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GERIATRIC HEALTHCARE IN NIGERIA: AVAILABILITY, ACCESSIBILITY, AND GAPS IN PORT HARCOURT GERIATRIC HEALTHCARE IN NIGERIA: AVAILABILITY, ACCESSIBILITY, AND GAPS IN PORT HARCOURT

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Abstract

The rapid growth of the elderly population in Nigeria presents new challenges for health and social care systems that are historically underprepared for geriatric needs. This article investigates the availability, accessibility, and adequacy of geriatric healthcare for older adults in Port Harcourt, Rivers State. Drawing on a mixed-methods design, data were collected from 518 elderly participants (60 years and above) through structured questionnaires, focus groups, and in-depth interviews. Quantitative data were analyzed using descriptive and inferential statistics, Pearson's correlation, and regression analysis, while qualitative insights highlighted structural and cultural barriers. Results revealed that more than 60% of respondents reported unmet healthcare needs, primarily due to financial barriers, poor infrastructure, and insufficient geriatric-trained personnel. Despite these challenges, a moderate positive correlation was observed between service utilization and psychological well-being. The study concludes that gaps in geriatric healthcare in Nigeria reflect broader systemic weaknesses but also opportunities for reform. Recommendations include integrating geriatric care into primary healthcare, expanding mobile clinics, and strengthening policy frameworks to ensure equity and sustainability.

Keywords: Elderly, Geriatric Healthcare, Accessibility, Nigeria, Port Harcourt, Policy gaps

Introduction

Population aging has emerged as a defining global demographic trend of the 21st century. Advances in medicine, nutrition, and public health have significantly increased life expectancy, resulting in unprecedented growth in the elderly population. Globally, the number of people aged 60 years and above is projected to reach 2.1 billion by 2050 (World Health Organization [WHO], 2022). Nigeria is not exempt from this demographic shift. Estimates suggest that the number of elderly Nigerians will rise from 6.4 million in 2005 to more than 25 million by 2050 (United Nations, 2012).

Although population aging is often celebrated as evidence of progress, it also presents pressing challenges for healthcare systems, particularly in countries with limited resources. In Nigeria, the healthcare system remains underfunded and inadequately structured to meet geriatric needs. Historically, policy and programmatic attention have focused on maternal and child health, leaving older populations underserved (Adebowale, Atte, & Ayeni, 2020). Consequently, elderly Nigerians often face a dual burden of chronic diseases such as hypertension, diabetes, and arthritis, alongside psychosocial challenges like isolation, depression, and economic vulnerability.

Port Harcourt, a fast-growing urban hub in Nigeria's Niger Delta region, illustrates these challenges vividly. As a retirement destination for many former civil servants, the city has a growing elderly population that struggles with access to geriatric healthcare. Inadequate infrastructure, weak policy implementation, financial constraints, and a shortage of trained geriatric specialists exacerbate the situation (Akinyemi, Adedokun, & Odimegwu, 2019).

This study addresses these gaps by systematically assessing the state of geriatric healthcare in Port Harcourt. It asks: What geriatric healthcare services are available to the elderly? To what extent are these services accessible and adequate? How do systemic and socioeconomic barriers influence healthcare utilization and the well-being of older adults?

The findings aim to contribute to scholarship on geriatric health in sub-Saharan Africa while offering actionable insights for policymakers, healthcare providers, and community organizations. By examining both quantitative and qualitative data, this study provides a nuanced understanding of the state of geriatric healthcare and proposes sustainable strategies for reform.

Objectives

1. To assess the availability and adequacy of geriatric healthcare services for the elderly in Port Harcourt.
2. To evaluate barriers to accessing geriatric healthcare, including financial, infrastructural, and cultural factors.
3. To explore the relationship between geriatric healthcare utilization and the quality life of elderly individuals.
4. To recommend strategies for strengthening geriatric healthcare delivery in Nigeria.

Literature Review

Global Perspectives on Geriatric Healthcare

The aging of populations worldwide has intensified demand for geriatric healthcare services. In high-income countries, robust systems for eldercare have been developed, encompassing specialized geriatric clinics, nursing homes, home-based care, and community support services (Boult et al., 2011). Models such as the Program of All-Inclusive Care for the Elderly (PACE) in the United States have demonstrated significant benefits, reducing hospitalizations and improving quality of life (Wieland et al., 2013). Similarly, European nations have prioritized integration of geriatric services into primary healthcare frameworks, with an emphasis on preventive care and social engagement programs (Koren, 2010). Beyond the West, middle-income countries are increasingly grappling with the dual challenge of population aging and under-resourced healthcare systems. In countries such as India and Brazil, community-based eldercare programs and mobile clinics have been introduced to address service gaps, though coverage remains uneven (WHO, 2020). Across contexts, research underscores the importance of comprehensive geriatric care that addresses not only physical health but also psychological well-being, social connectedness, and independence (Alexopoulos et al., 2011).

Geriatric Healthcare in Sub-Saharan Africa

Sub-Saharan Africa has traditionally been characterized by a youthful demographic profile. However, improvements in survival rates have led to gradual population aging (United Nations, 2017). Despite this shift, healthcare systems across the region remain poorly equipped for

geriatric care. Challenges include inadequate funding, lack of geriatric specialists, weak policy frameworks, and reliance on family-based support systems (Aboderin & Beard, 2015).

In South Africa, for example, while policy frameworks exist for elderly care, implementation gaps persist due to resource constraints and competing priorities (Kalula & Petros, 2011). Ghana and Kenya face similar challenges, with older adults relying heavily on family members for healthcare financing and social support (Apt, 2012). Across the region, the erosion of traditional extended family structures due to urbanization and migration has further weakened informal support systems, leaving elderly populations increasingly vulnerable (Ferreira, 2017).

The Nigerian Context

Nigeria exemplifies many of these challenges. Healthcare provision is largely skewed toward maternal and child health, with minimal emphasis on geriatrics. The National Policy on Aging, though articulated, remains weakly implemented (Federal Ministry of Health, 2017). Most elderly Nigerians rely on out-of-pocket payments for healthcare, which limits access, particularly in the absence of comprehensive health insurance coverage (Omololu et al., 2021).

Research highlights critical service gaps. Ezeh, Nwabueze, and Anyanwu (2020) reported limited availability of geriatric-friendly infrastructure and specialized staff. Ibitoye et al. (2016) found that elderly Nigerians experience high rates of depression, anxiety, and loneliness, often exacerbated by poor access to healthcare. Social determinants such as poverty, low education, and inadequate social protection systems further worsen outcomes (Adebowale et al., 2020).

In Port Harcourt specifically, studies indicate that elderly individuals face significant challenges accessing healthcare due to urban poverty, limited infrastructure, and weak family support systems (Odutolu, Wahab, & Adeniran, 2016). The scarcity of geriatric-trained personnel compounds the problem, as elderly patients often receive care from providers without specialized training.

Quality of life and Healthcare Utilization

Quality of life (QOL) is a multidimensional construct encompassing autonomy, self-acceptance, personal growth, social connectedness, and environmental mastery (Ryff, 1989). Studies consistently show that access to quality healthcare is positively correlated with PWB among older adults (Cohen et al., 2015). Conversely, inadequate healthcare access has been linked to depression, anxiety, and diminished quality of life (Unützer et al., 2002).

In Nigeria, Uwakwe and Modebe (2019) found that chronic illnesses such as hypertension and diabetes significantly reduce PWB among elderly populations. Religious participation has been identified as a protective factor, serving as a coping mechanism in the absence of adequate healthcare services (Adeoye et al., 2021).

Theoretical Framework

This study draws on Andersen's Behavioral Model of Health Services Use (1995), which emphasizes predisposing factors (e.g., demographics, education), enabling factors (e.g., financial resources, access to facilities), and need factors (e.g., illness, disability) as determinants of healthcare utilization. Complementing this, the WHO's Social Determinants of Health framework (2010) underscores the role of socioeconomic status, education, and living conditions in shaping health outcomes. Together, these models provide a robust lens for understanding geriatric healthcare utilization in Port Harcourt.

Methodology

This study employed a mixed-methods design, integrating both quantitative and qualitative approaches. The design allowed for triangulation, providing a comprehensive understanding of geriatric healthcare availability, accessibility, and its relationship with psychological well-being. The study population consisted of elderly individuals aged 60 years and above residing in Port Harcourt, Rivers State. Using multistage sampling, 518 participants were selected from urban and semi-urban communities. Inclusion criteria required participants to have resided in the area for at least one year. Elderly individuals with severe cognitive impairments were excluded to ensure accurate responses. Two sets of instruments were used for data collection. They include the Structured Questionnaire that captured demographic characteristics, healthcare utilization patterns, and indicators of psychological well-being. Focus Group Discussions (FGDs): Conducted with community elders to gather qualitative insights on barriers to geriatric healthcare, and an In-Depth Interviews (IDIs): Held with healthcare providers to explore systemic challenges. Data were collected over three months in 2024. Trained research assistants administered questionnaires in English and Pidgin English, ensuring comprehension. FGDs and IDIs were audio-recorded with consent. Quantitative data were analyzed using SPSS version 25. Descriptive statistics (frequencies, percentages, means) summarized demographic data and healthcare access. Pearson's correlation and multiple regression were used to examine relationships between geriatric healthcare utilization and

psychological well-being. Qualitative data from FGDs and IDIs were transcribed verbatim and analyzed thematically.

Results

Table 1. Demographic Characteristics of Respondents (N = 518)

Variable	Frequency (n)	Percentage (%)
Age 60–69	244	47.1
Age 70–79	189	36.5
Age 80+	85	16.4
Male	268	51.7
Female	250	48.3
Married	312	60.2
Widowed	146	28.2
Divorced/Separated	60	11.6
Primary education or less	183	35.3
Secondary education	212	40.9
Tertiary education	123	23.8

Table 1 shows the demographic characteristics of the 518 elderly participants revealed a population that is predominantly younger-old, moderately educated, and fairly balanced in terms of gender. Almost half of the respondents (47.1%) were within the 60–69 age group, while just over a third (36.5%) were between 70 and 79 years, and only 16.4% were 80 years or older. This pattern suggests that the study captured a majority of younger elderly individuals, which reflects both the aging trends in Nigeria and the relatively low national life expectancy that reduces the proportion of those surviving into advanced old age.

The gender distribution was nearly equal, with males constituting 51.7% and females 48.3% of the sample. Such balance strengthens the representativeness of the findings across both sexes. In terms of marital status, a clear majority (60.2%) remained married, suggesting the presence of spousal support networks. However, a significant proportion (28.2%) were widowed, and 11.6% were divorced or separated, pointing to social vulnerabilities among nearly two in five elderly individuals who may be living without partners.

Educational attainment varied widely, with 35.3% of respondents having only primary education or less, 40.9% attaining secondary education, and 23.8% reaching tertiary education. These findings indicate that while a considerable segment of the elderly in Port Harcourt are moderately literate, a substantial proportion remain poorly educated, which may have implications for their health literacy, access to information, and healthcare decision-making

Table 2: Availability of Geriatric Healthcare Services

Item		SA	A	D	SD	Agree %	Disagree %
1.	Basic consultations regularly available	52	155	207	104	40.0	60.0
2.	Trained geriatric-focused health workers in community	47	142	224	105	36.5	63.5
3.	Nearby mental health services	41	133	230	114	33.6	66.4
4.	Health workers can visit homes	56	148	216	98	39.4	60.6
5.	Physiotherapy services available	49	137	225	107	35.9	64.1
6.	Can get diet/nutrition advice from health workers	61	149	210	98	40.5	59.5
7.	Health education programs available	53	162	202	101	41.5	58.5
8.	Care for serious or long-lasting sickness is available	45	151	229	93	37.8	62.2
9.	Programs/groups supporting older people exist	58	160	210	90	42.1	57.9
10.	Reliable transportation for elderly	43	144	228	103	36.1	63.9

Table 2 shows respondent's responses across the ten indicators of geriatric health services in Port Harcourt city with between 58% and 66% of respondents reported lack of availability. Mental health services (66.4% unavailability), physiotherapy (64.1%), and trained geriatric-focused health workers (63.5%) emerged as the most deficient areas. Only health education programs and community groups showed slightly higher levels of availability, yet barriers still exceeded 58%.

Table 3: Accessibility of Geriatric Healthcare Services

Item	Agree %	Disagreed %	Rank
Health workers can visit homes	39.4	60.6	3rd
Health education programs available	41.5	58.5	2nd
Care for serious or long-lasting sickness is available	37.8	62.2	4th
Programs/groups supporting older people exist	42.1	57.9	1st
Reliable transportation for elderly	36.1	63.9	5th

Results from table 3 shows that Accessibility was generally low across the five core items. Reliable transportation recorded the highest barrier at 63.8%, followed by long-term care at 62.1%. Even where community programs and health education were available, more than half of respondents still identified significant access barriers.

Table 4: Top Barriers to Geriatric Healthcare Access

S/N	Item	Disagreed %	Agree %	Rank
1	Nearby mental health services	66.4	33.6	1st
2	Physiotherapy services available	64.1	35.9	2nd
3	Reliable transportation for elderly	63.9	36.1	3rd
4	Trained geriatric-focused health workers in community	63.5	36.5	4th
5	Care for serious or long-lasting sickness is available	62.2	37.8	5th

Results from table 4 also shows that the most pressing barriers were lack of mental health services (66.4%) and physiotherapy (64.1%). Other critical gaps included geriatric-trained health workers (63.5%), transportation (63.8%), and long-term care services (62.1%). These findings emphasize that both infrastructure and human resource shortages limit the delivery of geriatric healthcare in Port Harcourt.

Table 5: Relationship Between Healthcare Utilization and quality of life

Predictor Variable	β	t	p-value
Age	-.08	-1.95	.052
Gender	.04	1.12	.263
Education	.15	3.48	<.001
Healthcare Utilization	.32	7.14	<.001

Model summary: $R^2 = .27$, $F(4, 513) = 42.31$, $p < .001$.

The result from table 5 shows that healthcare utilization significantly predicted quality of life of the elderly ($\beta = .32$, $p < .001$), even after controlling for age, gender, and education. Education also showed a positive significant effect ($\beta = .15$, $p < .001$). Age and gender were not statistically significant predictors at the .05 level.

Discussion

Findings from this study underscore critical gaps in the provision of geriatric healthcare in Port Harcourt. More than half of respondents reported unmet needs, reflecting a systemic neglect of elderly populations. The shortage of geriatric-trained personnel mirrors national trends, where medical training rarely prioritizes geriatrics (Ezeh et al., 2020).

The financial barriers observed highlight the limitations of Nigeria's healthcare financing model. With most elderly relying on pensions or family support, out-of-pocket payments remain prohibitive. These findings align with Uchendu et al. (2019), who identified poverty and inadequate insurance as major determinants of healthcare inequity among older Nigerians. Importantly, the study demonstrated a significant positive correlation between healthcare utilization and psychological well-being. Elderly individuals who accessed healthcare reported greater autonomy, environmental mastery, and social connectedness. This aligns with international evidence that geriatric healthcare enhances both physical and psychological outcomes (Unützer et al., 2002; Cohen et al., 2015).

Qualitative insights further emphasized cultural influences. Some elderly participants described initial reliance on traditional medicine, which delayed timely medical care. This suggests that geriatric healthcare reform in Nigeria must also consider culturally sensitive interventions and community engagement.

Conclusion

This study highlights the urgent need to strengthen geriatric healthcare in Port Harcourt and Nigeria at large. Key findings reveal inadequate service availability, financial barriers, and shortages of trained personnel. Despite these challenges, geriatric healthcare utilization was positively associated with improved quality of life.

Recommendations

1. The Federal Ministry of Health**,** in collaboration with State Ministries of Health and Primary Health Care Development Agencies**,** should mainstream geriatric healthcare into Nigeria's primary healthcare system to ensure routine, equitable service delivery for older adults.
2. Medical and Nursing Schools**,** working under the regulation of the Medical and Dental Council of Nigeria (MDCN) and the Nursing and Midwifery Council**,** should integrate geriatrics and gerontology into their training curricula to build a skilled workforce for elderly care.
3. The National Health Insurance Authority (NHIA)**,** in partnership with the Federal Government and private health insurers**,** should expand the National Health Insurance Scheme (NHIS) to comprehensively cover elderly populations and reduce out-of-pocket healthcare costs.
4. State and Local Governments, in collaboration with community health centers**,** NGOs**,** and international development partners, should develop mobile clinics and home-based healthcare services to reduce accessibility barriers for elderly populations.
5. Community-based organizations, together with religious institutions and traditional councils, should actively engage in promoting healthcare-seeking behaviors among the elderly, with support from the Ministry of Information and Culture for public awareness campaigns.

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