Socio-Demographic Correlates of Elder Abuse in Obio/Akpor Local Government Area, Rivers State, Nigeria

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Abstract
Elder abuse is a public-health and human-rights concern that can undermine the safety, dignity, health and economic security of older adults. This study examined socio-demographic correlates of elder abuse among adults aged 65 years and above in Obio/Akpor Local Government Area (LGA), Rivers State, Nigeria. A descriptive cross-sectional design was used. The manuscript reports a multistage sample of 411 eligible older adults selected across the LGA's 17 wards. Data were collected with a semi-structured questionnaire and analysed in SPSS version 21 using descriptive statistics, chi-square tests and logistic regression, with statistical significance set at p < .05. The association tables report 56 respondents (13.6%) as having experienced abuse, with higher reported prevalence among adults aged 65–74 years (19.5%), men (16.6%), married/cohabiting respondents (20.7%), respondents living alone (84.6%), and those reporting monthly income of ₦20,000 or less (24.8%). The manuscript's separate summary of abuse types reports emotional abuse as the most common category (102; 45.1%), followed by financial abuse (63; 27.9%), physical abuse (41; 18.1%) and sexual abuse (20; 8.9%). These findings suggest that abuse prevention and detection should be sensitive to household arrangements, economic vulnerability and family relationships. However, the source manuscript contains material inconsistencies between the overall prevalence reported in its abstract and the association tables, as well as several statistical reporting discrepancies. These are explicitly identified in this recast rather than silently reconciled. The findings should therefore be interpreted cautiously until the original dataset and analysis output are checked.

Keywords*: elder abuse; older adults; socio-demographic correlates; Obio/Akpor; Rivers State; Nigeria*

1. Introduction

1.1 Background

Population ageing has increased the urgency of protecting older adults from violence, neglect and exploitation. Elder abuse is commonly understood as a single or repeated act, or the failure to take appropriate action, within a relationship of trust that causes harm or distress to an older person. It can include physical, emotional or psychological, sexual and financial abuse, as well as neglect, abandonment and the loss of dignity. The World Health Organization (WHO, 2024) estimates that approximately one in six people aged 60 years and older experienced some form

of abuse in community settings during the preceding year. The scale and consequences make elder abuse both a public-health concern and a violation of human rights.

Older adults are not a homogeneous population. Health status, functional ability, income, social networks, living arrangements and access to care differ substantially, shaping both exposure to harm and the ability to seek help. WHO (2024) identifies low income, poor physical or mental health, cognitive impairment and functional dependence among factors associated with vulnerability? At the relationship level, family dynamics and the financial dependence of a caregiver on an older person may also contribute to risk. These factors should not be treated as deterministic: their influence can vary across settings and should be examined empirically.

In Nigeria, elder care has often been organised through family and community relationships. Yet migration, economic pressures, changing household structures and limited access to formal care may complicate the provision of consistent support. A recent qualitative study of caregivers in south-west Nigeria discusses the role of family stress, caregiver circumstances and difficulties in reporting abuse (Insights into caregivers' perspectives on abuse of older persons, 2023). The Nigerian National Policy on Ageing also recognises the importance of dignity, participation, security and care for older persons (Federal Ministry of Humanitarian Affairs, Disaster Management and Social Development, n.d.). Policy commitments, however, need to be accompanied by accessible reporting mechanisms, community-level prevention and evidence about local patterns. Obio/Akpor LGA is part of the Port Harcourt metropolitan area in Rivers State. Its urban and peri-urban character, population mobility and diverse resident communities make it important to examine older adults' experiences within their specific social and economic setting. Local evidence can help public-health practitioners, community organisations and local authorities identify groups requiring additional attention, while avoiding assumptions that all older adults experience abuse in the same way.

1.2 Problem statement and rationale

Elder abuse may remain hidden when older people depend on relatives for housing, income, care or access to services, or when they fear stigma, retaliation or family conflict. The absence of a complaint does not necessarily indicate the absence of abuse. At the same time, prevalence estimates can vary substantially because studies use different definitions, recall periods, age thresholds, sampling methods and questions. It is therefore important to distinguish a study's own estimates from international estimates and to report the underlying denominators clearly.

The source study set out to examine the pattern of elder abuse and its association with socio-demographic characteristics in Obio/Akpor LGA. Its value lies in providing local observations about age, sex, marital status, living arrangements, children, religion, education, work, occupation, income and ethnic grouping. The manuscript's tables suggest potentially important differences across these characteristics. However, inconsistencies between the abstract and results tables affect the interpretation of the overall prevalence. A strengthened report must preserve the observed values while making the limits of the available reporting transparent.

1.3 Aim and objectives

The aim of the study was to examine the socio-demographic correlates and reported patterns of elder abuse among adults aged 65 years and above in Obio/Akpor LGA, Rivers State.

Specifically, the study sought to describe the forms of elder abuse reported by respondents; examine the association between selected socio-demographic characteristics and reported elder abuse; and identify implications for local prevention, early detection and support for older adults.

2. Methods

2.1 Study area and design

The study was conducted in Obio/Akpor LGA, Rivers State, Nigeria. The source manuscript describes the LGA as one of the 23 local government areas in Rivers State, with its headquarters at Rumuodomaya and 17 electoral wards. The area forms part of the Port Harcourt metropolitan region and includes Indigenous Ikwerre residents as well as people from other ethnic groups who have moved to the area. A descriptive cross-sectional design was adopted to examine reported abuse and its association with selected characteristics at one point in time.

2.2 Study population, eligibility and sample size

The target population comprised adults aged 65 years and above who had lived in Obio/Akpor LGA for at least one year. Critically ill older adults were excluded according to the source manuscript. The study used an estimated population of 165,738 older adults, although the manuscript does not provide the primary source or calculation details for this local population projection. The reported sample size was 411. The authors state that the calculation used a prevalence estimate of 58%, a standard normal deviate of 1.96, a precision level of 0.05 and an allowance for non-response. The formula is not legible in the supplied document and the arithmetic for the non-response allowance is not fully consistent; the sample-size calculation should therefore be checked against the original protocol before publication.

2.3 Sampling and data collection

A multistage sampling procedure was reportedly used to select 411 older men and women from the LGA's 17 wards. The questionnaire was pretested in Aluu community in Ikwerre LGA with 30 older adults who were not part of the study sample. Data were collected using a semi-structured questionnaire. The source document does not describe the stages of selection in sufficient detail to reproduce the sampling process, nor does it provide the full questionnaire or item-level operational definitions of abuse. These details should be supplied in a final journal submission.

2.4 Data analysis

The source manuscript reports that data were analysed using SPSS version 21. Descriptive statistics were used to summarise the data, while chi-square tests and logistic regression were reportedly used to examine associations. Statistical significance was set at $p < .05$ with 95% confidence intervals. The available tables, however, primarily present cross-tabulations, chi-square statistics and odds ratios without a clear statement of whether the odds ratios are crude or adjusted. The regression model specification, reference categories, missing-data handling and model diagnostics are not provided. Accordingly, this recast describes the reported associations as unadjusted or model-based only where the source does not permit certainty, and it does not claim independent causal effects.

2.5 Ethical considerations

According to the source manuscript, ethical approval was obtained from the Ethics Committee of the University of Port Harcourt and permission was secured from the Obio/Akpor LGA Council. Participants were informed about the purpose of the research, and informed consent was obtained with an assurance of confidentiality. The approval number, date of approval, consent procedure

for participants with impaired capacity and safeguarding/referral procedures for disclosures of abuse were not reported in the supplied manuscript and should be added where available.

3. Results

The results below reproduce the principal numerical findings reported in the source manuscript. Percentages are retained as reported where possible. Because several counts and percentages are inconsistent across sections, the results are presented with an explicit data-quality note rather than attempting to infer which value was intended.

3.1 Overall reported forms of elder abuse

The abstract reports that 226 respondents (76.4%) considered the way they were treated to constitute abuse. It also reports 226 cases distributed across four forms: emotional abuse, 102 (45.1%); financial abuse, 63 (27.9%); physical abuse, 41 (18.1%); and sexual abuse, 20 (8.9%). These counts sum to 226 and the percentages sum to 100.0%, suggesting that this distribution uses 226 as its denominator.

Reported form	Count	Percentage
Emotional abuse	102	45.1
Financial abuse	63	27.9
Physical abuse	41	18.1
Sexual abuse	20	8.9
Total	226	100.0

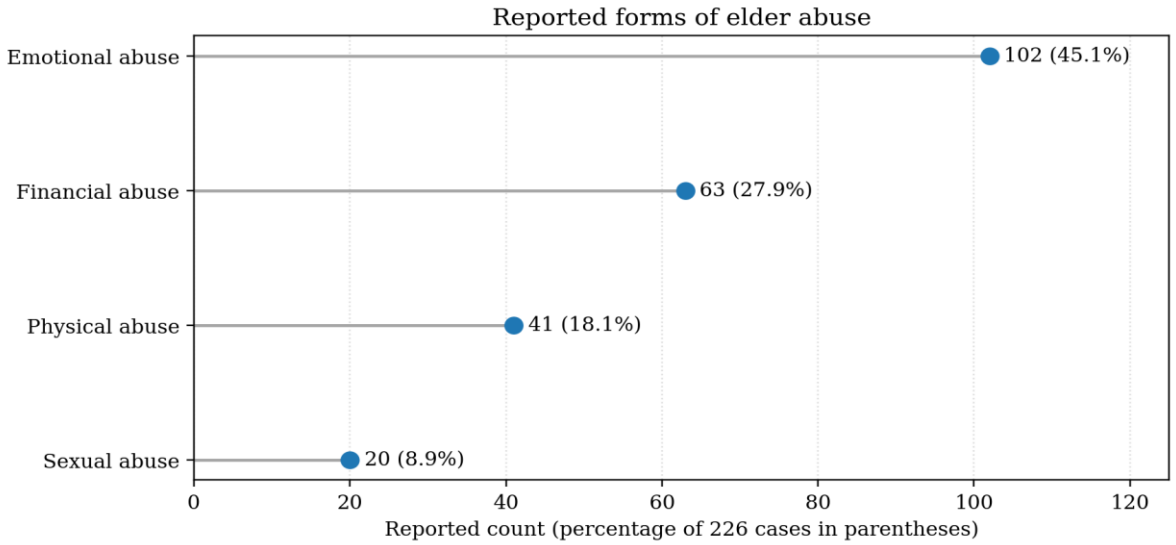

Figure 1. Cleveland dot plot of reported forms of elder abuse (n = 226).

Emotional abuse is the largest category in this distribution, accounting for just under half of the reported cases. Financial abuse is the second-largest category. This pattern indicates that prevention should not be limited to visible physical injury: verbal humiliation, intimidation, coercion and misuse of resources may also compromise older adults' dignity and security. The supplied manuscript does not provide the individual questionnaire items used to classify each form, so the categories should be interpreted according to the authors' reported labels.

3.2 Association between socio-demographic characteristics and elder abuse

Table 2 summarises the first set of reported associations. The percentages in the table are within-category prevalence figures as presented in the source manuscript. The table's chi-square and odds-ratio entries are reproduced, but some values appear internally inconsistent or incorrectly transcribed; these require confirmation against the original SPSS output.

Characteristic	Abuse: Yes n (%)	Abuse: No n (%)	Total	χ^2 (reported p)	OR (95% CI, as reported)
Age 65–74	45 (19.5)	185 (80.5)	230	5.657 (0.000)	3.76 (1.83–8.31)
Age ≥75	11 (6.1)	170 (93.9)	181	—	Reference/unspecified
Male	45 (16.6)	226 (83.4)	271	6.00 (0.014)	2.34 (1.17–4.67)
Female	11 (7.9)	129 (92.1)	140	—	Reference/unspecified
Married/cohabiting	53 (20.7)	203 (79.3)	256	28.90 (0.000)	13.23 (4.06–43.14)
Divorced/widowed	3 (1.9)	152 (98.1)	155	—	Reference/unspecified
No living children	13 (48.1)	14 (51.9)	27	29.27 (0.000)	7.36 (3.25–16.70)
At least one living child	43 (11.2)	341 (88.8)	384	—	Reference/unspecified
Living alone	11 (84.6)	2 (15.4)	13	57.49 (0.000)	43.14 (9.27–200.90)
Living with family	45 (11.3)	353 (88.7)	398	—	Reference/unspecified

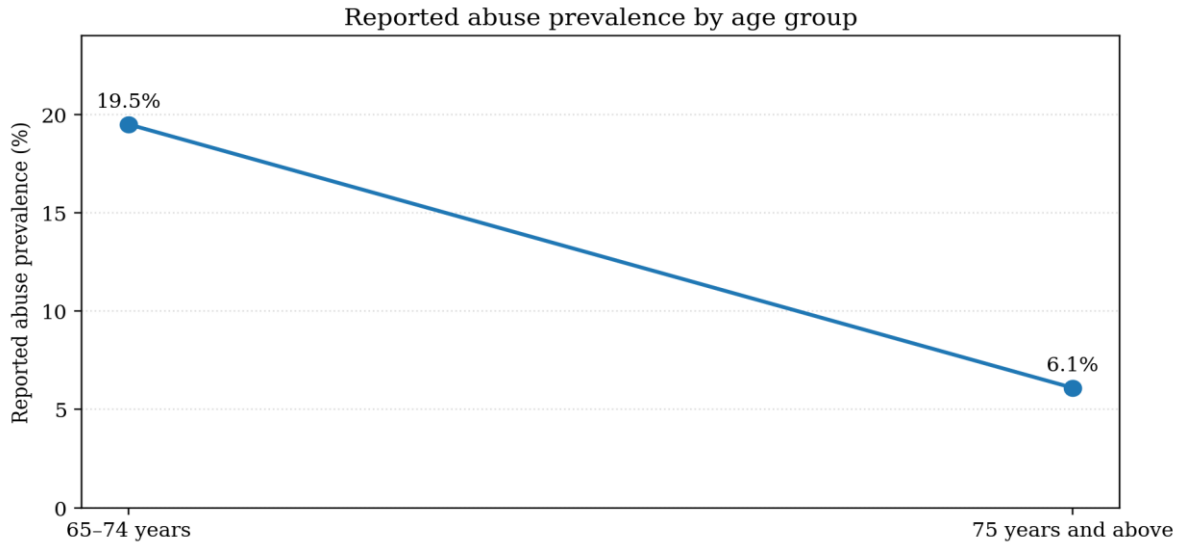

Figure 2. Line graph of reported elder-abuse prevalence by age group.

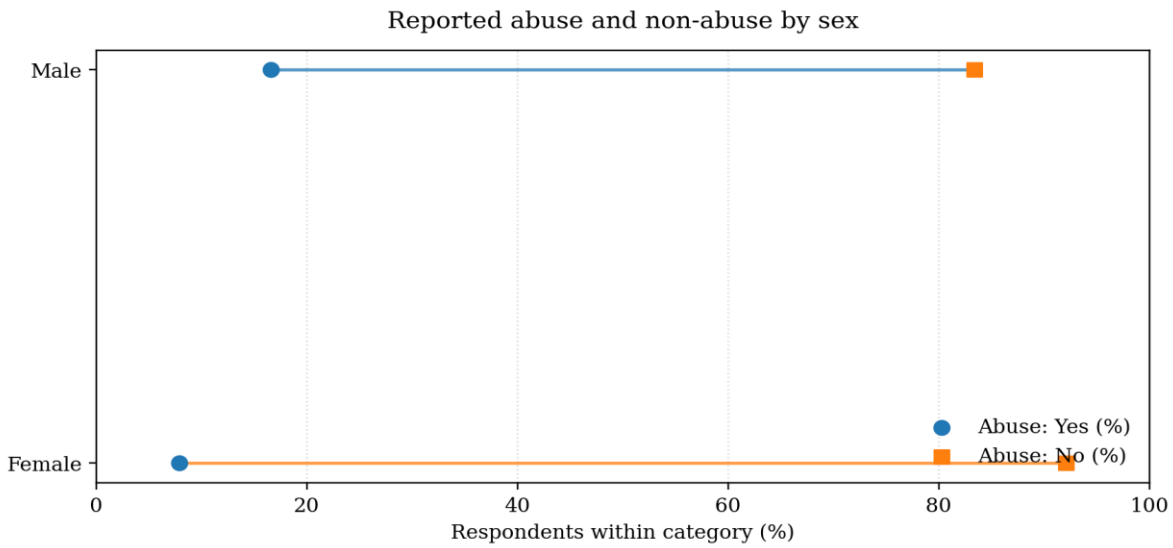

Figure 3. Dumbbell plot comparing reported abuse and non-abuse percentages by sex.

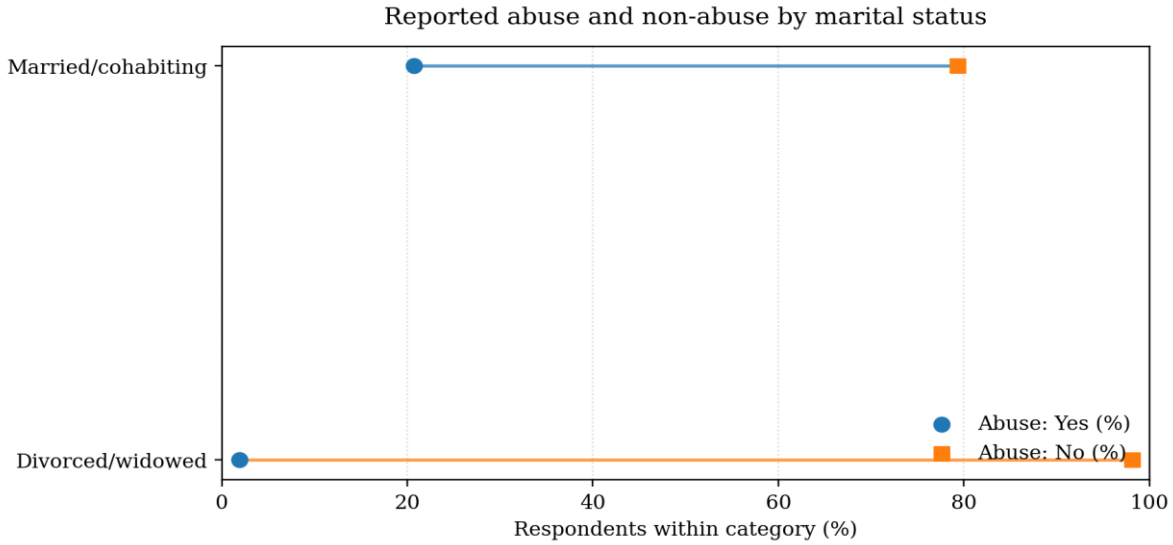

Figure 4. Dumbbell plot comparing reported abuse and non-abuse percentages by marital status.

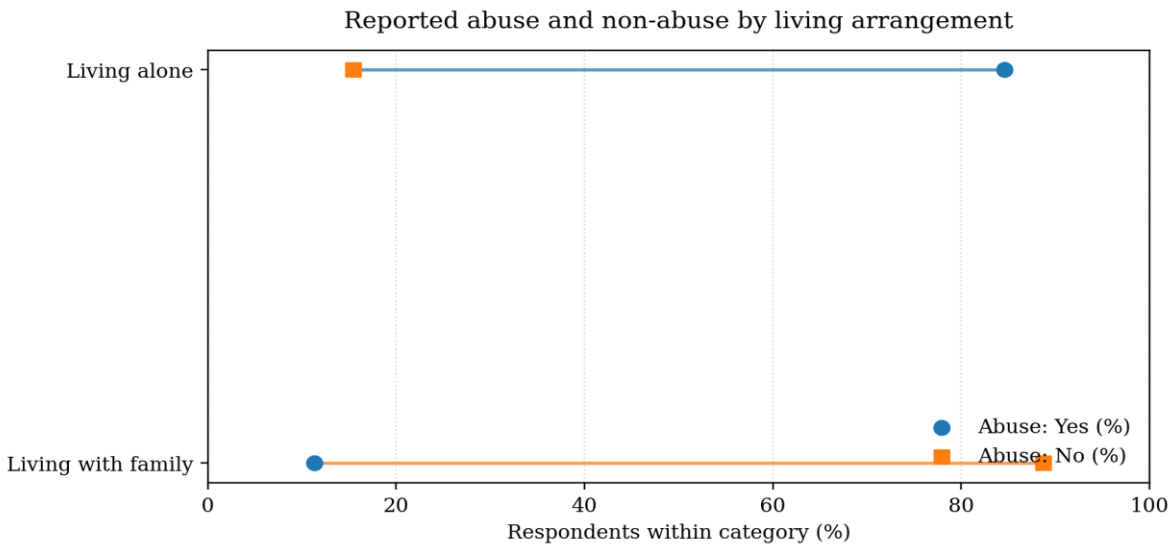

Figure 5. Dumbbell plot comparing reported abuse and non-abuse percentages by living arrangement.

The reported figures show higher abuse prevalence among respondents aged 65–74 years than among those aged 75 years and above. Men have a higher reported prevalence than women in this sample, while married or cohabiting respondents have a higher reported prevalence than the combined divorced/widowed group. The largest difference in this table is between respondents living alone and those living with family members. However, the living-alone group contains only 13 respondents, and its reported odds-ratio confidence interval is very wide. This suggests substantial uncertainty around the magnitude of the association. It would be inappropriate to conclude that living alone necessarily causes abuse; small cell counts, unmeasured factors and the source table's inconsistencies may affect the estimate.

The table also reports greater prevalence among older adults with no living children than among those with at least one living child. This may indicate the importance of support networks, but the presence of children does not guarantee safety or protection. The quality of family relationships, financial dependence, caregiving strain and access to community support were not measured sufficiently in the supplied report to establish the mechanisms behind the observed differences.

3.3 Other socio-demographic correlates

Characteristic	Abuse: Yes n (%)	Abuse: No n (%)	Total	χ^2 (reported p)	OR (95% CI, as reported)
Christianity	45 (11.5)	345 (88.5)	390	28.24 (0.000*)	0.12 (0.05–0.35)
Islam/African Traditional Religion	11 (52.4)	10 (47.6)	21	—	Reference/unspecified
Education ≤ primary	56 (15.4)	307 (84.6)	363	8.57 (0.001*)	0.85 (0.81–0.88)
Education ≥ secondary	0 (0.0)	48 (100.0)	48	—	Reference/unspecified
Working	11 (18.0)	50 (82.0)	61	1.20 (0.311)	1.49 (0.72–

					3.08)
Not working	45 (12.9)	305 (87.1)	350	—	Reference/unspecified
Military/professional/non-manual	0 (0.0)	89 (100.0)	89	17.92 (0.000*)	1.211 (1.5–1.27)
Skilled/other occupations	56 (17.4)	266 (82.6)	322	—	Reference/unspecified
Monthly income ≤ ₦20,000	52 (24.8)	158 (75.2)	210	45.25 (0.000*)	16.21 (5.74–45.78)
Monthly income ₦20,001–₦100,000	4 (2.0)	197 (98.0)	201	—	Reference/unspecified
Igbo/Ikwerre	45 (17.5)	212 (82.5)	257	8.79 (0.003*)	2.76 (1.38–5.52)
Yoruba/Hausa/other	11 (7.1)	143 (92.9)	154	—	Reference/unspecified

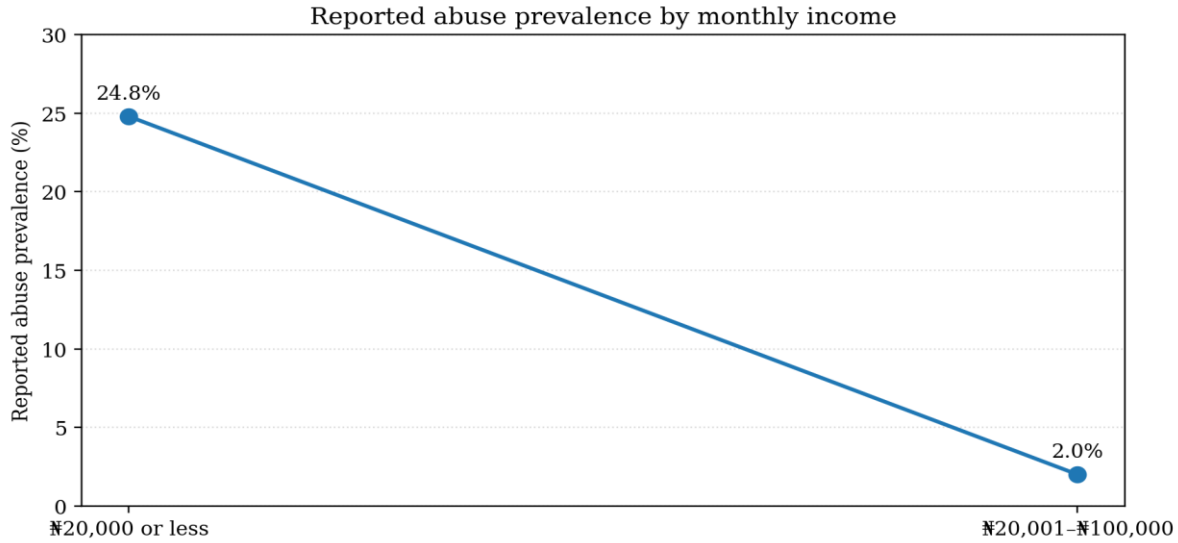

Figure 6. Line graph of reported elder-abuse prevalence by monthly income category.

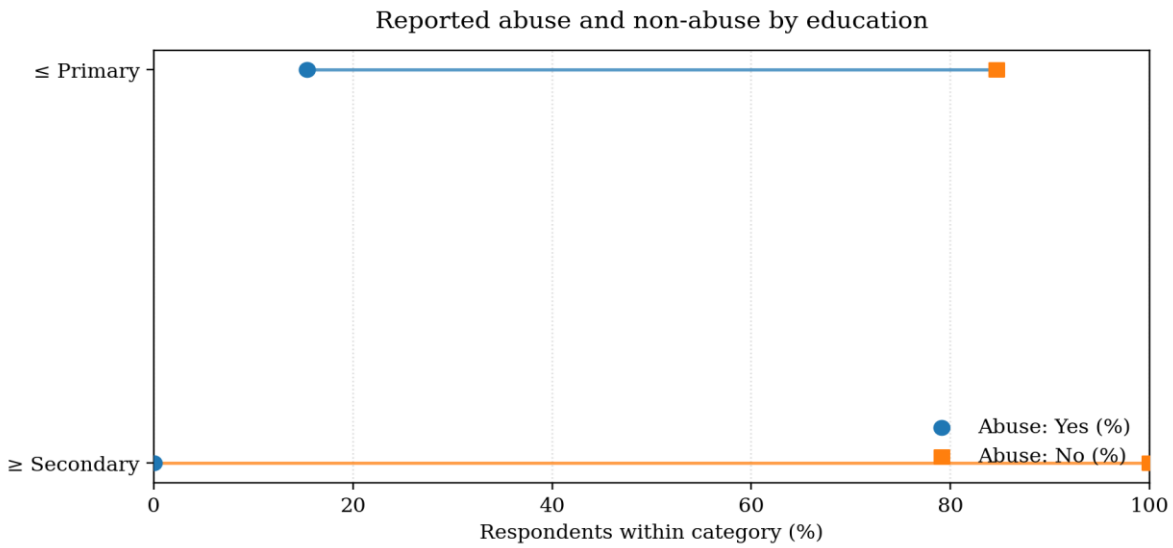

Figure 7. Dumbbell plot comparing reported abuse and non-abuse percentages by education.

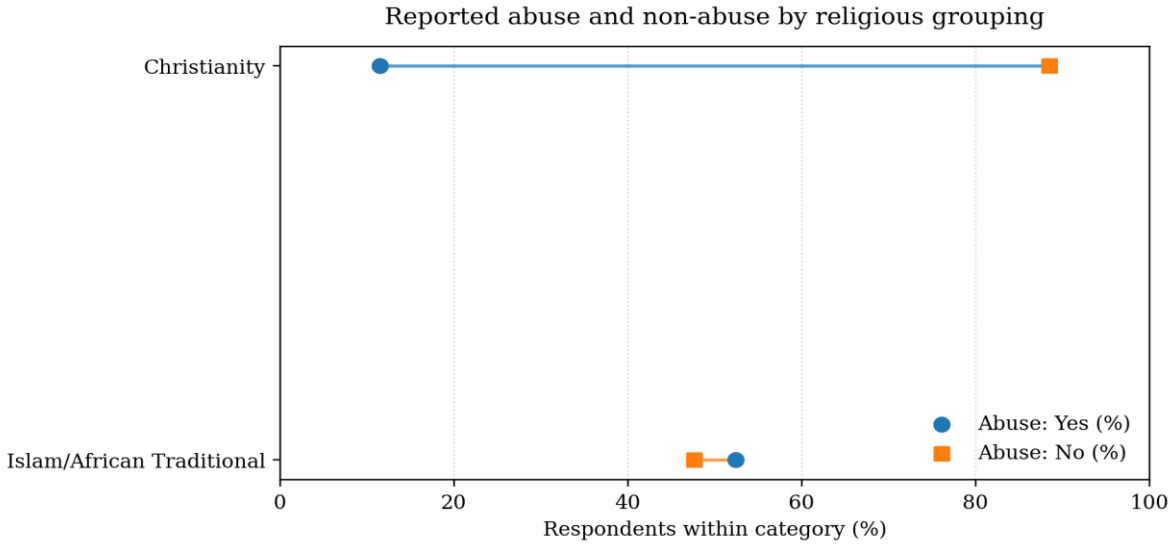

Figure 8. Dumbbell plot comparing reported abuse and non-abuse percentages by religious grouping.

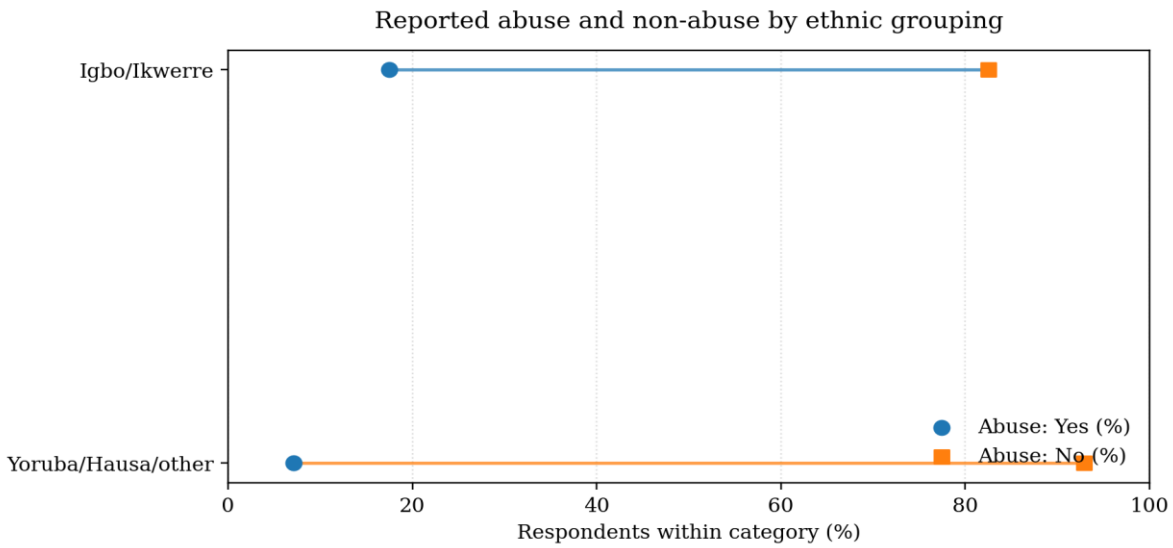

Figure 9. Dumbbell plot comparing reported abuse and non-abuse percentages by ethnic grouping.

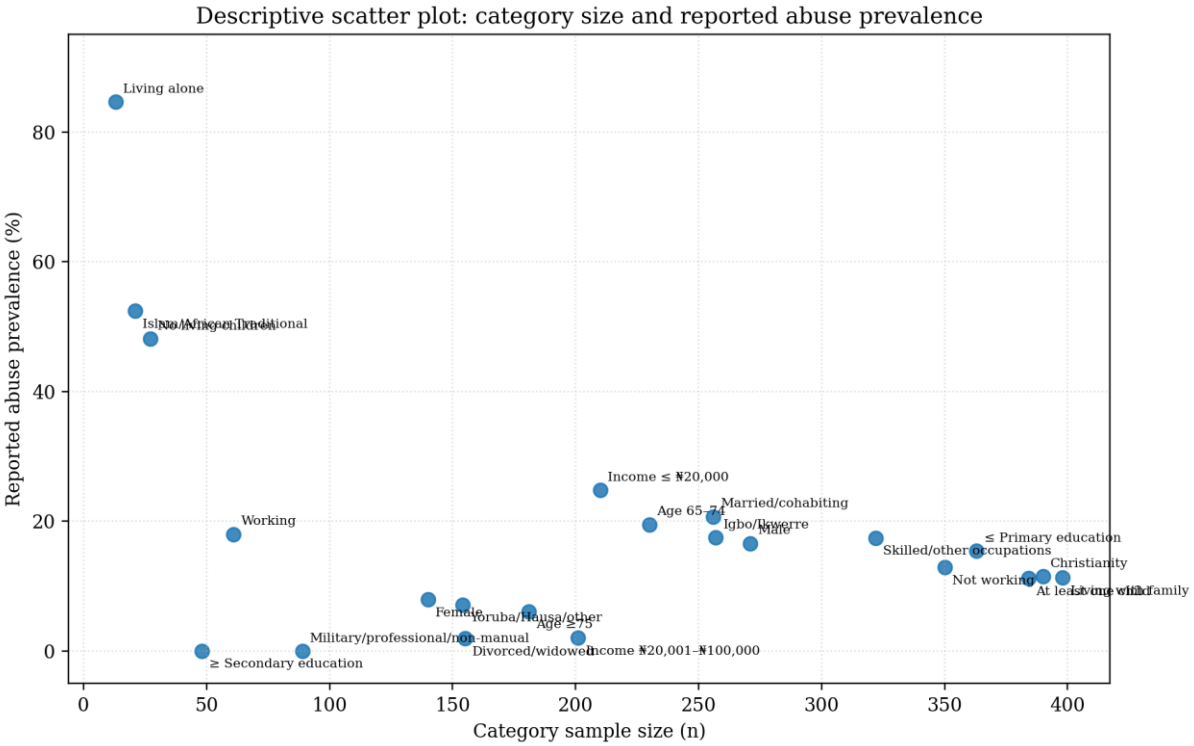

Figure 10. Descriptive scatter plot of category sample size against reported abuse prevalence. Each point represents a category reported in Tables 2–3; the plot is descriptive and does not imply causation.

Monthly income shows one of the clearest descriptive contrasts in the reported table: 24.8% of respondents earning ₦20,000 or less were classified as abused, compared with 2.0% among those in the ₦20,001–₦100,000 category. This is consistent with the broader literature identifying low income as a potential vulnerability factor, although the cross-sectional data cannot establish causation (WHO, 2024). The work-status comparison was reported as

statistically non-significant (p = .311), despite a higher prevalence among respondents who were working. The source table reports no abuse cases among respondents with secondary education or above and among the military/professional/non-manual category. Such zero cells require careful checking and may cause unstable or non-estimable odds ratios.

The source manuscript also reports differences by religious and ethnic group. These categories are uneven in size, particularly the 21 respondents classified as Islam/African Traditional Religion. The findings should be described as sample-specific associations, not as evidence that religion or ethnicity intrinsically causes abuse. Potential confounding by income, age, household composition, occupation and other variables would need to be assessed before making adjusted comparisons.

4. Discussion

This study addresses a locally important issue: the possibility that older adults in an urban local-government setting experience abuse within relationships where they expect care, trust or support. The source tables point to emotional abuse as the most frequently reported form in the separate type distribution, while income, living arrangements, marital status, age and other characteristics vary across the association tables. These findings reinforce the need to understand elder abuse as a multi-dimensional issue involving relationships, resources and social protection rather than treating it solely as physical violence.

4.1 Emotional and financial abuse as public-health concerns

The reported predominance of emotional abuse is consistent with international evidence that psychological abuse is often the most frequently reported category in community studies. WHO (2024), drawing on a systematic review, reports psychological abuse as more common than physical and sexual abuse in community settings? Emotional abuse can be difficult to identify because it may occur through repeated insults, threats, humiliation, intimidation, coercive control or deliberate exclusion. Health workers and community leaders should therefore ask older people about their treatment and sense of safety in private, using non-judgemental language and referral pathways. Financial abuse was the second-largest category in the source distribution. Economic exploitation may include taking pension income, controlling access to money, coercing transfers of property or withholding resources needed for food and care. The marked income contrast in the association table suggests that economic insecurity deserves attention, but poverty should not be treated as an individual failing or a sufficient explanation for abuse. It may interact with dependence, caregiver stress, limited formal services and weak reporting mechanisms. Programmes that strengthen income security and offer confidential advice on financial decisions may form part of a broader prevention response.

4.2 Household relationships and living arrangements

The reported high prevalence among respondents living alone is noteworthy, but it must be interpreted with caution because the group contains only 13 people. Living alone may reduce the immediate availability of support or witnesses, but it is not synonymous with social isolation and does not itself establish victimisation. Conversely, co-residence with family members can provide support while also creating circumstances in which coercion, neglect or exploitation can occur. Prevention programmes should assess the quality and safety of relationships rather than assume that any one living arrangement is uniformly protective.

The higher prevalence reported among married/cohabiting respondents than among the combined divorced/widowed group also differs from some expectations that bereavement or living without a spouse necessarily increases vulnerability. Differences across studies may reflect local household patterns, operational definitions, the composition of categories and small numbers. The present results should be treated as a prompt for further investigation, not a universal conclusion about marital status.

4.3 Age, sex, education and social position

The association table reports greater prevalence among adults aged 65–74 than among those aged 75 and above, and among men than women. These patterns differ from some international and Nigerian discussions that identify older women as particularly vulnerable in certain contexts. Such differences underline why results from one sample should not be generalised automatically to all older adults. Reporting practices, survival and participation effects, household roles and the sample's age and sex composition may influence observed patterns. Future analyses should examine interactions between sex, age, marital status, income and living arrangements.

The apparent absence of abuse in the higher-education group may point to the protective potential of literacy, resources or knowledge of rights, but the zero count may also reflect sample size, measurement or data-entry issues. The occupation table similarly contains a zero-abuse category and an odds ratio whose confidence interval appears malformed. The original data and statistical output must be reviewed before drawing firm conclusions. A journal-ready analysis should report adjusted odds ratios with clearly defined reference categories and valid confidence intervals, and should avoid interpreting odds ratios as risk ratios when the outcome is not rare.

4.4 Policy and practice implications

Nigeria's National Policy on Ageing provides a policy basis for promoting older people's dignity, security and care (Federal Ministry of Humanitarian Affairs, Disaster Management and Social Development, n.d.). At the local level, implementation can be strengthened through age-friendly primary healthcare, training for health and social-care workers, confidential referral systems, community awareness and practical support for caregivers. Local authorities and civil-society organisations can work with faith institutions and community associations to make clear that abuse is not an acceptable family matter to be concealed.

Health workers should be trained to recognise physical injury, unexplained financial hardship, fearfulness, withdrawal, poor hygiene, unmet medical needs and inconsistent accounts of care. Screening and referral should be conducted sensitively, with attention to privacy, decision-making capacity and the older person's wishes. Community-level programmes should provide information on where to seek help and should include men and women, older adults living alone and those living with relatives. Caregiver support, respite options and counselling may reduce strain, but they must not replace accountability where abuse has occurred.

At policy level, local governments should consider documenting and monitoring reports of elder abuse, coordinating health and social-welfare responses and ensuring that older people can access social protection without humiliating or costly procedures. Such measures should be designed with older adults themselves and evaluated using indicators such as awareness, referral completion, repeat victimisation and access to support. These recommendations are consistent with WHO's emphasis on caregiver interventions, financial-management support and multi-sectoral responses (WHO, 2024).

5. Study limitations and data-integrity considerations

Several limitations constrain interpretation. First, the cross-sectional design cannot establish temporal order or causality. Second, the study relies on self-report, which may be affected by recall, fear, stigma or different understandings of what constitutes abuse. Third, the exclusion of critically ill people may omit some highly vulnerable older adults. Fourth, the supplied manuscript does not adequately describe the multistage selection procedure, questionnaire validation statistics, item definitions, response rate or adjusted regression model.

Most importantly, the source manuscript contains a major inconsistency in the outcome totals. The abstract reports 226 respondents (76.4%) considering their treatment abusive and gives a distribution of 226 cases by type. By contrast, both socio-demographic association tables report 56 respondents with abuse and 355 without abuse, totalling 411; this corresponds to 13.6%, not 76.4%. The tables also contain inconsistent or apparently incorrect p-values, chi-square values, percentages and odds-ratio confidence intervals. For example, some prose descriptions do not match the corresponding table cells, and one reported confidence interval appears to have its lower bound greater than its upper bound. No chart or statistical narrative can resolve these discrepancies without the original dataset. Accordingly, figures in this recast are visual representations of values explicitly reported in the source manuscript, not a re-analysis of raw observations. The type-distribution chart uses the four counts that sum to 226, whereas the association charts use the within-group percentages printed in the socio-demographic tables. These denominators are different and must not be combined as if they represented a single internally consistent outcome measure. Before journal submission, the authors should reconcile the abstract and tables against the raw dataset and SPSS output, re-run all cross-tabulations and regression models, verify denominators and category labels, and replace any erroneous values. If the raw data cannot be recovered, the manuscript should state that limitation clearly and avoid presenting incompatible estimates as a single prevalence result.

6. Conclusion

The study set out to examine socio-demographic correlates of elder abuse in Obio/Akpor LGA, Rivers State. Its reported results identify emotional abuse as the leading category in the abstract's type distribution and show descriptive differences in abuse prevalence by age, sex, marital status, living arrangements, children, religion, education, employment, occupation, income and ethnic grouping. The income and living-arrangement comparisons are particularly striking, although the small number of respondents living alone and the uneven sizes of some subgroups warrant caution. The findings support a coordinated public-health and social-protection response that includes awareness, confidential identification, caregiver support, accessible reporting and protection of older adults' financial and personal autonomy. Nevertheless, the manuscript's conflicting overall counts and statistical inconsistencies prevent a definitive estimate of prevalence or confident interpretation of several associations. The principal conclusion is therefore twofold: elder abuse warrants targeted local prevention and support, and the underlying data must be verified before the numerical findings are used to guide policy or submitted for international peer review.

Recommendations

Local health facilities should incorporate respectful, confidential enquiry about mistreatment into appropriate consultations with older adults and establish referral links with social-welfare and protection services. Community organisations, religious institutions and traditional leaders

should promote public understanding of emotional, physical, sexual and financial abuse, while making clear that family status does not justify mistreatment. Local authorities should develop accessible reporting pathways and coordinate responses across health, social services, community groups and law-enforcement agencies where appropriate. Social-protection programmes should prioritise older adults facing severe economic insecurity and ensure that support can be accessed without dependence on potentially exploitative intermediaries. Caregiver education and respite support should be expanded where feasible, alongside safeguards for the autonomy and safety of older people. Finally, the authors should validate the raw dataset, correct the tables and rerun the analyses before making claims about prevalence, statistical significance or independent predictors.

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