

Evaluation of the relationship between social capital and quality of life of female heads of households in Yasouj

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ABSTRACT: According to studies conducted on female-headed households, women living in such households are very vulnerable and may face a lot of difficulties and obstacles both at the individual and macro level. As female heads of households do not have social capital, they are faced with many challenges and barriers; for instance, they commit crimes, make diversion and disruption in parenting responsibilities, face material and cultural poverty in the community, and ultimately encounter a reduction in their quality of life. The aim of this study was to evaluate the relationship between social capital and quality of life of female heads of households in Yasouj. This cross-sectional study was conducted on 200 female heads of households in Yasouj and it lasted for six months. Data collection tools included the followings: a demographic questionnaire, the Persian version of the World Health Organization Quality of Life (WHOQOL) questionnaire, and the World Bank questionnaire of social capital (SC-IQ). Statistical analysis was performed using SPSS statistical software and descriptive analytical statistics. The findings of this study showed that quality of life and social capital of female heads of households were completely interdependent and had a positive impact on each other. Based on the results, the quality of life of female heads of households in Yasouj was lower than the quality of life of general population in Yasouj. On the other hand, this group of women had a relatively low level of social capital. As a result, authorities must pay special attention to the problems of this group and design long-term plans and perform community-based researches in order to improve their quality of life and make fundamental changes to increase the social capital of this vulnerable group of women.

Keywords: female heads of households, social capital, quality of life, Yasouj city

I. Introduction

Social capital is one of the social determinants of health which affects the health of communities (Murayama et al., 2012). So, people who are living in a network rich of support, trust, and norms, have access to resources that have a positive effect on their health. Moreover, social capital can enhance the spread of health information and lead to the institutionalization of proper health behaviors, thus it can consequently affect health-related behaviors (Murayama et al., 2012). Hence, it is necessary to make an allowance for social capital in the health field. Studies in the fields of psychologists and psychiatrists show that there is a direct link between social capital and quality of life (Alvani, 2008; Ghaffari, 2006; Noghani, 2008). In communities with high levels of social capital, people's quality of life increases too (Lucumí et al., 2015). According to the definition proposed by the World Health Organization, quality of life is individuals' perception of their position in life in the context of the culture and value system in which they live and in relation to their goals, expectations and standards and concerns. Hence, it is an entirely subjective concept and is not visible by others; in fact, it is based on people's understanding of different aspects of life (Fayers and Machin, 2013). Several indicators can be used to measure social capital in a community at macro level; one of the indicators is the social protection provided for socially vulnerable groups (children, women, etc.) (Sieglar, 2014). Women in female-headed households are one of the vulnerable groups. Nowadays, because of changes in family structures due to war, urbanization, divorce, drug abuse by spouse, and so on, there are an increasing number of female-headed households around the world (Aghajanian and Thompson, 2013). Accordingly, the statistical data indicate the increasing number and proportion of female-headed households is in the last three decades (Aghajanian and Thompson, 2013). About 37.5% of households worldwide are headed by women (Moti, et al. 2008). According to the statistical data reported by the Social Welfare Organization in Iran during the past 10 years (1996 - 2006), 60300 people annually had been added to the population of female heads of households (Moti, et al. 2008). Because of issues

such as divorce, high burden of responsibilities, and multiple different roles, female heads of households are faced with a lack of social capital elements and have a limited social network. As a result, this vulnerable group of people is faced with many other obstacles and problems; for instance, they commit crimes and illegal acts to fulfill their needs and make diversions and disruptions in the upbringing of children. Such acts can increase the number of unstable families, make mental disorders in family members, lead to material and cultural poverty in the community, and ultimately reduce women's quality of life (Lewis et al., 2013). In view of that, it is necessary to pay a special attention to the social capital and quality of life of female heads of households. The quality of life of this group of women is of great importance because improving their quality of life can enhance the quality of life of the whole family. Therefore, effective interventions must be adopted and implemented to increase the quality of life of this group of people. The aim of this study was to evaluate the relationship between the elements of social capital and quality of life of female heads of households in Yasouj.

II. Theoretical Foundations

2-1. Social capital

Thanks to the efforts made by three theorists in the field of social science, i.e. Pierre Bourdieu, Robert Putnam, and James Coleman the term social capital was defined and re-conceptualized. Each of the three mentioned scientists proposed a specific definition. The works by these three theorists had a significant impact on the development of social capital theory and has brought this concept to the focus of scientists from different fields (Shahin, 2016). Social capital is linked with different concepts such as civil community and social communication (Sommerfeldt, 2013).

Pierre Bourdieu proposed the first modern systematic analysis of social capital. Bourdieu defined this concept as the sum of the actual or potential resources which are related to the possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition (Bertolini and Bravo, 2004). He discusses the so-called geographical space which is the outcome of both cultural capital and economic capital and his goal is the restoration of the Marxist theory of stratification (Piri, 2005). To theorize how social capital helps to obtain resources and power, he says that people have unequal access to network based resources. His theory introduces the negative aspects of social capital, especially highlights the exclusion of certain people from access to resources that belong to a network (Carpiano, 2008).

Coleman believes that social capital as a resource for action is one way of introducing social structure into the rational action paradigm (Askarinia et al., 2015). He did not consider social capital as a separate entity; rather he believes that it has diverse natures with two major elements. They all include aspects of social structure which facilitate the real relationships of actors (personal, group, and cooperative relationships) within the structure (Spellerberg, 2001). In other words, social capital includes some aspects of social structure which facilitate collective action (Suzuki et al., 2010) and provide resources for people to achieve their goals.

Robert Putnam, who is a political scientist, uses social capital term for a wide range of concepts, and defines it as: features of social organization, such as networks, norms, and trust that facilitate coordination and cooperation for mutual benefit and simultaneously provide access to public goods (Jones, 2010). His definition is focused on the collective benefits of social networks and the dimensions of social cohesion such as interpersonal trust and interaction norms; it also, covers the qualitative characteristics of social relations (Folland, 2007). Grootaert and Van Blaster proposed a useful theoretical framework for the study of social capital in cities. They discussed the scope, form, and channels used for the flow of social capital. The scope of social capital includes micro level, mid-level, and macro level. The study which was conducted by Robert Putnam on urban organizations in Italy in 1993 was a representation of micro level; in that study, social capital refers to different types of social structures such as individuals or family networks, norms, and common values. Mid-level is represented in studies by James Coleman; in Coleman's studies vertical relationships similar to horizontal relationships which exist within and between different identities, such as trade companies, are considered as social capital. Macro level includes social and political environment which forms social structures beyond the wide-ranging, local, and informal ties and horizontal and vertical hierarchies. It also covers the structures and institutional relations such as political systems, laws and regulations, judiciary systems, and political and civil liberties (Blanco and Campbell, 2006).

III. Methods

This cross-sectional study was conducted on female heads of households (200 women) in Yasouj and it lasted for six months. The response rate was 73.7%.

Data collection tools included the followings: 1) Demographic questionnaire which included questions about age, marital status (married, single, widowed, or divorced), level of education (illiterate, primary school, high school, and academic degree), employment (employed, unemployed), ethnicity, floor area per capita, number of dependents, average households income, households amenities, number of rooms available, length of stay in the current place, health insurance coverage, and chronic and current diseases. 2) Persian version of World Health

Organization Quality of Life Questionnaire (WHOQOL) which has four domains including physical health, psychological health, social relationships, and environmental health and each of these domains, respectively, have 7, 6, 3, 8 questions of Likert type. The questionnaire also has another two questions that do not belong to any of the domains and are intended to assess the overall status of health and quality of life in general (during analysis, these two questions were considered as a part of social relationship domain). Each domain can be scored from 4 to 20 points and higher scores indicate better quality of life (Tehrani et al., 2015). 3) World Bank Social Capital Questionnaire (SC-IQ) which is designed for developing countries and is used to evaluate the social capital at a households level. The “core questions” section of the questionnaire covers 27 key questions and six domains as follows: 1) Membership in associations and groups; 2) The social trust rate; 3) Contribution in team works and public activities; 4) Information and communication; 5) Social cohesion; and 6) The political empowerment and activity. Each domain has 3, 11, 3, 2, 10, and 5 questions, respectively which are either in form of Likert scale items, multiple choices questions, or yes/no items. In this questionnaire, every domain attains a score ranging from zero to 100. To determine the overall mean score of social capital, the mean scores of each domain were calculated (after standardizing the questions to switch them to a number between zero to one hundred).

Statistical analysis was performed using SPSS statistical software (version 21) and descriptive statistics such as mean and standard deviation. We also used analytical statistics such as Pearson correlation coefficient; moreover, to assess the effects of various factors on quality of life and social capital we used Multiple Linear Regression through which the variables were entered into the model and were simultaneously analyzed. In this model, the variables of age, number of dependents, floor area per capita, number of rooms, and length of stay in current place were entered as quantitative values while the variables of education level, marital status, occupation, language, insurance coverage, and current disease were entered as nominal values. As the two variables of per capita monthly income and floor area per capita on the one hand and the other two variables of chronic disease and current disease had overlaps, as a result, we only entered the variables of floor area per capita and the current disease into the model.

IV. Results

Table 1 presents the demographic data of the participants. The mean age of participants was 50.8 years (SD = 13.8). The mean years of education was 5.5 years (SD = 4.8 years). The mean number of dependents was 2.3 people (SD = 1.3) with a minimum and maximum of 1 to 7 persons, respectively. The majority of female heads of households were unemployed (71.1%). Of all, 61.2% of the participants had chronic cardiac, skeletal, and psychological diseases and hypertension.

Table 1: Demographic, social, and economic variables in the studied female heads of households

Variable	Mean	SD	Highest – Lowest
age	50.78	13.78	23-81
Per capita housing area (square meters)	60.08	26.68	6-150
Monthly family income	\$ 50.39	44.99	\$ 0-193
Duration of residence	21.43	16.29	0-55
	N	%	
Marital status			
Married	11	7.2	
Single	5	3.3	
Divorced	54	35.5	
Widow	77	50.7	
Education level			
Illiterate	42	27.6	
Primary	44	28.9	
High school	61	40.1	
University	5	3.3	
Employment Status			
Employed	39	25.7	
Non-employed	108	71.1	
Current Disease	Yes	90	25.9
	No	62	40.8

Table 2 presents the distribution of scores in the four domains of quality of life and six domains of social capital; it also presents the overall scores of quality of life and social capital (domains 1-3-4). Concerning the domains of quality of life, the minimum score belonged to environmental health domain with a mean score of 9.87 (SD = 2.44) and the maximum score belonged to a social relationship domain with a mean score of 12.61 (SD = 3.26).

Concerning the domains of social capital, the minimum and maximum mean scores, respectively, were observed in the domains of “Membership in associations and groups” with a mean score of 19.61 (SD = 17.11) and “Social trust” with a mean score of 51.04 (SD = 17.37).

Table 2: Distribution of the mean scores of different domains of quality of life and social capital in female heads of households

Variable	Mean (SD)	Highest – Lowest
Quality of life domains		
Physical health	11.73(2.34)	6-17.71
Mental health	10.99(3.12)	4-20
Social relationships (three question)	12.42(3.49)	4-20
Social relationships (five question)	12.61(3.26)	4-20
Environmental Health	9.87(2.44)	4-18
Total Quality of life	11.34(2.43)	4.57-18.18
Social capital domains		
Network	19.61(17.11)	0-69.44
Trust	51.04(17.37)	14.29-85.71
Cooperation	49.51(23.59)	0-91.67
Information and communication	44.85(17.06)	0-70.83
Social cohesion	49.16(11.20)	22.69-73.43
Political action	50.23(17.37)	5-81.67
Total Social capital	37.50(14.56)	1.39-71.76

Using multiple regression model we examined the effect of different variables on different domains of quality of life (the dependent variable) and the results showed that age, education level, marital status (divorced), having a disease, floor area per capita, and length of stay in the current place were significantly associated with quality of life.

Table 3: Effects of demographic, economic, and social variables on physical health domain of quality of life of female heads of households

Physical Health	Non-standardized coefficients		Beta	t	P-Value
	B	S.E			
Constant	11.38	0.59	---	19.34	≤0.0001
education	0.11	0.05	0.24	2.38	0.019
Occupation	---	---	---	-1.23	0.222
Living place area	---	---	---	0.67	0.502
The number of rooms	---	---	---	1.16	0.247
Duration of residence	0.04	0.01	0.26	2.54	1.013
A current disease	-1.48	0.53	-0.28	-2.80	0.006

*It is significant at α level less than 0.05.

Based on the results shown in Table 3, the variable of “length of stay in the current place” had a direct and positive relationship with the physical health domain of quality of life of female heads of households and the relationship was statistically significant. In other words, with increasing the length of stay in a place the physical health domain of quality of life of female heads of households improved. The results also showed that the variable of "presence or absence of a current disease" had an inverse and negative relationship with physical health domain of quality of life of female heads of households and the relationship was statistically significant. In other words, "presence of current disease" reduced the physical health domain of quality of life of female heads of households.

Table 4: Effects of demographic, economic, and social variables on psychological health domain of quality of life of female heads of households

Mental health	Non-standardized coefficients		Beta	t	P-Value
	B	S.E			
Constant	8.75	1.26	---	6.93	≤0.0001
Age	0.08	0.03	0.33	3.11	0.003
Occupation	---	---	---	-1.32	0.190
Number of dependents	---	---	---	-1.51	0.135
Living place area	---	---	---	0.61	0.545
The number of rooms	----	----	----	0.64	0.523
Duration of residence	---	---	---	1.67	0.098
Language	---	---	---	-1.95	0.054
A current disease	-2.85	0.74	-0.41	-3.86	0.0002

*It is significant at α level less than 0.05.

Based on the results shown in Table 4, the variable of “age” had a direct and positive relationship with the psychological health domain of quality of life of female heads of households and the relationship was statistically significant. In other

words, with increasing age the psychological health domain of quality of life of female heads of households improved. The results also showed that the variable of "presence or absence of a current disease" had an inverse and negative relationship with physical health domain of quality of life of female heads of households and the relationship was statistically significant. In other words, "presence of current disease" reduced the psychological health domain of quality of life of female heads of households.

Table 5: Effects of demographic, economic, and social variables on social relationship domain of quality of life of female heads of households

Social relationships (3 questions)	Non-standardized coefficients		Beta	t	P-Value
	B	S.E			
Constant	11.29	0.55	---	20.56	≤0.0001
Age	---	---	---	11.22	0.227
Occupation	---	---	---	-1.75	0.120
Number of dependents	---	---	---	-0.92	0.362
Duration of residence	0.06	0.02	0.28	3.01	0.003
Insurance coverage	---	---	---	-1.29	0.201
Social relationships (5 questions)					
Constant	8.73	1.27		6.90	≤0.0001
Age	0.08	0.02	0.33	3.31	0.001
Number of dependents	---	---	---	-1.28	0.203
income	---	---	---	0.00	0.977
Duration of residence	---	---	---	1.76	0.083
Insurance coverage	---	---	---	-1.40	0.166

* It is significant at α level less than 0.05.

Based on the results shown in Table 5, the variable of "length of stay in the current place" had a direct and positive relationship with the social relationship domain (question 3) of quality of life of female heads of households and the relationship was statistically significant. In other words, with increasing the length of stay in a place the social relationship (question 3) domain of quality of life of female heads of households improved. The results also showed that the variable of "age" had a direct and positive relationship with social relationship domain (question 5) of quality of life of female heads of households and the relationship was statistically significant. In other words, with increasing "age", the social relationship domain (question 5) of quality of life of female heads of households improved.

Table 6: Effects of demographic, economic, and social variables on environmental health domain of quality of life of female heads of households

Environmental Health	Non-standardized coefficients		Beta	t	P-Value
	B	S.E			
Constant	5.72	1.1	---	5.22	≤0.0001
Age	0.05	0.02	0.29	2.94	0.004
Married	---	---	---	0.61	0.542
Single	1.19	0.50	0.24	2.37	0.019
Widow	---	---	---	0.19	0.847
Number of dependents	---	---	---	-1.10	0.274
Living place area	0.02	0.01	0.20	2.20	0.030
Insurance coverage	---	---	---	-0.96	0.340

* It is significant at α level less than 0.05.

Based on the results shown in Table 6, the variable of "age" had a direct and positive relationship with the environmental health domain of quality of life of female heads of households and the relationship was statistically significant. In other words, with increasing age the environmental health domain of quality of life of female heads of households improved. The results also showed that the variable of "marital status (being single)" had a direct and positive relationship with environmental health domain of quality of life of female heads of households and the relationship was statistically significant. In other words, "single female heads of households" had a better status of environmental health than "married female heads of households".

Table 7: Effects of demographic, economic, and social variables on overall quality of life of female heads of households

Quality of life	Non-standardized coefficients		Beta	t	P-Value
	B	S.E			
Constant	9.62	1.02		9.39	≤0.0001
Age	0.06	0.02	0.31	2.56	0.013
Occupation	---	---	---	-1.43	0.157
Number of dependents	---	---	---	-1.11	0.271
Living place area	---	---	---	1.01	0.315
Duration of residence	---	---	---	1.53	0.129
Language	---	---	---	-1.26	0.211
Insurance coverage	---	---	---	-0.71	0.478
A current disease	-2.14	0.62	-0.42	-3.44	0.001

* It is significant at α level less than 0.05.

Based on the results shown in Table 7, the variable of “age” had a direct and positive relationship with the overall quality of life of female heads of households and the relationship was statistically significant. In other words, with increasing age the overall quality of life of female heads of households improved. The results also showed that the variable of "presence or absence of a current disease" had an inverse and negative relationship with the overall quality of life of female heads of households and the relationship was statistically significant. In other words, "presence of current disease" reduced the overall quality of life of female heads of households.

Table 8: Effects of demographic, economic, and social variables and overall quality of life on social capital of female heads of households

Total social capital	Non-standardized coefficients		Beta	t	P-Value
	B	S.E			
Constant	-10.01	9.36	---	-1.07	0.289
Age	0.41	0.14	0.32	2.98	0.004
income	---	---	---	-0.04	0.971
Duration of residence	---	---	---	1.43	0.157
Total Quality of life	2.56	0.68	0.41	3.77	0.0004

* It is significant at α level less than 0.05.

Based on the results shown in Table 8, the variable of “age” had a direct and positive relationship with the social capital of female heads of households and the relationship was statistically significant. In other words, with increasing age the social capital of female heads of households improved. The results also showed that the variable of "overall quality of life" had a direct and positive relationship with the social capital of female heads of households and the relationship was statistically significant. In other words, with increasing the overall quality of life, the social capital of female heads of households increased too.

V. Discussion and Conclusion

Most of female heads of households who participated in this study were middle-aged, unemployed, and were educated up to primary school or junior high school. Low education is one of the most important reasons of disqualification for many jobs and is one of the major obstacles for getting a job; thus, low education is also a reason for economic incompetence. Studies which have investigated the employment status of female heads of households have shown that because of women’s lower levels of education they have a more limited access to job opportunities than men in male-headed households. On the other hand, there is a very limited governmental support available for this group of women; the governmental supports provided are largely focused on short term services, and there is limited support to empower female heads of households. Most of them have temporary jobs and are working as workers, manual laborers, or housekeepers. According to the results of this research, compared with the general population of Yasouj, this group of women had lower mean scores of quality of life in all the four domains of physical, psychological, social, and environmental health. Therefore, apparently there are some factors, other than those existing in everyday lives of people, which are specifically attributed to female-headed households and affect women's quality of life. Female heads of households have several different roles simultaneously, and because of the lack of sufficient support in the family and community, they are faced with more serious problems. In this study, there was a significant relationship between age and overall quality of life and its domains including psychological health, environment, and social relationships. In view of that, with increasing age, the mentioned domains of quality of life of the studied women were reduced. In addition to physiological changes, several other problems may occur in the lives of female heads of households which can reduce their quality of life in older ages. Concerning physical health, in this study education was the only variable that was significantly associated with the quality of life of female heads of households. It seems that women with secondary education and higher had a better status in physical domain than those with a primary level of education or illiterates. The impact of Education on quality of life has been proved; even most of the studies have reported that the effect of education can be stranger than the effect of age on quality of life. It seems that which increasing the education level, this group of women will obtain more knowledge of their status and try to improve their situation. The desire to undergo medical examinations, and obtain information via studying books and related magazines can improve the physical health domain of the quality of life.

The results of this study also showed a significant relationship between environmental health domain and marital status (being divorced). The researchers believe that marital status in one of the determinants of all domains of quality of life. In addition, the presence of the spouse can help to reduce stress, cope with the environment, and reduce mortality and morbidity. In this study, there was a significant relationship between the length of stay in the current place and the two domains of quality of life i.e. physical health, and social relationships. Apparently, social capital variables, including a broader network of social relations with the neighbors for a longer period of time, have a positive impact on women quality of life. In this study, the variable of current disease had a significant inverse relationship with the domains of physical health, psychological health, and overall quality of life. This variable had the highest impact on the domain of psychological health than on the other domains. Psychologists believe that female heads of households have both material and emotional problems; therefore, they experience higher levels of stress and anxiety. Moreover, they are at higher risk of mental illness than married people. As a result, the chronic and current diseases of women can exacerbate their problems and could adversely affect their quality of life, as this group of people is more vulnerable to psychological health problems.

In this study, the mean score of social capital of female heads of households was 37.5 while the highest score was 71.7. So, it can be concluded that women's social capital is relatively low. According to Chant, the low level of social capital in female heads of households can be mainly attributed to their limited network of social relations and human relations; because of cultural issues and divorce, they usually prefer to be alone than to be

with others. On the other hand, due to their multiple roles and responsibilities, they often do not have enough time to spend on social relationships. Concerning the relationship between Social capital and quality of life of female heads of households, it was observed that the quality of life had a positive and significant impact on social capital.

As one of the weaknesses of cross-sectional studies, they cannot identify the priority of causes and effects. It is unknown whether high social capital improves the psychological health or mentally healthy individuals in a right environment achieve high social capital. Nevertheless, the relationship between social capital, health, and quality of life has been confirmed by different studies. Taking this close relationship into consideration, authorities could find out the improvements in each domain could strengthen the other domains. It should be also noted that social capital can be created. It is necessary to understand the concept and its importance to seek the skills required to create social capital. Then, its strong impact on various aspects of life can be realized.

The findings of the study showed that quality of life and social capital for female heads of households are completely interdependent and have a positive impact on each other. On the other hand, female heads of households in Yasouj have low levels of social capital and quality of life. Therefore, the authorities must pay special attention to this problem and design immediate and long term plans based on community-based research approaches. Such plans must be adopted and implemented in order to improve the quality of life and make fundamental changes to increase the social capital and participation of this vulnerable group.

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