




The Influence of Demographic Variables of Traditional Health Practitioners on Documentation of Indigenous Knowledge

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Abstract

Indigenous knowledge (IK) plays a crucial role in primary healthcare in many African communities. However, IK is gradually declining due to its predominantly oral transmission and a lack of interest from the younger generation. While various studies have examined IK, there is limited evidence on how demographic variables influence its documentation. This study investigated the relationship between demographic characteristics and the documentation of IK among traditional health practitioners (THPs) in Southwest Nigeria. A descriptive survey design was used to sample 362 THPs from a population of 3,850, applying the Yaro Yemane model. Data were collected through questionnaires and analyzed using descriptive statistics and Pearson's correlation. Findings showed that the majority of respondents were male (73.2%), aged 51–60 (45.3%), married (97.8%), and had over 25 years of experience. Despite varying backgrounds, there was no significant correlation between gender, age, marital status, or other demographic variables and the documentation of IK. The study concludes that demographic factors do not significantly influence IK documentation among THPs, highlighting the need for more systemic interventions to preserve and document IK irrespective of demographic attributes

Keywords: Indigenous knowledge, Documentation, Demographic variable, Traditional Health Practitioners, Southwest Nigeria, Demographic Influence

Introduction

Indigenous knowledge (IK) is a dynamic body of knowledge transmitted from generation to generation through the word of mouth. The knowledge resides in individuals, families, and the communities. IK has been widely adopted in agriculture, security and in management of animal and human health. The Knowledge is embedded in oral tradition hence; holders are under obligation to transfer the knowledge to their succeeding generation orally before their demise. Death is not predictable; many IK holders die in an unforeseen circumstance before their indigenous

knowledge is documented. This was corroborated by personal experience of the author, my grandmother was rich in indigenous knowledge of traditional bone setting, treatment of different kind of ailments using traditional medical knowledge. Before her demise, she was able to transmit the knowledge to my mother (Chief Mrs. Victoria Adeola Ojo) of a blessed memory. She was using her IK of herbs to cure different types of ailments within our community, the author intended documenting IK but she died before the commencement of the project.

IK was very important for the survival of

people most especially the rural dwellers, In Nigeria, traditional health practitioners plays prominent roles in primary healthcare in rural communities, some of the rural communities have ill equipped medical facilities and medical professionals are not attracted to rural areas because of poor social amenities coupled with heightened insecurity with cases of kidnapping of medical professionals for ransom. Despite continual relevance of IK, the knowledge has not being given the deserved recognition, there is this stigmatisation of practitioners as being devilish and primitive, unfortunately these negative perception have started during the colonial era. Colonial administrators believed that IK was based on trial and error; erroneous and misleading and that most of the claims of IK practitioners cannot be scientifically substantiated. According to a national health survey carried out in Nigeria, the larger percentage (63%) of birth handled by traditional health practitioners is higher than delivery handled by the hospitals 37% (National Population Commission, 2000). Rawal, Negi and Bhatt (2021) supporting this view submitted that the higher percentage of people in developing countries 70-95% depend on IK for their healthcare.

Demographic variables are the personal characteristics of the practitioners. These variables are age, gender, educational level, religion and length of practice. Study has shown that knowledge is influenced by gender, age, class, economic level and personal life experiences” (Tabuti & Damme, 2012). There is a relationship between gender and IK, the knowledge of women is quite different from men, because of the responsibilities of men and women in the society. Women naturally are very caring, they give birth to children and care for them and other members of the family; women are most likely to be more interested in IK that will enable them to fulfil their responsibilities. Men are to provide and protect their family, they are likely to possess IK that is related to their occupations such as agriculture, hunting, blacksmith, goldsmith, among others. Traditional health practice is an area dominated by men in Nigeria. There are more male traditional health practitioners than female (Ebijuwa & Mabawonku, 2015).

Age is an important demographic variable, Asmamaw, Mereta, and Ambelu (2020) found that age of respondents, family size, religion, membership of an association, the scope of farming and the rate of returns; influence the rate of utilization of IK. The study found that education had a negative but significant correlation with the utilisation of IK.

Mathibela, Egan, Plessis, and Potgieter (2015) found that traditional health practitioners’ around Blouberg began their professional practice between 18 and 23 years. A fractional part of the practitioners were more than 60 years and efforts were not intensified to integrate younger generation into the practice, with just 3% less than 35 years of age. The knowledge in no distant time may likely go into extinction with 47% of the traditional health practitioners that are 50 years and above.

Moreover, the study showed that years of experience of the THPs mirror their age pattern. 29% of the health practitioners have less than 10 years of experience and 21% have between 11 and 20 years of experience. 70% of the respondents have between 21 and 30 years of healing experience, while 43% have more than 30 years. The years of experience are very significant in alternative healthcare practice; the patrons will likely have more confidence in well-experienced traditionalists than those with little or no experience. The higher percentage of the practitioners, who participated in the study by Ebijuwa and Mabawonku (2015) were very experienced. The study also found that 45.3% of alternative healthcare practitioners in Oyo-State, who participated in the study, did not attend school while 22.5% attended primary school. They asserted that a low level of formal education was the reason for their engagement in traditional healthcare.

Statement of the Problem

Despite the growing recognition of indigenous knowledge as a valuable cultural and intellectual resource, its documentation remains inadequate in many parts of Nigeria, particularly in the South West region. This gap threatens the preservation, transmission, and utilization of indigenous knowledge in critical areas such as agriculture, health, conflict resolution, and environmental management. Several efforts to document indigenous knowledge have faced challenges related to accessibility, relevance, and sustainability. One often overlooked factor is the influence of demographic variables such as age, gender, educational background, occupation, and location on individuals’ willingness, ability, and motivation to participate in knowledge documentation. These demographic factors may significantly shape how indigenous knowledge is recorded, shared, and preserved for future generations.

However, there is limited empirical research exploring how these demographic variables affect

the documentation process in South West Nigeria, a region known for its rich cultural heritage and diverse indigenous practices. Without a clear understanding of these influences, efforts to document indigenous knowledge may remain fragmented, ineffective, or biased. This study seeks to fill this gap by investigating the influence of demographic variables on the documentation of indigenous knowledge in South West Nigeria. It aims to provide insights that can guide policymakers, researchers, and cultural institutions in developing more inclusive and effective documentation strategies that reflect the diverse experiences and contributions of different population groups.

Objectives of the study

The objectives of the study are to:

(i) find out the demographic variables of traditional health practitioners that determine documentation of indigenous knowledge in South-west, Nigeria;

(ii) determine the relationship between demographic variables (gender, age, marital status, years of experience, education, religion and area of specialisation) and documentation of IK by the traditional health practitioners;

Research Question

What are the demographic variables influencing documentation of IK among traditional health practitioners in South-west, Nigeria?

Research Hypothesis

There is no significant relationship between demographic variables (gender, age, marital status, years of experience, education, religion and area of specialization) and documentation of IK by the traditional health practitioners.

Literature Review

Several factors are affecting the preservation of IK in third world countries including Nigeria. Attitude, demographic characteristics gender, age, marital status, experience, socio-economic status, and political affiliation among others determine perceptions, reactions and accessibility to knowledge in the indigenous communities (Lwoga, Ngulube & Stilwell, 2010). Aluko (2018) submitted that women are playing significant roles in utilization, transmission and documentation of IK, the movement of younger men to cities in search of greener pasture is shifting the burden of maintenance of IK of traditional medicine

in rural areas to women. In some societies, women are not allowed to have access to indigenous knowledge of traditional medicine to prevent transmission of their family knowledge to another family through marital relationship. This practice is common among traditional healers in Kaliro District, Uganda (Tabuti & Damme, 2012). Women in Mali use their IK for personal and family sustenance; they use their IK for producing *Jatropha curcas* oil as raw material and fuel. *Jatropha curcas* was also used as medicine, the seeds were used to stop bleeding and guide against wound infection, they also use the leaves for malaria treatment, soap production, erosion control, soil improvement and as renewable energy for household (Olatokun & Ayanbode, 2009).

A study conducted by Weckmüller, Barriocanal, Maneja, and Boada (2019) revealed that there was no significant relationship between gender and knowledge of medicinal plants ($t = 0.7569$, $df = 53,169$; $p = 0.4525$). The equal knowledge between Waorani men and women were attributed to the close affinity of the people with the forest. Women worked closely with their husbands for survival. It was their usual practice to accompany their husbands to hunt for animals. The women also engaged in gathering fruits and other edibles in the forest, which may result in their deep knowledge of the medicinal plants as their male folk. The study conducted by Awas (2007) found that the medicinal knowledge of farmers in Ethiopia may be influenced by certain demographic variables. Giday, Asfaw, Woldu and Teklehaymanot (2009) in their study found that gender and age significantly influence farmers' knowledge of traditional medicine. Nzabona and Ntozi (2015) posited that possession of IK is a characteristic of the significance of older persons. A study conducted by Cheikhyoussef, Shapi, Matengu and Ashekele (2011) in the Oshikoto region, Namibia, found that among 47 traditional health practitioners interviewed, the majority 70% were women while 30% were men.

A study conducted by Weckmüller, Barriocanal, Maneja, and Boada (2019) revealed that there was a positive significant correlation ($R^2 = 0.43$, $p < 0.001$) between age and knowledge of medicinal plants. Kidane, Andel, Maesen and Asfaw (2014) in their study found that male participants identified more medicinal plants than their female counterparts and that religion, family size and education did not influence their knowledge of medicinal plants. The study revealed further that, there was a significant relationship between age and plant knowledge since

participants above 40 years have more plant knowledge than those below this age. A study conducted by Ayantunde, Briejer, Hiernaux, Udo and Tabo (2008) found that respondents between ages (10-30 years) identified fewer species, unlike the adult age group. They established a relationship between the age and the number of plant species identified for both ethnic groups. This suggests that knowledge of plant species drops after a certain age

A study conducted by Wanjohi, Sudoi, Njenga, and Kipkore (2020) showed that there were more males 71% than females 29% in the Marakwet Community, Kenya most of whom were aged over 55 years (39%) following those aged 46–55 years (29%), while those aged below 25 years were few. The majority had no formal education 38%, followed by those with secondary level of education 32% and then primary level of education 27%. The study found that those who have substantial knowledge were more than 66 years, less than 20% became traditionalists when they were between age thirteen to nineteen while less than 20% of the practitioners became traditional health practitioners at age thirty and above. In Namibia, the occupation of traditional health practice was highly recognised; the study found that 58% of the people that participated in this study regarded themselves as subsistence farmers though they use IK to treat ailments, with 28% as professional traditional health practitioners, 4% pensioners and herders, 37% farmers and 34% pensioners, respectively. Only 20% indicated that the knowledge of medicinal plants is the source of their livelihood.

Exposure to western education is one of the factors affecting documentation of IK. Exposure to western education and modern technology are reducing the interest of the younger generation in traditional knowledge (Msuya, 2007). This position is further strengthened by Giovannini, Reyes-García, Waldstein and Heinrich (2011) that education influences possession of IK in a negative way. Research carried out in Mexico attested to the fact that school attendance reduces the time for the acquisition of IK. They submitted that prolonged school attendance led to the increase in adoption of the western lifestyle and decrease in contact with indigenous communities.

In a study conducted by Khan, Ahmad and Rashid (2018) the information regarding the ethnobotany and the use of medicinal plants was collected from 87 local inhabitants of Northern Pakistan. Out of these, 69% and 31% women. Men informants, 27 Hakeem (Traditional herbal medicine practitioners),

and the remaining were mostly elderly people; 78% of informants were married and 22% unmarried. Furthermore, more informants were illiterate 30%, elementary school 27%, secondary school 20%, high school 15%, and university 8%.

A study by Aragaw, Afework and Getahun (2020) revealed that 73.13% of their respondents were females while 26.87% were males. The number of females in the sample collected from inhabitants of Debre Tabor, Amhara and North Central Ethiopia was higher than males; which may be attributed to the availability of females at the time of the interview and their roles in homes. The ages of participants ranged from 18 to 80 (mean age 35.73 ± 0.59 years). 12.2% could not read and write, 10% could read and write, 7% had an educational level of grades 1–6, 6.7% had an educational level of grades 7–12, 19.7% had a technical and vocational certificate, and 44.5% had a college diploma and above.

A study conducted by Ebijuwa (2015) showed that out of the 400 traditional health practitioners that participated in the study, 25% were between ages 41 and 50 years, and not one of them was less than 20 years of age. It also revealed that out of the 400 respondents, 77% were males and 23% were females. This implies that there were more male alternative health practitioners than females in the sample. The presence of more male than female traditional health practitioners may be attributed to the fact that some customs and traditions may favour males over females. In some clime, traditional health practice may exclusively be for males rather than for female gender most especially those of them within childbearing age, some traditions may prevent nursing mothers and pregnant women from engaging in traditional health practices.

The respondents were well experienced; the study showed that 35% of respondents had the highest number of years of experience, while 11% of them had the least number of years of experience. Education is important in the proper management of IK. The majority of the respondents 45% had no formal education, 27% had secondary education, 23% had primary education while 5% had other types of education. The distribution of the respondents by area of specialisation revealed that 79% were into general health practice, 10% were into maternal health, 5% were into childcare, 5% were into bone setting while 1% was into family planning. The result of the study showed that the respondents are into all forms of alternative health practices.

A study conducted by Kassa, Asfaw and Demissew (2020) revealed that there were 380 male and 34 female informants that participated in their study due to cultural reasons. Male informants identified more medicinal plants (5.542 ± 3.725) than female counterparts (4.765 ± 1.986) with a significant difference ($p = 0.0465$). The age ranged from 18 years to 96 years while age > 30 years (5.832 ± 0.213) were the elders than younger of age 18–30 years (4.149 ± 0.218) with significant difference ($p = 0.00001$); illiterate informants (6.295 ± 0.211) than literate informants (4.341 ± 0.287) with significant difference ($p = 0.00001$); key informants (13.367 ± 1.426) than general informants (4.862 ± 0.105) with significant difference ($p = 0.00001$).

A study conducted by Adekannbi, Olatokun and Ajiferuke (2016) found that traditional health practices have more male practitioners than females; the proportion of male practitioners varied from 54–68 per cent in the six states of the South-west, Nigeria. The practitioners whose age ranged between 41–50 years (36.4%) were the highest, followed by 51–60 years (31.1%) and those between the ages of 71–80 (8.3%) were the least. The general overview of the age distribution of the traditional health practitioners in the south-west, Nigeria according to this study revealed that the sample had more middle-aged respondents. However, the case of Ekiti and Lagos States, was different where respondents between the ages of 51–60 made up the largest proportion. The majority of traditional health practitioners in the South-west were Muslim 101 (44.3%), 92 (40.4%) belonged to traditional religion and 35 (15.4%) were Christians.

Generally, there were more Muslims among the respondents in Ekiti, Osun and the Oyo States while traditional worshipers were predominant in the sample obtained from Lagos, Ogun and Ondo States. The study revealed that the highest level of education of traditional health practitioners that participated in this study was secondary education 43.4% followed by primary education 38.2% while 18.4% had no formal education. A breakdown of this category showed that while most of the respondents in Ogun, Ondo and Osun states attained secondary education, a large proportion of respondents in Ekiti, Lagos and Oyo States had only primary education. It was also interesting to observe that all the respondents in Ondo State had either primary or secondary education; none was without formal education.

Adekannbi, Olatokun and Ajiferuke (2016) in their study found that years of experience of

the traditional medical practitioners predicted the knowledge transmitted. The binary logistic regression analysis was carried out using the Forward (Wald) method; 'years of experience' ($p = 0.000$, $df = 1$) was the only variable that predicted the amount of knowledge transmitted. Exp (B) value of 1.875 showed that for each point increase in the years of experience of traditional health practitioners, the propensity of transmitting all the knowledge of traditional medicine possessed increased by 1.875. This showed that there was a tendency for the practitioner who had spent between 41 to 60 years in the practice to transmit all their knowledge of traditional medicine; while those who had spent between 1 to 40 years tended to transfer just more than half of their knowledge of traditional medicine.

This finding suggests that while the practitioners with limited years of experience were not willing to transmit their knowledge, the experienced practitioners were ready to transmit their knowledge without exhibiting any fear. The older practitioners may worry less about what they make from their traditional practice while the younger ones are still very concerned about the money they are making from their traditional practice. The possibility of death for the older traditional health practitioners may also increase the propensity of transmitting their knowledge so that their IK does not die with them while the younger traditional health practitioners may likely want to monopolise their knowledge until they have made some gains before thinking of transmitting their IK.

A study conducted by Dapar, Alejandro, Meve and Liede-Schumann (2020) revealed that, out of 335 IK holders that participated in the study, 32% were female while 68% were male. Their age ranged from 18–87 years old. The educational level of the respondents revealed that 17% had primary education, 50% secondary education while 33% higher education showed that the majority are enlightened based on their academic qualification and their level of education will enable them to make informed decisions. Demographic characteristics of the Manobotribe of Agusan del Sur, Philippines and their knowledge of medicinal plants revealed that respondents with secondary education had more knowledge of medicinal plants ($Md = 116$, $n = 167$) compared to those with primary education ($Md = 105$, $n = 57$) and tertiary education ($Md = 92$, $n = 111$), respectively.

The results showed that respondents who completed tertiary education depended on modern

medicine to take care of their illness. They have knowledge of over-the-counter drugs for the treatment of their sicknesses rather than depending on the knowledge of medicinal plants while respondents with lower education had more medicinal plant knowledge, and most traditional healers had secondary education. The study found that men (Md = 116, n = 229) had more medicinal plant knowledge than women (Md = 104, n = 106), as revealed by the significant difference in both the Mann-Whitney U test ($p < 0.001$) and Kruskal-Wallis test ($p < 0.001$). The study also revealed that respondents who were farmers (Md = 118, n = 205) and animal husbandry (Md = 116, n = 47) had more medicinal plant knowledge compared with those employed in other sectors of the economy (Md = 98, n = 49) and the unemployed (Md = 96, n = 16) respondents.

These results suggested that Manobo people in the agricultural related profession will have more knowledge of medicinal plants than those who don't relate with nature for their daily activities. There is a significant difference in the knowledge of medicinal plants exhibited by the married and single respondents. The study found that married respondents (Md = 136, n = 147) showed higher medicinal plant knowledge than single ones (Md = 92, n = 188) as revealed by the very high significant difference in both the Mann-Whitney U test ($p < 0.001$) and Kruskal-Wallis test ($p < 0.001$). Grouping according to the age of the respondents, descriptive and inferential statistics revealed that respondents within the age group of more than 65 years old had the highest medicinal plant knowledge (Md = 173, n = 37). Followed by 50–65 years old (Md = 155, n = 53), 35–49 years old (Md = 102, n = 103), and 18–24 years old (Md = 96, n = 142), the difference is highly significant.

In a study conducted by Owoeye, Owoeye and Omolade (2024) on demographic attributes as predictor of documentation of indigenous knowledge by the traditional health practitioners Kwara State, Nigeria found that there was no significant relationship between gender and documentation of Indigenous knowledge ($r = 0.214$, $p > 0.05$). Similarly, there was 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.

Methodology

This study adopted a descriptive correlational survey design. The population consisted of 3,850 traditional health practitioners (THPs) across the six states of Southwest Nigeria: which are Ekiti (400), Ondo (200), Osun (500), Oyo (600), Ogun (150) and Lagos states (2000). These practitioners included herbalists, midwives, bone setters, traditional birth attendants, and traditional psychiatrists. Using the Yaro Yemane (1967) formula for sample size determination at a 5% margin of error, a sample of 362 respondents was calculated. Yamane formula is a simplified method for calculating the appropriate sample size when working with a known, finite population. It's mathematically expressed as:

$$n = \frac{N}{1 + N(e)^2}$$

- n = required sample size
- N = total population size
- e = acceptable margin of error (as a decimal, e.g. 0.05 for 5%)

It was chosen because the formula is straightforward requiring only population size and desired margin of error making it quick and accessible for researchers. It was designed for finite population while it's most often applied assuming a 95% confidence level.

Proportional allocation was applied based on the number of practitioners in each state. 38 THP from Ekiti State, 19 from Ondo State, 47 from Osun State, 56 from Oyo State, 14 from Ogun State and 188 from Lagos State, based on the population of THP in each state to the entire population in South West, Nigeria. Subsequently, purposive sampling was used to select the THPs who participated in the study because of their prominent roles in primary health care most especially in rural communities. The instrument for data collection was questionnaire, the instrument is divided into section A and B, section A which is the demographic variable and it has 9 items, while section B is the documentation of IK with 10 items, the instrument was developed by the researcher, face and content validity of the instrument was ensured by the scholars in the field of library and information science and experts in the field of test and measurement. Reliability test was conducted using Cronbach-Alpha statistical test that yielded a reliability coefficient $r = 0.88$ which was considered high enough for the study. Biographic variables were analysed using simple percentage and frequency count while inferential statistics of Pearson Product Moment Correlation was used to test hypothesis at 0.05 level of significance.

It was used to determine the relationship between demographic variables and documentation of IK while SPSS data analysis software was used for the analysis.

Data Presentation and Analysis

Research Question

What are the demographic variables influencing documentation of IK among traditional health practitioners in South-west, Nigeria?

Table 1: Demographic variables affecting documentation of indigenous knowledge among the Respondents

<i>Demographic variables</i>	<i>Frequency</i>	<i>Percentage</i>
Gender		
Male	265	73.2
Female	97	26.8
Age		
21- 30	6	1.7
31- 40	155	42.8
41- 50	37	10.2
51- 60	164	45.3
61 and above	-	
Marital Status		
Single	8	2.2
Married	354	97.8
Years of Experience		
5- 14	19	5.2
15- 24	65	18.0
25- 34	148	40.9
Above 34	130	35.9
Highest Education Qualification		
Primary	98	27.1
Secondary	152	42.0
Tertiary	35	9.7
No formal education	77	21.3

Occupation

Herbalists	177	48.9
Midwives	64	17.7
Bone- setters	23	6.4
Birth Attendants	44	12.2
Spiritualists	17	4.7
Traditional Psychiatrists	37	10.2

Religion

Islam	30	8.3
Christian	56	15.5
Traditional	265	73.2
Others	11	3.0

Area of Specialization

Bone- setting	20	5.5
Maternal health	87	24.0
Child care	19	5.2
Family planning	7	1.9
General health	202	55.8
Surgeon	27	7.5

Source: Field Survey

Table 1 revealed that 73.2% of the total respondents; representing the majority of the traditional health practitioners that participated in this study were male with the majority of the respondents being 51 years and above. The traditional health practitioners were majorly married (98%) and well experienced in the practice. It also revealed that, traditional health practitioners in South-west Nigeria attended at least primary school while the majority of them attended secondary schools; herbalists were more than other practitioners in this study. The majority of the practitioners were traditional worshipers and 55.8% specialised in general health practice.

Research Hypothesis: There is no significant relationship between demographic variables (gender, age, marital status, years of experience, education,

religion and area of specialization) and documentation of IK by the traditional health practitioners.

Table 2: Correlation matrix showing the Relationship between Demographic Variables and Documentation of IK

Variables	1	2	3	4	5	6	7	8	9
Gender (1)	1.000								
Age (2)	.165**	1.000							
Marital status (3)	.091	.057	1.000						
Years of Experience (4)	-.154**	-.256**	.209**	1.000					
Highest Education (5)	-.165**	-.162**	.088	.144**	1.000				
Occupation (6)	.027	-.086	.054	-.089	.144**	1.000			
Religion (7)	-.179**	-.077	-.095	.136**	.119*	-.240**	1.000		
Area of specialization (8)	-.409**	-.052	.062	.204**	.142**	-.123*	.095	1.000	
Documentation of IK (9)	.012	.001	.020	-.188**	-.060	-.228**	.017	.047	1.000

* $p < 0.05$, ** $p < 0.01$

The result of correlation matrix above indicates that there is no significant relationship between gender and documentation of indigenous knowledge ($r = 0.012$, $p > 0.05$). Similarly, between age ($r = 0.001$, $p > 0.05$), marital status ($r = 0.020$, $p > 0.05$), highest education ($r = -0.060$, $p > 0.05$), religion ($r = 0.017$, $p > 0.05$) and area of specialization ($r = 0.047$, $p > 0.05$) and documentation of indigenous knowledge is not statistically significant at 0.05 level of significance in each case. The null hypothesis is accepted. However, there exist a significant, low but negative correlation between years of experience ($r = -0.188$, $p < 0.01$), occupation ($r = -0.228$, $p < 0.01$) and documentation of indigenous knowledge at 0.01 level in each case.

Discussions of the findings

The objective of the study was to determine the influence of demographic variables of the traditional health practitioners on documentation of IK. The results indicated that there were more male traditional health practitioners than their female counterparts. This implied that there are more male traditional health practitioners than their female counterparts. Male gender is more favoured in traditional practice; some parent will not even reveal their IK to their daughter for the fear of transfer to another family after marriage. The finding of this study corroborates the earlier finding of Ebijuwa and Mabawonku (2015) that had more male traditional health practitioners than female in their sample. A similar study conducted

by Adekannbi, Olatokun and Ajiferuke (2016) found that traditional health practice is male-oriented; the proportion of male practitioners varied from fifty-four to sixty-eight per cent in the six states of South-west, Nigeria.

In another study by Ebijuwa (2015) showed that 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 female in the sample. A study conducted by Kassa, Asfaw and Demissew (2020) in Ethiopia revealed that there were three hundred and eighty males and thirty-four female informants that participated in their study due to cultural reasons.

A study conducted by Dapar, Alejandro, Meve and Liede-Schumann (2020) in the Philippines revealed that, out of three hundred and thirty-five IK holders that participated in the study, one hundred and six were female while two hundred and twenty-nine were male. A similar study conducted by Wanjohi, Sudoi, Njenga, and Kipkore (2020) in Kenya showed that male traditional practitioners were more than female in their sample. In a study conducted by Khan, Ahmad and Rashid (2018) in Northern Pakistan, the information regarding the traditional uses of plants was collected from eighty-seven local inhabitants in the study area. Out of these, sixty were male while twenty-seven were female.

The results of the study conducted by Aragaw,

Afework and Getahun (2020) in Ethiopia contradicts the finding of this study, there are more female traditional health practitioners two hundred and ninety-four were female while one hundred and eight were male. However, the study attributed the dominance of female in the sample to the availability of women while conducting the interview and their roles in caring for the family. Naturally, traditional health practice is a male-dominated profession; Olatokun (2010) posited that some norms restrict women from traditional practice because of childbearing. The knowledge of traditional medicine was kept from women in some clime, simply because they want the knowledge of traditional medicine to be revolving around their family. Tabuti and Damme (2012) found that healers in Uganda were not sharing their IK with their female children to prevent the transfer of their IK secrets to another family after marriage.

This study found that 43% of the practitioners that participated in the study were between 31- 40 years while 55% of the respondents were 41 years and above. This implied that there are more elderly in traditional healthcare practice; it is a general belief that the older the traditional health practitioner, the better the efficacy of their traditional medicine due to accumulated years of experience in the practice and young people are no more showing much interest in IK. This finding corroborates the study of Ebijuwa (2015) that revealed that out of the 400 traditional health practitioners that participated in the study, 25% were between ages 41 and 50 years, and no respondent was below 20 years. A study conducted by Adekannbi, Olatokun and Ajiferuke (2016) revealed that practitioners whose age ranged between 41–50 years (36.4%) were the highest, followed by 51–60 years (31.1%) and those between the ages of 71–80 (8.3%) were the least.

The outcome of this study is also similar to the Wanjohi, Sudoi, Njenga, and Kipkore (2020) which revealed that the highest number of the traditional health practitioners that participated in the study were above 55 years (39%) followed by 46–55 years (29%), while the age of few of them below 25 years. A study by Aragaw, Afework and Getahun (2020) in North-central, Ethiopia revealed that the ages of participants ranged from 18 to 80 (the mean age of the participants was 35.73 ± 0.59 years).

A study conducted by Dapar, Alejandro, Meve and Liede-Schumann (2020) revealed that, out of 335 IK holders that participated in the study, their age ranged from 18–87 years old (median age of 42 years). Nnadozie (2013) submitted that younger people prefer

to be a medical doctor than being a traditional witch doctor due to their exposure to education and western lifestyles. Discrimination of society against those practising IK is enough to discourage young people from traditional health practices. While orthodox medical doctors are honoured and respected, IK practitioners are viewed as primitive and devilish.

Naturally, traditional health practice is not the occupation for young people but rather for mature people who can figure out the rationale for any of their actions. Traditional health practitioners that have documented their IK may not likely allow their children to have access to the documented knowledge because of the possibility of misusing the knowledge. Some of them with criminal tendencies may use some knowledge of traditional medicine to commit crimes, oppress people in the society or engage in some antisocial behaviour because of the influence of such indigenous power. Furthermore, that the majority of the local healers that participated in this study were married. They were within the marriageable age, as a matter of fact in South-west, Nigeria, traditional practitioners in most cases marry more than one wife, by their occupation people most especially women come to them for solutions hence they find it so easy to get married to women of their choice. The study also revealed further that the practitioners were well experienced in professional practice.

This implied that the more experienced a traditional practitioner is, the more the level of confidence his patrons may likely have in his competence. The finding of this study supports the view of Das Gupta and Saha (2009), who submitted that IK is a knowledge established over a long period of experimentation and that the expertise is unique to an indigenous community, that is the reason for the difficulty in generalising IK, unlike scientific knowledge. The issue of experience is very germane in traditional health practice as well as the modern medical practice; the more experienced a practitioner, the more the level of patronage such may likely enjoy due to the experience gathered over the years.

The study found that most of traditional health practitioners in South-west, Nigeria that participated in the study had formal education. The majority attended secondary schools while some of them attended tertiary institutions. This is ascribed to the educational status of South-west, Nigeria. The number of universities in the South-west is higher than in any other geo-political zones in the country. It is a common perception that traditional health practitioners are

not literate, the fact that the region has the highest concentration of schools in the country may likely be accountable for the level of education of traditional health practitioners that participated in the study. The environmental factor is very much important to man and whatever he does. A practitioner who is not educated but lives in an environment where education is held in high esteem who also sent his children to school may likely appreciate the need to document his tacit IK than those living in the pure illiterate environment. There are more herbalists in this study and the highest area of specialisation of the practitioners in this study is general healthcare. The reason is that herbalists are generalists; they have little knowledge on virtually every area of traditional medicine though they may not be as knowledgeable in certain areas as the specialists.

The study further revealed that there are more traditional worshipers in this study than any other religion. This implied that the majority of respondents are traditional worshipers, traditional worship is the religion of traditional health practitioners, and Christians see the traditional worshipers and practitioners as pagans hence they usually warn their members from consulting them. Muslims also detest the traditionalist as idolaters and their faithful are not encouraged to consult them as well. Although some traditional practitioners claim to be Christians and Muslims, believing that the knowledge they have is what they use to benefit humanity without engaging in any form of wickedness coupled with the fact that God created herbs. This finding is equivalent to the finding of Ebijuwa and Mabawonku (2015), they have traditional worshippers in their study than other religions.

Conclusion

The study concluded that gender, age, marital status, highest education, religion, area of specialization do not significantly influence documentation of indigenous knowledge among traditional health practitioners in South-west, Nigeria. The means that documentation practices are not being constrained by these demographic variables therefore policymakers should formulate an inclusive documentation policies for THP without prioritizing or excluding any demographic group. There should be a focus on structural support instead of targeting specific age group or educational levels, policies on documentation should focus on providing enabling environments such as funding, ICT training and legal framework

to safeguard IK irrespective of who holds it, Libraries should partner with IK holders to get their knowledge documented and also collaborate to build repositories that collect IK from a wide pool of practitioners without bias, ensuring diversity in preserved knowledge. Public health initiatives should recognise that valuable IK exists across all demographics of THPs and collaborate effectively and efficiently to document IK of THPs before the knowledge go into extinction.

The study concludes that demographic variables do not significantly influence IK documentation. However, you do not explain what this means for policymakers, cultural preservation bodies, libraries, or public health stakeholders. 14. How can your findings inform programmes or strategies to support IK documentation? For instance, should efforts be tailored more to professional development, digitization, or institutional support rather than demographic targeting? 15. The study does not indicate whether it extends, challenges, or confirms existing theoretical frameworks or prior research. Consider explicitly stating how your findings relate to current discourse on Indigenous knowledge preservation. 16. The conclusion restates the findings but does not highlight what is new or significant about them. You should briefly discuss: 1. "What gap does this study fill?" "How might this shape future research, policy, or practice.

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