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COMMUNITY RESPONSES TO AGEISM: TOWARDS AN AGE-INCLUSIVE SOCIETY IN IGABI, KADUNA STATE

Amina Aliyu

Department of Sociology, Kaduna State University, Kaduna State, Nigeria

ameenaahalee123@gmail.com

ABSTRACT: Ageism, a pervasive global challenge, significantly impacts older adults in Nigeria, yet remains understudied in specific local contexts. This study investigates how social exclusion and limited healthcare access perpetuate ageism among older adults in Igabi, Kaduna State, guided by Social Exclusion Theory and the Structural Ageism Perspective. A mixed-methods approach was employed, combining a survey of 50 older adults with in-depth interviews and focus group discussions involving eight community stakeholders. Findings reveal that low community participation and exclusion from decision-making roles strongly correlate with experiences of ageism. Concurrently, healthcare barriers including unaffordable costs, prolonged waiting times, and a critical lack of geriatric services heighten perceptions of discriminatory treatment. Qualitative narratives illustrate how older adults are sidelined in family and community affairs and neglected within healthcare settings. The study concludes that ageism in Igabi is not merely an individual bias but is deeply embedded in structural and cultural processes that systematically marginalize the elderly. To combat this, integrated interventions are recommended, focusing on enhancing community participation, improving access to affordable and age-friendly healthcare, and challenging ageist stereotypes through targeted awareness campaigns.

Keywords: Age, Ageism, Community responses, Inclusive, Society

INTRODUCTION

Ageism, stereotyping, prejudice, and discrimination based on age, is a critical global issue. The World Health Organization (2021) estimates that nearly half the world's population holds ageist attitudes, underscoring the deep entrenchment of these biases across cultures. These perceptions manifest not only individually but also institutionally, where older adults are frequently depicted as dependent or burdensome in healthcare, workplaces, and media (Ayalon & Tesch-Römer, 2018; Officer & de la Fuente-Núñez, 2020). The consequences are severe, ranging from limited economic opportunities to adverse health outcomes, thereby threatening the goal of inclusive societies.

Research in the Global North has extensively documented ageism's prevalence. In the United States, studies link ageist attitudes to significant healthcare costs and workplace discrimination (Allen et al., 2021; Rippon et al., 2021). Similarly, in Germany, national surveys reveal persistent ageism in employment and public life, leading to premature social exclusion (Federal Anti-Discrimination Agency, 2022; Spuling et al., 2019). In contrast, Scotland has often addressed the

issue through grassroots, community-led initiatives like intergenerational learning and befriending services (Age Scotland, 2021).

Within Africa, the picture is more complex. In Ghana, research indicates a duality where cultural traditions confer respect upon elders, yet modernization and urbanization foster negative stereotypes (Akanle & Olutayo, 2019; Osei-Tutu et al., 2020). In Nigeria, similar tensions exist. While traditional family and faith-based networks provide crucial support, studies by Aboderin and Beard (2015) and Olonisakin et al. (2019) highlight increasing stigmatization, social exclusion, and systemic healthcare neglect faced by older adults. A critical gap in the literature is the scarcity of localized, empirical studies that move beyond general descriptions to analyze the specific structural and cultural mechanisms driving ageism in Nigerian communities. This study fills that gap by asking: How do social exclusion and healthcare barriers concretely shape ageist experiences in Igabi, Kaduna State? Our research contributes to the scholarship by providing a nuanced, context-specific analysis that can inform targeted, community-based interventions in under-researched Nigerian settings.

Statement of the Research Problem

In Nigeria, ageism presents a unique paradox. Despite cultural narratives venerating elders, older adults increasingly face marginalization, exclusion, and discrimination. Evidence indicates that older Nigerians experience age-based stigmatization, from derogatory labelling to exclusion from community decision-making (Aboderin & Beard, 2015; Olonisakin et al., 2019). Compounding this social exclusion, healthcare access is severely limited by systemic neglect, a dearth of geriatric services, and discriminatory provider attitudes (Ogunbameru, 2020; Oyetunde & Ojo, 2013). These intertwined issues diminish quality of life, increase vulnerability to poverty, and curtail civic participation.

This study identifies two core problems. First, social exclusion and negative stereotypes systematically marginalize older individuals in community, political, and family spheres, eroding traditional values of respect. Second, the scarcity of accessible, age-friendly healthcare exacerbates inequalities and reinforces ageist perceptions. This demonstrates that ageism in Nigeria is both an attitudinal and a structural problem, demanding a multifaceted investigation.

Research Questions

1. How does social exclusion shape the experiences of older adults in Igabi LGA, Kaduna State?
2. In what ways does the lack of accessible, age-friendly healthcare services contribute to ageism in Igabi LGA, Kaduna State?

Research Objectives

1. To investigate how social exclusion contributes to ageism against older adults in Igabi LGA, Kaduna State.

2. To examine how limited access to age-friendly healthcare services reflects and reinforces ageist practices in Igabi LGA, Kaduna State.

Theoretical Framework

This study is guided by Social Exclusion Theory (Silver, 1994; Levitas, 2006) and the Structural Ageism Perspective (Bytheway, 2005; Ayalon & Tesch-Römer, 2018).

Social Exclusion Theory elucidates how individuals are systematically barred from full societal participation due to economic, social, or cultural barriers. It is apt for analyzing the first objective, as it frames the marginalization of older adults in Igabi, through reduced decision-making roles and stereotyping as "unproductive", as a process of active exclusion that renders them socially invisible. The Structural Ageism Perspective highlights how institutional policies and systems create and sustain age-based disadvantages. This framework directly informs the second objective, revealing how healthcare barriers (inadequate services, dismissive treatment) are not random failures but manifestations of a system that deprioritizes older adults' needs.

Critique and Synthesis

While valuable, both theories have limitations. Social Exclusion Theory can be overly broad, making it difficult to isolate the specific drivers of ageism within overlapping exclusionary factors (Levitas, 2006). The Structural Ageism Perspective, meanwhile, risks portraying older adults as passive victims, potentially underestimating their agency and resilience (Bytheway, 2005). Furthermore, as both theories originated in Western contexts, their direct application to Nigeria, where extended family and communal practices profoundly shape aging, requires careful adaptation. Nevertheless, when synthesized, these frameworks provide a powerful, multi-level analytical tool. Social Exclusion Theory explains the interpersonal and community-level processes of marginalization, while the Structural Ageism Perspective exposes the institutional foundations of disadvantage. Together, they offer a comprehensive lens for understanding how social relations and structural systems collaborate to perpetuate ageism in Igabi.

METHODS

This study employed a convergent mixed-methods design to provide a holistic exploration of ageism in Igabi LGA. The quantitative component involved a cross-sectional survey of 50 older adults aged 60 and above, selected via multi-stage cluster sampling to ensure representation across the LGA's diverse wards. The sample size, while limiting statistical generalizability, was determined to be adequate for an in-depth, exploratory study within the project's resource constraints. Concurrently, the qualitative component involved eight participants, purposively selected older men, women, caregivers, community leaders, and health workers, who took part in focus group discussions (FGDs) and key informant interviews (KIIs). Data collection continued until thematic saturation was achieved in the qualitative data.

Structured questionnaires and semi-structured interview guides, translated into Hausa and pre-tested, were used. Ethical considerations, including informed consent and participant

confidentiality, were strictly adhered to. Quantitative data were analyzed descriptively and with bivariate tests using SPSS. Qualitative data were transcribed and subjected to thematic analysis following Braun and Clarke's (2006) framework. Findings from both strands were integrated through triangulation to develop a coherent understanding of the research problem.

RESULTS

Table 1: Socio-demographic characteristics of older adults (N = 50)

Variable	Frequency (n)	Percentage (%)
Age group (years)		
60–69	20	40.0
70–79	18	36.0
80+	12	24.0
Sex		
Male	28	56.0
Female	22	44.0
Education level		
No formal education	19	38.0
Primary	15	30.0
Secondary+	16	32.0

Source: *Field Survey, 2024.*

Table 1 outlines the socio-demographic details of the older adults who took part in the study. The age distribution shows that the largest group was between 60–69 years, followed closely by those aged 70–79, with a smaller but notable portion aged 80 and above. This indicates the study included perspectives from various stages of older age, representing both the relatively younger elderly and the very old. Regarding sex, slightly more men than women participated, reflecting a modest gender imbalance possibly influenced by household composition or availability during data collection. Educational levels varied, with over a third having no formal education, many with only primary schooling, and a smaller but significant share with secondary education or higher. This suggests many older adults in Igabi LGA face educational disadvantages, which could impact their social participation, health literacy, and experiences of exclusion.

Table 2: Association between social exclusion indicators and reported ageism

Social exclusion indicator	Experienced ageism (Yes, %)	Experienced ageism (No, %)
Low community participation (n=25)	76.0	24.0
High community participation (n=25)	32.0	68.0

No role in decision-making (n=30)	70.0	30.0
Has a role in decision-making (n=20)	35.0	65.0

Source: *Field Survey, 2024.*

Table 2 shows the relationship between social exclusion indicators and reported experiences of ageism among older adults in Igabi LGA. The results indicated that levels of community participation and involvement in decision-making strongly affected whether older people felt excluded or discriminated against. Specifically, among those with low community participation, as many as 76.0% reported experiencing ageism, compared to only 32.0% among those with high community participation. This pattern suggests that the more actively older adults participated in community activities, the less likely they were to face exclusion or ageist attitudes, implying that participation offers protection against ageism. Likewise, involvement in community decision-making also appeared to significantly lower the chances of experiencing ageist treatment. Among older adults who reported having no role in decision-making, 70.0% experienced ageism, while only 35.0% of those involved in decision-making reported such experiences. This indicates that decision-making power not only affirms the value of older adults but also shields them from marginalization. The findings therefore suggest that structural exclusion from everyday community processes, whether through limited participation in gatherings or the denial of leadership roles, directly reinforces both the perception and occurrence of ageism. In other words, older adults who are cut off from social and civic spaces tend to be treated as invisible or irrelevant, whereas those who stay engaged in community networks often receive greater respect and recognition. This conclusion aligns with the qualitative findings, where older adults expressed concerns about being ignored in meetings or pushed aside in family and community decision-making. Regarding this, the interviewees remarked:

Older Woman (FGD, rural community)

"In this village, once you pass sixty, people begin to look at you as if you are no longer useful. Before, I used to attend meetings and my voice mattered, but now when I speak, they laugh and say, 'Mama, you should rest, you are old.' Even when decisions involve land that I worked on with my husband, they disregard me as if I no longer have any rights. That is how they remove us from the community little by little."

Older Man (FGD community)

"When there are community gatherings, they will call the young men to sit in front, but we, the elders, are asked to sit at the back or sometimes outside. Before, our advice guided the youth, but now they say times have changed, and that we don't understand modern things. It makes us feel unwanted, like our experience no longer counts."

Community Leader (KII)

"I have observed that older people in Igabi are becoming isolated because younger generations see them as burdens. They are rarely invited to planning sessions or community development meetings. If they are present, their views are often ignored. It is painful because these are the

same people who built the foundations of the community, but now they are excluded from decision-making processes."

Caregiver (KII, family member of an older adult)
"In my own household, sometimes my children say their grandmother is too slow, and they don't want to wait for her when there are events. Even in family discussions, they rarely ask her what she thinks. I try to tell them that age should not erase respect, but I see the way they dismiss her, and it shows how exclusion starts even inside the home."

Older Woman (FGD, community)
"It is not only in meetings but also in daily life. If I go to the market, the sellers will first attend to the young customers, even if I came before them. They tell me to be patient because I am old. But being old does not mean I should be treated as invisible. Such small things pile up and make us feel excluded from society."

Health Worker (KII, Primary Health Centre)
"From my experience, older patients sometimes avoid coming to health talks or community programs because they believe no one listens to them. Younger participants dominate discussions and mock their questions. As a result, many elderly people feel rejected in public spaces, and this contributes to the belief that they are no longer valuable members of the community."

Both the survey and interviews indicated a consistent pattern: excluding older adults from community activities and decision-making roles increases the likelihood of experiencing ageism. The survey showed that participation and leadership opportunities reduced discrimination, while the personal stories of older men and women highlighted how exclusion manifested daily, being laughed at in meetings, asked to sit at the back at gatherings, or ignored during family discussions. Community leaders and caregivers noted that older adults' opinions were often dismissed, and health workers observed that many elderly individuals withdrew from programs because they felt ignored. Together, the quantitative and qualitative findings underscore that social exclusion is a primary pathway for ageism in Igabi LGA.

Objective 2: To examine how limited access to age-friendly healthcare services reflects and reinforces ageist practices in Igabi LGA

Table 3: Access to healthcare services among older adults (N = 50)

Healthcare access indicator	Frequency (n)	Percentage (%)
Difficulty affording healthcare	31	62.0
Long waiting time at facilities	35	70.0
Reported lack of geriatric services	29	58.0
Perceived respectful provider care	20	40.0

Source: *Field Survey, 2024.*

Table 3 outlines the barriers faced by older adults in Igabi LGA when accessing healthcare services. Most respondents reported difficulties in affording medical care, highlighting financial barriers as a major obstacle to timely and adequate treatment. Excessive waiting times at health facilities were also common, indicating structural inefficiencies that discouraged older adults from seeking care or made them feel neglected. Additionally, over half of the participants pointed out the lack of dedicated geriatric services, revealing a gap in the health system's capacity to meet the specific needs of ageing populations. Only a small percentage felt that healthcare providers consistently showed respect, raising concerns about dismissive or ageist attitudes among health workers. Overall, these findings suggest that issues related to affordability, inadequate geriatric infrastructure, and poor provider–patient interactions collectively contribute to a healthcare environment that does not fully accommodate older adults. The qualitative findings are highlighted below.

Older Man (FGD, rural community)

"Whenever I fall sick, the first problem is money. The hospital asks for payment before anything else, and sometimes I return home because I cannot afford the bills. At my age, I depend on my children, but if they have no money, I have to manage with herbs. This makes me feel that the healthcare system is not for people like us, who are old and poor."

Older Woman (FGD, peri-urban community)

"Even when I go to the health centre, I sit there from morning until afternoon before they call me. The younger people get restless and complain, but for us older ones, they say we should wait patiently. By the time it is my turn, the nurses are already tired, and they rush through everything. It is like our time and our health do not matter as much."

Health Worker (KII, Primary Health Centre)

"To be honest, we do not have proper services for the elderly. There are no specialized units or trained staff for geriatric care, so older patients are treated the same way as everyone else, despite their conditions being different and more complex. Sometimes, colleagues dismiss their complaints as 'just old age,' and this attitude discourages many elderly individuals from seeking care. They come less often because they feel they are not given respect or priority."

The survey results closely reflected participants' voices, highlighting key barriers faced by older adults in Igabi LGA. These included issues with affordability, lengthy wait times, lack of specialized geriatric services, and negative attitudes from healthcare providers. Quantitative data showed many respondents struggled to afford care, a sentiment echoed by elders who often left hospitals untreated due to costs, opting for herbs instead. The high reports of long waits aligned with qualitative stories of elders spending entire days at clinics and being rushed through consultations, suggesting their health concerns were undervalued. Additionally, the absence of geriatric services was confirmed by a health worker who admitted that facilities lacked dedicated units or trained staff for elderly care, neglecting their specific needs. Lastly, only a few respondents felt they received respectful treatment, consistent with reports of dismissive attitudes where staff dismissed complaints as merely "old age."

Table 4: Association between healthcare barriers and perceived ageism

Healthcare barrier	Reported ageist treatment (Yes, %)	Reported ageist treatment (No, %)
Difficulty affording care (n=31)	71.0	29.0
No difficulty affording care (n=19)	36.8	63.2
Long waiting time (n=35)	68.6	31.4
Short waiting time (n=15)	33.3	66.7

Source: *Field Survey, 2024.*

Table 4 shows that healthcare barriers strongly relate to older adults' perception of ageist treatment in Igabi LGA. Those who had difficulty paying for medical care were nearly twice as likely to report experiencing ageist treatment compared to peers without financial struggles, indicating that poverty worsens feelings of neglect and discrimination in health facilities. Likewise, long waiting times were linked to increased reports of ageist treatment, suggesting that delays in getting care may reinforce perceptions of being undervalued or deprioritized because of age. Conversely, older adults who could more easily afford care or experienced shorter wait times were less likely to feel discriminated against, showing that easier and more supportive healthcare access reduces the experience of ageism.

DISCUSSION OF FINDINGS

The findings align with the study's theoretical frameworks. Social Exclusion Theory (Levitas, 2006; Silver, 1994) explains how the systematic barring of older adults from community participation and decision-making creates a cycle of marginalization. Our quantitative data confirmed that exclusion directly increased reports of ageism, while qualitative narratives revealed the painful, everyday reality of this process, being laughed at in meetings or ignored in family discussions. This goes beyond passive neglect; it is an active process that constructs older people as irrelevant, thereby fostering discriminatory behaviors.

The Structural Ageism Perspective (Ayalon & Tesch-Römer, 2018; Bytheway, 2005) provides a critical lens for interpreting the healthcare findings. The barriers reported, unaffordable care, long waits, absent geriatric services, are not merely operational shortcomings but manifestations of a health system designed without older adults in mind. The dismissive attitudes of providers, where complaints are attributed to "just old age," epitomize how structural failures reinforce and normalize ageist stereotypes. In the strained healthcare context of Igabi, these institutional practices communicate that older lives are less valuable, thereby reinforcing their social devaluation.

This study situates these findings within the broader African context. Unlike in Ghana, where traditional respect somewhat buffers against marginalization (Akanle & Olutayo, 2019), the data from Igabi suggest a more acute erosion of these protective norms, possibly due to intense economic pressures. The research demonstrates that in this Nigerian setting, ageism is a synergistic

product of eroding social structures and neglectful institutional systems. While the sample size limits broad generalization, the depth of insight offers a valuable model for understanding ageism in similar peri-urban and rural African localities.

Conclusion

This study concludes that ageism in Igabi LGA is a multifaceted problem, deeply rooted in both socio-cultural practices and institutional structures. Social exclusion systematically diminishes the visibility and respect afforded to older adults, while a neglectful healthcare system perpetuates their marginalization through structural barriers and discriminatory practices. By applying Social Exclusion Theory and the Structural Ageism Perspective, the research demonstrates that ageism is not merely an individual attitude but a socially constructed and structurally upheld phenomenon. Forging an age-inclusive society in Igabi, and similar contexts, therefore requires integrated strategies that simultaneously revitalize communal respect and reform institutional policies to affirm the dignity and rights of older adults.

Recommendations

1. **Enhance Community Participation:** Local government and community leaders should formally integrate older adults into community development committees and decision-making forums, particularly on issues like land use and social affairs.
2. **Launch Targeted Sensitization Campaigns:** NGOs in partnership with local religious institutions should lead community-wide campaigns using radio and town halls to challenge ageist stereotypes and highlight the contributions of elders.
3. **Improve Healthcare Affordability:** The Kaduna State Government should expand health insurance schemes to explicitly cover older adults and introduce targeted subsidies for their medical care.
4. **Integrate Geriatric Care into Primary Health Care:** The State Ministry of Health should mandate training in geriatric care for primary health workers and establish dedicated, age-friendly service days or units within existing facilities to reduce waiting times and improve care quality.
5. **Develop a Local Age-Friendly Action Plan:** Policymakers should use this study's findings to inform the development of an Igabi-specific age-friendly action plan, aligning with the goals of Nigeria's National Policy on Ageing.

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