

Geriatric Social Care in a Nigerian Tertiary Hospital at Uyo: A Mixed-Methods Study

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Abstract

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Background: Elderly medical care draws from virtually all areas of medicine and surgery, while geriatric social care (GSC) addresses the broader social, psychological, public health and policy needs associated with ageing. Effective GSC is therefore important for promoting healthy ageing, maintaining functional independence and improving the quality of life of older adults. This study aimed to examine the knowledge, perceptions, and barriers, and collate recommendations of healthcare professionals at the University of Uyo Teaching Hospital (UUTH)

and as well, explore the experiences and perspectives of elderly patients attending the Elderly and Chronic Care clinic of UUTH, with a view to identifying gaps, and opportunities for strengthening geriatric social care services.

Methods: A mixed-methods study was conducted among 325 consenting participants, comprising 270 healthcare professionals and 55 elderly participants. The quantitative component employed a cross-sectional design, while the qualitative component involved Focus Group Discussions (FGDs) with elderly patients attending the Elderly and Chronic Care Clinic. Data were collected using a semi-structured questionnaire and an FGD guide. The questionnaire underwent test-retest reliability assessment, with a reliability coefficient of 0.8. Quantitative data were analyzed using descriptive statistics and chi-square tests with SPSS version 25. Statistical significance was set at $p \leq 0.05$. Qualitative data were analyzed thematically. Ethical approval was obtained from the UUTH Health Research Ethics Committee (NHREC/24/0622/UUTH).

Results: There was no statistically significant association between healthcare professionals' age, gender, professional role or years of professional experience and their knowledge and perception of GSC ($\chi^2=3.911$, $p=.418$; $\chi^2=0.211$, $p=.646$; $\chi^2=8.047$, $p=.090$; and $\chi^2=6.153$, $p=.188$, respectively). Major barriers identified by healthcare professionals included inadequate resources, limited awareness and insufficient training in geriatric social care. Findings from the FGDs showed that the elderly recognized the importance of social care but had varying levels of awareness, understanding and utilization of available services. Financial constraints, transportation difficulties, inadequate personnel and limited access to specialized geriatric services were major challenges.

Conclusion: Strengthening geriatric social care requires greater public awareness, workforce development, improved healthcare infrastructure, affordable or subsidized healthcare services, and stronger government commitment to programs for older adults.

Keywords: Geriatric social care; Older adults; Healthcare professionals; Geriatric care; Mixed-methods study; Nigeria.

Introduction

The integration of purpose-driven social care with elderly medical care in the healthcare delivery and academic systems in Nigeria in favour of the aged became available very recently.¹ However, the development of the first national policy document on ageing in this country occurred in 2018 under the Federal Ministry of Women Affairs and Social Development.² The commencement of training of Geriatric Social Care Givers (GSCGs) by the National Senior Citizens Centre (NSCC) in Abuja, represents a remarkable boost to elderly medical care in Nigeria, formally reducing significantly the gap between gerontology and geriatrics.³

Elderly Medical Care and Geriatric Social Care: Elderly medical care in Nigeria is inherently multifaceted, encompassing nearly all areas of medicine and surgery.⁴ In contrast, geriatric social care addresses the broader psychosocial dimensions of ageing, drawing from social science, psychology, public health, and policy.^{5,6} The establishment of training programs for Geriatric Social Care Givers by the National Senior Citizens Centre in Abuja to cater for persons

aged 60 years and above, is evidently a step forward in strengthening elderly care services nationwide.⁷

Nigeria, Africa's most populous nation, is experiencing a profound demographic shift marked by a rapidly expanding elderly population. According to the United Nations Department of Economic and Social Affairs (UN DESA), the number of Nigerians aged 65 years and above, is projected to nearly triple by 2050.⁸

Boosting of Current national effort regarding Care of the Elderly: Geriatric social care encompasses a wide range of services designed to support physical, emotional, and social well-being, including healthcare provision, social support systems, caregiver training, policy advocacy, and economic assistance. By integrating these components into general medical care, geriatric social care seeks to enhance quality of life and promote dignity in ageing.^{5,6,9} To effectively address these challenges, committed governmental and professional effort is required.

Aim: This study aimed to examine the knowledge, perceptions, and barriers, and collate recommendations of healthcare professionals at

the University of Uyo Teaching Hospital (UUTH) and as well, explore the experiences and perspectives of elderly patients attending the Elderly and Chronic Care clinic of UUTH, with a view to identifying gaps, and opportunities for strengthening geriatric social care services.

The findings are expected to provide critical baseline data for upgrading strategic plans by healthcare providers. Ultimately, this research seeks to contribute to enhancing geriatric care in UUTH as a case study for Nigeria, ensuring that the growing elderly population receives the support and dignity it deserves.

METHODOLOGY

Study Setting and Design

This was a hospital-based study conducted at the Elderly and Chronic Care Clinic of the Department of Family Medicine, University of Uyo Teaching Hospital (UUTH), Uyo. UUTH is a 700-bedded hospital in Akwa Ibom State, in the Niger Delta region of Nigeria. A mixed-methods approach was adopted, combining a cross-sectional design with structured Focus Group Discussions (FGDs) to gather information from healthcare professionals and elderly patients.

Study Population and sampling: The study population comprised 270 healthcare professionals (including doctors, nurses, pharmacists, laboratory scientists, physiotherapists, and dietitians) working at UUTH and 55 elderly patients who attended the Elderly Care Clinic of the Department of Family Medicine, UUTH from 1st December 2025 to 28th February 2026.

For the cross-sectional survey, a convenience sampling method was used to draw participants from healthcare professionals within the facility. This approach was adopted because healthcare professionals worked on different shifts, had varying clinical responsibilities, and were often unavailable at the same time. Recruiting participants who were readily available and willing to participate during the study period allowed efficient data collection with minimal disruption to patient care.

For the qualitative survey, elderly patients who had no mental illnesses, were not severely ill and attended the Elderly and Chronic Care Clinic were purposively selected to participate in the FGDs. Seven FGDs were conducted: six comprising eight elderly patients each and one with seven elderly patients.

Sample Size Estimation and Selection criteria: The sample size estimate for the quantitative survey was calculated using Leslie Kish's sample size determination formula for cross-sectional studies,¹⁰ with a prevalence rate of 50%,¹¹ since no similar study was available to draw from. A 95% confidence level was used, and a degree of accuracy (margin of error) of 5% was adopted.

The sample size was therefore worked out as follows: $n = Z^2 pq/d^2$

Where:

n = required minimum study sample size

Z = standard deviation, usually set to 1.96, which corresponds to a 95% confidence interval.

$p = 0.5$

$q = (1.0 - p) = 1 - 0.5 = 0.5$

d = the degree of accuracy desired, usually set at 0.05.

$$1.96^2 \times 0.5 \times 0.5$$

$$0.05^2$$

$$= 384.16$$

Considering that the total study population is less than 10,000 the above calculated sample size was adjusted using Finite population correction as:

$$n_f = n / (1 + (n - 1) / N)$$

Where:

n_f = final sample size

n = calculated sample size = 384.16

N = estimated population size of 901

$$= 269.59$$

Consequently, a minimum Sample size of 270 healthcare professionals working in UUTH at the time, was recruited into the study. The study also included 55 consenting elderly patients aged 60 years and above⁷ who were not too ill to engage in discussions.

Data Collection Methods: A semi-structured questionnaire was used to collect information from healthcare professionals. The questionnaires sought information on areas such as knowledge, perception, the availability of resources and their attitude to geriatric social care. The questionnaire was pre-tested among selected medical professionals and elderly patients at St. Luke's Hospital, Anua, a Senatorial District General Hospital in Uyo metropolis, to establish its applicability and validity, and a test-retest reliability coefficient of 0.8 was attained. All 270 questionnaires given to the healthcare professionals were returned with complete responses, giving a response rate of 100%.

The FGDs were conducted using a semi-structured discussion guide. The lead researcher moderated the discussions in Ibibio and English languages regarding which the participants were fluent, encouraging them to interact freely, share experiences, and elaborate on or respond to others' views. This approach facilitated the emergence of shared experiences, divergent perspectives, and context-specific insights into the care and social support needs of elderly persons. Areas explored were participants' experiences and perceptions of elderly care support, challenges in accessing care, and the availability and use of geriatric social services. With considerations for participant's confidentiality, having obtained permission from them, the discussions were audio-recorded but video-recording was not done. The moderator and the sixth researcher took notes of the participants' views and key points raised during the discussions. The notes were reviewed immediately after each session to ensure completeness and accuracy. Discussions took place on different days, in a conducive environment, and continued until the major themes relevant to the study objectives were sufficiently explored. Each discussion session lasted about 80 - 90 minutes.

Operational Definition and Scoring of Knowledge and Perception among healthcare professionals

Knowledge and perception toward geriatric social care were assessed using the 13 items contained in the healthcare professionals' questionnaire. The items assessed participants' exposure to elderly patients, confidence in caring for them,

perception of the respect and dignity accorded elderly patients, awareness of geriatric social care, self-rated knowledge of geriatric care, previous formal training, familiarity with relevant areas of geriatric practice, confidence in performing geriatric-care activities, application of geriatric knowledge in daily practice, engagement with sources of information on geriatric care, perceived importance of geriatric social care, and perception of the adequacy of healthcare services for elderly persons.

We treated knowledge and perception as related but conceptually distinct aspects of healthcare professionals' overall orientation toward geriatric social care. They were analyzed as a single composite variable because the study aimed to assess their overall orientation rather than develop and validate separate knowledge and perception scales. The 13 items were coded in a common direction in the analytical framework, such that higher endorsement indicated greater knowledge/awareness and a more favourable perception/disposition toward geriatric social care, while lower endorsement indicated the reverse.

Scores across the 13 items were summed without additional weighting to generate a knowledge-perception composite score. Observed scores ranged from 21 to 43, based on the study-specific operational classification used in the original analysis. Participants with composite scores of 21–29 were classified as having low knowledge-perception/disposition, whereas participants with scores of 30–43 were classified as having high knowledge-perception/disposition. This cut-off was used for descriptive and inferential analysis within the present sample and was not regarded as an externally validated diagnostic threshold.

Data Analysis: Data were analyzed using descriptive and inferential statistics. Frequencies and percentages were used to summarize participants' socio-demographic characteristics, knowledge-perception/disposition toward geriatric social care, identified challenges, and proposed strategies and resources.

Knowledge and perception/disposition were analyzed as a single composite outcome. The 13 Section B items were structured so that higher endorsements reflected greater knowledge/awareness and a more favourable perception/disposition. Item scores were summed to produce an overall composite score, which was classified as low (21–29) or high (30–43) according to the study-specific operational classification. Associations between knowledge-perception/disposition category and age, gender, professional role, and years of professional experience were examined using Pearson's chi-square test of independence. The assumptions of the chi-square test were assessed by examining expected cell frequencies. No expected frequency was below 1, and no contingency table contained more than 20% of expected frequencies below 5. Pearson's chi-square was therefore considered appropriate for the reported analyses. Statistical significance was evaluated at $p < .05$, and exact p -values and degrees of freedom were reported.

Ethical Considerations: Ethical clearance was obtained from the UUTH Research and Ethics Committee before the commencement of the study (NHREC/24/0622/UUTH). Written informed consent was also obtained from participants.

RESULTS

A total of two hundred and seventy (270) healthcare professionals and fifty-five (55) elderly participants were recruited into the study. Details of the socio-demographic characteristics of healthcare professionals are presented in Table Ia and Table Ib. The ratio of participants aged ≥ 41 years to those ≤ 40 years of age was 1:2. The male-to-female ratio in the professional group was almost equal (1:1.1), whereas the doctor-to-nurse ratio was 1:1.5.

Table I (a): Socio-demographic Characteristics of healthcare professionals' analysis using frequency count and simple percentage

Variable	Frequency (n=270)	Percentage (%)
Age group (Years)		
20-30yrs	85	31.5
31-40yrs	99	36.7
41-50yrs	58	21.4
51-60yrs	23	8.5
≥ 61 yrs	5	1.9
Gender		
Male	128	47.4
Female	142	52.6
Professional Role		
Doctor	69	25.6
Nurses	103	38.1
Social Worker	53	19.6
Physiotherapist	19	7.0
*Others	26	9.6
Years of Experience		
1-5yrs	90	33.3
6-10yrs	127	47.0
11-15yrs	34	12.6
16-20yrs	9	3.3
≥ 21 yrs	10	3.7
Religion		
Christianity	257	95.2
Islam	12	4.4
Traditional	1	.4
Tribe		
Ibibio	131	48.5
Igbo	76	28.1
Yoruba	52	19.3
Hausa	10	3.7
Annang	1	0.4

*Others-dietitians, laboratory scientists, health information, and clinical psychologists

Table Ib shows the characteristics of the Focus Group Discussion members. Here, the ratio of participants aged ≥ 75 years to those ≤ 74 years was 1:1.6, while the male-to-female ratio in this group was 1:1.4. As Christians largely inhabit the Niger Region of Nigeria, the ratio of Muslims to Christians in the FGD was 1:3.8.

Table Ib: Socio-demographic analysis of the focused group members using frequency count and simple percentage

Variable	Frequency (n=55)	Percentage (%)
Age group (Years):		
60–74 yrs	34	61.8
≥ 75 yrs	21	38.2
Gender:		
Male	23	41.8
Female	32	58.2

Occupation before Retirement/Current Job:

Trader	20	36.4
Farmer	22	40.0
Skilled Worker	9	16.4
Business	4	7.3

Religion:

Christianity	38	69.1
Islam	10	18.2
Traditional	7	12.7

Tribe:

Ibibio	23	41.8
Igbo	13	23.6
Yoruba	10	18.2
Hausa	6	10.9
Annang	3	5.5

Association between socio-demographic characteristics and knowledge, and perception toward Geriatric Social Care among healthcare professionals

Table II presents the association between participants' socio-demographic characteristics and their knowledge and perception toward geriatric social care. Age was not significantly associated with knowledge-perception/disposition, $\chi^2(4) = 3.911, p = .418$.

The association between gender and knowledge-perception/disposition was not statistically significant, $\chi^2(1) = 0.211, p = .646$.

Although some variation was observed across professional groups, the association between professional role and knowledge-perception/disposition was not statistically significant, $\chi^2(4) = 8.047, p = .090$.

Years of professional experience were not significantly associated with knowledge-perception/disposition, $\chi^2(4) = 6.153, p = .188$.

Table II: Association between socio-demographic characteristics and knowledge-perception/disposition toward Geriatric Social Care among healthcare professionals

Variable	Low n (%)	High n (%)	Total n (%)	χ^2 (df)	p-value
Age:				3.911 (4)	0.418
20–30 yrs	18 (6.7)	67 (24.8)	85 (31.5)		
31–40 yrs	31 (11.5)	68 (25.2)	99 (36.7)		
41–50 yrs	16 (5.9)	42 (15.6)	58 (21.5)		
51–60 yrs	4 (1.5)	19 (7.0)	23 (8.5)		
≥60 yrs	2 (0.7)	3 (1.1)	5 (1.9)		
Gender:				0.211 (1)	0.646
Male	32 (11.9)	96 (35.6)	128 (47.4)		
Female	39 (14.4)	103 (38.1)	142 (52.6)		
Professional roles:				8.047 (4)	0.090
Doctor	22 (8.1)	47 (17.4)	69 (25.6)		
Nurses	33 (12.2)	70 (25.9)	103 (38.1)		
Social Workers	8 (3.0)	45 (16.7)	53 (19.6)		
Physiotherapist	3 (1.1)	16 (5.9)	19 (7.0)		
Others	5 (1.9)	21 (7.8)	26 (9.6)		
Years of Experience:				6.153 (4)	0.188
1–5 yrs	26 (9.6)	64 (23.7)	90 (33.3)		
6–10 yrs	38 (14.1)	89 (33.0)	127 (47.0)		
11–15 yrs	4 (1.5)	30 (11.1)	34 (12.6)		
16–20 yrs	1 (0.4)	8 (3.0)	9 (3.3)		
≥21 yrs	2 (0.7)	8 (3.0)	10 (3.7)		

Significant p value ≤ 0.05

Table II shows that a greater proportion of participants demonstrated high knowledge and positive perceptions toward geriatric social care. Statistical analysis revealed no significant association between age and perception/knowledge towards geriatric care ($\chi^2 = 3.911, p = .418$).

The chi-square analysis showed no statistically significant association between gender and perception/knowledge toward

geriatric care ($\chi^2 = 0.211, p = .646$).

Also, the chi-square analysis revealed no statistically significant association between professional role and perception/knowledge towards geriatric social care ($\chi^2 = 8.047, p = .090$).

Statistical analysis equally revealed no significant association between years of experience and perception/knowledge towards geriatric social care ($\chi^2 = 6.153, p = .188$).

Table III: Analysis of key challenges affecting Geriatric social Care as observed by Healthcare Professionals using frequency and percentage.

Key Challenges	Frequency	Percentage%
Lack of awareness	58	21.5
Lack of training	58	21.5
Insufficient resources	69	25.6
High patient-to-staff ratio	37	13.7
Cultural biases	28	10.4
Financial constraints	17	6.3
Others	3	1.1
Total	270	100.0

Table III presents the analysis of key challenges affecting geriatric social care among healthcare professionals at the University of Uyo Teaching Hospital using frequency counts and percentages. Furthermore, it indicates that geriatric social care among healthcare professionals at the University of Uyo Teaching Hospital is affected by multiple interrelated challenges, with insufficient resources, lack of awareness, and inadequate training emerging as the most reported barriers.

Table IV: Analysis of the strategies and resources needed to enhance geriatric social care initiatives proffered by Healthcare Professionals, presented as frequencies and percentages.

Key strategies and Resources	Frequency	Percent
More healthcare professionals	107	39.6
Specialised geriatric care facilities	61	22.6
Medical equipment and laboratory support	48	17.8
Financial support for patients	43	15.9
Workshops and seminars	11	4.1

Table IV presents the analysis of the proposed strategies and resources needed to enhance geriatric social care initiatives among healthcare professionals at the University of Uyo Teaching Hospital using frequency counts and percentages.

The results in Table IV generally indicate that healthcare professionals at the University of Uyo Teaching Hospital recognized the need for comprehensive, multidimensional interventions to strengthen geriatric social care initiatives within the Hospital.

Focus Group Discussion Findings on Geriatric Social Care Among Elderly Participants

The FGDs explored elderly participants' awareness, experiences, perceptions, barriers and recommendations regarding geriatric social care (GSC) services. The major themes generated were as follows:

Awareness of Geriatric Social Care: The participants demonstrated varying levels of awareness, with lack of awareness of organized GSC services emerging repeatedly across groups. Sources of information included hospitals, school lectures and radio programs.

Experiences with Geriatric Social Care: The participants'

experiences of GSC were varied. Some participants reported using services related to healthcare support, medication assistance, routine health checks and social support, which they generally perceived as beneficial. Others had never accessed organized GSC services or were uncertain about their meaning and structure. Some associated geriatric care with regular support and follow-up.

Factors Influencing Utilization: Awareness and information were major determinants of utilization. Health-related needs and the desire for quality care and improved well-being also motivated healthcare-seeking behaviour, as reflected in comments such as “*For my health*” and “*quality of care.*” Conversely, lack of experience, inadequate information and insufficient healthcare support contributed to non-utilization.

Perceived Purpose and Quality of Services: The participants generally perceived GSC as supporting the well-being and quality of life of elderly persons by addressing physical, emotional and social needs. However, perceptions of adequacy and effectiveness varied. Although some acknowledged the benefits of available healthcare services, many considered GSC insufficiently accessible and affordable.

Barriers to Access: Financial difficulties, transportation challenges, inadequate healthcare personnel and limited resources were named as prominent barriers. Lack of awareness and poor dissemination of information were also repeatedly identified as limiting healthcare-seeking and participation in organized GSC programs.

Suggestions for Improvement: The participants recommended greater public awareness and sensitization, increased manpower, staff training and subsidized care. Other suggestions included: call for free medications, regular medical check-ups, workshops and improved communication between healthcare providers and elderly patients. Specific suggestions included: “*More manpower,*” “*Free medication,*” “*Checkup,*” “*Workshop,*” and “*Social media*” campaigns.

Overall Interpretation: The FGDs showed that elderly patients recognized the importance of GSC but had variable awareness, understanding and utilization of available services. Financial constraints, limited information, transportation difficulties and inadequate specialized services were major concerns, highlighting the need for more accessible, affordable and adequately staffed geriatric care.

DISCUSSION

This study assessed healthcare professionals' and elderly patients' perspectives on geriatric social care (GSC) at the University of Uyo Teaching Hospital and found positive knowledge, perceptions and attitudes towards GSC generally. Most participants recognized important resource and training gaps and the need to strengthen multidisciplinary approaches and specialized facilities for elderly patients. Key recommendations centred on workforce development, funding and public awareness.

Socio-demographic characteristics

The ratio of healthcare professionals aged ≥ 41 years to those ≤ 40 years was approximately 1:2, indicating a predominantly young workforce. This pattern is similar to that reported by Udo et al., who found a relatively young workforce involved in elderly care, with nurses constituting the majority.¹²

The elderly participants who participated in the FGDs were predominantly younger elderly (60–74 years), female, and largely engaged in farming and trading. This pattern is similar to that reported by Dangana-Onuche et al.¹³ The predominance of women among the elderly, often described as the “feminization of later life,” is well documented and is largely attributed to higher female life expectancy and greater survival into middle and late adulthood.¹⁴

Knowledge and perception towards geriatric social care

Most participants demonstrated substantial knowledge and positive perceptions regarding GSC. However, these favourable responses should be interpreted cautiously. They may reflect genuine professional commitment to elderly care, but could also have been influenced by social desirability bias, whereby participants provide responses consistent with perceived professional expectations rather than their actual views or experiences.

Insufficient resources were the most frequently reported challenge, identified by 69 participants (25.6%). These limitations included shortages of specialized equipment and facilities, assistive devices such as wheelchairs and canes, hearing aids, as well as medications, staffing and supportive social care services. Elderly patients often require multidisciplinary and long-term care encompassing medical, psychological, nutritional, rehabilitative and social support. Resource constraints may therefore compromise the quality and continuity of care. They may also limit the time available for detailed assessment, communication, emotional support, monitoring and coordinated management.¹⁵ High patient-to-staff ratios and excessive workloads can further contribute to stress and fatigue, potentially reducing communication quality and efficiency in delivering geriatric interventions.¹⁶

Cultural biases were identified by 28 participants (10.4%) as a challenge to GSC. Cultural beliefs and stereotypes about ageing may influence both the acceptance and quality of care. In some settings, older age may be associated with dependency, weakness, reduced productivity or social irrelevance, potentially contributing to negative treatment within families, communities and healthcare systems.¹⁷ Such misconceptions may also discourage healthcare-seeking behaviour, or reduce family support for institutional care.¹⁸ Healthcare professionals' own cultural beliefs may similarly influence their attitudes and communication with older patients. These findings highlight the importance of culturally sensitive care, public awareness, and promotion of dignity, respect and social inclusion for elderly patients.

Financial constraints were reported by 17 participants (6.3%). Although less frequently identified than other challenges, financial barriers remain relevant because care for elderly patients may involve long-term treatment, expensive medications, rehabilitation and highly demanding supportive services. Limited income, inadequate health insurance and dependence on family members may restrict access to quality care.¹⁹ Financial constraints may also affect institutional capacity to provide specialized facilities, recruit trained personnel and support continuing professional development.

Strategies for strengthening geriatric social care

The provision of additional healthcare professionals was the most frequently identified strategy, reported by 107 participants (39.6%). This finding reinforces the concern regarding high patient-to-staff ratios and suggests that workforce expansion is considered a major requirement for

improving GSC services.

Specialized geriatric care facilities were the second most frequently proposed strategy, identified by 61 participants (22.6%). Elderly patients may require age-friendly environments, mobility support, rehabilitation, chronic disease management, mental health services and long-term care interventions that are not always adequately accommodated within conventional healthcare settings.¹⁷

Workshops and seminars were identified by 11 participants (4.1%), the least frequently reported strategy. Nevertheless, continuing professional development through workshops, seminars, conferences and training programs can support healthcare professionals in maintaining up-to-date knowledge of emerging evidence, geriatric care practices and innovations in elderly care.²⁰

Contribution of the Focus Group Discussions

The FGDs complemented the quantitative findings by demonstrating that elderly patients recognized the importance of GSC but had varying levels of awareness and utilization of available services. While some participants reported positive experiences, others decried financial constraints, limited awareness, transportation difficulties, inadequate healthcare personnel and limited access to specialized geriatric services as very unfortunate challenges.

The qualitative findings further showed that elderly patients desire healthcare that is more accessible, affordable and responsive to their medical, emotional and social needs. Participants emphasized increased public awareness, workforce strengthening, improved infrastructure, free or subsidized healthcare and stronger government commitment to elderly healthcare programs.²¹ These findings reinforce the quantitative evidence that improving GSC requires attention not only to healthcare professionals and facilities, but also to the social and financial circumstances that influence elderly patients' ability to access and utilize care.

CONCLUSION

This study examined geriatric social care within elderly medical care, drawing perspectives from healthcare professionals at the University of Uyo Teaching Hospital and elderly patients attending the facility. The findings demonstrate positive perceptions of GSC generally, but also highlight important gaps in resources, workforce capacity, specialized facilities, awareness and affordability. Strengthening GSC, therefore, requires greater public awareness, workforce development, improved healthcare infrastructure, affordable or subsidized services, and sustained government commitment to elderly healthcare programs. Further research involving policymakers, caregivers and the elderly in rural settings is highly advocated, in order to provide a more comprehensive understanding of the barriers and opportunities for GSC in the Nigerian setting.

Recommendations: Given the hospital-based nature of this study, future research should employ multi-centre designs involving different geographical regions and levels of healthcare delivery. Longitudinal studies would also be valuable in assessing changes in GSC needs, service availability and utilization over time.

At the policy level, GSC should be prioritized within national public health strategies for ageing populations. This should include expanding training programs for geriatric social care providers and integrating geriatric care into broader healthcare and ageing

strategies. Policymakers should also support the development of geriatric-specific facilities, subsidize healthcare costs for the elderly, and implement public awareness campaigns on available services. Lessons from UUTH could inform similar interventions in other tertiary hospitals and under-served rural communities, particularly where older populations are increasing and traditional support systems are declining. These measures could improve the accessibility and effectiveness of GSC while promoting the dignity, health and quality of life of the elderly in our communities.

Limitations: This study was conducted at a single tertiary healthcare institution, which may limit the generalization of its findings to other Nigerian settings, particularly primary and secondary healthcare facilities. The sample size and participant characteristics may also not fully represent the diversity of experiences among healthcare professionals and elderly persons nationally. In addition, reliance on self-reported data introduces the possibility of response bias, including social desirability bias, which may have influenced participants' reporting of their perceptions and experiences.

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