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Documentation and Use of Indigenous Knowledge by Practitioners of Alternative Healthcare in Oyo State, Nigeria

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Abstract

This paper examines the role of alternative health practitioners in primary healthcare delivery in Oyo State. It is aimed at determining the documentation and use of indigenous knowledge in primary healthcare by practitioners of alternative healthcare given the dearth of scholarly works in this area in library and information studies. The descriptive survey research design and stratified random sampling techniques were used for the study. The study reveals that practitioners of alternative healthcare use indigenous knowledge in the provision of primary healthcare in treating various health challenges including maternal healthcare and HIV/AIDS, documenting their indigenous knowledge through the forms of writing in books, audio recording, video taping, drawing, photographing and story telling. Adequate documentation of indigenous knowledge in various formats that can make it accessible for use in managing diseases has significant implications for facilitating alternative healthcare's access to the different therapeutic uses of the indigenous knowledge in their healthcare delivery efforts in Oyo State. It is recommended that further studies can be carried out on the storage and retrieval of indigenous knowledge, as well as dissemination and transfer of indigenous knowledge by practitioners of alternative health in primary healthcare.

Keywords: Indigenous knowledge, documentation, primary healthcare, alternative health practitioners, Nigeria

Introduction

Indigenous knowledge (IK) has been described as a way of knowing, seeing, thinking and doing things by the people in a community over time such that it becomes a part of them and is being orally transmitted from one generation to another. It encompasses the skills, experiences and insights of the people which are applied to maintaining or improving their livelihood (Wahab, 2010). IK is embedded in community practices, institutions, relationships and rituals. Essentially, it acts as a tacit knowledge that is not easily codifiable.

Mutula (2002) opines that indigenous knowledge is passed on largely by oral methods. Furthermore, Mabawonku (2002) sees indigenous knowledge "as the basis for local decision-making in agriculture, healthcare, food preparation, education, natural resource management and a host of other socio-cultural activities in rural communities" . To Sam (2005), " indigenous knowledge is 'traditional' or 'local' knowledge embedded in the community and is unique to a given culture, location or society.'' Similarly, Ogunniyi (2013) regards indigenous knowledge systems (IKSs) as a conglomeration of thought systems or worldviews that have evolved

among various local communities over a considerable length of time. As such, one can conclude that it is the product of human interactions with nature and represented in various forms: verbal, graphic or written, thus emphasising the notion that indigenous knowledge is what people hold to be true.

The fact is that IK has input in societal development. Attesting to this, the World Development Report (1997) reveals that in the emerging global knowledge economy, a country's ability to build and mobilise knowledge capital is as essential for a sustainable development as the availability of physical and financial capital. Communities in many parts of the world, including Nigeria, have been known for their indigenous and self-reliant strategies in 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, long before their exposure to European influence (Wahab, 2010). There is growing interest in and appreciation of indigenous knowledge (IK) in Nigeria as it is part of everyday life; thus, it is usually regarded as a problem-solving mechanism for rural communities. An example of this is "omugwo"in Igbo culture, in which during the first four weeks after birth, the mother and the child are secluded and the mother relieved of duties, and are cared for by the grandmother of the newborn. The new mother is fed a stimulating hot soup made of dried fish, meat, yams, a lot of pepper and a special herbal seasoning called "udah", which helps the uterus to contract and helps in expelling blood clots (World Bank, 1998).

Notably, the holistic conception of health by the World Health Organisation (2002) led to the development of the Primary Health Care (PHC) approach to solving healthcare problems in the world, including the Third World (Nigerian Health Review, 2006). Herbal medicine is a good example of indigenous knowledge which has affected the lives of people around the globe (World Development Report, 1998). Of course, herbal medicinal knowledge, which is associated with traditional medicine, has evolved from indigenous knowledge. In developing countries like Nigeria, studies have shown that over 70% of the populace still depends on traditional medicine (NHR, 2006). The assertion agrees with several previous studies such as those of WHO (2002-2003; 2011), NDHS (2003), Jain, (2008), Cruz and Ramos (2006), Omo (2008), Sackey (2008), Chiota (2010) and Odukoya (2012).

Alternative health practitioners play a major role in healthcare in many countries (Andersen and Newman, 2003). They are often part of a local community, culture and tradition, and are mostly herbalists, diviners, bone-setters, surgeons, traditional birth attendants (TBAs), traditional healers, faith healers, spiritualists, mid-wives, and traditional psychiatrists.

Today, many indigenous knowledge systems (IKS) face a grave risk of going into the extinction because of their dependence on oral transmission rather than proper documentation. Also, the richness of indigenous knowledge which is mainly based on oral traditions has not been fully exploited to the advantage of all the people. This is due, among other things, to failure to document it properly, and this has resulted in failure to locate and utilise it. Efforts to properly document IK would revolutionise healthcare system at the local level for the betterment of existing and future generations. Thus, there is an urgent need for strategies for documenting this knowledge within the context of evolving scholarship. This study, therefore, hopes to plug in this hole by:

1. identifyingng out the demographic variables of the practitioners of alternative healthcare in primary healthcare;
2. examining the use of indigenous knowledge for primary healthcare by practitioners of alternative healthcare;
3. ascertaining the forms of documentation of indigenous knowledge in primary healthcare by practitioners of alternative healthcare; and
4. examining the major constraints to documentation and use of indigenous knowledge by alternative health practitioners in primary healthcare in Oyo State, Nigeria.

Review of Related Literature

Existing studies on indigenous knowledge (IK) documentation have shown that there should be intensive research on documentation of IK to ensure that such knowledge is not lost and information professionals should be responsible for the management of IK using modern information technology and techniques (Mabawonku 2002; Makara 2002; Ngulube 2002; Kaniki and Mphahlele

2002; Raserooka 2002; Magara 2002; Chisenga 2002; Omole 2005; and Nnadozie, 2013). The National Agency for Food, Drug Administration and Control (NAFDAC) urged herbal medicine practitioners to document procedures and ingredients to encourage generational knowledge transfer and safe health for upcoming generations (Daily Times NG, 2014). Although evidence exists in research reports on the use of indigenous knowledge in primary healthcare by WHO (2002-2003; 2011), NDHS (2003), Jain (2004), Cruz and Ramos (2006), Omo (2008), Sackey (2008), Chiota (2010) and Odukoya (2012) to the effect that about 80 - 85 per cent of the people in the developing world depend on and use traditional medicine for their primary healthcare needs. However, there is the need to carry out valid research on the documentation of IK in the provision of primary healthcare by practitioners of alternative healthcare.

Ghatapanadi, Johnson and Rajasab (2011) have also analysed the documentation of folk knowledge on medicinal plants of Gulbarga district, Karnataka. In Karnataka, the researchers conducted ethnobotanical studies on medicinal plants in different districts and they found that traditional knowledge on the use of plants as medicine was well documented, but the extensive reports on medicinal plants are limited. According to Owiny, Mehta and Maretzki (2014), indigenous knowledge was commonly preserved through oral means and demonstration rather than documentation. However, with the help of librarians (custodians of information), IK can now be easily preserved in different formats. Ngulube (2002) points out that storage of IK is not limited to text documents or electronic formats. He states that various media, including cassette tapes, films, storytelling, songs, gene banks etc., could be used depending on the type of information.

Despite the impressive accretion of research work conducted on indigenous knowledge within the past few decades in Nigeria, there has been little or no research findings on the documentation and use of indigenous knowledge in primary healthcare by the practitioners of alternative healthcare. It is therefore expected that besides the recommendation that will be put forward, this study will contribute immensely to the body of the existing knowledge of IK, especially in the library and primary healthcare. It is against this backdrop that this study sets out to investigate the documentation and use of indigenous knowledge by practitioners of alternative healthcare in the provision of primary healthcare in Oyo State, Nigeria.

Methodology

This study adopted a descriptive survey research design. The total population of alternative healthcare practitioners in Oyo State, Nigeria, was 27,000 (Chairman, AHPOS). The State has three senatorial districts, namely Oyo North, Oyo Central and Oyo South. Alternative health practitioners spread across the three senatorial districts of Oyo State, which consist of thirty-three local government areas. To have a definite sample size of alternative healthcare practitioners in Oyo State, the Taro Yamane's (1967) sample size formula was used to determine sample size of 400 respondents from the total population of the study. Stratified sampling technique was used to select twenty (20) local government areas from the 33 local government areas in the state. Purposive sampling technique was then used to select twenty (20) respondents each from the selected local government areas (i.e. equal allocation).

The data collected was through the use of a structured questionnaire designed for the purpose. Four hundred copies of the questionnaire (400) were administered, and all the four hundred (400) copies distributed were recovered in useable condition. This hundred percent (100%) return rate was made possible by the direct involvement of the researchers and the trained research assistants, who were directed to ensure 100% collection by initiating several visits, if need be. The returned copies of the questionnaire were analysed and interpreted, using simple percentages and frequencies in a systematic way.

Analysis and Discussion of Results

The study showed that many of the respondents were old people. In fact, 100 (25.0%) were between ages 41 and 50 years, and not one of them was less than 20 years.dge. It is understandable why there was a comparatively low number of young participants in the study, given the fact that young people are attracted to city lifestyle and readily settle there at the earliest opportunity (Nnadozie, 2013). The elderly have different sub-forms and levels of knowledge

compared with the young. However, this kind of knowledge held by the gatekeepers becomes endangered as reported by Raserooka (2002), Magara (2002), and Makara (2002). The result of the present study in this regard corroborates those of previous studies, and it confirms the fact that unless interventions that facilitate preservation for long term access are guaranteed, indigenous knowledge will go into the extinction.

Table 1: Profile of the Respondents

	VARIABLES	FREQUENCY	PERCENTAGE %
Age	21-30 years	35	8.8
	31-40 years	82	20.5
	41-50years	100	25.0
	51-60 years	97	24.2
	Above 60 years	86	21.5
Gender	MALE	308	77.0
	FEMALE	92	23.0
Years of experience	5-14 years	105	26.3
	15-24 years	141	35.3
	25-34 years	109	27.3
	Above 35 years	45	11.3
Highest quest education qualification	Primary Education	90	22.5
	Secondary Education	109	27.3
	Tertiary education	19	4.8
	Others	1	.3
	No formal education	181	45.3
Occupation	Herbalists	282	70.5
	Midwives	29	7.3
	Bone-setters	13	3.3
	Birth attendants	20	5.0
	Spiritualists	41	10.3
	Traditional psychiatrists	15	3.8
Religion	Islam	156	39.0
	Christian	74	18.5
	Traditional	169	42.3
	Others	1	.3
	Islam	156	39.0
Area of specialisation	Bone-setting	19	4.8
	Maternal health	41	10.3
	Child care	20	5.0
	Family planning	4	1.0
	General health	316	79.0

N=400

Although there are both male and female alternative healthcare practitioners, the result of this study showed that there were more male alternative healthcare practitioners than females in our sample. The study supports the submission of Kafaru (1998) (cited in Olatokun, 2010) who maintains that some norms that are accepted and observed within the traditional medical practice hinder women (especially those of child bearing age) from active participation in the practice. This explains the dominance of the male gender in the practice.

With regard to the number of years of experience as alternative healthcare practitioners, majority of the respondents are very experienced in the profession. Indigenous knowledge has been described as unique to a given community, culture or society because it is borne out of experience carefully built over a long period of testing and experimentation (Das Gupta and Saha, 2009).

Also, some of the alternative health practitioners had formal education. The low level of formal education explains why many of them still hold on to the profession. This result inadvertently underscores the assertion that while indigenous knowledge is largely in the hands of decrepit old people, the youth who should learn and acquire this knowledge from the elders to guarantee their survival are migrating to urban centres where they acquire alien values and ways of life (Langill, 1999). This study, therefore, confirms the findings of an earlier study by Kaniki and Mphahlele (2002) who observed that education has also made indigenous knowledge to be largely undocumented, making "bibliographic" control in traditional sense almost impossible. The point is that education is important in the proper documentation of indigenous knowledge.

The study also revealed that there are more traditional worshippers as compared to other forms of religion in alternative healthcare practice. The study has also shown that the alternative health practitioners are into all forms of health practices.

Table 2 shows the forms of documentation of indigenous knowledge by alternative health practitioners in primary healthcare. Documentation by writing (Mean =2.42) was ranked highest by the mean score rating. This result could be attributed to the fact that 54.9% of them had formal education. This was followed by storytelling (Mean =2.12), while digitising was the least (Mean =1.07) form of documentation. However, the study has shown that IK is still expressed and passed on orally. The study buttresses the submission of Nnadozie (2013) who noted that IK is disseminated and passed on from generation to generation by words of mouth based on what human memory can remember, and this rather poses a grave danger to the survival of IK. This lack of documentation of the IK by alternative healthcare practitioners in the provision of primary healthcare could lead to further loss of IK.

Table 2: Forms of Documentation of Indigenous Knowledge by Alternative Health Practitioners in Primary Healthcare

S\N	Form	Not Used (N %)	Fairly Used (N %)	Always Used (N %)	MEAN	S.D
1	Writing	98 (24.5%)	37 (9.3%)	265 (66.3%)	2.42	.86
2	Story telling	127 (31.8%)	100 (25.0%)	173 (43.3%)	2.12	.86
3	Gene banks	241 (60.3%)	46 (11.5%)	113 (28.3%)	1.68	.89
4	Recording audio	272 (68.0%)	69 (17.3%)	59 (14.8%)	1.47	.74
5	Video taping	293 (73.3%)	55 (13.8%)	52 (13.0%)	1.40	.71
6	Drawing	301 (75.3%)	72 (18.0%)	27 (6.8%)	1.31	.59
7	Photographing	338 (84.5%)	46 (11.5%)	16 (4.0%)	1.20	.49
8	Compact disc	359 (89.8%)	25 (6.3%)	16 (4.0%)	1.14	.45
9	Database	372 (93.0%)	23 (5.8%)	5 (1.3%)	1.08	.32
10	Digitizing	384 (96.0%)	6 (1.5%)	10 (2.5%)	1.07	.33

N=400

Table 3: Use of Indigenous Knowledge in Primary Healthcare

S\N	Health Challenges/ Diseases/ Illness	Never Used N (%)	Fairly Used N (%)	Used N (%)	Always Used N (%)	MEAN	S.D
1	Pile	85(21.3)	22(5.5)	137(34.3)	156(39.0)	2.91	1.14
2	Maternal health	74(18.5)	22(5.5)	187(46.8)	117(29.3)	2.87	1.04
3	Fever	83(20.8)	20(5.0)	189(47.3)	108(27.0)	2.80	1.06
4	Menstrual disorder	93(23.3)	38(9.5)	138(34.5)	131(32.8)	2.77	1.14
5	Skull disease	102(25.5)	18(4.5)	149(37.3)	131(32.8)	2.77	1.16
6	Headache	83(20.8)	30(7.5)	191(47.8)	96(24.0)	2.75	1.04
7	Stomach pain	86(21.5)	42(10.5)	182(45.5)	90(22.5)	2.69	1.05
8	Jaundice	82(20.5)	64(16.0)	152(38.0)	102(25.5)	2.69	1.07
9	STD(s)	96(24.0)	40(10.0)	159(39.8)	105(26.3)	2.68	1.11
10	Weak erection	96(24.0)	43(10.8)	153(38.3)	108(27.0)	2.68	1.11
11	Rheumatism	111(27.8)	28(7.0)	146(36.5)	115(28.8)	2.66	1.16
12	Skin disease	98(24.5)	39(9.8)	169(42.3)	94(23.5)	2.65	1.09
13	Snake bite	105(26.3)	46(11.5)	141(35.3)	108(27.0)	2.63	1.14
14	Low sperm count	103(25.8)	48(12.0)	142(35.5)	107(26.8)	2.63	1.13
15	Yellow sperm	102(25.5)	54(13.5)	132(33.0)	112(28.0)	2.63	1.14
16	Diabetes	101(25.3)	49(12.3)	177(44.3)	73(18.3)	2.55	1.06
17	Epilepsy	120(30.0)	49(12.3)	120(30.0)	111(27.8)	2.55	1.19
18	Mental illness	124(31.0)	43(10.8)	129(32.3)	104(26.0)	2.53	1.18
19	Asthma	105(26.3)	73(18.3)	147(36.8)	75(18.8)	2.48	1.07
20	Tuberculosis	104(26.0)	76(19.0)	143(35.8)	77(19.3)	2.48	1.08
21	Rheumatism	94(23.5)	83(20.8)	177(44.3)	46(11.5)	2.44	.97
22	Fibroid	116(29.0)	71(17.8)	158(39.5)	55(13.8)	2.38	1.05
23	Stroke	118(29.5)	93(23.3)	119(29.8)	70(17.5)	2.35	1.08
24	Hypertension	108(27.0)	92(23.0)	155(38.8)	45(11.3)	2.34	1.00
25	Unwanted pregnancy	140(35.0)	98(24.5)	115(28.8)	47(11.8)	2.17	1.04
26	Dislocation	171(42.8)	67(16.8)	118(29.5)	44(11.0)	2.09	1.08
27	Child care	185(46.3)	15(3.8)	197(49.3)	3(.8)	2.04	.99
28	Broken bones	181(45.3)	77(19.3)	93(23.3)	49(12.3	2.03	1.09
29	Convulsion	174(43.5}	88(22.0)	134(33.5)	4(1.0)	1.92	.90
30	HIV/AIDS)	219(54.8)	88(22.0)	74(18.5)	19	1.73	.92

N=400

Table 3 shows what use to which indigenous knowledge is put by the respondents in primary healthcare. Pile (Mean =2.91) ranked highest by the mean score rating, followed by maternal health and lastly by HIV/AIDS) (Mean =1.73). The study has shown that indigenous knowledge is used in treating various health challenges in primary healthcare. This finding corroborates the opinion of World Health Organisation (2002) which claimed that up to 80% of the world's population depend on and use traditional medicine for its primary health needs. The assertion agrees with several previous studies such as those of WHO (2002-2003; 2011), NDHS (2003), Jain,(2008) Cruz and Ramos (2006), Sackey (2008), Omo (2008) and Odukoya (2012), who maintain that about 80– 85 percent of the people in the developing world depend on traditional medicine for their primary healthcare needs. The result of this study also provides evidence that IK continues to play an important role in the healthcare system among rural communities.

Conclusion

The study concludes that documentation of indigenous knowledge by practitioners of alternative health in primary healthcare in Oyo State, Nigeria is poor. This is because the documentation of indigenous knowledge among alternative health practitioners in the provision of primary healthcare is fraught with several challenges. The study maintains that the practitioners use IK in primary healthcare for various health needs of the people. Thus, one can conclude that traditional medicine is of contemporary relevance, and it can help rural communities to achieve self-reliance in their primary healthcare needs.

The challenges faced by alternative health practitioners include the need to adequately document indigenous knowledge in various formats that can make it accessible for use. However, in a society predominantly dependent on oral information, there is a need to focus on the documentation of IK. The study contends that adequate documentation of indigenous knowledge in various formats that can make it accessible for use in managing diseases has significant implications for facilitating alternative healthcare's access to the different therapeutic uses of the indigenous knowledge in their healthcare delivery efforts in Oyo State.

Recommendations

The study recommends that: librarians should collaborate with practitioners of alternative healthcare to carry out systematic documentation of indigenous knowledge used in the provision of primary healthcare. It is also suggested that librarians should be proactive in the documentation of indigenous knowledge in primary healthcare bearing in mind their training and skills. Government and corporate organisations should collaborate with libraries by providing fund and basic equipment for the documentation of indigenous knowledge in primary healthcare. Efforts should be made to document IK in primary healthcare and make it available in appropriate formats. Alternative health practitioners should be trained by librarians on how best to document all indigenous knowledge practices used in the provision of primary healthcare. Government should come up with policies and action plan for the protection and development of IK. Future studies should be carried out on the storage and retrieval of indigenous knowledge, as well as dissemination and transfer of indigenous knowledge by alternative health practitioners in primary healthcare.

References

Andersen R.M. And Newman, J.F. (2003). *Societal and Individual Determinants of Medical Care Utilization in the United States*. Milbank Memorial Fund Quarterly- *Healthand Society* 51(1):95-124.

Cruz, P.D and Ramos, A.G. (2006). *Indigenous Health Knowledge Systems in the Philippines: A Literature Survey.* Paper Presented at the XIIIth CONSAL Conference, Manila, Philippines (2006). pp.1-20.

Chisenga, J. (2002). *Indigenous Knowledge: Africa's Opportunity to Contribute to Global Information Consent*. (Proceedings of SCECSAL Conference*). Pretoria, p.*93

Daily Times NG., 12 August 2014. NAFDAC Urges Herbal Medicine Practitioners to Document Procedures, Ingredients. Das Gupta, D. and Saha, A. (2009). *Indigenous Knowledge*

System in Agriculture and Rural Development. In: Agbamu, J.U. Ed. Perspectives in Agricultural Extension and Rural Development. Owerri: Springfield Publishers Ltd. pp. 58-86.

Ghatapanadi, S. R., Johnson, N. And Rajasab, A. H. (2011). *Documentation of Folk Knowledge on Medicinal Plants of Gulbarga District, Karnataka. Indian Journal of Traditional Knowledge* 10 (2) 349-353.

Jain, P. (2008). *Indigenous Knowledge Systems in Africa*. In Information *and Knowledge Management in the Digital Age* (Edited by L.O. Aina, S.M. Mutula and M.A.. Tiamiyu). Ibadan: Third World Information Services, pp.301-331.

Kafaru, E. (1998). *Application of Dosage and Norms in the Nigerian Traditional Healing Methods* In: Olatokun (2010) Indigenous Knowledge of Traditional Medical Practitioners in The Treatment of Sickle Cell Anemia. *India Journal of Traditional Knowledge*, 9(1)119-125

Kaniki, M.A. And Mphahlele, M. E. K. (2002). *Indigenous Knowledge for the Benefit of all: Can Knowledge Management be Used Effectively?* (Proceedings of SCECSAL Conference), Pretoria, pp.13-36.

Langil, S. (1999). *Indigenous Knowledge: A Resource Kit for Sustainable Development Researchers in Dryland Africa. The Overstory Agroforestory E-Journal*, 82: 1-8.

Mabawonku, I. M. (2002). *The Systematic Management of Indigenous Knowledge: A Review of Oral Information Projects in a Library School.* (Proceedings of SCECSAL Conference). Pretoria, pp.49-60.

Magara, E. (2002). *Community-Based Indigenous Knowledge GIS for Developing Countries:A Strategy for Uganda*. (Proceedings of SCECSAL Conference). Pretoria, pp.71-100.

Magga, O. H. (2005). *Indigenous Knowledge Systems –The True Roots of Humanism*. World Library and Information Congress. 71st JFLA General Conference and Council. Libraries-A Voyage of Discovery". August 14-18th, Oslo Norway.

Makara, M. (2002). *Management of Indigenous Knowledge in Lesotho: Prospects and Challenges for Information Professionals.* (Proceedings of SCECSAL Conference). Pretoria. pp.49-60.

Mutula, S. M. (2002). *The Didital Divide in Sub-Sahara Africa:Implications for the Revitalization and Preservation of Indigenous Knowledge Systems*. (Proceedings of SCECSAL Conference). Pretoria, pp.49-60.

Msuya, J. (2007**).** *Challenges and Opportunities in the Protection and Preservation of Indigenous Knowledge in Africa. International Review of Information Ethics*. Accessed 31 August 2012 Available at http://www.i-r-i-e.net/inhalt/007/38-msuya.pdf

Nakata, M., and Langton, M. (2005). *Australian Indigenous Knowledge and Libraries*. Available: http://www.alia.org.au/publishing/aarl/aarl_vol36_no2_2005(reprint).pdf

Ngulube, P. (2002). *Strategies for Managing and Preserving Indigenous Knowledge In The Knowledge Management Era*. (Proceedings Of SCECSAL Conference). Pretoria.

Nnadozie,C. O. (2013). Dissemination of Indigenous Knowledge in Rural Communities-in-Transition. *Nigerian Libraries* 46(1) 78-106.

Nigerian Health Review (2006). *Traditional Medicine Practice and Development in Nigeria.* Pp.293.

Odukoya, O. (2012). *Traditional Medicine Practice in Nigeria: Targets and Transformation.* The Nation Newspaper: Natural Health Sept. 13: 45-46.

Ogunniyi, M. B. (2013). *Harnessing Indigenous Knowledge Systems in Fostering Quality in Africa. Journal of African Culture and International Understanding*, No. 5, pp.13-23.

Omo, F. (2008). *New Drug to Combat Sickle Cell.* June 13th, [Online] Retrieved on August 25, 2012 at: http.//www. natural health africa. blogspot.com

Omole, D. W. (2005*). Indigenous Knowledge and African Libraries: ICT Issues and the Way Forward. (*Proceedings of SCECSAL Conference). Pretoria.P.143.

Owiny, S. A., Mehta, K. and Maretzki, A. N. (2014). *The Use of Social Media Technologies to Create, Preserve, and Disseminate Indigenous Knowledge and Skills to Communities in East Africa. International Journal of Communication*. (8): 234-247. Accessed 10th September, 2014. Available at *ijoc.org/index.php/ijoc/article/viewfile/1667/1067*

Sackey, E. (2008). *Protection of Traditional Knowledge in Africa.* Lecture Notes Delivered to Postgraduate Students at the Africa University, Mutare, Zimbabwe.

Sam, J. (2005). *Indigenous Scientific Knowledge and Sustainable Development in Ghana: An Overview. Ghana Library Journal* 17: 33-42

Wahab, B. (2010). *Indigenous Knowledge and Development Process. In 50 Years of Nationhood: Experiences in and Prospects for Sustainable Development in Nigeria.* Ibadan: Sustainable Development Summit (ISDS). pp.167-210.

World Development Report, (1997). *The State in a Changing World.* Washington, D.C.: World Bank .

World Development Report, (1998). *Indigenous Knowledge for Development: A Framework for Action*. Washington, D.C.: World Bank.

World Health Organisation (WHO), (2002-2003) WHO. *Traditional Medicine Strategy*: 2002–2003. [PDF] Geneva: World Health Organisation. Accessed 31 August 2012. Available at: http://apps.who.int/medicinedocs/pdf/s2297e/s2297e.pdf> 2003

Yamane, Taro. (1967). *Statistics: An Introductory Analysis.* 2nd Ed., New York: Harper and Row.

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