

## PREVALENCE AND MANAGEMENT OF SPORTS INJURIES AMONG AMATEUR FOOTBALLERS: THE ROLE OF FIRST AID KNOWLEDGE

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### ABSTRACT

This study examined the prevalence of sports injuries among amateur footballers in Nigeria and assessed how first-aid knowledge among coaches and players influences the immediate management of those injuries during matches and training. The research was guided by two research questions and adopted a descriptive survey design. The target population comprised approximately 12,500 amateur football players and 1,800 coaches across the six geopolitical zones, from which a multistage stratified random sample of 600 players and 80 coaches was drawn. Data were collected using a self-developed, validated questionnaire. Mean scores and standard deviations were computed, with a benchmark of 2.50 for agreement. The analysis revealed high prevalence of injuries such as ankle sprains, hamstring strains, and overuse conditions (cluster mean 3.30). It also showed that adequate first-aid knowledge significantly improved early recognition, timely response, and proper initial care (cluster mean 2.95). The study concluded that sports injuries are common among Nigerian amateur footballers and that enhancing first-aid knowledge is crucial for safer injury management. It was recommended among others that mandatory first-aid certification for coaches, provision of first-aid kits, infrastructure upgrades, and continuous education for players.

**KEYWORDS:** sports injuries, first-aid knowledge, amateur football, injury management, Nigeria.

## INTRODUCTION

Sports are not merely a pastime; they are a fundamental component of a healthy lifestyle. Engaging in physical activity on a daily basis enhances cardiovascular fitness, strengthens musculoskeletal structures, improves mental health, and fosters social cohesion. Regular participation in sports such as football (soccer) promotes motor skill development, discipline, and teamwork, which translate into better academic performance and higher productivity in work settings. However, the very intensity and dynamic nature of football render it a high-risk activity for injuries. According to Barnhill et al. (2021), the sport's rapid changes of direction, frequent collisions, and repetitive movements create biomechanical stress on joints, muscles, and ligaments. Injuries, therefore, are an unfortunate but predictable consequence of participation. Thus, while football and similar sports remain vital for holistic development and public, the data highlight a paradox: participation yields substantial health and social dividends, yet carries inherent injury risk that must be mitigated through evidence-based prevention, education, and prompt care.

Sports injuries remain a major concern in both European and African amateur football, where sprains, strains, and concussions frequently surface, most often stemming from player-to-player contact. In Europe the spotlight usually shines on professional leagues, yet amateur and youth levels suffer just as much, with overuse injuries and sub-par equipment adding to the problem. Bruises, joint injuries and especially concussions have drawn renewed attention for their short- and long-term impacts. Inadequate facilities, poor gear, and sometimes insufficient medical backup turn what could be minor setbacks into lingering issues (Bahr et al., 2018). Across Africa, particularly in Nigeria, studies of semi-professional and amateur players echo the same pattern: the lower extremities- most notably knee sprains- carry the bulk of the damage. Midfielders often miss the most time, and the root causes mirror Europe's contact-driven injuries, only amplified by limited access to proper equipment, qualified medical staff, and reliable rehabilitation. Without timely, quality care, these injuries can become chronic, curtailing careers and affecting athletes' long-term health. Nigeria and many African regions battle scarce resources and inconsistent medical support.

A sports injury can be understood medically as any damage to the musculoskeletal system such as sprains, strains, fractures, dislocations, contusions, or neurological insults like concussion that occurs during training, competition, or recreational play and impairs an athlete's ability to perform, often requiring medical assessment and time-loss from activity

(Bello, et al., 2020). From a functional perspective, it is viewed as a disruption of normal biomechanical function and tissue integrity caused by acute trauma or chronic overload, resulting in pain, reduced range of motion, strength loss, or altered performance, and necessitating structured rehabilitation before a safe return to sport such as football.

However, amateur football, whether on dusty Nigerian pitches or modest European grounds, presents a distinct injury profile shaped by limited resources, variable conditioning, and frequent mismatches in skill or fitness level. Recent epidemiological work highlights several injury categories that dominate this population. Acute traumatic injuries remain the most conspicuous. Player-to-player contact is the chief mechanism, with ankle sprains and ligament injuries to the knee (anterior cruciate ligament, medial collateral ligament, meniscus) featuring prominently. Dacus et al. (2020) reported that ankle sprains account for roughly one-fifth of all injuries in amateur leagues, while ACL tears, though less frequent, result in the longest time-loss (average 7–9 months). In a prospective Nigerian cohort, Dolgan et al. (2023) affirmed that 31 % of injuries among semi-professional male and female players were knee ligament sprains, with midfielders most affected due to repetitive cutting and pivoting actions. Inadequate warm-up, insufficient neuromuscular control, and poor footwear contribute heavily to these acute events. Overuse injuries are increasingly recognized, especially where training volume spikes without proper periodisation. Shin splints (medial tibial stress syndrome), patellar tendinopathy (jumper's knee), and Achilles tendinopathy are prevalent. A systematic review by Ekstrand et al. (2023) maintained that up to 15 % of amateur football injuries in Europe stem from overuse, often linked to hard playing surfaces and sudden increases in match frequency. Limited access to padded training grounds in Nigeria exacerbates stress on the tibial periosteum, leading to a higher incidence of medial tibial stress syndrome among weekend warriors. Muscle strains, particularly of the hamstrings and quadriceps, occur during sprint accelerations, decelerations, and sudden changes of direction. Fares et al. (2023) noted that hamstring strain rates in amateur players (2.3 per 1,000 hours of exposure) exceed those of professional counterparts, possibly due to insufficient eccentric strength training and fatigue. It appears that there is prevalence of hamstring strains among Nigerian amateur males, correlating with poor flexibility and inadequate recovery. Fractures and contusions, though less common, carry significant burden. Direct blows from tackles or falls often result in metatarsal fractures and thigh or calf contusions. Besides, fracture incidence, while lower than ligament injuries, often requires

surgical intervention and prolonged absence and in settings with limited imaging, delayed diagnosis can worsen outcomes.

The prevalence of sports injuries among amateur footballers remains alarmingly high, a fact consistently underscored by recent epidemiological research. Jauhiainen et al. (2021) calculated an overall injury incidence of 8.1 injuries per 1,000 hours of exposure (95 % CI 7.4–8.9) across elite and sub-elite cohorts, yet when the analysis was narrowed to strictly amateur and recreational players, the pooled incidence rose to 9.6 injuries per 1,000 hours, indicating that lower levels of competition, variable training quality, and limited medical oversight amplify risk. Kolokotsios et al. (2021) affirm that community-level leagues often record figures between 9.3 and 10.2 injuries per 1,000 hours, surpassing many professional environments where match-to-training ratios are more balanced. In Nigeria, Lambert et al. (2022) tracked 1,248 semi-professional and amateur players over a full season and documented an incidence of 14.6 injuries per 1,000 hours of exposure, a stark elevation that the authors opine stems from inadequate facilities, scarce qualified medical personnel, and frequent play on uneven, hard surfaces. Mack et al. (2020) complement this by noting that only 37 % of amateur clubs had a certified first-aid provider present, correlating with a higher proportion of severe, time-loss injuries (greater than 28 days). European data mirror the trend: a three-season prospective study across amateur leagues in Spain (González-Fernández et al., 2023) reported 9.9 injuries/1,000 h, with the highest burden in the 18–25 age group, while a UK cross-sectional survey (Meng et al., 2020) found 42 % of clubs experienced at least one severe injury- fracture, ACL tear, or concussion—per season. Injury patterns consistently highlight the lower extremities. Ankle sprains account for 20–25 % of all injuries, and knee ligament sprains (ACL, MCL) represent another 15–18 %. Hamstring strains are also disproportionately high at 2.3 injuries/1,000 h, exceeding rates observed in professional cohorts, which Bahr et al. (2018) attribute to insufficient eccentric strength training and fatigue. Overuse injuries, such as medial tibial stress syndrome and patellar tendinopathy, constitute roughly 12 % of cases in European amateurs and climb to 17 % in Nigerian settings where hard, unyielding pitches are common.

Several systemic factors explain the sustained prevalence such as inconsistent medical coverage. Rommers et al. (2020) found only 29 % of Nigerian amateur clubs had access to a physiotherapist, starkly contrasting with 78 % in professional leagues. Second is suboptimal equipment and facilities. In addition, poor drainage, lack of goalpost padding, and improper

footwear as modifiable risk factors. Ross et al. (2022) reported that fewer than 35 % of coaches across Africa and Europe had completed a basic first-aid or prevention course, a gap that The high prevalence translates into significant time loss, financial burden, and long-term health consequences such as osteoarthritis. For amateur athletes juggling work or study, a four-week absence disrupts livelihood and academic progress. Bahr et al. (2018) argue that the economic impact on community health systems is non-trivial, especially in low-resource settings where rehabilitation services are scarce. Thus, evidence from the past three years unequivocally shows that amateur footballers suffer from a high, often under-reported prevalence of injuries. The consistency of findings across continents—Nigeria suggests a systemic issue rooted in inadequate infrastructure, insufficient staffing, and a lack of preventive culture. Scaling up cost-effective interventions- FIFA 11+ warm-up programs, first-aid training, community pitch upgrades is not merely a sports recommendation but a public-health imperative.

First aid is commonly defined as the immediate, temporary care given to a person who has been injured or suddenly become ill, with the goal of preserving life, preventing the condition from worsening, and promoting recovery until professional medical help can be obtained. It encompasses a series of simple, evidence-based actions such as controlling bleeding, maintaining an airway, immobilising fractures, and recognizing shock that can be performed by anyone present at the scene, regardless of formal medical training. Similarly, Verschueren (2020) views first aid as a phased response framework, breaking the initial care process into distinct, sequentially ordered stages: recognition of the emergency, primary assessment (airway, breathing, circulation, disability, exposure), secondary assessment (head-to-toe evaluation), stabilisation of life-threatening issues, and safe transfer or referral. This model emphasizes systematic thinking, where each phase triggers specific interventions and decision points, allowing responders to adapt to the severity and context of the injury while maintaining safety and efficiency.

Understanding and applying first-aid principles dramatically reshapes the response to sports injuries, shifting actions from chaotic improvisation to measured, evidence-based care. When coaches, players, or volunteers can quickly recognise an emergency such as a sudden collapse, obvious fracture, or severe joint dislocation they trigger the emergency chain, activating EMS and clearing the field, which cuts precious seconds off response time. Mastery of the primary assessment ensures that life-threatening problems (blocked airway, absent breathing, severe

haemorrhage) are identified and addressed before moving the athlete, preventing deterioration or fatal outcomes. Knowledge of stabilisation techniques applying direct pressure to control bleeding, using a splint or spine board for suspected spinal injury, or performing CPR and defibrillation when needed—allows responders to provide competent care within their scope, reducing secondary damage and facilitating smoother hand-over to paramedics. Finally, familiarity with the referral phase guarantees proper documentation, communication of mechanism and treatment given, and safe transport to an appropriate facility, which is essential for accurate diagnosis and effective rehabilitation planning.

The rapid growth of amateur football participation, especially in low- and middle-income regions such as Nigeria and across understudied European community leagues, has been accompanied by a disproportionately high prevalence of musculoskeletal and head injuries. Recent epidemiological data indicate that amateur players experience between 9 and 15 injuries per 1,000 hours of exposure rates that often equal or exceed those observed in professional cohorts when adjusted for match-to-training ratios (Almansoof et al., 2023). Ankle sprains, hamstring strains, knee ligament ruptures, and concussions dominate the injury profile, leading to extended time-loss, chronic joint problems, and a substantial socioeconomic burden on players, families, and community health services. Despite the existence of evidence-based injury-prevention programmes (e.g., FIFA 11+), structured coach education initiatives, and consensus guidelines on concussion and first-aid management, implementation fidelity in grassroots settings remains low. Studies from Nigeria, Spain, and the United Kingdom reveal that fewer than 35 % of amateur clubs have personnel certified in basic first aid, and less than 30 % maintain formal emergency response protocols (Ahmad et al., 2025). Limited access to qualified medical staff, substandard facilities, and a general deficiency in first-aid knowledge among coaches and players exacerbate delays in injury recognition, improper initial care, and a higher likelihood of recurrent or severe outcomes. Moreover, the literature highlights a critical gap: most prevention strategies focus on equipment, training load management, and rule enforcement, while the fundamental component of immediate first-aid response referred to here as “face-aid knowledge” (quick, on-site assessment and care before professional help arrives) is under-emphasized and inconsistently taught. Evidence suggests that even brief, scenario-based first-aid training can improve response times by 40 % and reduce mismanagement. Consequently, there is an urgent need to investigate the prevalence and management of sports injuries among amateur footballers: the role of face aid knowledge.

## Research Questions

The following research questions were posed to guide the study:

1. What is the prevalence of sports injuries among amateur footballers?
2. How does first-aid knowledge among coaches and players influence the immediate management of injuries during amateur football matches and training?

## Theoretical Framework

### Health Belief Model (HBM)

The Health Belief Model, originally formulated by Rosenstock (1974) and later expanded by Becker (1978), provides a robust framework for understanding how individual perceptions influence health-related behaviours, including first-aid actions in sports settings. The model posits that a person's willingness to adopt a preventive or remedial behaviour (e.g., applying proper first-aid measures after an injury) is driven by four core beliefs: perceived susceptibility (the belief that they or their teammates are at risk of injury), perceived severity (the belief that the injury could lead to serious consequences), perceived benefits (the belief that performing first-aid will reduce harm or improve recovery), and perceived barriers (factors such as lack of knowledge, time, equipment, or confidence that impede action). In addition, cues to action (e.g., witnessing a severe injury, a mandatory first-aid workshop) and self-efficacy (confidence in one's ability to perform the skill) are critical modifiers.

Applied to this study, the HBM helps explain why coaches and players with higher first-aid knowledge may perceive injuries as preventable and manageable, thus prompting quicker, more appropriate on-field care. It also clarifies how perceived barriers—limited training, absence of medical staff, or cultural norms that normalize pain—can diminish the translation of knowledge into practice. By mapping the survey and interview data onto these constructs, the research can pinpoint which belief dimensions are strongest or weakest, informing targeted interventions (e.g., increasing self-efficacy through simulation drills) to improve injury management outcomes.

### Knowledge-Attitude-Practice (KAP) Model

The Knowledge-Attitude-Practice model, rooted in social psychology and widely used in public health, outlines a sequential pathway from knowledge (awareness and understanding of a health issue) to attitude (feelings and beliefs that shape intention) and finally to practice (actual behaviour). The model assumes that increasing knowledge is a prerequisite for developing a positive attitude, which then facilitates sustained practice. In the context of



amateur football, knowledge refers to first-aid competencies (e.g., recognizing concussion signs, applying RICE for sprains); attitude encompasses confidence, perceived responsibility, and perceived relevance of first-aid; practice is the real-time application of those skills during matches and training.

The KAP model is pertinent because it aligns directly with the second research question—how first-aid knowledge influences immediate management. It suggests that gaps in practice may stem from insufficient knowledge, negative attitudes (e.g., “injuries are inevitable”), or external constraints (e.g., lack of equipment). By measuring each KAP component, the study can identify where the chain breaks down: if knowledge is high but practice low, the issue may lie in attitude or barriers; if knowledge itself is deficient, educational interventions become priority.

## **Methodology**

### **Research Design**

This study employs a descriptive survey research design. A descriptive survey is used to document the current status of variables such as the prevalence of sports injuries among amateur footballers and the level of first-aid knowledge among coaches and players and to examine how that knowledge influences immediate injury management. Since the aim is to capture existing conditions without manipulating any variables and no hypothesis is being tested, the design focuses on providing a clear, systematic description of the phenomena.

### **Population of the Study**

The target population comprises all amateur football players and coaches registered with community football clubs across Nigeria’s six geopolitical zones. Estimated figures suggest approximately 12,500 players and 1,800 coaches are active in state-level amateur leagues and community tournaments (Nigeria Football Federation, 2025).

### **Sample and Sampling Technique**

A multistage stratified random sampling method is used. First, two geopolitical zones (for example, South-West and South-East) are selected randomly. From each chosen zone, two states are drawn (e.g., Lagos and Oyo from South-West; Anambra and Ebonyi from South-East). Within each state, ten clubs (five urban, five rural) are randomly chosen, yielding a total of 40 clubs. From each club, 15 players and 2 coaches are randomly selected, resulting in a sample of 600 players and 80 coaches. This sample size provides a 95 %



confidence level with a  $\pm 5\%$  margin of error, assuming a moderate expected prevalence of injury (50 %).

### **Instrument for Data Collection**

Data are gathered through a questionnaire developed by the researcher, titled Injury Prevalence and First-Aid Knowledge Questionnaire (IPFKQ). The questionnaire is made up of two sections: Section A collects personal data such as age, gender, role, years of experience, and club location; Section B contains 20 items—ten items addressing Research Question 1 (prevalence of injuries) and ten items addressing Research Question 2 (first-aid knowledge impact). Responses are measured on a four-point Likert scale: Strongly Agree (4), Agree (3), Disagree (2), Strongly Disagree (1). The benchmark for interpretation is 2.50: items with a mean score of 2.50 and above are regarded as “agreed,” while those below 2.50 are regarded as “disagreed.”

### **Reliability**

The instrument was subjected to a pilot test with 30 respondents (players and coaches) from a club not included in the main sample. Cronbach’s Alpha coefficient was computed to assess internal consistency, yielding  $\alpha = 0.86$  for the entire scale,  $\alpha = 0.82$  for the injury prevalence items, and  $\alpha = 0.79$  for the first-aid knowledge items. These values indicate good reliability and consistency of the questionnaire.

### **Method of Data Collection**

Ethical approval was obtained from the National Sports Commission, and informed consent was secured from club officials, coaches, and players (or guardians for minors). The researcher, assisted by four trained research assistants, distributed the questionnaires during scheduled training sessions using the Direct Delivery Method (DDM), allowing immediate retrieval. A 98 % response rate was achieved (588 players, 78 coaches returned usable forms). Completed questionnaires were placed in sealed envelopes to preserve anonymity.

### **Method of Data Analysis**

Data were analysed using SPSS version 29. For Research Question 1 (prevalence of injuries), injury incidence is expressed as the number of injuries per 1,000 hours of exposure, and the percentage of players injured in the past year is calculated. For Research Question 2 (impact of first-aid knowledge), a total knowledge score (maximum 40) is computed for each participant, and the mean and standard deviation are reported. Since the study is descriptive

and does not test hypotheses, only mean scores, standard deviations, and frequency distributions are used to summarize the data. No inferential tests (e.g., correlation or chi-square) are performed. Results are presented in narrative form supplemented by tables for clarity.

### Ethical Considerations

Participation was voluntary, and informed consent was obtained from all respondents. Confidentiality was maintained by removing identifying information, and data were stored securely for academic use only. Respondents were free to withdraw at any point without penalty.

## RESULTS

### Research Question One

What is the prevalence of sports injuries among amateur footballers?

**Table 2: Mean rating of respondents on prevalence of sports injuries.**

| S/N          | Items on prevalence of sports injuries                           | Mean (X)    | Remark        |
|--------------|------------------------------------------------------------------|-------------|---------------|
| 1.           | Majority of players experience at least one injury per season.   | 2.96        | Agreed        |
| 2            | Ankle sprains are the most common type of injury reported.       | 3.48        | Agreed        |
| 3            | Hamstring strains occur frequently during sprinting.             | 2.94        | Agreed        |
| 4            | Overuse injuries (e.g., shin splints) are prevalent in training. | 3.14        | Agreed        |
| 5            | Head/ concussion injuries are reported, though less frequent.    | 2.52        | Agreed        |
| 6            | Recurrent injuries are common among players with prior trauma.   | 3.70        | Agreed        |
| 7            | Injuries often result from inadequate warm-up/cool-down.         | 3.56        | Agreed        |
| 8            | Poor pitch conditions contribute to injury occurrence.           | 3.86        | Agreed        |
| 9            | Players with low fitness levels report higher injury rates.      | 3.64        | Agreed        |
| 10           | Lack of protective gear (e.g., shin guards) increases risk.      | 3.21        | Agreed        |
| <b>Total</b> | <b>Cluster Mean</b>                                              | <b>3.30</b> | <b>Agreed</b> |

All items (1-10) recorded mean scores above 2.50, indicating agreement on the prevalence of various injuries (ankle sprains, hamstring strains, overuse, concussions, etc.) among amateur footballers. The mean of means (3.30) reflects a high level of consensus that injuries are common and multifactorial in this population.

### Research Question Two

How does first-aid knowledge among coaches and players influence the immediate management of injuries during amateur football matches and training?

**Table 1: Mean rating of respondents on influence of first-aid knowledge on immediate injury management.**

| S/N          | Items on influence of first-aid knowledge on immediate injury management          | Mean (X)    | Remark        |
|--------------|-----------------------------------------------------------------------------------|-------------|---------------|
| 11           | Coaches with first-aid training recognize concussion signs faster.                | 2.85        | Agreed        |
| 12           | Players who received first-aid education perform initial RICE protocol correctly. | 2.80        | Agreed        |
| 13           | Presence of a first-aid kit improves confidence to act during injury.             | 2.96        | Agreed        |
| 14           | Knowledge of bleeding control reduces severity of wounds.                         | 3.20        | Agreed        |
| 15           | Proper first-aid knowledge shortens time to medical referral.                     | 2.59        | Agreed        |
| 16           | Coaches with training are more likely to immobilize a suspected fracture.         | 3.02        | Agreed        |
| 17           | First-aid training reduces incidence of mismanagement errors.                     | 3.62        | Agreed        |
| 18           | Players with basic first-aid skills assist teammates safely.                      | 3.44        | Agreed        |
| 19           | Adequate first-aid knowledge improves overall safety culture in the club.         | 2.98        | Agreed        |
| 20           | Lack of first-aid knowledge leads to delayed emergency response.                  | 3.01        | Agreed        |
| <b>Total</b> | <b>Cluster Mean</b>                                                               | <b>2.95</b> | <b>Agreed</b> |

All items (11–20) obtained mean scores above the cut-off of 2.50, indicating agreement that first-aid knowledge among coaches and players positively influences the immediate management of injuries during matches and training. The cluster mean of 2.95 confirms that better first-aid knowledge is associated with safer, more effective initial care.

## DISCUSSION

The present study determined the prevalence of sports injuries among amateur footballers and how first-aid knowledge among coaches and players influences the immediate management of injuries during matches and training. The results, presented in Tables 1 and 2, reveal a high prevalence of injuries and a consistent agreement that adequate first-aid knowledge significantly improves initial injury care. In line with Research Question 1, the findings show mean scores ranging from 2.52 to 3.86, all above the cut-off of 2.50, indicating agreement that injuries such as ankle sprains, hamstring strains, overuse conditions (shin splints), and occasional concussions are common among amateur footballers. The cluster mean of 3.30 underscores a notable presence of injury burden in this population. This aligns with recent epidemiological studies in Sub-Saharan Africa (Ahmad et al., 2025; Meng & Qiao et al., 2023) that reported injury incidences of 9–15 per 1,000 hours of exposure, with lower-limb injuries dominating. The high mean scores for items like poor pitch conditions (3.86) and lack of protective gear (3.21) highlight extrinsic risk factors that compound injury risk in community settings where infrastructure and equipment standards are variable.

Regarding Research Question 2, Table 1 shows mean scores from 2.59 to 3.62, all surpassing the benchmark of 2.50, indicating agreement that first-aid knowledge among coaches and players enhances recognition, timely response, and proper initial care (e.g., RICE protocol, bleeding control, immobilization). The cluster mean of 2.95 reflects a consensus that knowledge translates into safer on-field practices. These results mirror findings from Almansoof et al. (2023) who posited that coaches with a 12-hour first-aid program performed correct actions 38 % more often and reduced severe injuries by 27 %. Similarly, Fares et al. (2023) noted that Nigerian players with first-aid-trained teammates experienced lower recurrence rates and faster return to play. The high mean for “First-aid training reduces mismanagement errors” (3.62) and “Players with basic skills assist safely” (3.44) supports the Knowledge-Attitude-Practice (KAP) model, suggesting that knowledge improves confidence and practice during emergencies. The Health Belief Model (HBM) and KAP model, adopted as theoretical lenses, help interpret the findings. HBM’s constructs of perceived susceptibility

(injury risk) and perceived benefits (effective first-aid reducing severity) appear strong, as respondents recognized injury prevalence (high mean 3.30) and the protective value of first-aid knowledge (cluster mean 2.95). However, the moderate mean for “Lack of first-aid knowledge leads to delayed emergency response” (3.01) hints at perceived barriers (e.g., limited equipment, insufficient training) that may impede optimal practice, a gap also identified by Barnhill et al. (2021).

The study is limited by its descriptive design, reliance on self-report data, and sample scope confined to two geopolitical zones, which may not fully capture the diversity of amateur football across Nigeria. The four-point Likert scale might have restricted nuanced responses, and the 2.50 benchmark, though standard, may mask subtle differences in knowledge levels. Future research should employ a longitudinal design to track injury incidence and management outcomes after a structured first-aid intervention, incorporate objective assessments such as simulated drills, expand the sample to all six geopolitical zones, and compare urban versus rural disparities. In conclusion, the findings confirm that sports injuries are prevalent among Nigerian amateur footballers and that first-aid knowledge significantly influences the quality of immediate care.

## CONCLUSION

This study set out to determine the prevalence of sports injuries among amateur footballers in Nigeria and to examine how first-aid knowledge among coaches and players influences the immediate management of those injuries during matches and training. The findings reveal a high prevalence of injuries particularly ankle sprains, hamstring strains, overuse conditions, and occasional concussions. There is widespread agreement on the frequency and risk factors such as poor pitch conditions and inadequate protective gear. Moreover, the results demonstrate that adequate first-aid knowledge significantly improves early recognition, timely response, and proper initial care. The evidence underscores that the lack of first-aid training not only heightens the risk of mismanagement but also contributes to prolonged recovery and higher recurrence rates. Conversely, players and coaches who possess basic first-aid skills are more likely to apply effective protocols (e.g., RICE, bleeding control, immobilization) and to facilitate swift medical referral, thereby reducing injury severity and enhancing safety culture within clubs. Thus, the study concludes that sports injuries constitute a notable burden in amateur Nigerian football and that enhancing first-aid knowledge and accessibility to essential resources such as first-aid kits, proper pitch maintenance, and

protective equipment is essential for mitigating risks, improving immediate care, and fostering long-term athlete welfare.

### **Implications for National Development**

The findings of this study highlight that amateur footballers in Nigeria experience a high prevalence of injuries and that limited first-aid knowledge among coaches and players compromises immediate injury management, leading to prolonged recovery, increased recurrence, and heightened health risks. These outcomes have far-reaching implications for national development. When a significant portion of young adults in community sports suffers avoidable injuries or receives suboptimal care, the immediate consequence is loss of training and competition time, reduced athletic potential, and heightened medical costs for families and local health systems. Frequent injuries also discourage participation in sport, undermining efforts to promote physical activity, healthy lifestyles, and social cohesion—key pillars for a productive populace. From an economic perspective, the burden of preventable injuries translates into higher public health expenditures, loss of labor productivity (as injured players may miss work or school), and reduced contribution to the emerging sports industry, which includes local leagues, sponsorships, and tourism. Conversely, clubs that retain healthier players are more likely to achieve better performance, attract sponsors, and generate community pride, thereby fostering grassroots development and potential pathways for talent identification. Strengthening first-aid knowledge and emergency response capacity therefore becomes a strategic investment in human capital. Training coaches, players, and club officials in basic first-aid, ensuring availability of first-aid kits, and improving pitch safety standards can lower injury incidence and severity, shorten recovery times, and reduce long-term disability. This enhances school attendance for student-athletes, improves academic performance, and boosts overall educational outcomes, since healthier youths are more attentive and engaged in learning. Moreover, embedding injury-prevention and first-aid education within sports policies aligns with broader public health goals such as reducing trauma mortality, promoting safety awareness, and building a culture of health and safety across sectors. Investing in structured first-aid training, upgrading sporting infrastructure, and enforcing safety regulations for amateur leagues are not merely sport-related measures- they are essential components of a healthier, more productive, and resilient society. Without such interventions, the cycle of injury, disability, and lost opportunity will persist, curtailing Nigeria's human capital potential and slowing progress toward inclusive and sustainable growth.

## RECOMMENDATIONS

Based on the findings of the study, the following recommendations were made:

1. Sports federations and clubs must mandate a certified first-aid training program (minimum 8 hours) for all coaches and team captains, with renewal every two years, and ensure every team possesses a well-stocked first-aid kit and an emergency action plan that includes quick referral pathways to nearby health facilities.
2. Players should be encouraged to participate in basic first-aid workshops and refresher sessions, especially senior or leadership-role players, and to adhere to protective gear such as shin guards and ankle supports while practicing proper warm-up and cool-down routines.
3. Community stakeholders such as local governments, NGOs, schools, should organize regular injury-prevention campaigns focusing on pitch safety, safe playing techniques, and early injury reporting, collaborating with health institutions to provide on-site medical personnel or volunteers during matches and training in high-risk areas.
4. Policymakers in the Ministry of Sports and National Sports Commission must integrate first-aid certification as a requirement for club licensing and league participation, allocate funding for upgrading community pitches (lighting, drainage, surface quality) to reduce extrinsic injury hazards, and develop a national database to track injury incidence in amateur sports, informing future policy and resource allocation.

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