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Social Participation of Older Adults in Rural and Urban Areas: A Cross-Sectional Survey in Turkey

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ABSTRACT

Social participation is important in terms of active aging and quality of life during old age. This cross-sectional study aimed to determine the social participation of older adults in rural and urban areas in Turkey. Related factors were similarly identified. The sample comprised 1,224 people over the age of 60, with a mean of 69.78 ± 7.48 years. Among the participants, 61.4% live in urban areas. The data were collected in family health centers through face-to-face interview and the Interview Form, Social Participation Assessment Form, and Social Participation Dimension of the Turkish Version of the Aging Module of the World Health Organization Quality of Life (WHOQOL) Scale. The scores obtained from the social participation dimension of the scale among the elderly in urban areas were higher than those obtained among the elderly in rural areas ($p = .002$). In addition, older adults in the urban areas who talked on the phone several times a month ($p = .025$), went to concerts, theater/cinema, museum/exhibition, various visual/musical shows ($p = .046$), and engaged in gardening ($p = .032$) obtained higher scores in the social participation dimension than the other participants. Health care professionals should take an advocacy role in building relationships with policy makers and create suitable socialization opportunities for older adults in urban and rural areas.

Highlights

- Social participation is important in terms of active aging and quality of life during old age.
- This is the first study with a huge sample to compare the level of social participation of the elderly in rural and urban areas in Turkey.
- It provides information on the level of social participation of the elderly in a developing country.

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Social participation is an important determinant of health (Hao et al., 2017). Social participation involves a variety of formal and informal activities related to sharing time, money, effort, or any partnership with family members, friends, social groups, or the community (Ekström et al., 2011). Such engagement has three concepts, namely, social connections, informal social participation, and volunteering (Douglas et al., 2017). The concept of social participation is valued considerably among the elderly (Aroogh & Shahboulaghi, 2020). This importance increases when one considers maintaining active social relationships and building new ones for healthy aging and quality of life (Hao et al., 2017). But, with the COVID-19 pandemic, the isolation of the elderly has increased, which has created a disadvantage for the social participation of the elderly (Levasseur et al., 2022).

Moreover, social participation is recommended owing to its contributions to the prevention of non-communicable diseases, elimination of death-related thoughts, increase in cognitive functioning, lower level of frailty, and reduction in feelings of social isolation and loneliness (Baeriswyl & Oris, 2021; Choi et al., 2021; Dawson-Townsend, 2019; Feng et al., 2020; Ge et al., 2022). According to the results of a study examining the relationship between social participation and loneliness, social participation can not only directly reduce loneliness, but also reduce loneliness by increasing social support (Qualter et al., 2022). In addition, mortality and quality of life in old age are reported to be associated with social participation (Aroogh & Shahboulaghi, 2020). Numerous studies show that older adults that participate in social and productive activities enjoy higher levels of life satisfaction, suffer fewer depressive symptoms, have better cognitive function, and experience fewer falls than those who have no such engagements (Douglas et al., 2017; Gao et al., 2018; Hao et al., 2017; Kusmaedi et al., 2017; Li et al., 2017; Oliveira et al., 2016).

Owing to its close relation to health outcomes, social participation's inclusion on the agenda of health professionals providing services to older adults is inevitable. Nurses in particular, as the health professionals who interact the most with older adults in the society, have important roles, such as raising public awareness of the positive effects of social participation on health and encouraging social activities among older adults. Our search for studies on the social participation levels of older adults in urban and rural areas in Turkey revealed a gap in the literature, which we intend to fill with the current findings.

Literature on the social participation of the elderly primarily focus on its relationships with the perception of user-friendly neighborhood (Richard et al., 2008), life satisfaction in urban and semi-urban areas (Baeriswyl & Oris, 2021), and depressive symptoms (Choi et al., 2021). In China, the effect of social participation on the quality of life of the elderly living in rural and urban areas with at least one chronic disease was also examined (Feng et al., 2020). The current study differs from such literature in which the sample is selected from the general population that does not represent any specific group, living in both rural and urban areas that represent seven geographical regions of the country.

This study examines the social participation of older adults in rural and urban areas and its related factors.

The research questions are as follows:

- (1) Do social participation scores of older adults in rural and urban areas differ according to their sociodemographic and health-related characteristics?
- (2) Do social participation scores of older adults in rural and urban areas differ according to their social activities?
- (3) Do social participation scores of older adults in rural and urban areas differ according to their hobbies?
- (4) Do social participation scores of older adults in rural and urban areas differ according to their cultural activities?

Methods

This study follows the Strengthening the Reporting of Observational studies in Epidemiology (STROBE) Statement (von Elm et al., 2007) (See Appendix A).

Time and place

This cross-sectional study was conducted in nine provinces located in different geographical regions of Turkey between September 2018 and July 2019.

Participants

Figure 1 shows the recruitment of participants. In Turkey, primary health care services are provided in family health centers (FHCs). In the center of the provinces in seven geographical regions of Turkey (rural and urban), one FHC was chosen by a simple random method and from its registered customers, two groups of elderly participants were formed as rural and urban according to their residences. The elderly were interviewed at the FHC that they visited for any reason. Inclusion criteria for the study were registration with an FHC, being over 60 years of age, and voluntary participation. Exclusion criteria were neuropsychiatric disorders, such as Alzheimer's, dementia, cognitive impairment, and hearing impairment. Owing to internal and external migration to both metropolitan and small cities, the accurate number of older adults over the age of 60 (research population) in the provinces could not be determined. The G*Power 3.1.9.7 program was used to determine the minimum sample size. Data (effect size: 0.217, power: 0.80, α : 0.05) from Korkmaz Aslan et al. (2019) were used subsequently (Korkmaz Aslan et al., 2019). The sample size was determined as 702 people, with 351 in each group for rural and urban areas with 80% power. In considering a 20% data loss, the information of 842 people was collected. Consequently, 1,224 older adults (rural: 473, urban: 751) formed the current sample. [Figure 1. The recruitment processes of participant]

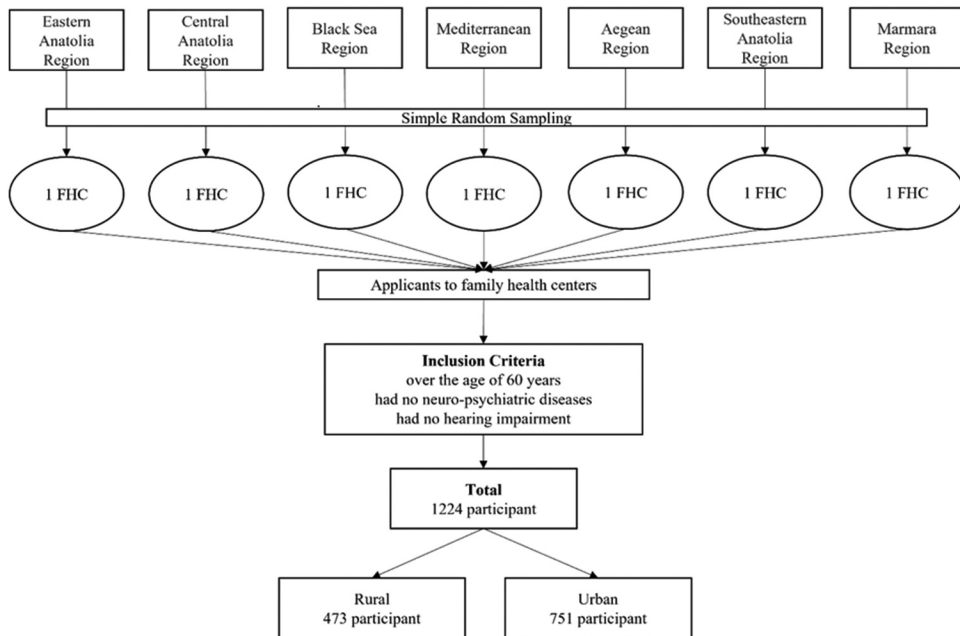


Figure 1. The Recruitment Processes of Participant.

Dependent and independent variables

In this study, the independent variables are the sociodemographic characteristics, health-related characteristics, and the place of residence of the participants. The dependent variables are the data and scores obtained from the Social Participation Assessment Form and the Social Participation Dimension of the Turkish Version of the Aging Module of the WHO Quality of Life Scale (WHOQOL-OLD-TR).

Data collection tools

The Interview Form, Social Participation Assessment Form, and the WHOQOL-OLD-TR were used to collect the data.

Interview form

In this form, the 14 items aimed at determining the sociodemographic characteristics of older adults and the factors that may affect their health/illness and social participation were confirmed on the basis of pertinent literature (Çetin et al., 2014; Ekström et al., 2013; Khullar, 1988; Li et al., 2017; Tomioka et al., 2017a). Expert opinions (from seven public health nurses and two family health physicians) were taken to ensure the validity and reliability of the form. No subsequent changes were made prior to the interview.

Social participation assessment form

The form was confirmed by the researchers on the basis of pertinent literature to determine how frequently older people participated in social, cultural, and leisure activities and whether such engagement was voluntary (Çetin et al., 2014; Ekström et al., 2013; Khullar, 1988; Li et al., 2017; Tomioka et al., 2017a). Expert opinions (from seven public health nurses and two family health physicians) were taken to ensure the validity and reliability of the form. The form comprises 13 items that question the participation of older adults in social, cultural, and leisure activities. A sample question is “how frequently do you participate in aforementioned activities?” and the options are as follows: “once or more per week,” “several times a month,” “several times a year,” and “never.” The higher the score obtained from the form is, the higher is the level of social participation. No subsequent changes were made prior to the interview.

Turkish version of the aging module of the WHOQOL-OLD-TR scale

The WHOQOL-OLD scale was adapted to Turkish by Eser et al. (2010) (Eser et al., 2010). The scale comprises six dimensions (sensory abilities; autonomy; past, present, and future activities; social participation; thoughts on death and dying; and intimacy) and 24 items. The responses are rated on a 5-point Likert type scale. The current study focuses on the “social participation” dimension and its four items. This dimension queries a person’s ability to participate (participation) in daily-life activities, especially in the community. The lowest and highest possible scores are 1 and 5, respectively, for each item and 4 and 20, respectively, for the overall dimension. A higher score indicates better quality of life (i.e., as the score increases, so does the quality of life). The Cronbach’s alpha value of the social participation dimension was 0.74 in the current study, compared with 0.76 in Eser et al. (2010).

Each dimension can be scored separately, and the Cronbach’s alpha value is checked for each sub-dimension. Previous studies have applied variations to shorten the scale and have developed different forms. Following several recommendations, the current study continued the testing variations (Fang et al., 2012). According to the 2020 statistics published by the state in Turkey, 16.9% of the elderly are illiterate, 15.9% are literate but have not completed schooling, and 45.5% are primary school graduates (Turkish Statistical Institute, 2021). Considering the low literacy rate of the elderly in Turkey and the possible difficulties in answering questions related to the entire scale, we used only the social participation sub-dimension in this study.

Data collection

Random sampling was employed to select the FHCs and participants in the study. Interviews were conducted with the elderly who visited the selected FHCs between 09.00 and 17.00, five days a week, for reasons such as need for

prescriptions, examination, and vaccination. The data were collected from the elderly at the FHCs after informing them about the purpose of the study and obtaining their informed consent for participation.

Ethical issues

Permissions to use the scale were obtained from the previous authors via e-mail. Ethics committee approval (Decision No: 146/Date: 18.04.2018) was obtained from the Non-Invasive Clinical Research Ethics Committee of Izmir Katip Celebi University to conduct the study. Furthermore, written consent was obtained from the participants.

Statistical method

The data obtained from the study were analyzed using the Statistical Package for Social Sciences version 21.0 (IBM Corp, 2012). Frequency statistics of all evaluated items were taken to evaluate the distribution of data and identify the missing and outlier values before seeking the answers in the analyses. Subjects with missing items were excluded. For outliers, the survey papers of the subjects were re-checked and subsequently the analysis was performed. The distribution of continuous data (age and social participation score) was evaluated through normality tests (Kolmogorov – Smirnov). The findings show that the age and social participation scores were not normally distributed. In addition, the number and percentage values for sociodemographic characteristics (sex, marital status, educational status, employment status, perceived income, caring for a grandchild, presence of chronic disease, perceived happiness, life satisfaction, and perceived health) were calculated. Similarly, these values were calculated for the social, cultural, and leisure activities (and sub-activities) attended by the elderly. The distribution according to the participant residence was evaluated using the chi-square test. To determine the social participation score according to the measured characteristics, the Mann – Whitney U test for bivariate data and Kruskal – Wallis test for data with more than two variables were performed. Two-way ANOVA was conducted to determine the difference between the social participation scores of participants based on their sociodemographic traits, place of residence, and other characteristics. P values < 0.05 were considered statistically significant.

Results

Table 1 presents the sociodemographic characteristics of the participants. Among them, 38.6% and 61.4% lived in rural and urban areas, respectively. The mean age of the participants in the rural areas was higher than that of those in the urban areas ($p < .001$). For education, the participants in the rural

areas were mostly primary school graduates whereas those in the urban areas reached high school, university, or higher education ($p < .001$). While the participants in the urban areas were mostly retirees, most of those in the rural areas had never worked ($p < .001$). In addition, those who reported that their income was less than their expenses were mostly rural dwellers ($p = .025$) whereas those who perceived their happiness as normal were mostly urban dwellers ($p = .043$). Participants who perceived their health as very good and good were rural dwellers and those who described their health as moderate were urban dwellers ($p = .002$) [Table 1. Distributions of Social Participation Scores and Places of Residence According to the Participants' Socio-demographic and Health-Related Characteristics].

Table 1. Distributions of social participation scores and places of residence according to the participants' socio-demographic and health-related characteristics.

	Rural n (%)	Urban n (%)	Total n (%)	SPS \bar{x} (SD)	Tests, p
Sex					
Female	271 (57.3)	418 (55.7)	689 (56.3)	11.97 (2.86)	¹ $p > 0.05$ ² MWU = -2.04 $p = 0.042$
Male	202 (42.7)	333 (44.3)	535 (43.7)	12.29 (2.98)	
Marital status					
Married	352 (74.4)	538 (71.6)	890 (72.7)	12.27 (2.90)	¹ $p > 0.05$ ² MWU = -3.45, $p = 0.001$
Single	121 (25.6)	213 (28.4)	334 (27.3)	11.68 (2.91)	
Educational status					
Illiterate	112 (23.7)	146 (19.4)	258 (21.1)	11.03 (2.94)	¹ $\chi^2 = 61.50$ $p < 0.001$ ² KW = 77.50 $p < 0.001$
5-year education	295 (62.4)	362 (48.2)	657 (53.7)	12.04 (2.70)	
8-year education	35 (7.4)	71 (9.5)	106 (8.7)	12.90 (2.95)	
11–15-year education	31 (6.6)	172 (22.9)	203 (16.6)	13.33 (2.98)	
Employment status					
Employed	32 (6.8)	48 (6.4)	80 (6.5)	13.4 (2.84)	¹ $\chi^2 = 21.82$ $p < 0.001$ ² KW = 37.63 $p < 0.001$
Retired	198 (41.9)	415 (55.3)	613 (50.1)	12.39 (2.89)	
Never worked	243 (51.4)	288 (38.3)	531 (43.4)	11.6 (2.85)	
Perceived income					
Less than expenses	144 (30.4)	177 (23.6)	321 (26.2)	11.35 (2.93)	¹ $\chi^2 = 7.41$ $p = 0.025$ ² KW = 43.11 $p < 0.001$
Equal to expenses	262 (55.4)	446 (59.5)	708 (57.9)	12.19 (2.73)	
More than expenses	67 (14.2)	127 (16.9)	194 (15.9)	13.07 (3.20)	
Presence of a chronic disease					
No	92 (19.5)	143 (19.0)	235 (19.2)	13.11 (2.63)	¹ $p > 0.05$ ² KW = 163.91 $p < 0.001$
At least one chronic disease	381 (80.5)	608 (81.0)	989 (80.8)	11.87 (2.93)	
Perceived happiness					
Unhappy	83 (17.5)	113 (15.0)	196 (16.0)	1.22 (3.16)	¹ $\chi^2 = 6.29$ $p = 0.043$ ² KW = 184.51 $p < 0.001$
Normal	199 (42.1)	371 (49.4)	570 (46.6)	11.7 (2.49)	
Very happy	191 (40.4)	267 (35.6)	458 (37.4)	13.43 (2.70)	
Life Satisfaction					
Not satisfied	79 (16.7)	127 (16.9)	206 (16.8)	1.28 (2.99)	¹ $p > 0.05$ ² KW = 163.91 $p < 0.001$
Normal	158 (33.4)	264 (35.2)	422 (34.5)	11.6 (2.54)	
Very much satisfied	236 (49.9)	360 (47.9)	596 (48.7)	13.1 (2.73)	
Perceived health					
Well/very well	206 (43.6)	266 (35.4)	472 (38.6)	13.1 (2.68)	¹ $\chi^2 = 12.95$ $p = 0.002$ ² KW = 129.92 $p < 0.001$
Moderate	183 (38.7)	369 (49.1)	552 (45.1)	11.92 (2.68)	
Poor/very poor	84 (17.8)	116 (15.4)	200 (16.3)	1.3 (3.08)	
Total	473 (100.0)	751 (100.0)	1224 (100.0)	12.11 (2.91)	

SPS: Social participation score, 1: Distribution of the Places of Residence According to Sociodemographic and Health-Related Characteristics, 2: Distribution of Social Participation Scores According to Sociodemographic and Health-Related Characteristics).

Figure 2 shows the distribution of social participation scores of elderly individuals in rural and urban areas based on their sociodemographic and health-related characteristics. The comparison revealed that males ($p = .042$) and married participants ($p = .001$) obtained higher scores from the social participation dimension of the WHOQOL-OLD-TR. In addition, as the participants' education level increased, their social participation scores also increased ($p < .001$). The social participation scores of retirees were lower than those of working participants but higher than those of participants who had never worked ($p < .001$). Moreover, as the perceived income ($p < .001$), happiness ($p < .001$), life satisfaction ($p < .001$), and perception of good health ($p < .001$) increased, social participation scores also increased. Meanwhile, social participation scores decreased with age ($p = .002$). The social participation scores of participants in the urban areas were higher than those of older adults living in the rural areas ($p = .006$). However, in the two-way ANOVA, the social participation scores of all sociodemographic variables show no significant difference according to the rural and urban areas [Figure 2. Social Participation Scores According to Sociodemographic Variables].

Of the participants, 91.3% talked to their friends/relatives/neighbors on the phone several times a month, 87.7% had get-togethers with these people, 75.6% were never involved in volunteering activities, 57.7% had never been to places such as restaurants/cafes, and 89.4% had never been to clubs for older adults (Table 2). Participants living in urban areas had more frequent calls with friends/relatives/neighbors on the phone ($p < .001$), get-togethers ($p = .031$), volunteering activities ($p < .001$), and visits to places such as a restaurant/cafe ($p < .001$) and senior clubs

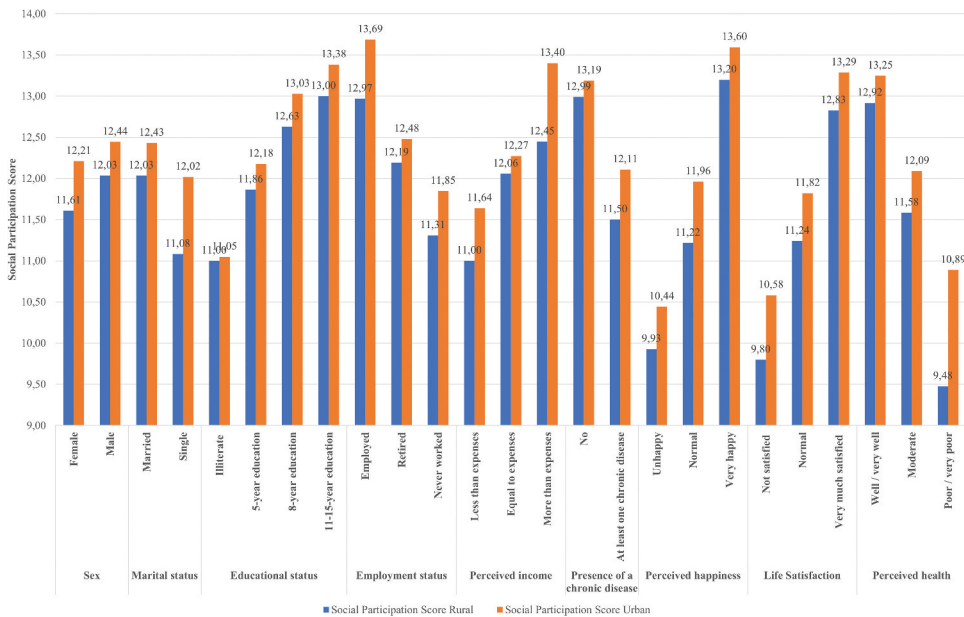


Figure 2. Social Participation Scores According to Sociodemographic Variables.

($p = .043$) than those living in the rural areas [Table 2. Distributions of Social Participation Scores and Places of Residence According to Participation Social – Cultural Activities/Hobbies].

Of the participants, those who met and talked to their friends/relatives/neighbors on the phone and participated in volunteering activities several times a month obtained higher social participation scores ($p < .001$). As the participants' frequency of visiting restaurants/cafes increased, their social participation scores also increased ($p < .001$). In general, participation in clubs for older adults increased the social participation scores ($p = .046$) (Table 2).

Participants who took long walks several times a month in urban areas attained high scores ($p < .001$). The rural dwellers who were involved in gardening had higher scores than those of urban dwellers who were not involved in gardening ($p < .001$). The proportion of urban dwellers who traveled ($p = .019$) or participated in sports activities ($p < .001$) and hobby groups ($p = .005$) a few times a month was higher than that of rural dwellers who never joined such activities.

Participants who never took walks within the scope of hobby-related activities had lower scores ($p < .001$) whereas those who engaged in gardening several times a month had higher scores ($p < .001$). The social participation scores of those who never joined sports activities ($p < .001$) or were never engaged in repairing mechanical equipment/tool ($p < .001$) were low and while those who participated in hobby groups several times a month were high ($p < .001$). As the frequency of travel increased, social participation score increased ($p < .001$) (Table 2).

Most of the participants (81.8%) never attended art activities, such as concerts, plays/cinema, museum/exhibition, various visual/musical shows, whereas 47.8% attended religious activities/ceremonies several times a month. While the number of the participants who had never gone to the aforementioned art activities was higher among rural dwellers ($p < .001$), those who had never participated in religious ceremonies were mainly urban dwellers ($p = .002$). Comparing the scores of participants in terms of the frequency of attending art ($p < .001$) and religious activities ($p < .001$) revealed no difference between those who participated in such activities a few times a month and a few times a year. Those who never participated in any of these activities obtained the lowest scores (Table 2).

Figure 3 and Table 3 present the results of the analysis of social participation scores according to the place of residence and various characteristics. The social participation scores of urban dwellers who talked on the phone several times a month ($p = .025$), went to art activities ($p = .046$), and engaged in gardening ($p = .032$) were higher than those of the participants in other groups [Figure 3. Two-Way Analysis of Variance Results of Social Participation Scores According to Place of Residence and Various Characteristics and Table 3. Two-Way Analysis of Variance Results of Social Participation Scores According to Place of Residence and Various Characteristics].

Table 2. Distributions of social participation scores and places of residence according to participation social - cultural activities/hobbies.

	Rural n (%)	Urban n (%)	Total n (%)	SPS \bar{x} (SD)	Tests, p
Social Activities					
Talking to friends/relatives/neighbors on the phone					
Several times a month	405 (85.6)	712 (94.8)	1117 (91.3)	12.24 (2.83)	$^1\chi^2 = 3.92 p < 0.001$ $^2 KW = 23.37 p < 0.001$
Several times a year	35 (7.4)	22 (2.9)	57 (4.7)	11.33 (3.09)	
Never	33 (7.0)	17 (2.3)	50 (4.1)	1.02 (3.64)	
Meeting with friends/relatives					
Several times a month	400 (84.6)	673 (89.6)	1073 (87.7)	12.33 (2.82)	$^1\chi^2 = 6.94 p = 0.031$ $^2 KW = 42.14 p < 0.001$
Several times a year	55 (11.6)	57 (7.6)	112 (9.2)	1.71 (2.96)	
Never	18 (3.8)	21 (2.8)	39 (3.2)	1.23 (3.64)	
Volunteering activities					
Several times a month	40 (8.5)	161 (21.4)	201 (16.4)	13.11 (2.84)	$^1\chi^2 = 43.05 p < 0.001$ $^2 KW = 28.44 p < 0.001$
Several times a year	29 (6.1)	69 (9.2)	98 (8.0)	12.37 (2.92)	
Never	404 (85.4)	521 (69.4)	925 (75.6)	11.87 (2.88)	
Going to restaurants/cafes etc.					
Several times a month	72 (15.2)	240 (32.0)	312 (25.5)	13.04 (2.75)	$^1\chi^2 = 56.38 p < 0.001$ $^2 KW = 44.70 p < 0.001$
Several times a year	68 (14.4)	137 (18.3)	205 (16.8)	12.23 (2.73)	
Never	333 (70.4)	372 (49.7)	705 (57.7)	11.66 (2.94)	
Cultural Activities					
Going to concerts, museums/exhibitions, visual/musical shows, watching movies or plays					
Several times a month	12 (2.5)	65 (8.7)	77 (6.3)	13.44 (3.26)	$^1\chi^2 = 62.18 p < 0.001$ $^2 KW = 28.38 p < 0.001$
Several times a year	22 (4.7)	123 (16.4)	145 (11.9)	12.92 (2.66)	
Never	438 (92.8)	562 (74.9)	1000 (81.8)	11.89 (2.88)	
Participating in religious activities/ceremonies					
Several times a month	247 (52.3)	337 (45.0)	584 (47.8)	12.30 (2.65)	$^1\chi^2 = 12.91 p = .0022$ $^2 KW = 15.32 p < 0.001$
Several times a year	125 (26.5)	184 (24.6)	309 (25.3)	12.37 (2.96)	
Never	100 (21.2)	228 (30.4)	328 (26.9)	11.53 (3.24)	
Hobbies					
Taking long walks					
Several times a month	203 (42.9)	412 (54.9)	615 (50.2)	12.66 (2.75)	$^1\chi^2 = 17.24 p < 0.001$ $^2 KW = 56.48 p < 0.001$
Several times a year	67 (14.2)	94 (12.5)	161 (13.2)	12.29 (2.76)	
Never	203 (42.9)	245 (32.6)	448 (36.6)	11.30 (3.01)	
Gardening					
Several times a month	269 (56.9)	313 (41.7)	582 (47.5)	12.58 (2.71)	$^1\chi^2 = 33.20 p < 0.001$ $^2 KW = 28.71 p < 0.001$
Several times a year	66 (14.0)	99 (13.2)	165 (13.5)	11.78 (2.88)	
Never	138 (29.2)	339 (45.1)	477 (39.0)	11.66 (3.09)	
Repairing mechanical tools/gadgets					
Several times a month	85 (18.0)	110 (14.7)	195 (15.9)	12.71 (2.95)	$^1 p > .05$ $^2 KW = 21.97 p < 0.001$
Several times a year	55 (11.6)	99 (13.2)	154 (12.6)	12.71 (2.74)	
Never	333 (70.4)	541 (72.1)	874 (71.5)	11.87 (2.91)	
Travelling					
Several times a month	85 (18.0)	182 (24.3)	267 (21.8)	13.13 (2.78)	$^1\chi^2 = 7.94 p = 0.019$ $^2 KW = 68.05 p < 0.001$
Several times a year	202 (42.7)	316 (42.1)	518 (42.4)	12.29 (2.77)	
Never	186 (39.3)	252 (33.6)	438 (35.8)	11.29 (2.94)	
Participating in sports activities					
Several times a month	32 (6.8)	130 (17.4)	162 (13.3)	13.71 (2.43)	$^1\chi^2 = 28.74 p < 0.001$ $^2 KW = 69.19 p < 0.001$
Several times a year	25 (5.3)	41 (5.5)	66 (5.4)	13.05 (2.88)	
Never	415 (87.9)	576 (77.1)	991 (81.3)	11.79 (2.89)	
Participating in hobby groups					
Several times a month	109 (23.0)	232 (30.9)	341 (27.9)	12.64 (2.72)	$^1\chi^2 = 1.47 p = 0.005$ $^2 KW = 18.071 p < 0.001$
Several times a year	27 (5.7)	51 (6.8)	78 (6.4)	12.51 (2.67)	
Never	337 (71.2)	468 (62.3)	805 (65.8)	11.85(2.99)	
Total	473 (100.0)	751 (100.0)	1224 (100.0)	12.11 (2.91)	

SPS:Social participation score, 1: Distribution of the Places of Residence According to Sociodemographic and Health-Related Characteristics, 2: Distribution of Social Participation Scores According to Sociodemographic and Health-Related Characteristics).

Discussion

Social participation is also an important factor for successful aging, which improves the quality of life (Curvers et al., 2018; Wang et al., 2016). Given that our search for studies on the difference between urban and rural dwellers in terms of social participation demonstrated a gap in the literature, the current study examined the level of social participation among older people living in rural and urban areas. The results determine the social participation levels of the elderly in rural and urban areas and its related factors. The findings are expected to provide guidance to health professionals, especially nurses, and relevant institutions/units for developing strategies and plans to encourage social participation among older adults to achieve active and healthy aging.

The results show that social participation was higher among those living in urban areas than among those in rural areas. Among urban dwellers, those who talked on the phone several times a month, participated in visual/musical shows, or were involved in gardening had higher social participation. Similar to the current study, extant literature (Chen et al., 2016; Meng & Chen, 2014; Vogelsang, 2016) reported that older people in urban areas had higher social participation scores. However, social participation was also found to be high among older adults in rural areas (Ribeiro et al., 2017; Tavares et al., 2014), and several studies reported no difference in terms of social participation between older adults in rural and urban areas (Chen et al., 2016; Lvasseur et al., 2015; Sewo Sampaio et al., 2013). With shorter distances between neighbors, relationships between people tend to be more permanent. Residents attend religious activities more regularly with the same people (Tavares et al., 2014). In Canada, greater social participation in metropolitan and urban areas was associated with having a larger, higher quality, and competent social network close to neighborhood resources (Lvasseur et al., 2015; Naud et al., 2019). The varying results in different countries may result from the dissimilar levels of development and cultures or the measurement tools used to assess social participation. Organizing community-based activities and interpersonal interactions based on resource sharing, active participation, and individual satisfaction may encourage older adults to participate in social activities (Aroogh & Shahboulaghi, 2020). Availability of easier and more accessible community resources or facilities can ensure social participation of the elderly and help them occupy themselves (Wang et al., 2016). The development of age-friendly environmental changes that support older adults to increase their social participation by considering the characteristics of different geographic settlements is equally important (Wang et al., 2016). At this point, healthcare professionals, municipalities, and non-governmental organizations must cooperate to ensure the establishment of organizations such as peer groups, clubs, foundations, and associations. Health care professionals can take an advocacy role in building relationships with policy makers and should assume a role in creating suitable activities in urban and rural areas.

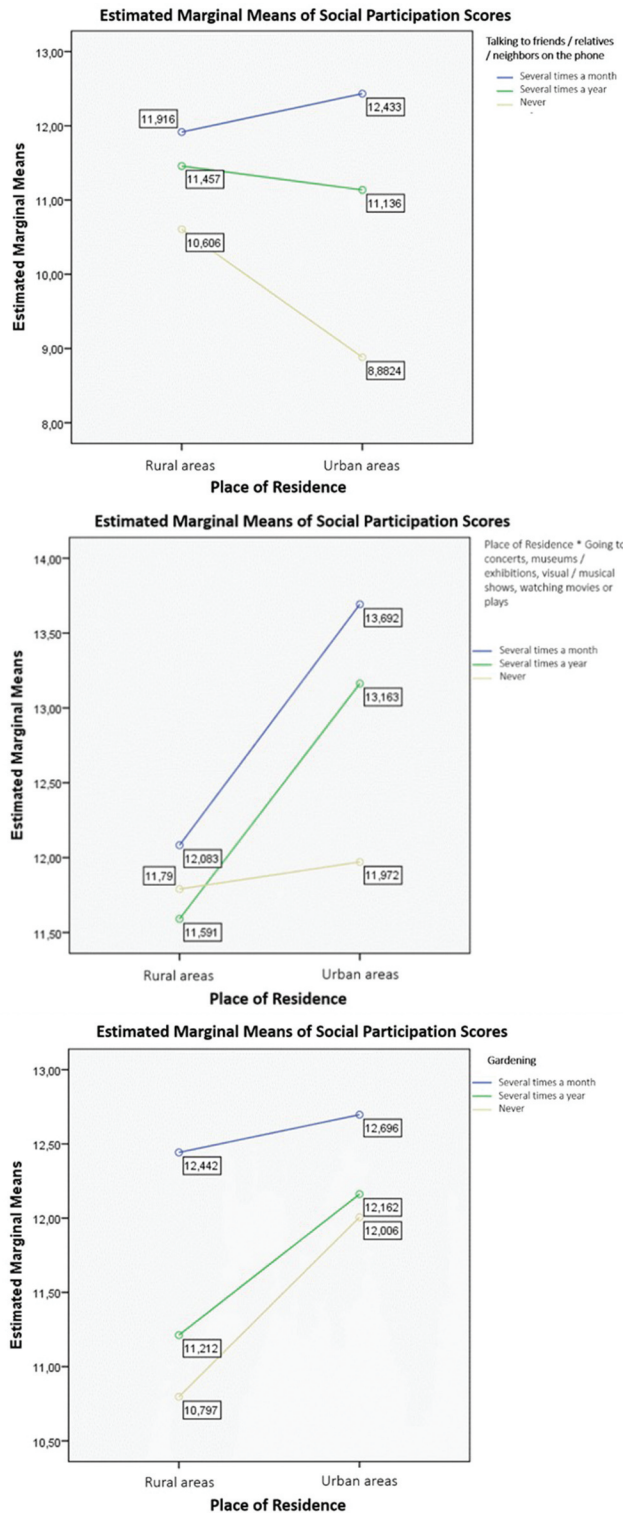


Figure 3. Two-Way Analysis of Variance Results of Social Participation Scores According to Place of Residence and Various Characteristics.

Table 3. Two-way analysis of variance results of social participation scores according to place of residence and various characteristics.

Factors	Sum of Squares	df	Average of Squares	F	p
Place of Residence	13.98	1	13.98	1.702	0.192
Talking to friends/relatives/neighbors on the phone	285.01	2	142.51	17.349	0.000
Place of Residence * Talking to friends/relatives/neighbors on the phone	61.09	2	30.54	3.718	0.025
Error	10004.83	1218	8.21		
Total	189941.0	1224			
Place of Residence	72.30	1	72.30	8.775	0.003
Going to concerts, museums/exhibitions, visual/musical shows, watching movies or plays	53.95	2	26.98	3.274	0.038
Place of Residence * Going to concerts, museums/exhibitions, visual/musical shows, watching movies or plays	50.77	2	25.38	3.081	0.046
Error	10019.05	1216	8.24		
Total	189651.0	1222			
Place of Residence	137.38	1	137.38	16.818	0.000
Gardening	341.89	2	170.94	20.927	0.000
Place of Residence * Gardening	56.54	2	28.27	3.461	0.032
Error	9949.27	1218	8.17		
Total	189941.0	1224			

In the current study, the level of social participation was higher among participants who were male, married, employed, and happy and had high education levels, no chronic disease, good income, life satisfaction, and health. These variables related to social participation have also been determined previously (Bilgili & Arpaci, 2014; Buffel et al., 2014; Curvers et al., 2018; Douglas et al., 2017; Yigen et al., 2018).

Another significant finding is that the social participation score decreases as age increases, corresponding to that of Buffel et al. (2014). This result is expected, owing to cognitive and physiological changes in older adults (Tomioka et al., 2017b). No correlation was determined between social participation and the presence of a chronic disease, having children, and caring for grandchildren. Notably, in the aforementioned studies, sociodemographic variables have similar influence on social participation in countries with different cultures and development levels. Social participation is accepted as a dimension and determinant of quality of life (Momenabadi et al., 2018), and the level of social participation in older adults is affected by various socio-economic and demographic factors (Amagasa et al., 2017; Bilgili & Arpaci, 2014; Momenabadi et al., 2018; Wu & Li, 2018). Given that participation in social and productive activities correlated with positive outcomes in various health indicators, such participation is particularly considered beneficial for older adults (Buffel et al., 2014). Thus, encouraging social participation by considering the sociodemographic variables that affect social participation can become a key strategy for their encouragement and empowerment, one of the basic principles of the health promotion movement (Buffel et al., 2014).

In the current study, the rate of social participation was also higher among older adults who continued participating in social, cultural, and leisure

activities. These social and cultural activities were more common in urban areas, which may be related to the greater availability and accessibility of resources, organizing supportive activities for older people among municipalities, and the high education level of urban dwellers. In literature, the participation of older people in social and cultural activities and hobbies in urban and rural areas vary from one country to another according to development level and cultural characteristics (Levasseur et al., 2015; Tavares et al., 2014; Vogelsang, 2016). The social participation of older adults improves the social and human capital of societies (Curvers et al., 2018).

Limitations

This study encountered several limitations. First, the data obtained by the questionnaire method were based on the verbal expressions of participants and reflected the views of older adults in several provinces in seven regions of Turkey. However, even in the same region, economic, cultural, and social characteristics vary from one province to another. Considering such variations is recommended while reading the findings. Secondly, data collection from individuals who came to the FHC for service may have affected the results because it is not a priority to consider social participation for the individual who applies due to a health problem. Given that no probabilistic sampling method was used, the results cannot be generalized to all societies.

Conclusion

In the current study, the social participation rate was higher among older adults in urban areas than among those in rural areas. To increase social participation of the elderly in both urban and rural areas, we recommend that different environmental factors should be addressed in public health initiatives. Within this context, nurses and other health professionals in primary care health services must consider health strategies by considering the special needs of urban and rural areas in their region. Availability and accessibility of resources need improvement and the development of initiatives for community mobility can be supported through intersectoral cooperation. Finally, more comprehensive quantitative and qualitative studies that examine older adults' social participation and quality of life can aim to reveal types of social participation and the genetic, cultural, and motivational factors that play preventive and facilitating roles.

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