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Sociodemographic determinants that influence quality of life in three municipalities in Colombia

Determinantes sociodemográficos que influyen en la calidad de vida en tres municipios de Colombia

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Abstract: Introduction: Quality of life is a multidimensional construct that encompasses different aspects of human life. It is related to individuals' sense of well-being and their degree of life satisfaction. The aim of this study was to analyze sociodemographic determinants and their influence on quality of life in three municipalities in Colombia. **Methodology:** A cross-sectional study was conducted using a convenience sample of 1,147 participants from three cities. A sociodemographic questionnaire and the WHOQOL-BREF instrument were administered to assess quality of life. Descriptive statistics, a normality test, and Spearman's correlation coefficient were used for data analysis. **Results:** A greater proportion of participants perceived their quality of life as good in the physical (60.5%) and psychological (52.7%) domains. Lower scores were observed in the social relationships and environmental domains. Significant associations were found across all four quality of life domains, primarily with age, educational level, and socioeconomic status. **Conclusions:** These findings indicate that certain sociodemographic variables are key determinants of individuals' perceptions of their quality of life.

Keywords: quality of life, sociodemographic determinants, WHOQOL-BREF, colombian population.

Resumen: Introducción: La calidad de vida es un constructo multidimensional que abarca diferentes aspectos de la vida humana. Se relaciona con la sensación de bienestar y el grado de satisfacción del individuo. El propósito del estudio fue analizar los determinantes sociodemográficos y su influencia en la calidad de vida en tres municipios de Colombia. **Metodología:** Estudio transversal, con una muestra por conveniencia de 1147 personas de tres ciudades. Se aplicó una encuesta sociodemográfica y el cuestionario WHOQOL-BREF para evaluar la calidad de vida. Se utilizaron estadísticas descriptivas, la prueba de normalidad y el coeficiente de correlación de Spearman. **Resultados:** Una mayor proporción de las personas evaluadas percibió su calidad de vida como buena en las dimensiones física (60,5%) y psicológica (52,7%). En las categorías de relaciones sociales y entorno, la valoración fue menor. Se encontraron asociaciones significativas en las cuatro categorías que componen la calidad de vida, siendo la significancia estadística la principal con las variables edad, nivel educativo y nivel socioeconómico. **Conclusiones:** Estos resultados indican que algunas variables sociodemográficas son determinantes clave en la percepción de la calidad de vida de las personas.

Palabras clave: calidad de vida, determinantes sociodemográficos, WHOQOL-BREF, población colombiana.

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1. Introduction

Quality of life is a complex construct that encompasses the multiple facets of human existence and their interaction with the environment (Seemann et al., 2011). This concept reflects individuals' well-being and overall satisfaction across physical, emotional, economic, and social domains (Schwartzmann, 2003). The World Health Organization (WHO) defines quality of life as "the individual's perception of their position in life within the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards, and concerns" (WHOQOL

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Group, 1995). This definition emphasizes quality of life as a comprehensive construct that integrates diverse aspects of life, including lifestyle preferences, housing conditions, educational attainment, job satisfaction, and economic well-being. Importantly, quality of life is interpreted both individually and collectively, according to people's beliefs, expectations, and needs (Velarde et al., 2002). Furthermore, it serves as a key indicator for assessing health status and evaluating the effectiveness of health-related interventions (Herdman et al., 2001).

Recent studies have highlighted a significant decline in physical and mental health across populations as a direct consequence of the health crisis (Pan American Health Organization, 2020). This underscores the importance of recognizing the COVID-19 pandemic as a critical factor influencing quality of life at both individual and collective levels (García & Pérez, 2021). These findings emphasize the need to incorporate this global health event into evaluations of population well-being, particularly in low- and middle-income countries, where health systems are constrained, resources are limited, and socioeconomic disparities are pronounced. Pavón et al. (2022) conducted an analysis of quality of life in several Latin American countries, including Colombia, during the COVID-19 pandemic. Their results highlight the adverse effects of emergency health measures on population well-being, while also examining the role of gender and lifestyle in shaping health perceptions.

Alemán (2021) reported that quality of life is associated with sociodemographic factors such as age, sex, satisfaction with health, and the perceived impact of the pandemic. The study highlighted that individuals who were less affected by the pandemic reported higher levels of quality of life. Additionally, women reported better quality of life across all questionnaire domains compared to men. Similarly, research conducted by González et al. (2023) indicated that variations in well-being can be explained by factors such as age, gender, income, and employment status. In related research carried out in Mexico, Ruiz et al. (2018) found that demographic variables significantly influenced quality of life, with statistically significant differences observed ($p < .05$). Specifically, the study showed that women experienced higher levels of psychopathological symptoms and lower overall quality of life compared to men across multiple dimensions.

Antoñanzas et al. (2022) emphasized the substantial impact of social determinants of health—such as housing conditions and sanitation—on everyday quality of life. They highlighted how sociodemographic characteristics, including education, income, gender, and age, play a significant role in shaping individuals' quality of life. In line with this perspective, Delannays et al. (2020) found that gender has a notable influence on quality-of-life perceptions, with a higher proportion of women (42.71%) reporting their quality of life as acceptable, whereas men were more likely (37.10%) to rate theirs as good or very good.

In Chile, Urzúa and Caqueo (2013) reported that quality-of-life assessments varied according to age and gender, with women over 50 years of age experiencing a marked decline in physical, psychological, and social well-being. In contrast, men exhibited stable or slightly improved scores in physical and psychological domains up to the age of 59. This body of evidence underscores the

relevance of the WHOQOL-BREF instrument, which has been widely recognized for its reliability, internal consistency, and capacity to assess quality of life accurately across multiple domains (Cardona & Higueta, 2022).

The Provincial Health Authority of Nariño, Colombia, reported in 2020 that the region was severely affected by the COVID-19 pandemic, with more than 45,000 confirmed cases, a situation further exacerbated by its distinctive geographical, cultural, and socioeconomic characteristics (Instituto Departamental de Salud de Nariño, 2020). Its border location and high rates of viral transmission significantly compromised residents' quality of life across health, economic, psychological, and social domains. This context underscores the urgent need for in-depth research on quality of life and sociodemographic factors in the department of Nariño.

Hidalgo et al. (2022) highlighted the intensified impact of COVID-19 in this region, particularly prior to the widespread availability of vaccines. Their findings identified men over the age of 70—especially those without ethnic affiliation and residing in areas with a high prevalence of non-communicable diseases—as the population group most vulnerable to the effects of the pandemic.

Therefore, conducting studies on quality of life and sociodemographic variables is particularly relevant in the Colombian context, and especially in the department of Nariño, in order to obtain first-hand evidence on how adults' perceptions of quality of life have changed in the post-pandemic period. This type of research is essential for several reasons: it provides insight into individuals' well-being and satisfaction across multiple life domains; it contributes to a deeper understanding of needs, values, preferences, and factors that influence quality of life; and it supports the design and implementation of policies and programs aimed at promoting comprehensive and sustainable human and social development (Urzúa & Caqueo, 2012).

In this context, the primary objective of the present study is to analyse the impact of sociodemographic factors on quality of life in three municipalities of the department of Nariño, Colombia.

2. Theoretical reference

Homegardens are mixed cropping systems that can provide a supplementary source of food and income to families (Galhena et al., 2013). The homegarden is the area near the house, which is used to produce food crops (tubers and roots, vegetables, fruits, medicinal plants, condiments, herbs, and others) as well as livestock; usually smaller animals (birds, rabbits, pigs and goats) intended for family feeding (Food and Agriculture Organization of the United Nations [FAO], 2000; Thamilini et al., 2019). As an agrobiodiversity system (Williams et al., 2018), the homegarden offers direct access to a variety of foods and nutrients (Issahaku et al., 2023) and contributes to the FNS, providing also a safety net for food shortages (Baliki et al., 2023; Oduor et al., 2019) like the ones during the COVID-19 pandemic due to movement restrictions (Cerdeña et al., 2022), which had a strong impact on areas with economies highly dependent on tourism, such as Monteverde.

2.1 Quality of Life and the Multidimensional Approach

Quality of life is a multidimensional construct that integrates physical, psychological, social, and environmental aspects of human well-being. According to the World Health Organization, quality of life is defined as an individual's perception of their position in life within the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards, and concerns (WHOQOL Group, 1995; World Health Organization, 2018). This approach acknowledges that the assessment of quality of life is inherently subjective and influenced by both individual and contextual factors.

From a biopsychosocial perspective, health-related quality of life is understood as the result of the interaction between biological conditions, psychological states, and characteristics of the social environment, making it a relevant indicator for research in public health and psychology.

2.2 Mental Health, Well-Being, and Sociodemographic Determinants

Mental health is understood as a state of well-being in which individuals are aware of their own abilities, are able to cope with the normal stresses of life, work productively, and contribute to their community (World Health Organization, 2022). Numerous studies have shown that sociodemographic variables such as age, educational level, and socioeconomic status significantly influence perceptions of quality of life and psychological well-being.

Social determinants of health constitute a fundamental explanatory framework for understanding these associations, as living conditions, access to resources, and social opportunities directly affect health outcomes and quality of life (World Health Organization, 2021).

2.3 Quality of Life and Mental Health in Pandemic Contexts

The COVID-19 pandemic had a significant impact on mental health and quality of life across populations, exacerbating pre-existing social inequalities. Studies conducted in Latin America reported substantial declines in the psychological, social, and environmental dimensions of quality of life, particularly among populations with lower socioeconomic resources.

In the Colombian context, research carried out during and after the pandemic has identified persistent impairments in psychological well-being and social relationships, highlighting the importance of analysing quality of life from a territorial and sociodemographic perspective (Gómez-Restrepo et al., 2022; Ministerio de Salud y Protección Social, 2021).

2.4 Normative and Programmatic Framework

The present study is framed within the international guidelines of the World Health Organization on health promotion and quality of life assessment, as well as the National Mental Health Policy of Colombia, which emphasizes the need to generate empirical evidence to guide health promotion, prevention, and mental health intervention strategies from a population-based and differential approach (Ministerio de Salud y Protección Social, 2020; World Health Organization, 2022).

3. Methodology

3.1 Approach

This study was conducted using a quantitative approach, with a non-experimental, correlational, cross-sectional design. The scope of the research was descriptive and correlational, as it sought to characterize quality of life levels in the study population and to examine the associations between sociodemographic variables and perceived quality of life, without intentional manipulation of variables (Creswell & Creswell, 2018; Hernández-Sampieri et al., 2020).

3.2 Study population

The reference population consisted of adults residing in three cities in the department of Nariño, Colombia: San Juan de Pasto, Ipiales, and San Andrés de Tumaco. The study included a total sample of $N = 1,147$ participants, distributed as follows: San Juan de Pasto ($n = 384$), Ipiales ($n = 379$), and San Andrés de Tumaco ($n = 384$).

Participants were selected using a non-probabilistic convenience sampling method, including individuals who met the inclusion criteria and voluntarily agreed to participate. Sample size estimation considered the population of each municipality (San Juan de Pasto: $N = 392,567$; San Andrés de Tumaco: $N = 115,810$; Ipiales: $N = 57,709$), with a 95% confidence level and a maximum allowable error of 5%, using the finite population sample size formula:

$$n = (Z^2 \cdot p \cdot q \cdot N) / (e^2 \cdot (N - 1) + Z^2 \cdot p \cdot q)$$

Where n represents the sample size, N the population size, Z the value associated with the confidence level, p the expected proportion, q its complement, and e the maximum allowable error.

Inclusion criteria were: being between 18 and 65 years of age, residing in one of the cities where the study was conducted, and voluntarily agreeing to participate by signing informed consent. No additional exclusion criteria were established. All participants who met the criteria were included in the statistical analysis, ensuring confidentiality and anonymity of the collected information.

3.3 Collection techniques

Data collection was carried out through the face-to-face administration of standardized instruments, conducted by four psychology professionals who had previously completed an intensive two-week training program. Prior to final data collection, field pilot tests were conducted to assess instrument adequacy and to standardize the administration procedure. Additionally, the study was presented to the community action boards of each municipality.

Quality of life was assessed using the WHOQOL-BREF questionnaire (WHOQOL Group, 1995), a standardized, self-administered instrument designed to evaluate subjective perceptions of quality of life in adult populations. The instrument consists of 26 items rated on a five-point Likert scale, with

higher scores indicating better perceived quality of life. The first two items assess overall quality of life and perceived health, while the remaining 24 items are grouped into four domains: physical health, psychological health, social relationships, and environment.

In addition, a sociodemographic questionnaire was administered to collect information on age, sex, area of residence (urban or rural), educational level, marital status, socioeconomic status, among other variables. In the analysis, sociodemographic variables were treated as independent variables, while quality of life and its domains were considered dependent variables.

3.4 Analysis processing

Data processing and analysis were performed using SPSS statistical software, version 20. Initially, a descriptive analysis was conducted to characterize sociodemographic variables and quality of life levels. For the calculation of WHOQOL-BREF domain scores, responses to items 3, 4, and 26 were reverse-coded, as these items assess the absence of the measured attribute. Subsequently, raw scores were transformed into standardized scores using an equivalence table, in order to facilitate domain comparisons and interpretation according to the guidelines established by the World Health Organization (1996).

For inferential analysis, a statistical significance level of $p < 0.05$ was established. The Kolmogorov–Smirnov test with Lilliefors correction was applied to continuous quality of life variables and each of its domains to assess data normality. As the normality assumption was not met, non-parametric tests were used. Spearman's correlation coefficient was employed to analyze associations between ordinal sociodemographic variables and quality of life scores. Additionally, the Mann–Whitney U test was used to compare quality of life differences across dichotomous sociodemographic variables, and the Kruskal–Wallis H test to examine differences among more than two independent groups, in accordance with the categorical nature and non-normal distribution of certain sociodemographic variables, (Field, 2022; Pallant, 2020).

4. Results

4.1 Population characterization

According to Table 1, the sample composition shows a higher proportion of male participants in Tumaco (22.6%) and Ipiales (18.1%). Additionally, a substantial proportion of respondents reported high educational attainment, which constituted the largest category (47.8%). Regarding marital status, being single was the most frequent category, accounting for 53.6% of the sample. Furthermore, the data indicate that the majority of participants belonged to the first socioeconomic stratum (59.9%), and the most represented age group ranged from 18 to 35 years.

Table 1

Sociodemographic variables among three municipalities in the province of Nariño

Sociodemographic variables		Ipiales n=379	Pasto n=384	Tumaco n=384	Total n=1147
Gender	Man	18,1%	14,4%	22,6%	55,1%
	Woman	14,9%	19,1%	10,9%	44,9%
Education level	Primary	3,7%	3,7%	4,6%	12,0%
	High school	12,8	9,6	16,1	38,5
	Higher education	16,6	19,4	12,4	47,8
	None	0,4	0,9	0,3	1,6
Marital status	Bachelor	17,9	20,1	15,6	53,6
	Married	9,9	7,8	10,7	28,5
	Common-law marriage	3,7	3,9	3,7	11,2
	Divorced	1,5	1,3	2,8	5,6
	Widower	0,1	0,3	0,7	1,0
Socioeconomic status ⁴	1	21,4	18,6	20,0	59,9
	2	7,3	9,3	6,4	23,0
	3	3,5	4,7	6,5	14,6
	4	0,6	0,8	0,6	2,0
	5	0,3	0,1	0,1	0,5
Age Ranges	18 a 35	15,8	20,3	13,8	49,9
	36 a 50	9,3	6,3	11,9	27,5
	51 a 65	7,9	6,9	7,8	22,7

Table 2 indicates that most respondents perceived their quality of life as either good or average across the four domains. However, significant differences were observed among the cities in certain categories. Regarding physical health, perceptions were predominantly positive, with 60.5% of participants rating this domain as good; similarly, the psychological domain also showed a favorable perception (52.7%). The domain with the least positive perception was social relationships, followed by the environment. Across all three cities, fewer than 15% of participants rated their social

⁴ In Colombia, the population is classified into socioeconomic strata, commonly referred to as "*estrato socioeconómico*" or simply "*estrato*." This system categorizes households based on income levels, living conditions, and access to basic services and infrastructure. It is primarily used for administrative and policy purposes, including the allocation of subsidies, utility tariff setting, and urban planning. Socioeconomic strata range from 1 to 6, where stratum 1 represents households with the lowest income levels and limited resources, and stratum 6 corresponds to the highest income levels, predominantly located in major urban centers such as the capital city, Bogotá.

relationships as very good or good, and fewer than 18% reported very good or good perceptions of their environmental conditions.

Table 2

Quality of Life Dimension Variables in Three Municipalities in the Province of Nariño

Quality of life variables		Ipiales n=379	Pasto n=384	Tumaco n=384	Total n=1147
Physical Health	Suitcase	0,0	0,1	0,0	0,1
	Regular	10,5	7,6	12,7	30,8
	Well	19,1	22,1	19,4	60,5
	Very good	3,5	3,7	1,4	8,6
Psychological	A little	0,8	1,0	1,0	2,8
	Regular	12,2	8,2	14,8	35,2
	Well	17,0	19,1	16,7	52,7
	Very good	3,1	5,1	1,0	9,2
Social Relationships	A little	3,4	3,4	5,8	12,6
	Regular	15,1	12,6	14,6	41,8
	Well	12,1	14,1	12,4	38,6
	Very good	2,4	3,4	1,1	7,0
Environment	A little	0,5	0,3	1,4	2,3
	Regular	14,7	12,4	19,5	46,6
	Well	16,3	18,4	11,9	46,6
	Very good	1,5	2,4	0,7	4,5

Table 3 shows negative correlations ranging from moderate to high between age and all four quality of life domains. In contrast, moderate to high positive correlations were observed between socioeconomic status, educational level, and the four domains. Physical health exhibited a significant negative correlation with age (-0.072^*) and significant positive correlations with socioeconomic status (0.073^*) and educational level (0.091^{**}). Regarding the psychological health domain, a significant negative correlation was found with age (-0.125^{**}), along with a significant positive association with educational level (0.106^{**}).

In the social relationships domain, a significant negative correlation was observed with age (-0.079^*), as well as significant positive correlations with socioeconomic status (0.099^{**}) and educational level (0.112^{**}). Finally, the environmental domain showed a significant negative correlation with age (-0.123^{**}), together with significant positive correlations with socioeconomic status (0.162^{**}) and educational level (0.231^{**}).

Table 3

Quality of Life Domains and Their Relationship with Gender, Socioeconomic Status, and Educational Level in Three Municipalities of the Department of Nariño

Quality of Life Domain	Variable	Age	Socioeconomic status	Level of schooling
Physical Health	Correlation coefficient	-0,072*	0,073*	0,091**
	Sig. (bilateral)	0,014	0,014	0,002
	N	1147	1147	1147
Psychological Health	Correlation coefficient	-0,125**	-0,017	0,106**
	Sig. (bilateral)	0,000	0,558	0,000
	N	1147	1147	1147
Social Relationships	Correlation coefficient	-0,079**	0,099**	0,112**
	Sig. (bilateral)	0,007	0,001	0,000
	N	1147	1147	1147
Environment	Correlation coefficient	-0,123**	0,162**	0,231**
	Sig. (bilateral)	0,000	0,000	0,000
	N	1147	1147	1147

5. Discussion

Quality of life is a comprehensive construct that reflects individuals' satisfaction and well-being across multiple life domains, including health, income, education, employment, social relationships, environmental quality, and other relevant factors. This study conducted a detailed analysis of the impact of sociodemographic determinants on quality of life in three municipalities of the department of Nariño, located in southwestern Colombia. By examining the correlations between quality of life domains and demographic characteristics, the study identified several significant findings.

The results showed that the physical health domain was negatively associated with age, indicating that higher age was related to lower levels of perceived physical health. In contrast, the study conducted by Rétsági et al. (2020) reported higher scores in the physical domain among older participants compared to younger individuals, suggesting a better perception of physical health in the older group ($p \leq 0.001$). This finding was attributed to the fact that the participants in that study were more physically active and regularly engaged in exercise. Additionally, previous research has indicated that increasing age is associated with a higher prevalence of chronic conditions, which contributes to a gradual decline in physical health (Castaño-Vergara & Cardona-Arango, 2015; Cortese, 2018). Another relevant factor in understanding this relationship is the functional component, which is closely linked to physical and mental performance. Physical capacity may vary

according to individuals' psychomotor and behavioral abilities to perform daily activities independently and autonomously, thereby influencing physical well-being as age increases.

Furthermore, the findings of this study revealed a positive association between physical health, socioeconomic status, and educational level, indicating that higher socioeconomic and educational attainment are linked to better physical health. In line with these results, Stringhini et al. (2017) reported that lower socioeconomic status is associated with poorer quality of life outcomes. Similarly, Rétsági et al. (2020) suggested that educational level plays a significant role in physical health and quality of life among individuals over 50 years of age. Their findings showed that individuals with university education were more likely to engage in regular physical activity ($p \leq 0.001$), whereas those with lower educational levels were more likely to rely on active transportation ($p = 0.035$). Nevertheless, a substantial proportion of participants (70.78%) demonstrated concerning levels of physical inactivity. According to Cusatis and Garbarski (2019), education influences health by enhancing access to information and resources that promote physical activity.

The study further showed that psychological health was negatively correlated with age and positively associated with educational level, suggesting that higher levels of education are linked to better psychological well-being. These findings are consistent with previous research by Lodhi et al. (2019) and Jurewicz (2015), which highlighted the influence of age and education on the psychological dimension of quality of life. Additionally, the results emphasized the relevance of social relationships, indicating that greater social interaction contributes significantly to individuals' overall quality of life. This is in line with the findings reported by Datta et al. (2015) and Puts et al. (2007), who underscored the protective role of social engagement in promoting well-being.

Psychological health, like other dimensions of health, is influenced by multiple social determinants, including religion, education, economic stability, and gender, among others. The literature suggests that the severity of mental health symptoms is associated with the presence of specific medical conditions and, consequently, with a decline in overall well-being. As noted by Lodhi et al. (2019), the burden of comorbidities increases with age, which may contribute to the development of mood disorders. Moreover, physical illnesses have been closely linked to emotional symptoms. In this context, the adoption of healthy lifestyle habits—such as maintaining a balanced diet, engaging in regular physical activity, and actively using social media for social connection—acts as a protective factor that promotes psychological well-being and helps prevent the onset of depressive or anxiety symptoms as individuals age (Barrera et al., 2022).

Regarding educational level, Utsav et al. (2017) reported that this variable is significantly associated with psychological health ($r = 0.172$, $p = 0.042$), and that income, duration of illness, and quality of life show differential associations across physical, social, psychological, and environmental domains. The authors explain that education shapes both individuals' perceptions of illness and their coping strategies, as well as their expectations regarding health services. Similarly, Kondirolli and Sunder (2022) found that education exerts a positive effect on psychological health across several indicators. Specifically, higher educational attainment was associated with a reduced likelihood of experiencing

depressive symptoms by 11.3% and anxiety symptoms by 9.8%. Additionally, each additional year of schooling was associated with a reduction in the mental health index.

Conversely, the present study identified an inverse relationship between age and the social relationships domain. In this regard, Datta et al. (2015) emphasized that quality of life can improve through social interaction, as participation in social activities positively influences social functioning and overall well-being. Individuals who engage more frequently in social activities tend to report higher quality of life scores than those with lower levels of participation. In line with this, Puts et al. (2007) highlighted the central role of social relationships in health and well-being. To maintain a good quality of life, older adults should prioritize physical and mental health, remain active, engage in enjoyable activities, foster supportive social connections, and live in environments that provide comfort and security.

In addition, Chang et al. (2020) underscored the importance of public spaces and the environmental context in relation to quality of life. Their findings showed that perceived environmental quality (57.7 ± 15.5) and satisfaction with public spaces (3.3 ± 0.7) were moderately associated with improved quality of life. Conversely, lower satisfaction with public spaces was linked to poorer quality of life, particularly in the physical and psychological domains. These results suggest that the availability and quality of public environments—such as parks, plazas, and recreational areas—play a fundamental role in promoting well-being, as positive experiences in these spaces contribute to more favorable overall life perceptions (Guarda et al., 2022).

Similarly, Zhang et al. (2017) demonstrated that factors within the environmental domain, including place of residence, are closely related to neighborhood perception and quality of life. Their results indicated that housing architecture, as well as the availability of services and facilities in the surrounding environment, significantly influence perceived well-being ($F = 4.248$, $p < 0.05$), residential satisfaction across housing types ($F = 12.727$, $p < 0.001$), and economic status ($F = 7.72$, $p < 0.001$). These findings reinforce the importance of considering not only housing characteristics but also environmental resources, which play a crucial role in fostering social relationships and strengthening community cohesion (Barrera et al., 2022).

Strengths of this study include the large sample size and the consideration of diverse regional contexts, as well as its contribution as one of the first reference studies conducted in the post-pandemic period. However, certain limitations should be acknowledged, including the use of non-probabilistic convenience sampling and reliance on self-reported measures, which may affect the generalizability of the findings.

6. Conclusion

The findings of this study indicate that sociodemographic determinants play a significant role in the perception of quality of life among adults in the municipalities evaluated in the department of Nariño. Age, educational level, and socioeconomic status were consistently associated with the

physical, psychological, social, and environmental domains of quality of life, revealing persistent inequalities in well-being. The negative association between age and physical health, psychological health, and social relationships underscores the need for interventions aimed at promoting healthy ageing, functional capacity, and active social participation.

The positive influence of educational level and socioeconomic status highlights the relevance of social determinants of health and the importance of public policies focused on reducing structural inequities in access to resources and opportunities. Additionally, findings related to the environmental domain emphasize the role of territorial contexts and the quality of public spaces as key components of quality of life.

These results provide empirical evidence to support health promotion and well-being policies based on an integrated, territorial, and social determinants-oriented approach. Study limitations include the use of non-probabilistic convenience sampling, the cross-sectional design, and reliance on self-report measures. Future research should incorporate longitudinal designs, probabilistic sampling, and mixed-methods approaches to further explore causal relationships and subjective experiences related to quality of life.

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8. Annexes

WHO/MSA/MNH/PSF/97.4
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WHOQOL-BREF



PROGRAMME ON MENTAL HEALTH
WORLD HEALTH ORGANIZATION
GENEVA

For office use only

	Equations for computing domain scores	Raw score	Transformed scores*	
Domain 1	$(6-Q3) + (6-Q4) + Q10 + Q15 + Q16 + Q17 + Q18$ $\square + \square + \square + \square + \square + \square + \square$	=	4-20	0-100
Domain 2	$Q5 + Q6 + Q7 + Q11 + Q19 + (6-Q26)$ $\square + \square + \square + \square + \square + \square$	=		
Domain 3	$Q20 + Q21 + Q22$ $\square + \square + \square$	=		
Domain 4	$Q8 + Q9 + Q12 + Q13 + Q14 + Q23 + Q24 + Q25$ $\square + \square + \square + \square + \square + \square + \square + \square$	=		

* Please see Table 4 on page 10 of the manual, for converting raw scores to transformed scores.

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ID number

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ABOUT YOU

Before you begin we would like to ask you to answer a few general questions about yourself: by circling the correct answer or by filling in the space provided.

What is your gender?	Male	Female
What is your date of birth?	____ / ____ / ____	
	Day	Month / Year
What is the highest education you received?	None at all Primary school Secondary school Tertiary	
What is your marital status?	Single Married Living as married	Separated Divorced Widowed
Are you currently ill?	Yes	No
If something is wrong with your health what do you think it is? _____ illness/ problem		

Instructions

This assessment asks how you feel about your quality of life, health, or other areas of your life. **Please answer all the questions.** If you are unsure about which response to give to a question, **please choose the one** that appears most appropriate. This can often be your first response.

Please keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life in the last two weeks. For example, thinking about the last two weeks, a question might ask:

	Not at all	Not much	Moderately	A great deal	Completely
Do you get the kind of support from others that you need?	1	2	3	4	5

You should circle the number that best fits how much support you got from others over the last two weeks. So you would circle the number 4 if you got a great deal of support from others as follows.

	Not at all	Not much	Moderately	A great deal	Completely
Do you get the kind of support from others that you need?	1	2	3	4	5

You would circle number 1 if you did not get any of the support that you needed from others in the last two weeks.

Please read each question, assess your feelings, and circle the number on the scale for each question that gives the best answer for you.

		Very poor	Poor	Neither poor nor good	Good	Very good
1(G1)	How would you rate your quality of life?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
2 (G4)	How satisfied are you with your health?	1	2	3	4	5

The following questions ask about how much you have experienced certain things in the last two weeks.

		Not at all	A little	A moderate amount	Very much	An extreme amount
3 (F1.4)	To what extent do you feel that physical pain prevents you from doing what you need to do?	1	2	3	4	5
4(F11.3)	How much do you need any medical treatment to function in your daily life?	1	2	3	4	5
5(F4.1)	How much do you enjoy life?	1	2	3	4	5
6(F24.2)	To what extent do you feel your life to be meaningful?	1	2	3	4	5

		Not at all	A little	A moderate amount	Very much	Extremely
7(F5.3)	How well are you able to concentrate?	1	2	3	4	5
8 (F16.1)	How safe do you feel in your daily life?	1	2	3	4	5
9 (F22.1)	How healthy is your physical environment?	1	2	3	4	5

The following questions ask about how completely you experience or were able to do certain things in the last two weeks.

		Not at all	A little	Moderately	Mostly	Completely
10 (F2.1)	Do you have enough energy for everyday life?	1	2	3	4	5
11 (F7.1)	Are you able to accept your bodily appearance?	1	2	3	4	5
12 (F18.1)	Have you enough money to meet your needs?	1	2	3	4	5
13 (F20.1)	How available to you is the information that you need in your day-to-day life?	1	2	3	4	5
14 (F21.1)	To what extent do you have the opportunity for leisure activities?	1	2	3	4	5

		Very poor	Poor	Neither	Good	Very good
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				poor nor good		
15 (F9.1)	How well are you able to get around?	1	2	3	4	5

The following questions ask you to say how good or satisfied you have felt about various aspects of your life over the last two weeks.

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
16 (F3.3)	How satisfied are you with your sleep?	1	2	3	4	5
17 (F10.3)	How satisfied are you with your ability to perform your daily living activities?	1	2	3	4	5
18(F12.4)	How satisfied are you with your capacity for work?	1	2	3	4	5
19 (F6.3)	How satisfied are you with yourself?	1	2	3	4	5
20(F13.3)	How satisfied are you with your personal relationships?	1	2	3	4	5
21(F15.3)	How satisfied are you with your sex life?	1	2	3	4	5
22(F14.4)	How satisfied are you with the support you get from your friends?	1	2	3	4	5
23(F17.3)	How satisfied are you with the conditions of your living place?	1	2	3	4	5
24(F19.3)	How satisfied are you with your access to health services?	1	2	3	4	5
25(F23.3)	How satisfied are you with your transport?	1	2	3	4	5

The following question refers to how often you have felt or experienced certain things in the last two weeks.

		Never	Seldom	Quite often	Very often	Always
26 (F8.1)	How often do you have negative feelings such as blue mood, despair, anxiety, depression?	1	2	3	4	5

Did someone help you to fill out this form?.....

How long did it take to fill this form out?.....

Do you have any comments about the assessment?

.....
.....

THANK YOU FOR YOUR HELP

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