Risk Factors Associated with 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 occur through physical, emotional, financial or sexual harm, neglect, abandonment, and violations of dignity. Older adults may be exposed to overlapping vulnerabilities associated with household relationships, social support, health needs and financial insecurity. This study examined reported patterns of elder abuse and selected sociodemographic, household and health characteristics of adults aged 65 years and above in Obio/Akpor Local Government Area (LGA), Rivers State, Nigeria. A descriptive cross-sectional study was conducted among 411 eligible older adults selected through a multistage sampling procedure. Data were collected using a semi-structured questionnaire that had been pretested among 30 older adults in Aluu community, Ikwerre LGA. The source manuscript reports descriptive statistics and the use of chi-square tests and logistic regression, with statistical significance set at $p < .05$. The source reports 226 older adults (76.4%) as considering their treatment abusive, although the denominator underlying this percentage is not stated and does not match the full sample of 411. Among the 226 cases used to describe abuse type, emotional abuse was most frequently reported (102; 45.1%), followed by financial abuse (63; 27.9%), physical abuse (41; 18.1%) and sexual abuse (20; 8.9%). Respondents were predominantly aged 65–74 years (56.0%), male (65.9%), married (60.3%), and not currently working (reported as 85.2% in the frequency table). Low monthly income was common: 51.1% reportedly earned no more than ₦20,000. Hypertension, diabetes and visual impairment were among the frequently reported health conditions. The manuscript states that sex, marital status and living status were significantly associated with abuse, but the underlying cross-tabulations, test statistics, odds ratios and confidence intervals were not provided. The reported predominance of emotional abuse and the prevalence of financial vulnerability support the need for family-centred education, accessible reporting pathways, social protection and health-service responses that recognise older adults' autonomy and safety. Because the source data contain internal inconsistencies and do not provide the inferential statistics needed to verify the reported associations, the findings should be interpreted cautiously.

Keywords*: elder abuse; older adults; emotional abuse; financial vulnerability; living arrangement; Obio/Akpor; Nigeria*

1. Introduction

1.1 Background

Population ageing has implications for public health, family care, social protection and human rights. Older adults contribute to family life and community knowledge, yet they may face risks when their autonomy, resources, safety or access to care are undermined. Elder abuse is commonly understood as a single or repeated act, or a failure to act appropriately, within a relationship where trust is expected, resulting in harm or distress. It includes physical, psychological or emotional, sexual and financial abuse, as well as neglect and other forms of degrading treatment (World Health Organization [WHO], 2024). The WHO estimates that approximately one in six people aged 60 years and above in community settings experienced some form of abuse during the preceding year. This global estimate should not be treated as a local prevalence estimate for Obio/Akpor, because prevalence varies with definitions, sampling, disclosure conditions and study design (WHO, 2024). Recent Nigerian studies likewise report substantial variation in the forms and prevalence of mistreatment across settings. A 2025 cross-sectional study in rural Edo State identified neglect, financial abuse and emotional abuse as common forms and reported associations with several social and economic characteristics (Okakah et al., 2025). These studies underscore the importance of locally grounded evidence. In Nigeria, family members often provide practical, emotional and financial support to older relatives. Family care can be protective, but dependence on a limited number of caregivers may also create opportunities for coercion, neglect, financial exploitation or verbal mistreatment, particularly where household resources are constrained or wider social support is weak. Poverty, inadequate pensions, social isolation, ageist assumptions and weak access to appropriate care may compound vulnerability. These are potential contextual mechanisms, not proof that any particular household or characteristic causes abuse. Obio/Akpor LGA forms part of the Port Harcourt metropolitan area in Rivers State. Its urban and peri-urban setting includes indigenous Ikwerre residents as well as people who have migrated from other parts of Nigeria. Understanding the experiences of older residents in this context can inform community health practice, social welfare responses and family-support initiatives.

1.2 Problem statement

Elder abuse can remain hidden because older people may depend on the person mistreating them, fear retaliation or abandonment, feel shame, or regard harmful treatment as a private family matter. Where reporting systems are inaccessible and community surveillance is weak, abuse may be normalised or remain undocumented. The study manuscript reports emotional abuse as the most common form among the recorded cases and states that some sociodemographic characteristics were associated with abuse. However, the source does not provide the detailed cross-tabulations or regression outputs required to assess the strength and precision of these relationships. A careful presentation must therefore distinguish the descriptive findings that can be reproduced from the associations asserted in the source.

1.3 Aim and objectives

The aim was to examine the patterns and selected risk factors associated with elder abuse among people aged 65 years and above in Obio/Akpor LGA, Rivers State.

The objectives were to describe the reported forms of elder abuse; summarise respondents' sociodemographic, household and health characteristics; and examine the study's reported interpretation of relationships between abuse and selected characteristics, while identifying the

limits of the available statistical reporting.

1.4 Significance

The study is relevant to public-health practitioners, primary-care providers, local government authorities, social-welfare agencies, community leaders and families. A stronger evidence base can support early identification, referral, confidential disclosure, caregiver support and economic protection. The results may also provide a baseline for future research, provided that subsequent analyses use clearly specified denominators and report complete statistical estimates.

2. Literature review

2.1 Forms and consequences of elder abuse

Emotional or psychological abuse includes insults, humiliation, threats, intimidation, persistent rejection and social isolation. Physical abuse involves acts that cause pain or injury, while sexual abuse involves sexual contact or activity without freely given consent. Financial abuse includes unauthorised use, control or appropriation of money, property or other assets. Neglect may involve failure to provide essential care, food, medicines, hygiene or protection when a duty to do so exists. These forms can overlap, and an older person may experience more than one form at the same time (WHO, 2024). The consequences extend beyond immediate injury. Abuse can contribute to depression, anxiety, reduced self-esteem, malnutrition, worsening chronic illness, functional decline, loss of assets, social withdrawal and premature mortality. It can also destabilise family relationships, increase demands on health and social services, and weaken trust within communities. The source manuscript's consequences table describes effects at four levels: older people, families, communities and the health sector. This multilevel framing is useful because elder abuse is not solely a private family issue; it also has implications for public institutions and social protection.

2.2 Risk factors across levels

Current public-health frameworks emphasise that elder abuse is rarely explained by one characteristic. Individual-level factors may include poor physical or mental health, functional dependence, cognitive impairment and low income. Potential perpetrator-related factors include substance misuse, mental-health difficulties, high stress, inadequate caregiving preparation and financial or emotional dependence on the older person. Relationship-level factors include prior family conflict and limited supportive relationships. Community and societal factors may include social isolation, ageism, normalisation of violence, inadequate services and economic insecurity (Centers for Disease Control and Prevention [CDC], 2024; WHO, 2024). These factors should be interpreted as risk markers rather than deterministic explanations. For example, disability or the need for assistance does not make abuse inevitable, and caregiver stress does not excuse mistreatment. Supportive care arrangements, adequate respite, accessible health services and strong social networks can reduce pressures and improve opportunities for disclosure. The WHO also cautions that the relevance of relationship type, marital status and other characteristics varies across settings (WHO, 2024).

2.3 Nigerian evidence and the present study

Nigerian evidence points to the importance of local context. Okakah et al. (2025), studying two rural communities in Edo State, reported neglect, financial abuse and emotional abuse among the common forms identified and found associations involving sex, marital status, employment,

education, living arrangement, financial status and dependency. A separate study in Oye-Ekiti reported associations between elder abuse, age, low income and limited formal education (Ipinnimo et al., 2024). These findings are not directly interchangeable with the Obio/Akpor sample: the studies differ in geography, age thresholds, sampling and measurement. They nevertheless demonstrate why locally specific estimates and transparent methods matter.

The present manuscript contributes a community-level account from Obio/Akpor. Its strongest directly reported result is the distribution of abuse types among 226 cases. Its sociodemographic and health tables also describe conditions that may be relevant to prevention planning. However, because the source lacks the detailed association tables and regression estimates, it cannot support a ranking of independent predictors or causal conclusions.

3. Methods

3.1 Study area and design

The study was conducted in Obio/Akpor LGA, Rivers State, within the Port Harcourt metropolitan area. The source describes the LGA as comprising 17 electoral wards and notes that its population includes indigenous Ikwerre residents and people from other ethnic groups. The study adopted a descriptive cross-sectional design involving adults aged 65 years and above.

3.2 Study population, eligibility and sample size

The target population comprised residents aged 65 years and above who had lived in Obio/Akpor LGA for at least one year. Critically ill older adults were excluded. The manuscript gives a projected older-person population of 165,738, although it does not provide the projection method or supporting population source. The sample-size calculation used a prevalence estimate of 58%, a 95% confidence level, and a 5% margin of error, then added an allowance for non-response to reach a target sample of 411. The printed calculation contains formatting and arithmetic inconsistencies; the intended final sample of 411 is retained here as reported.

3.3 Sampling and data collection

A multistage sampling technique was used to select 411 older adults from the 17 wards. The source indicates that a semi-structured questionnaire was used. A pretest involving 30 older adults in Aluu community, Ikwerre LGA, was conducted before the main study. The source does not describe the questionnaire's item-level validity, reliability coefficient, language translation procedure, response rate by ward, or the operational definition and screening instrument used to classify abuse.

3.4 Data analysis

The source reports that data were analysed using SPSS version 21. Means and standard deviations were specified for descriptive analysis, while chi-square tests and logistic regression were reportedly used for inferential analysis. Statistical significance was set at $p < .05$ with 95% confidence intervals. However, the source manuscript does not supply the relevant cross-tabulations, chi-square statistics, regression coefficients, odds ratios, confidence intervals or model diagnostics. Consequently, this recast reports the inferential claims as statements made by the source rather than as independently verifiable results.

3.5 Ethical considerations

The manuscript reports ethical approval from the Ethics Committee of the University of Port Harcourt and permission from the Obio/Akpor LGA council. It also states that informed consent was obtained after the study purpose was explained and confidentiality was assured. The approval reference number, date of approval, consent procedure for participants with impaired capacity and referral arrangements for disclosed abuse were not provided in the source.

3.6 Data integrity and reporting approach

For this recast, reported sample sizes and findings have been retained where possible. The original manuscript contains internal discrepancies in several frequency-percentage pairs and narrative summaries. Rather than silently correcting uncertain values or inventing missing inferential results, the relevant tables are accompanied by notes identifying material inconsistencies. Charts visualise the reported values only; they do not create additional observations or imply causal relationships.

4. Results

4.1 Reported patterns of elder abuse

The abstract reports that 226 older adults (76.4%) considered the way they were treated to constitute abuse. The denominator used to calculate 76.4% is not specified; 226 is 55.0% of the stated sample of 411, not 76.4%. The proportion should therefore not be presented as a verified prevalence estimate until the original dataset and denominator are checked. Among the 226 cases used for the distribution of abuse types, emotional abuse accounted for 102 reports (45.1%), financial abuse for 63 (27.9%), physical abuse for 41 (18.1%) and sexual abuse for 20 (8.9%). These counts sum to 226 and the percentages sum to 100%.

Table 1. Distribution of reported forms of elder abuse

Form of abuse	Frequency	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

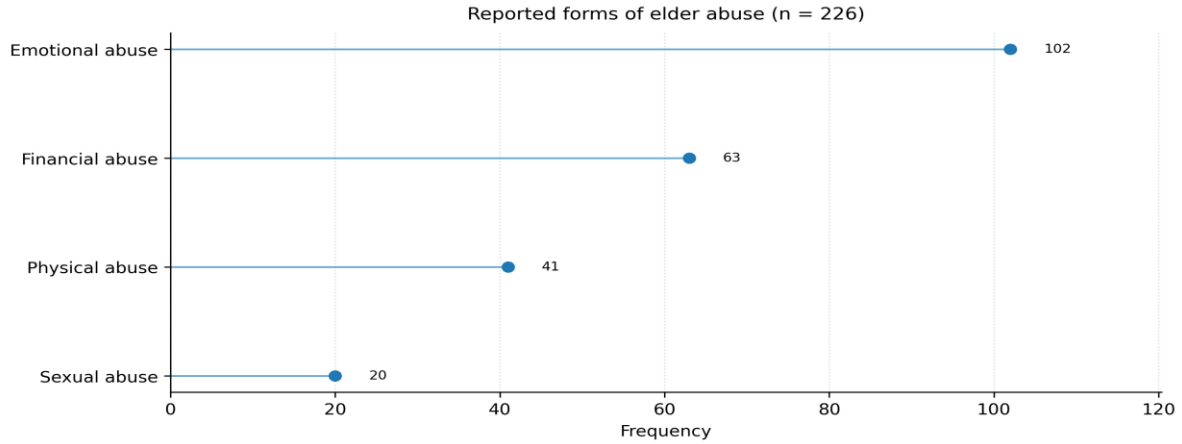


Figure 1. Distribution of abuse types among the 226 cases reported in the source.

The distribution indicates that emotional abuse was the most frequently recorded category in this sample, followed by financial abuse. This pattern highlights the importance of asking older adults about verbal humiliation, threats, coercive control and misuse of money, rather than relying only on visible physical injuries. The data do not show whether respondents experienced multiple forms of abuse, how abuse was operationalised, or who perpetrated each form.

4.2 Sociodemographic characteristics

Table 2. Age, sex and marital status of respondents (N = 411)

Characteristic	Category	Frequency	Reported %
Age	65–74 years	230	56.0
Age	75–84 years	120	29.2
Age	>85 years	61	14.8
Sex	Male	271	65.9
Sex	Female	140	34.1
Marital status	Married	248	60.3
Marital status	Divorced	63	15.3
Marital status	Widow/widower	92	22.4
Marital status	Cohabitation	8	1.9

Note. The reported age categories sum to 411. Percentages may differ slightly from calculations based on rounded values.

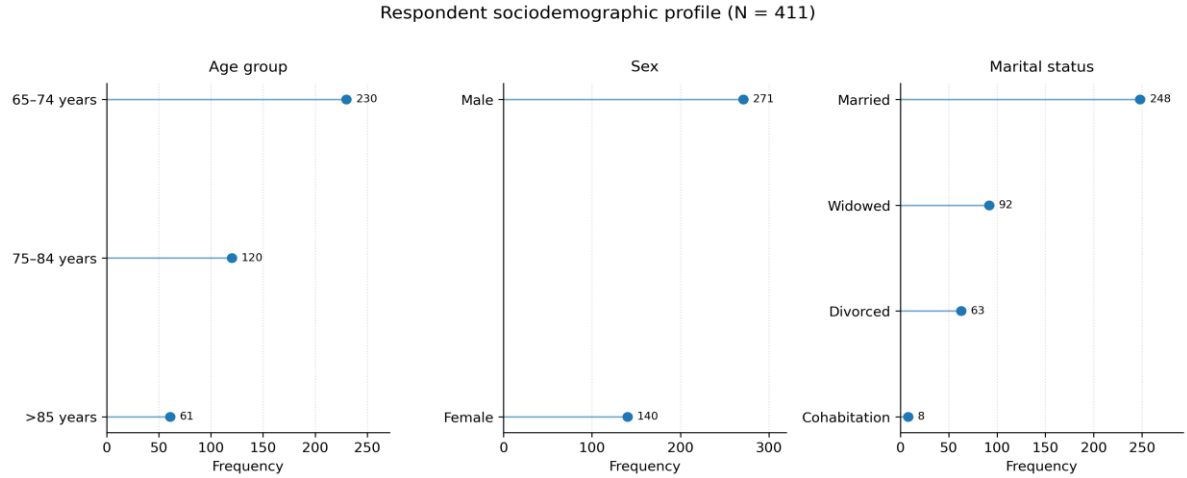


Figure 2. Reported age, sex and marital-status counts. The chart displays counts, not comparable subgroup rates.

More than half of the sample was aged 65–74 years (56.0%), while 14.8% were older than 85 years. Men accounted for 65.9% of participants and women for 34.1%. Married respondents formed the largest marital-status group (60.3%), followed by widowed respondents (22.4%) and divorced respondents (15.3%). These figures describe the composition of the sample; they do not establish that any age, sex or marital-status group faced greater risk. Such a conclusion requires abuse-specific rates and the corresponding statistical tests.

Table 3. Number of living children, living arrangement and religion

Characteristic	Category	Frequency	Reported %
Number of living children	None	17	4.1
Number of living children	1–2	21	5.1
Number of living children	3–4	71	17.3
Number of living children	5–6	119	48.2*
Number of living children	≥7	84	20.4
Living arrangement	Alone	13	3.2
Living arrangement	With spouse	171	41.6
Living arrangement	With children	121	23.4*
Living arrangement	With family members	96	23.4
Living arrangement	With caregiver	10	2.4
Religion	Christianity	390	94.9
Religion	Islam	18	4.4
Religion	African traditional religion	3	0.7

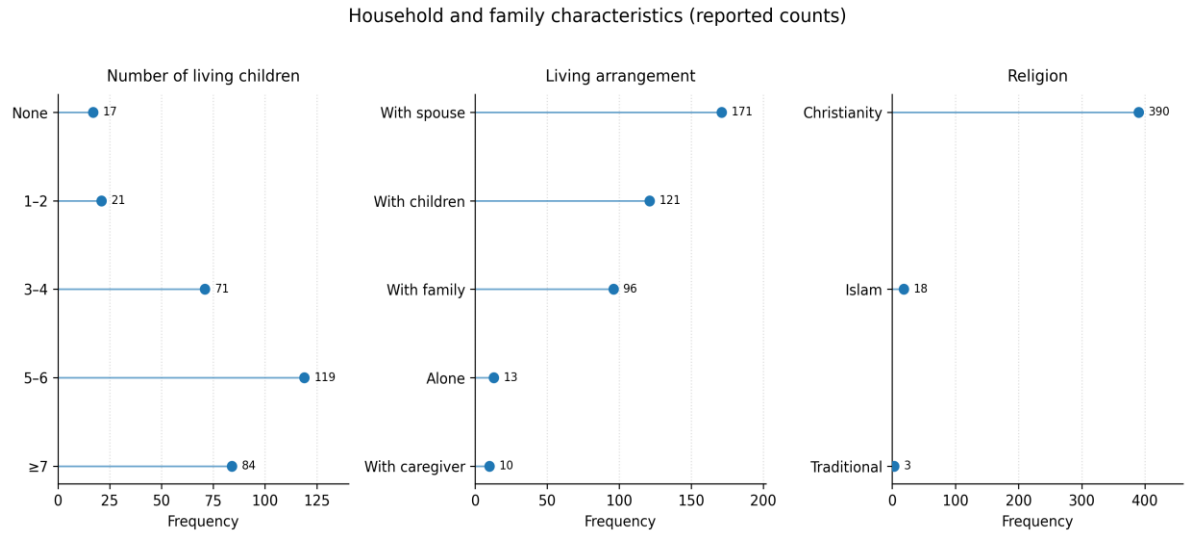


Figure 3. Reported counts for household and family characteristics. The child-count category is shown using the frequency in the table; see the discrepancy note.

Living arrangements were diverse. The source table reports that 171 participants lived with a spouse, 121 with children, 96 with other family members, 13 alone and 10 with caregivers. The small number reported as living alone should not be interpreted as evidence of low isolation without information about contact outside the household, mobility, social participation and access to help. The table also reports that most respondents identified as Christian (94.9%); this reflects the sample and should not be generalised to the entire LGA without a representative population comparison.

Table 4. Education, employment, retirement and occupation

Characteristic	Category	Frequency	Reported %
Education	No formal education	119	29.0
Education	Primary	244	59.4
Education	Secondary	36	8.8
Education	Tertiary	12	2.9
Currently working	Yes	61	14.8
Currently working	No	350	85.2
Retired (among those not working; n=350)	Yes	90	25.7
Retired (among those not working; n=350)	No	260	74.3
Occupation	Military/uniformed service	5	1.2
Occupation	Professional	14	3.4*
Occupation	Intermediate occupation	24	6.0
Occupation	Non-manual/business	46	11.2
Occupation	Manual skilled	95	23.1
Occupation	Partly skilled/trader/clerical	182	44.3
Occupation	Unskilled	10	2.4
Occupation	Never worked/long-term unemployed	28	6.8
Occupation	Other	7	1.7

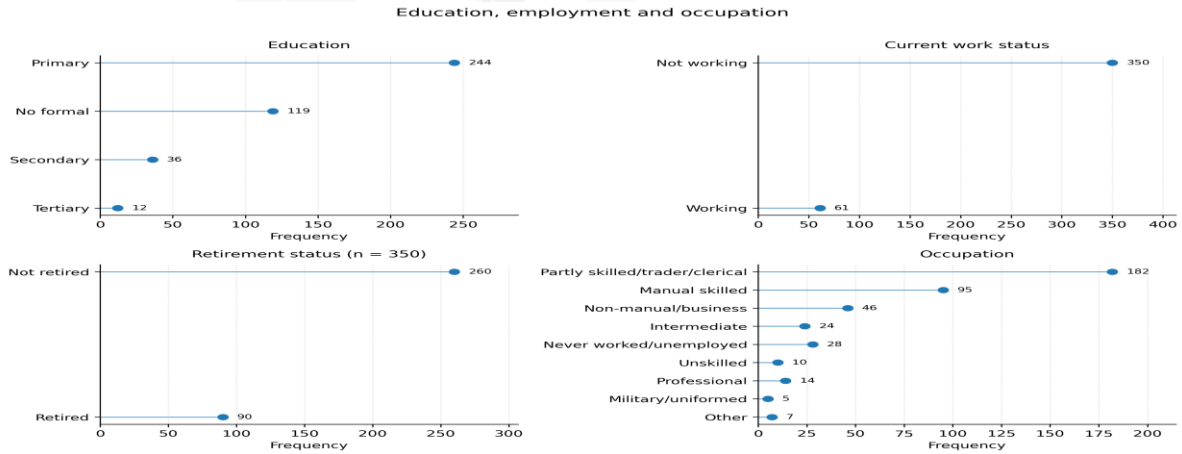


Figure 4. Education and employment counts as reported. Retirement categories apply only to the 350 respondents classified as not currently working.

Primary education was the highest reported educational level for 59.4% of respondents, while 29.0% had no formal education and 2.9% had tertiary education. The table indicates that 350 respondents were not currently working, although the accompanying narrative contains an incorrect percentage for this count. Partly skilled work was the largest occupational category (182; 44.3%), followed by manual skilled work (95; 23.1%). These characteristics may matter

for financial security and access to information, but the available results do not demonstrate that education or occupational category independently predicted abuse.

Table 5. Monthly income and ethnic identity

Characteristic	Category	Frequency	Reported %
Monthly income	≤ ₦20,000	210	51.1
Monthly income	₦20,001–₦60,000	138	33.1*
Monthly income	₦60,001–₦100,000	65	15.8
Ethnic identity	Ikwerre	250	60.8
Ethnic identity	Abua	90	21.9
Ethnic identity	Ijaw	45	11.0
Ethnic identity	Yoruba	3	0.7
Ethnic identity	Hausa	1	0.2
Ethnic identity	Igbo	7	1.7
Ethnic identity	Ibibio/Efik	10	2.4
Ethnic identity	Kalabari	5	1.2

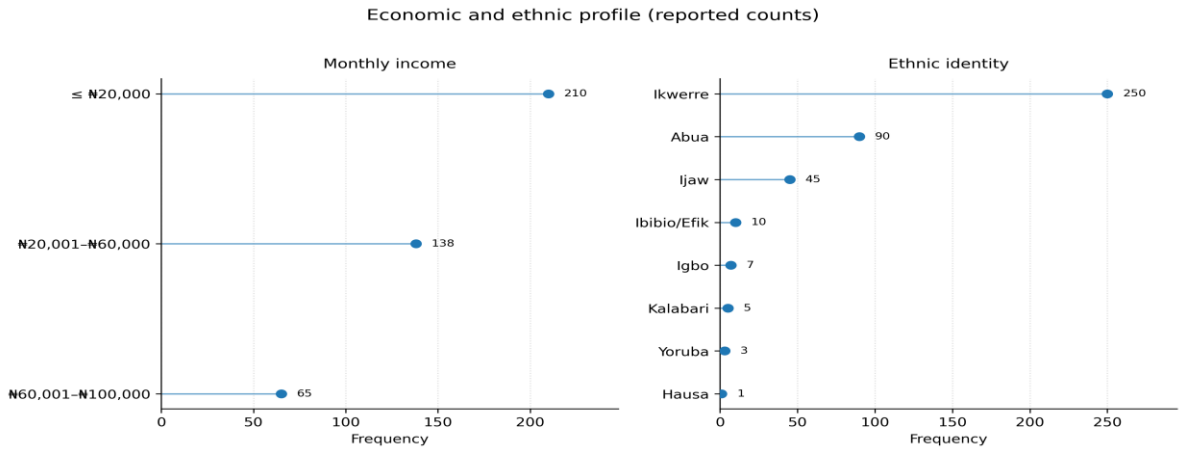


Figure 5. Distribution of respondents across reported monthly income categories.

Just over half of respondents were reported to earn no more than ₦20,000 monthly (210; 51.1%), and a further 138 were in the ₦20,001–₦60,000 category. This indicates substantial economic constraint within the sample, although the survey period and the meaning of income (individual or household, and before or after deductions) are not specified. Financial insecurity can limit the ability to purchase medicines, obtain transport, secure independent accommodation or seek assistance. It should not be assumed, however, that low income directly caused abuse in this study without a transparent analysis of abuse outcomes by income group.

4.3 Health status and access to care

Table 6. Self-rated health and current health problems

Measure	Category	Frequency	Reported %
Self-rated health	Very well	139	33.3*
Self-rated health	Well	243	59.6*
Self-rated health	Sick	22	5.4
Self-rated health	Very sick	7	1.7
Current health problem (multiple response)	Hypertension	117	28.47
Current health problem (multiple response)	Diabetes	93	22.63
Current health problem (multiple response)	Heart problem	12	2.92
Current health problem (multiple response)	Respiratory/lung disease	15	3.65
Current health problem (multiple response)	Hearing difficulty	21	5.11
Current health problem (multiple response)	Visual impairment	88	21.41
Current health problem (multiple response)	Arthritis	62	15.09
Current health problem (multiple response)	Immobility	34	8.27

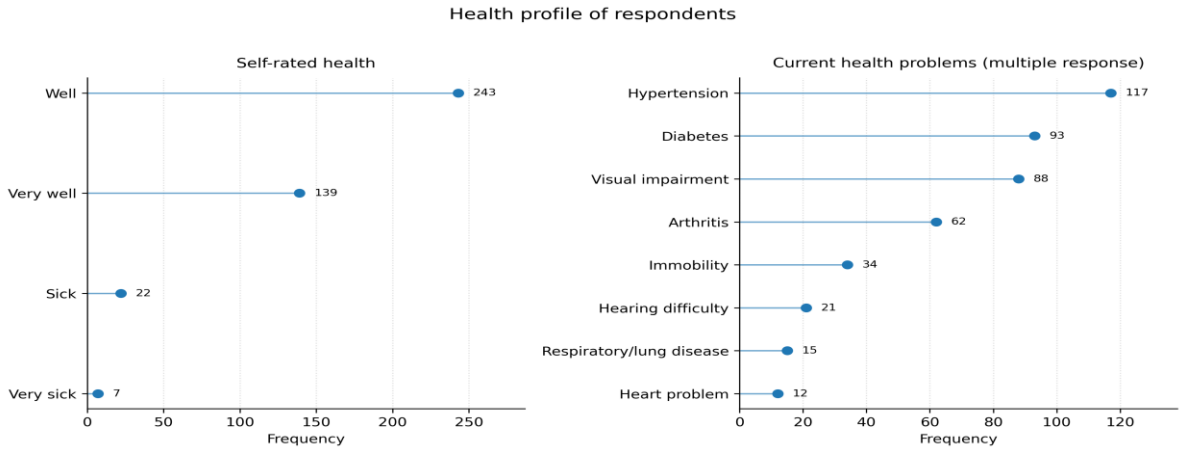


Figure 6. Counts for selected health conditions. Multiple conditions could be reported by one respondent.

The source reports that most respondents rated their health as well or very well, while a smaller proportion reported being sick or very sick. Hypertension (117), diabetes (93) and visual impairment (88) were the most frequently listed current conditions. Because respondents could report multiple conditions, the counts represent responses rather than mutually exclusive groups. Chronic conditions and sensory or mobility limitations can increase the need for support, but they are not evidence of abuse in themselves. Appropriate prevention should protect autonomy and access to care rather than treat older people's health needs as causes for blame.

Table 7. Duration of health problems, hospital treatment and payment

Measure	Category	Frequency	Reported %
Duration of health problems	≤12 months	107	26.0
Duration of health problems	13–24 months	203	49.4
Duration of health problems	25–36 months	43	10.4
Duration of health problems	37–48 months	20	4.8
Duration of health problems	49–60 months	22	5.4
Duration of health problems	61–72 months	12	2.9
Duration of health problems	≥73 months	4	1.0
Receiving hospital treatment	Yes	300	73.0
Receiving hospital treatment	No	111	27.0
Person responsible for hospital bills (n=300)	Self	80	26.7
Person responsible for hospital bills (n=300)	Health insurance	68	22.7
Person responsible for hospital bills (n=300)	Spouse/family members	131	43.6
Person responsible for hospital bills (n=300)	Other	21	7.0
Frequency of hospital visit (n=300)	On doctor's appointment	167	55.7
Frequency of hospital visit (n=300)	Whenever unwell	128	41.7*
Frequency of hospital visit (n=300)	Other	5	1.6

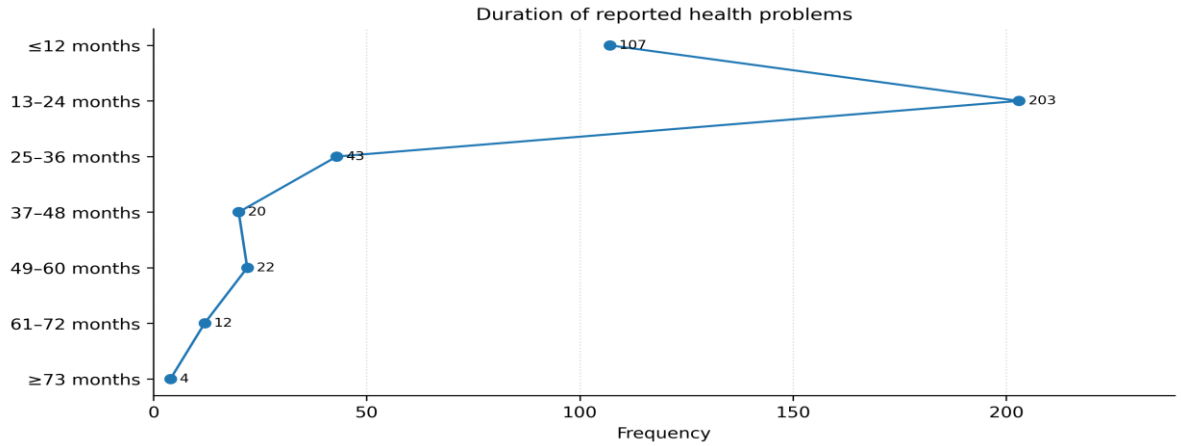


Figure 7. Duration of reported health problems.

Nearly half the respondents were reported to have had health problems for 13–24 months (203; 49.4%). Three hundred respondents (73.0%) reportedly received hospital treatment. Among those 300, spouse or family members were the most frequently reported source of bill payment (131; 43.6%), followed by respondents themselves (80; 26.7%) and health insurance (68; 22.7%). Reliance on relatives can be an important protective resource, but it can also create dependency if an older adult lacks independent funds or alternative support. These descriptive data do not establish that financial dependence led to abuse.

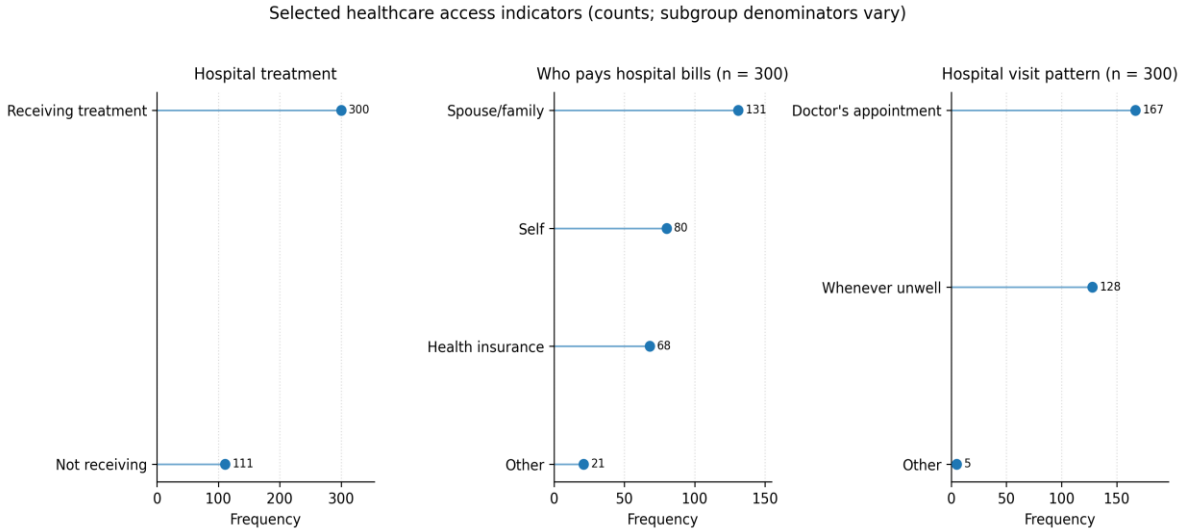


Figure 8. Selected healthcare access indicators. Subgroups differ by item; refer to table denominators when interpreting counts.

Table 8. Transport to hospital, medication use and adherence

Measure	Category	Frequency	Reported %
Means of visiting hospital	Self	77	25.7
Means of visiting hospital	Spouse	81	27.0
Means of visiting hospital	Children	132	44.0
Means of visiting hospital	Other family members	10	3.3
Currently on medication	Yes	209	69.7
Currently on medication	No	91	30.3
Number of drugs taken daily (n=209)	≤2	60	28.7
Number of drugs taken daily (n=209)	3–4	68	32.5
Number of drugs taken daily (n=209)	≥5	81	38.8
Always remember to take drugs (as printed)	Yes	61	29.1
Always remember to take drugs (as printed)	No	148	70.8
Always reminded to take drugs (n=148)	Yes	77	52.0
Always reminded to take drugs (n=148)	No	71	4.9

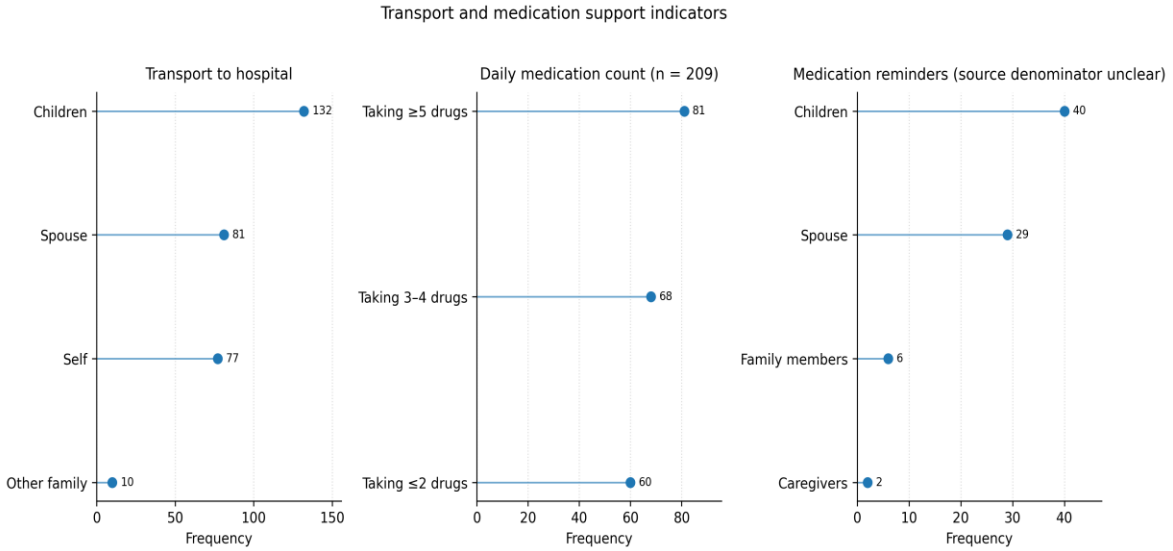


Figure 9. Selected transport, medication and support counts as reported. Different items use different denominators.

Children were the most frequently reported people accompanying respondents to hospital (132; 44.0%). Among respondents receiving medication, 81 were reported to take five or more drugs daily. The source's medication-adherence data contain serious inconsistencies: the table states that 61 respondents always remembered their medication and 148 did not, while the accompanying narrative reverses the interpretation. The reminder table also includes a percentage that does not match its frequency. These figures are retained as reported and should not be used for clinical or policy estimates until verified.

Table 9. Medication reminders, receipt of care and availability of medicines

Measure	Category	Frequency	Reported %
Person reminding respondent (source denominator unclear)	Spouse	29	37.7
Person reminding respondent	Children	40	51.9
Person reminding respondent	Family members	6	7.8
Person reminding respondent	Caregivers	2	2.6
Medical care when necessary (n=300)	Yes	184	61.3
Medical care when necessary (n=300)	No	116	38.7
Always have enough drugs (n=300)	Yes	190	63.3
Always have enough drugs (n=300)	No	110	36.7
Reason for insufficient drugs (n=110)	No money to buy	94	85.5
Reason for insufficient drugs (n=110)	No one to buy drugs	16	14.5

The table indicates that children were the most frequently reported source of medication reminders. It also reports that 110 respondents did not always have enough medicines, with lack of money accounting for 94 of these cases (85.5%). This is an important descriptive signal of affordability barriers. Nevertheless, because the manuscript contains conflicting counts for receipt of medical care and medication adherence, these results should be treated as provisional pending data validation.

5. Discussion

The most prominent finding in the source manuscript is the distribution of abuse types: emotional abuse accounts for 45.1% of the 226 reported cases, followed by financial, physical and sexual abuse. The prominence of emotional abuse is consistent with the need to look beyond visible injury when assessing older adults' safety. Verbal humiliation, threats, intimidation and coercive control may be less visible than physical violence but can undermine dignity, mental wellbeing and willingness to seek help. The WHO identifies psychological abuse as a major component of elder mistreatment internationally (WHO, 2024).

The second important theme is economic vulnerability. More than half of respondents were reported to earn no more than ₦20,000 monthly, and many depended on relatives to pay hospital bills or help them reach health facilities. The source also indicates that some respondents lacked enough money to obtain medicines. Financial insecurity can narrow an older adult's options when abuse occurs, particularly if the person who provides money, transport or medication is also the person responsible for mistreatment. This is a plausible pathway that merits investigation, not a causal conclusion demonstrated by the present descriptive data.

Household arrangements deserve similar care in interpretation. Most respondents reportedly lived with a spouse, children or other relatives, while only 3.2% were listed as living alone. Cohabitation may provide practical support and reduce isolation, but the presence of other household members does not guarantee safety. Abuse can occur within trusted relationships, and living arrangement must be examined alongside relationship quality, privacy, access to outside support and the older person's ability to make independent decisions. The source states that living status was significantly associated with abuse, but the absence of the underlying table and statistical output prevents verification of the direction or magnitude of the association.

The sample was predominantly male, and the source's concluding notes state that men were at higher risk than women. This finding differs from many service-based reports in which women constitute a large share of identified victims, although sex differences may vary by context and type of abuse. The current manuscript does not provide sex-specific abuse counts, rates or adjusted estimates. Therefore, it would be premature to conclude that men were more vulnerable in Obio/Akpor. A reanalysis should present the number and percentage experiencing each abuse type by sex, followed by unadjusted and adjusted estimates with confidence intervals.

Health needs were common, particularly hypertension, diabetes and visual impairment. These findings matter for care planning because older adults managing chronic conditions may need regular appointments, medication access and help with transport. However, the relationship between health status and abuse is complex. Poor health can increase dependence in some circumstances, while abuse itself can worsen health. Cross-sectional data cannot establish temporal order. The source's concluding claim that better health was associated with lower abuse should be supported with complete statistical results before it is retained as an inferential finding.

The Nigerian literature provides useful context but not direct validation of the Obio/Akpor estimates. Okakah et al. (2025) reported a high burden of abuse in rural Edo communities, with neglect, financial abuse and emotional abuse commonly reported and several sociodemographic associations. Ipinnimo et al. (2024) reported financial abuse and associations with age, income and education in Oye-Ekiti. Differences in settings and measurement may explain why the ordering and prevalence of abuse categories vary. Comparisons should therefore focus on shared prevention concerns and methodological transparency rather than treating percentages from different studies as directly equivalent.

A critical issue is the quality of statistical reporting in the source. Several frequency-percentage pairs do not reconcile; one narrative appears to reverse the medication-adherence categories; and the headline estimate of 226 respondents (76.4%) lacks a clear denominator. In addition, the abstract claims significant associations but provides no p-values, odds ratios or confidence intervals. Such problems do not necessarily invalidate the underlying fieldwork, but they prevent readers and reviewers from reproducing key results. Before submission to an international journal, the authors should verify the dataset, regenerate all tables directly from the analysis file and provide complete model outputs.

6. Public-health and policy implications

First, public education should make clear that emotional, financial and sexual abuse are forms of mistreatment and that older adults retain the right to dignity, privacy, informed choice and control over their resources. Community health workers, faith organisations, traditional leaders and local associations can help communicate this message without disclosing survivors' identities. Second, primary-care services should establish safe opportunities for older adults to speak privately with a health professional. Staff should be trained to recognise signs of abuse, ask non-judgmental questions, document disclosures carefully and refer people to appropriate social, legal or protection services. Referral procedures should prioritise the older person's safety and informed wishes, subject to applicable safeguarding obligations.

Third, local government and social-protection agencies should strengthen access to income support, affordable medicines, transport assistance and community-based care. Where older adults depend on relatives for essential needs, support should preserve autonomy and avoid making access to services conditional on a single family caregiver.

Fourth, family-caregiver programmes should offer practical training, respite options and information on chronic disease management. Caregiver stress may signal a need for assistance, but it must never be used to excuse violence, coercion or neglect. Programmes should also address harmful ageist beliefs and encourage respectful intergenerational relationships.

Finally, future studies should use clear definitions and validated screening tools, record the number of respondents eligible for each analysis, report non-response and missing data, and present complete cross-tabulations and regression results. Mixed-methods research could examine how older residents understand abuse, why they may not disclose it, which reporting routes they trust, and how financial dependency shapes decisions about safety.

7. Strengths and limitations

The study addresses an important and locally relevant public-health issue and includes a sample of 411 older adults, a multistage sampling approach, a pretest and reported ethical approval. It also considers demographic, household, economic and health characteristics rather than treating abuse as an isolated event. The limitations are substantial. The cross-sectional design cannot establish temporal sequence or causation. The sampling frame and ward-level selection procedures are insufficiently described to assess representativeness. The questionnaire, abuse definition and validation procedures are not fully documented. The source contains inconsistencies in counts, percentages and narrative interpretation, and the inferential results are not presented in enough detail to verify claimed associations. Some figures may reflect transcription or typesetting errors, but the correct values cannot be inferred reliably without access to the original dataset. These limitations should be resolved before peer review wherever possible.

8. Conclusion

This study describes elder abuse and selected demographic, economic and health characteristics among older adults in Obio/Akpor LGA, Rivers State. Emotional abuse was the most frequently reported category among the 226 cases used to describe abuse type, followed by financial, physical and sexual abuse. The sample also included substantial low-income and chronic-health burdens, and many respondents relied on family members for health-care costs or transport. These findings support prevention strategies that combine respectful family care, community awareness, confidential detection and referral, affordable health services and stronger social

protection.

The manuscript also reports associations between abuse and selected characteristics, including sex, marital status and living arrangement. Because the relevant statistical tables and model estimates are absent and several descriptive values conflict, those associations cannot be independently verified from the material available. The final publication version should be based on a validated dataset, with corrected denominators and complete statistical reporting. This is essential for ensuring that policy recommendations are both credible and ethically responsible.

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