



## DEMOGRAPHIC ATTRIBUTES AS PREDICTOR OF DOCUMENTATION OF INDIGENOUS KNOWLEDGE BY THE TRADITIONAL HEALTH PRACTITIONERS KWARA STATE, NIGERIA

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### Abstract

This study is on demographic variables as predictors of documentation of indigenous knowledge by traditional health practitioners. The study adopted a descriptive research design of the survey type, 30 traditional health practitioners in Kwara-State of Nigeria. Purposive sampling technique was adopted to select the study participants. Questionnaire was the instrument used for data collection that was analysed descriptively and inferentially. The study found that 60% of the respondents were male while 40% were female. 60% of the THPs were 61 years and above. Majority 90% were married and well-experienced in the profession. 60 % had 34 years and above experience only 20% did not have formal education, 20% were herbalists, 40% were midwives, and 30% bone- setters. 30% were Muslims, 50% were Christians and 20% were traditionalists. 10% of the respondents specialized in bone-setting, 30% specialized in maternal health, 30% specialised in child care, 20% specialized in family planning and 10% specialized in general health. The study also revealed that there is no significant relationship between gender, age, marital status, years of experience, educational qualification, occupation, religion, area of specialization and documentation of IK. The study concluded that demographic variables of THP in Kwara state do not influence their documentation of IK. The study recommended that librarians most especially those working in public libraries should collaborate with the knowledge holders to get their knowledge documented.

**Keywords:** Gender; Demographic attributes; Documentation, Indigenous Knowledge; Traditional Health Practitioners.

### Introduction

Indigenous knowledge (IK) has been conceptualized by various scholars based on their different perspectives, however, the major issue around IK is that it is a traditional knowledge that the indigenous people have been using for their survival. This knowledge has been applied in different areas such as agriculture, health, and security, among others. The knowledge is transmitted from one generation to another

through word of mouth, apprenticeship and informal training without being written in any form. This mode of transmission made the knowledge prone to distortion and gradually went into generation extinction. Modernization and westernization which began from colonization had redefined Africans making them lose their identity and cultural heritage including their indigenous knowledge, as well as changing the belief that everything about Africa is inferior



Africans see their IK as crude, and primitive, devilish and unscientific.

The knowledge of traditional medicine is still very relevant despite advanced medical practices globally. Traditional medicine can co-exist with the modern and serve as alternative health knowledge for the wellness of the people. Development partners like the World Bank are increasingly promoting indigenous knowledge in sustainable development in the areas of indigenous medical knowledge because it is evidence that there are times when modern medical science failed to tackle numerous complicated cases of sicknesses and diseases. Activities of the international pharmaceutical industries also learn credence to the fact that IK can be beneficial to human health. They have recognized and increased the use of herbs from Africa in the development of drugs with justified preference for traditional medicine in dire moments.

Demographic variables of the indigenous knowledge holders are very crucial in determining whether a knowledge holder will document his knowledge or not. Demographic variables are personal characteristics of the practitioners which may affect the documentation of IK. These variables are age, gender, educational level, religion and length of practice. Some studies have shown that knowledge is influenced by gender, age, class, economic level and experiences (Sillitoe, 1998; Somnasang & Moreno-Black, 2000, cited in Tabuti & Damme, 2012). Gender refers to the culturally-specific set of characteristics that identifies how women and men behave and how they relate to each other. It refers to the social differences, rather than the biological ones and varies widely both within and between cultures. Nature has imposed some sort of dichotomy between the responsibilities and IK of men and women in an indigenous community.

IK of women tends to differ from that of men because women play different roles in the homestead and the community. For instance, rural women possess more knowledge than men on the characteristics, distribution and site requirements of plants (Upadhyay, 2005). Indigenous knowledge can be gender differentiated as some aspects of IK are specifically dominated by men while some are peculiar to women. In spite of the usefulness of IK, most especially in traditional medicine; it is being neglected leading to the stunting of development. Nwokocha (2008) supporting this view opined that in medicine in the latter part of the preceding century; there were vigorous criticisms against traditional systems of healthcare delivery, almost to the point of suffocation. The consequences are that vital knowledge that might contribute to the future survival of man and animals is gradually being lost. World Health Organisation conference on Indigenous Knowledge held in Beijing in November 2008, highlighted the necessity for the preservation of traditional medical knowledge by declaring that the knowledge of traditional medicines, treatments and practices should be respected, preserved, promoted and communicated widely and appropriately through planned documentation.

The World Bank monitoring this trend quickly warned that IK faces extinction unless it is properly documented, analysed and disseminated and that within one generation the knowledge could be lost forever (Ahmed, 1994). There are a lot of issues with the documentation of Indigenous knowledge particularly with among which are the nature of the knowledge and the diverse oral tradition courier blamed for gross which made it poor or non-documentation of oral methods of transmission, plagued by the secrecy of the



holders about their knowledge, and the lack of codification of knowledge; most especially traditional healers (Tabuti & Damme 2012). Equally, the gradual extinction of indigenous knowledge systems in African communities may stem from the fact that individuals usually the elders in the communities are the repository of indigenous knowledge. This knowledge is passed down by word of mouth to the trainee when such knowledge is not passed down, the knowledge is lost with the death of the holder. Some solutions have been proffered to arrest this negative trend. One such is the resolution by the World Health Organization Executive Board held in January 2009 that emphasized the need for national policies to support the integration of traditional medicine into the health system (Economic and Social Council, 2009).

In Nigeria, studies have been conducted on different areas of indigenous knowledge Issa, Owoye and Awoyemi (2018) in a study on the attitude of traditional health practitioners to the documentation of indigenous knowledge found that traditional health practitioners have a positive attitude to the documentation of their IK, Ebijuwa and Mabawonku (2015) conducted a study on documentation of indigenous knowledge of traditional health practitioners in Oyo - State, Nigeria Omigie, Makinde, and Adeniran (2022) conducted a study on Documentation of Nigerian Indigenous Knowledge System: The role of the library very little is known from previous studies about attitude and demographic variables relating to documentation of IK by the traditional health practitioners. The researcher intends to look at the attitude of the traditional health practitioners to the documentation of IK together with their demographic variables to see how they affect the documentation of their knowledge.

## Statement of the Problem

Indigenous knowledge has played significant roles in the lives of various communities in many parts of the world, most especially in Nigeria in the areas of food production, provision of functionally efficient and appropriate shelter, efficient planning and management of settlements and ill-health, and the protection of the forest and its fragile ecosystem. Despite the numerous benefits of IK, the knowledge is still not properly documented and codified. Documentation of IK is very slow and frustrating because the majority of the practitioners are partially educated and can barely read and write. The fear of losing this very important knowledge is becoming inevitable and alarming as the practitioners are of the aged population that death can snatch at any time. Professionals particularly librarians are encouraged to promote documentation and codification of IK. This study contributes to the documentation of IK from the perspective of demographic variables of the practitioners which when factored can facilitate librarians to relate well with the practitioners to willingly their indigenous knowledge.

## Objectives of the study

The objective of the study is to:

- i. Determine and investigate the demographic attributes variables of traditional health practitioners in Kwara-State, Nigeria
- ii. Find out the relationship between demographic attributes variables (gender, age, marital status, years of experience, education, religion and area of specialization) and documentation of IK by traditional health practitioners.



### Research Questions

- i. What are the demographic attributes and variables of traditional health practitioners in Kwara State, Nigeria?
- ii. What is the relationship between demographic attributes variables (gender, age, marital status, years of experience, education, religion and area of specialization) and documentation of IK by traditional health practitioners?

### Research Hypothesis

Ho<sub>1</sub>: There is no significant relationship between demographic attributes (gender, age, marital status, years of experience, education, religion and area of specialization) and documentation of IK by traditional health practitioners.

### Literature review

IK sometimes is gender sensitive because of the roles it plays in the lives and families of the holders, some IK holders sometimes refuse to reveal their healing secrets for diverse reasons; often to prevent the transfer of their livelihood to other families and to protect their distinct identity (Tabuti & Damme, 2012). Samal and Dhyani (2006) in their study in the Indian Central Himalayas found that women possess more knowledge of indigenous practices, as more than 52% of them know 30 practices against 26.4% of men. They submitted further that women have also employed indigenous knowledge in the strategic management of bio-genetic resources by environmental conditions and diverse nutritional and social needs. Apart from possessing indigenous knowledge on medicinal health-care practices, they also possess indigenous knowledge to face the vagaries of changing weather, keep their homes free from germs, and store and preserve food grains, vegetables and food items (Samal, 2002). These women also

employed their IK in their agriculture with associated practices like mixed cropping and maintenance of soil fertility.

A study conducted by Famo and Machate (2023) in Chief Albert Luthuli Municipality found that women make more use of indigenous knowledge practices than men. There were more female than male participants in the study in that 54.8% were identified as female, with the remaining 45.2% being male. The study also found that 10.8% of respondents did not attend any formal school at all, 11.1% had primary education, 18.6% had tertiary education, while the majority, 59.5%, had high school education.

According to Olatokun and Ayanbode (2009), Nigerian women are endowed with indigenous knowledge of traditional medicine, land use and management, family healthcare, breeding of food crop species, preservation of seeds, and the domestication and use of wild edible plants. They also reported that women's pivotal role in sustainable development in rural communities is evident in their contributions to the family and society at large as wives and mothers. In addition, women engage in the production and marketing of foodstuff to enhance the local economy making more women custodians of biodiversity and knowledgeable in land use and management, child delivery, family planning, and health care.

A study conducted by Ugboma on the use of indigenous knowledge by women in rural areas in Nigeria, with particular reference to the Isoko ethnic nationality of the Delta State found that the literacy level of the rural women in the ten rural communities of the Isoko South Local Government Area of the Delta State, Nigeria is so low that the majority of them cannot read or write. It further revealed that the majority of them use



their indigenous knowledge to take care of their health, they make use of herbs and the use of herbs as preventive medicine has contributed to the reduction of infant mortality. Malaria and measles are the major diseases that kill infants, especially in rural areas (Ugboma, 2014).

In a study conducted by Ebijuwa and Mabawonku (2015), there were more male alternative healthcare practitioners than females in Oyo-State, Nigeria. Their findings further supported the earlier submission of Kafaru (1998), cited in Olatokun (2010) that revealed male dominance due to some acceptable and observable traditional medical practices that hinder women (especially those of child-bearing age) from active participation. A study conducted by Mathibela, Egan, Plessis, and Potgieter (2015) in the Blouberg area, Limpopo Province of South Africa found that the traditional healing profession in the area is dominated (80%) by females. Voeks (2007) in his study noted that women from Lençóis community in Bahia, Brazil, were more knowledgeable than men in identifying and naming useful medicinal plant species. In addition, women, rather than men, are the custodians of Lençóis medicinal plant knowledge. Another study in Ethiopia by Luizza, Young, Kuroiwa, Evangelista, Wodere, and Bussman,(2013) also revealed that it is local women, not men, who are the most knowledgeable about medicinal plants and veterinary services.

The role of formal education in the documentation of indigenous knowledge is contrasting. Education can be seen both as the cause of the loss of indigenous knowledge, as well as a unique way to mitigate and restore this loss (UNESCO, 2009). Studies have revealed the negative impact of formal education on the background knowledge and values acquired

by indigenous children in their communities before their contact with formal education. For instance, through education, ideologies of the people can be in power are transmitted, and indigenous knowledge should not be discriminated against as projected by homogenization rather than plurality with acclaimed scientific-based medicines (Mato, 2015; Stavenhagen, 2015). Experiences from developed nations like Canada, the United States and Australia showed the unquantifiable amount of indigenous knowledge was lost from the beginning of the 20th century when indigenous children were sent to residential schools (Ohmagari & Berkes, 1997), boarding schools (Reyhner and Eder, 2015) or dormitories in an attempt to assimilate them within the mainstream society. As Stavenhagen (2015) rightly pointed out the separation of indigenous children from their families and, consequently, from their cultural roots caused “irreparable harm to the survival of indigenous cultures and societies.

The strong western focus of education systems and institutions around the world keeps preventing a meaningful inclusion of the indigenous populations and their knowledge and practices within the formal schooling system. Among the factors involved in the westernization of the education system, there are the curricula, which usually lack contextual relevance and devalue indigenous knowledge (UNESCO, 2009; Barnhardt and Kawagley, 2005; Maurial, 2002); the teaching methodologies, such as the language of instruction, which is generally alien to the people concerned (Batibo, 2009; Wongbusarakum, 2009); the assessment strategies (Barnhardt and Kawagley, 2005); the faculty attitude (Radoll, 2015); and the values promoted, which often clash with traditional teachings (Nakashima, Galloway McLean, Thulstrup, Ramos Castillo, &Rubis, 2012).



Additionally, because of the time spent in school, Indigenous children spend less time in community settings and participating in traditional activities (Nakashima, Galloway McLean, Thulstrup, Ramos Castillo, & Rubis, 2012; Batibo, 2009; Ohmagari and Berkes, 1997) thereby making them believe that any knowledge that is not structured accordingly with the western knowledge system is inferior.

**Methodology**

This study adopted a descriptive research design of the survey type. The population comprises traditional healthcare practitioners in Kwara-State, North-Central Nigeria. This comprises herbalists, midwives, bonesetters, birth attendants and traditional psychiatrists. The sample size of this study is 30 respondents. Purposive sampling technique was used to select traditional health practitioners to participate in the study rather than other IK holders. The reason for selecting traditional health practitioners is the recognition of the important roles they play in primary health care in rural communities.

**Results**

**Research Question:** What are the demographic attributes of traditional health practitioners in Kwara State Nigeria?

**Table 1:** Demographic variables affecting documentation of Indigenous knowledge among traditional health practitioners

<i>Demographic attributes</i>	<i>frequency</i>	<i>Percentage</i>
<b>Gender</b>		
Male	18	60.0
Female	12	40.0
<b>Age</b>		
21- 30	03	10.0
31- 40	03	10.0
41- 50	03	10.0
51- 60	03	10.0
61 and above	18	60.0



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<b>Marital status</b>		
Single	03	10.0
Married	27	90.0
<b>Years of working experience</b>		
5- 14	03	10.0
15- 24	03	10.0
25- 34	06	20.0
Above 34	18	60.0
<b>Highest education qualification</b>		
Primary	12	40.0
Secondary	09	30.0
Tertiary	03	10.0
No formal education	06	20.0
<b>Occupation</b>		
Herbalists	06	20.0
Midwives	12	40.0
Bone- setters	09	30.0
Traditional Psychiatrists	03	10.0
<b>Religion</b>		
Islam	09	30.0
Christian	15	50.0
Traditional	06	20.0
<b>Area of specialization</b>		
Bone- setting	03	10.0
Maternal health	09	30.0
Child care	09	30.0
Family planning	06	20.0
General Health	03	10.0

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**Source: Field Survey, 2017**

Table 1 above shows that 60% of the total respondents were male while 40% were female. Distribution of the respondents according to age reveals that 10% of the respondents were, between age 21-30years, 10% were between 31- 40years age range, 10% were within the 41- 50 years bracket, 10% were between 51- 60years while 60% of the sample, which constitutes the majority, were 61years and above. The table also affirms that 10% of the respondents were single while 90% were married. 10% of the subjects had 5- 14 years of experience, 10% had 15- 24 years of experience, 20% had 25- 34 years of experience and 60% had 34 years

and above years of experience. 40% were holders of primary school certificates, 30% had secondary education, 10% had tertiary education and 20% had no formal education. 20% of the respondents claimed to be herbalists, 40% were midwives, 30% were bone- setters and 10% were traditional psychiatrists. Of the respondents, 30% were Muslims, 50% were Christians and 20% were traditionalists. The table also reveals that 10% of the respondents specialized in bone- setting, 30% specialized in maternal health, 30% specialised in child care, 20% specialized in family planning and 10% specialized in general health.



**Hypothesis:** There will be no significant relationship between Demographic variables (gender, age, marital status, years of experience, education, religion and area of specialization) and documentation of Indigenous knowledge by the traditional health practitioners.

**Table 2:** Pearson Correlation showing the Relationship between Attitude and Documentation of IK

	1	2	3	4	5	6	7	8	9
Gender(1)	1.000	.000	-.408*	.162	.647**	.000	.700**	-.288	-.214
Age (2)		1.000	-.236	.915**	.125	.312	.404*	.498**	-.629**
Marital Status (3)			1.000	-.232	-.264	.123	-.524**	.264	.436*
Years of Experience(4)				1.000	.324	.329	.611**	.377*	-.651**
Highest Education Qualification (5)					1.000	.227	.516**	.163	-.300
Occupation (6)						1.000	.263	.485**	.135
Religion (7)							1.000	-.138	-.486**
Area of Specialization (8)								1.000	-.438*
Documentation of IK (9)									1.000

\* p<0.05, \*\* p<0.01

The result in Table 2 above shows that there is no significant relationship between gender and documentation of Indigenous knowledge ( $r = 0.214$ ,  $p > 0.05$ ). The null hypothesis is not rejected. Similarly, there is no significant relationship between age and documentation ( $r = 0.629$ ,  $p > 0.05$ ), marital status ( $r = 0.436$ ,  $p > 0.05$ ), years of experience ( $r = 0.651$ ,  $p > 0.05$ ), highest education qualification ( $r = 0.300$ ,  $p > 0.05$ ), occupation ( $r = 0.135$ ,  $p > 0.05$ ), Religion ( $r = 0.486$ ,  $p > 0.05$ ) and Area of specialization ( $r = 0.438$ ,  $p > 0.05$ ) at level of significance.

### Discussion of the findings

The study found that there were more male traditional health practitioners in this sample than female. Traditional health practice is basically for male sensitive than female which may be attributed to the fact that there are some traditional practices which forbid women from the profession especially those within the childbearing age while older women may have more liberty to practice than those still rearing children. Women as wives of traditional health practitioners may be indirectly involved in the trade of their husbands



because it may likely be the source of the livelihood of the practitioners. The finding is corroborated by Ebijuwa (2015) out of the four hundred traditional health practitioners that participated in the study, three hundred and eight were male and ninety-two females. This suggests that there were more male alternative health practitioners than females in the sample.

The study also revealed that the majority 60% of the respondents were 61 years and above which is a negative signal to show that the younger generation is not showing interest in IK and if urgent steps are not taken to document the knowledge, it may likely go into extinction. Majority of them were married and well experienced in the profession. The practitioners in this study are more likely to enjoy more patronage because of their years of experience. Well-experienced traditional practitioners enjoy some sort of goodwill from their clients because of their years of experience which may likely influence their knowledge of the practice while the younger ones may not be trusted because of their inexperience.

Their educational qualification is what the librarians and documentalists can leverage because only 20% had no formal education; though 40% had primary education, however, it will be very easy to convince somebody who had formal education to document their knowledge that those who were not educated at all. Lack of formal education may not be a barrier to documentation of IK if the holders are willing to document with the use of mobile and advanced technologies, while the holders may not be able to read or write, their tacit knowledge can be converted to explicit through audio and video recording through a simple mobile phone. The study also revealed that there was no religious barrier since the traditional worshippers were the least in the sample, this shows that they still attend

their churches and mosques along with their traditional practices.

The study also found that there is no significant relationship between gender and documentation of indigenous knowledge of traditional health practitioners in Kwara state. The finding of this study negates earlier studies of Kassa, Asfaw and Demissew (2020) found that male informants in the Sheka Zone of Southern nations in Ethiopia document more IK than their female counterparts. Similarly, there is no significant relationship between age and documentation which does not support the earlier findings of Giday, Asfaw, Woldu and Teklehaymanot (2009) which stated that gender and age significantly influenced the knowledge of traditional medicine. Marital status, education qualification, occupation, religion area of specialization and years of working experience. However, the finding of this study is not in tandem with Adekannbi, Olatokun and Ajiferuke (2016), who found that years of experience of health practitioners predicted the amount of knowledge transmitted. The binary logistic regression analysis was carried out using the Forward (Wald) method; 'years of experience' was the only variable that predicted the amount of knowledge transmitted.

### **Conclusion**

The study concludes that there is no relationship between demographic attributes and documentation of indigenous knowledge. This implies that gender, age marital status, years of experience in traditional health practice, educational qualification, occupation, area of specialization and documentation of indigenous knowledge. Traditional health practitioners in Kwara State, Nigeria's decisions to document or not to document their Indigenous knowledge are not being influenced by any of their demographic attributes.



## Recommendations

1. Librarians and documentalists should as a matter of urgency work closely with traditional health practitioners to document their IK.
2. The knowledge holders should also be trained on how they could harness modern technology infrastructure to document their knowledge.
3. Public librarians should be alive to their responsibilities of enlightening IK holders of the need to document their knowledge.
4. The government should formulate a policy on the documentation of IK.

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