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Harmful Traditional Practices and their Perceived Health Effects among Residents of a Semi-Urban Community in South-South Nigeria

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ABSTRACT

Background: Harmful traditional practices remain a public health concern because of their potential physical, psychological, and social consequences. Their persistence is influenced by cultural beliefs, family expectations, social norms, and perceptions of their health effects. **Objective:** The aim of this study was to assess knowledge of harmful traditional practices and their perceived health effects among residents of Okada, Edo State, Nigeria.

Methods: A descriptive cross-sectional study was conducted among adult residents of Okada. A multistage sampling technique was used to recruit respondents from selected residential clusters. Data were collected using a structured, interviewer-administered questionnaire assessing sociodemographic characteristics, knowledge of harmful traditional practices, and perceived health effects. Knowledge was assessed using a 9-point composite score and categorized as poor, fair, or good. Data were analyzed using IBM SPSS Statistics version 27. Descriptive statistics, chi-square/Fisher's exact tests, and binary logistic regression were used, with statistical significance set at $p < 0.05$.

Results: A total of 294 respondents participated, giving a 99.3% response rate. The mean age was 39.34 ± 11.96 years, and 181 (61.6%) were female. Most respondents, 260 (88.4%), had heard of harmful traditional practices. Early/child marriage (77.2%) and female genital mutilation (75.5%) were the most commonly recognized practices. Infection (72.8%), and psychological trauma (71.1%) were the most frequently recognized health risks. The mean knowledge score was 6.28 ± 1.37 (69.8%), with 138 (46.9%) demonstrating good knowledge, 130 (44.2%) fair knowledge, and 26 (8.8%) poor knowledge.

Conclusion: Residents of Okada demonstrated generally good awareness and moderate-to-good knowledge of harmful traditional practices. However, important gaps existed in knowledge of relevant laws and policies, while perceptions of traditional practices remained inconsistent. Community-based health education involving healthcare workers, schools, families, community leaders, and the media should emphasize practice-specific health risks, correct misconceptions, and improve awareness of legal protections against harmful traditional practices.

KEYWORDS: harmful traditional practices, health effects, female genital mutilation, child marriage; scarification, Nigeria**.**

BACKGROUND

Traditional practices constitute an important part of the cultural identity and social organization of communities, particularly in many African societies. These practices are transmitted across generations and may influence beliefs about health, illness, reproduction, child-rearing, and healthcare utilization. Although some traditional practices are beneficial or harmless, others may have adverse consequences for health and well-being. The World Health Organization recognizes practices such as female genital mutilation, child marriage, harmful nutritional practices, female infanticide, and certain forms of traditional medical procedures as harmful traditional practices because of their potential to cause physical, psychological, and social harm.[1,2]

Harmful traditional practices remain a public health concern in Nigeria, where cultural beliefs and social expectations continue to influence health-related behaviours. Female genital mutilation, for example, remains practiced in different parts of the country[3–5] and may result in severe bleeding, infection, urinary and menstrual problems, sexual difficulties, psychological distress, and complications during childbirth.[6–8] Other practices, including traditional uvulectomy and unsafe forms of scarification or traditional treatment, may similarly expose individuals to complications such as hemorrhage, infection, injury, and delayed access to appropriate medical care.[9,10] Traditional uvulectomy, for instance, has been associated with serious complications including infection, tetanus, and hemorrhage.[11,12]

The continued existence of these practices is influenced by cultural norms, family expectations, perceived social benefits, community acceptance, and beliefs about their health or protective effects.[13–15] Consequently, individuals may recognize a practice as traditional without necessarily understanding its potential health consequences.[16] Knowledge and perceptions are therefore important determinants of whether harmful practices are accepted, rejected, continued, or challenged within a community.

Okada, a semi-urban community in Ovia North-East Local Government Area of Edo State, is characterized by diverse cultural and socioeconomic backgrounds. However, there is limited community-level evidence regarding residents' knowledge of harmful traditional practices and their perceptions of the associated health effects. Understanding these factors is essential for developing culturally appropriate health education and community-based interventions. This study therefore assessed the knowledge of harmful traditional practices and their perceived health effects among residents of Okada, Edo State, Nigeria.

METHODOLOGY

Study Area

The study was conducted among adult residents of Okada, Ovia North-East Local Government Area of Edo State, South-South Nigeria. Okada, the local government headquarters, lies approximately at latitude 6°44′11″ N and longitude 5°23′11″ E and covers about 2,302 km². The community comprises two political wards, Okada East and Okada West, with the Bini as the predominant ethnic group alongside Yoruba, Urhobo, Isoko, Hausa, Igbo, Ijaw, and Fulani residents. Farming and trading are major occupations, while Christianity is the predominant religion. Okada hosts Igbinedion University, Igbinedion University Teaching Hospital, a National Youth Service Corps orientation camp, and other commercial activities.

Study Design and Population

A descriptive cross-sectional study was conducted among adult residents of Okada. Residents who lived in Okada, were present during data collection, provided consent, and could communicate in English were eligible. Those unwilling to participate, not resident in Okada, unable to understand English, or too ill to participate were excluded.

Sample Size Determination

The minimum sample size was calculated using the Cochran formula for a single population proportion:

$n = Z^2pq / d^2$

where n = minimum sample size, Z = standard normal deviate at 95% confidence level (1.96), p = estimated proportion (16.1%), being the proportion of Nigerian adolescents reported to have been subjected to a harmful traditional practice,[17] $q = 1 - p$ (0.839), and d = desired precision (0.05).

Thus:

$n = (1.96^2 \times 0.161 \times 0.839) / 0.05^2 = 208$

Allowing for a 10% non-response rate:

$n_s = 208 / (1 - 0.10) = 232$

Therefore, the minimum required sample size was 232 respondents. To improve precision, 296 questionnaires were administered.

Sampling Technique

A multistage sampling technique was used. Okada was divided into six residential clusters: Uwaila Street, Yobosa Street, Iyaro Street, Salvation Ministry Street, Old Market Road, and Women Street. Clusters were selected by simple random sampling using balloting, after which eligible residents were recruited until the required sample size was reached.

Data Collection

Data were collected using a structured, interviewer-administered questionnaire adapted from relevant previous studies.[16,17] The questionnaire assessed sociodemographic characteristics, knowledge of harmful traditional practices, and perceived health effects. Knowledge items covered awareness of harmful practices, including female genital mutilation, child marriage, widowhood rites, and scarification; associated health risks; sources of information; and awareness of relevant laws and policies. A 9-point composite knowledge score was generated and categorized as poor (<50%), fair (50–70%), or good (>70%).

Perceived health effects were assessed using five Likert-scale statements addressing the physical effects of traditional practices on adolescents, perceived benefits of female genital mutilation, effects on physical health, health consequences of scarification and tribal marks, and the role of healthcare providers. These items were analyzed individually.

Pre-testing

The questionnaire was pre-tested among residents of Iguobazuwa, approximately 19 km from Okada, using 10% of the minimum sample size. Identified errors and ambiguities were corrected before the main study.

Data Analysis

Data were analyzed using IBM SPSS Statistics version 27. Descriptive statistics were presented as frequencies, percentages, means, and standard deviations. Associations between sociodemographic characteristics and knowledge category (poor/fair versus good) were assessed using the chi-square or Fisher's exact test, as appropriate. Binary logistic regression was used to identify factors independently associated with good knowledge, with results presented as adjusted odds ratios (aORs) and 95% confidence intervals (CIs). Variables were entered as categorical factors with specified reference categories, and some categories were collapsed to limit the number of model parameters. Statistical significance was set at $p < 0.05$.

Ethical Considerations

Ethical approval was obtained from Igbinedion University Teaching Hospital, Okada (Reference Number: **IUTH/R.24/VOL.I/157**. Each participant provided informed consent after being adequately briefed on the purpose and procedure of the study. Participation was voluntary, and respondents were assured of anonymity, confidentiality, and the freedom to withdraw at any stage without any form of penalty.

Financial support and sponsorship: Nil.

Conflicts of interest: There are no conflicts of interest.

RESULTS

Socio-demographic characteristics of respondents (Table 1; Figure 1)

A total of 294 respondents participated in the study, giving a response rate of 99.3%. The mean age was 39.34 ± 11.96 years (range: 18–64 years), with respondents aged 25–34 years constituting the largest age group, 93 (31.6%), followed by 35–44 years, 75 (25.5%). Females constituted the majority, 181 (61.6%), while males accounted for 113 (38.4%). Bini/Edo was the predominant ethnic group, 75 (25.5%), followed by Urhobo, 65 (22.1%), and Yoruba, 61 (20.7%). Christianity was the predominant religion, 196 (66.7%).

Nearly half of the respondents had tertiary education, 137 (46.6%), while 100 (34.0%) had secondary education. Trading/entrepreneurship was the most common occupation, 59 (20.1%), followed by students, 53 (18.0%), and unemployed respondents, 46 (15.6%). Most had lived in Okada for 1–5 years, 96 (32.7%), or 6–10 years, 94 (32.0%). Only 101 (34.4%) reported active involvement in traditional cultural practices, while 193 (65.6%) were not involved.

Knowledge of harmful traditional practices (Table 2; Figures 2 and 3)

Most respondents, 260 (88.4%), had heard of harmful traditional practices. Early/child marriage, 227 (77.2%), and female genital mutilation, 222 (75.5%), were the most commonly recognized practices, followed by widowhood rites, 188 (63.9%), and scarification, 168 (57.1%). Media, 180 (61.2%), and family members, 177 (60.2%), were the leading sources of information, while fewer than half reported receiving information from schools, 145 (49.3%), community leaders, 129 (43.9%), or healthcare workers, 126 (42.9%).

Infection was the most commonly recognized health risk, 214 (72.8%), followed by psychological trauma, 209 (71.1%), excessive bleeding, 204 (69.4%), death, 190 (64.6%), and infertility, 184 (62.6%). Similarly, infection, 216 (73.5%), and severe bleeding, 209 (71.1%), were the most commonly known health consequences. However, 47 (16.0%) reported knowing none of the listed consequences. A total of 229 (77.9%) believed that some traditional practices could be harmful to health, while 205 (69.7%) knew that female genital mutilation had no medical benefit.

Legal knowledge was comparatively limited. Although 178 (60.5%) knew that some harmful traditional practices were prohibited by law, only 123 (41.8%) could identify specific laws or government policies addressing them. The mean knowledge score was 6.28 ± 1.37 out of 9 (69.8%; range: 3–9). Overall, 138 (46.9%) had good knowledge, 130 (44.2%) fair knowledge, and 26 (8.8%) poor knowledge.

Factors associated with knowledge of harmful traditional practices (Table 3)

At bivariate analysis, educational level was the only socio-demographic characteristic significantly associated with knowledge category (χ^2=6.088, p=0.048). Good knowledge was reported by 35 (61.4%) respondents with no formal or primary education, compared with 42 (42.0%) with secondary education and 61 (44.5%) with tertiary education. Gender showed a non-significant trend, with good knowledge among 93 (51.4%) females and 45 (39.8%) males (χ^2=3.282, p=0.070). Age, ethnicity, religion, occupation, length of residence, and active involvement in traditional practices were not significantly associated with knowledge.

After adjustment, none of the variables was significantly associated with good knowledge, and the overall model was not significant (likelihood-ratio p=0.748; pseudo R^2=0.037). Compared with respondents with no formal or primary education, those with secondary education had lower but non-significant odds of good knowledge (adjusted OR=0.60, 95% CI: 0.29–1.28, p=0.190), as did those with tertiary education (adjusted OR=0.67, 95% CI: 0.33–1.35, p=0.264). Females had higher odds of good knowledge than males, but this was not statistically significant (adjusted OR=1.54, 95% CI: 0.90–2.64, p=0.118).

Perceived health effects of traditional practices (Table 4)

Perceptions of the health effects of traditional practices were mixed. A total of 217 (73.8%) agreed that traditional practices had a positive impact on adolescents' physical wellbeing, while 240 (81.7%) agreed that cultural practices led to better physical health in adolescents. However, 232 (78.9%) disagreed that practices such as female genital mutilation were beneficial for adolescents, including 137 (46.6%) who strongly disagreed.

Perceptions regarding scarification were evenly divided, with 147 (50.0%) agreeing that scarification or tribal marks directly affected adolescent health and 147 (50.0%) disagreeing. Most respondents, 215 (73.1%), agreed that healthcare providers played a major role in addressing health problems arising from harmful traditional practices.

Table 1: Socio-Demographic Characteristics of Respondents (N = 294)

Variable	Frequency (N = 294)	Percentage (%)
Age Group (years)		
18–24	33	11.2
25–34	93	31.6
35–44	75	25.5
45–54	48	16.3
55+	45	15.3
Gender		
Male	113	38.4
Female	181	61.6
Ethnicity		
Bini/Edo	75	25.5
Yoruba	61	20.7
Igbo	39	13.3
Urhobo	65	22.1
Others	54	18.4
Religion		
Christianity	196	66.7
Islam	60	20.4
Traditional	29	9.9
Others	9	3.1
Level of Education		
No formal education	17	5.8
Primary	40	13.6
Secondary	100	34.0
Tertiary	137	46.6
Occupation		
Student	53	18.0
Civil servant	37	12.6
Trader/Entrepreneur	59	20.1
Farmer	28	9.5
Teacher	28	9.5
Health worker	16	5.4
Banker	27	9.2
Unemployed	46	15.6
Length of Stay in Okada		
Less than 1 year	21	7.1
1–5 years	96	32.7
6–10 years	94	32.0
More than 10 years	83	28.2
Actively Involved in Traditional Cultural Practices		
Yes	101	34.4
No	193	65.6

Mean age ± SD = 39.34 ± 11.96 years; range 18–64 years.

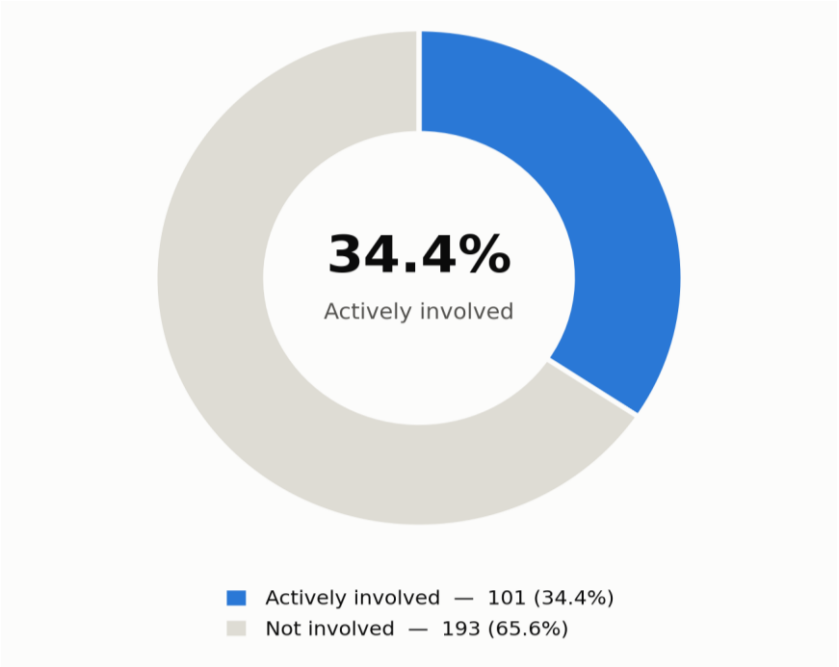


Figure 1: Active Involvement in Traditional Cultural Practices (N = 294)

Table 2: Knowledge of Harmful Traditional Practices and Composite Classification (N = 294)

Knowledge Variable	Frequency (N = 294)	Percentage (%)
Awareness of Harmful Traditional Practices		
Have heard about harmful traditional practices in Nigeria	260	88.4
Have not heard	34	11.6
Awareness of Specific Practices (multiple responses)		
Early/child marriage	227	77.2
Female genital mutilation	222	75.5
Widowhood rites	188	63.9
Scarification	168	57.1
Other harmful practices	62	21.1
Sources of Information (multiple responses)		
Media (TV, radio, internet)	180	61.2
Family members	177	60.2
School	145	49.3
Community leaders	129	43.9
Healthcare workers	126	42.9
Health Risks Recognized (multiple responses)		
Infection	214	72.8
Psychological trauma	209	71.1
Excessive bleeding	204	69.4
Death	190	64.6
Infertility	184	62.6
Health Consequences Known (multiple responses)		
Infection	216	73.5
Severe bleeding	209	71.1
Psychological trauma	199	67.7
Complications during childbirth	177	60.2
Do not know	47	16.0
Legal Awareness and General Belief		
Aware that some practices are prohibited by law	178	60.5
Knows specific laws or policies addressing them	123	41.8
Believes some traditional practices can be harmful	229	77.9
Aware that female genital mutilation has no medical benefit	205	69.7
Not sure whether female genital mutilation has a benefit	44	15.0
Composite Knowledge Category		

Poor (below 50%)	26	8.8
Fair (50–70%)	130	44.2
Good (above 70%)	138	46.9

Composite knowledge score: mean ± SD = 6.28 ± 1.37 out of a maximum of 9; observed range 3–9, corresponding to a mean knowledge percentage of 69.8%. Multiple responses were permitted for the awareness, source, risk and consequence items, so percentages within those blocks do not sum to 100%.

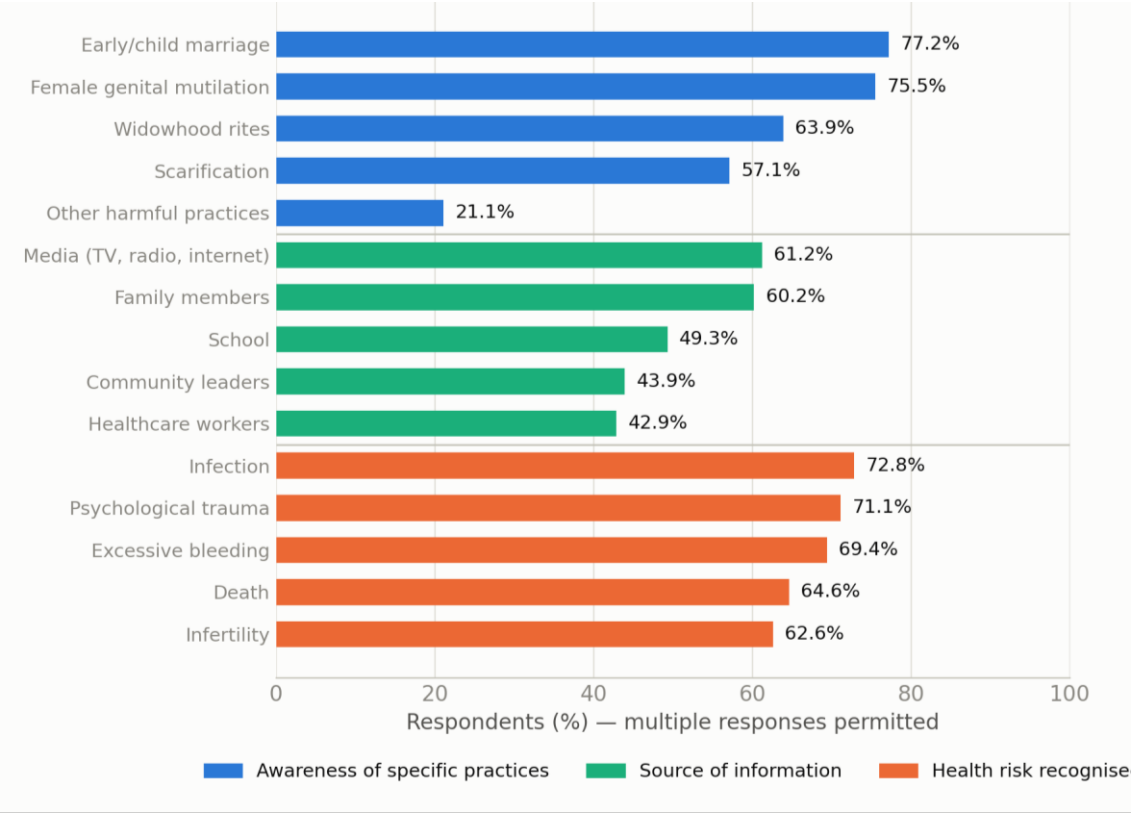


Figure 2: Awareness of Specific Harmful Traditional Practices, Information Sources and Recognized Health Risks

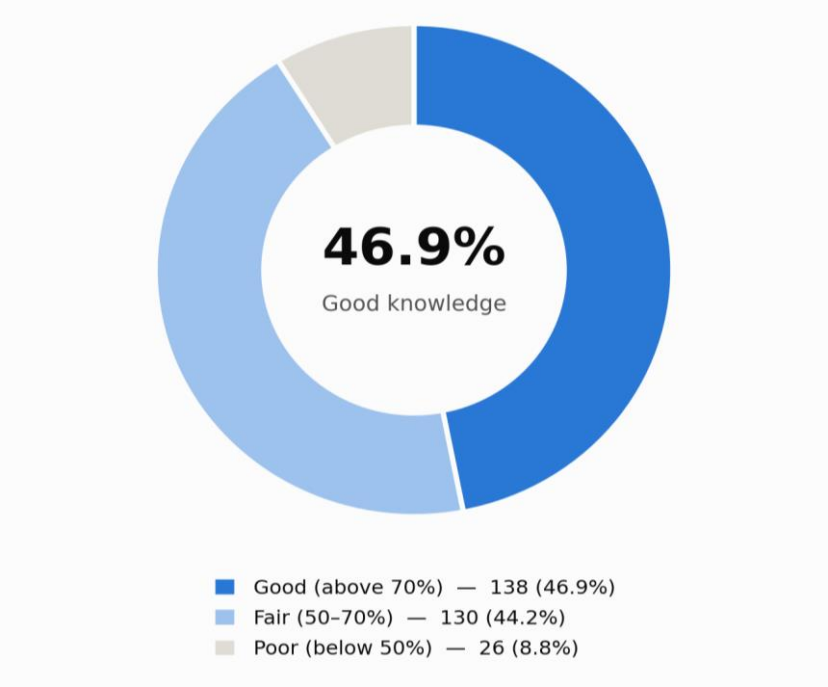


Figure 3: Knowledge Classification of Respondents (N = 294)

Table 3: Association Between Socio-Demographic Characteristics and Knowledge Category

Variable	Poor/Fair n (%)	Good n (%)	χ^2 (p)	Adj. OR (95% CI)†	p (adj.)
Age group (years)			**0.666 (0.717)**		
18–34 (reference)	19 (57.6)	14 (42.4)		1.00	—
35–44	48 (51.6)	45 (48.4)		1.33 (0.58–3.06)	0.508
45 and above	61 (49.6)	62 (50.4)		1.44 (0.64–3.25)	0.380
Gender			**3.282 (0.070)**		
Male (reference)	68 (60.2)	45 (39.8)		1.00	—
Female	88 (48.6)	93 (51.4)		1.54 (0.90–2.64)	0.118
Ethnicity			**4.484 (0.344)**		
Bini/Edo (reference)	35 (46.7)	40 (53.3)		1.00	—
Yoruba	35 (57.4)	26 (42.6)		0.54 (0.25–1.19)	0.126
Igbo	17 (43.6)	22 (56.4)		0.95 (0.39–2.31)	0.913
Urhobo	39 (60.0)	26 (40.0)		0.58 (0.27–1.25)	0.165
Others	30 (55.6)	24 (44.4)		0.74 (0.34–1.62)	0.453
Religion			**1.243 (0.537)**		
Christianity (reference)	107 (54.6)	89 (45.4)		1.00	—
Islam	28 (46.7)	32 (53.3)		1.17 (0.61–2.23)	0.641
Traditional or other	21 (55.3)	17 (44.7)		0.85 (0.37–1.94)	0.691
Level of education			**6.088 (0.048)***		
No formal or primary (reference)	22 (38.6)	35 (61.4)		1.00	—
Secondary	58 (58.0)	42 (42.0)		0.60 (0.29–1.28)	0.190
Tertiary	76 (55.5)	61 (44.5)		0.67 (0.33–1.35)	0.264
Occupation			**1.387 (0.708)**		
Student (reference)	28 (52.8)	25 (47.2)		1.00	—
Salaried employment	55 (50.9)	53 (49.1)		1.00 (0.47–2.13)	0.995
Trader or farmer	45 (51.7)	42 (48.3)		0.87 (0.41–1.86)	0.727
Unemployed	28 (60.9)	18 (39.1)		0.67 (0.27–1.67)	0.390
Length of stay in Okada			**0.495 (0.781)**		
Up to 5 years (reference)	65 (55.6)	52 (44.4)		1.00	—
6–10 years	48 (51.1)	46 (48.9)		1.10 (0.58–2.06)	0.773
Over 10 years	43 (51.8)	40 (48.2)		1.04 (0.55–1.99)	0.898
Active involvement in traditional practices			**0.512 (0.474)**		
Yes (reference)	57 (56.4)	44 (43.6)		1.00	—
No	99 (51.3)	94 (48.7)		1.27 (0.73–2.22)	0.400

***Statistically significant at $p < 0.05$. No estimate reached significance and the model was not significant overall (likelihood-ratio $p = 0.748$; pseudo $R^2 = 0.037$).**

Table 4: Perceived Health Effects of Traditional Practices (N = 294)

Statement	Strongly Agree n (%)	Agree n (%)	Disagree n (%)	Strongly Disagree n (%)
Traditional practices have a positive impact on adolescents' physical wellbeing	105 (35.7)	112 (38.1)	34 (11.6)	43 (14.6)
Traditional practices like female genital mutilation are beneficial for adolescents	26 (8.8)	36 (12.2)	95 (32.3)	137 (46.6)
Cultural practices lead to better physical health in adolescents	106 (36.1)	134 (45.6)	34 (11.6)	20 (6.8)
Scarification/tribal marks directly impact adolescent health	52 (17.7)	95 (32.3)	85 (28.9)	62 (21.1)
Healthcare providers play a major role in addressing health issues arising from harmful traditional practices	87 (29.6)	128 (43.5)	42 (14.3)	37 (12.6)

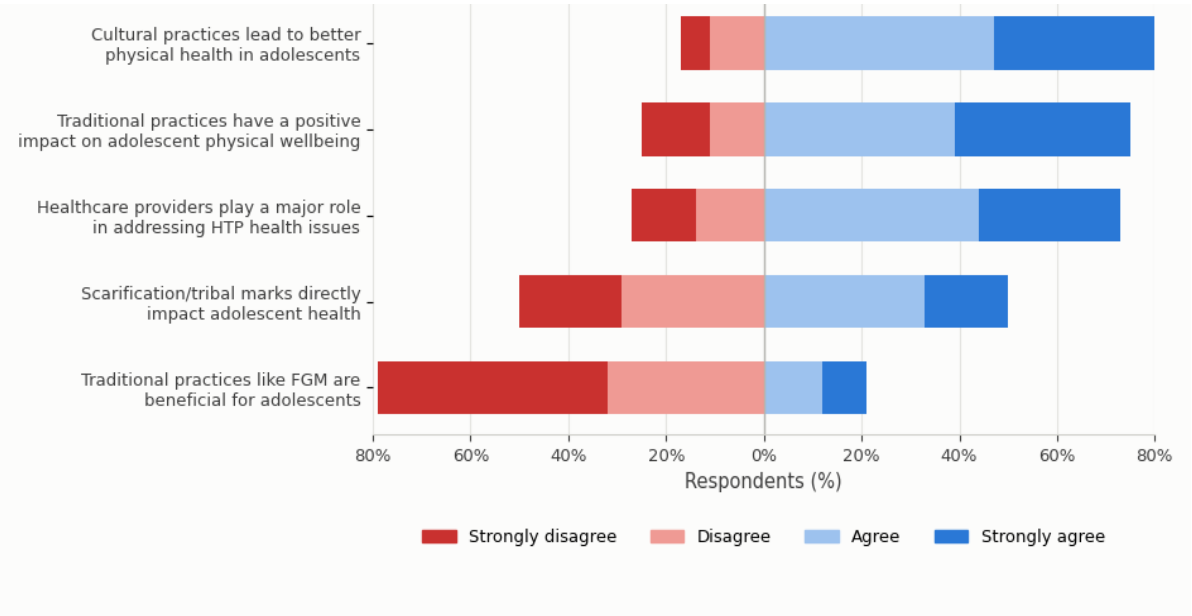


Figure 4: Responses to Statements on the Health Effects of Traditional Practices

DISCUSSION

This study assessed knowledge of harmful traditional practices (HTPs) and their perceived health effects among residents of Okada, Edo State. Awareness of HTPs was high and knowledge of the major health consequences was moderate to good. Knowledge was, however, uneven, and it was weakest in relation to the laws prohibiting these practices. Perceptions of traditional practices were also mixed, suggesting that recognizing particular practices as harmful may coexist with generally favourable attitudes towards traditional culture.

Awareness of HTPs was reported by 88.4% of respondents, a level consistent with findings from other Nigerian communities in which most residents have heard of these practices.[16,17] Awareness alone, however, does not indicate understanding, as studies among adolescents, market women, and women attending antenatal clinics in Nigeria have documented widespread familiarity with traditional practices alongside limited knowledge of their complications.[16–18] Early/child marriage and female genital mutilation were the most widely recognized practices in this study, although child marriage is comparatively uncommon in southern Nigerian communities.[19,20] Recognition in Okada therefore appears to be shaped more by national campaigns and media coverage than by local prevalence, which may also explain why scarification and other locally embedded procedures were recognized less frequently.[9]

Media and family members were the leading sources of information in this study, a pattern reported in other Nigerian settings where mass media and family networks are central to the transmission of information about harmful traditional practices.[15,18] Media exposure should not, however, be equated with effectiveness, as anti-FGM media campaigns in rural Nigerian communities have failed where cultural values are entrenched and where network coverage and electricity supply are unreliable.[21] Fewer than half of the respondents identified schools or healthcare workers as sources of information, which represents an important missed opportunity. Healthcare providers are well placed to deliver accurate and culturally appropriate education,[22] and structured health education programmes in Nigeria and elsewhere have significantly improved knowledge of the consequences of harmful practices and awareness of the legislation prohibiting them.[23,24]

Recognition of specific health consequences was relatively good, with infection, psychological trauma, excessive bleeding, death, and infertility most frequently identified. This ordering is consistent with reports from Nigerian studies of both community members and health workers, in which bleeding, infection, and the risk of blood-borne infection are the complications most readily named.[25] Clinical evidence supports these concerns, as traditional uvulectomy is associated with haemorrhage, sepsis, and hospital admission.[11] The 16.0% of respondents who could not identify any listed consequence nevertheless indicates a persistent gap. Comparable deficits have been documented in rural communities in south-eastern Nigeria, where knowledge of the health implications of female genital mutilation was low and health workers were themselves among the practitioners.[26] Misconceptions also persist among health professionals, some of whom regard certain forms of the practice as harmless.[27]

The gap between knowledge of health consequences and knowledge of the law was the most striking finding of this study. While 60.5% of respondents knew that some practices were prohibited, only 41.8% could identify a specific law or policy. Limited awareness of anti-FGM legislation has similarly been reported among Nigerian youths and in rural communities years after the relevant laws were enacted.[28,29] The legal framework is itself fragmented, as the principal federal legislation applies only to the

Federal Capital Territory while prohibition in Edo State rests on separate state law, and prosecutions have been few.[30] Residents who cannot identify the applicable law are unlikely to invoke it, and improving legal literacy should therefore form part of community health education.

Educational level was associated with knowledge category at bivariate analysis but did not remain significant after adjustment, and no sociodemographic variable independently predicted good knowledge. Good knowledge was, unexpectedly, most common among respondents with no formal or primary education. This most likely reflects the channels through which information reached this community, since media and family rather than school were the dominant sources reported. Comparable findings have been reported from other Nigerian communities in which education did not influence knowledge or perception of harmful traditional practices,[31] and incomplete knowledge has likewise been documented among health professionals, who are among the most educated groups studied.[25] Formal education alone therefore appears insufficient to confer practice-specific knowledge.

Perceptions of the health effects of traditional practices were mixed. Most respondents agreed that traditional practices had a positive influence on adolescent physical wellbeing, yet a similar majority rejected the view that practices such as female genital mutilation were beneficial. Rather than being contradictory, this pattern suggests that respondents distinguish between traditional culture in general, which they value, and specific practices they recognize as harmful. Similar divergence between attitude and behaviour has been reported in Nigeria and elsewhere in West Africa, where opposition to harmful practices coexists with their continued performance.[16,32] National survey data have likewise shown declining practice without corresponding change in perception.[5] Attitudes and practices therefore move independently, and neither can be inferred from the other.

Opinion on scarification was evenly divided. Scarification carries cultural meanings that female genital mutilation does not, functioning as a marker of identity and, in some settings, as an assumed remedy, with the health risk arising principally from the use of unsterile instruments rather than from the practice itself.[9,10] Nigerian evidence indicates that tribal marks, formerly regarded as signals of beauty and social standing, increasingly attract stigma and discrimination.[33] Respondents may therefore regard scarification as both cultural identity and health risk, and the even split may reflect genuine ambivalence rather than ignorance. The stronger rejection of female genital mutilation is consistent with sustained public advocacy, although reviews of such interventions caution that attitudes change more readily than behaviour.[34]

Most respondents agreed that healthcare providers have a major role in addressing health problems arising from harmful traditional practices. Providers are trusted within communities and are well positioned to deliver education, counselling, and early identification of complications.[22] In several Nigerian and West African settings, however, health workers have themselves been implicated in performing these procedures.[26,32] Any expanded clinical role should therefore be accompanied by training that addresses providers' own beliefs as well as those of their patients.

CONCLUSION

Residents of Okada demonstrated generally good awareness and knowledge of harmful traditional practices and their major health consequences. However, knowledge of relevant laws and policies was limited, and perceptions of traditional practices were mixed. While most respondents rejected the health benefits of female genital mutilation, many continued to view traditional practices generally as beneficial. These findings highlight the need to strengthen accurate, practice-specific knowledge and address misconceptions surrounding harmful traditional practices.

LIMITATIONS

The cross-sectional design limits causal interpretation. Self-reported responses may have been affected by recall and social-desirability bias, particularly regarding sensitive cultural practices. Restricting participation to English-speaking residents may have excluded some members of the community. The study was also conducted in a single semi-urban community, limiting generalizability to other settings.

RECOMMENDATIONS

Health education on harmful traditional practices should be strengthened through healthcare facilities, schools, community leaders, families, and the media, with emphasis on specific health consequences and relevant laws and policies. Healthcare workers should be more actively involved in community education and counselling. Community leaders and families should be engaged in addressing misconceptions while promoting beneficial cultural practices. Greater awareness of existing legal protections should also be encouraged to support prevention and reporting of harmful practices.

REFERENCES

1) Office of the United Nations High Commissioner for Human Rights. Fact sheet no. 23: harmful traditional practices affecting the health of women and children. Geneva: OHCHR; 1995.

2) Committee on the Elimination of Discrimination against Women, Committee on the Rights of the Child. Joint general recommendation no. 31 of the Committee on the Elimination of Discrimination against Women / general comment no. 18 of the Committee on the Rights of the Child on harmful practices. UN Doc. CEDAW/C/GC/31/Rev.1–CRC/C/GC/18/Rev.1. Geneva: United Nations; 2019.
3) World Health Organization. Female genital mutilation. Fact sheet. Geneva: World Health Organization; 2025.
4) Nnanatu CC, Atilola G, Komba P, Mavatikua L, Moore Z, Matanda D, et al. Evaluating changes in the prevalence of female genital mutilation/cutting among 0–14 years old girls in Nigeria using data from multiple surveys: a novel Bayesian hierarchical spatio-temporal model. PLoS One. 2021;16(2):e0246661. doi:10.1371/journal.pone.0246661.
5) Gbadebo BM, Salawu AT, Afolabi RF, Salawu MM, Fagbamigbe AF, Adebowale AS. Cohort analysis of the state of female genital cutting in Nigeria: prevalence, daughter circumcision and attitude towards its discontinuation. BMC Womens Health. 2021;21(1):182. doi:10.1186/s12905-021-01324-2.
6) Pallitto C, Ruiz-Vallejo F, Mochache V, Stein K, Vogel JP, Petzold M. Exploring the health complications of female genital mutilation through a systematic review and meta-analysis. BMC Public Health. 2025;25(1):1387. doi:10.1186/s12889-025-21584-z.
7) Berg RC, Underland V, Odgaard-Jensen J, Fretheim A, Vist GE. Effects of female genital cutting on physical health outcomes: a systematic review and meta-analysis. BMJ Open. 2014;4(11):e006316. doi:10.1136/bmjopen-2014-006316.
8) Abdalla SM, Galea S. Is female genital mutilation/cutting associated with adverse mental health consequences? A systematic review of the evidence. BMJ Glob Health. 2019;4(4):e001553. doi:10.1136/bmjgh-2019-001553.
9) Garve R, Garve M, Türp JC, Fobil JN, Meyer CG. Scarification in sub-Saharan Africa: social skin, remedy and medical import. Trop Med Int Health. 2017;22(6):708–15. doi:10.1111/tmi.12878.
10) Ayeni OA, Ayeni OO, Jackson R. Observations on the procedural aspects and health effects of scarification in sub-Saharan Africa. J Cutan Med Surg. 2007;11(6):217–21. doi:10.2310/7750.2007.00026.
11) Adoga AA, Nimkur TL. The traditionally amputated uvula amongst Nigerians: still an ongoing practice. ISRN Otolaryngol. 2011;2011:704924. doi:10.5402/2011/704924.
12) Getachew T, Negash A, Kebede SM, Cheru A, Eyeberu A, Tura AK. The complications of traditional uvulectomy and concurrent occurrences of cultural malpractices in Ethiopia: a systematic review and meta-analysis. Heliyon. 2024;10(19):e38978. doi:10.1016/j.heliyon.2024.e38978.
13) Shell-Duncan B, Wander K, Hernlund Y, Moreau A. Dynamics of change in the practice of female genital cutting in Senegambia: testing predictions of social convention theory. Soc Sci Med. 2011;73(8):1275–83. doi:10.1016/j.socscimed.2011.07.022.
14) Efferson C, Vogt S, Elhadi A, Ahmed HEF, Fehr E. Female genital cutting is not a social coordination norm. Science. 2015;349(6255):1446–7. doi:10.1126/science.aaa7978.
15) Oni TO, Okunlola DA. Contextual determinants of generational continuation of female genital mutilation among women of reproductive age in Nigeria: analysis of the 2018 Demographic and Health Survey. Reprod Health. 2024;21(1):39. doi:10.1186/s12978-024-01778-1.
16) Ikeaba NC, Balogun MR, Olubodun T, Okafor I. Harmful traditional practices among market women in Ojuwoye Market Mushin, South West, Nigeria. Ann Afr Med. 2022;21(3):208–16. doi:10.4103/aam.aam_112_20.
17) Gabriel-Job N, Udofia EA, Akani NA. Harmful traditional practices among adolescents: knowledge, perception and complications. Niger Health J. 2023;22(4):433–9.
18) Anyanwu CE, Torpey K, Sanni OF, Abiodun OP, Anyanwu ID. Knowledge and attitude of Nigerian women aged 15–49 years on the practice of female genital mutilation. J Epidemiol Public Health. 2025;10(2):171–82. doi:10.26911/jepublichealth.2025.10.02.04.
19) Mobolaji JW, Fatusi AO, Adedini SA. Ethnicity, religious affiliation and girl-child marriage: a cross-sectional study of nationally representative sample of female adolescents in Nigeria. BMC Public Health. 2020;20(1):583. doi:10.1186/s12889-020-08714-5.
20) Bolarinwa OA, Ahinkorah BO, Okyere J, Seidu AA, Olagunju OS. A multilevel analysis of prevalence and factors associated with female child marriage in Nigeria using the 2018 Nigeria Demographic and Health Survey data. BMC Womens Health. 2022;22(1):158. doi:10.1186/s12905-022-01733-x.
21) Wogu JO, Amonyeze C, Babatola Folorunsho RO, Aloh HE. An evaluation of the impact of media campaign against female genital mutilation (FGM) in the rural communities of Enugu State, Nigeria. Glob J Health Sci. 2019;11(14):37. doi:10.5539/gjhs.v11n14p37.
22) Agboeze J, Nwali MI, Orji ML, Nwobodo MI, Ugwoke SI, Nnaji TN. Exploring the persistence of female genital mutilation: primary healthcare providers' experience and their perspective on elimination. Niger Med J. 2026;67(1):84–92. doi:10.71480/nmj.v67i1.990.

23) Olunuga O, Robinson R, Ojajuni P, Opondo W, Gitari W, Owolabi I, et al. Impact of the StopCut project on the practice of female genital mutilation/cutting in Southwest Nigeria: a quasi-experimental study. BMC Public Health. 2025;25(1):768. doi:10.1186/s12889-025-21976-1.
24) Mahgoub E, Nimir M, Abdalla S, Elhuda DA. Effects of school-based health education on attitudes of female students towards female genital mutilation in Sudan. East Mediterr Health J. 2019;25(6):406–12. doi:10.26719/emhj.18.053.
25) Ashimi A, Aliyu L, Shittu M, Amole T. A multicentre study on knowledge and attitude of nurses in northern Nigeria concerning female genital mutilation. Eur J Contracept Reprod Health Care. 2014;19(2):134–40. doi:10.3109/13625187.2014.885940.
26) Odo AN, Dibia SIC, Nwagu EN, Umoke M, Umoke PCI. Towards characterization of female genital mutilation (FGM) in rural Nigeria. Afr Health Sci. 2020;20(4):1968–78. doi:10.4314/ahs.v20i4.55.
27) Onuh SO, Igberase GO, Umeora JO, Okogbenin SA, Otoide VO, Gharoro EP. Female genital mutilation: knowledge, attitude and practice among nurses. J Natl Med Assoc. 2006;98(3):409–14.
28) Uche AO, Obiora AV. Assessing social media influence on Nigerian youths' knowledge, awareness and attitude towards anti-female genital mutilation (FGM) legislative provisions. Asian J Educ Soc Stud. 2025;51(2):305–20. doi:10.9734/ajess/2025/v51i21787.
29) Nwali MI, Agboeze J. Culture, beliefs, attitude and peer group influence on female genital mutilation in Southeast Nigeria. Open J Obstet Gynecol. 2023;13(8):1350–62. doi:10.4236/ojog.2023.138113.
30) 28 Too Many, Orchid Project, TrustLaw. Nigeria: the law and FGM. Version 3. London: 28 Too Many; 2022.
31) Agbaje OS, Agu BN, Osakwe KC. Perception of harmful traditional practices among women of childbearing age in Oru West Local Government Area, Imo State. Sci J Public Health. 2015;3(2):150–60. doi:10.11648/j.sjph.20150302.11.
32) Kaplan Marcusán A, Riba Singla L, Laye M, Secka DM, Utzet M, Le Charles M. Female genital mutilation/cutting: changes and trends in knowledge, attitudes, and practices among health care professionals in The Gambia. Int J Womens Health. 2016;8:103–17. doi:10.2147/IJWH.S102201.
33) Adisa TA, Mordi C, Timming AR. Employment discrimination against indigenous people with tribal marks in Nigeria: the painful face of stigma. Work Employ Soc. 2023;38(3):787–808. doi:10.1177/09500170231173591.
34) Matanda DJ, Van Eekert N, Croce-Galis M, Gay J, Middelburg MJ, Hardee K. What interventions are effective to prevent or respond to female genital mutilation? A review of existing evidence from 2008–2020. PLOS Glob Public Health. 2023;3(5):e0001855. doi:10.1371/journal.pgph.0001855.