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ORIGINALS

Social Support, Functional Capacity, and Quality of Life in Older Adults in Wellness centers

Apoyo social, capacidad funcional y calidad de vida en adultos mayores de centros de bienestar

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ABSTRACT

Introduction: comprehensive management of the elderly is necessary to ensure quality of life in ageing.
Objective: Determine relationship between social support, functional capacity, and quality of life in older adults attending welfare centers in Cartagena, Colombia.
Materials and Method: descriptive, comparative, cross-sectional, and correlational study was conducted with 417 older adults. The Lawton and Brody functionality scale, the Multicultural Quality of Life Index, and the Social Support Scale were applied. The analysis used central tendency measures and statistical tests: Student's t, Mann-Whitney U, and Kruskal-Wallis H. Ethical guidelines: Resolution 008430 and the Helsinki Principles.
Results: Women represented 61.72% of the participants, with a median age of 68 to 80 years. Economically, 50.96% depended on a state subsidy and 38.76% on family support. Bivariate analysis showed statistically significant associations ($p < 0.05$) with age ($p < 0.001$), economic resources ($p = 0.045$), medication use ($p < 0.001$), physical activity ($p < 0.001$), and productive activity ($p = 0.004$). Correlation analysis revealed that quality of life and social support scores were moderately correlated ($r = 0.41$). Age was significantly associated with functionality ($p < 0.001$). A negative correlation between

age and Lawton and Brody scores (r = -0.21; p < 0.001) indicates increased dependence with advancing age, impacting health-related quality of life.
Conclusion: Older adults in welfare centers rely mainly on family or government financial support. It emphasizes the importance of strengthening support networks and involving families in care. It recommends interdisciplinary health strategies aimed at maintaining or improving functional capacity to enhance quality of life.

Keywords: Elderly adult; health-related quality of life; social support; functional independence

RESUMEN
Introducción: necesario manejo integral del adulto mayor para garantizar su calidad de vida en el envejecimiento.
Objetivo: Determinar relación entre apoyo social, capacidad funcional y calidad de vida en adultos mayores que asisten a centros de bienestar Cartagena-Colombia.
Método: Estudio descriptivo, comparativo, transversal y correlacional. Participaron 417 adultos mayores. Instrumentos: funcionalidad de Lawton y Brody, índice multicultural de calidad de vida y escala de apoyo social, el análisis incluyo medidas de tendencia central, t de Student, U de Mann Whitney y prueba H de Kruskal-Wallis. Ética basada en Resolución 008430 y principios de Helsinki.
Resultados: Predominaron las mujeres con 61.72%, viudas 30.86%, mediana de edad 68; 80 años. El 50.96% depende económicamente del Estado y el 38.76% de la familia. El análisis bivariado mostró significancia estadística (p<0.05) en edad p<0.001, recurso económico p<0.045, medicación p<0.001 y actividad física p<0.001. Las escalas de calidad de vida y apoyo social se correlacionan con puntaje de 0.41. La edad mostró significancia con la escala de Lawton y Brody p<0.001, y apoyo social y calidad de vida con p<0.05. Se observó correlación negativa entre Lawton y Brody y la edad (-0.21; p<0.001), indicando que, al aumentar la edad, disminuye el puntaje y aumenta la dependencia, afectando la calidad de vida.
Conclusión: Las personas mayores en centros de bienestar reciben apoyo económico familiar o estatal. La correlación evidencia la necesidad de fortalecer redes de apoyo e involucrar a la familia en los seguimientos. Se recomienda promover acciones interdisciplinarias en salud que mejoren su funcionalidad.

Palabras clave: Adulto mayor; calidad de vida; apoyo social; independencia funcional.

INTRODUCTION

The World Health Organization (WHO) defines active aging as ‘the process of optimizing opportunities for health, participation, and security to enhance the quality of life of people aging[1]. Active aging emphasizes the active involvement of the elderly on improving their aging process that occurs throughout their lives and which goes beyond a chronological age to maintain or improve health, social relations, and their functionality; with the last two being determining factors in the health of older adults, bearing a direct protective effect on physical and mental health, and well-being that converge in the quality of life as a form of social integration[2].

With respect to quality of life in the elderly, the WHO defines it as: "an individual’s perception of their position in life, considering their culture, values, goals, expectations, and concerns. It has to do with a very broad concept influenced in a complex way by the subject's physical health, psychological state, level of independence, relationship with essential elements of their environment, and social integration"[3].

Thereby, social integration, which indicates the set of contributions received from the relationships established with family, partners, friends, neighbors, institutions, community, and other support networks, is associated significantly with the health-disease process. Shortage of this social integration, is related with higher risk of disease and the elderly may be exposed to stress, being able to produce some physiological

effects directly or through psychological or behavioral processes that end up impacting upon the quality of life[4]. The aforementioned was shown in the study by Gonzales *et al.*, the direct relationship between social support and quality of life with a Spearman's Rho coefficient of 0.53, it meant that when the elderly showed minimal social support, the quality of life was also low. Likewise, Arteaga, Cogollo and Muñoz [5] propose that social support represents an important aspect in the health of the elderly, when documenting the direct relationship between social support and age progression, added to the fact that at the time of the review in adults with chronic non-communicable disease (CNCD) it was observed that 85% of those with negative social support are decompensated due to not following prescriptions from health personnel.

In a Mexican study, Mendoza-Núñez *et al.,*[6] confirmed that 65% of the elderly under treatment due to chronic disease were controlled by extra-familial social support compared to those uncontrolled. Communication practices, care received, and surveillance made it easier for them to carry out actions, like examining their bodies, changing habits, requesting information, and maintaining practices that optimize their wellbeing, compared with the group of elderly individuals who did not have the support[7].

Among the determining factors quality of life provides is the functional capacity in the elderly with cardiovascular diseases. These diseases can cause disability, understood as any serious limitation that affects the capacity of conducting activities for more than one year, and whose origin is related with a deficiency[8]. The deficiency is defined as the loss or anomaly of an organ or of its function, which impacts directly on the quality of life, social support, and functional capacity of the elderly[9].

Functional capacity is defined as the competency the person has to carry out activities of daily living without the need for supervision or help; besides, it is related with the ability to execute tasks within their context, which imply a degree of complexity. Usually, this concept is measured in the physical field, that is, by evaluating the ability to perform basic activities of daily living (BADL) and instrumental activities of daily living (IADL) [10]. This functional capacity may be shortened due to Chronic Non-communicable Diseases (CNCD); in 2021, these represented 86.6% of the total years lived with less functionality, impacting significantly the years of life potentially lost due to low physical activity and sedentary lifestyle, which leads to diminished muscle strength, associated with decreased muscle function and mobility. This generates a considerable economic burden for the families, as well as for health services[11].

Hence, when considering the dimensions exposed, it is fundamental to empower the social actors (caregiver, community leaders) and strengthen interinstitutional networks, which will strengthen public and social actions aimed at improving the quality of life of older individuals, promoting social support and minimizing their dependency (Comisión Económica para América Latina y El Caribe (CEPAL), 2022)[12,13].

Within this context, the Colombian Ministry of Health and Social Protection has acknowledged that people in situation of dependency are a priority for the General Social Security System in Health. This is due to the disease burden that, in many cases, is accompanied by functional dependency, which requires comprehensive management of the elderly that goes beyond the biological setting to guarantee their quality of life during aging[14–16].

According to the information exposed, it became necessary to determine the relationship among social support, functional capacity, and quality of life in the elderly attending wellness centers in three locations of the city of Cartagena, Colombia.

METHOD

A descriptive, comparative, cross-sectional, and correlational study was conducted, characterized by seeking to establish a relationship between variables and it was cross-sectional because it was limited to measuring the presence, characteristics, or distribution of a phenomenon in a population at a specific point in time[17]. The participants were older individuals who attend wellness centers in the city of Cartagena, Colombia. The universe was made up of 2,033 people belonging to 21 wellness centers, denominated life centers in Colombia, according to that contemplated in Legislation 1276 of 2009, with functions that contribute to providing comprehensive care to their needs and improving their quality of life.

The sample was calculated by taking as reference the expected 26.3% prevalence from the scale (Lawton-Brody Functionality), 95% confidence index, 4% error, yielding an initial sample of 464 participants. Given that this is a finite population, it was adjusted to 379 and 10% was added for unforeseen events, so – finally – the sample was 417 participants.

The study used simple random probability sampling. The director of each life center was asked to provide an Excel database of the elderly individuals who attend. Using a random number table, the sample was selected based on an arbitrary order of even numbers. If a person declined to participate or the selection was incomplete, the next individual in the random list was chosen until the full sample was obtained.

Prior to starting the data collection, permission was obtained from the directors of the different life centers in the three locations in Cartagena, coordinating with each life center director the day and hour to collect the information until obtaining the sample. A list was requested from each life center of the elderly individuals and from such list it was assessed that the older adult fulfilled the inclusion criteria of having attended the life center for over one year, and the older adult signing the informed consent. Thereafter, the survey was applied assisted by the researcher and two previously trained nursing professionals.

Before the start of the field work, an assisted pilot test was carried out in the three locations with the participation of 40 older adults to evaluate the time and comprehension of each question from the instruments applied; The duration for each one was 15 minutes, as counted by the researchers. The period to gather the information was during July 2023.

The study development complied with the ethical principles for research with humans, according to Resolution 08430 and was approved through Minutes 09 of 2023 from Universidad de Cartagena, Faculty of Nursing.

The instruments were selected for showing high reliability indices in previous research in Colombia, and the Lawton and Brody Scale has also shown its worth in measuring functionality in other countries[18]. In addition, this scale is included in the health

promotion route as a comprehensive assessment instrument for the elderly according to the Colombian Ministry of Health and Social Protection[19].

A: Multicultural Quality of life Index, capable of discriminating different levels of health-related quality of life (HRQoL). It shows high internal consistency (0.753), researchers have established values from 1 to 3 as poor; from 4 to 7 as regular; and from 8 to 10 as excellent. It is comprised of 10 dimensions: physical wellbeing, psychological/emotional wellbeing, self-care and independent functioning, occupational functioning, interpersonal functioning, socio-emotional support, community and service support, personal fulfillment, spiritual fulfillment, and overall quality of life perception[20–23].

B: The Medical Outcomes Study Social Support Survey (MOS-SS), measures four dimensions of functional social support:emotional/informational support, instrumental or tangible support, positive social interaction, and affection. The scale has a Cronbach's alpha reliability index of 0.941. Test evaluation: the sum of the value corresponding to: global index of social support: all responses is used. Emotional support: answers to question numbers: (3, 4, 8, 9, 13, 16, 17, and 19). Material aid: answers to questions: (2, 5, 12, and 15). Social relations of leisure and distraction: answers to questions: (7, 11, 14, and 18). Affective support: answers to questions (6, 10, and 20)[24].

C: Lawton and Brody's Functionality Scale evaluates functional capacity through eight items: ability to use a telephone, shopping, food preparation, housekeeping, laundry, mode of transportation, responsibility for own medication, and ability to handle finances. Each item is assigned a numerical value, 1 (independent) or 0 (dependent). The final score is the sum of the value of all the responses and ranges between 0 (maximum dependence) and 8 (total independence)[25]; [26].

The descriptive analysis used the Stata statistical software v17 (Stata Corporation, College Station, USA). The qualitative variables report percentages and absolute numbers; the quantitative variable (age) is presented as a measure of central tendency, the median, and of dispersion, the interquartile range, the normality distribution was evaluated, using the Shapiro-Francia test, which has reported good performance in different sample sizes[27,28]; the p values were < 0.05 for the age variable in the dependency level groups and in the perception of social support.

The comparison of the groups according to level of dependency and social support, for the category variables Pearson's Chi-square and Fisher's Exact tests were used; for the numerical variable (age) the comparison according to the levels of dependency (four levels: severe, moderate, slight, and independent) used the Kruskal Wallis test; the comparison of social support (two levels: without support and with support) used the Mann Whitney U test.

The correlation of the variables was performed using the Pearson correlation statistic, normal distribution was evaluated in the variables included in the correlation with the Shapiro-Francia test, with $p > 0.05$. Analyses were conducted in the Stata statistical software v17 (Stata Corporation, College Station, USA) and Excel to generate bar graphs.

RESULTS

Sociodemographic characteristics

Within the sociodemographic characteristics it is identified that a higher percentage are female, with 61.72% (258), with a median age of 73 (RI: 68; 80) years and 30.86% (129) are widowed. Regarding economic resources, 50.96% (213) receive State subsidy and 38.76% (162) has family aid (Table 1).

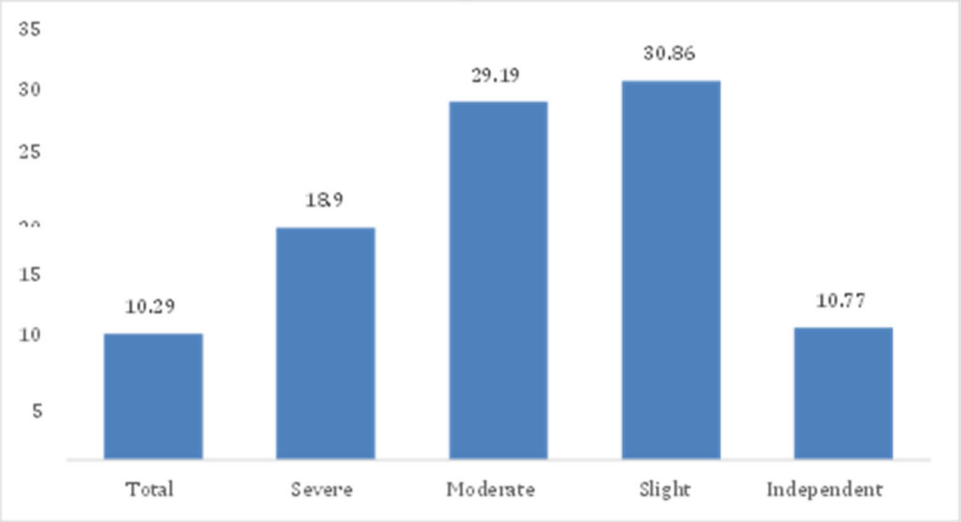
Table 1: Sociodemographic characteristics of the hypertensive older adults who attend a wellness center.

Variable	**(n) % (N=418)**
Sex	
Female	258 (61.72%)
Male	160 (38.29%)
Age. Median (RI)	68; 80 (73%)
Marital status	
Married	97 (23.21%)
Divorced	38 (9.09%)
Widowed	129 (30.86%)
Common law	45 (10.77%)
Single	109 (26.08%)
Economic resources	
Work	28 (6.07%)
Pension	15 (3.59%)
Subsidy	213 (50.96%)
Family aid	162 (38.76%)
Educational level	
None	63 (15.07%)
Primary	229 (54.78%)
Secondary	110 (26.32%)
Higher education	16 (3.83%)
Location	
1	113 (27.03%)
2	152 (36.36%)
3	153 (36.60%)

Functionality level of the hypertensive older adults according to the Lawton and Brody Scale

Of the older adults, 18.9% (79) were identified with severe dependency, and 29.19% (122) with moderate dependency (Figure 1).

Figure 1: Percentage distribution according to dependency level using the Lawton and Brody Scale.

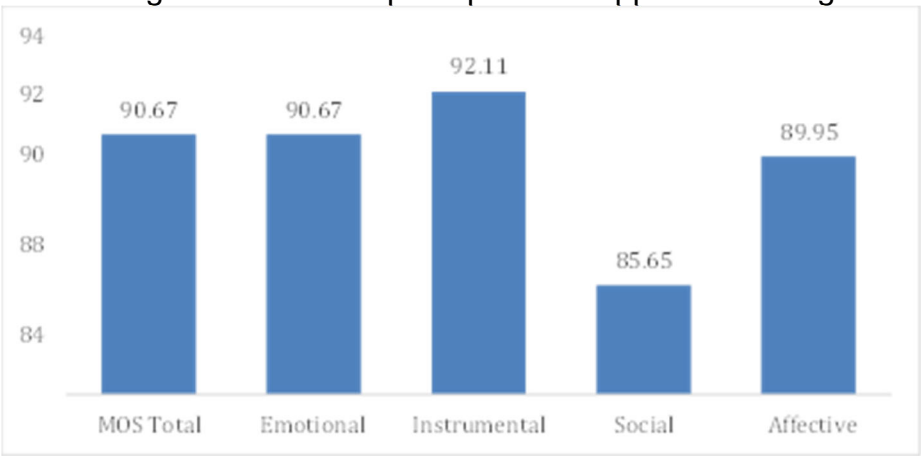


Upon comparing sociodemographic characteristics and the dependency levels according to the Lawton and Brody Scale for age, the Shapiro-Francia test was performed with p = 0.023, showing that it does not have normal distribution, therefore, the median and the interquartile range are presented, differences are observed according to age, sex, location, having hypertension, taking medications, as well as physical and productive activity, all with p < 0.001 (Table 2).

Medical Outcomes Study Social Support (MOS-SS) in hypertensive older adults who attend a life center

The affective support dimensions referring to demonstrations of affection were reported by 89.95% (376/418) and social support referring to the availability of people to share fun and get together was reported by 85.65% (358/418) (Figure 2).

Figure 2: Percentage distribution of perception of support according to dimensions.



When comparing the participants who, according to the MOS scale score, perceive themselves as unsupported (39) with those who perceive themselves as supported (379), significant differences are identified, according to age, economic resources, history of hypertension, diabetes, medication intake, use of visual aids, and productive activity.

The median age is higher in participants who perceived themselves with support, where the mean was 74.1 ± 8.1 years, while in those without support it was 74.5 ± 7.3 years, with p = 0.048. Regarding economic resources, for participants without support, 53.8% (21/39) of such come from family aid and for those with support, 53.0% (201/379) is from subsidies, with p = 0.045.

The use of visual aids is reported more by the group without support with 51.3% (20/39), while in the group with support it is 34.8% (132/379) (Table 2).

Table 2. Bivariate analysis among the sociodemographic characteristics with Lawton and Brody's dependency level scale and the MOS perception of support in the elderly attending a life center.

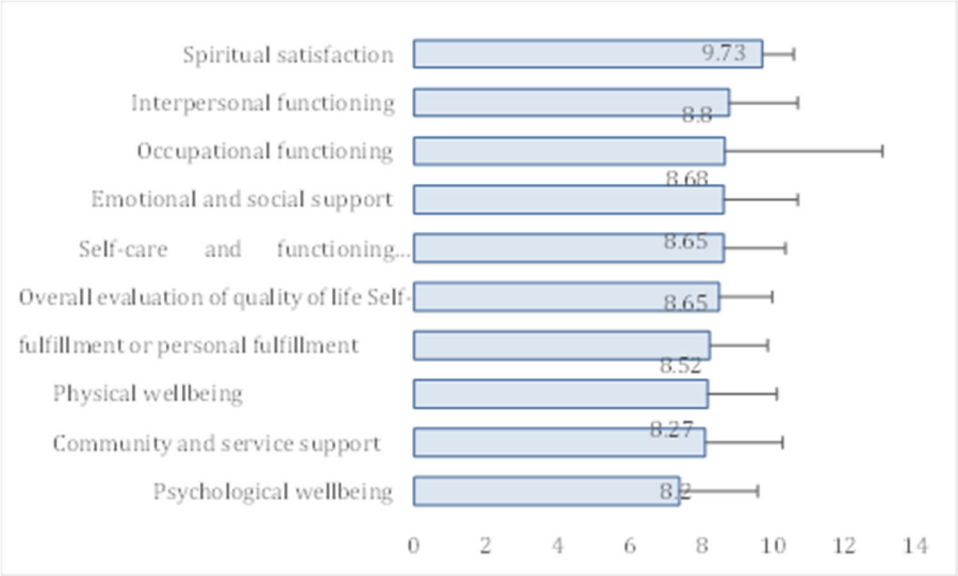
Variable	Study population	Dependency level according to Lawton and Brody						MOS social support		
	(418)	Total (43)	Severe (79)	Moderate (122)	Slight (129)	Independent (45)	p-value	Without support (39)	With support (379)	p-value
Age, median (IQR)	73(68; 80)	67 (80; 75)	78 (72; 83)	74 (69; 80)	72 (67; 76)	70 (67; 76)	**<0.001**	71.0 (67; 76)	74.0 (68; 80)	**0.036**
Sex							**<0.001**			0.47
Female	61.72(258)	65.1(28)	35 (44.3%)	72 (59.0%)	95 (73.6%)	28 (62.2%)		22 (56.4%)	236 (62.3%)	
Male	38.29(160)	34.9(15)	44 (55.7%)	50 (41.0%)	34 (26.4%)	17 (37.8%)		17 (43.6%)	143 (37.7%)	
Marital status							0.53			0.099
Married	23.21(97)	23.3(10)	16 (20.3%)	33 (27.0%)	28 (21.7%)	10 (22.2%)		4 (10.3%)	93 (24.5%)	
Divorced	9.09(38)	3 (7.0%)	5 (6.3%)	11 (9.0%)	17 (13.2%)	2 (4.4%)		3 (7.7%)	35 (9.2%)	
Widowed	30.86(129)	16 (37.2%)	28 (35.4%)	39 (32.0%)	35 (27.1%)	11 (24.4%)		15 (38.5%)	114 (30.1%)	
Common law	10.77(45)	3 (7.0%)	13 (16.5%)	10 (8.2%)	12 (9.3%)	7 (15.6%)		2 (5.1%)	43 (11.3%)	
Single	26.08(109)	11 (25.6%)	17 (21.5%)	29 (23.8%)	37 (28.7%)	15 (33.3%)		15 (38.5%)	94 (24.8%)	
Economic Resources							0.22			**0.045**
Work	6.07(28)	2 (4.7%)	6 (7.6%)	12 (9.8%)	8 (6.2%)	0 (0.0%)		3 (7.7%)	25 (6.6%)	
Pension	3.59(15)	1 (2.3%)	2 (2.5%)	5 (4.1%)	6 (4.7%)	1 (2.2%)		3 (7.7%)	12 (3.2%)	
Subsidy	50.96(213)	16 (37.2%)	45 (57.0%)	64 (52.5%)	67 (51.9%)	21 (46.7%)		12 (30.8%)	201 (53.0%)	
Family aid	38.76(162)	24 (55.8%)	26 (32.9%)	41 (33.6%)	48 (37.2%)	23 (51.1%)		21 (53.8%)	141 (37.2%)	
Educational level							0.18			0.95
None	15.07(63)	11 (25.6%)	17 (21.5%)	16 (13.1%)	15 (11.6%)	4 (8.9%)		6 (15.4%)	57 (15.0%)	
Primary	54.78(229)	23 (53.5%)	45 (57.0%)	70 (57.4%)	70 (54.3%)	21 (46.7%)		20 (51.3%)	209 (55.1%)	
Secondary	26.32(110)	7 (16.3%)	15 (19.0%)	32 (26.2%)	39 (30.2%)	17 (37.8%)		11 (28.2%)	99 (26.1%)	
Higher education	3.83(16)	2 (4.7%)	2 (2.5%)	4 (3.3%)	5 (3.9%)	3 (6.7%)		2 (5.1%)	14 (3.7%)	
Location							**<0.001**			0.086
1	27.03(113)	6 (14.0%)	14 (17.7%)	32 (26.2%)	50 (38.8%)	11 (24.4%)		6 (15.4%)	107 (28.2%)	
2	36.36(152)	17 (39.5%)	38 (48.1%)	45 (36.9%)	46 (35.7%)	6 (13.3%)		20 (51.3%)	132 (34.8%)	
3	36.60(153)	20 (46.5%)	27 (34.2%)	45 (36.9%)	33 (25.6%)	28 (62.2%)		13 (33.3%)	140 (36.9%)	
HBP							**<0.001**			**0.007**
No	5.74(24)	11 (25.6%)	4 (5.1%)	2 (1.6%)	4 (3.1%)	3 (6.7%)		6 (15.4%)	18 (4.7%)	
Yes	94.26(394)	32 (74.4%)	75 (94.9%)	120 (98.4%)	125 (96.9%)	42 (93.3%)		33 (84.6%)	361 (95.3%)	
Medications							**<0.001**			**0.001**
No	10.53(44)	14 (32.6%)	9 (11.4%)	9 (7.4%)	10 (7.8%)	2 (4.4%)		10 (25.6%)	34 (9.0%)	
Yes	89.47(374)	29 (67.4%)	70 (88.6%)	113 (92.6%)	119 (92.2%)	43 (95.6%)		29 (74.4%)	345 (91.0%)	
Hearing problems							**0.029**			0.43
No	92.82(388)	39 (90.7%)	68 (86.1%)	112 (91.8%)	125 (96.9%)	44 (97.8%)		35 (89.7%)	353 (93.1%)	
Yes	7.18(30)	4 (9.3%)	11 (13.9%)	10 (8.2%)	4 (3.1%)	1 (2.2%)		4 (10.3%)	26 (6.9%)	
Visual problems							**<0.001**			**0.042**
No	63.64(266)	17 (39.5%)	41 (51.9%)	79 (64.8%)	94 (72.9%)	35 (77.8%)		19 (48.7%)	247 (65.2%)	
Yes	36.36(152)	26 (60.5%)	38 (48.1%)	43 (35.2%)	35 (27.1%)	10 (22.2%)		20 (51.3%)	132 (34.8%)	
Physical activity							**<0.001**			0.58
No	27.03(113)	25 (58.1%)	24 (30.4%)	34 (27.9%)	21 (16.3%)	9 (20.0%)		12 (30.8%)	101 (26.6%)	
Yes	72.97(305)	18 (41.9%)	55 (69.6%)	88 (72.1%)	108 (83.7%)	36 (80.0%)		27 (69.2%)	278 (73.4%)	
Productive activity							**<0.001**			**0.004**
No	52.63(220)	34 (79.1%)	54 (68.4%)	63 (51.6%)	52 (40.3%)	17 (37.8%)		29 (74.4%)	191 (50.4%)	
Yes	47.37(198)	9 (20.9%)	25 (31.6%)	59 (48.4%)	77 (59.7%)	28 (62.2%)		10 (25.6%)	188 (49.6%)	

Source: Data from surveys applied. P value: Numerical variables (Kruskal-Wallis and Mann Whitney U), Categorical variable (Pearson's chi-squared, Fisher's exact test).

Multicultural Quality of life Index (qli-sp)

The spiritual satisfaction dimension obtained the highest score with 9.73 ± 0.88 and psychological wellbeing obtained the lowest score with 7.41 ± 2.19. (Figure 3).

Figure 3: Averages of the Quality-of-Life dimensions.



Quality of life, with cut-off point ≥ 8 = Excellent; it is identified that 85.89% (359/418) would have excellent and the remaining 14.11% (59/418) would have lower quality of life. In this process, differences are identified according to history of hypertension, diabetes, medication intake, physical activity and participation in productive activities, with p <0.05.

Correlation between sociodemographic characteristics and the scales measured (Lawton and Brody, quality of life, and social support)

When reviewing the correlation between the scores from the scales and age, a strong positive correlation is identified, with p <0.001, among the Lawton and Brody scores. The scores from the quality of life and social support scales also correlate with 0.41 score; with less intensity, a correlation with p <0.05 is observed between age and the score from the social support scale, and the Lawton and Brody scores with those from the social support and quality of life scales. In turn, with negative correlation the Lawton and Brody scores with age with -0.21 and p <0.001 are identified, indicating that when age increases, the Lawton and Brody score diminishes and greater dependency is identified (Table 3).

Table 3. Correlation among sociodemographic characteristics and the scales measured (Lawton and Brody, Multicultural quality of life, and MOS social support).

	Age	Lawton and Brody	MOS	QLI-Sp
Age	1			
Lawton and Brody	-0.21***	1		
MOS	0.11*	0.11*	1	
QLI-Sp	0.02	0.10*	0.41***	1

Source: Data from survey applied
p value: Pearson's correlation. *<0.05 **<0.01 ***<0.001
MOS: Medical Outcomes Study. Social support questionnaire
QLI-Sp: Multicultural Quality of life Index

DISCUSION

The research conducted with older adults who attend wellness centers (not institutionalized) responds to the need to know whether a relationship exists among the variables of social support, quality of life, and functionality – described in the literature as promotors of active aging. In that sense, the results reveal statistical significance among family support, economic resources, and physical activity as factors that double the probability of maintaining a good quality of life and a slight dependency category, even with a diagnosis of chronic disease. The family is a fundamental support for the participating older adults, with significant impact on their daily living and quality of life. Additionally, it can be a crucial source of emotional support, providing encouragement and motivation in occupational activities that contribute to improving their autonomy and wellbeing[29].

Among the sociodemographic findings, it is detailed that there were differences depending on the location, in terms of functionality, mainly due to infrastructure (ventilation, and walking and recreation areas); this is similar to that documented by García Ballesteros[42], and It is the concentration of the elderly in relatively small, closed spaces, which reduces their field of activities, and this can lead to the loss of functional capacity, that is, going from independence to dependency and – overall – to less mobility, to a more routine and repetitive daily behavior of spatial behaviors and is articulated with what is reported by Méndez[30], old age-friendly cities are the way people relate to and appropriate of their surroundings. This is an important part of the quality of life in urban spaces. Furthermore, it was shown that for South America, Colombia is a country that has not shown changes in this aspect, which generates an opportunity to promote this aspect from the cities.

The participating older adults are widowed or single; their educational level was predominantly primary and they depend on subsidies from the State or from their families. This could result in a high probability of keeping their basic needs unmet and impacting their quality of life. This economic aspect of the elderly was studied by Damián in Mexico, observing similarities with this study with the elderly depending on the State's subsidies; however, it is shown that the amount they receive does not meet their requirements and showed deterioration in the purchasing power of the household where these elderly individuals live, leading to maintaining a low economic level[31].

The low economy has repercussions on having less leisure or autonomy time and these – in turn – impact on the quality of life, as documented by Contreras-Hernández[32]. Likewise, said author mentions that the perception of quality of life could be associated with engaging in recreational activities that not only perform physical activities, but also interact with people their same age, with similar problems, share spaces, feel listened to as part of belonging to a social group.

Due to the foregoing, social support has been showing strength in the dynamics of older adults; being in centers or institutions where they manage to interact with others, has demonstrated that it generates a positive impact to maintain their functionality in activities of daily living, as reported by Bhatia *et al.,*[33]. In the elderly with mean age of 73 years, it was observed that the highest scores were for having social networks, associated with a higher proportion of time the participants lived "healthy and able" and with life expectancy, that is, total years of life lived without disabilities and healthy.

Wickramasinghe *et al*.,[34] reported that the physical components, social connection, and social support are the main determinants of health and wellbeing of older adults, and these act as buffers against the physiological and behavioral deficiencies they experience during old age and promote quality of life and the mean scores for these components were higher among non-institutionalized older adults than among institutionalized ones[35]. With regards to changes in functionality that tend to develop dependency with the activities of daily living, it was shown that they are in the moderate and severe categories; this was also exposed by Villalobos[36] and Edjolo *et al.,*[37], who documented a strong association between the passage of years in the elderly and functional dependency.

According to that proposed by Oliveira, Nossa and Mota-Pinto[38], As people age, their dependency tends to increase, making it more challenging to perform instrumental daily activities. This difficulty arises due to harmful organic and physiological changes linked to aging, which significantly reduce motor efficiency when carrying out tasks. Thereby, maintaining regulated physical activity in the elderly population increases by 2.53 times the probability of being in the slight dependency category, besides promoting quality of life, as evidenced in this research.

These findings agree with studies by Arrieta *et al.,*[39] Lam *et al.,*[40] and Hewitt[41], who argue that low-intensity physical activity can improve functional capacity, and that moderate-intensity physical activity has proven effective in the elderly.

With respect to the locations, it could be said that location 1 showed older adults with lower percentages of dependency and in location 3, 62.2% (28/45) are independent.

Among the potential limitations could be the time in years of attending the life center, feeling satisfied with what is offered according to the legislation that regulates wellness centers, which could lead to influencing the responses issued. Another limitation could be that only the quantitative component was considered that could be modified according to perception criteria, which fosters the need to develop a qualitative methodology where the voices of the different actors participating in the wellness centers show their perceptions in relation to the incorporation of the 2021-2030 public policy on aging and old age.

Recommendations: this study suggests exploring the perceptions of the elderly with respect to family and social support and which could be the barriers or facilitators for adherence in activities that promote active aging.

Similarly, it becomes relevant to have an interdisciplinary health team that, upon admission of older adults to wellness centers, can identify the condition of the older adult and carry out early screening to guide them according to established public-policy guidelines on aging and old age and respond to the global challenge of maintaining active aging in the elderly population.

CONCLUSION

The results herein provide evidence of the positive impact of promoting functional capacity and social support to maintain the active aging that impacts upon the quality of

life of the elderly who attend wellness centers. However, it was noted that even the wellness centers that were part of this study do not have programs synchronized with the needs presented by elderly.

Moreover, it was shown how social support from the family, when it plays an active role in the activities of the elderly, such as accompanying them during medical follow-up, maintaining adherence to treatment, and changes in their nutrition could improve psychological well-being and, consequently, increase the percentage in the quality of life item, making it necessary to include the family in the activities and responsibility of the older adults as requisite in the wellness centers.

There is also the promotion of support networks and proposals for healthy space days through agreements with environmental and sports sectors where transportation, nutrition, and care are guaranteed at each outing from the wellness centers.

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