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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**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
The sex ratio was of 0.62 and the average age 43.6 years with the epidemiologic characteristics of the patients having sociocultural representations were 110 is 30.5% of surveyed. The statistical threshold of significance retained is 5% for the proportions and T student or the ANOVA for the comparison analysis was analyzed by using the software Ear Information 6.0. The persecutive model with 4 pennies groups explanatory models of Saradon Eck pathology. According to the explanation that the patients gave of their lesion, the diagnosis, the therapeutic route and the explanation of parameters following were studied: the age, the sex, the profession, the Caucasians. The epidemiologic, clinical and psychological representations of their 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 recruited in consultation and 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[10]. 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 those 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 maculos 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 collair in Brazil[10]. And of that of Kouakou B J-P in Ivory Coast on the “disease of the bird “or convulsive crises”[11]. However, these studies compartmental on a disease contrary to our we 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 if[8,9,10,11]. 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 (53.6%) with a statistically significant difference (Table 3).

But this result differs from that of KONE[15] 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 why education is a key component of the treatment. The patients having cultural representations resulting 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 (53.6%) with a statistically significant difference (Table 3).

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The patients of Christian religion were represented with 59.2% of the population. This result is superposable with that of KONE and OWANA[12,13] which found a prevalence of Christian patients of 62% and 68.2% respectively in a study relating to the hernias of Abidjan and the patients having representations were most frequent (44.6%). KONE and OWANA[12,13] had already found a prevalence of towards these patients and had evoked a probable skew of selection can 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 the north.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Patients not having sociocultural representations</th>
<th>Patients having sociocultural representations</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>166</td>
<td>68</td>
<td>0.42</td>
</tr>
<tr>
<td>Male</td>
<td>85</td>
<td>42</td>
<td></td>
</tr>
<tr>
<td>Level of study (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>unschooled</td>
<td>40 (15.9)</td>
<td>37 (33.6)</td>
<td>0.00015</td>
</tr>
<tr>
<td>Primary</td>
<td>41 (16.3)</td>
<td>18 (16.4)</td>
<td>0.99</td>
</tr>
<tr>
<td>secondary</td>
<td>69 (27.5)</td>
<td>31 (28.2)</td>
<td>0.89</td>
</tr>
<tr>
<td>superior</td>
<td>103 (40.2)</td>
<td>24 (21.8)</td>
<td>0.00079</td>
</tr>
<tr>
<td>Elementary predominant lesions (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ulceration</td>
<td>16 (14.54)</td>
<td>13 (12.0)</td>
<td>0.02</td>
</tr>
<tr>
<td>macula</td>
<td>21 (19.09)</td>
<td>27 (25.7)</td>
<td>0.03</td>
</tr>
<tr>
<td>bubble</td>
<td>04 (3.63)</td>
<td>00 (00)</td>
<td>0.01</td>
</tr>
<tr>
<td>Functional signs (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain</td>
<td>25 (9.96)</td>
<td>35 (31.81)</td>
<td>0.00000</td>
</tr>
<tr>
<td>Pruritus</td>
<td>91 (36.25)</td>
<td>28 (25.45)</td>
<td>0.04</td>
</tr>
<tr>
<td>Fever</td>
<td>11 (4.38)</td>
<td>24 (21.81)</td>
<td>0.00000</td>
</tr>
<tr>
<td>Clinical types (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maculopapular rashes</td>
<td>33 (13.1)</td>
<td>22 (20)</td>
<td>0.09</td>
</tr>
<tr>
<td>Large legs</td>
<td>10 (3.9)</td>
<td>32 (29.1)</td>
<td>0.0000</td>
</tr>
<tr>
<td>Bullous dermatosis</td>
<td>5 (2.22)</td>
<td>12 (10.90)</td>
<td>0.0003</td>
</tr>
<tr>
<td>Tumors</td>
<td>37 (14.7)</td>
<td>14 (12.7)</td>
<td>0.6</td>
</tr>
<tr>
<td>Squamous dermatosis</td>
<td>55 (21.9)</td>
<td>23 (20.9)</td>
<td>0.8</td>
</tr>
</tbody>
</table>

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[12,13] had already found a prevalence of towards these patients and had evoked a probable skew of selection can 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 the north.

| 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) | Percentage(%) |
| Non explanation                   | 70                                               | 63.6 |
| Punitive models                    | 9                                                | 8.1  |
| Religious                          | 03                                               | 2.7  |
| Biomedical                         | 01                                               | 0.9  |
| psychosomatic                      | 00                                               | 0.00 |
| Pathogenic ground                  | 05                                               | 4.5  |
| Persecutives models                | 31                                               | 28.1 |
| Evil possession                    | 28                                               | 25.4 |
| Plot                               | 03                                               | 2.7  |
| Ecological                         | 00                                               | 0.00 |
| Hereditary (faulty grandfather)    | 00                                               | 0.00 |
| Destiny model (destiny of individual) | 00                                               | 0.00 |

| 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 | 1st intention | 2nd intention | 3rd 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          |

<p>| Table 3 Analysis comparative of the variables according to whether the patients had or not sociocultural representations, Teaching Hospital of Treichville, Abidjan, 2014. |
|--------------------------------------------------|--------------------------------------------------|-----------|</p>
<table>
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</tr>
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</table>
Thus although the man is sinning the punitive model accounts for
of simple explanation which does not make it possible to the patient
misunderstanding in the families and the vicinity. It is about a mode
vision which consists in seeing in others its criminal creates much
(Table 1)) and more specifically evil possession (90.3%,
the patients. In 63.6% of the cases, the patients having sociocultural
can be thus a brake with the effective assumption of responsibility of
the patients. In 63.6% of the cases, the patients having sociocultural
for the care system? This question finds its answer in the various places of
in Africa, the family plays a great part. That is attested by the fact
of geographical and financial accessibility. In the control of the care
Ivory Coast and African
110 (Table 2). This report is also made by several authors of the
consultation in the event of disease. Indeed in our study, the patients
or repeating and the patients who have large legs generally paid
“to have gone on a fetish”. The chronicity of pathologies pushes
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
evacuation 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
[10] 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
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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