

Support network, functional capacity, and cognitive decline of community-dwelling elderly people

Rede de apoio, capacidade funcional e declínio cognitivo de pessoas idosas da comunidade

Red de apoyo, capacidad funcional y deterioro cognitivo de las personas mayores que viven en la comunidad

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ABSTRACT

Introduction: The increase in life expectancy of the world's population results in a greater number of older adults with cognitive impairments and functional disabilities. The social support network, in addition to the socioeconomic context in which the individual is situated, can have significant impacts on the functionality and cognition of older adults. **Objective:** To analyze the association between social support networks and cognition and functionality in older adults, considering demographic and socioeconomic factors. **Methods:** This is a descriptive, observational, cross-sectional study conducted using questionnaires administered at a Family Health Unit in a municipality in the state of São Paulo. A questionnaire was used containing information on socioeconomic and demographic factors, social support networks (Medical Outcomes Study), activities of daily living (Katz Index and Lawton Scale), and cognitive function (Mini-Mental State Examination). Data were collected through follow-up home visits or at the Basic Health Unit itself. Data analysis was performed using Student's *t*-tests, ANOVA, and the chi-square test, with software SPSS, version 20.0. A significance level of 5% was adopted. **Results:** Among the 120 older adults, perceived support presented a mean of 51.49 points. There was a correlation between perceived social support network and instrumental activities of daily living, and between cognitive ability and perceived social support network ($p < 0.05$). **Conclusions:** Perceived social support was important for older adults' health, cognition, and functionality. These findings may guide the development of policies that emphasize strengthening the structures of social support networks for older adults.

Keywords: Health of the elderly; Cognitive disorders; Social support; Activities of daily living.

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RESUMO

Introdução: O aumento da expectativa de vida da população mundial traz como consequência um maior número de idosos com alterações cognitivas e incapacidades funcionais. A rede de apoio social, além do contexto socioeconômico no qual o indivíduo está inserido, pode trazer impactos significativos sobre a funcionalidade e a cognição do idoso. **Objetivo:** Analisar a associação das redes sociais de apoio com a cognição e a funcionalidade dos idosos, considerando fatores demográficos e socioeconômicos. **Métodos:** Trata-se de um estudo descritivo, observacional e transversal, realizado por meio de questionários aplicados em uma Unidade de Saúde da Família de um município do estado de São Paulo. Foi utilizado um questionário contendo informações socioeconômicas, demográficas, sobre a rede de apoio (Medical Outcomes Study), atividades de vida diária (Índice de Katz e Escala de Lawton) e capacidade cognitiva (Mini-Exame do Estado Mental). Os dados foram obtidos por meio de visitas domiciliares de acompanhamento ou na própria Unidade Básica de Saúde. A análise dos dados foi realizada utilizando o teste *t* de Student, a ANOVA e o teste qui-quadrado, com o *software* SPSS, versão 20.0. Foi adotado nível de significância de 5%. **Resultados:** Nos 120 idosos participantes, a percepção de apoio apresentou uma média de 51,49 pontos. Houve correlação entre a percepção da rede de apoio social e as atividades instrumentais de vida diária, e entre a capacidade cognitiva e a percepção da rede de apoio social ($p < 0,05$). **Conclusões:** A percepção da rede de apoio foi importante para a saúde do idoso, sua cognição e funcionalidade. Essas informações podem direcionar a formulação de políticas que enfatizem o fortalecimento das estruturas de rede de apoio para os idosos.

Palavras-chave: Saúde do idoso; Transtornos cognitivos; Apoio social; Atividades diárias.

RESUMEN

Introducción: El aumento de la esperanza de vida de la población mundial ha dado lugar a un mayor número de personas mayores con alteraciones cognitivas y discapacidades funcionales. La red de apoyo social, además del contexto socioeconómico en el que se inserta el individuo, puede tener un impacto significativo en la funcionalidad y cognición de los ancianos. **Objetivo:** Analizar la asociación entre redes de apoyo social y cognición y funcionalidad en ancianos, teniendo en cuenta factores demográficos y socioeconómicos. **Metodología:** Se trata de un estudio descriptivo, observacional y transversal, realizado a través de cuestionarios aplicados en un Unidad de Salud de la Familia (USF) de un municipio del estado de São Paulo. Se utilizó un cuestionario con información socioeconómica, demográfica, de red de apoyo (Medical Outcomes Study), de actividad diaria (Índice de Katz y Escala de Lawton) y cognitiva (Mini Mental State Examination). Los datos se obtuvieron mediante visitas domiciliarias de seguimiento o en la propia Unidad Básica de Salud (UBS). Los datos se analizaron mediante la prueba T de Student, ANOVA y la prueba Chi Cuadrado, utilizando el programa SPSS 20.0. Se adoptó un nivel de significación del 5%. Se adoptó un nivel de significación del 5%. **Resultados:** De los 120 ancianos participantes, la percepción de apoyo tuvo una media de 51,49 puntos. Hubo correlación entre la red de apoyo social percibida y las actividades instrumentales de la vida diaria, y entre la capacidad cognitiva y la red de apoyo percibida ($p < 0,05$). **Conclusiones:** La percepción de la red de apoyo fue importante para la salud de los ancianos, en términos de cognición y funcionalidad. Esta información puede orientar la formulación de políticas que hagan hincapié en el fortalecimiento de las estructuras de redes de apoyo para las personas mayores.

Palabras clave: Salud del anciano; Trastornos del conocimiento; Apoyo social; Actividades cotidianas.

INTRODUCTION

Population aging in Brazil and worldwide is a demographic and epidemiological reality that may be accompanied by an increased need for care among older adults, as they are more prone to developing chronic diseases and their sequelae.¹ The chronic nature of these diseases is closely linked to increased functional disability among older adults and a decrease in their autonomy. Functional dependence represents one of the most significant risk factors for mortality among older adults, as the decline in the ability to perform basic activities of daily living (BADLs) is associated with survival, and impairment in instrumental activities of daily living (IADLs) contributes to the tendency of older adults to become isolated in their homes, directly impacting social and emotional well-being.² The literature demonstrates that advancing age in both sexes is associated with poorer functional performance, with a prevalence of IADL impairment of 48.8% and BADL impairment of 20.4% among women, and among men, 29.3% for IADL and 13.1% for BADL.³

In addition to functional decline, the increased need for care is also justified by the growing number of older adults with cognitive impairments, a trend foreshadowed by the rise in life expectancy in recent

years.⁴ Cognitive decline is significantly associated with the potential social vulnerability of older adults, given that maintaining cognitive function is essential for their autonomy, functional independence, and quality of life.⁵

In this sense, it is understood that organic dysfunctions, including dementia, are also influenced by the social relationships individuals maintain within a social support network.⁶ The support network could function both as a protective factor against functional disability and cognitive impairment and as a positive impact on the health of older adults by providing resources (economic, informational, and emotional support) and by helping to maintain their autonomy within their family and sociocultural context.⁷ Recent studies show that older adults living in dysfunctional families have lower perceived social support (a score of approximately 78 on the social support scale) compared to those living in families with good family functioning (a score of approximately 95).⁸

Socioeconomic and demographic factors may also contribute to health problems and ineffective care. Thus, it is believed that older adults with limited and less structured social support networks would experience negative consequences regarding functional decline compared to older adults who have broader and more structured social support networks.⁹

Therefore, the objective of this study was to analyze the association between social support networks and cognition and functionality in older adults, considering demographic and socioeconomic factors.

METHODS

Design and Setting

This is a descriptive, observational, and cross-sectional study conducted using questionnaires administered at a Family Health Unit (USF; Unidade de Saúde da Família) located in a municipality in the state of São Paulo, specifically in a socially vulnerable community. According to data from the Unified Registry for Social Programs (CadÚnico, 2022), the USF São Camilo has 346 registered older adults.¹⁰

Sampling

To select the study participants, data from the USF in the São Camilo neighborhood were used to identify individuals aged 60 years or older. A statistical sample calculation was performed based on the prevalence of cognitive decline among older adults, which was 27.6%.¹¹ A design effect (deff) of 2 and a margin of error of 10% were adopted to obtain a minimum sample size of 178 older adults. An additional 10% was added to the sample to account for potential attrition, resulting in a total of 196 older adults. Participants were selected by convenience and at random. Initially, the researchers accompanied home visits conducted by Community Health Agents to older adults, according to a schedule previously established based on the registry of elderly individuals at the Basic Health Unit (UBS; Unidade Básica de Saúde), randomly selecting participants based on the demand for these visits. Subsequently, an active approach was adopted at the UBS, where older adults attending the unit were invited to participate in the study at the UBS itself.

The inclusion criteria were individuals aged 60 years or older, including both home-based and outpatient participants, treated at the USF São Camilo neighborhood of Jundiaí; who signed the Informed Consent Form (ICF) and agreed to voluntarily participate in the study. Exclusion criteria were patients

with severe psychiatric disorders and severe language and comprehension difficulties exhibited by the participant and observed at the time of assessment or identified beforehand through medical records.

Data Collection

Data collection was conducted by the researchers in the homes of the UBS users, by accompanying home visits carried out by the Community Health Agents, owing to their prior knowledge of the area. The objective was to accompany all agents on their respective visit days. Whenever possible, priority was given to ensure that the older adult was unaccompanied by family members or caregivers during the interview, so that they would not interfere with the participants' responses. When participants experienced difficulties answering the questionnaires, they often turned to their caregivers, which could compromise the tests.

A second strategy for contacting research participants involved the researchers' presence at the UBS itself, randomly inviting users over 60 years of age who met the project's inclusion criteria. In this case, the instruments were administered in a consultation room or private office, with preference given to participants who were accompanied only by the interviewer.

The following instruments were used:

- Socioeconomic and demographic characterization instrument;
- Medical Outcomes Study (MOS), consists of 19 questions that participants must answer based on an initial instruction: "If you need to, how often do you rely on someone?", selecting one of five possible responses according to a five-point Likert scale: 0 ("never"); 1 ("rarely"); 2 ("sometimes"); 3 ("almost always"), and 4 ("always"). It is used to assess the participant's social support network, which is measured by the frequency with which the individual has access to material, affective, and emotional support, as well as information and positive social interaction (the quality and frequency of interpersonal relationships that promote emotional well-being, a sense of belonging, and mutual support). Based on the responses, a final score is calculated for each dimension, ranging from 0 to 76 points, with a higher score indicating a higher level of social support.¹² Questionnaire available in the attachment (Annex);
- Katz Index, for assessing performance in BADLs, which involve self-care activities such as eating, bathing, dressing, personal hygiene, mobility, and maintaining control over bodily functions;¹³
- Lawton Scale, for assessing performance in IADLs, which include the ability to prepare meals, shop, use transportation, care for the home, use the telephone, manage one's finances, and take medications;¹⁴
- Mini-Mental State Examination (MMSE), for cognitive assessment and screening for dementia and related conditions, through the analysis of various domains (spatial and temporal orientation, immediate and recall memory, calculation, language-naming, repetition, comprehension, writing, and copying a drawing).¹⁵

The instruments were administered in the following order: Sociodemographic Questionnaire, MMSE,¹⁵ Katz Index,¹³ Lawton Scale¹⁴ and MOS.¹² The interviewer demonstrated how to properly answer the questionnaires and was able to clarify any questions the respondent might have.

Data collection was conducted in person using a structured questionnaire. The responses obtained were recorded manually and subsequently transcribed into a spreadsheet and coded in numerical format, following the scoring criteria established by the scale used. The entire process adhered to ethical research principles, ensuring the confidentiality of information and the anonymity of participants.

Statistical Analysis

For the descriptive analysis, quantitative variables were analyzed using measures of central tendency and dispersion. Qualitative variables, on the other hand, were expressed in terms of absolute and relative frequencies.

For the analytical analysis, the tests performed depended on the nature of the outcome variable. The MOS questionnaire was dichotomized at the median, which was 51, and this served as the study's outcome. A comparison of means was performed using Student's *t*-test or analysis of variance (ANOVA) for quantitative variables. If the outcome variable was qualitative, the chi-square test was performed. Pearson's correlation was performed on the continuous variables to quantify the degree and direction of the association between the variables: Relationship between the MOS domains and the Katz, Lawton, and MMSE scales.

A significance level of 5% was considered. The statistical software used for these analyses was the Statistical Package for Social Sciences (SPSS), version 20.0.

Ethical considerations

All participants signed the Informed Consent Form, and the study was approved by the Ethics Committee of the Faculdade de Medicina de Jundiaí (CAAE: 58880422.4.0000.5412). This research was conducted in accordance with the ethical and legal principles established in Resolution 466/12, which sets forth guidelines for research involving human subjects, as well as Resolution 510/2016.

RESULTS

Table 1 provides a descriptive sociodemographic analysis of the sample of older adults in absolute numbers (*n*) and percentages (%). Upon analyzing the results of the sociodemographic questionnaire administered to the 120 older adults, it was found that 70% of the sample was female. Among the participants, 40% were married, and the majority of participants reported being unable to write (53.3%). Furthermore, those falling into the category of earning up to two minimum wages per month accounted for 90% of the participants. It is worth noting the predominance of systemic arterial hypertension among the comorbidities identified in the questionnaire (77.5%).

Table 2 provides a descriptive analysis of the MOS, MMSE, Katz, and Lawton questionnaires. Analysis of the results of the social support network questionnaire (MOS) revealed a mean score of 51.49 points (± 20.06), with scores ranging from 0 to 76, indicating moderate social support among participants. When analyzing the results of the Katz and Lawton questionnaires, a predominance of the "no help" option was observed for performing activities of daily living. Regarding the results of the MMSE application, an average of 20.05 points (± 5.52) was found, with the instrument's score ranging from 0 to 29 points (the score was adjusted according to educational level, adopting a cutoff point of 25 points for individuals with 1–4 years of schooling). Furthermore, regarding the MMSE score, 62.5% of the sample obtained 19 points or higher, and 37.5% obtained up to 18 points, indicating that the majority had preserved cognitive function.

Table 3 presents a comparison between high and low perceptions of social support and the mean scores for the Lawton (IADL), Katz (BADL), and MMSE (cognitive) scales.

Table 1. Characteristics of participants. Jundiaí, 2023.

Category	Name	n	%
Gender	Male	36	30
	Female	84	70
Race	Black	20	16.7
	Brown	39	32.5
	White	61	50.8
	Yellow	0	0
	Indigenous	0	0
Marital status	Single	12	10.0
	Married	48	40.0
	Divorced	16	13.3
	Widowed	40	33.3
	Common-law marriage	4	3.3
Can read	Yes	63	52.5
	No	57	47.5
Can write	Yes	56	46.7
	No	64	53.3
Income	Up to two minimum wages	108	90
	More than two minimum wages	12	10
Diabetes	Yes	56	46.7
	No	64	53.3
Hypertension	Yes	93	77.5
	No	27	22.5
Dyslipidemia	Yes	54	45
	No	66	55
Other comorbidities	Yes	52	43.3
	No	68	56.7

Table 2. Results of the Katz, Lawton, MOS, and MMSE questionnaires.

Instruments	Instrument domains	Mean	Median	Standard Deviation	<18 points	≥19 points
KATZ	SA	5.36	6	1.20	N/A	N/A
	AP	0.44	0	0.77	N/A	N/A
	AT	0.21	0	0.83	N/A	N/A
LAWTON	SA	5.93	7	2.81	N/A	N/A
	AP	1.27	1	1.35	N/A	N/A
	NC	1.62	0	2.42	N/A	N/A
MOS	Material support	12.75	16	4.84	N/A	N/A
	Affective support	8.82	9	3.77	N/A	N/A
	Emotional support	20.85	24	10.32	N/A	N/A
	Positive social interaction	9.31	9	5.68	N/A	N/A
	Total score	51.49	51	20.06	N/A	N/A
MMSE	N/A	20.05	19	5.52	37.5%	62.5%

MOS: Medical Outcomes Study; MMSE: Mini-Mental State Examination; SA: no assistance; AP: partial assistance; AT: total assistance; NC: unable to perform; N/A: not applicable.

Table 3. Relationship between the MOS (median) and the Lawton, Katz, and MMSE scales. Jundiaí, 2023.

	Level of support	MOS	Mean	Standard Deviation	p-value*
LAWTON	SA	≤51 points	5.10	3,063	0.001
		≥52 points	6.77	2,273	
	AP	≤51 points	1.43	1,477	0.178
		≥52 points	1.10	1,203	
	NC	≤51 points	2.17	2,787	0.012
		≥52 points	1.07	1,867	
KATZ	SA	≤51 points	5.13	1,432	0.400
		≥52 points	5.58	0.869	
	AP	≤51 points	0.55	0.891	0.127
		≥52 points	0.33	0.629	
	AT	≤51 points	0.33	1,084	0.103
		≥52 points	0.08	0.462	
MMSE	N/A	≤51 points	18.55	5,067	0.003
		≥52 points	21.55	5,592	

MOS: Medical Outcomes Study; MMSE: Mini-Mental State Examination; SA: no assistance; AP: partial assistance; AT: total assistance; NC: unable to perform; *Student's t-test $p < 0.05$.

According to the results of the Lawton scale, participants who perceived greater social support showed a higher mean score in the “no assistance” category for IADv. Conversely, a lower mean for “unable to perform” was associated with those who perceived lower social support. In the Katz scale, there was no significant association between social support and autonomy in basic activities ($p > 0.05$). On the other hand, the MMSE showed a difference in mean cognitive performance according to perceived social support: MOS ($p = 0.003$), with a mean score of 21.55 among those with greatest support and 18.55 among those with the least support.

Table 4 shows the correlation between the domains of the MOS instrument and the Katz, Lawton, and MMSE scales. Among the four MOS domains, only “emotional support” showed a significant correlation ($p < 0.05$) with the Lawton and MMSE scales. In the Lawton scale, the correlation was

Table 4. Relationship between MOS domains and the Katz, Lawton, and MMSE scales.

		KATZ		LAWTON		MMSE		
		SA	AP	AT	SA	AP	NC	N/A
Material support	Pearson correlation	-0.125	0.055	0.134	-0.106	-0.02	0.126	0.014
	p-value	0.174	0.547	0.143	0.249	0.832	0.171	0.880
Affective support	Pearson correlation	0.079	-0.065	-0.052	0.084	0.019	-0.038	0.172
	p-value	0.392	0.479	0.572	0.360	0.836	0.683	0.060
Emotional support	Pearson correlation	0.176	-0.083	-0.18	0.362	-0.147	-0.281	0.223
	p-value	0.055	0.368	0.05	<0.001	0.109	0.002	0.014
Positive social interaction	Pearson correlation	0.125	-0.034	-0.143	0.156	-0.075	-0.122	0.166
	p-value	0.174	0.713	0.120	0.089	0.419	0.186	0.070

MOS: Medical Outcomes Study; MMSE: Mini-Mental State Examination; SA: no assistance; AP: partial assistance; AT: full assistance; NC: unable to perform; N/A: not applicable.

positive with the “no assistance” category ($r=0.362$, $p<0.001$) and negative with the “unable to perform” ($r=-0.281$; $p=0.002$). These results indicate that greater emotional support is associated with greater independence in instrumental activities. A significant correlation was also observed for MMSE scores ($r=0.223$; $p=0.014$), suggesting that older adults with better cognitive performance perceive greater emotional support.

DISCUSSION

As demonstrated in the present study, older adults’ perception of their social support network plays a significant role in preserving their cognitive abilities and in their ability to perform IADL. The regular and meaningful social interaction provided by the social support network can promote cognitive stimulation and intellectual activities, which are essential for maintaining health and cognitive functioning in older age. Through conversations, games, discussions, and the sharing of experiences, the social support network can provide an enriching environment, stimulating cognitive skills such as memory, attention, reasoning, and problem-solving. Furthermore, the social support network can help identify and address cognitive decline early on, favoring the search for appropriate services and interventions.^{16–18} The significant correlation found in the study between emotional support and cognitive ability should also be highlighted, as it reinforces the idea that a welcoming and emotionally stable environment enables the maintenance and promotion of cognitive function among older adults.

Compared to other Brazilian studies that assessed the perception of social support using the same instrument (MOS), the present study reveals a lower mean score (51.49).^{19,20} In this sense, low levels of perceived social support were significantly related, according to the findings of this study, to older adults’ functionality, particularly regarding IADL. On the other hand, the perception of having good social relationships and that this support network can help in times of need is an important factor in maintaining the quality of life of older adults.²¹ These results are consistent with other studies, such as the one conducted in Denmark with 1,396 older adults, which demonstrated that social relationships are critical for maintaining functional ability in older adults aged 75 and older.²²

Regarding the specific domains of the social support network assessment instrument (MOS), the “emotional support” domain stands out as the factor showing a statistically significant association with instrumental functionality (Lawton) and cognition (MMSE), as shown in Table 4. “Emotional support” was also the domain with the highest mean score when compared to the others. This finding corroborates the results found in another Brazilian study, which demonstrates that “emotional support offered to older adults acts as a protective factor against functional dependence.”¹⁹ These results reaffirm the assumption that social interactions that enable the sharing of advice, personal challenges, problems, and concerns among older adults encourage them to remain active and perform their activities independently.

It is important to highlight the significant role played by Primary Health Care in the care of the older adults. It should be noted that the regions where UBSs are most influential are those with the most vulnerable population and, consequently, where older adults are in a situation of greater social and functional vulnerability. In this context, the activities offered by Primary Health Care are of essential importance for identifying problems and promoting improvements in the comprehensive care of older adults. The provision of physiotherapy groups, conversation circles, and group therapy are examples of activities offered at UBSs that can have significant effects on the quality of life of older adults in vulnerable situations.²³

Regarding comorbidities among the study participants, 77.3% reported having a diagnosis of systemic arterial hypertension (SAH). SAH is a cardiovascular disease commonly found in older adults and can lead to complications such as decreased physical endurance, impaired muscle strength, and limitations in mobility. These adverse effects can directly impact the functionality of older adults, affecting their ability to perform basic tasks, but especially instrumental tasks.²⁴ Results from other studies demonstrate that chronic diseases, such as SAH, exert a significant influence on the determination of dependency in IADL.²⁵ In addition to SAH, other comorbidities were identified, such as diabetes mellitus, dyslipidemia, hypothyroidism, and a group of diverse conditions (others) that can compromise autonomy and cognition, which may directly influence the functional capacity of older adults. It is suggested that future studies investigate the association between chronic diseases and comorbidities and the perception of social support.

The socioeconomic status of older adults also plays a significant role in IADLs. These activities, such as managing medications, handling personal finances, and using technology, require financial resources, access to services, and specific skills. Older adults with higher socioeconomic status generally have more resources available to hire assistance, purchase assistive devices, and receive professional support to perform these activities efficiently. On the other hand, older adults with lower socioeconomic status, such as those in the present study, may face additional challenges, such as financial constraints, lack of access to adequate services, and limitations in knowledge and use of technology. These factors can negatively impact these older adults' ability to perform IADLs independently and satisfactorily.²⁶

Among the older adults participating in the study, 47.5% were unable to read, and 53.3% reported being unable to write. Illiteracy among older adults is a significant characteristic found particularly in underserved communities. In this context, precarious socioeconomic conditions and lack of access to adequate educational resources contribute to the prevalence of this problem. The absence of lifelong learning opportunities and the lack of investment in literacy programs targeting older adults in underserved communities perpetuate the educational marginalization of these individuals. The intersection of illiteracy and poverty creates a vicious cycle, as the lack of basic reading and writing skills hinders full participation in society, limiting access to jobs, health services, and opportunities for economic advancement.²⁷ Furthermore, illiteracy increases the likelihood of functional dependence among older adults by approximately 4 to 5 times.²⁸

Based on data from the study on older adults' cognitive ability and socioeconomic status, it is evident that income level significantly influences access to resources and opportunities that directly impact these individuals' cognitive health. Older adults with higher socioeconomic status generally have access to better-quality education, stimulating environments, and cognitive resources, all of which contribute to the development and maintenance of cognitive abilities throughout life. Additionally, a higher socioeconomic status is associated with better physical health, access to adequate healthcare, and a healthy lifestyle — all factors that can have positive effects on cognitive ability. On the other hand, older adults with lower socioeconomic status may face disadvantages, such as limited access to educational resources, greater exposure to risk factors for cognitive decline, and reduced access to health services. These factors may contribute to disparities in cognitive ability among older adults of different socioeconomic levels.²⁹

This study has limitations, including an achieved sample size smaller than the previously calculated. However, it was possible to obtain sufficient results to establish significant correlations between the

observed variables. Furthermore, since the MOS, Katz, and Lawton instruments do not have cutoff scores to establish objective classifications regarding the social support network and functionality, the median obtained from the MOS results was dichotomized, relating this to each variable of the other two instruments mentioned.

Finally, this study demonstrates its importance due to the fact that few studies have been conducted in communities with social vulnerabilities, which face significant limitations regarding access to education and health care, and in the development of a structured social support network. The results obtained in the study reinforce the need to promote social support networks for older adults, whether originating from the individual's family or provided by the government, so that they may remain independent for longer in carrying out their activities while preserving their cognitive abilities. The "emotional support" variable, included in the MOS questionnaire, stood out as the most influential factor on the instrumental activities and cognition of older adults, thus demonstrating a valuable correlation that warrants further exploration in future studies and in projects aimed at developing social support networks.

CONCLUSION

Analyzing the data obtained from the study, it is possible to conclude that the perception of a social support network is significantly associated with autonomy in performing activities of daily living, especially instrumental activities, as well as with cognitive ability. Furthermore, socioeconomic context emerges as an important influencing factor in the decline of cognitive ability, as well as in the low level of formal education and functional capacity among older adults.

The promotion of a solid social support network, combined with strategies for prevention, education, and comprehensive care, is essential to ensure the quality of life and well-being of older adults, as well as to address the challenges of population aging.

CONFLICT OF INTERESTS

Nothing to declare.

AUTHORS' CONTRIBUTIONS

VSFI: Conceptualization, Formal Analysis, Methodology, Writing – original draft, Writing – review & editing. ÉSA: Investigation, Methodology. CASV: Writing – original draft, Writing – review & editing. AS: Conceptualization, Funding acquisition, Supervision. MJB: Conceptualization, Data curation, Formal Analysis, Funding acquisition, Project administration, Supervision, Writing – original draft, Writing – review & editing.

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Annex. Social Support Scale – MOS.

Instructions: Please answer the questions below by stating: If you need to, how often do you rely on someone...	Never	Rarely	Sometimes	Almost always	Always
Material Support					
1- To help you if you are bedridden?	0	1	2	3	4
2- To take you to the doctor?	0	1	2	3	4
3- To help you with daily tasks if you get sick?	0	1	2	3	4
4- To prepare your meals if you cannot prepare them yourself?	0	1	2	3	4
Total					
Affective Support					
5- Who shows you love and affection?	0	1	2	3	4
6- Who gives you a hug?	0	1	2	3	4
7- Who you love and who makes you feel loved?	0	1	2	3	4
Total					
Emotional/Informational Support					
8- To listen to you when you need to talk?	0	1	2	3	4
9- Who you can trust to talk to about yourself or your problems?	0	1	2	3	4
10- To share your deepest concerns and fears with?	0	1	2	3	4
11- Who understands your problems?	0	1	2	3	4
12- To give you good advice in crisis situations?	0	1	2	3	4
13- To provide information that helps you understand a particular situation?	0	1	2	3	4
14- Who you really want advice from?	0	1	2	3	4
15- To give suggestions on how to deal with a personal problem?	0	1	2	3	4
Total					
Positive Social Interaction					
16- Who to do fun things with?	0	1	2	3	4
17- Who to take your mind off things with?	0	1	2	3	4
18- Who to relax with?	0	1	2	3	4
19- Who to have fun with?	0	1	2	3	4
Total					

Authors' own translation.

Source: Zucolo et al., 2019.¹²