

## THE IMPACT OF SOCIAL PARTICIPATION ON MENTAL HEALTH AMONG OLDER ADULTS: A COMPARATIVE STUDY BETWEEN URBAN AND SUBURBAN AREAS IN HO CHI MINH CITY

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**Abstract.** In Vietnam, traditional family and community culture has enabled older adults to maintain certain forms of social participation, such as living in multigenerational households, attending elderly association meetings at the ward level, and participating in religious or village festivals. However, urbanization and modern lifestyles risk narrowing these avenues for social engagement, particularly in urban settings where busy lifestyles and weakened neighborhood ties prevail. Research on social participation and mental health among older adults in Vietnam remains relatively sparse, especially studies comparing urban and suburban contexts. This study examines the impact of social participation on mental health among older adults, with a comparative focus between those residing in urban areas (District 5) and suburban areas (Hoc Mon District) of Ho Chi Minh City, Vietnam. The analysis revealed that older adults living in urban areas reported significantly higher levels of social participation compared to those their suburban counterparts. Similarly, the urban older adults reported greater satisfaction with their mental health than suburban older adults. Social participation demonstrated a moderate positive correlation with mental health and was identified as a statistically significant positive predictor of mental health. These findings highlight social participation as a crucial protective factor in enhancing the mental well-being of older adults.

**Keywords:** social participation, mental health, older adults, urban, suburban, Vietnam.

## 1. Introduction

Vietnam is entering a phase of population aging at one of the fastest rates in the world. In 2019, approximately 11.9% of the Vietnamese population was aged 60 years or older, and this proportion is projected to exceed 20% by 2035 [6]. Population aging poses significant challenges for both healthcare and social systems, particularly concerning the mental health of older adults. Globally, it is estimated that around 15% of individuals aged over 60 experience some forms of mental disorders, with depression being the most common [12]. In Vietnam, a community-based

study reported that up to 28.6% of older adults exhibited symptoms of depression, most of which were mild [9]. These figures raise urgent concerns about the need for mental health care among this rapidly growing demographic.

In this context, social participation among older adults is gaining attention as a potential strategy to enhance mental health. Social participation includes maintaining social relationships, engaging in community activities, participating in religious or volunteer groups, and joining hobby clubs [7]. Foundational theories such as Émile Durkheim's (1897) social integration theory and Robert Putnam's (2000) social capital theory suggest that community connection plays a crucial role in mitigating psychological disorders and enhancing individual resilience [4], [1]. Empirical studies have supported these theoretical propositions: Chen et al. (2024) indicate that both social integration and social capital predict positive impacts of community engagement and social connection on health and well-being in later life. Thus, social participation is regarded as a protective factor for the mental health of older adults, serving as a counterbalance to the risks posed by social isolation [2], [3].

Although the importance of social participation has been widely recognized, there remains a research gap in understanding its specific role in the mental health of older adults in Vietnam, particularly when comparing different living contexts such as urban and suburban/rural areas. The living environment may influence opportunities and modes of social participation, potentially leading to disparities in mental health outcomes.

Therefore, this study was conducted to analyze the impact of social participation on the mental health of older adults in Vietnam and to explore potential differences between urban and suburban areas. Specifically, the study aims to clarify: (1) the levels of social participation among older adults in the two areas; (2) differences in mental health between the two groups; and (3) the relationship between social participation and mental health, as well as any variations in this relationship by residential context. The findings are expected to provide scientific and practical evidence to support the development of appropriate interventions aimed at improving mental health for older adults across diverse social settings in Vietnam.

## **2. Content**

### **2.1 Theoretical framework**

Classical sociological theories and gerontological psychology have long emphasized the critical role of social connectedness in individual mental health. As early as the late 19th century, Emile Durkheim demonstrated that lower levels of social integration were associated with a higher risk of suicide, providing an early indication of the detrimental impact of social isolation on mental health [4], [1]. Today, the Social Integration Theory has been further developed, positing that maintaining close connections with family, friends, and the community helps older adults find meaning in life and reduces the risks of loneliness and depression. In parallel, the Social Capital Theory, advanced by Bourdieu and Putnam, asserts that social networks constitute a valuable form of "capital," providing emotional resources (such as comfort and encouragement) as well as material resources (such as information and assistance) to individuals, thereby promoting overall health [1]. Thus, from a theoretical standpoint, social participation through maintaining relationships and engaging in community activities is expected to have a positive impact on the mental well-being of older adults.

### **2.2. Research Methodology**

#### **2.2.1. Study Design and Participants**

This study employed a cross-sectional descriptive design with a quantitative analytical approach. The target population consisted of older adults (aged 60 years and above) residing in

Ho Chi Minh City, specifically in two districts: District 5 (urban area) and Hoc Mon District (suburban area). District 5 was selected to represent the urban context due to its central location, high population density, and the availability of numerous community and organizational activities for older adults. In contrast, Hoc Mon was chosen to represent the suburban setting, characterized by semi-rural features, more dispersed population distribution, and lower socio-economic conditions compared to the city center. The study sample was selected using a convenience sampling method from an existing survey dataset on older adults in these two areas. After excluding cases with incomplete information, the final sample size comprised 292 participants (127 from the urban area and 165 from the suburban area).

**Table 1. Sample Characteristics (N=292)**

Variable	N	Percentage (%)
<b>Gender</b>		
Male	129	44.2
Female	163	55.8
<b>Age group</b>		
60–69 years	118	40.4
70–79 years	117	40.1
80 years and older	57	19.5
<b>Educational attainment</b>		
Illiterate	18	6.2
Primary school	95	32.5
Lower secondary school	95	32.5
Upper secondary school	54	18.5
College/University	30	10.3
<b>Residential area</b>		
Urban	127	43.5
Suburban	165	56.5

*(Source: Author's self-collection)*

### **2.2.2. Measurement Instruments**

The primary independent variable in this study was social participation among older adults, quantified using a self-constructed Social Participation Scale consisting of four items. These four items capture different aspects of social engagement, including: (1) proactively participating in social activities suited to personal interests and capabilities; (2) participating in volunteer activities and contributing to the community; (3) learning new skills or knowledge through age-appropriate classes or training programs; and (4) using information technology (such as smartphones or social media) to interact and connect with friends and relatives. Each item was self-rated by the participants on a five-point Likert scale (1 = “Never/Strongly disagree” to 5 = “Always/Strongly agree”), reflecting the frequency or extent of participation. The overall social participation score is calculated by averaging the scores of the four items, with higher scores indicating more active social participation. Internal consistency testing shows that the scale has good reliability, with a Cronbach’s alpha of 0.767 for the four items, meeting the acceptable threshold for reliability.

The dependent variable of the study was the mental health of older adults, measured through their satisfaction with their mental well-being. Specifically, we employed a single-item measure

where respondents rated their overall satisfaction with their mental state (e.g., “How satisfied are you with your current mental well-being?”). Responses were recorded on a five-point Likert scale ranging from 1 = “Very dissatisfied” to 5 = “Very satisfied.” This single-item measure aims to capture the perceived mental well-being, encompassing feelings of happiness, purposes in life, stress levels, loneliness, and related aspects. Although using a single-item measure has certain limitations, it facilitates field data collection and has been employed in previous studies on older adults in Vietnam. Higher scores indicate more positive mental health outcomes (greater emotional well-being and lower levels of depression or anxiety).

In addition to these two main variables, the questionnaire also collects basic socio-demographic information from participants, including age, gender, educational attainment, and residential area (urban or suburban). These variables were used to describe the sample characteristics and to compare differences between the two residential groups.

### **2.2.3. Data collection procedure**

The data were collected directly through structured face-to-face interviews. A team of trained interviewers visited households with residents aged 60 years and older in the wards of District 5 and the communes of Hoc Mon District to invite participation in the study. Prior to the interviews, the participants were informed about the study's objectives, procedures, and confidentiality principles. Only those who consented and signed an informed consent form were included in the sample. Each older adult was then interviewed using a structured questionnaire. The average duration of each interview was approximately 20–30 minutes. The collected data were subsequently reviewed, cleaned, and coded for analysis.

### **2.2.4. Data analysis**

The data were analyzed using SPSS statistical software (version 26). First, descriptive statistics were conducted to profile the sample characteristics and key study variables. Percentages, means, and standard deviations were used to describe the socio-demographic characteristics of the sample (age, gender, education level, residential area) as well as the scores for social participation and mental health satisfaction.

Next, independent-samples *t*-tests were employed to examine differences between the urban and suburban groups. Specifically, *t*-tests were used to assess whether there were statistically significant differences between the two residential groups (urban vs. suburban) in terms of social participation scores and mental health satisfaction scores. Mean values, standard deviations, *t*-statistics, degrees of freedom (df), and two-tailed *p*-values were reported. The significance level was set at 0.05. Subsequently, Pearson correlation analysis was performed to evaluate the linear relationship between social participation and mental health satisfaction across the full sample (*N* = 292).

Finally, to test the hypothesis regarding the impact of social participation on mental health, a simple linear regression model was constructed, with social participation as the independent variable and mental health satisfaction as the dependent variable. Regression results included the standardized beta coefficient ( $\beta$ ), the coefficient of determination ( $R^2$ ), the *F*-statistic, and the associated *p*-value. Given the relatively large sample size and cross-sectional design, no additional control variables were included at this stage; the analysis focused on the crude effect of social participation. All analysis results were presented in tables (Table 1 through Table 6) to clearly illustrate the statistical findings.

## **2.3. Results**

### **2.3.1. Level of social participation among older adults**

The descriptive statistics presented in Table 2 show that the mean social participation score for the entire sample of older adults was 2.93 on a 5-point scale (*SD* = 0.78). The observed scores ranged from a minimum of 1.0 to a maximum of 5.0, indicating considerable variation between

individuals who hardly participated in any social activities and those who engaged very actively. Overall, a mean score of 2.93 suggests that the level of social participation among older adults was moderate but not particularly high. This finding also reflects the reality that many older adults in Vietnam, especially those residing in suburban areas, still face limitations in opportunities or abilities to engage in social activities beyond their family circle.

**Table 2. Descriptive Statistics of Key Variables**

Variable	Mean	Standard Deviation (SD)	Min–Max
Social_Participation_Score	2.93	0.778	1–5
MentalHealth_Satisfaction	3.62	0.780	1–5

*(Source: Author’s self-collection)*

Notably, when analyzing by residential area, the older adults living in urban areas exhibited significantly higher levels of social participation compared to their suburban counterparts. Specifically, the mean social participation score for the urban group was 3.4016 (SD = 0.5877;  $n = 127$ ), whereas the mean score for the suburban group was only 2.5606 (SD = 0.7061;  $n = 165$ ) (Table 3). This difference was statistically significant, with an independent-samples t-test yielding  $t = 10.839$ ,  $df = 290$ ,  $p = 0.000$  (two-tailed). In other words, the older adults residing in District 5 had a considerably greater capacity for participating in social activities compared to those living in Hoc Mon District. This result aligns with expectations that urban environments offer more opportunities for social engagement for older adults (such as joining clubs, religious groups, charity organizations, etc.), whereas older adults in suburban areas, particularly in more rural-like settings, may have fewer opportunities to participate in activities outside of the family sphere.

**Table 3. Comparison of Social Participation between Urban and Suburban areas**

Area	Mean Social Participation	Standard Deviation (SD)	N
Urban	3.4016	0.5877	127
Suburban	2.5606	0.7061	165

*Note: T-test results:  $t = 10.839$ ,  $df = 290$ ,  $p = 0.000$  (2-tailed).*

*(Source: Author’s self-collection)*

To gain a deeper understanding of the level of social participation, we examined the mean scores for each individual item in the four-item scale (details not shown in the tables). The results indicated that the surveyed older adults scored highest on the aspect of “proactively participating in social activities suited to your personal interests and capabilities,” with a mean score of approximately 3.5 out of 5. This suggests that when activities are appropriate to their preferences and abilities, many older adults are willing to engage. However, the aspects such as “participating in volunteer activities to support the community” and “learning new skills” received lower mean scores (around 2.4–2.6 out of 5), indicating that relatively few older adults engaged in these activities frequently. The use of information technology (e.g., smartphones, social media) to maintain contact with friends and relatives had a mean score of about 3.1/5, suggesting a moderate level of technology adoption among these older adults for social connection. Overall, these component scores depict a nuanced picture: older adults are willing to participate when suitable activities are available, but the extent of participation varies depending on the type of activity. Differences between urban and suburban areas were observed across almost all items: the urban group consistently outperformed the suburban group on all four aspects, particularly in participating in social activities aligned with personal interests and in using information technology for social engagement, with mean score differences of approximately 0.5–1.0 points per item.

### 2.3.2. Level of mental health satisfaction

Across the entire sample, the mean score for satisfaction with mental well-being was 3.62 out of 5 (SD = 0.78; see Table 2). This indicates that, overall, older adults were relatively satisfied with their mental well-being, although approximately one-quarter of participants had scores below the midpoint (below 3). Reported scores ranged from a minimum of 1 (very dissatisfied) to a maximum of 5 (very satisfied), reflecting considerable variation in mental states among individuals.

When comparing by residential area, the data in Table 4 show that the older adults living in urban areas had better mental health than those living in suburban areas. Specifically, the urban group had a mean mental health satisfaction score of 4.02 (SD = 0.766;  $n = 127$ ), significantly higher than the suburban group's mean score of 3.31 (SD = 0.640;  $n = 165$ ). An independent-samples t-test confirmed that this difference was statistically significant, yielding  $t = 8.579$ ,  $df = 290$ ,  $p = 0.000$ .

**Table 4. Comparison of mental health satisfaction between Urban and Suburban areas**

Area	Mean mental health satisfaction	Standard Deviation (SD)	N
Urban	4.02	0.766	127
Suburban	3.31	0.640	165

*Note: T-test results:  $t = 8.579$ ,  $df = 290$ ,  $p = 0.000$  (2-tailed).*

*(Source: Author's self-collection)*

It can be seen that older adults living in District 5 reported greater satisfaction with their mental well-being compared to those residing in Hoc Mon. This finding is consistent with the earlier results regarding social participation, suggesting that the urban environment not only facilitates greater social participation among older adults but is also associated with more positive mental health outcomes. Indirectly, this may reflect the positive impact of a socially connected living environment on the psychological well-being of older adults.

### 2.3.3. The relationship between social participation and mental health

Pearson correlation analysis indicated that the social participation score and mental health satisfaction score were positively correlated ( $r = 0.292$ ,  $p = 0.000$ ; Table 5). A correlation coefficient of 0.292 suggests a moderate relationship: the older adults who participated more actively in social activities tended to have better mental health. Although the correlation is not particularly strong, it clearly implies a positive trend: greater social engagement is associated with a more optimistic and satisfying mental state.

**Table 5. Pearson Correlation between Social Participation and Mental Health Satisfaction**

Variables	Social Participation Score	Mental Health Satisfaction
Social Participation Score	1	0.292 ( $p = 0.000$ )
Mental Health Satisfaction	0.292 ( $p = 0.000$ )	1

*Note: Pearson correlation, 2-tailed.  $N = 292$ ; Significance at the 0.01 level (2-tailed).*

*(Source: Author's self-collection)*

To further investigate the relationship, we conducted a simple linear regression analysis with social participation as the predictor variable for mental health.

The regression results (Table 6) showed that social participation had a positive and statistically significant impact on the mental health of older adults. Specifically, the standardized beta coefficient for social participation was 0.292, with a significance level of  $p = 0.000$ . This coefficient indicates that, for each one-unit increase in the social participation score (on a 5-point

scale), the mental health satisfaction score increased by an average of 0.292 units (also on a 5-point scale), holding other factors constant.

**Table 6. Regression Analysis: Effect of Social Participation on Mental Health Satisfaction**

Predictor variable	Standardized Beta ( $\beta$ )	Sig.	R <sup>2</sup>	F	Sig. F
Social Participation Score	0.292	0.000	0.085	26.978	0.000

*Note: Dependent variable: Mental Health Satisfaction.*

*(Source: Author's self-collection)*

The simple regression model explained approximately 8.5% of the variance in the dependent variable ( $R^2 = 0.085$ ) and was overall statistically significant ( $F(1, 290) = 26.978$ ;  $p = 0.000$ ). Although the  $R^2$  value is not high—which is typical for simple models—the results are sufficient to affirm that there is a causal relationship between social participation and mental health among older adults. In other words, the data support the hypothesis that social participation serves as a predictor of better mental well-being among older adults.

It is important to note that, given the cross-sectional nature of this study, we cannot definitively establish causal direction over time. There remains the possibility that better mental health enables older adults to be more active and interested in participating in social activities (i.e., a bidirectional relationship). However, combined with theoretical and empirical evidence from previous research (to be discussed later), the hypothesis suggesting that social participation positively influences mental health appears well-founded. Overall, the findings confirm two key points: (1) social participation is positively associated with mental health among older adults; and (2) there are significant differences between urban and suburban groups in terms of both levels of social participation and mental health status.

## **2.4. Discussion**

The findings of this study provide important empirical evidence regarding the influence of social participation on the mental health of older adults in the Vietnamese context, while also highlighting differences between urban and suburban areas. Overall, the results align well with theoretical expectations and global research trends, while also revealing notable local characteristics.

*First*, social participation appears to have a clearly positive impact on the mental health of older adults. Those who actively engaged in community activities reported higher levels of mental well-being and exhibited fewer negative symptoms, such as feelings of loneliness or depression, compared to those who were socially withdrawn. The regression results confirmed that social participation directly predicts improvements in mental well-being, reinforcing the hypothesis that social connectedness serves as a protective factor for mental health in later life. This finding is consistent with previous international studies. For example, Gao et al. (2024) found that social participation significantly reduced depression scores among older adults in China [5], while Liang (2024) also reported that higher levels of social participation were associated with lower feelings of loneliness and higher quality of life among older individuals [8]. Psychosocial mechanisms suggest that through engaging in community activities, older adults maintain interpersonal relationships, share emotions, and provide mutual support, thereby experiencing greater meaning and joy in life and mitigating the risk of depression and anxiety [11]. Conversely, social isolation and lack of engagement can expose older adults to loneliness and boredom key risk factors for deteriorating mental health. Thus, our study reinforces the importance of creating opportunities for older adults to maintain active social lives to enhance their mental well-being.

*Second*, the study clarifies disparities between urban and suburban areas regarding both the level of social participation and mental health status among older adults. The older adults residing in District 5 (urban area) participated significantly more in social activities and reported higher mental well-being compared to those living in Hoc Mon (suburban area). This highlights the influential role of urban settings in shaping the social lives of older adults. In an urban environment like District 5—with more developed socioeconomic infrastructure and convenient transportation—older adults have a wider range of activity options: meeting friends at cafes, participating in clubs (such as fitness groups, poetry clubs, chess clubs), and engaging in organizations like the Elderly Association, Veterans Association, or local volunteer groups. These activities not only encourage physical activity but also provide social joy, helping maintain an optimistic mental state. Conversely, in suburban districts like Hoc Mon, opportunities for organized activities are more limited. Older adults in such areas often stay within the household sphere, taking care of grandchildren, doing household chores, or engaging in light labor; dedicated cultural or recreational centers for older adults are scarce. Limited public transportation further restricts their mobility for social interaction. Thus, it is unsurprising that their level of social participation is lower and that many report less vibrant mental well-being. Our findings align with a survey in Turkey, where rural older adults scored significantly lower on social participation compared to their urban counterparts [13], and complement observations by Sun and Lyu (2020) in China, where differences in social participation partly explained mental health gaps between urban and rural areas [10].

*However*, it is essential to recognize some specificities in the Vietnamese context. Unlike some Chinese studies reporting stronger protective effects of social participation in rural areas [10], our study shows that the benefits of social participation are more evident among urban older adults—those already exhibiting higher levels of participation. This may be because Hoc Mon, although categorized as suburban, is undergoing rapid urbanization, resulting in the erosion of traditional community bonds without yet establishing sufficient new organizations for older adults. Thus, suburban older adults may fall into a “social gap,” lacking both traditional and modern forms of social engagement, placing them at a disadvantage compared to their urban counterparts. In contrast, urban older adults not only benefit from urban amenities but also demonstrate adaptability and proactive efforts to find activities that suit their interests (likely due to higher educational attainment and better technological literacy, as indicated in the sample). Therefore, they can better leverage the advantages of social participation. This suggests that different strategies are needed depending on residential context: in highly developed urban areas, activities should be diverse and plentiful to meet higher demands; in suburban areas, there is a need for more proactive efforts to organize and encourage older adults to participate, compensating for the current lack of opportunities.

From a practical perspective, these findings have important implications for the care of older adults. First, enhancing social connections and encouraging social participation should be recognized as key objectives in comprehensive care programs for older adults, alongside medical and material care. Local governments and social organizations should maximize opportunities for older adults to engage, contribute, and feel part of their communities. Specifically, at both urban and rural sites, it is crucial to develop more clubs and interest-based groups for older adults. Models such as cultural clubs, fitness groups, religious groups, or hobby groups (chess, gardening, cooking, poetry, etc.)—if appropriately organized—will attract regular participation from older adults, providing environments for peer interaction, exchange, and mutual learning. Additionally, it is necessary to encourage the formation of self-managed groups and mutual support groups in suburban communities, where formal government programs may not fully reach. For instance, older adults in neighborhoods could form “grandparent-grandchild” groups or peer groups to meet regularly, check in on each other, and thus reduce feelings of isolation and disconnection.



For urban areas such as Ho Chi Minh City, where several elderly care programs already exist (such as the Intergenerational Self-Help Club model and community-based elder care programs organized by the Elderly Association), it is essential to further integrate activities that promote social connection into these initiatives. For instance, health centers and local People's Committees could collaborate to organize specialized sessions on health and culture for older adults within the community, inviting them to participate both to gain knowledge and to provide social interaction opportunities. Utilizing technology is another feasible strategy: establishing Zalo or Facebook groups for elderly members would create frequent interaction channels, especially useful during periods of social distancing like the COVID-19 pandemic. Moreover, the participation of families and the community should be actively encouraged. Children and grandchildren should motivate and facilitate (in terms of time and transportation) older family members to engage in activities outside the home; neighbors should also make efforts to connect with elderly individuals living alone and invite them to join neighborhood activities.

In summary, based on the findings of this study, it is evident that enhancing the mental health of older adults cannot rely solely on medication or individual psychological therapy but requires social interventions that foster their connection with the community. Particular attention should be given to older adults living in suburban and peri-urban areas, who are at risk of being “left behind” during rapid development processes. Creating a socially inclusive and friendly environment for older adults everywhere will help them “live happily, healthily, and meaningfully,” thereby reducing the burden of mental illness and improving the overall quality of life for the aging population in Vietnam.

### **3. Conclusions**

This study affirms that social participation is an important protective factor for the mental health of older adults. Those who maintain strong social engagement through community activities and friendships tend to be happier, more satisfied with their lives, and at lower risk of depression and loneliness. Moreover, the study reveals a significant difference between urban and suburban areas: older adults living in urban areas (specifically District 5) demonstrated higher levels of social participation and better mental health compared to their suburban counterparts (specifically Hoc Mon District). This highlights the influential role of residential context in shaping the lives of older adults and suggests that care policies and programs should be tailored to regional characteristics.

Based on these findings, several practical implications are proposed. First, it is necessary to promote and create enabling environments for older adults to participate more actively in social activities. Local governments and social organizations should develop networks of clubs and interest-based groups for older adults in both urban and rural areas, ensuring that older people everywhere have access to appropriate social spaces. Particularly in suburban and peri-urban areas, the formation of self-managed groups and mutual support networks initiated by older adults themselves should be encouraged to help reduce feelings of isolation. At the same time, existing elderly care programs should integrate more social interaction activities—such as community gatherings, volunteer work, and group outings—to foster engagement and bring joy to older individuals. Finally, families and communities should play a proactive supporting role, encouraging older adults to participate in external activities rather than becoming isolated. These coordinated efforts will contribute to building a dynamic aging society where older adults can live healthily, both physically and mentally.

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