

Sociocultural Representations of the Patients Reached of Dermatoses at the African Black, Teaching Hospital of Treichville, Abidjan, Ivory Coast

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ABSTRACT

AIM: To identify the representations which the African black patients have their dermatoses in order to improve their support.

MATERIALS AND METHODS: It was a cross-sectional study with descriptive and analytical aiming carried out with the service of dermatology of Teaching Hospital of Treichville, from March 31st, 2014 to May 29th, 2014. Had been included in-patients, and 10 patients per day in consultation on a simple mode of recruitment by including a patient on two. The representations were appreciated on the punitive models, persecutives and destiny of Saradon Eck.

RESULTS: 110 out of 361 patients (30.5%) had sociocultural representations; the sex-ratio of 0.62; the median age of 43.6 years and 78.7% of provided education for 73% ($n = 110$) consulted in first intention a traditional physicians, a charlatan or a camp of prayer;

63.6% did not have explanations on their representations; 28.18% had some on the persecutive models; 8.18% on the punitive models and any on the model destiny. The origin of the representations was the family (67.2%), the patient himself (66.3%), and the friends (20%). 78% adhered to it, 19.2% doubted and 2.8% did not believe in it. The papules were more represented but the difference was significant for the bubbles, the maculae and ulcerations ($p = 0.05$). Lastly, one noted, among them, more patients presenting of the large legs (29.1%), the squameuses dermatoses (20.9%) and maculo-papulous rash (20%). **CONCLUSION:** To question the patients on their sociocultural representations face their dermatoses in Black Africa can help the support because it is a spirit which lives much of them.

Key words: Dermatoses; Sociocultural representations; Black africa

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INTRODUCTION

The adhesion of the patients to traditional or cultural representations of the disease should be perceived by the doctors neither like an obstacle with the comprehension of the scientific speech, nor like an obstacle with the establishment of a solid therapeutic alliance. There can be divergence between the models of the patients and the doctors without there being competition^[1,2]. On the contrary, the taking into account of the explanatory models and the etiologic theories of the patients in the device of care can support therapeutic alliance from the

clinical point of view but also from the point of view of public health. That will without any doubt make it possible to reduce the delays of consultation and lost sight of the fact, especially in Black Africa where these two data burden the vital prognosis. It is thus pressing to understand the sociocultural representations that the patients make their diseases in order to improve their assumption of responsibility. Several studies were conducted in many medical specialities^[3,4,5] but in dermatology the data are still partial. We carried out this study in order to describe the sociocultural representations of the patients seen for dermatoses at CHU of Treichville.

It will be more specifically about: (1) to describe the various epidemiologic aspects of the patients reached of dermatoses and having a sociocultural representation; (2) to identify the models of representation; (3) to identify the various clinical aspects of the dermatoses associated with the sociocultural representations; (4) to describe the therapeutic route of the patients having sociocultural representations.

MATERIALS AND METHODS

It was about an exploratory study aimed descriptive and analytical. It was held with the service of dermatology and venerology of Teaching Hospital of Treichville. The study period went from March 31st, 2014 to May 29th, 2014 so 2 months. The population of study concerned the patients seen in consultation with the service of dermatology as those who were hospitalized during this period. All the patients were included having a dermatoses. The recruitment of the patients was carried out as follows: 10 patients per day were recruited in consultation according to a mode of random recruitment simple. It consisted in including a patient on two presenting themselves to the reception. After an enlightened assent one gave a map to him. It was re-examined after the consultation in an office envisaged for this purpose submitting our questionnaire to him. In the event of refusal the patient coming just after this last was included. Then recruitment was done with one on two patients. All in-patients were of office included in the study. Were not included in the study the dumb blind men, deaf persons, the children (0 to 15 years) and the Caucasians. The epidemiologic, clinical and psychological parameters following were studied: the age, the sex, the profession, the place of dwelling, signs functional, the prevalent elementary lesion, the diagnosis, the therapeutic route and the explanation of pathology. According to the explanation that the patients gave of their pathology they were classified in 3 great groups according to the explanatory models of Saradon Eck^[6]. These models are: the punitive model with 4 pennies groups (religious, biomedical, psychosomatic and the ground) then the persecutive model with 4 pennies groups (possession, plot, ecological and hereditary) and finally the destiny model based on the destiny of the individual. The data were compiled and analyze with the software Ear Information 5.1. The statistical analysis was analyzed by using the software Ear Information 6.0 (EPITABLE). The statistical tests used were the chi-square tests two for the proportions and T student or the ANOVA for the comparison of averages. The statistical threshold of significance retained is 5%.

RESULTS

For this period we inquired 361 patients. The patients having sociocultural representations were 110 is 30.5% of surveyed.

Epidemiologic characteristics of the patients having sociocultural representations vis-a-vis their dermatoses

The sex ratio was of 0.62 and the average age 43.6 years with the

extreme ones going from 18 to 81 years. The patients coming from the town of Abidjan were represented to a total value of 80% in the population of those having sociocultural representations however the patients coming from the interior of the country had sociocultural representations of their pathology in 46.8% of the case against 28% pour those coming from Abidjan. Provided education for were represented to 66.4%, the Christian religion with 59.2%, Muslims with 31.8%, the animists with 4.5%, and 4.5% of Buddhists and other religions. As for the senior officers, they accounted for 24.5%, the informal sector 38.2% and them without employment 24.5%. The average time of consultation was 441.37 days is approximately 1 year 2 months with the extreme ones going from 2 to 3650 days. These representations generally came from the family (67.24%), the patient himself (66.34%) and the friends (20%). The patients adhered to these socio cultural representations in 78% of the cases, doubted in 19.2% of the cases and did not believe in 2.8% of the cases. The patients who stated to have had medical explanations their diseases accounted for 90.9% (100 patients) among them, 98 patients affirmed to be convinced against 2 who were not convinced.

Clinical aspects of the patients having sociocultural representations of their dermatoses

With regard to the prevalent elementary lesions, the patients had sociocultural representations in 54.5% for papulous lesions, 19.1% for maculae, 14.6% for ulcerations, 7.3% for blisters and bubbles, in 2.7% for scales and 1.8% for vegetations. The pain was associated with the sociocultural representations in 31.8%, the pruritus in 25.4% and the fever in 21.8%. According to the groups of pathologies, the large legs were associated with the sociocultural representations in 29.1% follow-up of the squamous dermatoses in 20.9% then rash maculous and/or papulous in 20%, the ulcerous dermatoses in 14.5%, the systemic diseases and the tumours accounted for 12.7% each one and finally the bullous dermatoses in 10.9%.

DISCUSSIONS

In our study we found a female prevalence that it is in the general population or that which had sociocultural representations. This result differs from the study from Hannah L and collar in Brazil^[7]. And of that of Kouakou B J-P in Ivory Coast on the “disease of the bird “or convulsive crises^[8] However, these studies compartmental on a disease contrary to our were made on all the dermatoses. The analytical study did not show a significant difference between the woman and the man (Table 3).

The women and the men thus have the same tendencies to have sociocultural representations as the data of the literature attest it^[9,6,10,11]. In Africa in general, the women consult more the dermatologists than the men; that not because they have more dermatoses than the men but because they always wish to improve their skin.

Our population of study was represented by young adults with an average age 40.06 years. The subjects having sociocultural representations were slightly older 43.6 years with a statistical difference which was significant compared to those not having representations, 38.7ans (Table 3). That could be explained by the fact why the young people are more leaning towards the modernism whereas the old subjects still preserve the prejudices and cultural traditions receipt in heritage of their parents. These designs guide their attitude and their choice towards the disease. The sociocultural prevalence of the representations in our population of study was of 30.5%. It differs from that from OWONA and MANOU^[12,13] which

found a prevalence respectively of 58% and 68.2% in the psychiatric and neurological affections.

The prevalence of the sociocultural representations in the dermatoses was not found in the literature. However this difference observed could be explained by the fact that these studies had been conducted on chronic pathologies (the insanity and hemiplegias), sources of despair bringing to various interpretations of the disease. In our study, the patients coming from the interior of the country had the most sociocultural representations with 46.8% compared with 28% for those of Abidjan with a significant difference ($p = 0.009$ with the threshold 5%). The populations of the interior are generally inked in our culture and tradition. They are referred by general doctors in the event of recourse to the medical care conventional. In this context the evacuation of the patients towards Abidjan could be perceived by the patient and his entourage like a complication of their pathology and thus involve various interpretations. Also this difference could be explained by the strong proportion of illiterates in the rural population like raised MANOU^[13] and collar in their study. The high rate of illiteracy of this rural population is related to the total low level of schooling of the population of the Ivory Coast and, illiteracy ineluctably has an impact on the perception of the disease and its handicap according to the psychiatrist and psychoanalyst PRIGENT^[14]. Our results confirm this analysis of PRIGENT since the patients not having been provided education for had the most sociocultural representation (33.6%) with a statistically significant difference (Table 3).

But this result differs from that of KONE^[8] with 27% of the subjects not provided education for. According to him the school level would not affect any the sociocultural representations because of strong proportions of frameworks were found in the literature like having representations. However the statistically significant difference found in the group of the not provided education for patients makes us evoke that education would thus constitute an efficient way to get rid of the social prejudices of the diseases. That is attested by the fact that the patients having a higher school level did not have sociocultural representations in 101 cases against 24 cases having sociocultural representations with a significant difference (Table 3).

The patients of Christian religion were represented with 59.2% follow-ups of the Muslims (31.8%). This result is superposable with that of KONE and OWONA^[8,12] which found a prevalence of Christian patients. Among these Christians, the catholics were represented in our study as in that of OWANA^[12]. The religious faith, in front of despair, thus does not slow down this state of mind. The average time of consultation of the patients having representations sociocultural was 441.37 days. This time of consultation is slightly longer than that of the patients not having sociocultural representations (418.17 days). This delay of consultation can be dependent their routes therapeutic. Indeed 70.9% of them consulted a tradipratician, a charlatan, a camp of prayer or other nonmedical structures, in first intention and in 27.27% in second intention. According to NGANGA^[15] in a study relating to the hernias of which 48% were allotted to the intrigues from sorcery and 25% with the physical effort, the time of first doctor visit, at the hospital of Brazzaville, was of more than 3 years for 34% of the adults and 45% had recourse the surgical alternative only after being wearied various types of traditional treatment, beverages, infusions of plants, frictions, ablutions, scarifications local, grigris of mineral or animal origin, interdicts food. We did not find studies conducted on the dermatoses allowing us to make more refined comments. On the 100 patients having sociocultural representations and which stated

Table 1 Distribution of the patients reached of dermatoses and having sociocultural representations according to the explanatory model of Saradon Eck, Teaching Hospital of Treichville, Abidjan, 2014.

Explanation of the disease	Frequency (n=110)	Pourcentage(%)
Non explanation	70	63.6
Punitive models	9	8.1
Religious	03	2.7
Biomedical	01	0.9
psychosomatic	00	00
Pathogenic ground	05	4.5
Persecutives models	31	28.1
Evil possession	28	25.4
Plot	03	2.7
Ecological	00	00
Hereditary (faulty grandfather)	00	00
Destiny model (destiny of individuel)	00	00

Table 2 Distribution of the patients reached of dermatoses and having sociocultural representations according to their therapeutic rout, Teaching Hospital of Treichville, Abidjan, 2014.

Place of consultation	1 st intention	2 nd intention	3 intention
Traditional physicians	45	13	2
Peripheral health facilities	28	41	17
Camp of prayer	21	13	1
Charlatans	7	2	0
Others	5	2	1
Teaching Hospital	4	35	50
Total	110	106	71

Table 3 Analysis comparative of the variables according to whether the patients had or not sociocultural representations, Teaching Hospital of Treichville, Abidjan, 2014.

Variables	Patients not having socio cultural representations	Patients having sociocultural representations	P
Sexe			
Female	166	68	0.42
male	85	42	
Level of study n(%)			
unschoolled	40 (15.9)	37 (33.6)	0.00015
Primary	41 (16.3)	18 (16.4)	0.99
secondary	69 (27.5)	31 (28.2)	0.8 9
superior	101 (40.2)	24 (21.8)	0.00079
Elementary predominant lesions n(%)			
ulceration	16 (14.54)	13 (5.20)	0.002
macula	21 (19.09)	27 (10.75)	0.03
bubble	04 (3.63)	00 (00)	0.01
functional signs n(%)			
Pain	25 (9.96)	35 (31.81)	0.00000
Pruritus	91 (36.25)	28 (25.45)	0.04
Fever	11 (4.38)	24 (21.81)	0.0000
Clinical types n(%)			
Maculopapular rashes	33 (13.1)	22 (20)	0.09
Large legs	10 (3.9)	32 (29.1)	0.0000
Bullous dermatosis	5 (2.22)	12 (10.90)	0.0003
Tumors	37 (14.7)	14 (12.7)	0.6
Squamous dermatosis	55 (21.9)	23 (20.9)	0.8

to have had medical explanations their diseases, 98 patients affirmed to be convinced against 2 who were not convinced. This underlines the fact that the explanations, maintenance council with the patient make it possible to dissipate a good amount of incomprehension and to improve adhesion of the patients to their disease and with the treatment. The patients having cultural representations resulting from the ethnic group of Akans were most frequent (44.6%). KONE and OWANA^[8,12] had already found a prevalence of towards these representations and had evoked a probable skew of selection that the selection of the patients had been made in Abidjan zones naturally inhabited by Akans. But the ethnic groups of the south do not have more sociocultural representations than the ethnic

groups of north according to our statistical tests carried out. The elementary lesions with type of ulceration, macula and bubble were most frequently associated with the cultural representations socio with statistically significant differences (Table 3). These generally visible elementary lesions and of chronic evolution could constitute the main reasons of this report. The functional signs such as the pain and the fever were associated with the socio cultural representations with statistically significant differences (Table 3). These signs generally translate a suffering difficult to support by the patient and can thus deteriorate the quality of life of this last. These signs when they become chronic cause several interrogations and comments on behalf of the community. With regard to the pruritus; the difference was not statically significant (Table 3). This result is different from that of HANNAH^[7] which related to the diffuse pruritus. That could explain this difference since our work concerned to him all the pruritus (localised or diffuse). The large legs (bacterial dermohypodermatitis acute and disease of kaposi) and the squamous dermatoses, respectively 29.1% and 20.9% and the maculo-papulous rash (20%) were most frequently associated with sociocultural considerations with significant differences (Table 3). Pathologies associated with these representations are in general chronic diseases or repeating and the patients who have large legs generally paid “to have gone on a fetish”. The chronicity of pathologies pushes the populations to as well make several consultations in modern medicine as traditional (Table 2). The lack of satisfactory therapeutic answers leaves free course to various interpretations. These facts find their petrols in the fact that African in general and of the Ivory Coast in particular does not have the culture of the chronic diseases. For African in general, the chronicity of the pathology could be perceived like a transgression of a divine law or established by the man, or the non-observance of an interdict or the fact of a fate launched by others. Extremely of these facts revealed above a question remains: which reports the patients maintain with the health care system? This question finds its answer in the various places of consultation in the event of disease. Indeed in our study, the patients had consulted in first intention the tradipratician in 45 cases out of 110 (Table 2). This report is also made by several authors of the Ivory Coast and African^[7,12,16,17]. One also should not occult the factor of geographical and financial accessibility. In the control of the care in Africa, the family plays a great part. That is attested by the fact that in our study the family was most frequently responsible for the evocation of cultural considerations socio in 74 cases (67.24%). Indeed it is it which would hold financial means and thus which would dictate therapeutic control adopted. All means are put in place to make accept the decisions with the patients. That is backed up by our results or 78% of the patients adhered to these sociocultural considerations. According to Castles^[18] a good scientific knowledge of the disease allows an adhesion the treatment. These considerations can be thus a brake with the effective assumption of responsibility of the patients. In 63.6% of the cases, the patients having sociocultural representations did not have explanations of their diseases (Table 1). This result differs from those of the literature^[19,20]. However those which found explanations generally used the persecutive models (Table 1) and more specifically evil possession (90.3%, $n = 31$). This vision which consists in seeing in others its criminal creates much misunderstanding in the families and the vicinity. It is about a mode of simple explanation which does not make it possible to the patient to be called into question but rather consists in showing the others. Thus although the man is sinning the punitive model accounts for only 8.1% including 2.7% of monk (Table 1).

CONCLUSION

The sociocultural representations of the diseases constitute a rather important shutter of the assumption of responsibility of the patients. The dermatoses, pathologies displaying do not escape this rule. At the end of this study we note that these representations are rather frequent with the service of dermatology of Teaching Hospital of Treichville especially on the persecutive models. A good knowledge of these representations by medical staff will make it possible to improve adhesion of the patients to the treatment and their follow-up.

CONFLICT OF INTERESTS

The authors declare that they do not have conflict of interests.

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