

High Spiritual Needs and Associated Factors Among Older Adults in a Nigerian Primary Care: Relevance for Holistic Geriatric Practice

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Research Article

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Abstract

Background: Older adults often experience complex health challenges that heighten their spiritual needs, which are essential to holistic care yet, largely unaddressed in primary care.

Method: This mixed-method convergent parallel study assessed spiritual needs and associated factors like depression, anxiety, chronic medical conditions, quality of life (QoL), and satisfaction with care among consenting adults aged 60 years and above attending the primary care clinics of the University of Ilorin Teaching Hospital, Nigeria. The quantitative component involved 280 participants selected through systematic random sampling, while 20 purposively selected participants took part in in-depth interviews. Data were collected using interviewer-administered semi-structured questionnaires: the Spiritual Needs Questionnaire, Hospital Anxiety and Depression Scale, Service Quality tool, and WHOQOL-BREF. Quantitative data were analysed using SPSS version 27, with chi-square tests and multivariate logistic regression at a significance level of $p < 0.05$. Qualitative data were analysed thematically using Atlas.ti.

Results: Prevalence of spiritual needs was 75.0%, especially in the religious domain. Statistically significant associations were found between spiritual needs and anxiety ($p = 0.045$), health satisfaction ($p = 0.023$), overall QoL ($p < 0.001$), and geriatric syndromes ($p = 0.037$). The predictors were age ($OR = 7.198$), overall QoL ($OR = 1.835$), presence of geriatric syndromes ($OR = 1.858$), and satisfaction with usual care ($OR = 0.266$).

Qualitative findings revealed spirituality as a central coping resource linked to healing and resilience, yet unaddressed in clinical practice. Participants recommended integrating spiritual care into geriatric services.

Conclusion: Primary care older adults have high prevalence of unmet spiritual needs and incorporating spiritual care into primary care practice may improve holistic outcomes and patient satisfaction.

BACKGROUND

Globally, the population is undergoing a rapid demographic shift, with an increase in the older adult population. The proportion of people aged 60 years and above is expected to double from 12 percent in 2015 to 22 percent by 2050, exceeding 2 billion [1]. This ageing population is occurring more rapidly in developing countries such as Nigeria than in developed countries [1]. Nigeria, the most populous black nation in the region, currently has the largest aging population in Africa, with an estimated projection of more than 25 million adults aged 60 years and older by 2050 [2].

Ageing is usually associated with multidimensional, complex and interconnected challenges that span from physical, psychological, social, and economic domains to spiritual domains [3].

Physically, aging predisposes people to chronic diseases, multimorbidity, and functional and cognitive declines that increase dependency [4,5]. Other physical challenges include nutritional problems, sensory impairments and polypharmacy arising from multimorbidity [4,6].

The psychological challenges common in older adults include depression and anxiety, which are usually associated with isolation, declining health status, financial challenges and bereavement [5,7,8]. The challenges of the spiritual dimension include existential issues, the search for meaning in life, end-of-life issues, and unmet spiritual needs. Others included loss of self-esteem, adjustment difficulties and fear of dependency. However, social challenges include loneliness, social isolation, ageism, elder abuse and neglect, as well as a decline in the traditional family structure of care and support [7,9]. The economic challenges associated with aging expose older adults to poverty, unemployment and lack of social security, especially in African countries such as Nigeria [7,9]. The challenges of the spiritual dimension include existential issues, the search for meaning in life, end-of-life issues, and unmet spiritual needs. All these problems pose unique challenges for the health care system, particularly in developing countries such as Nigeria[2,10]. The interplay of all these challenges affects the overall health, quality of life, and well-being of older adults [3]. As such, the need for integrated, comprehensive and holistic care that involves more than just physical treatment becomes obvious [3].

Recently, holistic care approaches have emerged as evidence-based strategies for addressing these multifaceted health challenges in older adults through comprehensive, person-centered interventions that go beyond traditional disease-focused models [3,11]. Holistic geriatric care refers to a comprehensive and person-centered care approach that integrates physical, psychological, social, cultural, and spiritual needs with medical management [1,3]. It addresses all aspects of an older adult's well-being rather than just treating isolated medical conditions by recognizing the complex, multifaceted needs of older individuals, as it aims to promote healthy aging, enhance independence, and improve overall quality of life [3,12,13]. It is associated with evidence-based favorable health outcomes such as better medication adherence, a reduction in emergency room visits, a reduction in fall risk and related injuries, improved mobility, increased quality of life and improved patient satisfaction. [4,14]

However, despite being a crucial aspect of holistic care, especially in the face of aging, ill health, suffering, and end of life, the spiritual dimension of holistic care is often overlooked. However, spirituality is an important dimension of humanity that is just as important as physical and psychosocial dimensions [3]. Studies have demonstrated that older adults exhibit more spiritual and religious tendencies as they age, as well as having increased need and desire for spiritual attention [16,17,18]

Oz (2022) demonstrated in a study that older people desire that their health care providers discuss and show more concern for their spirituality[19]. A review by Pearce (2013) revealed that as many as 41-94.0% of elderly people prefer medical professionals to address their spiritual needs, which they unfortunately fail to do[20].

Spiritual needs can be described as the inner search for meaning, life purpose, transcendence, and connection with something larger than oneself [21,22]. It is the externalization of an individual's current spiritual state [21,22]. Spiritual needs are the internal desires of an individual for meaning, purpose, connectedness, transcendence, inner peace, and a relationship with the sacred or divine, especially in times of suffering, illness, aging or end of life. They manifest as longing for religious practices,

existential reflection, reconciliation, emotional comfort, or opportunities to give and receive compassion. In the context of healthcare and elderly care, they support a patient's spiritual well-being, help them cope with suffering, maintain dignity, and foster hope. It has been noted that all individuals have spiritual needs, although their manifestations and priorities vary[23].

In older adults, spiritual needs are exaggerated and become more pronounced as they face life transitions, declines in physical health and functions, and end-of-life issues. Bussing et al. (2021) emphasized that spiritual needs are particularly important to elderly people, especially those faced with frailty and mortality, according to their book titled "Spiritual needs in research and practice" [24].

Addressing the spiritual needs of patients has consistently been shown in studies to be positively associated with better health and better end-of-life outcomes [18,25,26,27]. Conversely, poor quality of life and well-being have been linked to inattention given to patients' unmet spiritual needs [26]. Findings from the literature have shown that the majority of patients with serious illnesses (71–99.0%) value spirituality, and the majority of these patients (50–96.0%) want spiritual care [26].

Over the years, the World Health Organization (WHO) and the World Organization of Family Doctors (WONCA), as well as other bodies, have included spiritual care as a significant aspect of healthcare, particularly in the definitions of palliative care and primary care, respectively [28]. The WHO and WONCA have independently recommended that routine management of primary care patients, including older persons, be patient-centered and holistic by incorporating spiritual care [29]. However, there is a scarcity of Nigerian and SSA data on the prevalence and type of spiritual needs of primary care older adults in this region, which can inform clinicians on the best approach to adopt these WHO and WONCA recommendations. This is an issue that necessitates the current study to bridge this gap in knowledge.

This study aimed to assess the spiritual needs and associated factors for holistic care of older adult patients seen in primary care settings in UITH, Ilorin, and Nigeria, with the aim of bridging the existing gaps in knowledge and providing actionable insights for improving the holistic well-being and health outcomes of this patient population.

METHODOLOGY

The study was a hospital-based convergent parallel mixed method design study. The study was carried out at the adult male and female clinics in the General Outpatient Clinic (GOPC) of the Family Medicine Department of the University of Ilorin Teaching Hospital (UITH), Ilorin, Kwara State, Nigeria. Ethical approval for the study was obtained from the Ethical Review Committee of the University of Ilorin Teaching Hospital. The study population consisted of all older adult patients aged 60 years and older who presented at the GOPC for their usual care. Older adult patients who presented with serious conditions requiring emergency attention and who were too sick to correctly respond to the questions were excluded from the study.

The sample size for the quantitative analysis was determined using Cochran's sample size formula for populations less than 10,000. A total of 280 consenting older adult patients who met the inclusion criteria were recruited for the study. The respondents were selected using the systematic random sampling method. Recruitment was performed only within the official working hours of 8 am to 4 pm, five days a week (excluding weekends). The questionnaires for data collection were pretested by administering them to 30 older adult patients at the state General Hospital in Ilorin (which is approximately 10% of the study sample size). The study instrument used was a semistructured interviewer-administered questionnaire divided into three sections, A–C; section A included sociodemographic characteristics, section B included medical history, and section C collected data on patients' spiritual needs, quality of life, anxiety, depression, and level of satisfaction. The validated standardized tools included the Spiritual Needs Questionnaire (SpNQ-20), the Brief Version of the WHO Quality of Life Questionnaire (WHO QoL Bref), the Hospital Anxiety and Depression Scale (HADS), and the Service Quality Questionnaire (SERVQUAL).

For qualitative reasons, respondents were selected purposively from the consenting older adult patient pool in the clinics who met the inclusion criteria. A total of twenty consenting older adult patients were thus recruited. An interview guide with open-ended questions was used to explore spirituality, spirituality in the context of health and healthcare, satisfaction with care when spirituality is considered, and perceptions of integrating spirituality into healthcare. In-depth interviews lasted for approximately 40 minutes. All transcripts were anonymised and stored securely.

Quantitative data were analyzed using the SPSS version 27 statistical software package. Descriptive statistics were employed by way of frequencies, means, and standard deviations to ascertain proportions and patterns of spiritual needs, QoL, depression, anxiety, and level of satisfaction with usual care. Associations between categorical variables (such as spiritual needs and overall QoL, spiritual needs and depression/anxiety) were obtained by the chi-square test, and the p value was set at <0.05 for statistical significance. Multiple regression analysis was used to eliminate the effect of confounders and thus ascertain genuine statistical associations and predictors of spiritual needs among the older adult study participants.

The qualitative data were analyzed using reflexive thematic analysis as described by Braun & Clarke (2021), which provides a systematic and flexible framework for identifying, analyzing, and interpreting patterns of meaning across participants' narratives [30]. The qualitative data management software ATLAS.ti was used to support the coding and organization of the data and for analysis.

RESULTS

A total of 280 respondents aged 60 to 95 years with a mean age of 69 ± 6.99 years participated in the study. There were twice as many females (67.1%) than males (32.9%), and the majority (89.6%) were Yorubas by tribe. A total of 62.9% were Muslims, and 35.4% were Christians. In terms of marital status, there were more married (63.2%) than widowed (31.4%) participants, with just 2.5% of them being single.

A little above half were in monogamous marriages (53.9%), while 45.4% were in polygamous marriages. Respondents were more likely to not have a formal education (45.0%) than were respondents in other categories of educational attainment. A little above a quarter (26.4%) were retired civil servants and small business owners, while 23.6% were petty traders. The sociodemographic characteristics of the respondents are presented in Table 1.

The proportion of patients with spiritual needs in this study population was 75.0%. A total of 210 respondents (75.0%) had overall spiritual needs scores above the obtainable average score of 30, while 70 of them (25.0%) had overall spiritual needs scores below the average score of 30. This is presented in Figure 1.

The predominant spiritual needs domain was 'religious needs', with a mean of 1.93 ± 0.61 . This was closely followed by the 'giving/generativity needs', for which the mean was 1.73 ± 0.57 . Existential and inner peace needs were the least common needs in this study population (1.14 ± 0.65 and 1.14 ± 0.61 , respectively). In terms of categorizing the needs into 'low', 'moderate' and 'high', all the domain needs fell within the 'moderate' category, which was above 1.1 but less than 2.0. This is represented in Figure 2.

Most (61.0%) of the participants rated their QoL as 'good', while 17.0% of the participants rated it 'very good' or 'neither poor nor good'. Only 5.0% of the participants rated their QoL to be 'poor'. Slightly more than half of them (51.8%) claimed they were 'satisfied' with their health, while a quarter (25.0%) were 'neither satisfied nor dissatisfied', and 17.9% were dissatisfied. Only 4.3% and 1.1% were 'very satisfied' and 'very dissatisfied', respectively. The respondents' overall quality of life in this study, for which the median (50th percentile) score was 59.4 as the cutoff, was 53.2%, leaving 46.8% of the participants with poor QoL. This is demonstrated in Figure 3.

On the depression subscale of the HAD tool, 72.0% of the respondents had normal scores, 22.0% had borderline scores, and only 6.0% had scores in the depressive range. Therefore, the prevalence of depression in elderly individuals presenting at primary care clinics in UITH was 6.0%. Similarly, the majority of the respondents (72.5%) had normal anxiety scores; slightly less than a quarter (21.4%) had borderline anxiety scores, while only 6.1% had abnormal anxiety scores, for which the prevalence of anxiety in this study population was 6.1%.

The overall level of satisfaction with their usual care received by the participants in the primary care clinics of UITH was 73.9%. A quarter of them (25.4%) expressed a moderate level of satisfaction, while only 0.7% had low satisfaction. In terms of the level of satisfaction in the various domains, 80.7% of the participants expressed satisfaction in the 'assurance domain' (that is, competence, skill and professionalism of the healthcare provider). This was followed by the Reliability domain with 78.6% (ability to deliver promised care well) and then 65.7% in the Empathy domain (ability to give attention and individualized care to patients). The responsiveness domain (ability to respond promptly to patient needs) was the next most common domain, with 61.1% expressing high satisfaction and 36.4% moderate satisfaction. Participants were least satisfied in the Tangibility domain (physical appearance of facility, staff and equipment), with only 55.4% having high satisfaction.

There were 260 respondents (92.9%) who had one or more chronic diseases, especially hypertension (75.7%), musculoskeletal conditions (58.6%), peptic ulcer disease (27.9%), and diabetes mellitus (24.6%). The majority (87.1%) also admitted to having one or more geriatric syndromes, especially visual impairment (17.9%), sleep disorders (12.5%), forgetfulness (12.1%), and immobility (10.7%).

As can be seen in table 2, spiritual needs in this study were significantly associated with anxiety ($p=0.045$), the health satisfaction score ($p= 0.023$), overall QoL ($p= <0.001$), and the presence of geriatric syndrome ($p= 0.037$). This can be seen in Table 4. Respondents with abnormal anxiety scores (94.1%) reported greater spiritual needs than did those with normal anxiety scores. A linear relationship was also observed between spiritual needs and satisfaction with health, where those who were neither satisfied nor dissatisfied (85.7%) with their health reported greater spiritual needs. Similarly, most respondents (81.3%) who had one or more geriatric syndromes reported having high spiritual needs. However, overall QoL exhibited an inverse relationship with spiritual needs, where most (87.2%) participants who reported good QoL had greater spiritual needs.

Although most of the respondents who reported abnormal or borderline depression (82.4% and 82.3%, respectively) had high spiritual needs, the difference was not statistically significant ($p = 0.214$). Similarly, satisfaction with usual care was not significantly associated with spiritual needs, despite 100.0% of those with low satisfaction reporting high spiritual needs. The rating of QoL, presence of chronic conditions and presence of both chronic conditions and geriatric syndromes did not exhibit statistically significant associations with spiritual needs.

The predictors of spiritual needs are shown in Tables 3 and 4 after multivariate logistic regression was performed, which controlled for the influence of unidentified confounding variables to some extent. Age was the only sociodemographic predictor of spiritual needs in this study. Individuals aged 81 years and above (oldest old) were seven times more likely to report high spiritual needs than were those aged 60 to 70 years ($OR = 7.198$, 95% $CI=1.234-41.990$, $p = 0.028$). The clinical predictors of spiritual needs were satisfaction with usual care, overall QoL, and the presence of geriatric syndrome. Satisfaction with usual care predicted spiritual needs, as those with higher satisfaction with usual care (as indicated by the SERVQUAL score) had lower odds of reporting spiritual needs ($OR = 0.266$, 95% $CI: 0.074-0.952$, $p = 0.042$). However, among the study participants, those who expressed good overall QoL were approximately two times more likely to report high spiritual needs than were those who reported poor QoL ($OR=1.835$, 95% $CI=1.049-3.208$; $P = 0.033$). Similarly, having geriatric syndromes was associated with almost two times greater odds of having spiritual needs than was not having geriatric syndrome ($OR = 1.858$, 95% $CI=1.053-3.277$, $p = 0.032$). This is demonstrated in Table 4 below

QUALITATIVE RESULTS

Most participants in this aspect of the study were aged 60–79 years (90%), with a mean age of 70 ± 7.05 years. A total of 70.0% of the sample was female. The majority were Muslims (60.0%), while 40.0% were Christians. The interviews revealed a highly religious cohort with substantial unmet spiritual needs in clinical care, despite overall satisfaction with routine medical services. Four key themes emerged.

Conceptualization of Spirituality:

Spirituality was described as a personal and continuous relationship with God, expressed through prayer, worship, and engagement with sacred texts. Participants linked spirituality closely to emotional well-being, coping, and healing. One respondent noted, “My faith helps me connect to God, my sole source of hope and support.”

Perceived Impact on Health:

All participants regarded spirituality as important to their health. Many attributed resilience, recovery, or strength during illness to prayer and faith practices. As one participant stated, “In my stroke, God is my source of strength.”

Unmet Spiritual Needs in Healthcare:

Most respondents reported that healthcare providers did not inquire about or address their spiritual concerns. This omission was perceived as a gap in holistic care. A participant remarked, “You are the first person to ask.”

Recommendations for Integration:

While generally satisfied with care at the GOPC, participants suggested that integrating spiritual support such as interfaith chaplaincy services, respect for prayer practices, spiritual counseling, and greater provider sensitivity would enhance satisfaction and promote holistic care.

Overall, the findings underscore the centrality of spirituality in the lives of older adults and highlight a perceived need for its integration into primary care to strengthen holistic geriatric practice.

DISCUSSION

The majority of respondents were aged 60–70 years (67.5%), reflecting predominance of the younger-old category, consistent with earlier reports that this group more frequently utilizes outpatient services [31,32]. A total of 67.1% of the females were affected, aligning with evidence that women live longer and demonstrate greater healthcare utilization [33,34].

The prevalence of high spiritual needs (75.0%) is comparable with findings in geriatric populations in Europe and North America across clinical and community settings [24,35,36,37].

For example, Ramezani et al. (2019) reported that all their elderly study participants expressed at least one spiritual need [35]. These findings highlight spirituality as an important yet often underrecognized component of holistic geriatric care, with documented benefits for quality of life and psychological outcomes. This underscores the need to empower primary health care providers to identify and then provide such needed care to the elderly population presenting in primary care clinics.

Apart from high spiritual needs, the present study equally identified a high burden of physical needs (92.9% of chronic conditions and 87.1% of geriatric syndrome conditions), which is in tandem with findings from previous studies [32,38,39]. The prevalence of psychological morbidity in this cohort was

lower than that in reports from other geopolitical regions of Nigeria, possibly reflecting geographical and cultural differences in coping patterns and social structures. Notably, despite the relatively low burden of depression and anxiety and the high level of satisfaction with usual care, overall quality of life was not correspondingly high. This finding suggested that unmet spiritual needs may represent an additional dimension influencing perceived well-being. A significant association was observed between spiritual needs and overall QoL ($p < 0.001$) and between spiritual needs and health satisfaction ($p = 0.023$), consistent with findings from both local and international studies [40-44]. These results indicate that spirituality is closely intertwined with broader perceptions of health and life satisfaction. Qualitative accounts further reinforced this relationship. Statements such as “Prayer healed my eye pressure” and “In my stroke, God is my source of strength” illustrate the perceived therapeutic and supportive role of spirituality. Participants consistently attributed healing, resilience, and coping capacity to their spiritual practices. These findings align with those of Adedeji et al. (2023), who reported that older adults relied on spirituality as a coping mechanism during the COVID-19 lockdown, irrespective of underlying medical conditions [45]. Taken together, these findings underscore spirituality as a significant contributor to perceived well-being among older adults.

A significant association was also found between spiritual needs and anxiety ($p=0.045$), consistent with Nigerian and international evidence linking spirituality to emotional well-being [18,46-51]. However, no significant association was found with depression ($p=0.214$), despite evidence of inverse relationships in other contexts [52,53,54]. Spiritual needs were significantly associated with geriatric syndromes ($p=0.037$), consistent with the findings of previous reports suggesting that spirituality is a coping resource during functional decline [55,56,57]. However, the presence of chronic conditions alone was not predictive, suggesting that severity or functional impact may be more influential than diagnosis per se [57,58].

Regression analysis revealed that age 81 years and older significantly predicts greater spiritual needs ($OR=7.198$), supporting evidence that spirituality gains prominence with advancing age [59,60]. Higher satisfaction with usual care predicted lower spiritual needs, consistent with reports linking unmet spiritual needs to lower care satisfaction [60,61]. Interestingly, high overall QoL predicts greater spiritual needs, suggesting that spirituality may contribute to well-being rather than merely responding to distress [42-44,57].

Overall, these findings demonstrate complex relationships between spirituality, psychological well-being, QoL, and geriatric vulnerability. While psychological stability appears relatively preserved, unmet spiritual needs remain evident. Integrating culturally appropriate spiritual care into primary care may enhance holistic geriatric practice. Further longitudinal studies are recommended to clarify causal pathways and contextual influences involved.

CONCLUSION AND RECOMMENDATION

This study demonstrated a high prevalence of spiritual needs among older adults attending primary care at UITH, Ilorin, and identified key predictors of these needs within this population. These findings reinforce the existing evidence that older patients in primary care settings experience not only physical and psychosocial challenges but also significant spiritual needs that warrant clinical attention. The qualitative component provided contextual depth, revealing that spirituality is central to participants' meaning-making, coping, and overall well-being. Despite high levels of satisfaction with biomedical care, respondents consistently reported that their spiritual concerns were rarely acknowledged by healthcare providers. This perceived gap underscores the need to integrate spiritual assessment and support into routine primary care consultations to provide truly personalized and holistic geriatric care.

In light of these findings, it is recommended that primary care practitioners incorporate structured spiritual care into clinical practice. Policy efforts should also prioritize capacity building through training and retraining primary care physicians in spiritual care skills, alongside strengthening geriatric services and increasing the geriatric workforce. Addressing spiritual needs within primary care may enhance patient satisfaction, support comprehensive care delivery, and improve the overall well-being of older adults.

Declarations

Availability of data and material: The study data are available from the corresponding author upon reasonable request.

Ethics approval and consent to participate: Ethical approval for the study was obtained from the Ethics and Research Committee of the University of Ilorin Teaching Hospital (approval number: ERC PAN/2024/08/0533). Formal permission to conduct the study was obtained from the Head of the Department of Family Medicine at the study facility. Throughout the research process, the rights, comfort, dignity, and confidentiality of the participants were strictly upheld. Written informed consent was obtained from all participants after adequate explanation of the study objectives and procedures, and they were informed of their right to withdraw at any stage without any consequences for their care. To ensure confidentiality, no identifying information was recorded on the study tools, and participants' privacy was carefully protected during the data collection. All the study records were securely stored and accessible only to authorized personnel. The study was conducted in accordance with Good Clinical Practice principles, and every effort was made to ensure that participation posed no risk of harm, discomfort, or distress to the respondents.

Consent for publication: This statement is not applicable in this study.

Competing Interests: The authors declare that they have no competing interests.

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Authors Contribution: The study was conceived by AN. The proposal was written by AN but reviewed by ES,YR,and OO. The data were collected and analyzed by AN. The manuscript was written by AN and reviewed by ES, YR, and NK.

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Tables

Table 1 to 4 are available in the Supplementary Files section.

Figures

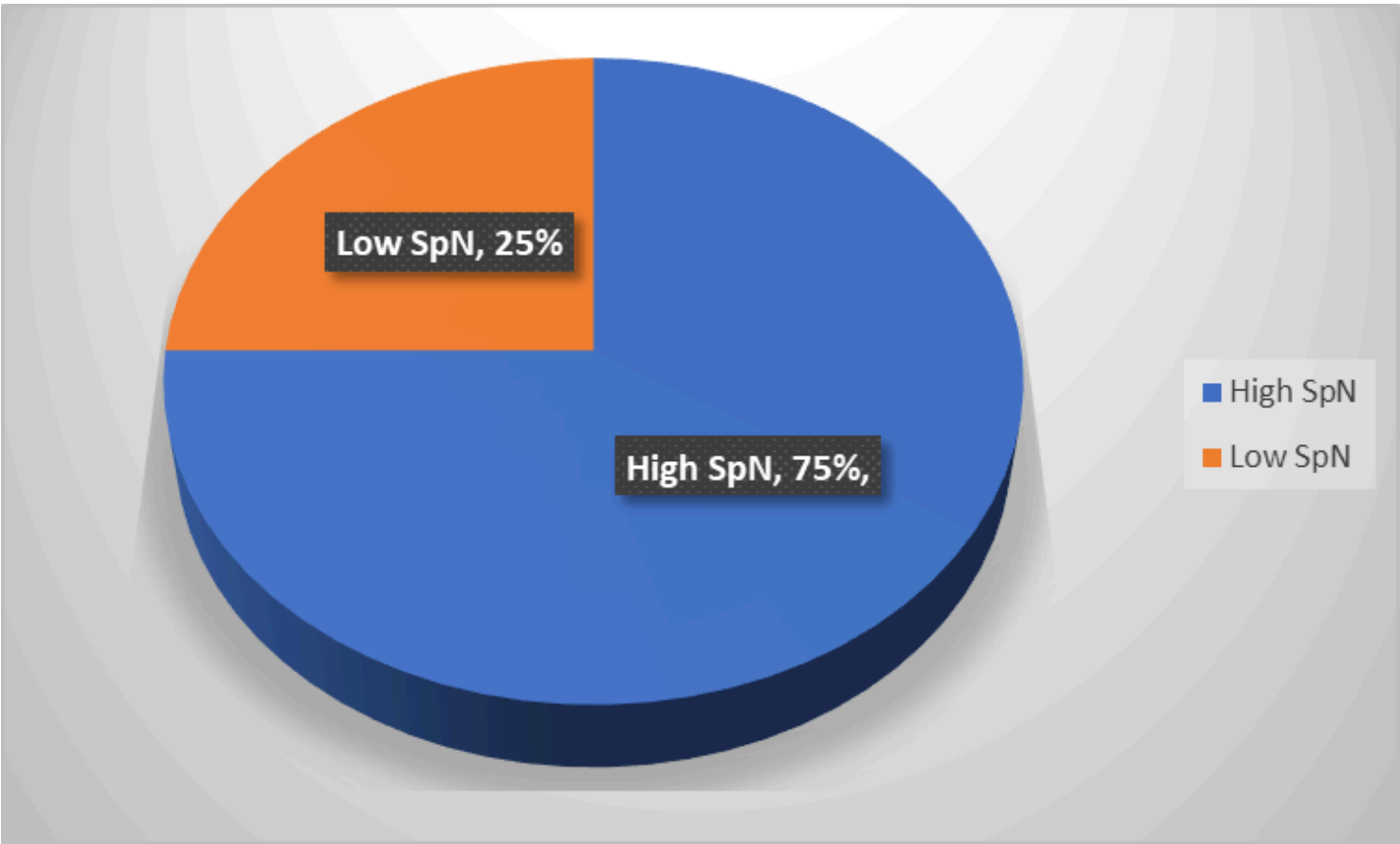


Figure 1

Prevalence of SpN among the older adult patients seen in the primary care clinic of UITH.N=280

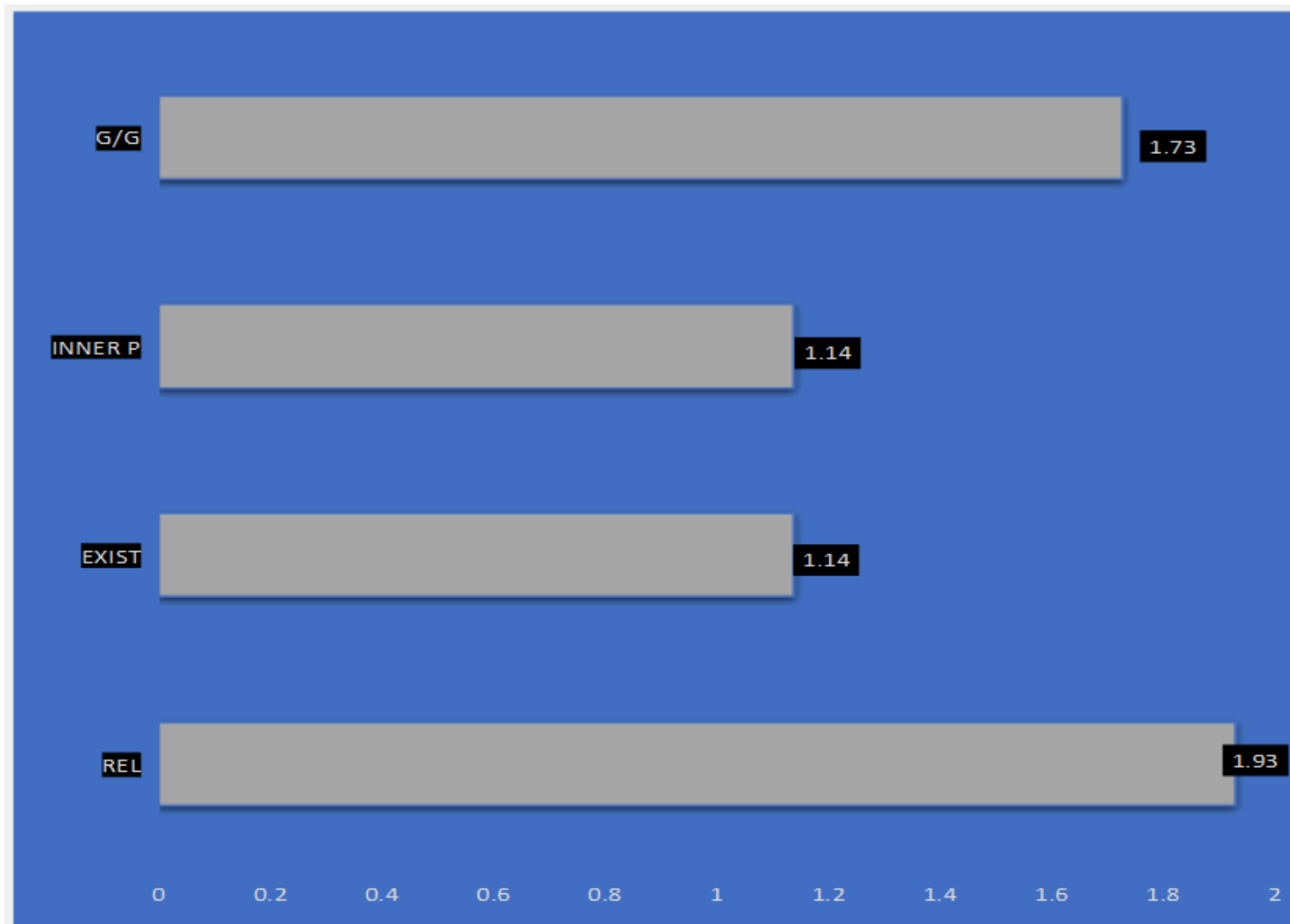


Figure 2

Pattern of SpN among the older adult patients seen in the primary care clinic of UITH.N=280

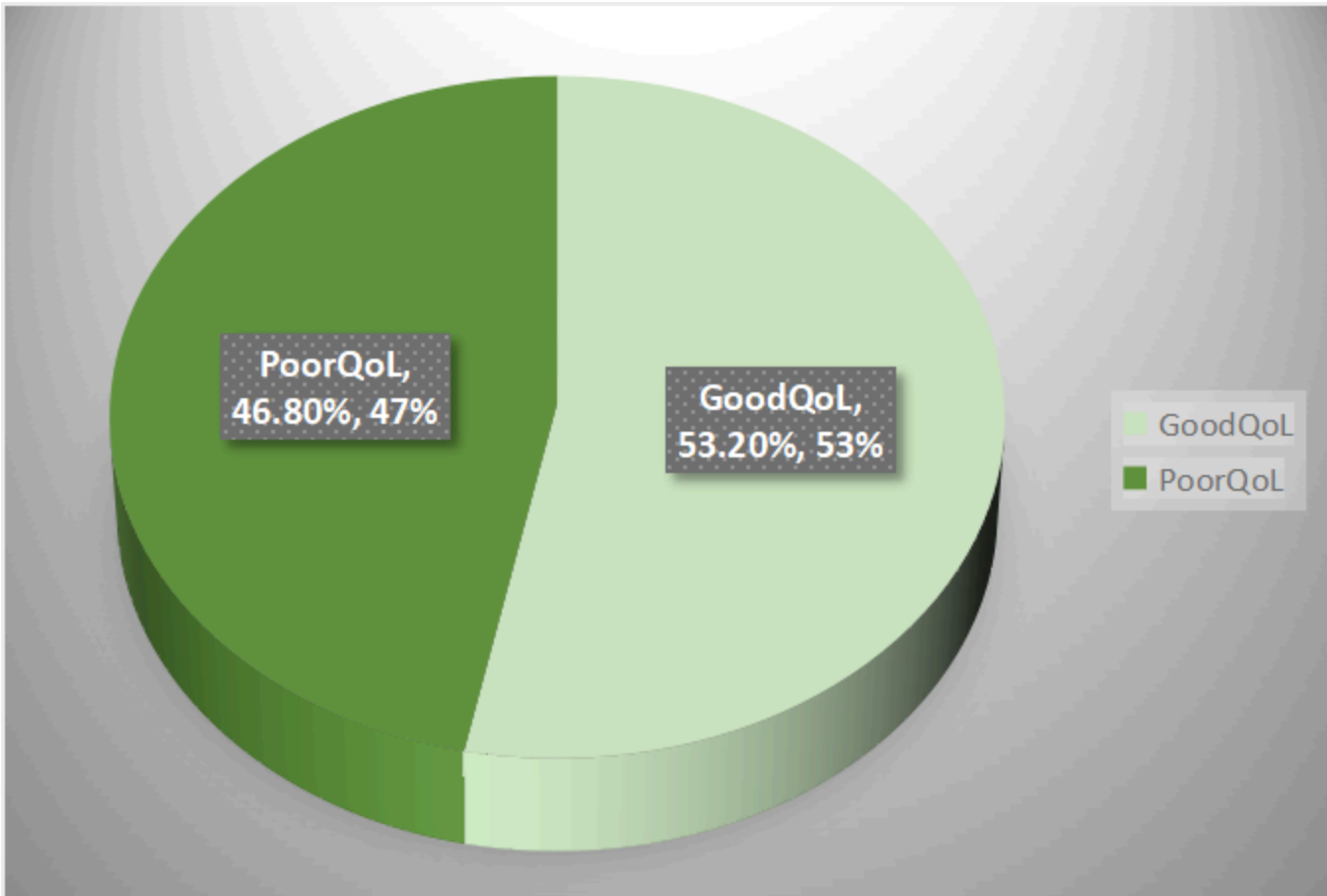


Figure 3

QoL among the older adult patients seen in the primary care clinic of UITH. N=280

Supplementary Files

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- [Table1.SociodemographiccharacteristicsofrespondentswithHIGHSpN.docx](#)
- [Table2.AssociationsofHIGHSpN.docx](#)
- [Table3ClinicalpredictorsofHIGHSpN.docx](#)
- [Table4.ClinicalpredictorsofSpN.docx](#)