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Review Article

Reimagining geriatric care in Nigeria: Challenges, systemic gaps, and the emerging role of innovative community-based home healthcare – A narrative review

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ABSTRACT: Rapid global population ageing presents a major public health challenge, particularly in Low- and Middle-Income Countries (LMICs) like Nigeria, where the elderly population is projected to exceed 23 million by 2050. Nigeria's healthcare system remains severely unprepared, focusing traditionally on acute infectious diseases while neglecting the chronic, complex needs of older adults. This narrative review synthesised findings from 46 academic articles and policy reports identified via major bibliographic databases (e.g., PubMed, Scopus) and grey literature from 2014 to 2024. The data was analysed across four thematic areas: demographic trends, service gaps, access barriers, and global care models. The findings indicate a systemic crisis in Nigerian geriatric care, characterised by a critical shortage of specialists (fewer than ten geriatricians), high reliance on prohibitive out-of-pocket health expenditure, and the operational non-implementation of the 2021 National Policy on Ageing. Service delivery is fragmented and dependent on untrained informal caregivers. Comparative analysis of international models (India's NPHCE, Brazil's FHS, South Africa's WBOTs) suggests that integrated, task-shifting, community-based approaches are viable and scalable solutions. In conclusion, the geriatric health in Nigeria is critically underserved and financially exclusive. This review strongly recommends the immediate execution of the National Policy on Ageing, paired with reform of the national health insurance benefit package, to adopt and scale integrated community-based care models that bridge the specialist and access gaps.

Keywords: Ageing population, community-based healthcare, geriatric healthcare, health policy, home-based care.

INTRODUCTION

Globally, the population of individuals aged 60 years and above is rising rapidly, with projections estimating that there will be more than 2 billion older adults by 2050, effectively doubling the number recorded in 2020 (United Nations Department of Economic and Social Affairs, 2020). Nigeria, the most populous country in Africa, is currently undergoing this demographic transition. The elderly population (aged 60 years and above) was estimated at 9 million in 2020 and is expected to exceed 23 million by 2050 (United Nations Department of Economic and Social Affairs, 2020). This demographic shift, once considered a phenomenon of high-income countries, is increasingly evident in low- and middle-income countries (LMICs), where healthcare systems are often under-resourced and poorly prepared to manage the growing needs of an ageing population (World Health Organisation, 2015).

However, unlike high-income countries that have had decades to prepare for population ageing, Nigeria faces the dual challenge of rising elderly care demands and an underdeveloped healthcare infrastructure. The country's

health priorities have traditionally focused on maternal and child health, infectious diseases, and emergency care, leaving geriatric healthcare largely neglected (Ameh *et al*., 2014).

Existing literature reveals significant gaps in the provision of geriatric services in Nigeria. These include the severe shortage of trained geriatricians (Onwuzoo, 2020), the lack of dedicated geriatric wards in most hospitals, limited community-based support systems, and systemic failures in policy implementation (Osi-Ogbu, 2024). Furthermore, traditional family-based eldercare is declining due to urban migration, economic pressures, and changing societal structures, increasing the vulnerability of elderly individuals, particularly in rural communities (Onwuzoo, 2020).

Community-based home healthcare has emerged globally as a potential model for delivering cost-effective, culturally acceptable, and accessible care for older adults, especially in resource-constrained settings (Low *et al*., 2011). Despite its promise, there is limited discussion in Nigerian literature on how such models could be adapted, scaled, or implemented sustainably. Hence, this review aims to evaluate the current state of geriatric care provision in Nigeria, identify systemic and policy-related gaps, and assess the potential and viability of adapting global community-based home healthcare models for the Nigerian context.

METHODOLOGY

This study employed a narrative review approach to synthesise existing literature on the state of geriatric care in Nigeria and explore the potential of community-based home healthcare models. The methodology adhered to established guidelines for narrative reviews, including structured literature identification, critical synthesis, and thematic analysis.

Sources of information

Relevant literature was sourced from a combination of academic, peer-reviewed journals, and grey literature, including government policy documents and publications from non-governmental and development agencies. The main academic databases used included: PubMed/MEDLINE, Scopus, Google Scholar, African Journals Online (AJOL), ResearchGate, and ScienceDirect. In addition to academic sources, policy briefs, and official statistical data from authoritative bodies such as the World Health Organisation (WHO), United Nations (UN), and the Nigerian Federal Ministry of Health were also consulted to provide essential context-specific insights and statistical support.

Search terms

A comprehensive keyword strategy was developed to capture a wide scope of relevant literature. Boolean operators (AND, OR) were used to combine terms, ensuring both breadth and specificity. The following terms were applied (individually and in various combinations):

- **Population/topic:** “Geriatric care” OR “Elderly health” OR “Ageing population” OR “Older adults”.
- **Intervention/model:** “Community-based healthcare” OR “Home care” OR “Home-based healthcare” OR “Models of care” OR “Elder care innovations”.
- **Location/context:** “Nigeria” OR “Sub-Saharan Africa” OR “Developing countries” OR “LMICs”.
- **System/policy:** “Health system gaps” OR “Primary healthcare” OR “Geriatric policy” OR “Geriatrician shortage” OR “Healthcare access elderly” OR “Rural health elderly”.

Searches were limited to English-language publications between 2014 and 2024 to meet the inclusion criteria.

Selection criteria

The following criteria were applied for the inclusion and exclusion of identified articles:

Inclusion Criteria:

- **Publication period:** Articles published between January 2014 and May 2024 were prioritised to capture a contemporary decade of data and trends. Older landmark references were included where historically or conceptually relevant.
- **Geographic focus:** Articles focused on geriatric care, ageing, elderly health policies, or healthcare delivery specifically in Nigeria or comparable low- and middle-income countries (LMICs).
- **Intervention models:** Publications explicitly discussing models of community-based, home-based, or primary-level care designed for older adults.
- **Study type:** Review articles, original research, case studies, and policy papers relevant to Sub-Saharan Africa.
- **Language and availability:** Materials are published in English and available in full text.

Exclusion Criteria:

- Studies focused solely on high-income country contexts without clear comparative relevance or lessons for LMICs.
- Non-health-related ageing studies (e.g., sociology of ageing without direct healthcare relevance, economic studies unrelated to health financing).
- Editorials, letters, or commentaries lacking empirical data or detailed methodological analysis.

Data extraction and thematic synthesis

Data from the final set of included studies and reports were systematically extracted using a standardised data abstraction matrix. Key information extracted included: author, year of publication, study design, geographic focus, specific findings related to geriatric service gaps, data on workforce and infrastructure, policy context, and descriptions of community-based care models and their outcomes. The extracted data were subjected to thematic analysis, whereby findings were grouped into four key thematic areas (Demographic Trends, Service Gaps, Barriers, and Global Models) to facilitate a coherent narrative synthesis of the results.

Methodological considerations and limitations

This study used a narrative review approach, which is ideal for scoping the current policy landscape and synthesising qualitative policy insights. However, the methodology has limitations. It does not include a formal, systematic quality assessment of the included studies, which is characteristic of systematic reviews, nor does it quantify an effect size. Therefore, the selection and synthesis inherently rely on the authors' judgment and expertise to present a focused, balanced, and evidence-based narrative interpretation of the literature.

RESULTS

Study selection

An initial pool of 312 articles was identified across the databases. After removing 73 duplicates and screening 239 studies, 82 articles were retained for full-text review. Following the application of inclusion and exclusion criteria, 46 studies and policy reports were ultimately included in this review (Figure 1). The findings are synthesised into four key thematic areas: (1) Demographic and Epidemiological Trends in Ageing, (2) Current State of Geriatric Services in Nigeria, (3) Barriers and Gaps in Elderly Health Policy and Access, and (4) Global Community and Home-Based Elderly Care Models.

Demographic and epidemiological trends in ageing

The included studies consistently identified a rapid demographic transition in Nigeria. Data extracted from the reviewed literature indicates a projected increase in the population aged 60 and above, estimated to rise from approximately 9 million in 2020 to over 23 million by 2050 (United Nations Department of Economic and Social Affairs, 2020; Kavi Healthcare, 2024).

The review identified a dual burden of disease among this demographic. High prevalence rates were reported for non-communicable diseases (NCDs), specifically hypertension, diabetes, arthritis, and chronic respiratory illnesses (Low *et al*., 2011; World Health Organisation, 2020). Furthermore, the literature highlights a rising incidence of visual and cognitive impairments. The reviewed studies note that while life expectancy has seen modest gains, the "healthy life expectancy" remains low, with many elderly individuals spending their final years in states of functional decline (World Bank, 2023a).

Current state of geriatric services in Nigeria

The synthesis of findings reveals a severe scarcity of specialised geriatric care and significant infrastructural deficits, summarised in Table 1.

Workforce and infrastructure gaps

The literature indicates fewer than ten officially trained geriatricians serving the entire population (Onwuzoo, 2020). Geriatric medicine is largely absent from undergraduate medical and nursing curricula, resulting in a general workforce lacking specific competencies in elderly care (Akintayo-Usman and Usman, 2021; Adeloye *et al*., 2017).

Review of facility-based assessments shows that most tertiary and secondary health facilities lack specialised geriatric units. The University College Hospital (UCH) Ibadan and the University of Benin Teaching Hospital (UBTH) were identified as the primary exceptions, with UBTH noted for its specialised geriatric services (Adebusoye *et al*., 2021; Osi-Ogbu, 2024).

Mental health services and well-being

Beyond physical health services, the review highlights critical gaps in the provision of mental health and psychosocial support. Studies indicate a high prevalence of poor psychological well-being, depression, and loneliness among the elderly, often linked to socioeconomic stressors and the erosion of traditional support systems (Cadmus *et al*., 2015; Ibitoye *et al*., 2014). The literature notes that psychosocial health challenges, while pervasive, are often overlooked or misdiagnosed in general health settings, lacking dedicated assessment and referral pathways within the primary care system (Animasahun and Chapman, 2017). Specialised services for geriatric mental health, including dementia and delirium management, are virtually non-existent outside of tertiary institutions.

Service delivery

Outside of specialised centres, elderly care is delivered in

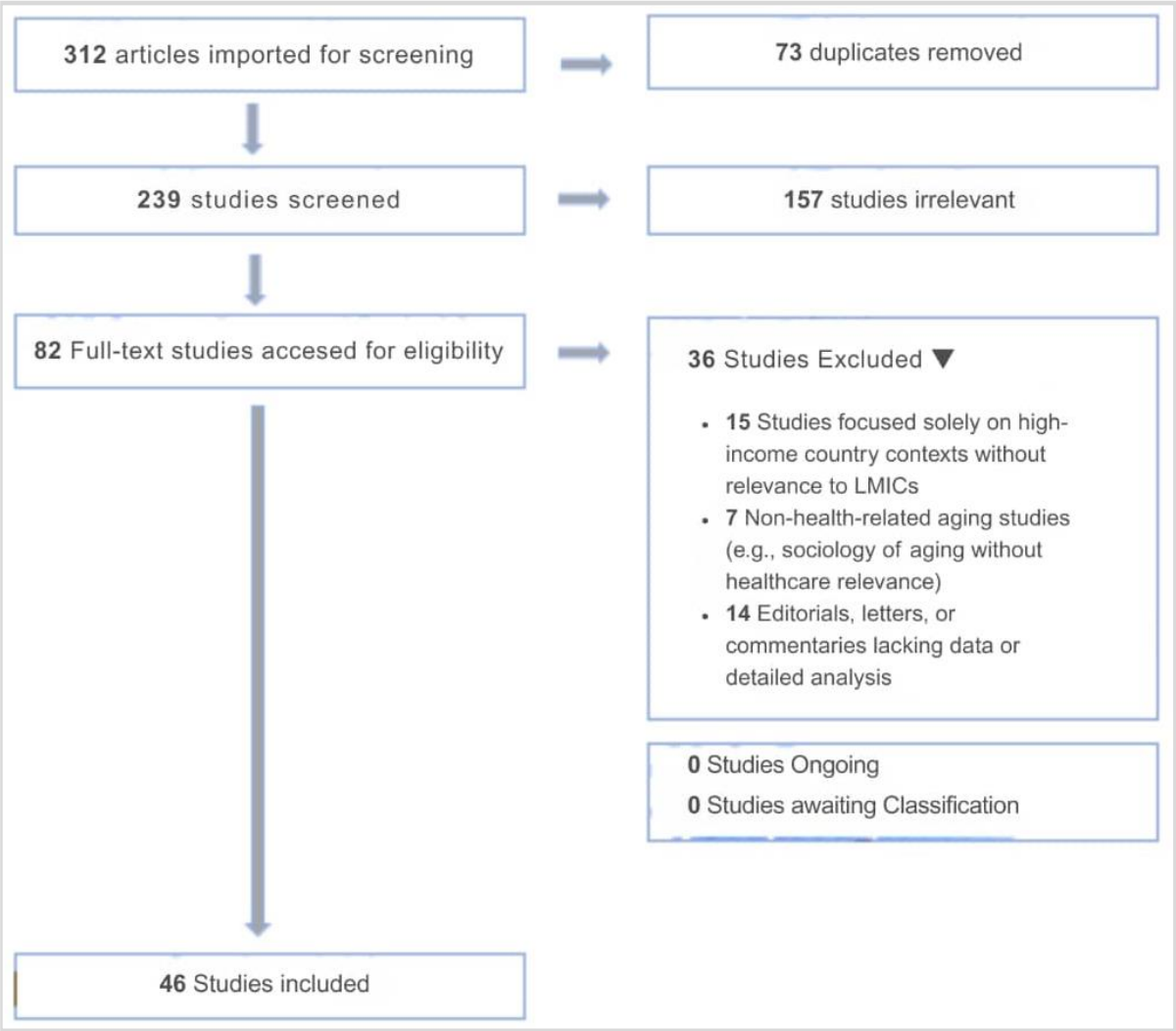

Figure 1. PRISMA-style flow diagram illustrating the number of records identified, screened, assessed for eligibility, and included in the final review (N=46).

general outpatient departments. The findings show a lack of routine protocols for geriatric syndromes, such as falls, frailty screening, and polypharmacy management (Osi-Ogbu, 2024).

Barriers and gaps in elderly health policy and access

The review identified five major barriers hindering healthcare access for the elderly:

- **Geographical Access:** Studies focused on rural demographics found that elderly individuals often travel significant distances to access Primary Health Care (PHC) centres. Terrain difficulties and lack of public transport were cited as primary impediments to access (Ameh *et al*., 2014; Alenoghena *et al*., 2014; Cadmus *et al*., 2021).
- **Financial Constraints:** The literature identifies out-of-pocket payments as the dominant financing mechanism, accounting for the vast majority of expenditure (World Bank, 2023b). Studies indicated that significant numbers of elderly patients resorted to catastrophic health expenditure to fund healthcare (Aregbeshola and Khan, 2018), with the National Health Insurance Authority (NHIA) offering minimal geriatric coverage (Ani, 2014).
- **Workforce Shortages:** Beyond the lack of specialists, the brain drain of general practitioners was cited as a factor further depleting the pool of clinicians available to treat older adults (Salako, 2023).
- **Sociocultural Factors:** The erosion of the extended family system due to urbanisation was a recurrent theme. Findings suggest an increasing number of elderly persons are living in isolation without traditional family support networks (Okoye, 2013; Nnah, 2024).

Table 1. Summary of workforce and infrastructure gaps in nigerian Geriatric Care.

Thematic Area	Key Findings / Gap	Supporting Citation
Workforce Scarcity	Fewer than 10 trained geriatricians serve the national population	Onwuzoo, 2020
Education Gap	Geriatric competencies are largely absent from medical and nursing undergraduate curricula	Akintayo-Usman and Usman, 2021; Adeloye *et al*., 2017
Infrastructure Deficit	Most secondary and tertiary hospitals lack dedicated geriatric wards or specialised units	Osi-Ogbu, 2024
Service Protocols	Absence of routine screening and management protocols for geriatric syndromes (e.g., frailty, falls, cognitive impairment) at the PHC level	Osi-Ogbu, 2024; Animasahun and Chapman, 2017
Specialized Centres	Specialised services are concentrated in very few centres (e.g., UCH Ibadan, UUTH)	Adebusoye *et al*., 2021

Table 2. Key global community-based elderly care models and outcomes.

Country	Model Name	Key Features / Strategy	Outcome / Relevance to Nigeria	Supporting Citation(s)
India	National Programme for Health Care of the Elderly (NPHCE)	Task-shifting model using ASHAs for home visits, geriatric outpatient services, and chronic disease management.	Demonstrates scalable, low-cost community engagement and primary care integration.	Ministry of Health and Family Welfare, Government of India, 2011
South Africa	Ward-Based Outreach Teams (WBOTs)	Proactive, multidisciplinary teams focused on defined geographic wards for preventive care and health promotion.	Offers a model for decentralized, geographic-specific care delivery in PHC settings.	South African National Department of Health, 2018
Brazil	Family Health Strategy (FHS)	Universal coverage model where multi-professional teams provide continuous, integrated home visits and primary care for registered families.	Excellent example of fully integrating proactive elderly care into the core national PHC system.	Bastos *et al*., 2017
Global Policy	Integrated Care for Older People (ICOPE)	WHO framework emphasizing person-centred care to maintain intrinsic capacity and shift services to the community.	Provides a high-level policy framework for service restructuring in LMICs.	World Health Organisation, 2015

- **Policy Gaps:** While the National Policy on Ageing (2021) was identified, the review indicates a critical lack of operational frameworks or specific budgetary allocations to implement it (Federal Ministry of Humanitarian Affairs, Disaster Management and Social Development, 2021), and lacks a specific legislative equivalent to the robust Older Persons Act (2006) found in South Africa which provides a clearer legal mandate for elder rights and protection (Republic of South Africa, 2006).

Global community and home-based elderly care models

The systematic search identified several international models of care, summarised in Table 2, that are currently being referenced in literature relevant to LMICs. The key models identified include:

- India: The Home-Based Care for the Elderly (NPHCE) program, utilising Accredited Social Health Activists (ASHAs) (Ministry of Health & Family Welfare, Government of India, 2011; NITI Aayog report, 2021).
- South Africa: Ward-Based Outreach Teams (WBOTs) comprising nurses and community health workers (South African National Department of Health, 2018).
- Brazil: The Family Health Strategy (FHS), employing multidisciplinary teams for home visits (Bastos *et al*., 2017; Macinko and Harris, 2015).

Additionally, the review found emerging, though limited, local initiatives in Nigeria, including the "Geri-Care Health Scheme" pilot (Nnah, 2024; National Senior Citizens Centre, 2022) and private sector home-care providers (e.g., Triverge Health) operating primarily in urban centres (Triverge Health, 2024).

DISCUSSION

This review highlights a critical and widening divergence between Nigeria's rapidly ageing population and its current healthcare capacity. The findings confirm that geriatric care

remains on the periphery of national health planning, characterised by fragmented service delivery, a severe scarcity of specialists, and deep financial exclusion. Unlike high-income nations, where geriatric care is often institutionalised and heavily subsidised, Nigeria's system currently relies disproportionately on a shrinking extended family model and general outpatient services that are ill-equipped to manage complex, multi-morbid geriatric syndromes.

Implications of workforce and policy gaps

The alarming scarcity of the specialised geriatric workforce, with fewer than ten certified geriatricians for a population projected to reach 23 million older adults by 2050 (Onwuzoo, 2020), represents a catastrophic systemic void. This deficit is immediately worsened by the "brain drain" phenomenon (Salako, 2023), which critically weakens the generalist medical pool that forms the primary care frontline. The key implication is that the clinical burden of complex geriatric syndromes shifts almost entirely onto untrained informal caregivers, predominantly women, who are ill-equipped to manage conditions like dementia or polypharmacy (Tanyi *et al*., 2018; Okoye, 2013).

This situation is compounded by "clinical inertia", a phenomenon where providers fail to initiate or intensify therapy for chronic conditions like hypertension, despite its high prevalence in Sub-Saharan Africa. (Van der Linden *et al*., 2020).

This workforce crisis is reinforced by a profound competence gap stemming from the exclusion of geriatric medicine from core medical curricula. The consequence is not merely a lack of specialists, but the widespread under-diagnosis of treatable age-related conditions such as depression, delirium, and frailty, which are often fatalistically misattributed as inevitable aspects of ageing (Ibitoye *et al*., 2014; Baiyewu *et al*., 2025). This underscores the need for "skilling up" the existing workforce, shifting the focus from traditional medical roles to specialised elder-care careers (Nwaiwu, 2024).

From a policy standpoint, the 2021 National Policy on Ageing remains a pivotal legislative achievement; however, the lack of operationalisation found in our results renders it a symbolic "paper policy" (Federal Ministry of Humanitarian Affairs, Disaster Management and Social Development, 2021). The critical implication is the disconnect between federal intent and sub-national execution. For this policy to translate into tangible clinical outcomes, its objectives must be explicitly and formally integrated into the National Health Act and the Primary Health Care Under One Roof (PHCUOR) strategy (Aboderin, 2022).

Comparative analysis of global care models and systemic integration

The review established that successful community-based models in India, Brazil, and South Africa offer a viable blueprint for Nigeria. These nations share similar socio-economic constraints and communal social structures, suggesting high translatability of their successes.

- The success of India's use of Accredited Social Health Activists (ASHAs) demonstrates that non-specialist health workers can effectively manage elderly care if adequately trained (Ministry of Health & Family Welfare, Government of India, 2011). This implies that relying solely on producing more geriatric specialists is insufficient. Instead, an immediate and scalable stopgap is the upskilling of Community Health Extension Workers (CHEWs) to perform essential geriatric assessments, such as falls risk screening and medication adherence checks.
- Brazil's Family Health Strategy (FHS) provides a strong model for systemic integration, functioning as a core component of the national health system (Bastos *et al*., 2017; Ministry of Health of Brazil, 2018). Nigeria's emerging efforts are fragmented; the identified private home care providers (e.g., Triverge) are market-driven and siloed (Okere, 2024). The implication of this fragmentation is the deepening of a two-tier healthcare system: high-quality care for the urban elite versus neglected public clinics for the majority facing significant geographic and financial barriers.
- South Africa's Ward-Based Outreach Teams (WBOTs) are well-documented, though challenges remain regarding team composition and funding sustainability (Schneider et. al., 2018; South African National Department of Health, 2018). These models demonstrate that systemic integration is more effective than the "paper policies" often seen in the region (Aboderin, 2010).

For Nigeria, the path forward must avoid the pitfalls of high-income models and instead focus on the unique health needs of older people in Sub-Saharan Africa (Aboderin and Beard, 2015; WHO, 2017)

Challenges to implementation and the case for financing reform

While community-based care presents the most viable structural alternative to hospital-centric services, its deployment in Nigeria faces unique logistical and operational challenges. The significant geographical barriers identified in our results, particularly in remote rural areas, exacerbate issues of poor infrastructure, necessitating substantial investment in transport and secure data governance at the PHC level. Furthermore, persistent issues of insecurity, coupled with intermittent funding and a lack of sustained political will at the state level, pose substantial risks to maintaining a reliable, high-frequency home-visiting service. Success will depend not only on technical task-shifting but on securing sustained

political commitment and dedicated, shielded state-level budgetary allocation.

The localised "Geri-Care Health Scheme" pilot (Nnah, 2024; National Senior Citizens Centre, 2022) indicates a local willingness to adopt decentralised care, but scalability requires formal integration into the Primary Health Care (PHC) framework. The highest hurdle remains the chronic financial exclusion resulting from the heavy reliance on out-of-pocket expenditure (Aregbeshola and Khan, 2018). To ensure the sustainability and accessibility of any community-based model, financing reform is paramount. We urgently recommend the expansion of the National Health Insurance Authority (NHIA) benefit package to cover community-based geriatric services (Ani, 2014; National Primary Health Care Development Agency, 2020). Prioritising chronic geriatric care coverage, similar to maternal and child health, is essential to mitigate financial toxicity and encourage timely care seeking.

CONCLUSION

Nigeria stands at a critical demographic crossroads. The current "business as usual" approach, which relies heavily on fragmented tertiary hospital services and an overstretched family support system, is demonstrably unsustainable for an ageing demographic burdened by a rising tide of Non-Communicable Diseases. This narrative review suggests that the most viable and scalable path forward is the immediate, systemic adoption of integrated, community-based care models successfully utilised in other Global South nations. Future interventions must prioritise three pillars: the urgent implementation of the 2021 National Policy on Ageing, the inclusion of geriatric competencies in primary care training for task-shifting, and the expansion of the National Health Insurance Authority (NHIA) benefit package to cover community-based and non-hospital management of the elderly. A primary limitation of this narrative review is the absence of formal quality assessment of the included studies and the reliance on existing published data, which may be subject to publication bias.

CONFLICT OF INTEREST

The author declare that they have no conflict of interest.

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