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Home-Based Primary Care: Advancing Aging in Place in Nigeria by 2026

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Abstract

Nigeria is undergoing a demographic transition characterized by a rapidly growing older population, while healthcare systems historically oriented toward maternal and child health remain insufficiently equipped to address the complex needs of older adults. Although aging in place has emerged as a sustainable model of eldercare, Nigeria's reliance on family-centered caregiving often imposes substantial financial, emotional, and physical burdens on caregivers in the absence of structured support. This study investigates the feasibility, outcomes, and challenges of Home-Based Primary Care (HBPC) in Nigeria and evaluates its potential to advance aging in place by 2026, with particular attention to health outcomes, caregiver burden, hospital utilization, healthcare expenditure, cultural acceptance, and policy implications. A mixed-methods design was employed from January 2024 to December 2025. Quantitative surveys involved 500 adults aged 60 years and above from urban communities in Lagos and Abuja and rural communities in Oyo and Benue, while qualitative interviews were conducted with 50 older adults, caregivers, and healthcare providers. A pilot HBPC program provided routine medical check-ups, medication delivery, physiotherapy, and psychosocial support. Quantitative data were analyzed using descriptive statistics, chi-square tests, and logistic regression, whereas qualitative data were examined through thematic analysis using NVivo. The findings show that 68% of participants reported improved chronic disease management, while hospital readmissions decreased by 32%. Functional independence scores increased by 15 points in urban areas and 10 points in rural areas,

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while psychological well-being and social relationship indicators improved by 21% and 18%, respectively. Caregiver strain decreased by 40%, and household healthcare expenditure declined by 27%. Qualitative findings further revealed strong cultural acceptance of HBPC, trust in community health workers, and reduced caregiver burden, although workforce shortages, funding constraints, and supply-chain inefficiencies remained significant barriers. The study concludes that HBPC represents a viable approach to advancing aging in place in Nigeria by improving health outcomes, reducing caregiver burden and healthcare costs, and supporting the dignity and independence of older adults. The findings contribute to geriatric and primary healthcare policy by demonstrating the potential value of integrating structured home-based services into Nigeria's health system and highlight the need for strategic investment, workforce development, and institutional support, including through the National Senior Citizens Centre, to facilitate broader implementation.

Keywords: Aging in Place; Caregiver Burden; Geriatric Care; Home-Based Primary Care; Older Adults

INTRODUCTION

Nigeria is undergoing a demographic transition marked by a steady increase in its elderly population. Improvements in life expectancy, driven by advances in healthcare and reductions in infectious disease mortality, have contributed to this shift. Fertility rates have also declined, leading to a larger proportion of older adults relative to younger cohorts. According to the National Population Commission (2024), the number of Nigerians aged 60 and above is projected to double by 2035. This demographic change presents new challenges for a healthcare system historically focused on maternal and child health. Elderly care has not received proportional attention in policy or practice. Consequently, older adults often face neglect in accessing healthcare services. The growing elderly population requires specialized interventions to address chronic diseases and functional decline. Without adequate planning, Nigeria risks a crisis in eldercare. The demographic transition also has socioeconomic implications, including increased dependency ratios. Families are bearing the burden of care without sufficient institutional support. This context underscores the urgency of exploring sustainable eldercare models.

Globally, the concept of "aging in place" has emerged as a preferred model of eldercare. Aging in place refers to enabling older adults to remain in their homes and communities while receiving appropriate medical and social support. This approach is widely recognized for its cost-effectiveness compared to institutional care. It also enhances dignity, autonomy, and quality of life for older people (WHO, 2025). Studies in developed countries show that aging in place reduces healthcare costs by minimizing hospital admissions. It also improves psychosocial outcomes by maintaining social connections. In developing countries, aging in place is particularly relevant due to limited institutional facilities. Nigeria has very few nursing homes, and those that exist are often stigmatized. Families prefer to care for elders at home, consistent with cultural traditions. Aging in place aligns with these cultural preferences. It also addresses gaps in institutional infrastructure. Thus, aging in place is both a practical and culturally acceptable model for Nigeria.

In Nigeria, aging in place resonates strongly with cultural traditions. Family-centered care is deeply embedded in Nigerian society. Older adults often prefer to remain within their households rather than relocate to institutional facilities. Institutional eldercare is scarce and often viewed negatively. Folorunsho (2025) notes that many Nigerians perceive nursing homes as abandonment of family responsibilities. This cultural context makes home-based care more acceptable. Families see caring for elders as a moral obligation. However, without structured support, family caregivers face significant burdens. These include financial strain, emotional stress, and lack of training. Caregiver burnout is a growing concern. Aging in place requires systems that support both elders and caregivers. HBPC offers a structured way to achieve this. It integrates professional healthcare into the home environment, complementing family caregiving traditions. Home-Based Primary Care (HBPC) is a healthcare delivery model designed to support aging in place. HBPC involves providing medical, nursing, and psychosocial services directly in the patient's home. It reduces reliance on hospital-based care. HBPC is particularly effective for managing chronic diseases. It also supports functional independence by providing rehabilitation services. Low, Yap, and Brodaty (2011) found that HBPC reduces hospital admissions and improves patient satisfaction. HBPC integrates preventive, curative, and rehabilitative services. It also addresses psychosocial needs, such as counseling and social support. HBPC is adaptable to diverse cultural contexts. In Nigeria, HBPC aligns with family caregiving traditions. It provides professional support while respecting cultural norms. HBPC thus represents a promising model for eldercare in Nigeria.

Evidence from other countries demonstrates HBPC's effectiveness. In Brazil, the Family Health Strategy integrates HBPC into primary care. This has reduced hospital admissions and improved quality of life. In India, the National Programme for Health Care of the Elderly emphasizes community-based care. HBPC models in these countries have shown positive outcomes. Mbagwu, Adeyemi, and Okafor (2025) highlight similar trends in African contexts. HBPC improves chronic disease management. It also enhances patient satisfaction. These outcomes suggest HBPC could be transformative in Nigeria. Nigeria shares similar challenges with other low-resource settings. HBPC addresses these challenges by decentralizing care. It brings healthcare closer to patients. This reduces barriers to access. HBPC's success elsewhere provides a strong rationale for its adoption in Nigeria. Nigeria's healthcare system faces systemic challenges. Infrastructure is inadequate, particularly in rural areas. Workforce shortages are acute, with few trained geriatricians. Health insurance coverage is limited. Most older adults rely on out-of-pocket payments. This creates financial barriers to care. Federal Ministry of Information (2021) notes that poverty exacerbates eldercare challenges. Informal caregivers provide most eldercare. They often lack training and resources. This leads to suboptimal care. Chronic diseases are poorly managed. Hospital admissions are frequent and costly. HBPC offers a way to address these systemic gaps. By decentralizing care, HBPC reduces reliance on hospitals. It also supports caregivers with professional assistance.

The National Policy on Ageing (2021) outlines goals of independence, security, and dignity for older persons. It emphasizes aging in place as a priority. However, implementation has been slow. Many elderly Nigerians remain without structured support. HBPC offers a practical pathway to operationalize this policy. It embeds care within communities. This aligns with policy goals. Federal Ministry of Information (2021) highlights the need for community-based eldercare. HBPC provides a model for achieving this. It integrates medical and social support. It also reduces financial barriers. HBPC thus operationalizes policy commitments. It translates policy into practice. This strengthens Nigeria's eldercare system. The establishment of the National Senior Citizens Centre (NSCC) in 2021 was intended to coordinate eldercare programs. The NSCC is mandated to implement the National Policy on Ageing. However, its capacity remains limited. Funding and staffing constraints hinder its effectiveness. NSCC (2026) reports challenges in scaling eldercare programs. HBPC integration into national health strategies is still evolving. The NSCC could play a key role in institutionalizing HBPC. It can provide oversight and

coordination. It can also standardize HBPC services. Strengthening the NSCC is essential. It ensures HBPC programs are sustainable. It also enhances accountability. The NSCC can bridge policy and practice. This strengthens eldercare delivery in Nigeria.

International frameworks provide guidance for HBPC implementation. WHO's Integrated Care for Older People (ICOPE) emphasizes community-based, person-centered care. ICOPE provides tools for assessing and managing older adults. It aligns with aging in place principles. Nigeria's adoption of HBPC aligns with these global priorities. It contributes to the Decade of Healthy Ageing (2021–2030). WHO (2025) emphasizes the importance of integrated eldercare. HBPC operationalizes this framework. It provides comprehensive care in the home. It also addresses social determinants of health. HBPC thus aligns with global best practices. Nigeria's adoption of HBPC strengthens its international commitments. It also enhances global collaboration. Cultural acceptance of HBPC is high in Nigeria. Family caregiving traditions remain strong. Elders prefer to remain at home. HBPC supports this preference. It integrates professional care into the home. This reduces caregiver burden. Folorunsho (2025) notes that caregivers face financial and emotional strain. HBPC provides relief. It supports caregivers with medical assistance. It also reduces hospital visits. This improves caregiver well-being. HBPC thus benefits both elders and caregivers. It strengthens family caregiving traditions. It also enhances healthcare outcomes.

This study investigates HBPC's feasibility in Nigeria. It examines outcomes and challenges. The focus is on advancing aging in place by 2026. A mixed-methods design is employed. Quantitative surveys capture health outcomes. Qualitative interviews capture lived experiences. Pilot program evaluation provides real-world data. The study includes urban and rural settings. This ensures representativeness. It triangulates findings across methods. This strengthens validity. The study contributes to eldercare research. It informs policy and practice.

By examining HBPC's role in Nigeria's eldercare system, this research contributes to policy discussions. It also informs healthcare planning. It engages with global debates on sustainable models of aging. Findings aim to inform strategies for aging with dignity. WHO (2025) emphasizes dignity as central to eldercare. HBPC operationalizes this principle. It enables elders to remain in their homes. It reduces reliance on hospitals. It supports

caregivers. It aligns with cultural traditions. It strengthens Nigeria's healthcare system. It contributes to global goals. It transforms aging from a challenge into an opportunity.

Literature Review

The concept of aging in place has been widely studied across different regions of the world. It refers to the ability of older adults to remain in their homes and communities while receiving appropriate healthcare and social support. This model is increasingly recognized as a sustainable approach to eldercare, particularly in resource-constrained settings (WHO, 2025). Studies in high-income countries demonstrate that aging in place reduces healthcare costs by minimizing hospital admissions. It also enhances psychosocial well-being by maintaining social connections. In low- and middle-income countries, aging in place is often the default due to limited institutional facilities. Nigeria exemplifies this trend, with few nursing homes and strong cultural traditions favoring family caregiving (Folorunsho, 2025). Research shows that institutional eldercare is stigmatized in Nigeria, making aging in place culturally acceptable. However, without structured support, families face significant burdens. This underscores the need for models like HBPC. HBPC integrates professional healthcare into the home environment. It complements family caregiving traditions.

Home-Based Primary Care (HBPC) is a healthcare delivery model designed to support aging in place. It involves providing medical, nursing, and psychosocial services directly in the patient's home. HBPC reduces reliance on hospital-based care. It is particularly effective for managing chronic diseases. It also supports functional independence by providing rehabilitation services. Low, Yap, and Brodaty (2011) found that HBPC reduces hospital admissions and improves patient satisfaction. HBPC integrates preventive, curative, and rehabilitative services. It also addresses psychosocial needs, such as counseling and social support. HBPC is adaptable to diverse cultural contexts. In Nigeria, HBPC aligns with family caregiving traditions. It provides professional support while respecting cultural norms. HBPC thus represents a promising model for eldercare in Nigeria.

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Nigeria's healthcare system faces systemic challenges. Infrastructure is inadequate, particularly in rural areas. Workforce shortages are acute, with few trained geriatricians. Health insurance coverage is limited. Most older adults rely on out-of-pocket payments. This creates financial barriers to care. Federal Ministry of Information (2021) notes that poverty exacerbates eldercare challenges. Informal caregivers provide most eldercare. They often lack training and resources. This leads to suboptimal care. Chronic diseases are poorly managed. Hospital admissions are frequent and costly. HBPC offers a way to address these systemic gaps. By decentralizing care, HBPC reduces reliance on hospitals. It also supports caregivers with professional assistance.

The National Policy on Ageing (2021) outlines goals of independence, security, and dignity for older persons. It emphasizes aging in place as a priority. However, implementation has been slow. Many elderly Nigerians remain without structured support. HBPC offers a practical pathway to operationalize this policy. It embeds care within communities. This aligns with policy goals. Federal Ministry of Information (2021) highlights the need for community-based eldercare. HBPC provides a model for achieving this. It integrates medical and social support. It also reduces financial barriers. HBPC thus operationalizes policy commitments. It translates policy into practice. This strengthens Nigeria's eldercare system.

The establishment of the National Senior Citizens Centre (NSCC) in 2021 was intended to coordinate eldercare programs. The NSCC is mandated to implement the National Policy on Ageing. However, its capacity remains limited. Funding and staffing constraints hinder its effectiveness. NSCC (2026) reports challenges in scaling eldercare programs. HBPC integration into national health strategies is still evolving. The NSCC could play a key role in institutionalizing HBPC. It can provide oversight and coordination. It can also standardize HBPC services. Strengthening the NSCC is essential. It ensures

HBPC programs are sustainable. It also enhances accountability. The NSCC can bridge policy and practice. This strengthens eldercare delivery in Nigeria.

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Cultural acceptance of HBPC is high in Nigeria. Family caregiving traditions remain strong. Elders prefer to remain at home. HBPC supports this preference. It integrates professional care into the home. This reduces caregiver burden. Folorunsho (2025) notes that caregivers face financial and emotional strain. HBPC provides relief. It supports caregivers with medical assistance. It also reduces hospital visits. This improves caregiver well-being. HBPC thus benefits both elders and caregivers. It strengthens family caregiving traditions. It also enhances healthcare outcomes. Studies in Africa highlight HBPC's potential. Mbagwu et al. (2025) report that HBPC improves chronic disease management. It also enhances patient satisfaction. HBPC reduces hospital admissions. It supports functional independence. These outcomes are consistent across different contexts. HBPC is adaptable to local needs. It aligns with cultural traditions. It addresses systemic healthcare gaps. HBPC is cost-effective. It reduces reliance on hospitals. It supports caregivers. HBPC thus represents a sustainable model for eldercare in Africa.

Research in Nigeria highlights eldercare challenges. Folorunsho (2025) notes that poverty exacerbates eldercare issues. Out-of-pocket payments create financial barriers. Health insurance coverage is limited. Infrastructure is inadequate. Workforce shortages are acute. Informal caregivers provide most eldercare. They often lack training and resources. This leads to suboptimal care. Chronic diseases are poorly managed. Hospital admissions are frequent and costly. HBPC offers a way to address these challenges. It decentralizes care. It supports caregivers with professional assistance. HBPC's effectiveness is supported by global evidence. Low et al. (2011) found that HBPC reduces hospital admissions. It

improves patient satisfaction. HBPC integrates preventive, curative, and rehabilitative services. It addresses psychosocial needs. HBPC is adaptable to diverse cultural contexts. It aligns with family caregiving traditions. HBPC provides professional support. It respects cultural norms. HBPC thus represents a promising model for eldercare. It is cost-effective. It enhances quality of life. HBPC is sustainable.

Nigeria's adoption of HBPC aligns with global priorities. WHO's Decade of Healthy Ageing emphasizes integrated eldercare. HBPC operationalizes this framework. It provides comprehensive care in the home. It addresses social determinants of health. HBPC aligns with global best practices. Nigeria's adoption strengthens its international commitments. It enhances global collaboration. HBPC contributes to sustainable development goals. It improves health outcomes. It reduces healthcare costs. It supports caregivers. HBPC is transformative. HBPC's success depends on policy support. The National Policy on Ageing emphasizes aging in place. HBPC operationalizes this policy. It embeds care within communities. It integrates medical and social support. It reduces financial barriers. HBPC translates policy into practice. It strengthens eldercare systems. Federal Ministry of Information (2021) highlights the need for community-based eldercare. HBPC provides a model for achieving this. It aligns with policy goals. It enhances sustainability. HBPC is essential.

HBPC also requires institutional support. The NSCC is mandated to coordinate eldercare programs. It can institutionalize HBPC. It can provide oversight and coordination. It can standardize HBPC services. Strengthening the NSCC is essential. It ensures sustainability. It enhances accountability. NSCC (2026) reports challenges in scaling eldercare programs. HBPC integration is still evolving. Strengthening the NSCC bridges policy and practice. It strengthens eldercare delivery. It enhances outcomes. Future research should focus on HBPC's long-term impact. Longitudinal studies are needed. They should assess mortality and morbidity. They should evaluate cost savings. Digital health innovations could enhance HBPC. Telemedicine can support rural delivery. Mobile health applications can improve monitoring. Collaboration is essential. Government, NGOs, and private providers must work together. Public-private partnerships can mobilize resources. They can expand training. They can ensure sustainability. HBPC can transform eldercare in Nigeria.

MATERIALS AND METHODS

Study Design

This study employed mixed-methods design, integrating quantitative surveys, qualitative interviews, and pilot program evaluation. The rationale was to capture both measurable health outcomes and the lived experiences of older adults receiving home-based primary care (HBPC). By combining these approaches, the research ensured that statistical data could be contextualized with cultural and social insights.

The study was conducted over a two-year period (January 2024 – December 2025), allowing for longitudinal tracking of health outcomes and satisfaction levels. This timeframe was chosen to provide sufficient duration for HBPC interventions to demonstrate measurable impact. Both urban and rural settings were included to reflect Nigeria's diverse healthcare landscape. Lagos and Abuja represented urban centers with relatively better healthcare infrastructure, while Oyo and Benue provided rural perspectives where access to hospitals is limited.

A pilot HBPC program was embedded within the design to test feasibility and scalability. This program included routine medical visits, medication delivery, physiotherapy, and psychosocial support. Outcomes from the pilot informed broader survey and interview findings. Triangulation was emphasized throughout the design, ensuring that findings from surveys, interviews, and pilot program data were cross-verified. This strengthened validity and reduced bias, making conclusions more representative of Nigeria's elderly population.

Population and Sampling

The study population consisted of adults aged 60 years and above, residing in Nigeria. This age threshold was selected based on WHO's definition of older adults and Nigeria's demographic trends. Participants were required to have lived in Nigeria for at least five years to ensure cultural and healthcare system familiarity.

A stratified sampling technique was employed to balance representation between urban and rural areas. Within each stratum, random sampling was used for surveys, while purposive sampling was applied for interviews to capture diverse socioeconomic and health backgrounds. The quantitative survey included 500 participants, divided equally between

urban and rural communities. This sample size was determined using power analysis to ensure statistical significance in detecting differences between groups.

For qualitative interviews, 50 participants were selected, including elderly individuals, caregivers, and healthcare providers. This smaller sample allowed for in-depth exploration of experiences and perceptions. Healthcare providers (30 in total) were also included to provide professional perspectives on HBPC implementation. This triangulation of elderly, caregiver, and provider voices enriched the dataset and ensured a holistic understanding.

Data Collection

Data collection was multi-layered, beginning with structured surveys administered via tablets equipped with encrypted software. These surveys captured demographic data, health status, access to care, and quality of life indicators using validated instruments such as WHOQOL-BREF and the Barthel Index. Qualitative interviews were conducted in both English and local languages (Yoruba, Hausa, Igbo) to ensure inclusivity. Certified translators assisted where necessary, and interviews were audio-recorded with participant consent.

The pilot HBPC program provided real-world data. Services included routine medical check-ups, medication delivery, physiotherapy, and psychosocial support. Outcomes such as hospital readmission rates, patient satisfaction, and caregiver burden were tracked.

Community health workers played a central role in data collection, acting as trusted intermediaries between researchers and participants. Their involvement increased response rates and reduced participant anxiety.

Data integrity was maintained through double-entry verification for surveys and transcription checks for interviews. This ensured accuracy and minimized errors in the dataset.

Materials

Survey instruments included standardized tools: WHOQOL-BREF for quality of life, Barthel Index for functional independence, and structured questionnaires for healthcare access. These instruments were chosen for their global validity and adaptability to local contexts. Medical equipment used in the pilot program included portable

diagnostic kits such as blood pressure monitors, glucometers, and pulse oximeters. These tools enable healthcare providers to deliver essential services directly in participants' homes.

Data recording was facilitated by tablets with encrypted survey software, ensuring confidentiality and reducing paper-based errors. Cloud-based storage was used for secure backup. Translation support was provided by certified translators familiar with medical terminology. This ensured that participants could express themselves fully in their preferred language.

Additional materials included caregiver strain indices, satisfaction rating scales, and cost-analysis templates. These tools allowed for comprehensive evaluation of HBPC's impact across multiple dimensions.

Data Analysis

Quantitative data was analyzed using SPSS software. Descriptive statistics summarized demographic and health characteristics, while inferential tests (Chi-square, logistic regression) assessed associations between HBPC and outcomes such as hospital readmissions and quality of life. Qualitative data were analyzed using NVivo software. A thematic coding framework was developed iteratively, capturing cultural perceptions, barriers, and enablers of HBPC. Themes were validated through peer debriefing and member checking with participants.

Integration of findings was achieved through triangulation. Quantitative improvements in health outcomes were contextualized with qualitative insights into cultural acceptance and caregiver relief. Cost analysis was conducted by comparing household healthcare expenditures before and after HBPC implementation. This provided evidence of economic sustainability.

This gives policy-relevant recommendations, ensuring that findings could inform Nigeria's healthcare planning for 2026 and beyond.

RESULTS

Quantitative Findings

The quantitative analysis revealed significant improvements in health outcomes, access to care, and quality of life among participants receiving HBPC. Hospital readmission

rates decreased, functional independence improved, and medication adherence increased. Quality of life indicators also showed notable gains.

Indicator	Baseline (Pre-HBPC)	Post-HBPC (6 months)	% Change/ Improvement
Chronic condition management	42% adequate	68% adequate	+26%
Hospital readmission rate	25%	17%	-32%
Barthel Index (Urban)	Avg. 65	Avg. 80	+15 points
Barthel Index (Rural)	Avg. 60	Avg. 70	+10 points
Medication adherence	45%	59%	+14%
WHOQOL-BREF Psychological score	52	63	+21%
WHOQOL-BREF Social relationships	50	59	+18%

Qualitative Findings

Thematic analysis of interviews highlighted cultural acceptance of HBPC, trust in providers, caregiver relief, and systemic barriers. Elderly participants valued HBPC as consistent with family-centered traditions, while caregivers reported reduced stress. Workforce shortages and supply chain challenges were noted as barriers.

Theme	Key Insights
Cultural Acceptance	Elderly participants valued HBPC as consistent with family-centered traditions
Trust in Providers	Direct contact with community health workers fostered trust and reduced anxiety
Barriers	Workforce shortages, funding gaps, and medication supply chain issues
Caregiver Relief	Caregivers reported reduced stress and improved work-life balance
Theme	Key Insights
Cultural Acceptance	Elderly participants valued HBPC as consistent with family-centered traditions
Trust in Providers	Direct contact with community health workers fostered trust and reduced anxiety

Pilot Program Evaluation

The pilot HBPC program demonstrated measurable benefits in reducing hospital admissions, improving patient satisfaction, and lowering caregiver burden. Cost analysis indicated HBPC reduced household healthcare expenditures compared to hospital-based care.

Outcome Measure	Baseline	Post-HBPC	% Change/Impact
Hospital admissions	25%	12%	-52%
Patient satisfaction ("very satisfied")	60%	85%	+25%
Caregiver strain index score	18	11	-40%
Average healthcare expenditure per household	₦120,000/year	₦87,600/year	-27%

Access to Care

Access to healthcare improved significantly under HBPC. Participants reported reduced travel burden, increased adherence to medications, and higher satisfaction levels, particularly in rural communities.

Indicator	Baseline	Post-HBPC	% Change
Reduced travel burden	0%	74%	+74%
Increased medication adherence	45%	59%	+14%
Rural satisfaction with HBPC	0%	82%	+82%
Urban satisfaction with HBPC	0%	70%	+70%

DISCUSSION

The results of this study demonstrate that HBPC significantly improves health outcomes, reduces hospital admissions, and enhances quality of life among older adults in Nigeria. These findings are consistent with evidence from Brazil, where integrated home care programs reduced hospital admissions and improved continuity of treatment (Genaro, Silva, & Andrade, 2024). Similarly, India's National Programme for Health Care of the Elderly (NPHCE) showed that community-based eldercare improved chronic disease management and reduced caregiver burden (Channon, Hosseinpoor, & Williams, 2012). Our findings also align with longitudinal studies in Sub-Saharan Africa, which emphasize the importance of community-based interventions in addressing the projected 218% increase in elderly populations by 2050 (Akinrolie, Mensah, & Dlamini, 2024). Improvements in functional independence scores mirror outcomes reported in South Africa's HAALSI study, where home-based interventions supported daily living activities (Kalu, Smith, & Hoffman, 2021). Quality of life gains in psychological well-being and social relationships are consistent with MDPI studies in Brazil, which found that home care improved emotional health and reduced isolation (Genaro et al., 2024). These parallels suggest HBPC is adaptable across diverse cultural and economic contexts. Nigeria's results

confirm HBPC's potential as a scalable solution for eldercare. The magnitude of improvement in Nigeria underscores the urgent need for structured policy support. HBPC thus represents both a culturally acceptable and evidence-based model for advancing aging in place.

Despite positive outcomes, HBPC faces systemic barriers in Nigeria. Workforce shortages remain critical, with fewer than ten trained geriatricians nationwide (Mbagwu, Adeyemi, & Okafor, 2025). This mirrors findings in Integrity Research Journals, which highlight Nigeria's systemic crisis in geriatric care due to specialist shortages and reliance on informal caregivers (Mbagwu et al., 2025). Funding constraints also pose challenges, as most elderly Nigerians rely on out-of-pocket payments, like findings in India where wealthier populations disproportionately accessed inpatient care (Channon et al., 2012). Supply chain inefficiencies undermine HBPC delivery, particularly in rural areas, echoing challenges reported in African Researchers Magazine, which noted structural failures in elderly care systems across Africa (Adebiyi, 2020). Caregiver strain remains high, consistent with MDPI studies in Brazil where caregivers reported loneliness, emotional burden, and sleep disturbances (Genaro et al., 2025). These barriers highlight the need for systemic reforms. Without investment in workforce development, HBPC programs risk being under-resourced. Financial reforms, including expansion of health insurance, are essential to reduce inequities. Addressing supply chain gaps will ensure consistent delivery of medications and diagnostic tools.

The findings underscore the urgent need to operationalize Nigeria's National Policy on Ageing (2021). Similar delays in policy implementation have been reported across Africa, where aging policies remain underfunded and poorly enforced (Adeleke, 2022). Strengthening the National Senior Citizens Centre (NSCC) is essential to institutionalize HBPC programs, echoing recommendations from Integrity Research Journals that emphasize institutional reform (Mbagwu et al., 2025). Integrating HBPC into the National Health Insurance Authority Act would provide sustainable financing, comparable to Brazil's reforms that reduced inequality in elderly inpatient care (Channon et al., 2012). Nigeria's policy efforts must also align with WHO's Decade of Healthy Ageing, which emphasizes integrated, community-based care (WHO, 2025). Comparative studies in Sub-Saharan Africa highlight the importance of longitudinal data to inform policy, yet Nigeria has limited use of such datasets (Akinrolie et al., 2024). Policy enforcement must prioritize equity, ensuring rural populations benefit equally. Institutional support through NSCC can

standardize HBPC services nationwide. Financing reforms will reduce reliance on out-of-pocket payments. Policy action is critical to transform HBPC from pilot programs into national eldercare strategy.

International experiences provide valuable lessons for Nigeria. Brazil's Family Health Strategy demonstrates how HBPC integration into primary care reduces hospital admissions and improves quality of life (Genaro et al., 2024). India's NPHCE highlights the role of task-shifting to community health workers in expanding eldercare coverage (Channon et al., 2012). South Africa's HAALSI study shows that home-based interventions support functional independence and reduce caregiver burden (Kalu et al., 2021). Nigeria's HBPC outcomes mirror these successes, suggesting adaptability across diverse contexts. However, unlike Brazil, Nigeria's health system reforms remain limited, creating inequities like those observed in India (Channon et al., 2012). Comparative reviews emphasize that integrated, task-shifting, community-based approaches are scalable solutions for LMICs (Mbagwu et al., 2025). Nigeria's adoption of HBPC aligns with WHO's ICOPE framework, emphasizing person-centered care (WHO, 2025). Global evidence confirms HBPC's effectiveness in reducing costs and improving outcomes. Nigeria must adapt these models to its unique cultural and systemic context. Aligning HBPC with global frameworks enhances opportunities for international funding and collaboration.

Future research should focus on longitudinal studies to assess HBPC's long-term impact. Longitudinal studies in Sub-Saharan Africa highlight the need for sustained evaluation to inform policy (Akinrolie et al., 2024). Nigeria must invest in similar datasets to track HBPC outcomes over time. Digital health innovations, such as telemedicine, could enhance HBPC delivery, particularly in rural areas, consistently with recommendations from Integrity Research Journals (Mbagwu et al., 2025). Mobile health applications can improve monitoring and reduce travel burdens. Comparative studies in Brazil emphasize the importance of caregiver support, suggesting Nigeria should integrate emotional and educational resources for caregivers (Genaro et al., 2025). Collaboration between government, NGOs, and private providers will be critical to scaling HBPC nationwide. Public-private partnerships can mobilize resources and expand training. Nigeria must also align HBPC with Sustainable Development Goals, particularly SDG 3 on health and well-being. Future directions should prioritize sustainability, equity, and innovation to transform eldercare in Nigeria.

CONCLUSION

This study concludes that Home-Based Primary Care (HBPC) represents a viable approach to advancing aging in place among older adults in Nigeria. The findings show improvements in chronic disease management, functional independence, psychological well-being, and social relationships, alongside reductions in hospital readmissions, caregiver strain, and household healthcare expenditure. Specifically, 68% of participants reported improved chronic disease management, hospital readmissions declined by 32%, caregiver strain decreased by 40%, and household healthcare expenditure fell by 27%. Functional independence also improved in both urban and rural settings. Qualitative findings further indicate strong cultural acceptance of HBPC and trust in community health workers, although workforce shortages, funding constraints, and supply-chain inefficiencies remain important barriers to broader implementation. Collectively, these findings demonstrate that structured home-based care can support the health, dignity, and independence of older adults while reducing pressures on caregivers and healthcare services.

This study contributes to geriatric and primary healthcare research by providing empirical evidence on the feasibility and outcomes of HBPC within the Nigerian context, where formal systems of eldercare remain limited and family-centered caregiving predominates. By integrating quantitative outcomes with the experiences of older adults, caregivers, and healthcare providers, the study clarifies the potential role of HBPC as a culturally acceptable and community-oriented model of eldercare. Practically, the findings support the integration of structured home-based services into Nigeria's primary healthcare system and underscore the importance of strategic investment in workforce development, sustainable financing, reliable supply systems, and institutional coordination. Strengthening the National Senior Citizens Centre and incorporating HBPC within existing health financing and ageing-policy frameworks may facilitate the transition from localized pilot initiatives toward more systematic provision of home-based eldercare.

Future research should employ longitudinal designs to determine whether the observed health, functional, economic, and caregiver-related outcomes are sustained over time and across different Nigerian settings. Further studies should also examine the effectiveness and feasibility of digital health and telemedicine approaches for extending HBPC to underserved and rural populations, as well as interventions that provide educational and psychosocial support for caregivers. Comparative research across

geographical and socioeconomic contexts would further clarify variations in accessibility, implementation, and outcomes. In addition, future investigations should examine sustainable models of collaboration among government institutions, nongovernmental organizations, and private healthcare providers to determine how HBPC can be expanded while maintaining equity, continuity, and quality of care.

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