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A scoping review of public health challenges and systemic barriers facing unmet health and social care needs of older populations in Nigeria

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Abstract

Nigeria's aging population is increasing steadily, yet health and social care systems remain in-adequately prepared to address the complex needs of older adults. Unmet health and social care needs contribute to poor health outcomes, functional decline, reduced quality of life, and grow-ing inequities among older populations. This scoping review mapped and synthesized existing evidence on unmet health and social care needs among older adults in Nigeria, with particular attention to public health challenges and systemic barriers affecting access to care.

A scoping review was conducted following the PRISMA-ScR framework. Electronic searches were performed across PubMed, Scopus, ScienceDirect, SpringerLink, Wiley Online Library, Frontiers, and Discovery databases for studies published between 2010 and 2025. Data were extracted and synthesized using thematic analysis.

A total of 43 studies met the inclusion criteria. Overall, 4 major themes emerged: demographic and epidemiological transitions, unmet health needs, unmet social care needs, and system-ic/public health barriers. Older adults experienced substantial unmet needs related to chronic disease management, mental health services, oral healthcare, preventive care, and assistance with activities of daily living. Key barriers included poverty, high out-of-pocket healthcare costs, inadequate geriatric services, workforce shortages, weak social protection systems, geo-graphical inequities, and policy gaps. Social isolation, caregiving burdens, and limited commu-nity-based support further compounded vulnerabilities.

Older adults in Nigeria face significant unmet health and social care needs driven by intersect-ing socioeconomic, health system, and policy challenges. Strengthening geriatric care, expand-ing social protection, integrating health and social services, and improving evidence-based poli-cy development are essential to promote healthy and dignified aging in Nigeria.

Key words: unmet, health and social care needs, older populations, public health challenges, systemic barriers.

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Introduction

Nigeria, as the most populous country in Africa, is undergoing a profound demographic transition characterized by an aging population. According to recent estimates, the proportion of individuals aged 60 years and above is expected to rise from approximately 6% in 2020 to over 10% by 2050, driven by improvements in life expectancy and declining fertility rates.[1] This shift presents unprecedented challenges for the nation's health and social care systems, which are traditionally oriented toward maternal and child health rather than geriatric needs.[2] Unmet health and social care needs among older populations refer to gaps in access to essential medical services, personal assistance, and social support that compromise well-being and quality of life.[3] In Nigeria, these unmet needs are exacerbated by socioeconomic factors, including poverty, which affects over 70% of older adults, limiting their ability to afford healthcare.[4] Public health challenges in tracking these needs stem from a lack of robust data systems and epidemiological surveillance tailored to older adults. For instance, chronic conditions such as hypertension, diabetes, and neurodegenerative diseases like Alzheimer's are increasingly prevalent, yet underdiagnosed due to insufficient screening programs.[5,6]

Moreover, the COVID-19 pandemic highlighted vulnerabilities, with older Nigerians facing higher mortality risks due to limited access to vaccines and care.[7] Social care needs, including support for activities of daily living (ADLs) and mental health, remain largely unmet, with family-based care systems strained by urbanization and migration.[8,9] Barriers include geographical inaccessibility in rural areas, where over 60% of older adults reside, and cultural stigmas around mental health.[10,11] Systemic barriers further compound these issues, encompassing policy deficiencies, workforce shortages, and financial hurdles. Nigeria's National Health Insurance Scheme covers less than 5% of the population, leaving most older adults reliant on out-of-pocket payments.[12] Healthcare facilities often lack age-friendly infrastructure, such as ramps or geriatric wards, leading to underutilization.[13-15] Additionally, there is a scarcity of trained gerontologists and social workers, with medical education curricula rarely incorporating geriatrics.[16,17]

These challenges are not unique to Nigeria but are amplified in low- and middle-income countries (LMICs), where global aging trends demand urgent action.[18,19] Advancing research in tracking unmet needs is crucial for informing policy and interventions. Narrative reviews like this one synthesize existing evidence to identify gaps and propose solutions.[20] Prior studies have documented high rates of unmet needs for ADLs among rural elderly, influenced by household structures and poverty.[21,22] Mental health issues, including depression and dementia, are prevalent but under-addressed due to stigma and limited services.[23,24]

Oral health, often overlooked, contributes to nutritional deficiencies and overall morbidity.[1,11] Furthermore, HIV among older adults adds complexity, with multimorbidity increasing care demands.[4] This scoping review was conducted to map and synthesize existing evidence on unmet health and social care needs among older adults in Nigeria, with a specific focus on public health challenges and systemic barriers, and to consolidate evidence on these themes, emphasizing the need for enhanced tracking mechanisms, such as community surveys and digital registries, to monitor unmet needs effectively.[25,26] By integrating perspectives from diverse studies, it seeks to bolster the robustness of findings for public awareness, highlighting intersections of poverty, gender, and urban-rural divides.[27,28] Ultimately, addressing these challenges is essential for achieving Sustainable Development Goal 3 (good health and well-being) and promoting equitable aging in Nigeria.[7,29]

Objective of the study

This review aimed to map and synthesize the existing evidence on unmet health and social care needs among older adults in Nigeria, with a focus on the public health challenges and systemic barriers affecting access to and utilization of care. Specific objectives include the following: i) to identify and summarize the major unmet health needs experienced by older adults in Nigeria, including physical, mental, oral, and preventive healthcare needs; ii) to examine the unmet social care needs of older adults, particularly those related to ADLs, social support, caregiving, and community participation; iii) to explore the public health challenges associated with population aging in Nigeria, including the growing burden of non-communicable diseases (NCDs), multimorbidity, and health inequalities; iv) to identify systemic barriers to healthcare and social care access, including financial, geographical, cultural, infrastructural, and policy-related constraints; v) to synthesize evidence on existing strategies, interventions, and policy responses aimed at addressing the needs of older adults in Nigeria; vi) to identify knowledge gaps and priority areas for future research, policy development, and health system strengthening to support healthy and dignified aging in Nigeria.

Methods

Study design

This review followed a comprehensive and structured literature search strategy consistent with the PRISMA-ScR framework. Given the heterogeneity of available evidence and variability in study designs, a scoping approach was deemed most appropriate to capture the breadth of literature and identify key conceptual domains rather than assess effect sizes.

Search strategy

A systematic search was conducted in November 2025 across multiple electronic databases, including PubMed, ScienceDirect, SpringerLink, Scopus, Frontiers, Wiley Online Library, Discovery databases, and grey literature. A combination of controlled vocabulary and free-text keywords was used, including: "unmet needs health social care older adults Nigeria", "public health challenges aging population Nigeria", and "barriers healthcare elderly Nigeria". Boolean operators (AND, OR) were applied to refine and expand the search strategy. The search was limited to peer-reviewed English-language publications published between 2010 and 2025 to capture contemporary evidence on aging and health system responses in Nigeria. Reference lists of included studies were also manually screened to identify additional relevant publications.

Eligibility criteria

Inclusion and exclusion criteria

Studies were included if they focused on older adults aged ≥60 years in Nigeria or provided Nigeria-specific data within broader LMIC analyses; addressed unmet health needs, unmet social care needs, or systemic/public health barriers affecting older populations; or were peer-reviewed empirical studies, reviews, or policy-relevant research articles.

Studies were excluded if they focused exclusively on non-older populations (*e.g.*, maternal, child, or adolescent health); were not contextually relevant to Nigeria or did not disaggregate Nigeria-specific findings; or were non-scholarly sources (*e.g.*, opinion pieces without empirical or review basis).

Risk of bias assessment

The methodological quality of included studies was assessed using the Joanna Briggs Institute (JBI) critical appraisal checklists appropriate to each study design. Each domain was rated as low, moderate, or high risk of bias. An overall risk-of-bias score was assigned based on the aggregate of domain ratings. *Supplementary Table 1* presents the risk of bias assessment of the included studies.

Study selection

Two independent reviewers screened titles and abstracts against the eligibility criteria. Full texts of potentially eligible studies were retrieved and assessed independently. Disagreements were resolved through discussion, with recourse to a third reviewer where consensus could not be reached. The study selection process is documented using a PRISMA flow diagram (Figure 1).

Data extraction and synthesis approach

A standardized data extraction form was developed and piloted on 3 studies. Data extracted included authors, year of publication, study design, setting, sample size, participant characteristics, type of cosmetic surgery, key findings related to trends and mental health outcomes, and conclusions. Data synthesis followed a thematic analysis approach. Extracted findings were coded and organized into descriptive themes, which were subsequently refined into analytical themes through iterative discussion among the review team.

Screening procedure

Records identified n=218: PubMed n=45, Scopus n=38, ScienceDirect n=36, SpringerLink n=30, Wiley Online Library

n=28, Frontiers n=20, Discovery Database n=15, grey literature n=6. Records removed before screening n=48. Records screened n=170. Records excluded n=43. Reports assessed for eligibility n=127. Records excluded n=84: reasons - not relevant to older adults n=20, not Nigeria/LMIC relevant n=30, no unmet needs/barrier focus n=24, non-scholarly/opinion pieces n=10. Total studies included n=43. Figure 1 presents the screening and selection process of the included studies.

Quality appraisal

The quality of included studies was appraised using the JBI checklists. Studies were assessed across domains of methodological rigor, including clarity of research objectives, appropriateness of study design, sampling strategy, measurement validity, and analytical approach. Each study received a quality assessment score of high, moderate, or low and a corresponding risk-of-bias score. The quality appraisal of the included studies is presented in *Supplementary Table 1*.

Results

Characteristics of included studies

The included studies demonstrated notable geographic and methodological diversity. Most empirical studies were conducted in urban and peri-urban regions of Nigeria, particularly in the Southwest and Southeast, with fewer studies focusing on rural or northern populations. This geographic concentration may limit national representativeness. Regarding study design, qualitative studies were frequently used to explore lived experiences of unmet needs, particularly in relation to oral health, psychosocial care, and caregiver burden. These studies provided rich contextual insights but were limited by small sample sizes and potential selection bias. Quantitative surveys and cross-sectional studies were commonly used to assess healthcare access, ADL limitations, and health-seeking behaviors.

While these studies provided measurable estimates of unmet needs, they were limited by self-reported data and the inability to infer causality. Review studies and policy analyses contributed significantly to synthesizing broader system-level challenges, including workforce shortages, financing gaps, and policy fragmentation. However, variability in methodological rigor across reviews introduced heterogeneity in evidence strength. Commentary and protocol-based studies primarily contributed to framing emerging issues (such as dementia care and aging research priorities) but did not provide empirical validation. Overall, despite methodological limitations across individual studies, convergence of findings across diverse study types strengthens confidence in the identified thematic domains of unmet health needs, unmet social care needs, and systemic barriers. barriers. *Supplementary Table 2* presents the characteristics of the included studies.

Thematic synthesis/key themes

The thematic synthesis of the included studies identified 4 interrelated domains:[1-26,28-45] demographic and epidemiological transitions, unmet health needs, unmet social care needs, and systemic/public health barriers shaping vulnerability among older adults in Nigeria.

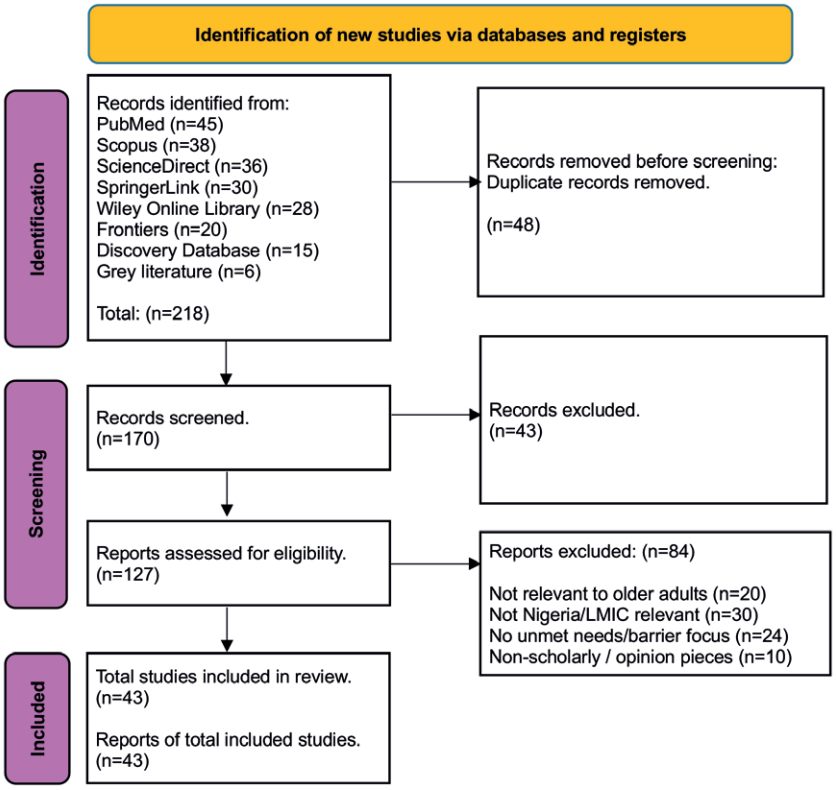

Figure 1. Diagram of the PRISMA 2020 Process for Systematic Reviews and Meta-Analyses.

Demographic and epidemiological trends

Nigeria is experiencing a gradual but steady demographic shift characterized by population aging, with older adults increasing at an estimated annual rate of approximately 3.2%. This transition is occurring alongside a rising burden of NCDs, resulting in increasing multimorbidity among older populations. Hypertension remains highly prevalent (estimated >40% in some cohorts), alongside increasing rates of diabetes, chronic respiratory disease, and cardiovascular conditions.[6,30] Neurodegenerative conditions, including dementia and Parkinsonian disorders, are also becoming more visible in clinical and community settings, although likely underdiagnosed due to limited diagnostic capacity. Compounding these trends is the intersection of aging and infectious disease burden, particularly among older adults living with HIV, where long-term survival has increased age-related comorbidity risk.[4,5] Marked rural-urban disparities persist, with rural populations experiencing greater unmet needs due to reduced access to healthcare infrastructure and migration-driven erosion of traditional family support systems.[3,22]

Unmet health needs

Unmet health needs among older adults remain substantial and multidimensional. Evidence suggests that approximately 30-50% of older adults experience inadequate access to chronic disease management services, particularly for hypertension and diabetes care continuity.[12,15] Mental health conditions are increasingly reported, with depression affecting up to 25% of older adults in some studies, although underdiagnosis is likely due to limited psychiatric screening capacity in primary care settings.[20,23] Oral health is consistently neglected, contributing to pain, impaired nutrition, and reduced quality of life, with limited integration of dental services into geriatric care pathways.[11,31] Preventive care deficits are also evident, including low uptake of vaccinations such as pneumococcal immunization and poor access to routine eye screening services, contributing to avoidable disability.[18,30] Overall, health service delivery for older adults remains episodic, reactive, and poorly integrated across care levels.

Unmet social care needs

Social care deficits are equally pronounced and closely linked to health outcomes. Approximately 40% of older adults require assistance with ADLs, particularly among widows, individuals living in poverty, and those without extended family support.[21,32] Social isolation is increasingly recognized as a major determinant of poor mental health and functional decline, exacerbated by urban migration and weakening intergenerational household structures.[8,33] Care provision is largely informal and family-dependent, placing significant financial and psychological burden on caregivers, with limited formal social protection systems in place.[34,35] Community-based elder care services remain scarce, fragmented, or non-existent in many regions.

Public health challenges and systemic barriers

Multiple structural and health system barriers underpin the persistence of unmet needs among older adults. These include chronic poverty, weak health financing mechanisms, and persistent out-of-pocket expenditure that limits access to continuous care.[1,14] Health workforce shortages, particularly in geriatrics and mental health, further constrain service delivery capacity. Infrastructure deficits, especially in rural primary healthcare facilities, reduce service availability and continuity of care.[10,36] Cultural and behavioral barriers, including stigma around mental illness and aging-related dependency, also influence care-seeking behavior and service uptake. Clinical system challenges such as polypharmacy and inadequate deprescribing practices reflect gaps in provider training and geriatric pharmacology knowledge.[37,38] At the policy level, the absence of a comprehensive national geriatric health strategy, including dementia-specific frameworks, limits coordinated action and sustainable service planning.[2,24]

Discussion

Overview of principal findings

The findings highlight the complex and multidimensional nature of unmet health and social care needs among older adults in Nigeria.[1-26,28-45] The evidence demonstrates that these unmet needs arise from an interaction between demographic aging, rising NCD burden, weak health system capacity, and persistent socioeconomic deprivation. Collectively, these factors reinforce a cycle of vulnerability that disproportionately affects older populations. Across the included studies, four interrelated domains were consistently identified: demographic and epidemiological transitions, unmet health needs, unmet social care needs, and systemic/public health barriers. These domains reflect not only service delivery gaps but also structural determinants embedded within Nigeria's broader health and social systems.

Comparison with global, lower, and middle-income country evidence

The findings align strongly with broader evidence from LMICs, where population aging is occurring alongside constrained health system readiness.[19,25] Similar patterns of unmet chronic care needs, fragmented geriatric services, and reliance on informal caregiving have been documented across sub-Saharan Africa and other resource-limited settings. However, Nigeria presents a more pronounced burden due to the combined effects of weak social protection systems, high out-of-pocket expenditure, and limited integration of geriatric care into primary healthcare delivery.[17,40] In contrast, high-income countries increasingly rely on structured long-term care systems, digital health records, and routine functional screening to identify unmet needs early.[16,18] The absence of comparable infrastructure in Nigeria contributes to delayed diagnosis, poor continuity of care, and underestimation of functional decline among older adults.

Public health implications of unmet health needs

The burden of NCDs, including hypertension, diabetes, and chronic respiratory conditions, represents a central public health challenge. These conditions are often poorly managed due to limited access to continuous care, medication affordability constraints, and weak primary care follow-up systems.[7,26] Mental health conditions, particularly depression and cognitive impairment, remain underdiagnosed and undertreated, reflecting gaps in screening capacity and mental health workforce shortages.[20,29] Oral health and sensory impairments (vision and hearing loss) further contribute to functional decline and reduced quality of life but remain largely neglected within routine geriatric care pathways. Importantly, the clustering of multimorbidity without integrated

care models increases the risk of preventable disability and hospitalization among older adults.

Social determinants of health and care deficits

Unmet social care needs are strongly shaped by broader social determinants, including poverty, widowhood, gender inequality, and family structure transitions. Approximately 40% of older adults require assistance with ADLs, yet formal support systems remain minimal.[21,32] Traditional family-based caregiving systems are increasingly strained due to urban migration, economic pressures, and changing household structures. This has resulted in increased social isolation, which is closely linked to poorer mental health outcomes and functional decline.[8,33] The absence of formal long-term care infrastructure places disproportionate caregiving responsibility on families, often without financial or institutional support.[34,35] This creates a hidden care economy that is both unsustainable and inequitable.

Systemic and health system barriers

The persistence of unmet needs is fundamentally driven by systemic weaknesses within Nigeria's health system. These include chronic underfunding of health services; high reliance on out-of-pocket expenditures; workforce shortages, particularly in geriatrics and mental health; poor infrastructure at primary healthcare level; and weak referral and continuity-of-care systems. Financial barriers remain the most significant obstacle to accessing care, particularly for older adults without stable income or pension support.[1,14] Geographic inequities further exacerbate disparities, with rural populations facing limited access to trained healthcare providers and diagnostic services.[10,36] At the clinical level, inappropriate prescribing practices and inadequate deprescribing frameworks highlight gaps in geriatric pharmacological knowledge among healthcare providers.[37,38]. At the policy level, the absence of a comprehensive national geriatric health strategy continues to limit coordinated planning and implementation of age-friendly health services.[2,24]

Ethical and human rights considerations

The findings raise important ethical and human rights concerns regarding the dignity and care of older adults. The lack of structured geriatric services and persistent neglect of functional and social care needs contradict principles of equitable health access and dignified aging. This is particularly relevant in the context of international human rights frameworks, which emphasize the right to health, social protection, and non-discrimination in older age. The absence of enforceable geriatric care policies further compounds vulnerability among older populations in Nigeria.

Strengths and limitations

Strengths of the review

This scoping review has several strengths. First, it synthesizes evidence from 43 studies,[1-43] providing a broad mapping of unmet health and social care needs among older adults in Nigeria. The inclusion of diverse study designs enhances the comprehensiveness of the findings. Second, the review applies a structured thematic synthesis approach, allowing for systematic identification of recurring patterns across heterogeneous evidence sources. Third, the use of multiple databases and inclusion of studies spanning both health and social domains strengthens the robustness and policy relevance of the findings.

Limitations of the review

Despite these strengths, several limitations should be acknowledged. The review is dependent on the availability and quality of existing literature, which remains limited in scope and geographical coverage. This introduces potential publication bias, as studies from well-resourced or urban settings may be overrepresented. Additionally, reliance on predominantly cross-sectional and self-reported data limits causal interpretation and may introduce reporting bias. The narrative synthesis approach, while appropriate for scoping reviews, may also introduce a degree of interpretive subjectivity. Furthermore, the small number of included studies limits generalizability and highlights the overall paucity of research on geriatric health in Nigeria.

Conclusions

This scoping review demonstrates that older adults in Nigeria face substantial and multidimensional unmet health and social care needs driven by rising NCDs burdens, weak health system capacity, and persistent socioeconomic inequalities. These challenges are compounded by fragmented service delivery and limited integration of geriatric care into existing health and social systems. Addressing these gaps requires a shift toward integrated, age-responsive health and social care models, strengthened primary healthcare systems, and targeted policy reforms that prioritize equity and long-term care sustainability. Without such interventions, the burden of preventable morbidity and functional decline among older populations is likely to increase, with significant implications for individuals, families, and the broader health system.

Recommendations

Based on the synthesized evidence, recommendations are organized into short-term (immediate), medium-term, and long-term structural actions to support feasible implementation within Nigeria's health and social care system.

Short-term ("quick win") interventions

These are low-cost, high-impact strategies that can be implemented within existing primary healthcare and correctional/community health structures.

1. Routine functional screening in primary care: introduce simple, validated tools such as grip strength testing, gait speed assessment, and basic ADL screening during routine visits for older adults.
2. Targeted nutritional support: implement community- and facility-based nutritional supplementation programs for high-risk older adults, particularly those with multimorbidity, low body mass index, or functional decline.
3. Basic geriatric training for healthcare workers: develop short in-service training modules focusing on aging, multimorbidity management, deprescribing principles, and recognition of frailty indicators.
4. Integration of mental health screening: embed brief depression and cognitive screening tools into routine primary care consultations for older adults.
5. Community health outreach: strengthen existing community health worker programs to include periodic home visits for older adults, especially in rural areas.

Medium-term health system strengthening

These interventions require moderate investment and coordination between primary care, public health, and social welfare systems:

1. Integration of geriatric care into primary healthcare: establish designated "older adult care pathways" within primary health centres, including referral linkages for specialist care.
2. Expansion of National Health Insurance coverage for older adults: reduce out-of-pocket expenditure by prioritizing older populations within expanded insurance benefit packages.
3. Development of standardized screening protocols: adopt national guidelines for frailty screening, multimorbidity management, and functional assessment tailored to low-resource settings.
4. Workforce development: scale up training in geriatrics, geriatric nursing, and community-based elder care within medical and nursing curricula.
5. Strengthening referral systems: improve continuity of care through structured referral pathways between primary, secondary, and tertiary facilities.

Long-term structural and policy reforms

These require sustained political commitment and cross-sectoral coordination.

1. Development of a National Geriatric Health Policy: establish a comprehensive policy framework addressing health, social care, disability support, and aging.
2. Creation of integrated health and social care systems: formalize coordination between the Ministry of Health and social welfare agencies to provide holistic elderly care.
3. Establishment of age-friendly health infrastructure: adapt primary and secondary healthcare facilities to be physically accessible and responsive to older adults' needs.
4. Development of long-term care systems: gradually establish formal long-term care services, including assisted living and community-based elder support programs.
5. Investment in health information systems: develop national databases for aging and chronic disease tracking to support evidence-based planning and monitoring.

Cross-cutting enablers

To ensure sustainability and effectiveness, the following enabling factors are essential.

1. Political commitment and financing: increased budgetary allocation for aging and chronic disease care within national health planning.
2. Public awareness and community engagement: reduce stigma associated with aging, disability, and mental health through health promotion campaigns.
3. Equity-focused implementation: prioritize rural populations, widows, and socioeconomically disadvantaged older adults in program design.
4. Multisectoral collaboration: engage ministries of health, social welfare, finance, and civil society organizations in coordinated aging strategies.

Implementation barriers and mitigation

Key barriers and potential solutions include the following.

1. Limited workforce capacity: address through task-shifting and targeted training of primary healthcare workers.
2. Financial constraints: leverage health insurance expansion and donor-supported pilot programs.
3. Weak infrastructure: use phased implementation starting with high-burden regions.
4. Cultural barriers and stigma: integrate community leaders and faith-based organizations into awareness campaigns.

Overall, a phased and context-sensitive approach is required. Immediate low-cost interventions can be used to generate early impact, while medium- and long-term reforms focus on institutionalizing geriatric care within Nigeria's health and social systems.

Future research directions

Future research should prioritize longitudinal cohort studies to better understand the progression of unmet health and social care needs over time. There is also a need for implementation research evaluating scalable geriatric care models in primary healthcare settings. The development and validation of context-appropriate frailty and functional screening tools is essential to improve early detection and monitoring of vulnerability among older adults. Emerging research should also explore intersections between aging, climate vulnerability, migration, and economic insecurity, particularly in rapidly urbanizing contexts. Additionally, digital health innovations for tracking unmet needs may offer promising solutions if adapted to local infrastructure constraints.

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Online supplementary material:

Supplementary Table 1. Risk of bias and quality assessment.

Supplementary Table 2. Summary of the included studies.

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