British Journal of Multidisciplinary and Advanced Studies,6(6)1-49, 2025
Health and Medical Sciences
Print ISSN: 2517-276X
Online ISSN: 2517-2778
https://bjmas.org/index.php/bjmas/index

Evidence-Based Solutions Addressing the Unmet Health and Social Care Needs among Older Adults in Sub-Saharan Africa: A Systematic Review

Gideon Ehidiamen
Senior Registrar, Plastic and reconstructive surgery, Irrua Specialist Teaching Hospital, Edo State, Nigeria

Tracy Esele Omoataman
Registrar, Department of Mental Health and Behavioural Medicine. Irrua Specialist Teaching Hospital, Edo state Nigeria

doi: https://doi.org/10.37745/04973 Published December 03, 2025

Citation: Ehidiamen G. (2025) Evidence-Based Solutions Addressing the Unmet Health and Social Care Needs among Older Adults in Sub-Saharan Africa: A Systematic Review, *British Journal of Multidisciplinary and Advanced Studies*, 6(5)1-49

Abstract: *Emerging evidence indicates that older populations across Sub-Saharan Africa face a disproportionately high burden of unmet health and social care needs. Gaining a clearer understanding of these unmet needs is essential for informing the development of strategies, policies, and programmes that can strengthen service delivery, promote equity, and improve health and social outcomes among older adults. This study thus aimed to synthesise a range of existing evidence addressing the unmet health and social care needs of the aged in sub-Saharan Africa. Three electronic databases—PubMed, Springer Nature Link, and African Journals Online—were systematically searched. A comprehensive search strategy was developed using a combination of keywords, and a two-stage screening process was employed. A total of 31 studies met the inclusion criteria. The findings from these studies were synthesised narratively. The review identified a wide range of unmet health and social care needs among older adults in Sub-Saharan Africa. These included a high prevalence of non-communicable diseases, nutritional deficiencies, limitations in activities of daily living, social isolation, depression, and psychological distress. Many of these unmet needs were linked to broader social determinants of health and inequalities, such as financial hardship, poor living conditions, unhealthy lifestyle factors, societal beliefs about ageing and western medicine, geographical disparities, gender inequality, and weaknesses within the health system. Formal care was often regarded as a last resort. The findings indicate an urgent need for sensitisation and public awareness about the challenges associated with ageing, and how to ensure healthy ageing. This will help reduce the stigma and marginalisation of the elderly and also encourage the acceptance of Western medicine. Further research focusing on coordinated care models and the role of technology in enhancing service delivery is essential to inform policy and practice in the region.*

Keywords: unmet needs, older adults, SSA

British Journal of Multidisciplinary and Advanced Studies,6(6)1-49, 2025
Health and Medical Sciences
Print ISSN: 2517-276X
Online ISSN: 2517-2778
https://bjmas.org/index.php/bjmas/index

INTRODUCTION

The population of sub-Saharan Africa (SSA) is undergoing one of the quickest demographic transitions in the world, with the number of people aged 60 years and older expected to rise by 165 million in 2050, compared to 46 million in 2015 [1–3]. The public health implications of this demographic change are significant, as the demand on the healthcare service increases exponentially with age, as older adults have a higher chance of developing chronic and degenerative illnesses, including hypertension, diabetes, cancer, chronic renal disease, respiratory diseases, frailty, and mental health disorders, like depression and cognitive impairments [4].

Unlike most high-income countries, which had well-established, robust healthcare and social protection infrastructures before widespread population ageing, SSA countries are mostly low and medium-income countries facing persistent poverty, fragile health systems, and limited public resources [5]. As a result, many older persons are moving into situations that lack the fundamental structural and institutional capacities needed to address their health and social care needs.

Mounting evidence across SSA shows that the older population experiences a disproportionately high prevalence of unmet health and social care needs [2]. According to Sandman and Hofmann, a health and social care need is unmet when there is a problem that has not been provided with an adequate solution [6]. Building upon this idea, the definition of unmet needs has been formulated in the context of the gap between the healthcare services, in this case, the needs of older adults that are considered necessary and the services that they actually obtain [7]. This disparity is an indicator of care access, which is ethically problematic.

Unmet needs among older adults are influenced by various factors strongly associated with social determinants of health and inequalities, including education, gender, income, access to social and health services, adequate nutrition, quality housing, and favourable environmental conditions. However, there is limited knowledge about how these factors are addressed for older adults in sub-Saharan Africa [8]. Currently, structural changes—such as urbanisation, labour migration, and declining fertility—are weakening the family support systems, which are the primary care system for older individuals in the region [9,10]. There is an urgent need to synthesise existing evidence on effective strategies to meet the unmet care needs of older adults. In the last decade, the number of publications on ageing-related issues in SSA has increased and is gaining attention in scholarly literature [11]. However, there has been no systematic review focused on the unmet care needs of older people in SSA. The need to evaluate and respond to unmet health and social care needs for older adults in SSA is becoming a pressing matter, as many countries within the region were caught unprepared due to the rapid demographic shifts,

revealing a lack of sensitivity and policy foresight toward the needs of this growing age group [12].

At present, the prevalence of disability among adults aged 45 years and older in SSA is among the highest globally. For instance, women in SSA experience disability rates that are 54% higher than their counterparts in Europe and 21% higher than those in Asia. Among men, disability rates are 16% higher than those recorded in both Europe and Asia [13]. This raises critical concern that *"if the needs of older adults are already inadequately met, what will be the consequence when the ageing population more than triples?"* [11]. Estimates are already indicating that chronic noncommunicable diseases (NCDs), which accounted for only 27% of deaths in Africa in 2008, are projected to rise to 47% of all deaths by 2030 [14]. Given the demographic, social, and structural challenges confronting eldercare in SSA, there is a pressing need for a systematic review to synthesise evidence addressing the unmet needs of older adults. This review aims to fill the knowledge gap by gathering and synthesising all available evidence on the unmet care needs of older adults in SSA. It seeks to provide a comprehensive understanding of the range of unmet care needs within this population, assess the effectiveness of existing interventions addressing these needs, and suggest practical solutions to overcome the challenges identified in current programmes.

Theoretical Background

Unmet care needs are the manifestations of health inequities, which are avoidable and unfair systematic disparities in health conditions and access to health resources among different groups of people [12]. They are the result of *'social determinants of health'* or *'social and environmental factors'* where individuals live or find themselves in, either by birth, work or age. They are not accidental or arbitrary, but they are mostly beyond the control of individuals.
The theoretical framework summarised in Figure 2.1 illustrates how these social determinants lead to a set of socioeconomic positions. These positions shape specific health determinants, which reflect individuals' placement within social hierarchies and influence their exposure, experiences, and vulnerability to health-compromising conditions based on their social status.

Print ISSN: 2517-276X
Online ISSN: 2517-2778
https://bjmas.org/index.php/bjmas/index

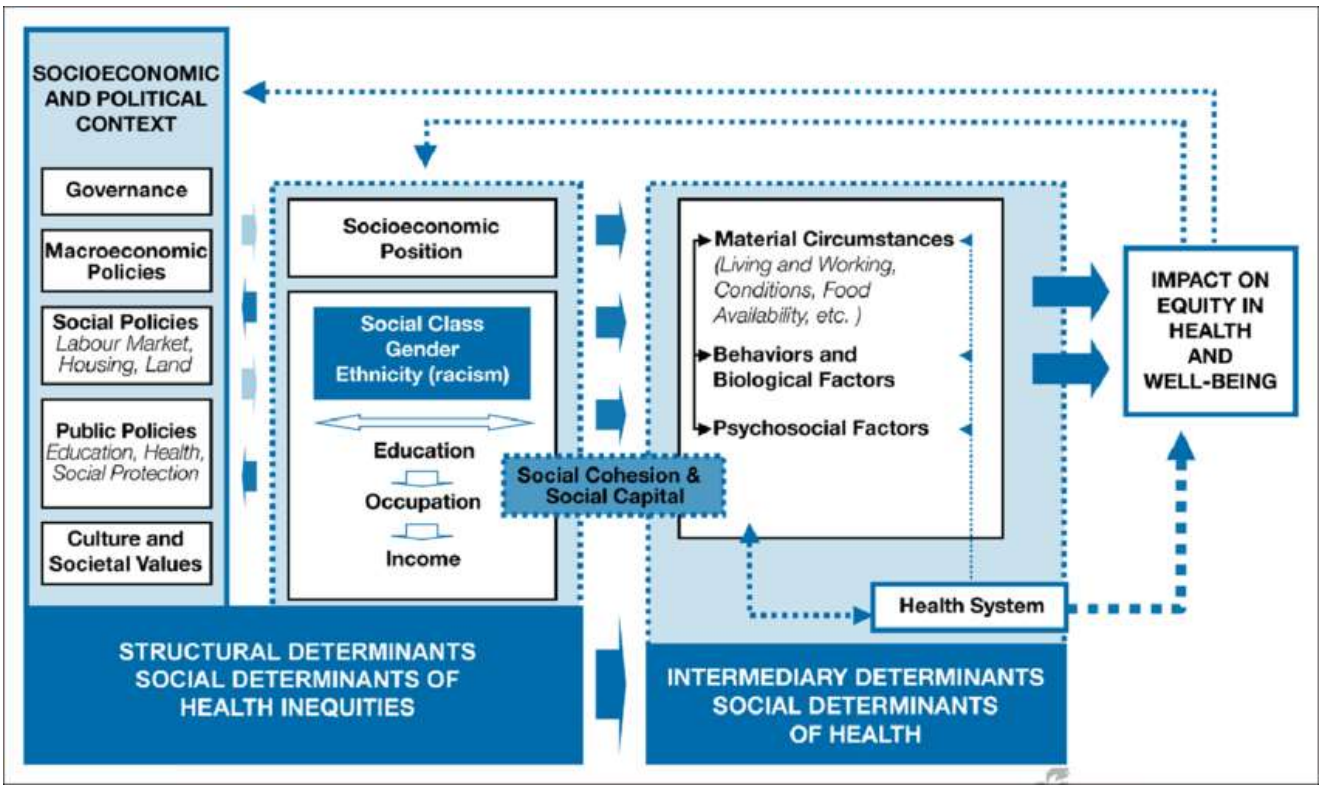

Figure 2. 1 World Health Organisation social determinants of health framework *[15]*

Structural determinants create social groups and class divisions, as well as those that determine people's socioeconomic standing in hierarchies of power, prestige, and access to resources. Figure 2.1 shows that the largest structural factors and proxy indicators are: Race/ethnicity, Income, Occupation, Education, Gender, and Social Class.

The framework also acknowledges intermediate determinants of health, or the immediate conditions that impact health outcomes. The primary types of intermediary determinants of health include: material circumstances including housing and neighbourhood quality, spending capacity (e.g., having the money to purchase nutritious foods, comfortable clothing, etc.), and the work environment; psychosocial circumstances including psychological stresses, stressful living conditions, relationships, support systems and coping mechanism; and behavioural and/or biological factors including dietary patterns/ nutritional intake, alcohol and tobacco consumption, physical inactivity, and genetic predispositions; and the health system itself including availability, affordability, accessibility, and acceptability of services [15].

The Unmet Care Needs of Older Persons

Older adults are generally defined as individuals aged 65 and above [16]. However, definitions may vary, and alternate terms such as aged, elders, seniors, or senior citizens are used

interchangeably. A scoping review found that most studies addressing unmet care needs classify them into three primary categories: physical, psychosocial, and spiritual needs [7]. Unmet physical care needs included physical conditions, safety and monitoring, and 'activities of daily living' (ADL). Physical conditions relate to NCDs; Safety and monitoring include needs concerning medication management and related oversight; and ADL covers basic self-care tasks such as feeding, mobility, continence management, toileting, bathing, and dressing [17–20]. Unmet psychosocial care needs consisted of emotional support, interpersonal relationships, access to social services, engagement in social activities, and information and communication provision. Some of these unmet needs at a systemic level stem from a lack of available community nursing, rehabilitative, or specialist services [17–19,21,22]. Finally, unmet spiritual needs are less frequently reported and mainly involve religious or spiritual support.
Among the three categories of care needs identified, most of the unmet care needs were physical care omissions. This implies that in diverse care settings, delivery of care is not always adequate to address the basic physical healthcare needs of the aged [7].

Social Determinants of Health and Inequalities

Research indicates higher unmet care needs in older women than men in Malawi, South Africa, and other developing nations [23]. Similarly, unmet care needs were associated with isolated housing, rural residence, and widowed or divorced marital status. Those living with others generally benefit from emotional and material support, consistent with social support theory.

Analysing this relationship, a study in Tanzania emphasised the necessity of diagnosing individuals properly, since this kind of population most frequently relies solely on family care and lacks sufficient income to meet the costs [24]. Many older adults have backgrounds in informal occupations such as farming, fishing, or petty trading—professions typically excluded from formal pension schemes [25]. Consequently, those aged 60 and above often face financial hardship unless they receive continuous income from work or family support.

Education/health literacy is a key factor influencing health behaviours and is essential for empowerment and quality of life [26]. Poor health literacy leads older adults to prefer spiritual healing over evidence-based care. According to a study in Ghanaian slums, many older adults trust traditional medicine more than formal healthcare services [28]. The beliefs of older people in South Africa about health include the perception that body and soul cannot be separated, and that spirituality and relationships are essential in sustaining health.[28]

Environments with Poor housing structures, poor ventilation, uneven walkways, absence of water supply and poor sanitation have been linked to the high prevalence of unmet needs of the older adults [29–32]. Community structures (private or public) to keep the quality of health and social care are nonexistent.

Print ISSN: 2517-276X
Online ISSN: 2517-2778
https://bjmas.org/index.php/bjmas/index

Health and Social Care in SSA

Since organised systems of care are typically absent in SSA regions, families take the largest share in care provision to older individuals [33,34]. Most of the family care is delivered by female family members, including children, middle-aged, and elderly [35–37] but some studies report a significant role of men in caregiving [38]. Nevertheless, it is also found that a significant number of elderly individuals do not get any family care at all [39]. There is also some additional evidence suggesting that unorganised and unregulated domestic workers have a role to play in the provision of long-term care [36]

There is considerable evidence indicating a shortage of qualified and specialised healthcare professionals, including doctors, nurses, therapists, and support staff, for older adults in SSA [40]. There are a few elderly care facilities, such as day centres, rehabilitation centres, and retirement homes, most of which have only basic services and primitive equipment. As a result, care is mainly provided at the residences of older adults or through family caregivers [39]. Notably, some countries, including Kenya, South Africa, Mauritius, Ghana, Seychelles, and Tanzania, have developed models of long-term elderly care. However, the costs of such care vary widely across these countries, ranging from free or subsidised services to very expensive options [41]

Besides material resource deficits, there are also major gaps in caregiving knowledge in SSA [39]. The majority of family caregivers provide care with little or no formal training, which makes them ill-equipped to handle complex care issues. For example, most caregivers do not know the nature of dementia, its behavioural impacts, and the right responses that would reduce caregiving burdens and enhance the lives of older adults. Such knowledge gaps may contribute to the risks of elder abuse, which may be caused by the stress of caregivers or deliberate exploitation to gain financial benefits [42]. Also, the cultural beliefs occasionally cause accusations of witchcraft against older people, usually older women who are mentally or physically deteriorated, which leads to ostracism, torture, or even murder [43].

METHODS

This study employed a secondary research design to synthesise evidence that fulfilled the pre-specified eligibility criteria of the study. The review was conducted based on the recommendations on how systematic reviews are to be carried out, as outlined in the ‘Cochrane Handbook’ [44]. The reporting was done in accordance with the ‘Preferred Reporting Items of Systematic reviews and Meta-analyses’ (PRISMA) statement [45]. Figure 3.1 shows the research design process.

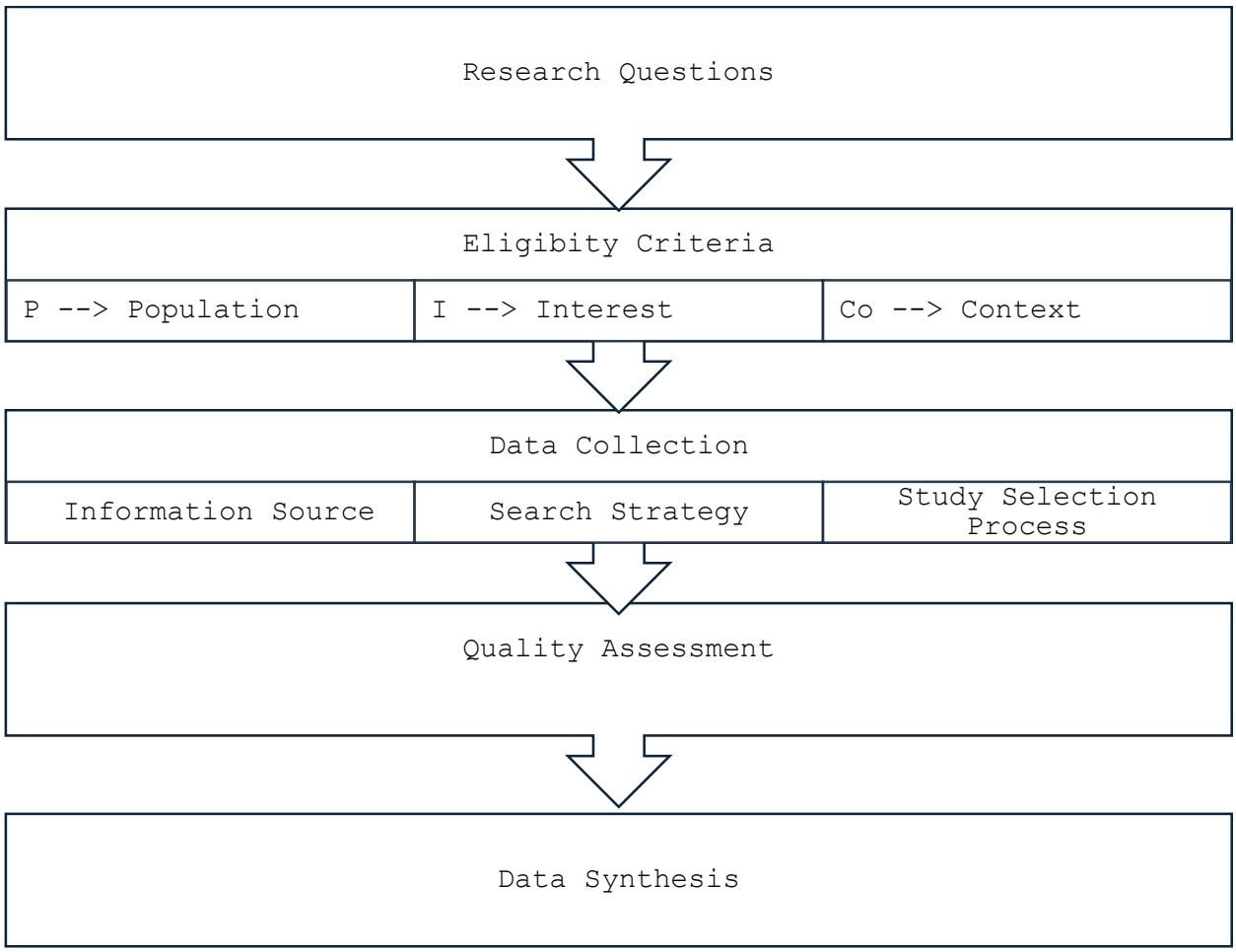

Figure 3. 1 Research Design Flowchart

Research Question

The start of any systematic review is the development of a priori, clear, and specific research questions [46]. Developing clear research questions is essential for selecting the right concepts, strategies, and outcome measures. Although the PICO framework – 'Population,' 'Intervention,' 'Comparison,' and 'Outcome' – is generally considered a standard method of developing research questions and search strategies, it does not apply to all evidence types, especially qualitative research. To address this shortcoming, researchers proposed alternative frameworks that are suited to various methodological paradigms [47].

In the case of narrative studies, the PICo framework – 'Population,' 'Phenomena of Interest,' and 'Context' is usually preferred. This model changes the focus to the interaction of the participants with an experience, service or event, thus allowing a more in-depth exploration of subjective views and lived experiences. PICo helps to improve the relevance and accuracy of

qualitative systematic reviews by making sure that the research question is consistent with the interpretive quality of the evidence under synthesis [47].

Table 3. 1 Research questions formulation

P	"What groups of participants are of interest?"	The heterogeneous older population in SSA
I	"Which experiences or events are primarily concerned?"	unmet care needs
Co	"What are the primary conditions and background circumstances?"	Social determinants of health and inequalities

Eligibility Criteria

All the inclusion and exclusion criteria essential for conducting the study were listed according to the PICo framework, along with other study aspects such as report status and research design. This information will allow for transparent justification of the inclusion and exclusion decisions made during the screening process [45]

Print ISSN: 2517-276X
Online ISSN: 2517-2778
https://bjmas.org/index.php/bjmas/index

Table 3. 2 Eligibility Criteria for included and excluded studies

Category	Inclusion criteria	Exclusion criteria
Population	Heterogeneous group aged 60 years and above.	Population group <60 years
Interest	- Studies that investigate the unmet care needs of the elderly.	- Studies that do not explicitly address unmet needs or focus solely on other health outcomes without linking to access or care gaps.
Context	Research conducted in SSA encompassing both rural and urban settings and includes community-based, institutional, and healthcare facility contexts.	Studies conducted outside the sub-Saharan African region or those that did not provide disaggregated data for this context. The six African countries not classified as part of SSA are Algeria, Tunisia, Libya, Morocco, Egypt, and Western Sahara [48].
Research Design	Primary data All study designs	Secondary data Reviews
Report status	Studies published in English Studies published from 2020 to 2025 Peer-reviewed journal articles	Non-English language studies Grey literatures

Data Collection

Information Sources

Fundamentally, the systematic review process for data collection relies on a thorough and careful search of various literature sources, such as bibliographic databases, grey literature, study registries, and others [49]. Nevertheless, the scope of this research was limited to studies published in reputable, peer-reviewed databases. Since no single database can offer a complete and precise list of all studies fitting the systematic review criteria, a well-considered data collection plan was implemented using multiple databases [50]. The choice of databases was also crucial because each contained different sets of peer-reviewed articles, often specialising in diverse fields. Therefore, to reduce the risk of missing key studies, subject-specific databases on health and social care were included, thereby improving the quality of the review process [51].

PubMed was chosen as one of the main databases because it is one of the most popular databases of literature on public health [52]. Springer Nature Link was added because of its large number of peer-reviewed journals in a wide area of knowledge, including public health and social sciences [53]

In addition to these international platforms, attention was also given to the issue of regional representation. Studies have shown that global databases often underrepresent research outputs from SSA [50]. To address this gap, African Journals Online (AJOL) was incorporated into the search strategy. AJOL, operational since 1998, is the largest and most widely used online collection of peer-reviewed, African-published scholarly journals. Its inclusion ensured broader coverage of regionally produced and contextually relevant literature that may not be indexed in mainstream international databases.

Search Strategy

Search strategy is a vital part of any systematic review, as it serves as the primary tool for gathering data that supports the findings [54]. To achieve balance, the search strategy was developed based on a combination of several related words for each key concept in the review topic. These words were then combined using Boolean operators OR, AND, and NOT in a way that makes the search results both sensitive and specific.

Table 3. 3 Search terms

"Unmet needs" **OR** "forgone health care"	**AND**	Old* **OR** Elderly **OR** Aged	**AND**	"Sub-Saharan Africa" **OR** developing countries OR "low and medium income countries"

The search syntax could not be uniformly applied since it yielded different search results across each database, owing to their unique interfaces. As a result, PubMed was initially searched on non-indexed references and adjusted on other databases where necessary (see Table S1 in the appendix).

Data Extraction and Selection Process

Following the systematic search of each database, search results were exported to an electronic spreadsheet (Microsoft Excel) to be screened. A systematic screening of all the retrieved records was done to determine their eligibility to be included in the review. As per the best practice guidelines in systematic reviews, the study selection was a two-stage screening process [55]
All articles retrieved in the initial stage were screened using the predefined inclusion and exclusion criteria based on their titles and abstracts. This is a pre-filtering step designed to eliminate clearly irrelevant studies. Articles proceeded to the next stage, involving full-text screening of potentially relevant publications, when the information in the title and abstract was insufficient to make a definitive decision.

The second stage involved full-text screening of the potentially relevant publications identified during the initial screening. Full articles were retrieved and examined in detail to determine whether they met all eligibility criteria for inclusion in the final synthesis. Overall, screening

should be conducted by a minimum of two reviewers to minimise the chances of selection bias and the likelihood of overlooking pertinent studies [50]. However, as this was a degree requirement, a high degree of autonomy was required. Therefore, the author performed the assessment independently, with the guidance of a supervisor [56].

Quality Assessment

Several tools and checklists can help assess the quality of included studies. However, when a systematic review involves several types of study design, the researcher should be consistent in the selection of tools applied to evaluate the quality and reliability of the studies included in the review [54]. Thus, it is better to apply various checklists from a single source than to select and choose among different sources.

Consequently, the quality and reliability of studies included in this review were evaluated with the help of the 'Critical Appraisal Skills Programme (CASP) tool,' a well-established and thoroughly designed tool that allows assessing the quality and reliability of research in any study design [57]. It has a set of customised checklists of particular methodologies, including cohort studies, qualitative research, and randomised controlled trials, which include a sequence of prompt questions that evaluate key elements of study quality (see Table S2 in the appendix).
To increase the accuracy of the quality assessment, Cochrane suggests two assessors [58]. Nevertheless, in this study, the whole screening procedure was carried out by one researcher because of practical limitations.

Data Synthesis

When findings include data from different study designs that are not suitable for combining in an analysis, a narrative synthesis is usually appropriate. Narrative synthesis, as defined by Popay et al., is a systematic method of synthesising multiple studies that primarily relies on textual and descriptive techniques to tell the story of the evidence [59].

Preliminary Synthesis of the Findings of Included Studies

The initial synthesis was carried out to systematically describe, compare and organise the findings of all the included studies. This step formed the basis of further analytical interpretation and served to form a clear and structured overview of the available evidence based on unmet health and social care needs among older adults in SSA. Each study was first reviewed and summarised using a standardised set of features to ensure consistency and comparability. These included: country of origin; study design; study setting, including whether the study was conducted in a community, health facility, residential institution, or other location; methodology and summary of findings.

Tabulation of this information facilitated visual comparison and enabled the identification of recurring issues and divergent findings across the evidence base. Following tabulation, thematic analysis techniques were employed to further synthesise the data.

Print ISSN: 2517-276X
Online ISSN: 2517-2778
https://bjmas.org/index.php/bjmas/index

Assessing the Robustness of the Synthesis

The quality of the methodology of each of the included studies was critically appraised, although it was not taken into account in the interpretation of results. Limitations in the evidence base were clearly recognised. Lastly, sensitivity analyses were performed to investigate the effect of the quality of studies on the general results. This included reconsidering the main narrative themes in terms of the quality of the methodology, thereby challenging the consistency and validity of the synthesis results

RESULT

Figure 4.1 presents the PRISMA flow chart that demonstrates the workflow of identification, screening, and selection of studies, the decisions made at each stage, and their justification, which allows the process to be repeated.

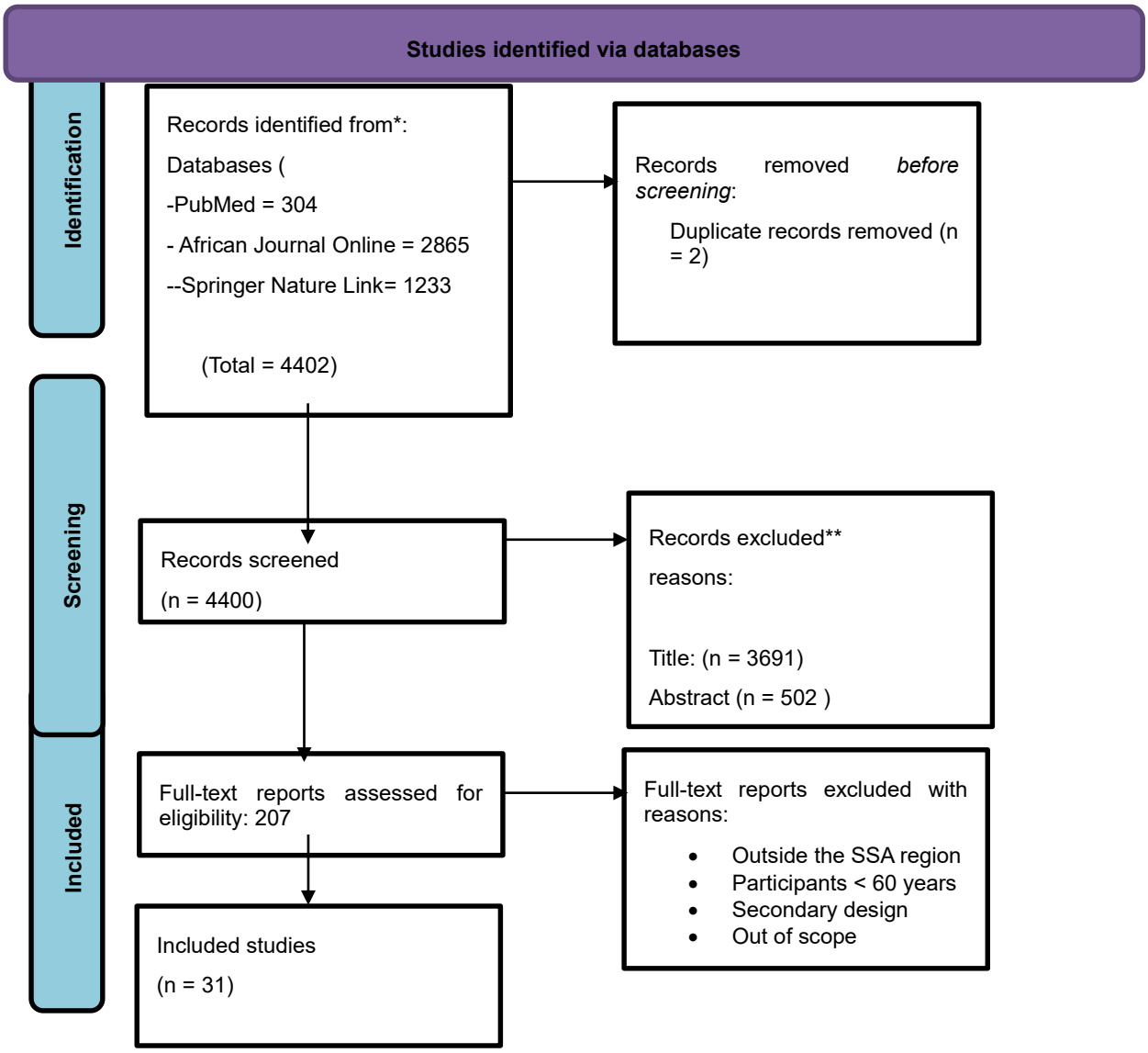

Figure 4. 1 Flowchart of the bibliographic database search.

Characteristics of Included Studies

The electronic database search initially identified 4,402 articles. After removing duplicates, 4,400 articles remained for title and abstract screening, from which 207 were selected for full-text review. After reviewing the full-text, 31 papers matched the inclusion criteria and were included in this systematic review (see Figure 4.1).

The geographical distribution of studies indicated Tanzania as the most frequent (n = 9), followed by Ghana (n = 6), Uganda (n = 3), Nigeria (n = 3), Cameroon (n = 2), Democratic

Republic of Congo (DRC) (n = 2), South Africa (n = 2), Malawi (n = 1), Zambia (n = 1), Ethiopia (n = 1), and Côte d'Ivoire (n = 1). Hospital settings were predominant (n = 11), with other studies conducted in community (n = 10), rural (n = 4), peri-urban (n = 2), and urban (n = 4) environments.

The methods most frequently utilised were interviews (n = 12), questionnaire surveys (n = 8), medical records and clinical assessments (n = 7), focus groups (n = 5), and standardised surveys adhering to the WHO framework (n = 2). Two studies that initially appeared relevant were excluded due to subjective decisions by the researchers (see Table S3, S4, and S5 in the Appendix for a detailed breakdown of study characteristics)

Types of Unmet Needs in SSA

Unmet Physical Needs

i. Physical Conditions

NCDs are the most prominent health challenges among older adults in SSA [60,61]. Multimorbidity, defined as the coexistence of two or more NCDs, is reported in over 70% of older adults [62,63]. The majority of women (90%) aged greater than 40 years of age were found to have at least one NCDs, with 75% experiencing multimorbidity, and 40% having discordant multimorbidity, defined as the co-occurrence of diseases requiring divergent care [64].

Hypertension is the most prevalent NCD in nearly all studies, often coexisting with diabetes, anaemia, and ischemic heart disease [61,63–67]. These conditions often go undiagnosed and undertreated, with a large proportion of elderly individuals unaware of their diagnosis or lacking access to ongoing treatment. For instance, in rural KwaZulu-Natal, over 90% of individuals who screened positive for diabetes had not received any formal care [62].

ii. Nutrition

Food insecurity and insufficient nutrition are pressing concerns for this population [68]. In Tanzania, Chamba et al identified high rates of anaemia among hospitalised elderly individuals, with many cases attributable to micronutrient deficiencies, particularly iron, vitamin B12, and folate [64]. This underscores the absence of consistent nutrition counselling and support in geriatric care. Similarly, Yakubu et al reported that many older adults lacked access to specialised nutritional services, leaving them vulnerable to diet-related illnesses and poor recovery from other conditions [65].

iii. Activities of Daily Living

Evidence consistently shows that older adults in SSA experience substantial limitations in Activities of Daily Living (ADLs) due to the high prevalence of frailty, which declines their physical and functional wellbeing [68,71–73]. These impairments are often unaddressed due to a lack of community-based services, caregiver support, and assistive devices for older adults. In

Nigeria, over 60% of older adults in urban areas and 46% in rural regions reported a lack support with ADLs, particularly bathing, taking medications, transportation, cooking, cleaning, fetching water, and shopping, especially women who are more likely to be confined to the household sphere [68,72]

Unmet Psychosocial Needs

About one-third of older adults battle with depressive symptoms, psychological distress, social isolation, and cognitive health deficits [64,74] Despite this burden, mental health remains marginalised in both public discourse and healthcare delivery, with primary care workers often untrained in assessing geriatric mental health [65]. There is limited evidence on psychological services or community support mechanisms addressing mental health challenges for depressive symptoms and emotional distress of older adults[60,64,75–77]

Older adults frequently face a decline in social connections and struggle with sleep, often preoccupied with concerns about meeting their daily needs while simultaneously contemplating the inevitability of death [61,74]. There is a significant need for opportunities to connect with peers and the community through social events and group activities to combat isolation [68].

Factors Influencing the Unmet Needs in SSA

Structural Determinants

i. **Income:**

Financial constraints were a major factor limiting access to basic necessities such as food, healthcare, and housing, which directly contribute to their unmet physical and psychosocial needs [62,65,74,75,78]. Findings indicate that older adults below the highest income quintile have higher odds of hypertension, elderly persons living with human immunodeficiency virus (EPLHIV), and frailty [60,67,68,73,79]

ii. **Education:**

Higher education was significantly associated with a higher likelihood of NCDs, indicating that more educated individuals in this population had an increased risk [66]. However, low levels of formal education among older people restrict their access to information and health literacy, limiting their ability to navigate health and social care systems effectively. This educational disadvantage also reduces their empowerment to advocate for better services and support[62,68,76,80].

iii. **Geographical Location:**

Older adults living in urban areas are more likely to be hypertensive than those in rural areas [66,67]. The urban environment in SSA is associated with increased psychological stress due to factors such as traffic, work deadlines, and general lifestyle demands, which contribute to higher hypertension risk[67].

The urban area had more unmet needs of assistance with ADL than the rural area [72]. This was attributed to the community lifestyle in the rural regions, where one can be called upon to help,

and this might not be the case in the urban regions, where people tend to live a cosmopolitan lifestyle.

iv. Gender:

Older women disproportionately bear the brunt of socioeconomic disadvantage, including lower financial resources, limited family support, heavier caregiving roles, greater longevity and poorer educational background than males in SSA[68,76,81]. This gender inequality translates into higher levels of unmet physical and psychosocial needs among older women, such as dementia, depression, hypertension, frailty, and activities of daily living.

Intermediary Determinants

i. Material Circumstances

Older adults in SSA frequently live under challenging material conditions that significantly impact their health and well-being. For example, Sichalwe et al. describe rural elderly subjects living far from healthcare facilities, complicating access [78]. Findings revealed that inadequate healthcare infrastructure and long travel distances were key barriers [65]. Mulinde emphasised the lack of access to affordable care facilities [82]. This material deprivation extends to food insecurity, as a large number of older adults struggle to access affordable, nutritious food, such as limited meal frequency and low dietary diversity, leading to undernutrition and weight loss, which directly contribute to frailty [68,73]. Inadequate access to water and sanitation services, as rural older women frequently hiked greater distances to gather water, while water access difficulties in urban areas had to do with intermittent availability and cost [61].

ii. Psychosocial Circumstances

The collapse of traditional intergenerational support owing to urban migration, economic strain, and shrinking family sizes has left many older adults without regular companionship or caregiving support [72,74,76,79]. Institutional capacity to support older adults is limited [74]. Without strong social networks and coping resources, older people are prone to mental health challenges such as dementia, depression and anxiety, which worsen physical health outcomes and diminish overall well-being[81]

Older persons with suspected dementia or depression often experience marginalisation and are less likely to be brought for medical assessment due to beliefs that such conditions are a normal part of ageing or linked to spiritual afflictions [81,83,84]. In HIV-positive elderly populations, fear of disclosure due to anticipated stigma leads to social isolation and delayed access to services, compounding both mental and physical health burdens [60].

Mistrust of biomedical care, rooted in colonial history and reinforced by perceptions of poor service quality, also leads many elders to prefer traditional medicine. In SSA, elders reported non-recourse to formal healthcare due to past medical abuses and a belief in traditional or spiritual causation of illness [65,79]. This cultural inclination, while sometimes adaptive, may delay diagnosis of treatable conditions like cataracts, hypertension, or dementia.

iii. Behavioural and Biological Factors.

Lifestyle patterns were shown to play a significant role in influencing physical and psychosocial health outcomes. For example, Dai et al. showed that lifestyles such as physical inactivity, overweight, and obesity influenced the risk of hypertension more than medical history [67]. Although fruit and vegetable intake was shown not to be significantly related to hypertension, however, some studies reported on multimorbidity and visual impairment, conditions often influenced by nutrition and lifestyle factors such as physical inactivity and poor diet arising from socioeconomic deprivation [62,82].

older adults in SSA often continue physically demanding work beyond their comfortable capacity due to economic necessity, which accelerates their frailty development [73]. Findings also indicate a relationship between alcohol consumption and psychosocial distress and cognitive decline[75]. Depressive symptoms and impaired executive functioning are positively associated with higher levels of alcohol consumption.

iv. Health System Factors

There is significant underutilisation of outpatient healthcare by older adults across SSA [78]. For many, hospital visits are considered a last resort [71], with greater reliance placed on traditional medical practitioners and self-medication [61]. A further challenge lies in the limited geriatric training among healthcare workers and the shortage of age-friendly services [60,65,68,73,83]. Older persons are frequently managed by clinicians, physicians, and nurses who may lack the expertise to address multi-morbidity and polypharmacy in later life. In many cases, lower-level healthcare providers are not equipped to respond to these unmet needs, which can result in the manifestation of ageist attitudes in the delivery of care [65]

Most public health facilities are understaffed, old, overcrowded, lacking in clean amenities and tools to detect and manage age-related conditions [60,73,85,86]. The limited availability of diagnostic services adversely affected physical health service delivery [73,85,86]. Many hospitals do not have access to basic imaging (MRI, ECG, TTE) or laboratory testing needed to manage chronic or cognitive conditions [63,87]

Medication availability is inconsistent, and referral systems are fragmented [65]. Even where health insurance schemes such as the ‘Community Health Fund’ (CHF) or ‘National Health Insurance Scheme’ (NHIS) exist, coverage is incomplete, bureaucratic procedures are burdensome, and service quality remains low [68,85,86]. Insured elderly expressed frustration and distrust due to administrative delays and limited perceived benefits, which affected their psychological well-being and engagement with the health system[85,86].

For elderly individuals living with multiple chronic and infectious diseases, the lack of coordinated care results in repeated clinic visits, long waiting times, and treatment gaps [62,65,77] Ageist attitudes among some healthcare workers further discourage elderly patients, who report being treated dismissively or as a burden [68,85,86].

Additionally, transportation barriers and physical access to healthcare facilities are consistently cited. Many elderly people reside in rural areas where health facilities are sparse and located far from their homes [65,68,83]. In studies from Uganda and Tanzania, only one in five injured elderly patients arrived at a hospital via ambulance, with most relying on taxis or relatives, leading to treatment delays and adverse outcomes [70].

Addressing the unmet health and social care needs among older adults in SSA

Unorganised Care/Support

i. Family Care

Older adults primarily rely on informal care provided by family members [73]. Children are the primary carers; however, they are frequently far away and unable to provide the necessary help. Spouses also play a significant role as primary caregivers. This form of support is limited to older adults who are married or have living partners [65,88]. For widowed, single, divorced, or separated individuals, the absence of spousal care often exacerbates their vulnerability and unmet needs. During hospitalisation, families play a crucial role in providing personal care and assistance with feeding, which helps alleviate the burden on healthcare providers in settings where hospital staff and resources are limited [73]. Family support may be constrained or, in some cases, absent due to factors such as financial incapacity and health impairment among potential family caregivers [65,88]

ii. Non-family Care

Beyond the support provided by immediate family, older adults also draw on assistance from a wider network that includes siblings, in-laws, friends, neighbours, religious groups, and traditional healers [61,88]. Access to such non-family support depends not only on the benefactor's proximity, but also on the strength and frequency of contact, the perceived value of the relationship, and the benefactor's capacity to shoulder the responsibility of providing help. For example, neighbours are often well-placed to offer immediate assistance in emergencies due to their closeness, while friends and religious groups may provide emotional support in times of depression, loneliness, or anxiety through companionship and faith-based encouragement.

Findings revealed that older adults experience a sense of joy when family, friends, or neighbours extend support during times of need[76]. The presence of someone willing to assist has a profound positive impact on the psychosocial well-being of older people.

Organised care/support

i. Informational Support

Most older adults who had access to digital information and communication technologies (ICT), such as television and radio, reported that these tools made it easier to communicate with their social workers [76]. Access to such information can enhance social interaction, encourage

community engagement, and support meaningful face-to-face contact, particularly in the context of giving and receiving advice. Furthermore, participation in elders' group forums, community meetings, and digital platforms aimed at reducing isolation has been shown to improve the emotional well-being of older people.

ii. Health Insurance Scheme

In general, health insurance was considered as a useful tool to help access healthcare. The findings of various studies point to its possible role in offering financial risk insurance, reducing the weight of healthcare expenses among the poorer communities, and a major avenue towards the realisation of universal health coverage [68,85,86].Nevertheless, research also points to disparities in access depending on the type of insurance scheme [85,86]. Moreover, growing patient dissatisfaction has been reported, with insured individuals often describing healthcare staff as discourteous, impolite, and unhelpful. Findings further indicate systemic shortcomings—particularly within health insurance schemes—in supporting older adults' active involvement in decisions concerning their own healthcare.

iii. Counselling and home visits

Frequent communication and interactions between counsellors and patients were linked to reduced depression severity [89]. Older adults who had more consistent counselling and home visits experienced lower rates of depressive symptoms. Counselling helped patients manage stigma, stress, and hopelessness related to living with HIV/AIDS, improving their self-esteem and emotional well-being. Home visits remove obstacles, including mobility limitations, accessibility issues, and stigma, enabling targeted psychological support and family participation, which are crucial in low-resource contexts (Ibid).

iv. Adult Daycare Centres (ADCs)

ADCs provide a vital space for social interaction, emotional support, and skill development, which together help older persons move from feelings of isolation and marginalisation towards inclusion and empowerment [77].

DISCUSSION

This study examined the unmet care needs of older adults in SSA, the factors that affect such needs and how they are being addressed. The results classified the unmet care needs into two general categories: unmet physical health needs and unmet psychosocial needs. Physical needs are mostly associated with the presence of disease conditions like diabetes, hypertension, and vision or hearing impairments, as well as nutritional deficiencies and the lack of proper support with ADL. Psychosocial needs, in their turn, were primarily associated with the absence of emotional support, depressive symptoms, dwindling social networks, social isolation, psychological distress, sleep disorders, and cognitive impairment.

The research also identified several factors affecting the unmet care needs of older adults, which were categorised into structural and intermediary determinants. The structural determinants involved financial constraints, which restrict the capacity to afford basic needs like food, clean water, healthcare and proper housing. The elderly living in urban centres were identified to be more susceptible to physical and psychological unmet needs. Moreover, low educational levels were associated with low health literacy, which further increased the unmet needs. There were also gender inequalities where older women were more disadvantaged than men in accessing their health and social care needs. The Intermediate determinants included poor living conditions, unhealthy lifestyle behaviours, marginalisation and stigma, and cultural beliefs that tend to favour traditional medicine over Western medicine. There was also a perceived feeling of neglect by family members. The health system had issues such as long distances to health facilities, poor behaviour of certain health professionals, long waiting times in large health centres, and poor performance of health insurance.

Overall, the findings indicate that unmet health needs may outweigh unmet social needs among older adults in SSA, a trend consistent with the previous observations [7]. This imbalance may reflect the fact that many of the most effective interventions in SSA target psychosocial rather than physical needs. For instance, studies report that older adults view the presence of family and friends who can assist during times of need as having a substantial positive effect on their social well-being [61,76]. This is consistent with earlier studies in which participants defined social care in terms of receiving support from family and friends, help with self-care, and monetary assistance [90–92]. In addition, most effective organised support systems examined in this study primarily sought to enhance social interaction, provide emotional support, and assist with the management of stigma, stress, and depression.

Implication for Practice

This study highlights the urgent need to improve healthcare services for older adults in SSA. It identified the need for rapid sensitisation and awareness initiatives targeting older persons, communities, and social protection schemes to diminish the stigma and marginalisation of ageing, distrust of Western medicine and low literacy levels, which were major factors contributing to underutilisation of medical facilities.

Promoting good impressions of healthcare services may play a vital role in promoting increased utilisation of existing healthcare resources, as suggested by Wairiuko et al., who found a strong association between individuals holding predominantly favourable views of healthcare services and a higher likelihood of service utilisation [93].

More deliberate policy action is required to improve healthcare access for older individuals. This involves developing and improving healthcare infrastructure, hiring more healthcare personnel, assuring regular supply of medications and diagnostic facilities, and minimising time-consuming administrative procedures. While the promotion of health insurance schemes

represents a promising pathway for improving access to care among the elderly, significant government effort is required to make this a practical reality. Health insurance policies should be revised in order to improve implementation and extend service coverage.

In addition, a structured and continuous training programme for healthcare professionals is essential. Training should cover geriatric care, effective patient communication, and awareness of care rights, to improve caregiving competencies, minimise the risk of abuse, and provide stronger support for families.

Implication for Research

This study identified gaps in current health and social care services across SSA. Older persons living in SSA often face multimorbidity rather than a single health, mental or social condition. Future studies should focus on the implications of a coordinated care system for adult care in SSA. In addition, ICT proves effective in addressing social needs among older adults. Further studies can be done on the use of digital technologies to facilitate better healthcare services in meeting the needs of older persons in SSA.

Strengths and Limitations

This review adhered to established guidelines for conducting systematic reviews, thereby enhancing its transparency, methodological rigour, and overall reliability. A major strength of the review lies in the use of a comprehensive search strategy that drew on three databases. These databases were carefully selected to capture both subject-specific literature (health and social care) and regionally relevant evidence from SSA, thereby ensuring that the review was responsive to the contextual complexity of the research question. The review included inclusion of high-quality studies, as assessed through the CASP checklists. This ensured that the synthesis was based on research with strong methodological foundations, enhancing the validity and credibility of the findings.

However, restricting the review to studies published in English may have omitted potentially important information published in French, Portuguese, or local African languages, which are widely used across SSA. The decision to also limit the review to studies published within the last five years, although useful for capturing recent developments, may have overlooked important earlier research that remains relevant. While the review covered a range of countries, the included studies were still concentrated in a handful of nations, which may limit the generalisability of findings to other underrepresented countries in the region. Finally, the heterogeneity of the included studies made it difficult to perform direct comparisons, and the reliance on narrative synthesis may have introduced interpretive bias.

CONCLUSION

The review identified significant unmet physical and psychosocial needs among older adults in SSA, including chronic diseases, nutritional deficiencies, lack of assistance with daily activities, depression, social isolation, and cognitive decline. Health inequalities such as poverty, low education, gender, geographical location, lifestyle as well as weak health systems contribute to these unmet needs.

Informal care from family and community members is the primary source of support, but is increasingly strained by changing social structures. Formal interventions like health insurance schemes, counselling services, and adult daycare centres show promise but face implementation challenges. There is an urgent need to improve access to and quality of health and social care services for older adults in SSA through policy changes, health system strengthening, workforce training in geriatric care, and addressing societal attitudes.

REFERENCES

[1] World bank. Sub-Saharan Africa | Data 2025. https://data.worldbank.org/region/sub-saharan-africa (accessed June 24, 2025).
[2] World Health Organisation. Evidence gaps on unmet health and social care needs in the WHO African Region 2025.
[3] World Health Organisation. Multi-country cross-sectional and longitudinal studies to quantify unmet needs for health and social care among older people 2025. https://wkc.who.int/resources/projects/item/multi-country-cross-sectional-and-longitudinal-studies-to-quantify-unmet-needs-for-health-and-social-care-among-older-people (accessed August 7, 2025).
[4] Agyemang-Duah W, Peprah C, Peprah P. Barriers to formal healthcare utilisation among poor older people under the livelihood empowerment against poverty programme in the Atwima Nwabiagya District of Ghana. BMC Public Health 2019;19. https://doi.org/10.1186/S12889-019-7437-2,.
[5] Attafuah PYA, Everink IHJ, Lohrmann C, Abuosi AA, Schols JMGA. Improving health and social care services for slum-dwelling older adults: Perspectives of health professionals. Front Public Health 2022;10:988076. https://doi.org/10.3389/FPUBH.2022.988076/PDF.
[6] Sandman L, Hofmann B. Why We Don't Need "Unmet Needs"! On the Concepts of Unmet Need and Severity in Health-Care Priority Setting. Health Care Analysis 2019;27:26–44. https://doi.org/10.1007/S10728-018-0361-2,.
[7] Kalánková D, Stolt M, Scott PA, Papastavrou E, Suhonen R. Unmet care needs of older people: A scoping review. Nurs Ethics 2021;28:149–78. https://doi.org/10.1177/0969733020948112/ASSET/FEE346E3-F42C-4732-BDA8-82D7317848D2/ASSETS/IMAGES/LARGE/10.1177_0969733020948112-FIG1.JPG.
[8] Amberbir A, Cyuzuzo C, Boah M, Uwinkindi F, Kalinda C, Yohannes T, et al. Understanding needs and solutions to promote healthy ageing and reduce multimorbidity

in Rwanda: a protocol paper for a mixed methods, stepwise research study. BMJ Open 2025;15:89344. https://doi.org/10.1136/bmjopen-2024-089344.

[9] Mobolaji JW. Unmet Needs for Support in Activities of Daily Living among Older Persons: The Effects of Family and Household Structures in a Low- and Middle-Income Context. Geriatrics 2024;9:5. https://doi.org/10.3390/GERIATRICS9010005.

[10] Adamek ME, Chane S, Kotecho MG. Family and kin care of elders in sub-Saharan Africa. Health and Care in Old Age in Africa 2020:61–77. https://doi.org/10.4324/9780429020759-4.

[11] Adamek ME, Gebremariam Kotecho M, Chane S, Gebeyaw G. Challenges and Assets of Older Adults in Sub-Saharan Africa: Perspectives of Gerontology Scholars. J Aging Soc Policy 2022;34:108–26. https://doi.org/10.1080/08959420.2021.1927614.

[12] World Health Organisation. To meet the unmet : preparing for health equity challenges in WHO South-East Asia Region. World Health Organization. Regional Office for South-East Asia; 2023.

[13] Payne CF, Mkandawire J, Kohler HP. Disability Transitions and Health Expectancies among Adults 45 Years and Older in Malawi: A Cohort-Based Model. PLoS Med 2013;10:e1001435. https://doi.org/10.1371/JOURNAL.PMED.1001435.

[14] World Health Organisation. Noncommunicable disease (NCD) deaths, number 2025. https://www.who.int/data/gho/data/indicators/indicator-details/GHO/gho-ghe-ncd-deaths-in-thousands (accessed August 26, 2025).

[15] Solar O, Irwin A. A conceptual framework for action on the social determinants of health. Social Determinants of Health Discussion Paper 2. Geneva: 2010.

[16] National Institutes of Health. Age 2025. https://www.nih.gov/nih-style-guide/age (accessed August 24, 2025).

[17] Wieczorowska-Tobis K, Talarska D, Kropińska S, Jaracz K, Tobis S, Suwalska A, et al. The Camberwell Assessment of Need for the Elderly questionnaire as a tool for the assessment of needs in elderly individuals living in long-term care institutions. Arch Gerontol Geriatr 2016;62:163–8. https://doi.org/10.1016/J.ARCHGER.2015.10.005.

[18] Ferreira AR, Dias CC, Fernandes L. Needs in nursing homes and their relation with cognitive and functional decline, behavioral and psychological symptoms. Front Aging Neurosci 2016;8:156317. https://doi.org/10.3389/FNAGI.2016.00072/BIBTEX.

[19] Blackman I, Henderson J, Weger K, Willis E. Causal links associated with missed residential aged care. J Nurs Manag 2020;28:1909–17. https://doi.org/10.1111/JONM.12889,.

[20] Holup AA, Hyer K, Meng H, Volicer L. Profile of Nursing Home Residents Admitted Directly From Home. J Am Med Dir Assoc 2017;18:131–7. https://doi.org/10.1016/J.JAMDA.2016.08.017.

[21] Makaroun LK, Teno JM, Freedman VA, Kasper JD, Gozalo P, Mor V. Late Transitions and Bereaved Family Member Perceptions of Quality of End-of-Life Care. J Am Geriatr Soc 2018;66:1730–6. https://doi.org/10.1111/JGS.15455.

[22] Marrero J, Fortinsky RH, Kuchel GA, Robison J. Risk Factors for Falls Among Older Adults Following Transition From Nursing Home to the Community. Medical Care Research and Review 2019;76:73–88. https://doi.org/10.1177/1077558717697012.
[23] Wandera SO, Ntozi J, Kwagala B. Prevalence and correlates of disability among older Ugandans: evidence from the Uganda National Household Survey. Glob Health Action 2014;7. https://doi.org/10.3402/GHA.V7.25686.
[24] Kisoli A, Gray WK, Dotchin CL, Orega G, Dewhurst F, Paddick SM, et al. Levels of functional disability in elderly people in Tanzania with dementia, stroke and Parkinson's disease. Acta Neuropsychiatr 2015;27:206–12. https://doi.org/10.1017/NEU.2015.9.
[25] Kpessa-Whyte M. Aging and Demographic Transition in Ghana: State of the Elderly and Emerging Issues. Gerontologist 2018;58:403–8. https://doi.org/10.1093/GERONT/GNX205.
[26] Nkrumah Agyabeng A, Ahwireng PO, Bawole JN, Mickson MK, Ahenkan A. Understanding electricity nightmare and health implications among slum dwellers in Ghana. Health Educ 2022;122:493–505. https://doi.org/10.1108/HE-06-2021-0089.
[27] Attafuah PYA, Everink IHJ, Lohrmann C, Abuosi AA, Schols JMGA. Improving health and social care services for slum-dwelling older adults: Perspectives of health professionals. Front Public Health 2022;10:988076. https://doi.org/10.3389/FPUBH.2022.988076/PDF.
[28] Bohman DM, Van Wyk NC, Ekman S. Existing and evolving in two minds: Beliefs in relation to health and illness expressed by older South Africans. Afr J Nurs Midwifery 2014;16:139–52. https://doi.org/10.25159/2520-5293/37.
[29] Joshi MR, Chalise HN. Elderly Abuse and Quality of Life. Journal of Medical Evidence 2021;2:113–9. https://doi.org/10.4103/JME.JME_140_20.
[30] Choi E, Bhandari TR, Shrestha N. Social inequality, noise pollution, and quality of life of slum dwellers in Pokhara, Nepal. Arch Environ Occup Health 2022;77:149–60. https://doi.org/10.1080/19338244.2020.1860880,.
[31] Attafuah PYA, Everink I, Abuosi AA, Lohrmann C, Schols JMGA. Quality of life of older adults and associated factors in Ghanaian urban slums: a cross-sectional study. BMJ Open 2022;12:e057264. https://doi.org/10.1136/BMJOPEN-2021-057264.
[32] Alaazi DA, Stafinski T, Evans J, Hodgins S, Oteng-Ababio M, Menon D. "Our Home Is a Muddy Structure": Perceptions of Housing and Health Risks Among Older Adults in Contrasting Neighborhoods in Ghana. Front Public Health 2021;9:650861. https://doi.org/10.3389/FPUBH.2021.650861.
[33] Scheil-Adlung X. Long-term care protection for older persons: A review of coverage deficits in 46 countries. International La 2015:115.
[34] World Health Organisation. World report on Ageing And Health. Geneva: 2015.
[35] van Eeuwijk P. The elderly providing care for the elderly in tanzania and indonesia: Making 'Elder to Elder' Care Visible. Sociologus 2014;64:29–52. https://doi.org/10.3790/SOC.64.1.29.

[36] Aboagye E, Agyemang OS, Tjerbo T. Elderly demand for family-based care and support: evidence from a social intervention strategy. Glob J Health Sci 2014;6:94–104. https://doi.org/10.5539/GJHS.V6N2P94,.
[37] Nortey ST, Aryeetey GC, Aikins M, Amendah D, Nonvignon J. Economic burden of family caregiving for elderly population in southern Ghana: The case of a peri-urban district. Int J Equity Health 2017;16. https://doi.org/10.1186/S12939-016-0511-9,.
[38] Nortey ST, Aryeetey GC, Aikins M, Amendah D, Nonvignon J. Economic burden of family caregiving for elderly population in southern Ghana: the case of a peri-urban district. International Journal for Equity in Health 2017 16:1 2017;16:1–9. https://doi.org/10.1186/S12939-016-0511-9.
[39] World Health Organisation. Towards long-term care systems in sub-Saharan Africa: WHO series on long-term care. . World Health Organisation 2017. https://iris.who.int/bitstream/handle/10665/340535/9789241513388-eng.pdf (accessed July 5, 2025).
[40] Assunção M, Pinto S, Jose H. Public and health policy for the aged in Africa to the South of Saara. Rev Bras Enferm 2020:e20190313.
[41] Essuman A, Agyemang FA, Mate-Kole CC. Long-term Care for Older Adults in Africa: Whither Now? J Am Med Dir Assoc 2018;19:728–30. https://doi.org/10.1016/j.jamda.2018.07.012.
[42] Pillemer K, Burnes D, Riffin C, Lachs MS. Elder Abuse: Global Situation, Risk Factors, and Prevention Strategies. Gerontologist 2016;56:S194–205. https://doi.org/10.1093/GERONT/GNW004,.
[43] Gedfew M, Getie A, Akalu TY, Ayenew T. Prevalence and types of elder abuse in Sub Saharan Africa, systematic review and meta-analysis, 2023. J Natl Med Assoc 2024;116:292–301. https://doi.org/10.1016/J.JNMA.2024.05.002.
[44] Higgins J, Thomas J, Chandler J, Cumpston M, Li T, Page M, et al. Cochrane Handbook for Systematic Reviews of Interventions | Cochrane. 2024.
[45] Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. The BMJ 2021;372. https://doi.org/10.1136/BMJ.N71,.
[46] LEAD. CONDUCTING A SYSTEMATIC REVIEW: METHODOLOGY AND STEPS. Krea University: CGIAR GENDER Platform; n.d. https://doi.org/10.1007/978-3.
[47] Hosseini M-S, Jahanshahlou F, Akbarzadeh MA, Zarei M, Vaez-Gharamaleki Y. Formulating research questions for evidence-based studies. Journal of Medicine, Surgery, and Public Health 2024;2:100046. https://doi.org/10.1016/J.GLMEDI.2023.100046.
[48] World Bank. Africa Overview: Development news, research, data | World Bank 2025. https://www.worldbank.org/en/region/afr/overview (accessed August 24, 2025).
[49] MacFarlane A, Russell-Rose T. Search Strategy Formulation: A Framework For Learning. ACM International Conference Proceeding Series 2016;14-16-June-2016. https://doi.org/10.1145/2934732.2934752.
[50] Lefebvre C, Glanville J, Marshall C, Thomas M-IM, Wieland LS. Technical Supplement to Chapter 4: Searching for and selecting studies . Cochrane Handbook for Systematic

Reviews of Interventions Version 63 2022. https://training.cochrane.org/handbook/current/technical-supplement-chapter-4-searching-and-selecting-studies-v63 (accessed July 6, 2025).

[51] Gusenbauer M. Search where you will find most: Comparing the disciplinary coverage of 56 bibliographic databases. Scientometrics 2022;127:2683–745. https://doi.org/10.1007/S11192-022-04289-7.

[52] National Institute of Health. About - PubMed 2025. https://pubmed.ncbi.nlm.nih.gov/about/ (accessed September 7, 2025).

[53] Springer. About Springer Nature Link 2023. https://www.springer.com/gp/help/about-springerlink/18548 (accessed September 7, 2025).

[54] Phillips V, Barker E. Systematic reviews: Structure, form and content. J Perioper Pract 2021;31:349–53. https://doi.org/10.1177/1750458921994693.

[55] Centre For Reviews and Dissemination. Systematic reviews: CRD's guidance for undertaking reviews in health care - Centre For Reviews And Dissemination. University of York, 2009. https://books.google.com.ng/books/about/Systematic_Reviews.html?id=MgCYtAEACAAJ&redir_esc=y (accessed November 9, 2025).

[56] Flemming K, Booth A, Garside R, Tunçalp Ö, Noyes J. Qualitative evidence synthesis for complex interventions and guideline development: clarification of the purpose, designs and relevant methods Handling editor Soumyadeep Bhaumik. BMJ Glob Health 2019;4:882. https://doi.org/10.1136/bmjgh-2018-000882.

[57] Long HA, French DP, Brooks JM. Optimising the value of the critical appraisal skills programme (CASP) tool for quality appraisal in qualitative evidence synthesis. Research Methods in Medicine & Health Sciences 2020;1:31–42. https://doi.org/10.1177/2632084320947559.

[58] Noyes J, Booth A, Moore G, Flemming K, Tunçalp Ö, Shakibazadeh E. Synthesising quantitative and qualitative evidence to inform guidelines on complex interventions: clarifying the purposes, designs and outlining some methods. BMJ Glob Health 2019;4. https://doi.org/10.1136/BMJGH-2018-000893.

[59] Popay J, Roberts H, Sowden A, Petticrew M, Arai L, Rodgers M, et al. Guidance on the conduct of narrative synthesis in systematic reviews: A product from the ESRC Methods Programme. 2006.

[60] Abdulai M, Tabong PTN, Bonful HA, Addo-Lartey A, Sarfo B. Exploring quality of life among elderly persons living with HIV in Accra, Ghana. PLoS One 2025;20. https://doi.org/10.1371/JOURNAL.PONE.0324824,.

[61] Attafuah PYA, Everink IH, Lohrmann C, Abuosi A, Schols JM. Health and social needs of older adults in slum communities in Ghana: a phenomenological approach used in 2021. Archives of Public Health 2023;81:1–15. https://doi.org/10.1186/S13690-023-01056-9/TABLES/2.

[62] Kohler S, Bärnighausen T, Kazonda P, Leyna GH, Lohmann J, Killewo J, et al. Chronic Conditions and Multimorbidity Among Middle-Aged and Elderly Peri-Urban Dwellers

in Dar es Salaam, Tanzania. Int J Public Health 2024;69:1606387. https://doi.org/10.3389/IJPH.2024.1606387/FULL.

[63] Ferro EG, Abrahams-Gessel S, Jardim TV, Wagner R, Gomez-Olive FX, Wade AN, et al. Echocardiographic and Electrocardiographic Abnormalities Among Elderly Adults With Cardiovascular Disease in Rural South Africa. Circ Cardiovasc Qual Outcomes 2021;14:E007847. https://doi.org/10.1161/CIRCOUTCOMES.121.007847/SUPPL_FILE/CIRCCVQO_CIRCCQO-2021-007847_SUPP2.PDF.

[64] Stieglitz LM, Adams LB, Bärnighausen T, Berghöfer A, Kazonda P, Killewo J, et al. Depressive symptoms and their association with age, chronic conditions and health status among middle-aged and elderly people in peri-urban Tanzania. Cambridge Prisms: Global Mental Health 2023;10:e27. https://doi.org/10.1017/GMH.2023.17.

[65] Wandera SO, Golaz V, Kwagala B, Ntozi JPM, Ayuku DO. "These are just finishing our medicines": older persons' perceptions and experiences of access to healthcare in public and private health facilities in Uganda. BMC Health Serv Res 2024;24:1–13. https://doi.org/10.1186/S12913-024-10741-6/PEER-REVIEW.

[66] Ayisi-Boateng NK, Mohammed A, Opoku DA, Sarfo FS. Frequency & factors associated with apparent resistant hypertension among Ghanaians in a multicenter study. J Clin Hypertens 2020;22:1594–602. https://doi.org/10.1111/JCH.13974,.

[67] Dai B, Addai-Dansoh S, Nutakor JA, Osei-Kwakye J, Larnyo E, Oppong S, et al. The prevalence of hypertension and its associated risk factors among older adults in Ghana. Front Cardiovasc Med 2022;9. https://doi.org/10.3389/fcvm.2022.990616.

[68] Braimah JA, Rosenberg MW. "They Do Not Care about Us Anymore": Understanding the Situation of Older People in Ghana. Int J Environ Res Public Health 2021;18:2337. https://doi.org/10.3390/IJERPH18052337.

[69] Chamba C, Nasser A, Mawalla WF, Masamu U, Budodi Lubuva N, Tebuka E, et al. Anaemia in the Hospitalized Elderly in Tanzania: Prevalence, Severity, and Micronutrient Deficiency Status. Anemia 2021;2021:9523836. https://doi.org/10.1155/2021/9523836.

[70] Yakubu HA, Boakye-Yiadom J, Marfo RO, Oteng R, Oduro G. Characteristics and outcomes of geriatric injuries presenting to an urban emergency department in Ghana. African Journal of Emergency Medicine 2025;15. https://doi.org/10.1016/j.afjem.2025.05.007.

[71] Ambagtsheer RC, Moussa RK. Association of frailty with health service utilisation and health care expenditure in sub-Saharan Africa: evidence from Côte d'Ivoire. BMC Geriatr 2021;21:1–12. https://doi.org/10.1186/S12877-021-02377-6/TABLES/7.

[72] Fasiku MM, Durowade KA, Bojuwoye MO, Ahmed A, Osinubi MO, Musa OI, et al. Unmet needs for assistance with activities of daily living among elderly in rural and urban areas in Kwara State Central Senatorial District, Nigeria. Babcock University Medical Journal 2021;4:78–85. https://doi.org/10.38029/bumj.v4i2.84.

[73] Davidson SL, Emmence L, Motraghi-Nobes SM, Bickerstaff E, Rayers G, Lyimo G, et al. Assessing frailty amongst older people admitted to hospital in a low-income setting: a

multicentre study in northern Tanzania. BMC Geriatr 2024;24. https://doi.org/10.1186/S12877-024-04789-6,.

[74] Alebel AS, Bihonegn AA, Adamek ME. "It's a Period of Constant Loss": Perspectives of Aging Among Older Adults in Gondar City, Ethiopia. J Hum Rights Soc Work 2024;9:576–85. https://doi.org/10.1007/S41134-024-00319-X/METRICS.

[75] Liu S, Kazonda P, Leyna GH, Rohr JK, Fawzi WW, Shinde S, et al. Emotional and cognitive influences on alcohol consumption in middle-aged and elderly Tanzanians: a population-based study. Sci Rep 2024;14. https://doi.org/10.1038/s41598-024-64694-1.

[76] Omosefe OM, Mukhtar EA. Social support services and the psychosocial wellbeing of the elderly in Nigeria: Implication for social work practice. Journal of Social Work in Developing Societies 2023;32:32–49. https://doi.org/10.4314/jswds.v5i2.3.

[77] Heever I Van den. From marginalisation to belonging: The transformative value of adult daycare centres for adults with disabilities. South African Journal of Occupational Therapy 2025;55. https://doi.org/10.17159/2310-3833/2025/VOL55NO1A9.

[78] Sichalwe MM, Mwesiga CC, Kessy AT, Behera MR. Factors affecting utilization of outpatient healthcare services among the elderly population in Butiama and Musoma districts, Tanzania: A community-based cross-sectional study. PLoS One 2024;19. https://doi.org/10.1371/JOURNAL.PONE.0304687,.

[79] Gouttefarde P, Gay E, Guyot J, Kamdem O, Socpa A, Tchundem G, et al. The shifts in intergenerational relations in Cameroon and their potential impact on the health of older adults. BMJ Glob Health 2024;9. https://doi.org/10.1136/BMJGH-2023-014678,.

[80] Stieglitz L-M, Bärnighausen T, Leyna GH, Kazonda P, Killewo J, Rohr JK, et al. Patterns of comorbidity and multimorbidity among middle-aged and elderly women in peri-urban Tanzania. Journal of Multimorbidity and Comorbidity 2022;12:26335565221076256. https://doi.org/10.1177/26335565221076254.

[81] Ikanga J, Reyes A, Kaba D, Akilimali P, Mampunza S, Epenge E, et al. Prevalence of suspected dementia in a sample of adults living in Kinshasa-Democratic Republic of the Congo. Alzheimer's and Dementia 2023;19:3783–93. https://doi.org/10.1002/ALZ.13003;JOURNAL:JOURNAL:15525279.

[82] Mulinde B, Atukunda I, Kawooya I, Sebabi FO, Mukunya D, Batte C, et al. Prevalence and risk factors for visual impairment among elderly patients attending the eye clinic at Mulago National Referral Hospital, Uganda: a cross-sectional study. Afr Health Sci 2022;22:124. https://doi.org/10.4314/AHS.V22I2.18S.

[83] Galbraith-Olive MA, Safic S, Mwaipopo L, Ernest A, Gray WK, Urasa S, et al. Care needs of people with dementia in Tanzania and associated impact on carers: A cross-sectional, observational study. Dementia 2024;23:1021–35. https://doi.org/10.1177/14713012241262570.

[84] George G, Fricker M, Todd O, Makowa D, Tembo C, Dotchin C, et al. Screening for delirium and dementia in older hospitalised adults in Zambia. J Neurol Sci 2022;436:120186. https://doi.org/10.1016/j.jns.2022.120186.

[85] Amani PJ, Tungu M, Hurtig AK, Kiwara AD, Frumence G, San Sebastián M. Responsiveness of health care services towards the elderly in Tanzania: Does health

insurance make a difference? A cross-sectional study. Int J Equity Health 2020;19:1–9. https://doi.org/10.1186/S12939-020-01270-9/TABLES/2.

[86] Amani PJ, Hurtig AK, Frumence G, Kiwara AD, Goicolea I, San Sebastiån M. Health insurance and health system (un) responsiveness: a qualitative study with elderly in rural Tanzania. BMC Health Serv Res 2021;21:1–11. https://doi.org/10.1186/S12913-021-07144-2/PEER-REVIEW.

[87] Yohe EO, Alonso A, Drane DL, Patel SS, Schwinne M, Epenge E, et al. Predictors of white matter hyperintensities in the elderly Congolese population. Front Aging Neurosci 2025;17. https://doi.org/10.3389/fnagi.2025.1491477.

[88] Mobolaji JW, Akinyemi AI. Complementary support in later life: investigating the gender disparities in patterns and determinants among older adults in South-Western Nigeria. BMC Geriatr 2022;22:1–12. https://doi.org/10.1186/S12877-022-03393-W/TABLES/3.

[89] Amanyire JM, Aheisibwe I, Asiimwe R, Rukundo GZ. Counselling and depressive symptoms in older adults with HIV/AIDS in mbarara, Uganda. BMC Psychol 2025;13:1–11. https://doi.org/10.1186/S40359-025-03178-X/TABLES/4.

[90] Kjellstrand J, Clark M, Caffery C, Smith J, Eddy JM. Reentering the Community after Prison: Perspectives on the Role and Importance of Social Support. American Journal of Criminal Justice 2022;47:176–201. https://doi.org/10.1007/S12103-020-09596-4/METRICS.

[91] Lu S, Wu Y, Mao Z, Liang X. Association of formal and informal social support with health-related quality of life among Chinese rural elders. Int J Environ Res Public Health 2020;17. https://doi.org/10.3390/IJERPH17041351,.

[92] Gyasi RM, Phillips DR, Amoah PA. Multidimensional Social Support and Health Services Utilization Among Noninstitutionalized Older Persons in Ghana. J Aging Health 2020;32:227–39. https://doi.org/10.1177/0898264318816217,.

[93] Wairiuko JW, Cheboi SK, Ochieng G, Oyore JP. Understanding the Context of Healthcare Access among the Elderly in Informal Settlement Kibera, Nairobi, Kenya. International Journal of Health Sciences & Research (WwwIjhsrOrg) 2015;5:11.

[94] Williams BM, Kayange L, Purcell L, Charles A, Gallaher J. Elderly trauma mortality in a resource-limited setting: A benchmark for process improvement. Injury 2021;52:2651. https://doi.org/10.1016/J.INJURY.2021.07.001.

[95] Massi DG, Doumbe GKPC, Owona Manga LJ, Magnerou AM, Mapoure NY. Stroke Characteristics in the Elderly: A Hospital-Based Study in Cameroon. Neuroepidemiology 2025;59:99–109. https://doi.org/10.1159/000539576,.

[96] Chireshe R, Manyangadze T, Naidoo K. Lived experiences and expectations of people living with HIV and co-morbid diabetes regarding primary care services in Harare, Zimbabwe: Patient perspective on burden of disease. BMC Health Serv Res 2025;25:1–8. https://doi.org/10.1186/S12913-025-12949-6/FIGURES/1.

[97] Ibrahim M. Medical Returnees: Somali Canadians Seeking Psychosocial and Spiritual Care in East Africa. Cult Med Psychiatry 2024;48:731–46. https://doi.org/10.1007/S11013-024-09869-1/METRICS.

Appendices

Table S 1 search syntax across databases

Database	Search syntax	Date assessed (2025)	Number of studies identified	Filter
PubMed	((("unmet needs"[Title/Abstract]) OR ("forgone health care"[Title/Abstract])) AND (old[Title/Abstract]) OR (elderly[Title/Abstract])) AND (Africa[Title/Abstract] OR ("developing countr*"[Title/Abstract]))	13th July	304	Limit to 5 years; No language restriction
Springer Nature Link	("unmet needs" OR "forgone health care") AND (Old* OR elder*) AND (Africa OR developing countr*)	14th July	1233	Research articles only Limit to 10 years; No language restriction
African Journal Online	(unmet needs OR forgone health care) AND (Old OR elder)	13th July	2865	Limit to 10 years; No language restriction
Total			4402	

Quality Assessment of Included Studies

Table S 2 CASP Checklist: For Descriptive/Cross-Sectional Studies

Author	Checlists										
	I	II	III	IV	V	VI	VII	VIII	IX	X	XI
[82]	"yes"	"yes"	"can' t tell"	"yes"	"yes"	"can' t tell"	"yes"	"yes"	"yes"	"can' t tell"	"yes"
[78]	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"
[67]	"yes"	"yes"	"yes"	"can' t tell"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"
[75]	"yes"	"yes"	"yes"	"can' t tell"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"

Author	Checklists										
	I	II	III	IV	V	VI	VII	VIII	IX	X	XI
[87]	"yes"	"yes"	"can' t tell"	"yes"	"yes"	"can' t tell"	"yes"	"yes"	"yes"	"can' t tell"	"yes"
[70]	"yes"	"yes"	"yes"	"can' t tell"	"yes"	"yes"	"yes"	"yes"	"yes"	"can' t tell"	"yes"
[73]	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"
[66]	"yes"	"yes"	"yes"	"can' t tell"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"
[83]	"yes"	"yes"	"can' t tell"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"can' t tell"	"yes"
[81]	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"
[69]	"yes"	"yes"	"can' t tell"	"yes"	"yes"	"can' t tell"	"yes"	"yes"	"yes"	"can' t tell"	"yes"
[85]	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"
[64]	"yes"	"yes"	"yes"	"can' t tell"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"
[84]	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"
[62]	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"
[63]	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"
[71]	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"
[72])	"yes"	"yes"	"can' t tell"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"
[76]	"yes"	"yes"	"can' t tell"	"can' t tell"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"
[89]	"yes"	"yes"	"can' t tell"	"can' t tell"	"yes"	"can' t tell"	"yes"	"yes"	"yes"	"yes"	"yes"
[88]	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"

Table S 3 CASP Checklist: For Qualitative studies

Author	Checklists									
	I	II	III	IV	V	VI	VII	VIII	IX	X
[65]	"yes"	"yes"	"yes"	"yes"	"yes"	"can' t tell"	"yes"	"yes"	"yes"	"yes"
[60]	"yes"	"yes"	"yes"	"yes"	"yes"	"can' t tell"	"yes"	"yes"	"yes"	"yes"
[79]	"yes"	"yes"	"yes"	"yes"	"yes"	"can' t tell"	"yes"	"yes"	"yes"	"yes"

Author	Checklists									
	I	II	III	IV	V	VI	VII	VIII	IX	X
[68]	"yes"	"yes"	"yes"	"yes"	"yes"	"can't tell"	"yes"	"yes"	"yes"	"yes"
[86]	"yes"	"yes"	"yes"	"yes"	"yes"	"can't tell"	"yes"	"yes"	"yes"	"yes"
[77]	"yes"	"yes"	"yes"	"yes"	"yes"	"can't tell"	"yes"	"yes"	"yes"	"yes"
[74]	"yes"	"yes"	"yes"	"yes"	"yes"	"can't tell"	"yes"	"yes"	"yes"	"yes"
[61]	"yes"	"yes"	"yes"	"yes"	"yes"	"can't tell"	"yes"	"yes"	"yes"	"yes"

Table S 4 CASP Checklist: For Cohort Studies

Author	Checklists											
	I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII
[94]	"yes"	"yes"	"yes"	"yes"	"yes"	"can't tell"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"	"yes"
[95]	"yes"	"yes"	"can't tell"	"yes"	"yes"	"can't tell"	"yes"	"yes"	"can't tell"	"yes"	"can't tell"	"yes"	"yes"	"yes"	"yes"	"yes"

Table S 5 Predefined themes of included studies

Articles	**Number (%) of studies**

Unmet Physical Needs	15
Unmet Psychosocial Needs	9
Structural Determinants	16
Intermediary Determinants	23
Informal Care	4
Formal care	6

Table S 4 characteristics of included studies

Author and Year	Study Location	Research Purpose	Research Design	Population Details			Method of Data Collection	Method of Data Analysis
				Age	Gender	Settings		
[82]	Uganda	Determined the incidence and aetiology of vision impairment in the elderly in a referral hospital.	A cross-sectional study	60 years of age or older	Male and Female	Hospital -based	Structured questionnaire	-Descriptive statistics - Bivariate analysis - Multivariate analysis

Author and Year	Study Location	Research Purpose	Research Design	Population Details			Method of Data Collection	Method of Data Analysis
				Age	Gender	Settings		
[65]	Uganda	Explored health system barriers for older persons accessing care.	cross-sectional study design.		52 older persons	Community-based	- In-depth interviews - focus group discussions	Thematic analysis

Author and Year	Study Location	Research Purpose	Research Design	Population Details			Method of Data Collection	Method of Data Analysis
				Age	Gender	Settings		
[78]	Tanzania	Investigated the factors that influences the older adults in rural districts on the use of outpatient health care services	A cross-sectional study	60 years of age or older	48% male and 52% female	Rural communities	Structured questionnaires	- logistic regression - Descriptive statistics - bivariate analysis,
[60]	Ghana	Evaluated the quality of life of EPLHIV, and investigated the specific issues they experience in relation to physical, psychological, social, and environment	Cross-sectional qualitative study	50 years of age or older	46% male and 54% female,	Hospital	Semi-structured interviews and focus group discussions	Thematic analysis

Author and Year	Study Location	Research Purpose	Research Design	Population Details			Method of Data Collection	Method of Data Analysis
				Age	Gender	Settings		
		al health areas.						
[95]	Cameroon	Explored stroke features and predictors of poor outcomes in older adults.	A 4-month retrospective observational study	60 years of age or older	48.6% male and 51.4% female	Hospital -based	Medical records	- Descriptive statistics - Binary logistic regression

Print ISSN: 2517-276X
Online ISSN: 2517-2778
https://bjmas.org/index.php/bjmas/index

Author and Year	Study Location	Research Purpose	Research Design	Population Details			Method of Data Collection	Method of Data Analysis
				Age	Gender	Settings		
[67]	Ghana	Examined the prevalence and associated risk factors of hypertension in older adults.	A Cross-sectional study	50 years of age or older	3,997 older persons	Urban/rural	Structured interviews	Binary logistic regression

Print ISSN: 2517-276X
Online ISSN: 2517-2778
https://bjmas.org/index.php/bjmas/index

Author and Year	Study Location	Research Purpose	Research Design	Population Details			Method of Data Collection	Method of Data Analysis
				Age	Gender	Settings		
[75]	Tanzania	Assessed the depressive symptoms, cognition, and alcohol use in the ageing population.	A Longitudinal Study		31.19% male and 62.16% female	Community-based	Interviews	Zero-inflated negative regression

Author and Year	Study Location	Research Purpose	Research Design	Population Details			Method of Data Collection	Method of Data Analysis
				Age	Gender	Settings		
[87]	Democratic Republic of Congo (DRC)	Investigated the demographic, clinical, and vascular risk factors predicting the presence and severity of white matter hyperintensities (WMH) detected on MRI brain scans in an elderly Congolese population.	cross-sectional study	50 years of age or older			- clinical assessment - interviews	Multiple regression analysi
[70]	Ghana	Described the injury patterns and mortality predictors in elderly emergency department patients.	A prospective cross-sectional study	60 years		Hospital	Interviews and medical records	Logistic regression, analysis

Author and Year	Study Location	Research Purpose	Research Design	Population Details			Method of Data Collection	Method of Data Analysis
				Age	Gender	Settings		
[73]	Tanzania	Determined the rate of frailty in older adults hospitalised and examined their demographic and clinical features.	a prospective observational design	60 years of age or older		Hospital -based	-structured questionnaire	-Descriptive statistics -chi-square analysis
[66]	Ghana	Researched the occurrence of resistant hypertension and the risk factors.	Cross sectional		983 participants aged 64 years or younger, 588 participants aged 65 to 74 years, and 341 participants aged 75 years of age or above	hospital	- Questionnaire - medical history	-chi-square tests - t-tests - Bivariate logistic regressi - multivariate logistic regre
[79]	Cameroon	Examined the evolving status of older individuals in society and analysed how shifts in intergenerational	Qualitative research design	50 years of age or older		Urban	Focus group discussions	Thematic analysis

Author and Year	Study Location	Research Purpose	Research Design	Population Details			Method of Data Collection	Method of Data Analysis
				Age	Gender	Settings		
		relationships might impact their well-being.						
[83]	Tanzania	Examined the care needs, care strategies, and the caregiving burden of persons with dementia and their carers.	cross-sectional, observational study.			Hospital based	Interview	Non-parametric analysis, analysis
[68]	Ghana	Examined the lived experiences of older people	Qualitative study	60 years of age or older		Community-based	- semi-structured interviews - culturally sensitive sharing circles.	Thematic analysis
[81]	DRC	Investigated dementia prevalence and associated risk factors.	Cross sectional	65 years of age or older	365 older adults (51% male and 49% female)	Community-based	- clinical assessments - Structured interviews	regression and logistic regression.
[69]	Tanzania	Assessed the prevalence of anaemia and micronutrien	Descriptive cross-sectional study	60 years of age or older		Hospital-based	Structured questionnaire	Descriptive statistics

Author and Year	Study Location	Research Purpose	Research Design	Population Details			Method of Data Collection	Method of Data Analysis
				Age	Gender	Settings		
		t deficiencies in hospitalised elderly.						
[94]	Malawi	Assess trauma patterns and outcomes among elderly patients.	Retrospective cohort study	65 years of age or older		Hospital-based	Medical records	Statistical analysis
[85]	Tanzania	Examined the relationship between health insurance and healthcare responsiveness.	A cross-sectional study combining quantitative and qualitative sub-studies	60 years of age or older	1,899 elderly people (48% male and 52% female)	Community-based	Standardised household surveys based on the WHO Study on Global Ageing and Adult Health instrument; qualitative data collected through focus group discussions and interviews	Descriptive analysis

Author and Year	Study Location	Research Purpose	Research Design	Population Details			Method of Data Collection	Method of Data Analysis
				Age	Gender	Settings		
[64]	Tanzania	Assessed the prevalence and analysed their relationship with age, chronic disease comorbidity, and subjective health status among peri-urban middle-aged and elderly adults.	Cross-sectional	40 years of age or older		Peri-urban area	Computer-assisted interviews	Statistical analysis
[84]	Zambia	Assessed the prevalence and causes of dementia and delirium in elderly inpatients.	Cross-sectional, two-stage validation			Hospital-based	- Clinical assessment	Statistical analysis
[62]	Tanzania	Researched the occurrence and trends of NCDs and multimorbidity in older residents of peri-urban areas.	Cross-sectional study			Peri urban	Household survey	- Descriptive statistics - Logistic regression
[63]	South Africa	Determined the incidence and nature of echocardiographic and electrocardiographic	Cross-sectional observational study	40 years of age or older		Rural		- Chi-square - Logistic regression

Author and Year	Study Location	Research Purpose	Research Design	Population Details			Method of Data Collection	Method of Data Analysis
				Age	Gender	Settings		
		abnormalities in the elderly with cardiovascular disease in a rural community.						
[71]	Côte d'Ivoire (Ivory Coast)	Explored the association between frailty, healthcare use, and costs.	Cross-sectional	50 years of age or older	860 older adults (57.1% male and 42.9% female)	Community-based	standardised surveys based on the WHO framework.	- Descriptive statistics - Logistic regression
[86]	Tanzania	Explored the elderly perceptions and experiences of health services based on insurance status.	Qualitative explanatory study	60 years of age or older,	78 participants 48% male and 52% female	Rural settings	Eight focus group discussions	Qualitative content analysis
[72])	Nigeria	Determined the unmet needs of ADL in rural and urban elderly.	Cross-sectional analytical study	60 years of age or older		Community based	Semi-structured questionnaires	Descriptive statistics

Author and Year	Study Location	Research Purpose	Research Design	Population Details			Method of Data Collection	Method of Data Analysis
				Age	Gender	Settings		
[76]	Nigeria	Examined the social support services that could be offered to the psychosocial well-being of the elderly.	descriptive survey research	65 years of age or older	100 senior citizens	Community-based	structured questionnaire	Descriptive statistics
[77]	South Africa	Researched the views of adults with severe-profound disabilities who were in ADCs.						
[74]	Ethiopia	Researched the lived experiences and views of	Phenomenological qualitative study		10 older adults		in-depth interviews	Thematic analysis

Author and Year	Study Location	Research Purpose	Research Design	Population Details			Method of Data Collection	Method of Data Analysis
				Age	Gender	Settings		
		ageing in older adults						
[89]	Uganda	Explored the relationship between counselling and depressive symptoms in older adults with HIV/AIDS,	A cross-sectional research design	60 years of age or older	265 older adults (150 women, 115 men)	Hospital -based	Questionnaire	Logistic Regression
[61]	Ghana	Investigated self-reported health and social needs of elderly people in city slums.	A qualitative exploratory descriptive design		25 older adults	Community-based	semi-structured interviews	thematic content analysis

Author and Year	Study Location	Research Purpose	Research Design	Population Details			Method of Data Collection	Method of Data Analysis
				Age	Gender	Settings		
[88]	Nigeria	Explored the trends and predictors of access to complementary supports in older adults.	A cross-sectional study	65 years of age or older	827 older adults (394 men and 433 women)	Community-based	questionnaire	Poisson–logit hurdle model

Table S 6 characteristics of studies that should be included but excluded

Author and Year	Study Location	Research purpose	Research Design	Population Details			Method of Data Collection	Method of Data Analysis
				Age	Gender	Settings		
[NO_PRINTED_FORM] [96]	Zimbabwe.	Examined the lived experiences and expectations of individuals with HIV and T2DM concerning the main healthcare they receive.	A cross-sectional, descriptive, qualitative study	older than 18 years		Hospital-based	semi-structured interviews	Thematic analysis

Author and Year	Study Location	Research purpose	Research Design	Population Details			Method of Data Collection	Method of Data Analysis
				Age	Gender	Settings		
[97]	Canada and Kenya (fieldwork in Nairobi)	Explored the psychosocial issues, health-seeking behaviour, obstacles to mental health services, and the significance of transnational spiritual healing.	Ethnographic qualitative study			spiritual healing centres and medical clinics.	- Ethnographic fieldwork - in-depth interviews	

Note: The studies were excluded because the **age of the participants did not meet the predefined inclusion criteria** for the review. While some older adults were involved, the **majority of participants who informed the findings of the studies were below the specified age range** set in the inclusion and exclusion criteria.