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Does spatial location matter? Traditional therapy utilisation among the general population in a Ghanaian rural and urban setting

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Summary Despite the recognition for rising consumption rate of traditional medicine (TRM) in health and spatio-medical literature in the global scale, the impact of location in traditional therapy use has been explored least in Ghana. This paper analysed the role of spatial variation in TRM use in Kumasi Metropolis and Sekyere South District of Ashanti Region, Ghana. A retrospective cross-sectional and place-based survey was conducted in a representative sample ($N = 324$) selected through systematic random sampling technique. Structured interviewer-administered questionnaires were espoused as the main research instruments. Data were analysed with Pearson's Chi-square and Fisher's exact tests from the Predictive Analytics Software (PASW) version 17.0. The study found that over 86% reported TRM use. Whilst majority (59.1%) of the respondents had used TRM two or more times within the last 12 months, biologically-based therapies and energy healing were common forms of TRM accessed. Although, the use of TRM did not vary ($p > 0.05$), knowledge about TRM, modalities of TRM and the sources of TRM differed significantly across geographically demarcated rural and urban splits ($p < 0.005$). The study advances our understanding of the spatial dimensions as regards TRM utilisation.

Introduction

Access to health care is a critical component of a healthy start to life. In 1978, the World Health Organisation (WHO) adopted the Primary Health Care (PHC) model as a conceptual basis for effective and cost-effective health care

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delivery for populations globally.[1,2] As part of its cardinal principles, PHC ensures a continuous and organised supply of essential health services to all without unreasonable geographic and/or financial barriers. Although the core orientation of PHC is crucial for equitable progress in health, significant challenges in access to health care persist in low- and middle-income countries. The conventional modern medicine is still inept in handling most tropical and neglected diseases. Traditional medicine (TRM) remains a major component of PHC of every culture throughout the world and it has assumed the goals of PHC.[2] TRM is employed as the strategy for curative, health promotion/rehabilitative and disease prevention approaches in both economically developed and developing countries.[1,3]

People residing in Africa, Asia and Latin America have used TRM for hundreds of thousands of years to meet their primary health care needs.[4,5] The World Medical Situation found that between 70% and 95% of populations in low- and middle-income countries rely on TRM for their PHC needs.[6] In recent times, individuals and communities in the advanced world have also adopted various types of TRM including biologically-based treatments, body-mind-therapies as well as energy or distant healing interventions. Indeed, an increase in the use of TRM is evident by the emergence and rapid growth in the number of herbal outlets, herbal clinics and hospitals in sub-Saharan Africa and elsewhere.[7–13] In Ghana, TRM practice has been a momentous part of the history of medicine. The contribution of TRM to health care in Ghana is tremendous as more and more individuals and communities, especially the underserved, resource-constrained and the excluded who are presumably unable to afford orthodox medical care wholly or partially consume traditional medical therapies.[14] TRM plays a crucial part alongside the orthodox medical practice in meeting the health needs of the vast majority of Ghanaians.[15,16] Approximately, 70% of Ghanaians use alternative medicine[17] including traditional herbal medicine, psychosomatic treatments and faith based medical regimen.

With the increasing popularity, interest and use of TRM, it is crucial to understand the nature and extent of TRM use from a spatial perspective.[4,9] Besides, the relative importance of geographic location among the key predictors of TRM utilisation needs to be analysed. Whilst a clearer picture is painted regarding spatial analysis of TRM use among populations elsewhere,[18] the subject remains grey in the African context. Little attention has been given to research to analyse the impact of geography on the utilisation of traditional health services. In the analysis of TRM utilisation, the composite effects of spatial variation and interrelated variables of rural and urban settings have unfortunately been considered least in Ghana. No previous TRM utilisation study has focused on spatial variation of TRM among the general population in Ashanti Region. For more meaningful conclusions to be established as regards TRM utilisation, locational impacts cannot be glossed over. In response, this study tailors location-related analysis of the role of spatial variation in the TRM utilisation in the Kumasi Metropolis and Sekyere South District of Ashanti Region, Ghana.

Spatial variation and TRM utilisation: empirical perspective

Research has validated the position that utilisation of TRM differs geographically between rural and urban divide (for example Adams et al.[18]). Nonetheless, not much empirical work has been done on the impact of spatial variation on TRM utilisation in sub-Saharan Africa. Most studies in this regard are concentrated in the developed and other regions elsewhere. Corpus of evidence indicates that people who reside in non-urban areas have a higher rate of use of TRM/Complementary and Alternative Medicine (CAM) than people of urban communities.[18,23] Adams et al.,[24] Sibbritt et al.,[25] Shreffler-Grant et al.,[26] Sibbritt et al.,[27] Nilsson et al.,[28] and Friedman and Lahad[29] show in various studies that in general, rural and urban settings present different socio-economic, politico-environmental, health status, health beliefs and prevalence of disease burden. This phenomenal diversity contributes to a difference in terms of self-rated health[30] which informs health care seeking-behaviour and utilisation of health care resources.

Using data from Survey of the Australian Longitudinal Study on Women's Health conducted in 2007, Adams et al.[31] studied the urban-rural divide in complementary and alternative medicine use among 10,638 women and found that women who consulted a CAM practitioner varied significantly by place of residence. They noted that 28% resided in the urban areas, 32% resided in rural areas whilst 30% resided in remote areas. This finding supports the observation of Shreffler-Grant et al.[26] and Wilkinson and Jelinek[32] which report that CAM is found to be used by older rural adults as a common strategy for maintaining health and wellbeing compared with their urban counterparts.

From North America and Australia, Wilkinson and Simpson,[33] MacLennan et al.[34] and Herron and Glasser[35] have independently depicted that populations in rural and remote communities are associated with higher CAM demand taking their urban counterparts as benchmark. In a retrospective analysis of 237,500 claims data of two large United States insurance companies in Washington State for calendar year 2002, Lind et al.[36] noted that the proportion of claimants using chiropractors was higher in rural than urban residents even though users of chiropractic treatment in metropolitan areas made more chiropractic visits than users in non-urban areas.[31] Lack of conventional health providers in rural areas did not completely explain this difference, nor did differences in patient cost-sharing or demographics.[36] In Australia, the perspectives on the use in communities of complementary and alternative medicine study, based on a survey of 459 residents in Victoria revealed significantly higher rural use of self-prescribed supplements, chiropractic and Bowen therapy than in urban areas.[31,37,38]

In a survey of malaria treatment in remote areas of Mali, Graz et al.[39] observe that most children with reported uncomplicated malaria were first treated at home (87%) with modern medicines alone (40%), a mixture of modern and traditional treatments (33%), or traditional treatment alone (27%). The upsurge use of TRM by populations in non-urban environments is evident. In a cross-sectional survey of 1427 participants from the Australian Longitudinal Study on