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SOCIO-CULTURAL DISPOSITIONS AND ACCEPTABILITY OF INSTITUTIONAL CARE FOR THE ELDERLY IN SOUTHWESTERN NIGERIA

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Abstract
Nigeria's ageing population has increasingly exposed the limitations of traditional family-based caregiving systems. This study examined the socio-cultural factors influencing the acceptability of institutional eldercare in Southwestern Nigeria, where caregiving is traditionally regarded as a moral and familial obligation. A mixed-methods research design was adopted, combining quantitative surveys with focus group discussions and key informant interviews involving 400 participants drawn from Lagos, Ogun, and Oyo States. Quantitative data were analyzed using descriptive statistics, chi-square analysis, and logistic regression, while qualitative data were subjected to thematic analysis. Findings revealed strong cultural resistance to institutional eldercare, as 78% of elderly and 72% of family caregivers perceived care homes as inconsistent with African cultural values and family expectations. Nevertheless, changing socio-economic realities, including urbanization, migration, and increasing dual-income households, were gradually reshaping attitudes toward caregiving. More than half of caregivers (55%) and a substantial proportion of eldercare providers (80%) acknowledged that institutional care could complement family support where necessary. Educational attainment, age, and marital status significantly predicted willingness to accept institutional care ($p < .05$). Qualitative findings further indicated growing support for culturally adapted and family-inclusive models of institutional care. The study concludes that although family-based caregiving remains culturally preferred, emerging demographic and economic pressures are encouraging cautious acceptance of hybrid caregiving arrangements that integrate professional and family support. The study recommends culturally responsive eldercare policies, public sensitization programmes, and affordable institutional care frameworks to improve acceptance and service accessibility in Nigeria.

Keywords: Socio-cultural, disposition, acceptability, care.

INTRODUCTION

Life expectancy has steadily improved around the world, contributing to a rapid rise in the number of elderly. Global projections indicate that by 2050, more than two billion people will be aged 60 years and above, and close to 80% of this growth will occur in developing regions (World Health Organization, 2015). Although Sub-Saharan Africa has historically been defined by a youthful population, the region is now experiencing one of the fastest rates of

population ageing (Nzima & Maharaj, 2020). This shift has increased the urgency of developing structured eldercare systems that are capable of meeting the social, medical, and emotional needs of older people.

High-income countries such as Japan and Sweden have responded to ageing pressures by investing in formal eldercare infrastructure, subsidized nursing homes, and community-based care models (Maki & Yamaguchi, 2014; Song & Tang, 2019). By contrast, most low-income and lower-middle-income countries lack comprehensive policies, funding platforms, and formal care institutions. This is particularly evident in African countries, where reliance on family networks remains dominant despite shrinking support systems (Aboh & Druye, 2020; Nzima & Maharaj, 2020).

In Nigeria, the extended family has traditionally functioned as the primary source of support for older relatives. Cultural expectations place the responsibility for caregiving on adult children, who are morally obligated to provide emotional, physical, and financial care (Ajomale, 2007; Omotayo, 2015). However, modern socio-economic realities have weakened this traditional system. Young people migrate to urban areas in search of employment, women now participate more actively in the labour market, and most households operate under dual-income demands (Amare et al., 2021). As a result, caregiving burdens have intensified while the capacity of families to provide long-term care has declined.

Nigeria's ageing population is increasing at a rate faster than available support systems. Estimates suggest that the number of older persons will reach 16 million by 2030 and could exceed 45 million by 2060 (National Population Commission, 2009). Yet, institutional eldercare remains rare and contested. Many Nigerians perceive care homes as foreign, un-African, or disrespectful to cultural values that emphasize filial duty and communal belonging (Nmadu et al., 2018; Nwafo, 2022). Private care facilities are also expensive, leaving institutional care inaccessible to most low- and middle-income families.

Despite these cultural barriers and financial limitations, the number of private eldercare homes in Southwestern Nigeria has grown considerably in recent years, largely due to the dwindling strength of family-based caregiving. However, public attitudes toward these facilities remain poorly understood, and empirical research on cultural acceptance of institutional eldercare is limited. This study therefore investigates how traditional beliefs, economic realities, and changing family structures influence public acceptance of institutional eldercare in Southwestern Nigeria.

Although several studies have examined ageing, family support systems, and elder vulnerability in Africa, limited empirical attention has been given to how sociocultural values shape public acceptance of institutional eldercare within the Nigerian context. Existing discussions have largely focused on the welfare challenges of older persons, with insufficient emphasis on the cultural meanings attached to institutional care and how these meanings influence caregiving decisions, policy implementation, and service utilization. Furthermore, policy-oriented debates on ageing in Nigeria have paid inadequate attention to the implications of cultural resistance for the planning, regulation, and delivery of formal eldercare services.

This gap in knowledge presents significant risks for social policy and programme development. Without a proper understanding of sociocultural attitudes toward institutional care, governments and service providers may adopt eldercare models that are poorly aligned with

community expectations and local realities. Such policy misdirection can undermine utilization of care services, reinforce public distrust, and weaken the effectiveness of interventions designed to support the elderly. In addition, the failure to integrate sociocultural realities into eldercare planning may result in financially unsustainable programmes, socially rejected, or inaccessible to the populations they are intended to serve.

Against this backdrop, this study contributes to both empirical scholarship and policy discourse by examining how cultural beliefs, demographic transitions, and socio-economic pressures interact to shape the acceptability of institutional eldercare in Southwestern Nigeria. Through understanding sociocultural context, the study provides evidence that can guide the development of culturally responsive and socially acceptable eldercare policies and services in Nigeria and similar African settings.

Statement of the Problem

Although institutional eldercare facilities are gradually emerging across Southwestern Nigeria, cultural norms continue to position family caregiving as the only acceptable model. Resistance to formal care remains strong, even among households that are no longer able to meet the daily needs of older relatives. Many families struggle with work obligations, health challenges, financial strain, or geographic separation, yet still avoid considering institutional care due to stigma and cultural judgment.

With limited scholarly evidence in Nigeria on how sociocultural values shape acceptance of care homes, policymakers and practitioners lack the information needed to design culturally appropriate eldercare interventions. The absence of research-driven insights restricts planning for ageing populations and weakens advocacy for regulated, affordable institutional care models. This study addresses that gap by interrogating the cultural, social, and demographic factors influencing public attitudes toward institutional eldercare in Southwestern Nigeria.

Objectives of the Study

The study was designed to:

1. Examine how cultural norms, beliefs, and family expectations influence perceptions of institutional eldercare in Southwestern Nigeria.
2. Identify the socio-demographic predictors of willingness to accept institutional eldercare among elderly individuals, caregivers, and eldercare professionals.
3. Explore how urbanization, migration, and economic pressures are reshaping caregiving practices.
4. Recommend culturally responsive strategies that could improve public acceptance of institutional care.

THEORETICAL FRAMEWORK

This study is anchored on four complementary theoretical perspectives that help explain how cultural values, family roles, and social changes shape attitudes toward institutional eldercare in Southwestern Nigeria.

Modernization Theory argues that economic development, urban growth, and changing family structures weaken traditional care arrangements. In the Nigerian context, labour mobility, smaller household sizes, and migration have reduced the availability of full-time caregivers within the home. Although these changes create space for institutional eldercare, deeply rooted cultural values still generate resistance to it.

Role Theory highlights socially assigned responsibilities within families, especially the expectation that children, often women, should care for ageing parents. The conflict between traditional caregiving roles and the reality of dual-income households helps explain why

many families experience guilt or social pressure when considering institutional care, even when it becomes necessary.

The Cultural Relativity Perspective emphasizes the need to understand eldercare within local norms and cultural meanings. In many Nigerian communities, caring for elders is closely tied to identity, spirituality, and family honour. As a result, placing older persons in care homes is often viewed as a sign of disrespect or abandonment, regardless of the caregiver's capacity or intentions.

Finally, Social Exchange Theory focuses on reciprocity in family relationships—elders cared for their children, so children are expected to return that support in old age. However, when distance, work demands, or limited resources disrupt this reciprocity, institutional care becomes a practical supplement. Hybrid models that integrate family involvement with formal care reflect a gradual re-negotiation of these social expectations.

Together, these theories provide a useful lens to interpret why resistance persists, why attitudes vary across age groups, and why institutional eldercare is expanding despite cultural opposition.

LITERATURE REVIEW

Traditional Family-Based Eldercare in Africa

Across Africa, the family has long been regarded as the natural and primary support system for older relatives. Eldercare is often understood as a duty rooted in kinship, spirituality, and communal identity (Ajomale, 2007; Omotayo, 2015). Parents nurture children in early life, and children are expected to return that care as their parents age—a reciprocal relationship that reinforces family bonds and social continuity.

Research from Ghana, Nigeria, and Cameroon shows that older persons rely heavily on children and extended family for emotional companionship, financial support, and help with daily activities (Nangia, 2016; Mesi et al., 2021). Women, particularly daughters, frequently shoulder the majority of caregiving tasks, reflecting longstanding gendered social roles across African societies (Schatz & Seeley, 2015).

However, the sustainability of family-based care has weakened due to widespread socio-economic change. Urban migration, rising living costs, and the breakdown of extended family households have left many elderly without dependable support systems. Studies report that younger adults often migrate for employment, leaving behind ageing parents with limited assistance (Amare et al., 2021). Dual-income households also reduce the time available for caregiving, forcing families to explore other options.

While family care remains culturally idealized, its limitations are increasingly evident. In response, some communities have adopted emerging alternatives such as community elder centres, paid caregivers, or informal group support networks (Palmer et al., 2014; Mesi et al., 2021). These developments indicate a slow shift from purely family-based care toward more structured arrangements.

Emergence of Institutional Eldercare in Africa

Formal eldercare institutions are becoming more visible in several African countries, particularly in urban areas where traditional support structures have weakened. Historically, such facilities were criticized as Western imports that clashed with African norms

(Lombard & Kruger, 2009; Ramaboa & Fredericks, 2020). Yet, rising demand, driven by increased life expectancy and chronic health conditions, has made professional care unavoidable (Dawud et al., 2022; Kraus & Riedel, 2022).

In Ghana and Nigeria, private facilities now cater to families who cannot provide full-time support at home. These institutions offer services ranging from personal care to medical supervision. However, they are often expensive and operate with wide variation in quality due to weak regulation (Nwafo, 2022; Mbam et al., 2022). Public facilities remain inadequate, leaving most elderly without formal care options.

Evidence from Tanzania, South Africa, and Cameroon indicates that hybrid models, where families remain involved while institutions provide professional support, are gaining traction as a culturally acceptable compromise (Mesi et al., 2021; Nzima & Maharaj, 2020). This transition highlights how institutional care is adapting to African cultural contexts rather than replacing tradition.

Cultural Resistance to Institutionalization

Despite growing need, institutional eldercare continues to face strong resistance in most African societies. The elderly often fear isolation, loss of identity, and disconnection from family. Families themselves worry about community judgment, viewing institutional care as a sign of irresponsibility or moral failure (Nmadu et al., 2018; Nwafo, 2022). In some cases, the stigma is so strong that families prefer inadequate home arrangements over seeking professional support.

Pilot studies in Nigeria and Ghana show that acceptability improves when cultural elements—such as communal dining, traditional food, religious practices, and open visitation—are incorporated into care facilities (Mesi et al., 2021; Nzima & Maharaj, 2020). These adaptations help reduce stigma by showing that institutional care can align with cultural values rather than oppose them.

METHODOLOGY

This study employed a mixed-methods approach, integrating both quantitative and qualitative strategies to provide a comprehensive assessment of socio-cultural attitudes toward institutional eldercare in Southwestern Nigeria. The quantitative component consisted of a cross-sectional survey that allowed for the collection of measurable data on perceptions, while the qualitative aspect, comprising focus group discussions (FGDs) and in-depth interviews, captured deeper contextual insights, lived experiences, and cultural nuances surrounding caregiving.

The research targeted populations across Lagos, Oyo, and Ogun States, which represent major socio-economic and cultural hubs in Southwestern Nigeria. Participants were drawn from three main groups: elderly (aged 60 years and above), family caregivers, and institutional eldercare workers. Policymakers, community leaders, and health professionals involved in the care of the elderly were also engaged as key informants. Participants were selected based on clearly defined inclusion criteria. Elderly individuals included in the study were aged 60 years and above who were either living within communities or receiving support from institutional care settings. Family caregivers were adults directly involved in providing physical, emotional, or financial support to older relatives for at least six months before the study. Institutional eldercare workers comprised professional and non-professional staff employed within registered care facilities, while key informants included policymakers, healthcare professionals, and community

leaders with knowledge of ageing and eldercare practices in the study locations.

The study population reflected diverse demographic backgrounds in terms of gender, marital status, educational attainment, occupation, and residential location (urban and rural communities). This diversity enhanced the representativeness of the findings and strengthened the contextual understanding of attitudes toward institutional eldercare in Southwestern Nigeria. These states were purposely selected because they contain both urban and rural communities, as well as a growing number of institutional care facilities. A multistage sampling process was adopted. First, states were stratified into urban and rural areas. Next, care institutions and communities were deliberately chosen to ensure representation across diverse social settings. Using Cochran's formula for sample determination, a total of 400 participants were selected, including: 200 elderly, 120 family caregivers, 50 institutional eldercare workers, and 30 key informants. This sample size strengthened the representativeness and statistical reliability of the findings.

Two main instruments were used. For the quantitative phase, a researcher-designed questionnaire, the Institutional Care Disposition and Acceptability Questionnaire (ICDAQ), was administered. The instrument captured demographic details, cultural perceptions, attitudes toward institutional care, and predictors of acceptability. To ensure content and contextual validity, the questionnaire was subjected to expert review by specialists in gerontology, social work, sociology, and research methodology. Their feedback guided revisions to question clarity, cultural sensitivity, language appropriateness, and contextual relevance to Nigerian caregiving realities.

A pilot study involving 30 participants from a neighbouring community outside the main study locations was conducted before the main data collection. Findings from the pilot exercise helped refine ambiguous items, improve question sequencing, and assess the appropriateness of culturally sensitive concepts relating to family responsibility, ageing, and institutional care.

Because many participants were more comfortable communicating in indigenous languages, the questionnaire and interview guides were translated into Yoruba and back-translated into English to ensure consistency of meaning. Research assistants fluent in English, Yoruba, and Pidgin English assisted during administration to improve comprehension and cultural appropriateness. Certain terminologies associated with institutional care were simplified and contextualized to align with local understandings and avoid negative or stigmatizing interpretations. Content validity was ensured through expert review, and reliability testing produced a Cronbach's alpha coefficient of 0.82, indicating high internal consistency.

For the qualitative phase, a semi-structured interview guide was developed for FGDs and in-depth interviews. The guide explored cultural meanings attached to caregiving, personal experiences, and opinions about institutional eldercare models.

Data collection spanned a period of three months. Trained research assistants administered questionnaires in person to improve clarity and ensure full completion. FGDs and interviews were conducted in English, Yoruba, or Pidgin depending on participant preference. All sessions were audio-recorded with permission and later transcribed. Additional field notes captured non-verbal cues and contextual observations.

Quantitative data were processed using the Statistical Package for Social Sciences (SPSS) version 26. Descriptive statistics (frequencies, means, and percentages) summarized respondent characteristics, while chi-square tests and binary logistic regression identified relationships between socio-demographic variables and institutional care acceptability.

Qualitative transcripts underwent thematic content analysis, allowing recurring patterns and themes to emerge. Findings from both strands were triangulated to provide a balanced interpretation.

RESULTS AND FINDINGS

Demographic Characteristics of Respondents

The study categorized participants into three groups: elderly, family caregivers, and institutional eldercare providers. A total of 200 elderly participants participated, representing both community-dwelling and institutionalized individuals. As shown in **Table 1**, most respondents were female (55%) and between 60–69 years (51%). Roughly one-third (30%) had no formal education, while half were currently married. These features reflect the diversity of the ageing population in Southwestern Nigeria.

Table 1: Demographic Characteristics of Elderly Respondents

Variable	Frequency (n=200)	Percentage (%)
Gender		
Male	90	45.0
Female	110	55.0
Age		
60–69 years	102	51.0
70–79 years	68	34.0
80+ years	30	15.0
Educational Level		
No formal education	60	30.0
Primary education	80	40.0
Secondary education	40	20.0
Tertiary education	20	10.0
Marital Status		
Married	100	50.0
Widowed	80	40.0
Single/Divorced	20	10.0

The mean age of the older adult respondents was 71.4 years (SD = 8.2), indicating that the study largely captured perspectives from individuals in the early-to-middle stages of old age. The dominant age category was 60–69 years, which accounted for slightly over half of the elderly participants. This age distribution is important because attitudes toward institutional eldercare may vary across stages of ageing, health dependency, and social support needs.

Among the 120 family caregivers (**Table 2**), the majority were women (58.3%) aged between 40–59 years (54.2%). More than two-thirds (66.7%) were married, and 41.7% had attained at least secondary education. This suggests that caregiving responsibilities primarily fall to middle-aged women balancing work and domestic duties.

Table 2: Demographic Characteristics of Family Caregivers

Variable	Frequency (n=120)	Percentage (%)
Gender		
Male	50	41.7
Female	70	58.3
Age		
20–39 years	40	33.3
40–59 years	65	54.2
60+ years	15	12.5
Educational Level		

No formal education	10	8.3
Primary education	30	25.0
Secondary education	50	41.7
Tertiary education	30	25.0
Marital Status		
Married	80	66.7
Single/Divorced	40	33.3

The mean age of family caregivers was 46.8 years (SD = 9.5), reflecting the concentration of caregiving responsibilities among economically active adults who often combine caregiving with employment and family obligations.

The 50 eldercare providers (**Table 3**) were largely female (60%), within the 30-39-year age bracket (50%), and highly educated (80% possessed tertiary qualifications). Half of them had 5-10 years of experience, indicating a moderately skilled workforce within the institutional care sector.

Table 3: Demographic Characteristics of Institutional Eldercare Providers

Variable	Frequency (n=50)	Percentage (%)
Gender		
Male	20	40.0
Female	30	60.0
Age		
20-29 years	15	30.0
30-39 years	25	50.0
40+ years	10	20.0
Educational Level		
Secondary education	10	20.0
Tertiary education	40	80.0
Years of Experience		
Less than 5 years	20	40.0

The mean age of institutional eldercare providers was 35.6 years (SD = 6.4), suggesting that the professional care workforce is relatively young and potentially more receptive to emerging formal caregiving models.

Gender and Attitudes toward Institutional Care

Gender differences significantly influenced perceptions of institutional eldercare. Of the elderly respondents, 45% were male and 55% female. A larger proportion of women (60%) expressed disapproval of institutional eldercare, viewing it as inconsistent with traditional values, while half of the male respondents were neutral or supportive.

A chi-square analysis confirmed a statistically significant relationship between gender and attitude toward institutional care (χ^2 (2) = 15.34, $p < .05$). Qualitative findings supported this pattern: female participants repeatedly described caregiving as a moral responsibility, with statements such as, *"As daughters, it's our duty to care for our parents; sending them away would bring shame."* Conversely, male respondents tended to adopt a pragmatic stance, citing time and work constraints: *"I can't be home all day; a care facility might be more practical."*

Age and Acceptability of Institutional Care

Age was also found to be a strong predictor of acceptance. As displayed in **Table 4**, respondents aged 80 years and above were the most supportive of institutional care (55%), whereas those between 60–69 years were most resistant (50%). Logistic regression indicated that older age significantly increased the likelihood of acceptance ($\beta = 0.48$, $p < .01$).

Table 4: Age and Acceptability of Institutional Eldercare

Age Group (Yrs)	Positive (%)	Neutral (%)	Negative (%)
60-69	30.0	20.0	50.0
70-79	40.0	15.0	45.0
80+	55.0	10.0	35.0

Older respondents explained that they did not wish to burden their families: *"I would rather be cared for professionally than trouble my children."* In contrast, younger elderly participants feared separation: *"A home would feel like exile from my family."*

Education, Marital Status, and Cultural Beliefs

Educational attainment correlated strongly with openness to institutional care. Participants with tertiary education were substantially more accepting (70%) than those without formal schooling (25%). The relationship between education and attitude was statistically significant (χ^2 (3) = 21.56, p < .01). Those with higher education levels tended to associate institutional care with professionalism and modern healthcare.

Similarly, marital status shaped acceptance; widowed respondents (60%) were more willing than married ones (40%), likely due to loneliness and absence of spousal support (β = 0.32, p < .05). Qualitative excerpts underscored these sentiments: *"I live alone now; being in a care centre would help me socialize,"* said one widowed participant.

Cultural beliefs continued to act as a major barrier. Nearly three-quarters (74.8%) viewed institutional care as contrary to African traditions, although 58.4% conceded that it could complement family caregiving if properly adapted. Focus group narratives revealed three dominant themes: moral duty, erosion of family bonds, and acceptance as a last resort. A caregiver remarked, *"Leaving parents to strangers is a moral failure,"* while another commented, *"If such facilities reflected our culture, they might be acceptable."*

Sociocultural Disposition toward Institutional Eldercare

Across respondent categories, attitudes reflected strong family and communal values (**Table 5**). Ninety percent of older participants and 85% of caregivers believed family care remained the ideal. However, 55% of caregivers and 80% of providers agreed that institutional care could complement home support. Elders emphasized love and gratitude as reasons for keeping care within the family, while caregivers acknowledged increasing difficulty in meeting obligations due to work and economic demands. Care providers presented the most pragmatic outlook, describing institutional care as *"a support system, not a replacement."* Overall, findings suggest a gradual shift from absolute resistance to cautious acceptance, particularly among younger and urban populations.

Table 5: Sociocultural Disposition

Statement	Elderly Individuals (n=200)	Family Caregivers (n=120)	Elder care Providers (n=50)
"Family care is the ideal for elderly care."	90.0%	85.0%	50.0%
"Institutional care is un-African."	78.0%	72.0%	40.0%
"Institutional care can complement family care."	45.0%	55.0%	80.0%

Cultural Resistance to Institutional Care

Cultural opposition persisted across groups, as indicated in **Table 6**. Over 70% of elderly and caregiving respondents agreed that institutionalizing elders brought shame to families, compared with 40% of care providers. The elderly expressed fears of disconnection from family and heritage: *"A care home would make me feel forgotten,"* one respondent explained.

Family caregivers highlighted community judgement: *"People would think we abandoned our parents."* Providers, however, argued that their services bridge existing gaps, not replace families. Many facilities integrate communal dining, worship, and traditional activities to mitigate stigma, which some participants acknowledged as helpful.

Table 6: Cultural Resistance

Statement	Elderly Individuals (n=200)	Family Caregivers (n=120)	Eldercare Providers (n=50)
"Using institutional care brings shame to the family."	75.0%	68.0%	40.0%
"Placing elders in care homes signifies neglect."	72.0%	65.0%	35.0%
"Care homes disconnect elders from their roots."	80.0%	75.0%	50.0%

Changing Societal Dynamics and Caregiving Capacity

Urbanization, economic strain, and migration have reshaped family caregiving roles. As shown in **Table 7**, 80% of caregivers and 72% of the elderly agreed that urbanization weakens family caregiving. Dual-income employment was cited by 75% of caregivers and 70% of providers as a key limitation. Qualitative data further illustrated these pressures. One caregiver confessed, *"Our work schedules make it almost impossible to provide full-time care."* Older participants lamented isolation caused by migration: *"My children live far away; they can't visit often."* Providers saw these shifts as justification for formal support: *"Urban families need care partners, and that's what we offer."*

Table 7: Changing Societal Dynamics

Statement	Elderly Individuals (n=200)	Family Caregivers (n=120)	Elder Care Providers (n=50)
"Urbanization has weakened family caregiving."	72.0%	80.0%	65.0%
"Dual-income households reduce caregiving capacity."	60.0%	75.0%	70.0%
"Traditional family values around eldercare are declining."	55.0%	68.0%	50.0%

Acceptability of Institutional Eldercare

Acceptance levels varied notably among the three categories (**Table 8**). Only 15% of elderly respondents considered institutional care highly acceptable, compared to 25% of family caregivers and 60% of eldercare providers. More than half of elderly respondents (55%) completely rejected institutionalization, mainly for cultural and emotional reasons. Caregivers displayed moderate openness, often describing institutional care as *"a last resort."* Providers expressed strong advocacy for their facilities, noting benefits such as social interaction, medical monitoring, and reduced family stress.

These variations underline the generational and experiential divide shaping perceptions of eldercare in Nigeria.

Table 8: Institutional Care Acceptability

Level of Acceptability	Elderly Individuals (n=200)	Family Caregivers (n=120)	Elder care Providers (n=50)
Highly Acceptable	15.0%	25.0%	60.0%
Moderately Acceptable	30.0%	45.0%	35.0%
Not Acceptable	55.0%	30.0%	5.0%

DISCUSSION

The findings of this study illuminate the complex relationship between traditional family values, socio-economic realities, and the emerging discourse on institutional eldercare in Southwestern Nigeria. Despite gradual shifts in social and economic structures, the preference for home-based care remains deeply embedded in Nigerian culture. This is consistent with the broader African narrative, where filial duty and communal solidarity are regarded as moral imperatives (Nzima & Maharaj, 2020; Nwafo, 2022).

The results reveal that cultural beliefs remain a primary determinant of resistance to institutionalization. Most participants considered caring for ageing parents a moral responsibility, not merely a family choice. Such sentiments reinforce earlier studies in Ghana, Cameroon, and South Africa, which reported similar resistance driven by the symbolism of family honour and collective responsibility (Mesi et al., 2021; Lombard & Kruger, 2009). For many respondents, sending an elderly person to a care facility equates to abandoning one's cultural identity, even when such facilities might offer better professional care.

However, the evidence also points to subtle but significant transformations in attitudes. Younger caregivers and institutional staff were notably more accepting of eldercare facilities. This generational divide underscores the effect of modernization and changing family dynamics, which have redefined caregiving capacities. Urbanization, migration, and increased female labour participation have eroded the traditional extended-family system and reduced the availability of unpaid family carers. Similar trends have been documented in Kenya and Ethiopia, where young adults' migration to urban centres has weakened inter-generational support systems (Amare et al., 2021; Nangia, 2016).

The influence of education also emerged strongly: respondents with higher educational attainment demonstrated greater openness toward institutional care. Education appears to moderate cultural rigidity by exposing individuals to new caregiving paradigms and professional service models. This finding aligns with research from Tanzania and South Africa showing that formal education and social exposure correlate positively with acceptance of alternative eldercare arrangements (Ramaboa & Fredericks, 2020; Mwaikuka et al., 2023).

Gender dynamics likewise shaped perceptions. Women, traditionally expected to provide care, were more resistant to institutional options than men, reflecting the persistence of gendered caregiving expectations. As female labour force participation increases, however, this norm is being challenged. Several women in this study acknowledged the strain of balancing employment with caregiving, echoing findings by Schatz and Seeley (2015), who observed that caregiving burdens among African women often result in stress and financial hardship.

Economic constraints further complicate attitudes toward eldercare institutions. Many participants expressed willingness to consider formal facilities if they were affordable and culturally sensitive. This mirrors findings from other low- and middle-income countries where cost remains a major barrier to care utilization (Kraus & Riedel, 2022). Without government support or subsidized services, institutional eldercare in Nigeria will likely remain accessible only to high-income families, perpetuating inequality among ageing populations.

Cultural resistance also stems from the fear that institutional settings isolate elders from familiar environments and community networks. Yet, the study found increasing recognition, particularly among caregivers and professionals, that institutional care can complement family efforts rather than replace them. This perspective corresponds with Nzima and Maharaj's (2020) concept of "blended care models," which advocate integrating professional support within culturally acceptable frameworks.

The pattern that emerges, therefore, is not one of total rejection but of cautious adaptation. Families are beginning to reconcile cultural expectations with contemporary realities by exploring hybrid caregiving arrangements. Facilities that incorporate traditional foods, religious activities, and opportunities for family visitation are seen as more acceptable. This demonstrates the potential for culturally responsive institutional models to bridge the gap between heritage and practicality.

In sum, the discussion highlights three key insights. First, cultural norms continue to exert dominant influence on eldercare choices, but economic and demographic pressures are gradually reshaping these preferences. Second, the generational divide between younger caregivers and the elderly signals a slow but steady evolution in social thinking about ageing. Third, education and exposure to professional care models can accelerate the acceptance of institutional eldercare, provided such services are designed to respect community values and affordability constraints.

CONCLUSION AND RECOMMENDATIONS

Conclusion

This study examined the socio-cultural underpinnings that influence the acceptability of institutional eldercare in Southwestern Nigeria. The findings reveal a strong cultural commitment to family-based caregiving, shaped by moral, religious, and communal values that view eldercare as a sacred duty. Despite this, growing urbanization, migration, and economic pressures have eroded the capacity of families to provide consistent and adequate care. As a result, institutional eldercare is slowly emerging as an alternative, though still contested, model of support for older persons.

The research underscores that resistance to institutional care stems largely from its perceived contradiction with African values of kinship and filial responsibility. Yet, the data also show a gradual softening of this resistance, particularly among younger caregivers, educated respondents, and professional care providers. This evolving outlook reflects the changing social fabric of Nigerian society, where economic necessity and exposure to modern caregiving methods are driving re-evaluation of traditional norms.

Institutional eldercare, when integrated with cultural practices and community participation, has the potential to complement family-based systems rather than displace them. Therefore, sustainable eldercare policy in Nigeria must pursue a dual path: protecting cultural ideals of

family solidarity while developing affordable, professionally managed care institutions.

Policy Implications and Recommendations

Arising from the findings of this study, the following policy implications and recommendations were proposed:

1. Eldercare facilities should consciously incorporate indigenous practices, such as communal dining, traditional ceremonies, and religious observances, to maintain cultural familiarity and emotional comfort for residents. Doing so will help reduce the perception that institutional care is "un-African."
2. National and state agencies should sponsor education campaigns to correct misconceptions that institutional care represents family neglect. Messaging should reframe care homes as *complementary* supports rather than replacements for family involvement.
3. The government should establish a dedicated regulatory authority for eldercare services to ensure licensing, monitoring, and compliance with minimum standards. Consistent oversight will build public confidence and protect residents' welfare.
4. Institutional care should be made accessible to low- and middle-income households through public-private partnerships, subsidies, or sliding-scale payment systems. Tax incentives for families supporting elderly relatives can further reduce the financial burden of care.
5. Investment in the training of geriatric social workers, nurses, and caregivers is vital for service quality. Professional education programmes and continuous skill development should be integrated into Nigeria's higher-education and vocational systems.
6. National policies should align with global frameworks such as the WHO's *Decade of Healthy Ageing (2021-2030)*, adapting their principles to local cultural realities.
7. State governments should establish community-based day care centres where the elderly can receive daytime care, meals, recreation, and basic healthcare before returning home to their families. This hybrid model may reduce caregiving pressure while preserving family bonds.
8. Eldercare facilities should adopt family-inclusive care models that encourage regular visitation, shared caregiving, and family participation in decision-making. This may help reduce the stigma associated with institutional care.
9. Government and non-governmental organizations should integrate eldercare services into existing community structures such as churches, mosques, community associations, and primary healthcare centres to improve awareness, accessibility, and cultural acceptance.
10. Caregiver support and respite programmes should be introduced to provide counselling, temporary relief services, and financial support for family caregivers experiencing stress and burnout.
11. State governments should establish affordable pilot eldercare facilities through public-private partnerships, particularly in rapidly urbanising areas, to improve public trust and demonstrate culturally responsive care models.
12. Professional social workers should play a greater role in eldercare planning, counselling, advocacy, family mediation, and community sensitization to bridge the gap between traditional family care and formal support systems.

Contribution to Knowledge

The findings of this study reveal a critical tension between enduring African cultural expectations surrounding family caregiving and the growing socio-economic realities that

increasingly limit families' ability to provide full-time care for the elderly. While institutional eldercare continues to face considerable cultural resistance, particularly among elderly and traditional caregivers, the evidence suggests that attitudes are gradually shifting in response to urbanization, migration, changing family structures, and economic pressures.

The central argument emerging from this study is that institutional eldercare in Nigeria cannot succeed through the wholesale adoption of Western care models alone; rather, acceptance depends on the extent to which formal care systems are culturally adapted, family-inclusive, affordable, and socially legitimized. The study therefore advances knowledge by demonstrating that sociocultural context remains a decisive factor in shaping eldercare preferences, utilisation, and policy acceptance in African societies.

From a policy perspective, the findings underscore the importance of developing culturally responsive eldercare frameworks that integrate professional support with traditional family participation. Failure to recognize these sociocultural realities may lead to poorly designed interventions, low utilisation of formal services, and public resistance to ageing policies. For practice, the study highlights the need for social workers, healthcare professionals, and care providers to adopt culturally sensitive approaches that preserve the elderly's sense of identity, dignity, and belonging while addressing growing care demands.

The study contributes to emerging African gerontological scholarship by providing empirical evidence on how culture, modernisation, and caregiving transitions intersect to shape the future of eldercare in Nigeria.

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