicated that the lowest health-oriented lifestyle with a mean of 275.89 is obtained by the low class and the highest health-oriented lifestyle with a mean of 300.17 is obtained by the upper middle classes. The ANOVA test results with significance level of zero indicates that there is no significant difference between the means. In other words, people who regard themselves as members of the low classes, show the lowest levels of helth-oriented behavior. The descriptive results and ANOVA test results are provided in the table below.

total 294.25	high 294.675	Upper middle 300.17	Middle class 294.14	Lower middle 285.91	Low class 275.89	means
Significance level	f	Mean Square	Degree of freedom	Sum of squares	The source of variations	
0.000	7.27	4987.77 686.102	4 687 691	19951.08 471352.2 491303.2	Intergroup Intragroup Total	Health-oriented lifestyle

Determinants of health-oriented lifestyle: regression model

Stepwise multiple regression analysis was used to determine the relative influence of independent variables on health-oriented lifestyle. 3 out of the five independent variables, i.e. social capital, cultural capital and age entered the equation and accounted for 23 percent of health-oriented lifestyle variances. Other variables that are not included in the research model accounted for the remaining health-oriented lifestyle variances. Among these three variables, the social capital with beta coefficient of 0.4 had a significantly larger share compared to other variables. I.e., assuming that other variables are controlled, with a unit of variation in social capital, health-oriented lifestyle would undergo a variation of 0.40 unit.

Cultural capital and age (with beta coefficient of 0.182 and 0.124 respectively) entered the regression equation. In this regression model, the co-linearity indices were also investigated. According to the Results of the following table, the tolerance factor and VIF were at an acceptable level. I.e. the gender and economic capital have exited the regression model. The following tables show the results of multivariate regression analysis.

همبستگی چندگانه		R square	Modified R square		Durbin Watson
0.489		0.239	0.233		1.989
Significance level	f	Squares mean	Degree of freedom	Sum of squares	Source of variation
0.000	43.732	22555.762 515.765	3 418 421	67667.285 215589.8 283257	regression remaining total

VIF	Tolerance factor	Significance level	T	Beta	P	
		0.000	22.773		197.329	Y-intercept
1.108	0.903	0.000	8.974	0.43	0.973	Social Capital
1.263	0.792	0.000	3.794	0.11	0.183	Cultural capital
1.161	0.861	0.007	2.696	0.1	0.249	Age

Conclusion and suggestions for further studies:

The present study was an attempt to investigate the health-oriented lifestyle of citizens and their determinants with an emphasis on human capitals. In other words, the main goal in this study was to determine the effect of structural factors on the health-oriented lifestyle and the theories of Bourdieu, Giddens, Cockerham and Weber were used for this purpose. The results showed that the study has achieved the predetermined goals and the results are consistent with the theoretical framework.

According to the Cockerham theory and another generalized theory that asserts that religious and political ideologies have a significant impact on health-oriented lifestyle choices, It can be said that Islam and the political systems have had a decisive role as intervening variables in enhancing the level of health-oriented lifestyle especially in terms of smoking, drugs addiction and alcohol drinking.

According to the results, considering different dimensions of health-oriented lifestyle such as: daily mobility, poor nutrition, smoking and alcohol use, environmental health and exercise, the mean score of health-oriented lifestyle may vary based on gender. In other words, health-oriented lifestyles are more frequent among women than men. Gender, as a social circumstance in the society, plays a very effective role in terms of lifestyle choices. As the results showed, women are ranked higher than men in terms of all aspects of health-oriented lifestyle, exception for exercise, and this can be due to lack of sports facilities and the specific cultural attitude towards women's sports in our society. Therefore, it is necessary to provide women with sports facilities and pave the ground for culture building in terms of cultural attitudes towards women's sports. As for marital status, married people have healthier lifestyles compared to single and divorced people. The fact that married people have the healthiest lifestyles and the divorced people have the least healthy lifestyles is quite consistent with the results obtained by White and Lillard & Rogers. Social support for married people and proper nutrition have play an important role in this regard, therefore these factors should be taken into consideration in order to provide the grounds for marriage of the youth and increasing the stability of family bonds.

In addition, the results of the study show that social, economic and cultural capital have a significant and direct relationship with health-oriented lifestyle. In other words, with any rise in the level of social, economic and cultural capital of citizens, their lifestyle will become healthier. And this is also consistent with the theories of Bourdieu, Giddens, Weber and Cockerham. However, according to the results, the impact of social capital is higher than economic capital. As the results of multivariate regression analysis showed, social capital, from among other independent variables, has the largest share in explaining the health-oriented lifestyle of citizens. Therefore, different aspects of human capital, especially the social and cultural capital should be taken into account in the health-related plans.

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