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# SOCIOLOGICAL ANALYSIS OF ADULT PATIENTS WITH DEPRESSION AT THE OBAFEMI AWOLOWO UNIVERSITY TEACHING HOSPITALS COMPLEX, ILE-IFE, OSUN STATE

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# SOCIOLOGICAL ANALYSIS OF ADULT PATIENTS WITH DEPRESSION AT THE OBAFEMI AWOLOWO UNIVERSITY TEACHING HOSPITALS COMPLEX, ILE-IFE, OSUN STATE



**BY**

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# DEDICATION

This research work is dedicated to my Helper, Redeemer and saviour, Christ Jesus for showing me mercies and granting me this privilege.

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## ABSTRACT

The study examined the influence of socio-economic factors (marital status, occupation and religious affiliation) on the prevalence of depression. It also investigated patients' perception and knowledge of the illness and identified the coping mechanisms adopted by adult patients with depression at the Obafemi Awolowo University Teaching Hospitals Complex (OAUTHC). This was with a view to exploring the socio-cultural context of depressive disorders in the study area.

Data were obtained from primary and secondary sources. A Case-Control design was adopted. The study population consisted of two categories of adult patients (18-60years): those with primary depressive conditions and those without depression seeking treatment over a 5 year period (2002-2007) at the OAUTHC. Based on the hospital records, 110 adult patients with depression and 309 adult patients without depressive conditions met the inclusion criteria. All the 110 adult patients with depression were selected for the Case Group, while an equal number of 110 adult patients were selected for the Control Group using a simple random sampling technique. A total of 220 copies of questionnaire were administered on the two categories of adult patients. In-depth interviews were held with 14 psychiatric caregivers (3 Doctors and 11 Nurses) in the hospitals. Also, case files of patients with depression were consulted for relevant secondary information. Data were analysed using descriptive and inferential statistics.

The results showed that there were more young adults (18-40 years) in the Case Group (71.8%) than the Control Group (51.3%). Also 58.6% of married female adults were in the Case Group compared to the Control Group (41.4%); however, no significant relationship was found between marital status and depression ($\chi^2 = 0.05$, $P > 0.05$).

There were more Christians (76.9%) than Muslims (23.1%) in both Groups. No significant relationship was found between occupational status and depression ($\chi^2 = 7.9$, $P > 0.05$). Patients' perception and knowledge of depression revealed a multi-causal orientation. Among the Case Group, 79.5% linked depression to negative life events, genetics (40%), and unhealthy life style (39.8%), while 43.6% of the Control Group associated depression with negative life events and unhealthy life style (52.6%). Also 70 % of the Case Group disagreed that there was a cure for depression, while 51.3% of the Control Group felt otherwise. On drug use, 65% of the Case Group considered it as burdensome; only 42.3% of those in the Control Group shared a similar view. Religion was a common coping measure among respondents in both Groups. However, a significant relationship was found between the age of respondents in both groups and their decisions to seek God's help ($\chi^2 = 11.5$, $P < 0$ .05), and a similar significant relationship was also observed in their attitudes to prayers ($\chi^2 = 11.2$, $P < 0.05$).

The study concluded that more young adults and married females had been diagnosed with depression at the Teaching Hospital. Also, depression aetiology from patients' view was multi-causal and more old adults had preference for religious measures in coping with depression than the young adults.

# CHAPTER ONE

# INTRODUCTION

## 1.1 Background to the Study

Depression, a health-related problem has been with human beings for several centuries. No human society is immune to depression. It affects all age categories and gender. The concept of depression has attracted different definitions and interpretations among health professionals. From the professional perspective, depression is a condition characterizing an individual, it encompasses a set of experiences which include the following symptoms: feelings of sadness, dejection, hopelessness or despair, coupled with extremely pessimistic thoughts about one's self, situation and future prospects; lack of interest or pleasure in activities usually engaged in, along with social withdrawal; various bodily complaints including aches and pains, difficulty in sleeping, fatigue, loss of appetite(or sometimes overeating);and in some cases suicidal thoughts or actions(Stoppard,2000). By inference, depression causes a lot of personal suffering, impairs the quality of life and causes disability (Kivela & Pahkala, 2001; Wells,Stewart,Hays, et al., 1989); and can occur as a single episode in a life time, or as one of many episodes, or as part of an alternation with mania (American Psychiatric Association, 1994).

Globally, depression has been ranked fifth among women and seventh among men as a cause of morbidity (World Development Report, 1993). Among developing nations in particular, depression has been proposed to be the leading cause of disease burden (Murray & Lopez, 1997). An earlier estimate by Murray and Lopez (1996) has also shown that by the year 2020, depression will not only be a global phenomenon, but will be the second most important cause of disability after Ischaemic heart disease. Thus, the continuous changes in socio-economic and political arrangements coupled with the effects of globalisation may

have consistently placed many adults in developing nations at a higher risk of suffering a major depression-not just sadness, but a paralysing listlessness, dejection, self-pity and an overwhelming hopelessness-over the course of a life span than those in developed nations (Bhugra & Mastrogianni, 2004; Meertens, Scheepers & Tax, 2003). Against this backdrop, many adults in developing nations are faced with the added social challenges of meeting their social responsibilities in the face of insufficient resources. The constant struggle among adults, in particular, in meeting societal demands may have further exposed them to various stressors and depressive symptoms. Bhugra and Mastrogianni, (ibid) identified depression as the most frequent cause of morbidity in adults and represent a significant public health problem. Available statistical evidence on Nigeria and Senegal, by age group, showed a prevalence of depression in adults within ages 30-44 years and 45-59years accounting for a rate of 21.2 and 20.0(males), 34.0 and 32.0(females) per 1000 population respectively. Next group in prevalence rate comprised adults within the age range of 60-69years accounting for 16.1 per 1000 population (Global Burden of Disease Project, 2000).

Although one may want to argue that there are other health-related problems facing developing nations alongside depression, but the disturbing part of this problem is the inadequacy of modern health care facilities in Nigeria to cope effectively with the problem. For instance, many sufferers do not know the limits of their pain threshold, hence they believe they are still coping well, when in actual fact, they have reached their limits. A lot of them end up slumping while still working. On the contrary, in the developed nations where modern health care facilities are readily affordable, available and more accessible, over-diagnosis of depression has been identified as a critical problem (BBC News Report on Depression, 2005).While depression has been recognized and is being addressed in many developed nations, serious efforts have not been made among developing nations toward

increasing accessibility, acceptability and affordability of modern health care services among their populace. For instance, recent efforts by the Nigerian government have been in the direction of refinancing health care cost through the introduction of health insurance schemes which may further widen the existing gap between the poor and the rich, the urban and rural dwellers, in terms of access to quality health care services.

Harpham(1994) opined that many developing countries are showing trends towards urbanized living with population shifts from rural settings to the non-existing "bright city lights". Presently many developing nations have started manifesting rapid urbanization and industrialization which have facilitated general overcrowding, slums, large scale unemployment, lack of opportunity for creative living and the additional effects of the widespread ethnic and religious conflicts with their own attendant problems (such as loss of lives and properties among others). All these have worsened the general living conditions of adults. However, Seligman (1991) posited that both urbanization and industrialization are not the only explanatory variables responsible for the elevated levels of depression especially in the West, but that depression has partly increased due to breakdown in social relationships. The series of social, economic and political changes witnessed in the recent past in Nigeria may have increased the incidence (the number of persons contracting a disease during a given point in time per 1,000 population) and prevalence (the number of persons who have a particular disease at a given point in time per 1,000 population) of depression among the different age cohorts and different social categories in the society. Presently, many Nigerians have lost their means of livelihood, loved ones and breadwinners in incidents such as communal crisis (for instance, the recent communal clashes between the Ifes and Modakekes), and the thoughts of starting from the beginning have frustrated some completely. Of particular importance to this study is the prevalence of depression among

adults, some of whom are retired from active service forcefully or voluntarily and whose pensions are irregular. Some of these retirees have collapsed and died out of frustration, some are on the verge of committing suicide due to lack of means of livelihood. The young and old aged adults are not left out. Many adults in these social categories are repeatedly being confronted with challenges arising from events such as unemployment, retrenchments, high cost of living, job insecurity, and threats to lives and properties through burglary, and armed robbery among others. To compound their problems, these sets of adults are constantly saddled with responsibilities especially towards their immediate and extended families, with less social support from the government.

Culturally, the way people experience and react to life events and depressive symptoms have been found to vary from one geographical location to another. With regards to cultural variations in experiences and reactions, Desjarlais, Eisenberg, Good, et.al (1995), argued that cultural background among other variables is likely to determine whether depression will be experienced and expressed in psychological and emotional terms, or in physical terms; yet in Nigeria, many empirical studies have not been undertaken in this regard. How long are developing cultures going to fold arms and flounder in the burden of disease and its antecedent impacts on the general society? Prevention of the problem of depression seems to be a better alternative. However, this alternative may remain an illusion until a socio-cultural understanding and analysis of the problem is undertaken. Thus, the existence of culture specific experiences and reactions to different types of stressors will require a socio-cultural perspective. This study attempts at providing a socio-cultural explanation outside the dominating biomedical interpretations available in the literature. Are there variations in depression rates among adult patients (young and old aged)? Are there any significant variations in socio-economic and demographic characteristics and the adult patients'

experiences and reactions to life events and depressive symptoms? Are clinically defined depressive symptoms acceptable to them? What are the available social support and level of utilization among adults who are experiencing depression and receiving treatments at the Obafemi Awolowo University Teaching Hospitals Complex, Osun State? The above issues among other relevant ones were the focus of this thesis.

### 1.2 Statement of the Problem

Depression has been rated as one of the leading causes of morbidity and mortality in many developing nations, Nigeria inclusive (Murray & Lopez, 1997). This health related problem has not only won a global presence, but as earlier stated, it will be the second most important cause of disability after Ischaemic heart disease by the year 2020 (Global Burden of Disease Study project, 2000). Although depression affects all age categories, however, available statistical data on Nigeria indicated a high prevalence of the problem among adults (males and females) between ages 15-69. Paradoxically, majority of this social category also constitute a large proportion of the labour force whose health and that of the other members of the larger society generally influence the living standards of both households and countries. In the same vein, health expenses at times can easily become burdensome for households (Wagstaff & van Doorslaer, 2003) and ill health could also have an indirect influence on labour and income through productivity and work hours (Bell, Devarajan, & Gersbach, 2003). Although the need to understand and provide solutions to the increasing prevalence of depression among adults in Nigeria remains critical, there is still the paucity of empirical studies on the problem. The need for a socio-cultural analysis of the problem at this juncture cannot be overemphasised. Hence, this study aims at providing a socio-cultural understanding of the problem of depression among adults in Ile-Ife, Nigeria.

### 1.3 Research Questions

The following research questions are then designed to capture the issues raised in this study:

(i). Are there peculiarities in the socio-economic and demographic characteristics of adults experiencing depressive symptoms? Are there more females than males among those suffering from depression?

(ii). What occupational categories are predominant among adults experiencing depression?

(iii). How are the causes of depression perceived and interpreted by both the young and old adults?

(iv). Are there more married adults experiencing depressive symptoms than others?

(v). What coping strategies are employed by adults experiencing depressive symptoms?

### 1.4 Objectives of the Study

The general objective of this study is to produce a sociological analysis of adult with depression at the Obafemi Awolowo University Teaching Hospitals Complex (Ile-Ife and Ilesa), Osun State. The specific objectives are as follows:

(i) examine the influence of socio-economic factors (gender, age, marital status, occupation, and religious affiliations) on the prevalence of depression,

(ii) investigate the patients' perception and knowledge of the illness; and

(iii) identify the coping mechanisms of adults experiencing depression in the study population.

## 1.5 Significance of the Study

The study is being undertaken to contribute to the available body of knowledge on depression as a health related problem. The study will shed light on the categories of people who experience depression (whether more females than males, more Christians than Moslems or otherwise, more of the married or single adults or more of the younger than the older ones among others). Such information is necessary in order to effectively curb the incidence and prevalence of depression, especially as it will hopefully inform the designing of appropriate intervention protocol targeting different groups. Furthermore, since experiences, reactions/expressions of life events and depressive symptoms are culture bound, it is hoped that a documentation of adults' experiences will enrich our knowledge on depression by providing a socio-cultural framework for conceptualising and researching on depression; this will further move us closer to achieving a culturally defined solution and the much desired preventive measures to the problem of depression that will be readily acceptable to all groups.

In effect, this study will provide a baseline data that may assist policy makers, family therapists, and marriage counsellors, researchers among other stakeholders in coming up with initiatives that are rooted in the people's culture, thereby making treatment, diagnosis and care more participatory, compatible with peoples' style and sustainable.



## 1.6 Operational Definitions of Terms

The following terms are defined as follows:

**Caregivers:** are those classified in this study as doctors, nurses, and social workers responsible for meeting the health needs of the depressed respondents.

**Depression:** is a common mental disorder that presents with altered/low mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration. These problems can become chronic or recurrent and lead to substantial impairments in an individual's ability to take care of his or her everyday responsibilities (WHO, 2006).

**Incidence:** This is the number of persons becoming depressive during a given time period per 1,000 population at risk.

**Life Events:** these are events obtainable in individual's interaction with others on a day-to-day basis and could also vary across gender and age.

**Prevalence:** this is the number of persons who have depression at a given point in time per 1,000 population.

**Old Adults**: they are defined in this study as those within the age group of 41-60 years.

**Quality of marriage:** it is a multidimensional concept, however, in this study it is based on couple's perception of their marriage as satisfactory or not, even in the face of stress and inherent conflicts in marriage.

**Significant others:** these are people perceived by the adults as important to them or their lives.

**Stressors**: These are negative events that could be found in any social interaction. Common examples are marital stressors including losses related to the destruction of the family, loss of home, unemployment, marital and family discord, disruption of peer.

**Young Adults**: for this study are individuals from within the age group of 18 -40 years.

# CHAPTER TWO

# REVIEW OF LITERATURE

Several studies from different paradigms on depressive disorder have produced a rich body of knowledge on this problem. However, in this chapter, attention is focused on available relevant literature on the problem of depressive disorders among adults by laying emphasis on the predisposing factors responsible for the problem among adults. Hence, for a more focused review, the discussions will be based around the following sub themes:

- The Concept of Depression
- Aetiology of Depression
- Marriage and Depression
- Social Stressors, Moderators and depressive symptoms
- Illness behaviour and the process of recovery

## 2.1 The Concept of Depression

There are cultural and gender variations in the interpretation of depression. Depression as an illness could occur as a primary psychiatric condition or a secondary condition to a physical illness. When it is a primary condition, it is either unipolar or bipolar. Depression has acquired descriptions which range from normal unhappiness, through persistent and pervasive ways of feeling and thinking, to psychosis (Hale, 1997). The existing diversities in the meaning of the concept have made it difficult to provide a uniform definition.

However, Hamilton (1989) from the biomedical orientation broadly described depression in the following ways:

{a} a particular mood associated with a reaction to a (real or potential) loss or failure. Depression of this kind is a normal human reaction clearly related to the events that have produced it, not only in time but also in intensity.

{b} Depression is also used to refer to a pathological mood present in many mental disorders and even as a corollary of somatic disease. The simplest distinction between normal and abnormal depressed mood is that the latter is unrelated to external events or out of proportion to them.

{c} Depression is also used to signify a syndrome, that is a collection of symptoms that constitute a coherent pattern, sometimes called depressive disorder. It has an identifiable, usually recurrent course, and distinct intervals between each phase. It is known to have a genetic component and there is reasonably good evidence of an underlying biochemical disturbance. The descriptions (b & c) above contain the basic behavioural features that constitute the predominant biomedical definitions of depressive disorder. Thus many of the clinically diagnosed depressive patients are usually expected to have displayed some of these features at different degrees before wearing the label of depressive disorder. It is assumed that many of the patients in this study have one time or the other displayed some of these behavioural parameters at various degrees in their interactions with the caregivers; a necessary condition to gaining the label depressed.

A closer look at the above interpretations (a, b and c) points to both biological and psychological dimensions as the predominant views of what depression is. However, a niche for the importance of social factors in the aetiology of depression was presented in Brown and Harris's (1978) study of the social origins of depression. They argued clearly that

adverse life event and other stress-inducing occurrences, when combined with conditionally generated vulnerability, increased the chances of clinical depression (both reactive and endogenous) (cited in Oxford Dictionary of Sociology (1998). The diversity enshrined in interpreting and describing depression as a behavioural disorder has posed series of challenges to researchers, practitioners and other stakeholders in mental health. To overcome some of these constraints using an objective and common framework, the World Health Organisation and the American Psychiatric Association among other institutions have so far produced various typologies at different historical epoch.

### 2.1. 2 Classification of Depression

The international classification of diseases (ICD) formed by World Health organization (WHO) is used as a standardized basis for the categorisation of diseases. Earlier, it did not have a separate section for mental disorders. In the sixth revision (WHO, 1948), however, chapter V was devoted to psychiatric disorders. Parallel to ICD, a diagnostic system in the field of psychiatry was developed by the American Psychiatric Association (APA), called the Diagnostic and Statistical Manual of Mental Disorders (DSM).

### 2.1.3 Diagnostic Statistical Manual of Mental Disorders

The first version was published in 1952 (APA, 1952) following ICD-6. The second version of DSM (APA, 1968) was published simultaneously with ICD-8 (WHO, 1967). Later, DSM -III (APA, 1980) and ICD-9 (WHO, 1977) were published concurrently and in a manner that allowed cross-reference.

DSM-III integrated three methodological innovations: the sorting of mental disorders according to joint descriptive clinical features; the use of specific diagnostic criteria; and the

multi-axial system (Skodol & Spitzer, 1982). It was meant to be impartial in its views in terms of aetiology and it was to be useable across different theoretical orientations. This, however, influenced the classification of disorders based on the quantity and sternness of symptoms rather than on aetiology.

After DSM-111, three revisions have been published: DSM-111-R (APA, 1987), DSM-IV (APA, 1994) and DSM-W-TR (APA, 2000). Depression has been broadly classified into two types based on the above classifications: unipolar and bipolar and as such, research efforts and treatment regimes have also toed this broad categorisation. One of the main features of the syndrome of unipolar depression is a cluster of signs and symptoms, including depressed mood, loss of interest, disturbances in sleep, appetite, and psychomotor activity, including a lack of energy, difficulty in concentrating, and thoughts of worthlessness or guilt (Kaelber, Moul & Farmer, 1995). It has been further classified into three mood disorders: Major depressive (MDD), dysthymic disorders, and depressive disorders not otherwise specified (APA, 1994). On the other hand, Bellenir (2002) described bipolar disorder as a recurrent mood disorder featuring one or more episodes of mania or mixed episodes of mania and depression. Bipolar disorder (also known as bipolar affective disorder and, manic depression) is distinct from major depressive disorder by virtue of a history of manic or hypomanic (milder and not psychotic) episodes. Other notable differences concern the nature of depression in bipolar disorder. Its depressive episodes are basically connected with an earlier age at onset, a greater likelihood of reversed vegetative symptoms, more frequent episodes or recurrences, and a higher familial prevalence. It also differs from other non-bipolar disorder in the therapeutic effect of lithium salts. Bipolar disorder has in recent times been shown to be treatable by means of in-depth family therapy (Miklowitz, 2000; Miklowitz & Hooley, 1998). In this particular study, attention will be on the incidence and prevalence of both

depressive disorders as observed from available clinical records of adults seeking treatment at the Obafemi Awolowo University Teaching Hospitals Complex. The reason for this decision is influenced by available statistics indicating a high incidence and prevalence of these depressive disorders among adults (15-69years) in Nigeria (See table 1, p.21).

### 2.2. Aetiology of Depression

The search for the causes of depression, like any other phenomenon has produced various theories and explanations in the fields of psychiatry, psychology, neurosciences, sociology and other related disciplines. These different schools of thought (cognitively oriented, psychoanalytic, and existentialist among others) have developed their own approaches to the phenomenon as well as specific methods of treatment. The aetiology of depression in adulthood is however understood to be multi-faceted in nature. It is therefore significant to note the different factors that are of importance in the aetiology of depression in adulthood, as they may be playing different roles in preceding, precipitating and maintaining depression and in preventing recovery from it. While this study may not be able to do justice to all these, the social processes facilitating depression among adults were examined. There is need to examine some other models that have contributed in enriching our understanding of the phenomenon of depression as a health related problem. This is necessary, since no model is self-sufficient in presenting a complete reality of any phenomenon. Hence, the biological, psychosocial and the social models are briefly discussed.



#### 2.2.1 Biological models of depression

The biological model is built on the notion that the brain which controls every part of the body could also serve as the explanatory variable in the aetiology of depression.

Achievements from genetics and biochemistry may have motivated proponents of this model to concentrate more on understanding the brain and hormonal changes in particular as they relate to depression. The brain controls our conscious behaviour (walking and thinking) and our involuntary behaviour (heartbeat and breathing).The brain also regulates our emotions, memory, self-awareness and thought processes (Bellenir, 2002).

Though the essential causes of depression are not explicit in this model, there are clues suggesting that various systems in the brain may cause depression or be affected by it. For instance, major depression is characterized by excessive sleep. So it is possible that the brain stem, responsible for sleep, plays a role in depression. This has been applied in explaining postpartum depression (a range of physical, emotional, and behavioural changes that many new mothers experience following the delivery of their babies) and adjustment problems among menopausal women. Despite the success recorded in using this model to answer some of the questions raised by depressive symptoms' association with biological changes in the body system, postpartum depression still remains a complex mixture of biological, emotional and behavioural changes. The exact cause of this condition is still unknown (Bellenir, 2002).



**2.2.2 Psychosocial models of depression.**

A central assumption in these models is the role of stress in the predisposition of individuals to depression. The social ("stress") component in psychosocial models has its origins in formulations linking onset of depression with exposure to events of unfavourable or undesirable consequences for an individual, particularly events involving loss or failure. Such events, because of their negative implications for individual's adaptation, have been termed "stressful life events". The form of psychosocial model that has attracted most consideration lately is one labelled as "diathesis-stress". According to the diathesis-stress

approach, if an individual with certain psychological uniqueness(e.g. traits, attitudes among others) conceptualized as the "diathesis", experiences a stressful life event(the "stress" component) which in some way matches or is congruent with the psychological diathesis, that individual is likely to become depressed( Stoppard,2000).

### 2.2.3 Social models of depression

Social models staunchly centre on those features of the social environment that may make some individuals more prone to depression. Apostles of these models have pointed to the significance of social structural factors (such as poverty, living conditions, employment status), interpersonal relationship (for "social support"), and other sources of adversity arising within the framework of people's everyday lives in understanding depression. Proponents of the paradigm have also acknowledged the diversity in the nature of these factors, how they are perceived (by individuals and groups) and how they are reacted to across cultures.

Two broad streams can be discerned in the attempt to expand social models of depression. The first, illustrated in Brown and Harris (1978) focused on women, with an exception that the causal processes identified will have general applicability. The social causal model developed by Brown and Harris (ibid) overlaps to some extent with psychological models as contained in the emphasis placed on the role of stressful life events in explaining depression. They attempted to overcome the supposed limitations of the life stress approach by considering the meaning of events in the context of people's lives. They did this by addressing the meaning of events, not merely their occurrence. Hence, this social model offers one avenue for explaining depression in women. An application of this model in an African context could also be found in Broadhead and Abas's (1998) approach of

capturing the relationship between life events and depressive symptoms experiences of selected urban women in Zimbabwe. While depression has remained a public health problem between men and women, little effort has been made at capturing some peculiar experiences of men within the adulthood processes and the associated depressive symptoms. In this study, it is also assumed that the social model when employed will provide more meaningful understanding of the factors associated with depression among male and female adults in Osun State, Nigeria.

A second similar broad stream is the feminist approach. Writers such as McGrath, Keita, Strickland, and Russo (1990), have demonstrated the richness of the feminist approach in understanding depression among women using feminist theories and methodologies. These efforts among others have further attracted attention to social factors that are precise to women's lives (mostly found in network of social relationships e.g. marriage) and which may explain the predominance of women among the depressed (Stoppard, 2000).



**2.3 Marriage and Depression**

Current knowledge has shown the complex nature of aetiology of depression. From the models discussed above, depression can be caused by several factors including interpersonal relationships. Interpersonal relationships are the relationship between individuals and the reactions and emotions of each individual expressed directly and discreetly to each other. Interpersonal relationships could occur either in the private or public sphere of life. The search for explanations within the dynamics of social relations have revealed an association between increased prevalence of life stress before the onset of major depression (e.g., Brown, Harris & Hepworth, 1995; Depue & Monroe, 1991; Monroe, 2001). Similar studies have reported that more life events are connected with lower marital adjustment (Gotlib &

Whiffen, 1989). Some other studies have linked onset or exacerbation of depressive symptoms to ones' own life events (Brown & Harris, 1978; Brown, et al 1995). Among the Yoruba in Nigeria, for example, the importance placed on children and fertility in marriages is so high that it reflects in their daily lives (e.g. proverbs, songs, lyrics and greetings). For instance an adage says, "Omo ni ere aiye" meaning - Children are of great value as they are seen and appreciated as the gains of living. While a stressor such as infertility may threaten the marriage quality, many western researchers did not emphasize such an influence in their studies. Thus, the socio-cultural context of adults is assumed in this study to be critical to understanding the outcomes of adults' perceptions and reactions to negative events in any interpersonal relationships and depressive disorder.

Hence, currently there is still a gap in the knowledge with regard to studies exploring the socio- cultural context of depressive disorders among Nigerians. Some of the recent studies on the problem of depression have reflected only a portion of the problem (e.g. Alarape, Okurame & Odum, 2001; Ukpong & Owolabi, 2004). Moreover, these studies were not aimed at understanding the social milieu producing or facilitating depression among adult individuals in general. Although the studies have enriched the existing pool of knowledge on depression, they have neglected the much needed understanding of the dynamics of social positions men occupy and the social responsibilities they have to deal with as adults could expose them to depressive symptoms. A good example of such is the social expectations imposed on adult men as "breadwinners". The social interpretation of this concept places higher financial responsibilities on men than women. Thus, responsible married men are expected to make conscious efforts towards fulfilling their social obligations. Negligence or failure could at times cause either psychological or social consequences or at times both. For instance, Christian male adults are bound by the Biblical injunction which states that "…he

who cannot feed his family is worse than an infidel" (The Holy Bible, I Timothy 5:8). Some men thus feel very committed, but recent happenings in the economy (such as the increasing rate of unemployment, underemployment, low remuneration system especially in the public sector, retrenchment exercises, non-payment of pensioners, increasing cost of living in the face of depressed economy) have made it almost impossible for them to cope. Some might be made to consider options such as suicide, alcoholism, taking of hard drugs, marital violence among others, as escape routes. In Nwosu and Odesanmi's (2001) study on suicide, a review of autopsy records revealed that the rate of completed suicide among Nigerians was 0.4 per 100,000 populations with a male to female ratio of 3.6 to 1. Although this study did not include the causes of such deaths, the social expectations' and the dilemma of meeting social obligations could be contributory. One may want to infer that the challenges being experienced by many Nigerian adults, among other factors, may have constantly placed adult males and females at various states of depressive experiences.

While depression is an age long problem, a recent statistical estimate of depression among other health problems across the world categorised Nigeria and Senegal examples of countries with a high prevalence among individuals between age 15-69years (See Table 1, p.21). Moreover, as earlier stated adults within age 30-44years and 45 to 59years accounts for 21.2 and 20.0 per 1000 population respectively. Since these adults also constitute majority of the labour force, the need for a more focused understanding of this problem in Africa, Nigeria in particular becomes very pertinent. While some of the predisposing factors responsible for depressive disorder remain relevant to the understanding and solving of the associated implications, the process of recovery could be influenced by the illness behaviour of the sufferers. This behaviour is also situated within the socio-cultural milieu in which the disorder occurs.

Table1: Showing a **Sub-** region Prevalence of ICD-10 depressive episodes (Rates per 1000 population) in Nigeria and Senegal

| Region and sub region | Mortality | | Gender | Total population (million) | Prevalence by age group | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Adult | Child | | | | | | | | | | |
| Africa | | | | | 0-4 | 5-14 | 15-29 | 30-44 | 45-59 | 60-69 | 70-79 | 80+ |
| AfrD (e.g. Nigeria, Senegal) | High | High | Male | 147.1 | 0.0 | 11.0 | 13.1 | 21.2 | 20.0 | 16.1 | 6.5 | 4.9 |

*(Source: Global Burden of Disease, 2000).*



### 2.4. Effects of Depression on Married Adults

Efforts to explore the social dynamics of depression among married adults have shown that living with a depressed person can be burdensome, and this may explain the greater distress in the marriages with a depressed spouse (Benazon & Coyne, 2000). From the same perspective, Dudek, Zieba, Jawor, et.al, (2001) found that female spouses of depressed patients report more depressive symptomatology and distorted thinking patterns than did a control sample. Furthermore, gender analysis of perception showed that the female spouses perceived the quality of their marital relationships to be poorer than the male spouses. In a series of studies with community dwelling older couples, Tower and Kasl (1995, 1996a, 1996b) found that depressive symptoms in one spouse influenced depressive symptoms in the other. When the couple reported being close, the depressive symptoms were found to moderate the interaction effect more than if the couple were not close. The husbands were found to have fewer depressive symptoms, while their wives reported no need for emotional

support. Wives, conversely, had greater number of symptoms, while their husbands reported that they had "no one" available for support. Wives who felt closer to their husbands had fewer depressive symptoms, but for men, closeness was associated with greater number of symptoms.

Clear boundaries have not been achieved as Husbands' and wives' responses to their spouses' symptomatic behaviours and dysfunctions appear to be cyclic (Lewinsohn, 1969; Lewinsohn & Shaffer, 1971). This means that sometimes the depressed spouse's behaviour brings out empathy. Expressed negative emotion from family members has been associated with depressive episodes. These may not be the cause of the depression, but could perhaps be a response to it (Hayhurst, Cooper, Paykel, Vearnals, & Ramana, 1997). Possibly contributing to the cyclic nature of the partners' marital interaction is the depressed spouse's response to the other's assistance. Since depression appears to be chronic, rather than acute, family members will be living with the disability for many years (Coyne & Benazon, 2001). Obviously, depression, like marital distress, needs to be considered more like diabetes or asthma than like appendicitis. Therefore, the patient and other family members will need to understand its complex aetiology and learn skills to help them adapt over the patient's lifetime. However, as pointed out by Coyne and Benazon (ibid), 80% to 85% of patient's life will be more-or-less symptom free. Coyne and Benazon (ibid) states further that most individuals in the general population with mild symptoms do not progress to a full episode of depression. This may be compounded further in a developing population were underreporting and poor diagnosis of depressive symptoms are challenges to contend with in the face of acute unequal distribution of modern medical facilities and limited number of psychiatrists.

Some of the interpersonal and social problems, which are likely to confront individuals with depression and their spouses, have been reviewed by Joiner (2001) and Katz (2001). According to Joiner (ibid), researchers and theorists have found that some depressed individuals are given to behaviours that produce interpersonal stress and burden in other family members. Factors that could lead to stress for other family members include, for example their excessive and frequent reassurance seeking, seeking self-verifying or self-confirming feedback, which for many depressed individuals is seeking negative feedback , expressing a negative view of themselves, the world, and the future, which produces a pervasive sense of hopelessness; feelings of lack of social support from significant others; and a tendency toward shyness, which makes them more vulnerable for depression(Katz, ibid).

**2.5 Stressors, Moderators and Depressive Symptoms**

In the literature, certain variables have been reported as mediators in the interaction between life events and depression. Whisman (2001) has called for a search for factors that serve to moderate and or mediate the impact of both depression and distress on the lives of adults. Moderators are variables that influence who is at risk for depression in a distressed interpersonal relationship and who is not. In other words, moderators help us to understand which specific individuals are at risk in a web of social relations. The literature suggests that life events may be related to individual and marital outcomes through moderated or mediated relationships. Since life events occur in the framework of ongoing marital relationships, they produce conditions that the couple must bargain with as a unit. Variability between couples in the behaviour that spouses demonstrate during problem solving might moderate the relationship between life events and adjustments. Many life stressors stem from relationships,

whether in a dating relationship or married relationship. Such problems leading to distress may result from difficulties in communication, parenting, sexual intimacy, finances, immaturity among others (Monroe, 2001). Hence, moderator models assume that fairly stable attribute "affects the direction and /or strength of the relation" between a predictor variable and an outcome variable (Baron & Kenny, 1986).

Effective communication has been acknowledged as one of the moderating variables. How couples communicate and solve problems may be a critical component of spouses' adaptation to stressors taking into consideration the fact that life events can create new sources of marital conflict or worsen existing conflicts (Christensen & Pasch, 1993). Similarly, Monroe (2001), in a study among newly married couples argued that the newlywed phase may be a critical transition if patterns established in this period set couples on a particular trajectory toward marital success or failure. Newlyweds also may be more vulnerable to stressors during the early stages of marriage because their conflict resolution skills are more likely to be less developed compared to older couples. This potential susceptibility may be compounded by increased exposure to potentially stressful life events (relocation, completing formal education, or starting a new job) that are often encountered during the early stages of the marriage. The skills that couples use to solve marital problems are considered to be integral in adapting to stressors because external stressors create problems with which couples must contend. An acknowledgement of the roles of in-laws and relatives need to be considered as critical variables in the communication process and problem resolution of marital processes in a setting like Nigeria.

Reactions from significant others (in-laws and relatives in particular) to certain marital events such as infertility and infidelity in marriages is very common in many Nigerian families. Again, when such problems arise, women are often the focus. Some marriages have

collapsed simply on the basis of suspicion of the wife's infidelity either by the significant others or by such women's husbands. In contrast, attitude towards infidelity is rather different if the husbands were to be the accused, though, there seems to be variation across the three main Nigerian ethnic groups (Hausa, Igbo and Yoruba). However, the patriarchal nature of the Nigerian society favours men when they are the 'accused'. They tend to enjoy some levels of social support, even when infidelity occurs during the period of dating before the actual marriage. Reactions and interference from the significant others during periods of negative marital events in relatives' or friends' marriages may be functional or dysfunctional in some cases to the much needed social support and the expected moderating roles of the significant others. The significant others' role in marriage becomes obvious in a culture like the Yoruba where marriage is often seen as a family affair and not just a relationship between the couples alone. This is usually displayed when couples are confronted with both negative and positive marital events and even before such couples are joined as husband and wife. For instance, during the mate selection process, engagement and dowry payments, families' and relatives' opinions and influence are prominent. It would be necessary to note that effective communication between couples and their significant others could also minimise the level of destructive interference that significant others could have on marital satisfaction; however the validity of this factor needs to be explored in relation to the mediating roles of the significant others regardless of whether or not negative marital events are present.

Marital interaction consists of two individuals interacting in a relationship that they and others define as a marriage. Individuals also have the ability to behave, and as such their individual characteristics and vulnerabilities play a part in marital interaction. Biophysical characteristics, such as biological sex are almost generally employed as a marker in cultural institutions to define gender roles (Acker, 1992). Gender roles may play a part in marital

distress and co-occurring depression. Gender appears to be a multidimensional social construct of biological and behavioural variables that functionally control some aspects of the couple's marital relations (Kiecolt-Glaser & Newton, 2001). Therefore, gender issues become relevant in a study on marriage and depression. For example, it is well known that women are twice as likely to suffer from unipolar depression as are men (Whisman, 2001). As a result, more wives are depressed than husbands. However, this does not mean that marriage causes depression in women. The relationship appears to be bi-directional; martial distress enhances depressive symptoms, and depression increases marital distress (Fincham & Beach, 1999).

Marriage is known to insulate both women and men from depression (Horwitz, White, & Howell-White, 1996). Waite and Gallagher (2000) reported on a study that controlled for race, education, family structure, income, and living arrangements, and found that married people, whether with or without children at home, were less depressed and were emotionally healthier than comparable singles. Marriage has been shown to be related to greater psychological well-being, physical health, and longevity (Coyne & Benazon, 2001). However, if marriage insulates both men and women from depression why then are more women depressed than men? One explanation may be that both marital distress and depression affect women differently than men as recent findings suggest that the relationship between marital distress and depression may follow a different path for men and for women. Fincham, and Beach, (1999) found that husbands' depression predicted marital distress both at the time and in the next 18 months. For wives, the causal paths were the other way round, marital distress predicted wives current and future depressive symptoms.

Physiological factors may play a part in the differing rates of depression between men and women. In a report, Kiecolt-Glaser (2002) stated that during discussions between husbands and wives, the wives' immune systems were consistently elevated above those of their

spouses and these results continued throughout a 24-hour period in which the couples remained in close proximity. Similarly, Kiecolt-Glaser and Newton (2001) reported that there are correlations between self-rated health and reports of marital quality and cohesion. In addition, there are correlations between self-rated health and reports of partner behaviours that were perceived as unsupportive and punishing. Gender parity was found for most of the self-rated marriage-- health studies. However, two studies reported stronger links for women (Levenson, Carstensen, & Gottman, 1993; Levenstein, Kaplan, & Smith, Levenstein, 1995). Taken together, these studies suggest that marital distress affects both spouses but may have greater impacts on women.

Some have argued that male and female power differences may account for differential rates of depression between men and women (Whisman, 2001). Recently, it has been suggested that gender serves an institutional function (Acker, 1992), which maintains gender differences. Halloran (1998), for example, has proposed that inequity in marital power may be another variable that directly relates to depression and marital stress. In the study, he reviewed several works that partially support unequal power in marriage being associated with both depression and marital distress. Since the support is only partial, power differences in marriage do not appear to be universally causative for distress or for depression. From the foregoing, there is, at present, no conclusive support for the theory that marital stress follows different paths from marital satisfaction/dissatisfaction to depression for men and women, but central to the different pathways is the process of recovery from illness.



### 2.6. Illness Behaviour and the Process of Recovery

Illness behaviour creates a useful way of understanding and describing the many psychosocial influences that affect how people monitor their bodies, define and interpret their

symptoms, come to view themselves as sick and disabled, take remedial action, and use lay and professional sources of help (Mechanic, 1978). The concept draws on psychological theories of perception, cognition, and meaning attribution and on theories of social relationships. Illness behaviour is best conceptualized as a process. It is usually a bidirectional interaction between four elements—symptom perception, symptom interpretation, symptom expression, and coping behaviours. An overview of these four elements becomes relevant to this study as patients are assumed to have witnessed at least one of these stages before being taken to the hospital for care; hence a brief look at the process is undertaken.

### 2.6.1 Symptom Perception

The process of illness behaviour most times begins when a noticeable change in bodily function is interpreted as a symptom of ill health. Symptoms are necessarily experienced against the background of a particular individual's ordinary functioning. For a change in functioning to be interpreted as a symptom it must have evoked concern that the alteration is somehow not normal and is not readily accounted for except in the framework of illness. Such interpretation affect our perceptions such that the processes of perceiving and assigning meaning to symptoms become intertwined with values and beliefs and influence each other (Cassell, 1985). However, the degree of awareness of one's own health problem may vary from one culture to another and may include a near denial of the presence to an almost total preoccupation with it, and the reasons for attending to a health problem may vary, but one of the most powerful influences on the way in which symptoms are perceived and the amount of attention paid to them is the meaning attributed to those symptoms.

### 2.6.2 Meaning Attribution

Meaning attribution about the cause and likely outcome of symptoms is influenced by a host of psychosocial and cultural factors as well as by a person's prior experience with illness. Assigning meaning to symptoms can be a conscious process that helps people structure the experience or it may occur outside of awareness. A person's report of symptoms inevitably represents the nature and significance of the experience to that person. A person's appraisal of meaning may be as important to symptom formation as the disturbances in functioning for which the meaning is invoked (Cassell, 1985).

The meanings given by a patient to an event has effect on the symptoms and illness behaviour and help to order experience in several ways (Taylor, 1983). First, meaning is associated with a sense of coherence or purpose for life events. Patients seek to comprehend why a health problem has occurred and what impact it has had and will have in the future. Causal attributions are formed by patients to account for current unfortunate circumstances. These formulations shape the meaning of the situation and can open or close options for actively dealing with it or the feelings it evokes. Second, the ability to assign meaning to an illness or to symptoms has been found to enhance some patients' sense of self-mastery over a problem or crisis (Lewis, 1982). In contrast, it has been observed that those patients who believe they have little or no control over their health and well-being work less effectively with health care providers to achieve rehabilitation (Pilowsky, 1984).

Finally, the personal meaning of an illness or symptom may affect self- esteem either positively or negatively. Personal meanings are likely to be influenced by the shared meanings of the group to which the individual belongs. Some studies of various socioeconomic, cultural, and religious groups reveal that the meanings associated with illness tend to vary by group membership (e.g. McKinlay, 1975; Meertens, Scheepers, & Tax,

2003). The interpretation of symptoms and the meaning assigned to them may have a profound influence on coping responses. The way people perceive a change in their physical functioning (whether or not is due to sickness), will obviously influence their help-seeking behaviours (Moses, Ngugi, Bradley, et al, 1994).

### 2.6.3. Help-Seeking Behaviour and Other Coping Responses

Like all the other aspects of illness behaviour, coping with depressive symptoms or any other illness is determined by many factors and varies from person to person (Turner & Lloyd, 1999; Turner, Wheaton, & lloyd, 1995; Wheaton, 1994). Coping responses may be more or less adaptive and more or less consciously motivated. Although some people may deny their symptoms (Carver, Scheier, & Weintraub, 1989), others may exaggerate them. The abnormal functioning that occurs in chronic illness leads inevitably to compensatory behaviour that may have positive or negative effects on subsequent symptoms and functional levels. Illness behaviour and suffering can exist in the absence of a diagnosable disease. Effective treatment of patients with chronic disease requires that health care professionals view illness broadly and not only in terms of a narrow disease model. Some proportion of people with chronic pain use alternative care systems either in lieu of or as adjuncts to the traditional medical care system. Some alternative practices have developed as a reaction to what a number of people perceive to be shortcomings in traditional medical care (Weiss & Lonnquist, 2006). The holistic health care and self-care movements are examples of such alternative approaches, and both of them receive considerable support from some physicians for much of their work and for their basic philosophies (Inglis & West, 1983). More recent research suggests that religious and folk practices may be effective insofar as they take into account essential psychosocial factors, such as patients' explanatory models of illness, that

are often neglected by conventional medicine (Kleinman & Sung, 1979). In addition, these modes may help alter the meaning of illness in such a way as to allow a different and healthier response (Csordas, 1983; Bourguignon, 1976; Frank, 1973).

The above explanations and some of the studies have confirmed the relevance of understudying and incorporating patients' views in consulting and treatment. To a large extent and to the best of the researcher knowledge, studies focussing especially on patients' perception of mood disorders and their illness behaviour are scarce especially in the Nigerian context. Hence, this study will contribute in this regard by exploring the knowledge and perception of depression among adult patients with depression in a Nigerian tertiary hospital. While the study may not account for the various stages involved and the pathways common among this group of respondents in seeking cure, it will however, explore the aetiology of depression from the patients' and health care givers' perspectives.

# CHAPTER THREE

# THEORETICAL FRAMEWORK

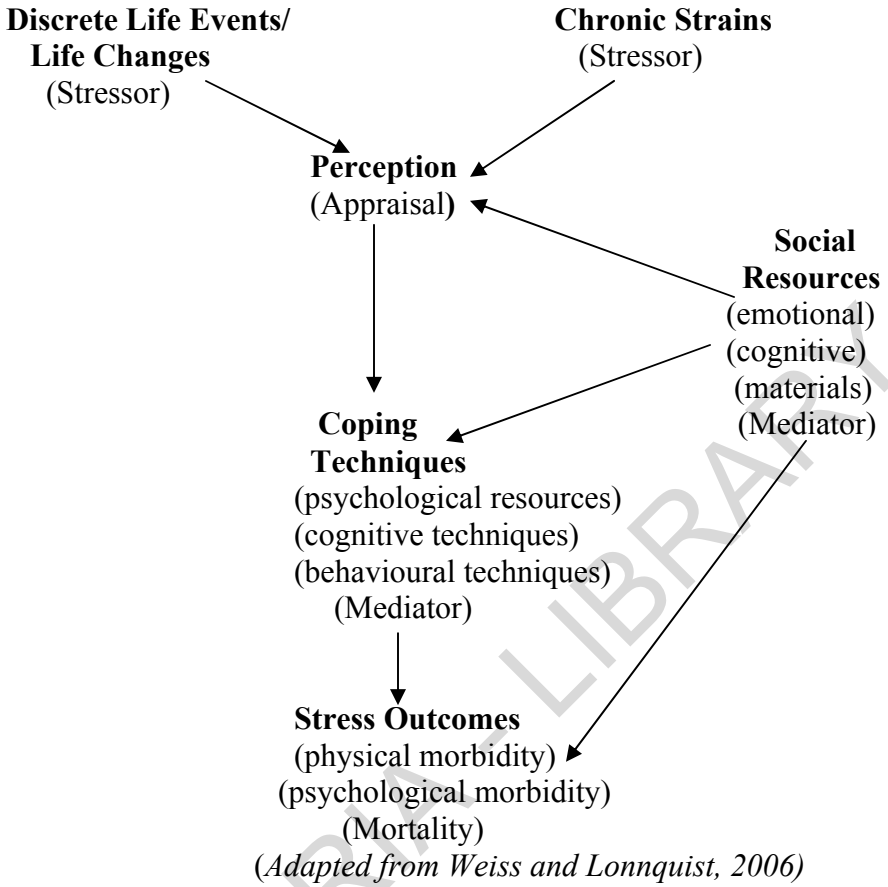
The study is anchored on two theoretical approaches, one micro and the other macro in orientations. The Social Stressor model was used in explaining interpersonal relationships as related to depressive symptoms at the micro level while the political economy theory was used in projecting the social context in which the social interactions and depression among adults are produced.

## 3.1 Social Stressor Model

From the literature, many studies have emphasised the usefulness of the social stressor framework in explaining the link between life events and depression among different social categories (e.g. Broadhead & Abas, 1998; Brown, Harris & Hepworth, 1995; Hegarty, Gunn, Chrondros, & Small, 2004; Kendler, Hettema, Butera, Gardner, & Prescott, 2003; Monroe, 2001; Nazroo, Edwards & Brown, 1998; Turner & Lloyd, 2004). Individual responses to stress are diverse and vary in both primary and secondary effects which form the biological pathways along which a person's experiences, living and working conditions, interpersonal relations, life style, diet, personality traits, and general socioeconomic status can affect the body (Health and Behaviour, 2001:40). However notable contributions from Morton Lieberman, (1982), Pearlin and Aneshensel, (1986) have enriched the sociological value of social stress models in understanding health-related problems including depression. Although stress is a broad intellectual concept, the Social Stressor model highlights the importance of using sociological perspective to understand the following areas:

- The nature and dynamics of how social forces and circumstances (life events) create stressful situations (e.g., depressive symptoms among adults).
- How the perception or appraisal of stressors affects the manner in which they are handled
- How the appraisal of stressors affects the enactment of social roles (and strain created in these roles).
- How social resources influence the likelihood of stressful circumstances occurring, the appraisal of these circumstances, the extent to which role enactment is problematic, the ability of individuals to cope, the coping mechanisms they adopt, and the extent to which the stressful circumstances result in negative stress outcomes.

Figure 2. **A model of the Stress Process**




(*Adapted from Weiss and Lonnquist, 2006)*



### 3.1.2 Discrete Life Events

Life events are significant specific events or experiences that interrupt an individual's usual activities and require some change. A number of life events could be anticipated (e.g., Marriage, divorce, gaining employment, forming a business, retirement, beginning or ending of a child's education.) and unanticipated life events (e.g., death of a loved one, a sudden failure, sudden loss of a job, and learning of a terminal illness).Efforts by researchers to determine the effects of these specific life events on stress levels have resulted in the use of three kinds of techniques: (1) studies of the psychiatric effects of specific events such as reactions to combat natural and human disasters,(2) comparison of the number and types of

life events experienced by the psychiatric patient prior to their hospital admission to those for a non-patient control group, and (3) general population surveys examining the relationship between life events, stress, and illness (Weiss & Lonnquist,2006). A basic notion emphasized in many of these studies is that all life changes are potentially harmful because of the readjustment required, a submission questioned by Pearlin (1989).There are some life changes that may not be negatively interpreted by individuals depending on their paradigm or cultural background. How do experiencing undesirable life events impact health, negatively or positively? Researchers have reported relationship between adverse life events and certain depressive disorders (Dohrenwend, 2000).

However, the effects may not last for a long period of time. A critical mediator in this relationship is a certain social resource which when available could lighten the burden of reacting to undesirable life events and when not available, may predispose adults in such social circumstances to depressive disorder. For instance, interpersonal relationship such as marriage is seen as a critical variable that could produce resources for adults in order to minimize or eliminate depression and replace with good psychological well-being. However, recent findings on marriage and depression have revealed that the marital quality (a product of multiple variables including social resources) rather than marital status alone moderates the rate at which married individuals, the single or divorced experience depressive symptoms (e.g. Cano, Weisberg & Gallagher, 2000).

Thus, it is assumed in this study that marital status alone will not be a sufficient immunity to depressive disorder. Adults (males and females) are constantly entangled in a network of relationships that could predispose them if care is not taken to depressive disorders. Some studies on marital processes have shown that married adults experiencing satisfaction in their marriages are more likely to enjoy the associated benefits of marriage. While those

experiencing negative marital impacts are more likely to exhibit depressive symptoms. As earlier indicated, a small body of recent work has demonstrated a plausible relationship between marital stressors and a wide range of negative consequences including depressive symptoms, diagnoses of major depression, and additional marital stressors such as separation. By inference, this implies that marital stressors may increase one's risk of marital dissolution as it is hard to forgive or trust a spouse who has initiated stressors such as infidelity or a first incidence of violence into a relationship built on emotions and trust (Cano, Christian-Herman, O 'Leary, & Avery-Leaf, 2002; Cano, & O 'Leary, 2000; Cano, & O 'Leary, 2002; Christian- Herman, O'Leary, & Avery-Leaf, 2001; Cano, O 'Leary, & Heinz, 2004). Are all life events and their interpretations the same among individuals across cultures? As earlier discussed, findings have confirmed variations among different social categories and cultures.

Moving beyond households, while some adults have gained one form of employment or another, several individuals in Nigeria over the recent past have lost their jobs or businesses due to various reforms such as the current economic reforms which started with the inception of the Obasanjo's administration. A major criticism against the administration's economic reforms is its lack of "human face". Thus many observers have stressed that the reform has not minimised the effects of the hardships (loss of jobs, premature retirements, and increasing cost of living in the face of dwindling social resource) on individuals and households.

### 3.1.3 Chronic Strains

These represent the second major type of stressor. Pearlin (1989) explains chronic strains as the relatively enduring problems, conflicts and threats that many people face in their daily lives. The most predominant bases for these types of stressors are family problems with spouse, in-laws, parents, or children; love or sex problems, problems in any locality that involve competition. Are married adults (both males and females) the same in terms of exposure to the inherent risks in an interpersonal relationship such as marriage? It is assumed in this study that there would be some forms of negative life events and different meanings attached to such events that could have predisposed adults in this study to depressive symptoms. Pearlin (ibid) recommended that emphasis be placed on problems that originate within the boundaries/boarders of major social roles and role sets. Taking such stance is presumed to be important in exploring the enduring nature of relationships that exist in role sets. In addition, they tend to be particularly relevant in that relationships and strains that develop are likely to be of great significance to the individual. Are adult men and women in Osun State placed on the same role sets? Adult males are distinct from their female counterparts in role sets.

Gender and cultural variations put both males and females in different positions which influence their perceptions, reactions and interpretations of various social and individual challenges. For instance, married adults (males and females) experiencing infertility (depending on other factors such as education, income, religion and age of the couples), may be more predisposed to depression especially the females in a culture like the Yoruba, where the value placed on children in marriage commands strong social significance. In a culture such as this, married couples(especially the females) having infertility problems will not only

contest with the psychological disappointments of not meeting the social goal of procreation in marriage, but may also face series of opposition from the significant others. In contrast, married male adults in the same cultural setting may have to struggle more with the challenges of meeting the economic needs of their households and those of relatives than the issue of infertility; and failure at achieving this could at times create dissatisfaction and stress for such men. There are other life events apart from the above that could be classified as chronic strains. The above scenario only illustrates likely gender reactions and interpretations of the concepts of "motherhood" and "breadwinner" which may possess a fruitful framework in explaining the prevailing gender differences in depressive symptomatology among adults in Nigeria.

### 3.1.4 Coping and Social Support

Many adults develop a repertoire of personal responses that can be activated when certain negative life events arise. This repertoire consists of responses which are acquired through socialization experiences and evolve over time as particular techniques work or fail to work to mediate stress. In this study, coping is defined as things adults people do to prevent, avoid, or control emotional or life distress. Pearlin and Schooler( 1978) further described coping to include efforts geared at : (i) reducing or modifying the negative life situation so that it will not be a progressing problem; (ii) controlling the meaning of the problem, by "cognitively neutralizing" the situation; and (iii) controlling the stress created by the situation.

Furthermore, adults sometimes rely on their significant others when faced with some negative life events. Social resources are assumed to be available to adults when faced with such events. These resources could be in form of emotional support or material support (Weiss & Lonnquist 2006). Two primary models have been developed to explain the effects

of social support on stress and stress outcomes. These are the main effect and the buffering effect models of social support (Weiss & Lonnquist, ibid).The main effect model asserts that social support contributes directly to well-being and positive health and that these beneficial effects occur even in the absence of stress. The general sense of well-being that social support provides, includes, the feelings of being accepted, the understanding that others care and are reachable, and the level of comfort within one's social environment which may contribute to inner feelings of satisfaction and other outer expressions of good health. The second model, the buffering effect asserts that the social support acts as a buffer which tends to lessen the likelihood of negative stress outcomes occurring as a response to high stress levels. The support offered by others according to this model, provides some sense of security and confidence that assures one that the stressful circumstances can be handled and that even the specific assistance in handling the situation will be available (Weiss & Lonnquist, ibid).



**3.2 Political Economy theory**

Adults in this study are assumed to also have within their disposal some levels of social resources. Although the degree of these social resources may vary from one interpersonal relationship to the other, it could also vary on the basis of gender. However, it is expected that the quality of these resources play vital roles in adults' predisposition and experiences of depression in their different social interactions. How do adults who are experiencing depression perceive their health related problem? Do their roles within and outside homes conflict and do these in anyway contribute to their exposure to stressors? The social stressors will thus be further conceptualised within the political economy framework. The theory explains the impacts of the political and economic sectors on adults. The political Economy

approach seeks explanations for social phenomena primarily at the level of the web of political and economic relations in which individuals and groups are enmeshed. Classical Political Economy theories have been influenced greatly by works of individuals such as Adam Smith, Thomas Malthus, David Ricardo, Karl Marx, W.S Jevons, Carl Menger, and J.B. Clark (Duncan, 1999). Although political economy is built on orderly and rigorous concepts and theories, they play a very different intellectual role from the concepts and theories of the physical and biological sciences. This may be attributed to the complexity of human social interaction and the difficulty we have in confronting our own social existence objectively. Hence, to have a 'grand unified' theory of political economy may not be plausible and no attempt of such is made in this study. However, each of the conflicting theories of political economy explains part of the truth, but each contains its own limitations. Despite this disparity, it may not be an overemphasis that the central theme in political economy analysis is the critical roles of politics and economy in defining, shaping and directing other 'structures' and obtainable social relations or interactions in the lager society.

However, a major part of our discussion here will be based on Karl Marx's work. Marx opined that in the social production of life, human beings enter into finite relations that are requisite and independent of their will and the relations of production that correspond to a definite stage of development of their material productive forces. The sum total of these relations constitutes the economic structure of society, the real foundation, on which correspond definite forms of social consciousness. The production of material life, conditions the social, political and intellectual life processes in general. It is not the consciousness of men on material that determine their being; on the contrary, it is their social being that determines their consciousness. At a certain stage of their development, the material productive forces of society come in conflict with the existing relations of production, or-

what is but a legal expression for the same thing with the property relation within which they have been at work, hitherto. From forms of development of the productive forces these relations turn into their fetters (Duncan, 1999). This understanding further influenced Marx's submission that it was difficult for an individual to act socially except through the web of existing social institutions and relationships. Many interpersonal relationships operate within a network of social institutions created and regulated by the society. As such, individuals are expected to also possess certain social resources or requirements which most times are class based in order to be able to perform the responsibilities ascribed to their various positions in life. The males' roles for instance differ from that of the females'. This again placed both adult men and women on different axis in the prevailing production spectrum and their experiences of social stressors and depressive symptoms.

In the final analysis, the dynamics of politics (pursuit of power, acquisition of power, consolidation and use of power) and economics (the pursuit of wealth, its consolidation and its cruise use) remain crucial to our understanding and exploration of depression among adults. The two factors (politics and economy) are inseparable entity in social analysis and the reactions or relationships that would emerge from any social system. Both variables shape developments in many spheres of the human society, including the interpersonal relationships of adults with other members of the society. The prevailing gross socioeconomic inequity leading to mass poverty, illness, illiteracy among other social problems are interconnected with the political economy. Though, past and present Nigerian governments have made and are making frantic efforts at refocusing the Nigerian economy through various policies, the impact of such policies and the cumulative impact of past government policies such as the Structural Adjustment Programme (implemented by the military administration of Ibrahim Babangida) have also resulted in loss of jobs, forceful

retirements, unpaid benefits or gratuities, and loss of properties in some locations. While one may not out rightly condemn some of these policies due to the perceived long term benefits when sensibly and duly implemented, the immediate effects on people are crippling. As such, the effects of politics and the economy on adults could be disastrous, especially in situations where social supports and other cushioning factors that could have lessened its impacts are absent. There is no doubt that life stressors could be traced to the dynamics of political economy, for when there is political unrest/instability productivity is affected, income is reduced, savings are eroded and chaos and violence are easily triggered within the homes. This culminates into stressors that will eventually enhance the experiencing of depressive symptoms. The theories thus provided appropriate anchor for the present study.

### 3.5 Hypotheses

The major assumption is that there are social stressors which predispose adults to depressive states. Therefore, the following hypotheses were tested:

(i) A higher proportion of younger adults are more likely to be depressed than older adults;

(ii) Adults on a higher socio-economic level (education and occupation) will suffer more depressive symptoms than those on a lower rung of the socio-economic ladder;

(iii) Depression will be more pronounced among married than unmarried adults; and

(iv) Older adults will adopt more positive coping mechanisms to depression than younger adults.

# CHAPTER FOUR

# RESEARCH METHODOLOGY

This Chapter is focused on the methods and techniques of data collection employed in generating relevant data. The chapter is organized and discussed under the following sub-headings: the description of the location of the study, the study population, techniques of data collection, procedure for data analysis and the problems encountered.

## 4.1 Location of the Study

The study was carried out in Osun State of Nigeria. The state occupies a land mass of approximately 8,602 square kilometres and was carved out of the old Oyo State on August 27, 1991.The State is bounded on the West by Oyo State, Ondo and Ekiti States in the East, Kwara State in the North and Ogun State in the South. The Main Towns are: Ejigbo, Ila-Orangun, Ile-Ife, Ilesha, Ikirun, Iwo and Oshogbo. Based on the 1991 Census, Osun State had a population of 2,158,143 in the following distribution: 1,043,126males and 1,115,017 females (National Population Census, 1991).

The State has a teaching hospital under the auspices of Obafemi Awolowo University. This Teaching Hospital provides tertiary health care services to Osun, Ekiti, Ondo and neighbouring States in south-western Nigeria with catchments of over 10 million people (Ukpong & Owolabi, 2004).

The Obafemi Awolowo University Teaching Hospitals Complex (OAUTHC) comprises of three Hospitals and three (3) auxiliary health centres, namely: Ife State Hospital(ISH) situated along Ilesa road at the North Eastern section of Ile-Ife town. It has a bed space of 362; second is the Wesley Guild Hospital (WGH) located at Ilesa, it has about 204 bed

spaces and lastly, a Dental Hospital located within the College of Health Sciences, Obafemi Awolowo University Campus, Ile-Ife. There are also the Rural Comprehensive Health Centre (RCHC) located at Imesi-Ile, the urban Comprehensive Health Centre, Eleyele, Ile-Ife, and the Multipurpose Comprehensive Health, located at Ilesa.

It is important to note that the OAUTHC has psychiatric units only in the teaching hospital complex in Ile-Ife and at the Wesley Guild Hospital, Ilesa. Patients from within Osun and neighbouring States are regularly referred from hospitals within the State or outside to either the Psychiatric units in Wesley Guild Hospital or the one at the Teaching Hospital Complex, Ile-Ife for medical consultation and treatment.

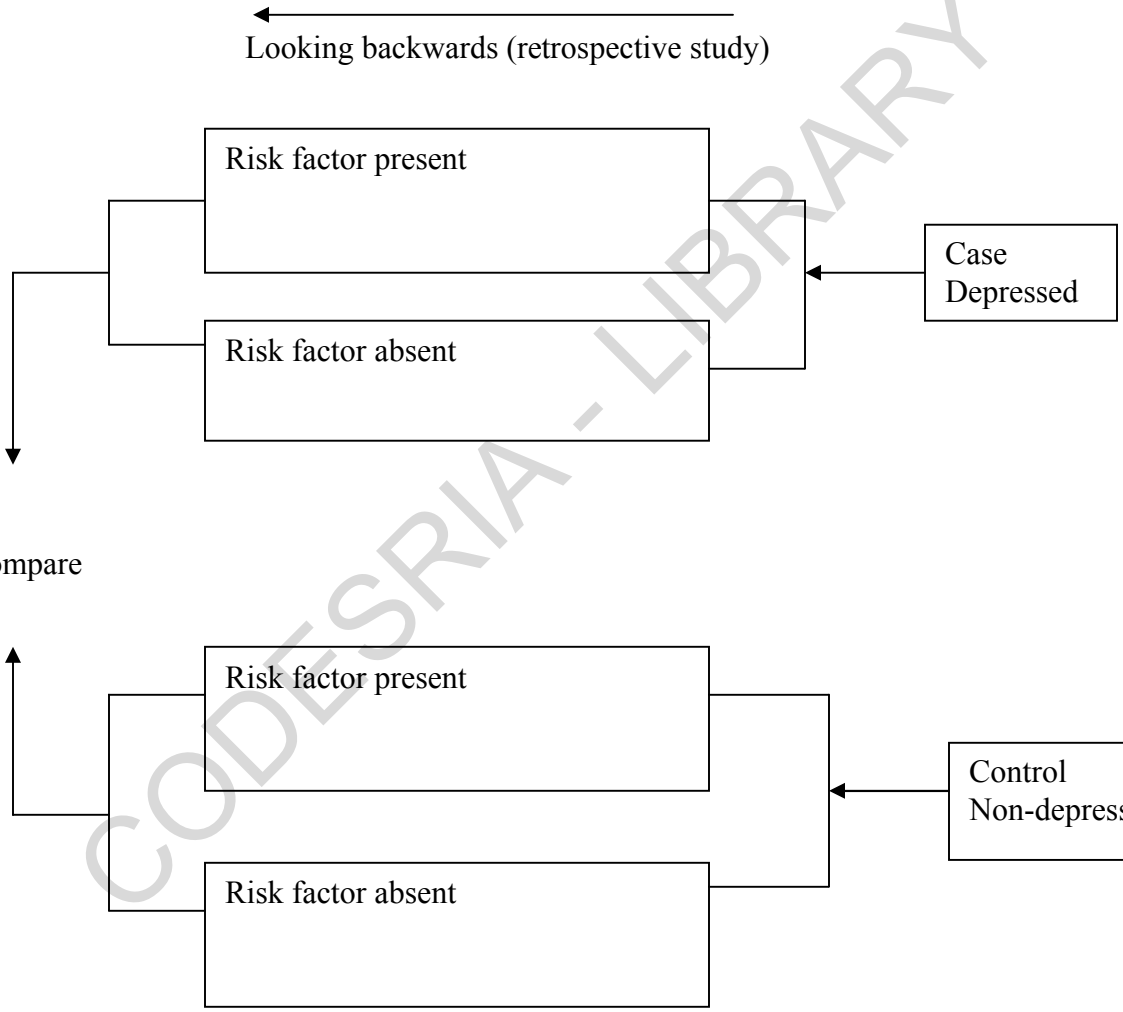
**4.2 Research Design**

A Case-Control Research Strategy was adopted for this study. Here the odd of exposure to risk factors among the patients who have depression (Cases) is compared with the odd of exposure among those without depression. This type of research design provides an insight into what factors have contributed to the depression in the study group, for it would provide an exposure to the predisposing factors or variables available in the lives of adults experiencing depressive symptoms vis –a-vis those adults that are not diagnosed with depressive symptoms. Here the history of the adults in the 2 groups was compared to ascertain what risk factors are more prevalent in the lives of those who end up suffering from depression compared to the other group, the control group. In order to control for confounding variables, the 2 groups were matched. (In this case, the case and control groups were similar in age (adults' 18-60years) and the period during which they visited the hospital. Emphasis was placed on anonymity of subjects and confidentiality of information obtained. Since the study dealt with a sensitive issue and

since information was obtained from patients' files, an ethical clearance was obtained from the University Research Ethics Committee. (Copy of the ethical clearance certificate is attached in the appendix).

See the diagram below. Figure 4

**Diagram of Case Control Study**




*(Adapted from Holland, et al, 1985)*

### 4.3 The Study Population

This study was conducted on a population of adults that were diagnosed and treated or being currently treated for depression (Cases) and those treated for other chronic disease (Control) at the Obafemi Awolowo University Teaching Hospitals Complex, from January 2002 to January, 2007. The target population consisted of adults (18-60years) patients seen at the Obafemi Awolowo University Teaching Hospitals over a 5 year period (2002-2007), including those who had depression and those who did not. Specifically, those without depression were recruited from adults with the following chronic disease conditions: asthma, diabetes mellitus, heart problem, hypertension, and stroke. The study population was selected from this.

### 4.4 Sampling Procedure and Sample Size

The hospital register was used as the sampling frame of patients seen at the hospital over a 5year period (2002 -2007). Based on the records, 110 adults (18-60years) were clinically diagnosed with depression. As such all the cases of depression based on the above criteria were recruited as the Case group. Some Medical Students in the psychiatric units were voluntarily co-opted in the selection of cases. This is to ensure a valid selection of cases diagnosed to be depressive. Similar criteria were used in recruiting adults (18-60years) diagnosed with other chronic non-communicable diseases (asthma, diabetes mellitus, heart problem, hypertension, and stroke) as the control. For every case, a control patient was also selected. There were 309 such eligible control and 110 of these were selected using simple random sampling technique.

Selected patients with depression and other disease conditions were categorised into two groups as young (18-40years) and old adults (41-60 years) as defined in this study. In total, 220 adult patients based on the above criteria were selected.

Finally, all healthcare givers (Nurses and Doctors) at the psychiatric units of the teaching hospitals were considered for the in-depth interviews. However, only 14 informants (10 Nurses and 4 Doctors) eventually participated in the in-depth interviews as others were not available after series of repeated visits.

**4.5 Pre-Test**

A pre-test of the survey instrument was carried out among 10 outpatients suffering from other mood disorders apart from primary depressive condition. This was done with the assistance of a psychiatrist at the psychiatric out-patient unit of the Obafemi Awolowo University Teaching Hospitals. Friday, which was one of the patients' clinic days, was selected. Information gathered through this exercise was used in improving the questionnaire. Some questions were reviewed to enhance clarity, while some were dropped. This helped to standardize the instruments to enhance reliability. For the qualitative data, informal interview based on the research objectives was held by the researcher with a consultant at the unit which led to the addition of some questions in the in-depth interview guide and the need to drop some questions. These steps were considered relevant to ensure the validity of the data.

### 4.6 Techniques of Data Collection

Both quantitative and qualitative data collection instruments were used. Both primary and secondary sources of data were explored. An interviewer administered structured questionnaire was administered to the selected respondents. Selected respondents were contacted either at their homes based on addresses collected from the registers or when they came for clinical appointments. This was necessary as there may be some patients within the period that may have stopped visiting the hospital for medical check ups or consultations.

Patients' case notes were also consulted as a secondary source of data. Lastly, a qualitative instrument of data collection (In-depth Interview) was employed in producing qualitative data. These in-depth interviews were conducted among hospital staff (the Psychiatric nurses and doctors). Also, case studies of some patients with depression were undertaken. Such data were obtained from the case files. Finally, a triangulation of methods and data generated through the quantitative and qualitative techniques was done to further enhance the validity of the data.



### 4.7 Data Processing/Analysis

Quantitative data generated through the interviewer administered questionnaire were processed and analysed with the aid of two computer statistical analysis soft ware: Epi-info 6 and Statistical Package for Social Science (SPSS) version 13. The Data entry was done using Epi-Info 6 in order to minimize data entry errors and to make provisions for checks. Thereafter, the data were exported to SPSS for analysis. Descriptive and inferential statistical analyses were employed in testing and interpreting the relationships among the variables.

On the other hand, the content analysis of the qualitative data gathered through the In-depth Interviews was processed and analysed thematically using ZY index. Finally, quantitative and qualitative data generated were triangulated.

### 4.8 Problems Encountered

The major problems encountered have to do with accessing the contact addresses of selected patients that have stopped coming for their clinical appointments; and getting those still coming for check ups to participate in the study. About 10 percent of the addresses extracted from the patient's files were not accessible and in some cases the researcher was told the respondents have relocated to an unknown destination. However, the researcher was able to overcome this through persistence and support of one of the social workers in the psychiatric unit. The other problem of getting patients to participate was less cumbersome. This was easily overcome through the support of some of the psychiatrists attending to the patients, but this was after they had been assured of anonymity and confidentiality. Most times, researcher would sit close to the consultation room and interact with patients as soon as they were through with the psychiatrist.

Another difficulty was more of timing and scheduling appointments with the psychiatrists for in-depth interviews. Securing interviews with psychiatrist nurses was relatively easier compared with the doctors. In fact, it took the researcher over three months to secure four in-depth interviews with the doctors. This is understandable since doctors' work under pressure, especially at a teaching hospital where they are expected to consult as well as teach their students. Again, the numerical strength of doctors at the psychiatric unit (as in similar units) was very low when their ratio is compared to that of psychiatric nurses.

Selection of patients' case files was less stressful as medical students who volunteered to assist in this regard were very supportive. Lastly, retrieval and consultation of patients' files was much easier due to the filling system in operation at the hospital's library.

# CHAPTER FIVE

## DATA ANALYSIS, RESEARCH FINDINGS AND DISCUSSION.

The previous chapter focused on the methodology, procedures adopted in selecting the samples and the field work that led to the production of relevant data. In this section, both quantitative and qualitative data gathered among the various respondents (Depressed adults patients; non-depressed patients) and the informants (healthcare givers) as well as the secondary data generated through the depressed patients' case files were presented, analysed and discussed. The analysis was based on a total of 156 respondents instead of the earlier projections of 220 respondents. Response rate was 71 percent among the Cases. The reasons for the non-response rate are due to lack of access to some Cases' contact addresses, which represented about 10 percent, change in contact address without any alternative(15%) and a few respondents who declined participation. As such, only 78 Controls were also considered.

The analysis and discussions were organised under the following sub-themes: socio-demographic and economic characteristics of respondents, respondents' perception and knowledge of their illness, the coping strategies employed by the respondents and testing of relevant hypotheses.

## 5.1: Socio-Demographic and Economic Characteristics of Survey Respondents.

### Table 5.1: Percentage Distribution of Respondents by Socio-demographic and Economic Characteristics.

| Variable | Case (N= 78) | Control (N=78) | Total N= 156 |
|---|---|---|---|
| **Sex** | | | |
| Male | 30(38.5%) | 44(56.4%) | 74(100%) |
| Female | 48(61.5%) | 34(43.6%) | 82(52.6%) |
| **Age** | | | |
| 18-22 years | 7(9.0%) | 5(6.4%) | 12(7.7%) |
| 23-27 years | 9(11.5%) | 2(2.6%) | 11(7.1%) |
| 28-32 years | 21(26.9%) | 13(16.7%) | 34(21.8%) |
| 33-37 years | 7(9.0%) | 5(6.4%) | 12(7.7%) |
| 38-42 years | 13(16.7%) | 7(9.0%) | 20(12.8%) |
| 43-47 years | 11(14.1%) | 17(21.8%) | 28(17.9) |
| 48-52 years | 5(6.4%) | 4(5.1%) | 9(5.8%) |
| 53-60 years | 7(9.0%) | 23(29.5%) | 30(19.2%) |
| **Mean** | | | 39.87 years |
| **Standard deviation** | | | 12.04years |
| **Educational level of respondents** | | | |
| None | 3(3.8%) | - | 3(1.9%) |
| Primary | 7(9.0%) | 12(15.4%) | 19(12.2%) |
| Secondary | 26(33.3%) | 25(32.1%) | 51(32.7%) |
| Post secondary | 42(53.8%) | 41(52.6%) | 83(53.2%) |
| **Religion** | | | |
| Christianity | 64(82.1%) | 56(71.8%) | 120(76.9%) |
| Islam | 14(17.9%) | 22(28.2%) | 36(23.1%) |

Source: Field Survey, 2007

**Table 5.1: Percentage Distribution of Respondents by Socio-demographic and Economic Characteristics**

| Variable | Case (N=78) | Control (N=78) | Total (N=156) |
|---|---|---|---|
| **Marital status** | | | |
| Single | 21(26.9%) | 17(21.8%) | 38(24.4%) |
| Married | 56(71.8%) | 60(76.9%) | 116(74.4%) |
| Divorced | 1(1.3%) | - | 1(.6%) |
| Widowed/widower | - | 1(1.3%) | 1(.6%) |
| **Type of marriage** | | | |
| Monogamy | 46(59.0%) | 54(69.2%) | 100(64.1%) |
| Polygyny | 11(14.1%) | 7(9.0%) | 18(11.5%) |
| **Occupational status before ill health** | | | |
| Civil servant | 14(17.9%) | 18(23.1%) | 32(20.5%) |
| Clergy | 1(1.3%) | 1(1.3%) | 2(1.3%) |
| Farming | 1(1.3%) | 1(1.3%) | 2(1.3%) |
| Retiree | 1(1.3%) | 4(5.1%) | 5(3.2%) |
| Self employed | 5(6.4%) | 8(10.3%) | 13(8.3%) |
| Student | 17(21.8%) | 12(15.4%) | 29(18.6%) |
| Teaching | 24(30.8%) | 14(17.9%) | 38(24.4%) |
| Trading | 13(16.7%) | 19(24.4%) | 32(20.5%) |
| Unemployed | 2(2.6%) | 1(1.3%) | 3(1.9%) |

**Source:** Filed Survey 2007.

Table 5.1 above presents the socio-demographic and economic characteristics of the respondents. The study covers a total of 156 respondents with a total of 30 males and 44 females in the Case group, while 44 and 34 males and females respectively are in the Control. About 56 percent of the Cases and 32 percent of the Controls are between the ages of 18-37 years, while those within the age bracket of 38-60 years account for about 36 percent of the Cases and about 51 percent of the Controls. Similar proportions of the Cases (53.8%) and the Control (52.6%) had post secondary education. This shows an encouraging increase in the desire for post secondary education in the locality. In contrast, about 7 percent of Cases and 12 percent of Controls had primary education. The desire for education among the respondents in both groups seem high as only less than 2 percent of the Cases had no formal education, while none was recorded among the Controls. It is note worthy that the two towns (Ile-Ife and Ilesa) in which the Teaching hospital is located also has two public higher Institutions namely: Obafemi Awolowo University and the Osun State College of Education respectively.

Christianity is the dominant religion of the respondents. Majority of the Cases (82.1%) and Controls (71.8 %) indicated Christianity as their religion, while 17.9 percent of the Cases and about 28 percent of the Controls indicted Islam. No respondent in the two groups indicted Traditional religion, but this does not imply the non-existence of traditional religion in the locality. Christianity and Islam have gained some level of prominence in the locality. This is obvious going by the number of physical structures advertising their presence. In contrast, traditional religion in practise lacks such formal organisation, but the religion still commands critical influence in the belief system of people in the study locality especially when it involves health related cases that are chronic or terminal. It is not surprising that none of the respondents mentioned being affiliated with the traditional religion especially in

Ile-Ife where we are told that an Orisa is worshipped every day of the 364 days of every normal year. But as observed in previous studies, people may not want to publicly admit to practising the traditional religion. Even those who patronise the practitioners or priests do so either in the dead of night or under cover. They pack their cars in a different place and walk to the priests (Akintude, 1982; Odebiyi, 1980**)**. On marital status, 71.8 percent of the Cases and 76.9 percent of the Controls are married, while about 26.9 percent of the Cases and 21.8 percent of Controls are single. Only less than 1 percent of the Cases are divorced and only 1 percent of the Controls are widowed.

About 59 percent of the Cases and 69 percent of the Controls had monogamous families, while slightly above 14 percent of Cases and only 9 percent of the Controls practice polygyny. Since the practice of polygny has been associated with stress (Gage-Brandon, 1992). It is not surprising that polygyny is more prevalent among the Cases (14.1%) than the Control group (9.0%). Occupation has essentially been seen not only as a determinant of income, but as an indicator of social class and access to social resources and information associated with class (Pebley & Goldman, 1995). Occupation-wise, teaching is the predominant occupation (24.4%) among the two groups. Among the Cases, 30 percent were Teachers, while 17 percent were Teachers in the Control group. In contrast, more Civil Servants (23.1%) were found among the Controls than the Cases (17.9%). It is obvious that about 45 percent of the respondents in both groups are employees. The preponderance of teaching occupation may not be unconnected with cultural expectations and economic realities. Teaching may also have become a viable option as there are both public and private schools in the locality to meet the yearnings of the people for western education, with public schools having a larger number of teachers. In addition, the presence of Osun State College

of Education in Ilesa may have also contributed to the increase in the numbers of teachers in the locality.

Trading accounted for about 24.4 percent and 16.7 percent of the occupation of respondents in the Control and Cases' respectively. However, more students were found among the Cases (21.8%) than among the Control (15.4%).

## 5.2 In-depth Interviews with Health Caregivers

**Table 5. 2: Socio-demographic characteristics of Health Caregivers (Psychiatrists)**

| **Variable** | **Doctors** | **Nurses** | **Total** |
|---|---|---|---|
| **Sex** | | | |
| Female | 1 | **2** | **3** |
| Male | 3 | **8** | **11** |
| **Age** | | | |
| **Mean** | **39.25years** | **51.1years** | |
| **Marital Status** | | | |
| Married | **3** | **9** | |
| Single/Unmarried | **1** | **1** | |
| **Religion** | | | |
| Christianity | **3** | **9** | |
| Islam | **1** | **1** | |

**Source:** Field Survey 2007

Table 5.2 presents the socio-demographic characteristics of the informants in the in-depth interviews. The interviews were held with health caregivers at the psychiatric units. It is obvious that there are more nurses than the number of doctors in the psychiatric units. And majority of the psychiatrics nurses are males. Even among the psychiatrists interviewed only one was a female. The mean age of the respondents show that majority of the nurses are in

their fifties, while the mean of the doctors was about 40years. Majority of the respondents are married and by religious affiliation more than 95 percent are Christians.

### 5.3 Respondents' marital status, gender and health problem

**Table 5.3: Percentage Distribution of Respondents by health problem, gender and marital status**

| Variable | | Case | Control | Total |
|---|---|---|---|---|
| Married | Male | 22 (37.9%) | 36 (62.1%) | 58 (100%) |
| | Female | 34 (58.6%) | 24 (41.4%) | 58 (100%) |
| | Total | 56 (48.3%) | 60 (51.7%) | 116 (100%) |
| Single/Unmarried | Male | 8 (50.0%) | 8 (50.0%) | 16 (100%) |
| | Female | 14 (58.3%) | 10 (41.7%) | 24 (100%) |
| | Total | 22 (55.0%) | 18 (45.0%) | 40 (100%) |

**Source:** Filed Survey 2007

From table 5.3 above, a total of 56 of the Cases and 60 of Controls were married. 22 respondents in the Cases and 18 in the Controls were either single or unmarried. On marital status and gender, 62.1percent of the Controls were males and are married, while 41.4 percent were females and are married. Among the Cases, 37.9 percent were males and are married. It is important to note that more than half of the Cases (58.6%) were females and more than two thirds of the females were married. Generally, many of the Cases were married (71.8%) and out of this figure, more than half were females. This is worthy of note since earlier studies (Ogedengebe, 1986, Murray & Lopez, 1996) had noted high incidence of depression among females than males, and among married females than females who are

singles. It is again in line with other studies on the prevalence of depression among married females than married males (Brown & Harris, 1978; Murray & Lopez, 1996). Though, it may be difficult to generalize across board, as depression aetiology confirms multiple factors.

### 5.4 Respondents' perception and knowledge of depression.

**Table 5.4.1: Percentage Distribution of Respondents' perception and knowledge of depression.**

| Variable | Strongly Agree | Moderately agree | Neither agree Nor disagree | Moderately disagree | Strongly disagree | Total |
|---|---|---|---|---|---|---|
| **Depression is as a result of a biological abnormality** | | | | | | |
| **Case** | 10(12.8%) | 22 (28.2%) | 12(15.4%) | 27(34.6%) | 7(9.0%) | (78)100% |
| **Control** | 5(6.4%) | 6(7.7%) | 3(3.8%) | 35(44.9%) | 29(37.2%) | (78)100% |
| **Stress or negative life experiences causes depression** | | | | | | |
| **Case** | 30(38.5%) | 32(41.0%) | 7(9.0%) | 8(10.3%) | 1(1.3%) | (78)100% |
| **Control** | 7(9.0%) | 27(34.6%) | 12(15.4%) | 14(17.9%) | 18(23.1%) | (78)100% |
| **Loss of touch with ones spiritual core or faith in God could cause depression.** | | | | | | |
| **Case** | 3(3.8%) | 24(30.8%) | 26(33.3%) | 24(30.8%) | 1(1.3%) | 78(100.0%) |
| **Control** | 2(2.6%) | 7(9.0%) | 2(15.4%) | 37(47.4%) | 20(25.6%) | 78(100.0%) |

**Source:** Filed Survey 2007.

**Table 5.4.1: Percentage Distribution of Respondents' perception and knowledge of depression.**

| Variable | Strongly agree | Moderately agree | Neither agree nor disagree | Moderately disagree | Strongly disagree | Total |
|---|---|---|---|---|---|---|
| **Depression could be the result of an unhealthy lifestyle** | | | | | | |
| **Case** | 13(16.7%) | 18(23.1%) | 17(21.8%) | 27(34.6%) | 3(3.8%) | 78(100.0%) |
| **Control** | - | 30(38.5%) | 1(14.1%) | 29(37.2%) | 8(10.3%) | 78(100.0%) |
| **I do not have any idea about the cause(s) of depression** | | | | | | |
| **Case** | 5(6.4%) | 57(73.1%) | 7(9.0%) | 8(10.3%) | 1(1.3%) | 78(100.0%) |
| **Control** | 6(7.7%) | 32(41.0%) | 18(23.1%) | 8(10.3%) | 14(17.9%) | 78(100.0%) |
| **There is a cure for depression** | | | | | | |
| **Case** | 9(11.5%) | 49(2.6%) | 12(15.4%) | 6(62.8%) | 2(7.7%) | 78(100.0%) |
| **Control** | 8(10.3%) | 32(41.0%) | 20(25.6%) | 11(14.1%) | 7(9.0%) | 78(100.0%) |
| **I think depression is better treated in the hospitals** | | | | | | |
| **Case** | 1(1.3%) | 24(30.8%) | 46(59.0%) | 5(6.4%) | 2(2.6%) | 78(100.0%) |
| **Control** | 6(7.7%) | 35(44.9%) | 31(39.7%) | 3(3.8%) | 3(3.8%) | 78(100.0%) |
| **Depression is better treated through traditional medicine** | | | | | | |
| **Case** | 3(3.8%) | 8(10.3%) | 46(59.0%) | 19(24.4%) | 2(2.6%) | 78(100.0%) |
| **Control** | 1(1.3%) | 5(6.4%) | 35(44.9%) | 24(30.8%) | 13(16.7%) | 78(100.0%) |

**Source:** Filed Survey 2007.

Table 5.4.1 above reveals the views of the Cases and Controls in relation to their perception of the nature of depression and how informed they are in terms of having adequate knowledge. To understand respondents' views in this regard, six questions were asked using a Likert scale of 5 point as the highest. Respondents' views were scaled from

strongly agree to strongly disagree. In order to gain insight into respondents' perception of predisposition to depression on genetic basis, the statement 'Depression is as a result of a biological abnormality' was asked. On the average, about 40 percent of the Cases considered their problems as biologically determined. Among the Controls, less than one third perceived a link between depression and biological abnormality. Although it is obvious that there are no consensus among the two groups on the biological determinant of depression; there is still a level of acceptance among them that biological factors could be responsible for the health problem. The severity and relapses of the health problem among the Cases may have made some of them to be sceptical about the link between their health problem and family background as some of them may prefer to externalise the cause rather than see it as an internally related problem such as being biologically determined or connected to family background.

Generally, there is an attitude of unwillingness of Cases to associate their health problem with either their genetic or family background which may be associated with the social stigma associated with psychotic disorders in the locality. Presently there is still a level of stigmatisation ascribed to individuals who have one time or the other suffered a mental disorder. This is similar to findings from other studies (Ogedengbe, 1986). Hence, the family histories of intending couples are still being ascertained to rule out such stigmatising ailments as depression, insanities and among others. (Fadipe, 1970). The degree of adherence to such practise may have diminished compared to what was obtainable 37 years ago, yet it is still relevant in today's' marriages among the Yoruba's.

While it may be difficult attributing psychotic disorders totally to family background or biological factors, there is some level of evidence to support this assumption even among health care givers and significant others. For instance in the in-depth- interview held with the

Psychiatric Nurses and Doctors in the psychiatric units, there was a consensus among the informants in their perception of depression. Most of them agreed that there were some links between depression and biological or family background. While there are few studies on perceptions of the causes of depression in a depressed population, a study although from a different culture confirmed that depressed patients hold more biological beliefs than non-depressed patients (Kuyan, Brewin, Power & Furnham, 1992). Below is an extract from the interviews:

**Extract 1: in-depth interview with a Psychiatrist at Wesley Guild Ilesa**

*"...some individual are biologically predisposed to depression, any little negative life event could trigger it on in them..."*

Also supporting this assumption is the case study presented below of a depressed adult patient.

**Case 1: Extract from a patient's case file**

*Adegbola(pseudo name) was a 22year old female student of a Polytechnic in the south western part of Nigeria. She was in her second year of her National Diploma in Laboratory Technology when she was presented for clinical investigation. From the history given by her mother, it was revealed that the patient's elder sister was presently on treatment for a mental disorder also at a Teaching hospital in south western Nigeria and in fact Adegbola's problem started shortly after she paid the elder sister a visit at the hospital.*

In the light of the above case, a respondent with such family background may likely attribute the cause of the health problem to factors within the family or genetic make up. Probing further on respondents' perception and knowledge of the health problem, they were asked if a stress or negative life experience could be responsible for the health problem. Among the Controls, close to average(43.6%) strongly and moderately agreed that stress or negative life experiences could be responsible for the health problem. This implies that more than one third of the Control strongly and moderately agreed with the notion. However, among the Cases, over 75 percent moderately and strongly agreed that stress or negative life events influenced their present health status. The variation in the perception and knowledge of respondents on the influence of stress or negative life experiences seems to be in consonance with evidence from the literature. Although such evidence had clearly linked depression with negative life events or stressors (Brown & Harris, 1978; Broadhead, & Abas, 1998), there are times the sufferers seem to believe differently. Their perception differs from what professionals and caregivers perceived to be responsible for their problems. This is corroborated by some findings from the In-depth Interview (see extract below)



**Extract 2: from in-depth interview with a Male Psychiatric Nurse at Wesley Guild Ilesa**

*... Many a time depressed patients may not want to agree that they are depressed and when they do, they are likely to see it as a normal way of life. Again, while those responding to treatment may reason and agree with their caregivers on what may be responsible for their problems and why they have to be in the hospital, there are still times they will not.*

Moving from the physical dimension to the spiritual level, respondents were asked if they perceived the problem to be associated with "Loss of touch with ones spiritual core or faith in

God could cause depression". About 34.6 percent of the Cases did see their problem as being associated with losing touch with their spiritual core or faith in God. Again less than one quarter (11.6%) of the Controls moderately and strongly disagreed with the statement as regards this health problem. The Cases toed different paths, about one third of them strongly and moderately agreed with the statement, while similar proportion neither agreed nor disagreed.

Evidence from the literature has shown that unhealthy lifestyle such as substance abuse could be responsible for psychotic disorder including depressive disorder. As such respondents were also asked if they perceive unhealthy lifestyle to be responsible for the health problem. Among the Controls, a fairly high proportion moderately agreed (38.5%) and a similar proportion also moderately disagreed (37.2%) that the problem could have resulted from unhealthy lifestyle. To the Cases, 39.8 percent strongly and moderately agreed that there was an association between unhealthy life style and their health problem, while less than average in the group also neither agreed nor disagreed. Respondents were asked further questions on what they considered to be unhealthy lifestyle. As indicated in table 5.4.2 below, four types of unhealthy life styles were suggested as contributory factors to this ill-health. From table 5.4.2 below, it seems to an extent that a significant proportion of the respondents consider unhealthy lifestyles as likely influence on psychotic disorders.

**Table 5.4.2: Percentage Distribution of Respondents' by what they considered as unhealthy life style**

| What they considered to be unhealthy life style | Case | Control | Total |
|---|---|---|---|
| Alcoholic | 21.8% | 26.9% | 38(100%) |
| Lack of exercise | 32.1% | 24.4% | 44(100%) |
| Poor diet | 25.6% | 25.6% | 40(100%) |
| Substance abuse | 20.5% | 23.1% | 34(100%) |
| **Total** | 78(50.0%) | 78(50.0%) | 156(100%) |

**Source:** Field Survey, 2007.



Since it may be possible for some of the respondents to be sceptical in agreeing with clinical explanations for this health problem, they were asked to rate the statement 'I do not have any idea about the cause(s) of depression '. Among the Cases, majority (79.5%) moderately and strongly agreed that they had no idea on what could have caused their health problem. Similarly, about 48.8 percent of the Control group also strongly and moderately agreed that they had no idea on what could be responsible for depression. There seems to be low level of awareness among the Cases about the predisposing factors to psychotic disorders, despite efforts at popularising the aetiology of depression and other psychotic disorders by healthcare givers and other stakeholders.

Furthermore, to explore respondents' views with respect to patients' chances of recovering from the health problem, they were asked if they perceive a solution to depression. In reacting to this, close to two thirds of the Controls strongly and moderately agreed that there is a cure for the health problem. On the other hand, more than two thirds of the Cases moderately and strongly disagreed that there is a cure for their health problem. It is not too surprising that some of the Cases (78.5%) seeking treatments through the orthodox

medicine still felt unsure of solution to their health problems. From the patients' case files, it was observed that many of the Cases were brought to the hospitals by their significant others which may be against the patients will at times.

Respondents were also asked questions relating to their perception of the plausibility of getting a solution to the health problem through orthodox medicine. This question is considered to be relevant if they were to be free in making a choice of healing treatment. In view of this, they were asked if they thought the health problem is better treated in the hospitals. About 52.6 percent of the Controls moderately agreed, while close to 40 percent of them neither agreed nor disagreed that the health problem could be better treated in the hospital. Among the Cases, a high proportion neither agreed nor disagreed (59.0%) with the statement. Going by these responses, there are signals that an appreciable number of the Cases lack sufficient hope of regaining back their health by seeking treatments at the hospitals. What about seeking for cure through another means such as traditional medicine? Some studies have shown increasing patronage of traditional medicine and reasons for this have been associated with some socio-cultural factors (Owunmi, 1994). Respondents were also asked if they thought depression could be better treated through traditional medicine. Among the Controls, over two thirds percent neither agreed nor disagreed that this health problem could be a better treated through traditional medicine and about 50 percent felt otherwise, as they strongly and moderately agreed with the statement.

Similarly over 50 percent of the Cases neither agreed nor disagreed with the idea, whereas less than one quarter strongly and moderately agreed that their health could be better treated through alternative medicine. Therefore it appears there is complexity in the choices of the Cases about the choice of treatment that would better meet their demands. Although this study did not investigate respondents' views on the non-socio-cultural factors that could be

responsible for their views, it appears that some are satisfied and hopeful of regaining their health through either of the healing systems (modern or traditional).

### 5.5. Coping Strategies of Respondents

**Table 5.5.1: Percentage Distribution of Respondents by Compliance to drug use/ appointments/check ups as coping strategy.**

| Variable | Strongly agree | Moderately agree | Neither agree Nor disagree | Moderately disagree | Strongly disagree | Total |
|---|---|---|---|---|---|---|
| **I do not like using traditional medicine** | | | | | | |
| **Case** | 3(3.8%) | 21(26.9%) | 10(12.8%) | 34(43.6%) | 10(12.8%) | 78(100.0%) |
| **Control** | - | 21(26.9%) | 11(14.1%) | 26(33.3%) | 20(25.6%) | 78(100.0%) |
| **I do not like using orthodox/ western medicine** | | | | | | |
| **Case** | 2(2.6%) | 15(19.2%) | 8(10.3%) | 36(46.2%) | 17(21.8%) | 78(100.0%) |
| **Control** | - | 2(2.6%) | 7(9.0%) | 35(44.9%) | 34(43.6%) | 78(100.0%) |
| **I have used traditional medicine shortly before coming to the hospital** | | | | | | |
| **Case** | - | 29(37.2%) | 9(11.5%) | 30(38.5%) | 10(12.8%) | 78(100.0%) |
| **Control** | 3(3.8%) | 30(38.5%) | 14(17.9%) | 22(28.2%) | 9(11.5%) | 78(100.0%) |

**Source:** Filed Survey 2007.

**Table 5.5.1: Percentage Distribution of Respondents by Compliance to drug use/ appointments/check ups as coping strategy.**

| Variable | Strongly agree | Moderately agree | Neither agree Nor disagree | Moderately disagree | Strongly disagree | Total |
|---|---|---|---|---|---|---|
| **I am currently using both orthodox and traditional medicine** | | | | | | |
| **Case** | 2(1.3%) | 13(16.7%) | 15(19.2%) | 36(46.2%) | 12(15.4%) | 78(100.0%) |
| **Control** | - | 13(16.7%) | 16(51.6%) | 24(30.8%) | 25(32.1%) | 78(100.0%) |
| **I try to use my drugs regularly** | | | | | | |
| **Case** | 11(14.1%) | 55(70.5%) | 6(7.7%) | 6(7.7%) | - | 78(100.0%) |
| **Control** | 13(16.7%) | 48(61.5%) | 15(19.2%) | - | 2(2.6%) | 78(100.0%) |
| **I make efforts to come for check up /appointment when due** | | | | | | |
| **Case** | 5(6.4%) | 62(79.5%) | 6(7.7%) | 3(3.8%) | 2(2.6%) | 78(100.0%) |
| **Control** | 16(20.5%) | 39(50.0%) | 14(17.9%) | 4(5.1%) | 5(6.4%) | 78(100.0%) |
| **I think it is too stressful using some of the drugs** | | | | | | |
| **Case** | 5(6.4%) | 50(64.1%) | 11(36.7%) | 8(10.3%) | 4(5.1%) | 78(100.0%) |
| **Control** | 7(9.0%) | 26(33.3%) | 19(24.4%) | 9(11.5%) | 17(21.8%) | 78(100.0%) |

**Source:** Filed Survey 2007.

**Table 5.5.1: Percentage Distribution of Respondents by Compliance to drug usage/ appointments/check ups as coping strategy.**

| Variable | Strongly agree | Moderately agree | Neither agree Nor disagree | Moderately disagree | Strongly disagree | Total |
|---|---|---|---|---|---|---|
| **I think my situation will improve without using drugs** | | | | | | |
| **Case** | 6(7.7%) | 17(21.8%) | 26(32.1%) | 20(25.6%) | 9(11.5%) | 78(100%) |
| **Control** | - | 3(3.8%) | 25(32.1%) | 22(28.2%) | 28(35.6%) | 78(100%) |
| **I hate coming for check up/ appointments** | | | | | | |
| **Case** | 3(3.8%) | 37(47.4%) | 10(12.8%) | 22(28.2%) | 6(7.7%) | 78(100%) |
| **Control** | 4(5.1%) | 16(23.1%) | 16(20.5%) | 20(25.6%) | 20(25.6%) | 78(100%) |

**Source:** Filed Survey 2007.



Recovery from illness involves a complex process of which certain roles are expected to be played by the different actors involved in the healing process. One of such roles is the social expectations on the patient to desire and seek recovery. This entails compliance by the patient to the treatment regimes obtainable within the healing system where healing is sought as well as the desire to get well. To appreciate compliance to treatment regimes, respondents were asked questions related to their compliance to drug use and clinical appointments/check-ups. Current evidence has shown a high level of patronage for traditional medicine along side orthodox medicine (Boderker, 2000). However, respondents were asked if they liked using traditional medicine or not. On the average, it appears that many of the Controls have little reservations for traditional medicine as more than two thirds strongly and moderately disagreed that they do not like using traditional medicine. The Cases share

similar views with the Controls, as about the same proportion strongly disagreed (12.8%) and moderately disagreed (43.6%) that they do not like using traditional medicine. On the average, it appears there is no difference in the opinions of respondents in the two groups as a high proportion of the Cases and Controls were in approval and use traditional medicine.

To corroborate the above findings, respondents were also asked if they do not like using western or orthodox medicine. A high proportion (88.5%) of the Controls strongly and moderately disagreed with the statement. There is no variation in the preference of the Cases towards the use of western medicine. For instance, among the Cases, 46.2 percent moderately disagreed, that they do not like using western medicine. Finally, there seems to be a similar trend in the number of Cases and Controls who like using traditional medicine as well as western medicine.

To further understand respondents' recent use of traditional medicine, they were asked if they had used traditional medicine shortly before visiting the hospitals. Among the Controls, 38.5 percent moderately agreed that they have used traditional medicine shortly before coming to the hospitals. Similarly, the Cases also indicted that they used traditional medicine shortly before visiting the hospitals as 37.2 percent moderately agreed. The use of traditional medicine among the two groups before visiting the hospitals could be explained within the socio-cultural context of illness behaviour. Hence from the above table 5.5.1, it is obvious that many respondents from either group have tried alternative medicine before coming to the hospitals.

Substantiating this is an extract from the in-depth interviews with the health care givers.

**Extracts 3: In-depth interview with a Male Psychiatrist at Ile-Ife**

*… to an extent some of the patients usually delay before seeking treatment at the hospitals and when they finally do, quite a number of them do default which most times may be attributed to the relapse of episodes. The reasons for such actions may, however, be complex and require further research; but there are indications that many do visit other healing centres before coming to the hospitals. Although there are exceptions but it appears to be common among patients.*

To understand patients' views, respondents were asked if they are currently using traditional medicine simultaneously with other medications being given at the hospitals. Further questioning and probing showed that few Controls (16.7%) are currently using both traditional and orthodox medicine. Similarly, less than one quarter of the Cases strongly and moderately agreed that they are currently using both medicines. The above views appear similar and it may not be far from the prohibition of use of non-orthodox medicine alongside the orthodox while receiving treatments in a modern hospital.

As earlier stated, compliance to drugs and clinical appointments are critical to patient recovery from ill health. As such to capture respondents' attitude towards drug use and compliance to clinical appointments they were asked "I try to use my drugs regularly". Among the Controls, overwhelming proportion reported regular drug use as 61.5 percent moderately agreed that they use their drugs regularly. Among the Cases, their attitude was indifferent as more than 70 percent also moderately agreed with the statement. It is evident that few respondents from both groups did strongly and moderately agree that they do not use

their drugs regularly. The reasons for the infrequent use of prescribed drugs may be found in the side effects of some drugs and the lack of appreciable improvements as may be expected by the patients after the use of some drugs. However, respondents were asked if they considered the use of some of their drugs as a stressful obligation. A relatively high percentage of the Controls strongly and moderately agreed (42.3%), while about 43.3 percent moderately and strongly disagreed that using some drugs was too stressful. However among the Cases, an appreciable percentage felt using some of their drugs was burdensome, as about 64 percent moderately agreed. The above findings show mixed feelings of respondents' perception of whether or not their use of prescribed drugs was burdensome. Are there some who are not favourably disposed to the use of drugs and who considered their problem as one beyond drugs or do they actually believe their problems will improve without drugs? To clarify this, respondents were asked if they thought their health condition would improve without the use of drugs. Among the Controls, about 64 percent moderately and strongly disagreed; while about 33 percent neither agreed nor disagreed. Among the Cases, a similar proportion (32.1%) neither agreed nor disagreed and about 29 percent strongly and moderately agreed. It is obvious that while some respondents may have lost interest or hope in the efficacy of the drugs as an adequate measure in restoring back their health, some still believed that their compliance to prescribed drugs through regular use could be of benefit to their health. Earlier, Becker and Maiman (1975) argued that compliance of patients with healthcare prescriptions may in part depend on social beliefs and the social milieu in which care is given.

Moving away from drug compliance, respondents were asked if they hated coming for clinical appointments when due. Among the Controls, about 26 percent strongly and moderately agreed that they hated coming for clinical appointments, while about 23 percent

moderately disagreed. Slight variations were observed among the Cases, as about 51.2 percent strongly and moderately agreed that they hate going for clinical checkups.

### 5.5.2 Coping Strategies of Respondents

**Table 5.5.2: Percentage Distribution of Respondents and their views about the strategy for seeking support for instrumental reasons.**

| Variable | Seeking support for instrumental reasons | | | | | |
|---|---|---|---|---|---|---|
| | Strongly agree | Moderately agree | Neither agree Nor disagree | Moderately disagree | Strongly disagree | Total |
| **I ask people who have had similar illness what they did** | | | | | | |
| **Case** | 2(2.6%) | 19(24.4%) | 16(20.5%) | 20(25.9%) | 21(26.7%) | 78(100%) |
| **Control** | 4(5.1%) | 38(48.7%) | 14(17.9%) | 7(9.0%) | 15(19.2%) | 78(100.) |
| **I try to get advice from someone about what to do to regain back my health** | | | | | | |
| **Case** | 2(2.6%) | 27(34.6%) | 9(11.5%) | 23(29.5%) | 17(21.8%) | 78(100%) |
| **Control** | 2(2.6%) | 45(57.7%) | 14(17.9%) | 15(19.2%) | 2(2.6%) | 78(100%) |
| **I talk to someone to find out more about the illness** | | | | | | |
| **Case** | 2(2.6%) | 28(35.9%) | 8(10.3%) | 26(33.3%) | 14(17.9%) | 78(100%) |
| **Control** | 7(9.0%) | 46(59.0%) | 15(19.2%) | 7(9.0%) | 3(3.8%) | 78 (100%) |

**Source:** Filed Survey 2007.

### 5.5.2 Coping Strategies of Respondents

**Table 5.5.2: Percentage Distribution of Respondents and their views about the strategy for seeking support for instrumental reasons.**

| Variable | Seeking support for instrumental reasons | | | | | |
|---|---|---|---|---|---|---|
| | Strongly agree | Moderately agree | Neither agree Nor disagree | Moderately disagree | Strongly disagree | Total |
| **I talk to someone who could do something concrete about the illness** | | | | | | |
| **Case** | - | 42(53.8%) | 5(6.4%) | 15(19.2%) | 16(20.5%) | 78(100%) |
| **Control** | 4(5.1%) | 47(60.3%) | 16(20.5%) | 3(3.8%) | 8(10.3%) | 78(100%) |

**Source:** Filed Survey 2007.



Apart from drug use and compliance to clinical appointments, another important aspect in the patients' recovery process is the availability of social networks. Cockerham (2000) defines social networks as the social relationships a person has during day-to-day interaction that serve as the normal avenue for the exchange of opinion, information and affection. These networks include their significant others, members of their immediate group, community members as well as their healthcare givers. However, patients' willingness to accept or reject their network opinions, information and affection including advice from their caregivers would have an impact on their recovery process from the illness. With this backdrop, respondents were asked if they asked people who have had similar health problems what they did in overcoming their problems. Among the Controls, about 49 percent moderately agreed that they asked people who had similar health experiences what steps they took in resolving their problems, and a lower proportion strongly disagreed (19.2%). In a different dimension, the Cases also had a similar proportion that strongly and moderately disagreed (52.6%) that

they asked those who had similar health experiences what they did in overcoming their problems. The above findings indicate that quite a number of the Cases are not prone to accepting information from those they knew and who have had similar health challenges like theirs.

Subsequently, respondents were asked if they tried to get advice from someone about what to do to regaining back their health. About 2.6 percent of the Controls strongly agreed that they try to get advice from someone on what to do with regards to ill health. A higher proportion moderately agreed (57.7%). Among the Cases, an appreciable proportion moderately agreed (35.9%), but a similar proportion (33.3%) indicated that they moderately disagreed. Generally, the level of sharing and seeking advice from others seems higher among the Control than the Case group; a probable reason could be that they get advice from their healthcare givers and other individuals than the Cases do.

Similarly, respondents were asked to voice their reaction to another statement: "I talk to someone who could do something concrete about my problem". About 60.3 percent of the Controls moderately agreed they do, and about 3.8 percent moderately disagreed. Among the Cases, 53.8 percent moderately agreed that they talk to someone who could do something concrete about their health situation, and a fair proportion (39.7%) moderately disagreed. Generally, it appears that more of the Cases do not like to share information on their health status with others when compared with the Controls. This is also in consonance with the behavioural traits of those with mood disorders.

Findings from the in-depth interview with health care givers also confirmed this. See extract below.

**Extracts 4: In-depth interview with a Male Psychiatric Nurse at Ile-Ife**

*...Generally many depressed patients tend to see those around them including their health givers as their enemies. This may however reduce as times goes on and as patients respond progressively to treatment regimes.*

### 5.5.3 Coping Strategies of Respondents

**Table 5.5.3: Percentage Distribution of Respondents and their adoption of positive reinterpretation and growth as coping measures.**

| Variable | Positive reinterpretation and growth | | | | | |
|---|---|---|---|---|---|---|
| | Strongly agree | Moderately agree | Neither agree Nor disagree | Moderately disagree | Strongly disagree | Total |
| **When ill I look for something good in what is happening** | | | | | | |
| **Case** | 3(3.8%) | 54(69.2%) | 13(16.7%) | 4(5.1%) | 4(5.1%) | 78(100%) |
| **Control** | 13(16.7%) | 49(62.8%) | 12(15.4%) | 3(3.8%) | 1(1.3%) | 78(100%) |
| **I try to see ill-health in a different light to make it seem positive** | | | | | | |
| **Case** | 17(21.8% | 44(56.4%) | 12(15.4%) | 3(3.8%) | 2(2.6 %) | 78(100%) |
| **Control** | 13(16.7%) | 47(60.3%) | 11(14.1%) | 4(5.1%) | 3(3.8%) | 78(100%) |
| **I try to learn something from illness** | | | | | | |
| **Case** | 3(3.8%) | 61(78.2%) | 9(11.5%) | 1(1.3%) | 4(5.1%) | 78(100%) |
| **Control** | 14(17.9%) | 51(65.4%) | 9(11.5%) | 4(5.1%) | - | 78(100%) |
| **I try to grow as a person as a result of experiencing ill-health** | | | | | | |
| **Case** | 14(17.9% | 51(65.4%) | 9(11.5%) | 2(2.6%) | 2(2.6%) | 78(100%) |
| **Control** | 16(20.5%) | 48(61.4) | 8(10.3%) | 6(7.7%) | - | 78(100%) |

**Source:** Filed Survey 2007.

The table 5.5.3 above presents respondents interpretation of their health condition. These interpretations are also embedded in patients' social milieu within the larger society and the

healing system. Respondents were asked to consider the statement "When ill I look for something good in what is happening". Among the Controls, about 1.3 percent strongly agreed, and a higher proportion moderately agreed (62.8%). A similar upward trend was observed among the Cases, only 5 percent strongly agreed, while a high proportion also moderately agreed (69.2%). Again there is an indication here that some of the Controls and the Cases considered their present condition "undesirable". Probing further, respondents were again asked how they perceive this statement "I try to see ill-health in a different light, to make it seem positive". This again generated responses similar to the above.

### 5.5.4 Coping Strategies of Respondents

**Table 5.5.4: Percentage Distribution of Respondents and their choice of religion as coping strategy.**

| Variable | Turn to religion | | | | | |
|---|---|---|---|---|---|---|
| | Strongly agree | Moderately agree | Neither agree Nor disagree | Moderately disagree | Strongly disagree | Total |
| **I seek God's help** | | | | | | |
| **Case** | 2(2.6%) | 24(30.8%) | 5(6.4%) | 21(26.9%) | 26(33.3%) | 78(100%) |
| **Control** | 5(6.4%) | 8(10.3%) | 3(16.7%) | 27(34.6%) | 25(32.1%) | 78(100%) |
| **I put my trust in God** | | | | | | |
| **Case** | 4(5.1%) | 19(24.4%) | 7(9.0%) | 23(29.5%) | 25(32.1%) | 78(100%) |
| **Control** | 18(23.1%) | 17(21.8 %) | 5(6.4%) | 20(25.6%) | 18(23.1%) | 78(100%) |
| **I try to find comfort in my religion** | | | | | | |
| **Case** | 6(7.7%) | 24(30.8%) | 6(7.7%) | 18(23.1%) | 24(30.8%) | 78(100%) |
| **Control** | 19(24.4%) | 20(25.6%) | 7(9.0%) | 13(16.7%) | 19(24.4%) | 78(100%) |
| **I pray more than usual** | | | | | | |
| **Case** | 8(10.3%) | 16(20.5%) | 23(29.5%) | 20(25.6%) | 11(14.1%) | 78(100%) |
| **Control** | 15(19.2%) | 19(24.4%) | 13(16.7%) | 23(29.5%) | 8(10.3%) | 78(100%) |

**Source:** Filed Survey 2007.

The table 5.5.4 contains the distribution of respondents and their adoption of religion as a coping measure for their health problem. Religious coping refers to the use of religious beliefs or practices to cope with stressful life circumstances (Koenig, Cohen, Blazer, et al, 1992; Pargament, 1997). Examples of religious coping include prayer, seeking comfort from one's faith, and obtaining support from members of a church or Mosque. As earlier reported information on respondents' religious affiliation shows Christianity (82.1%) and 71.8 percent as predominant religion among the Cases and Controls respectively, while 17.9 and 28.2 percent among the Cases and Control indicated Islam. Religion has a lot of influence on individual's perception and reaction to life events including health related problems such as depression and chronic illnesses. This belief system also comes into play in patients' reactions to treatment and their expectations of gaining recovery.

Hence, respondents were asked to respond to the statement 'I seek God's help'. About 66.7 percent of the Controls strongly and moderately disagreed that they sought God's help in their pursuit of recovery. A similar percent was also recorded among the Cases as 60.2 percent strongly and moderately disagreed that they sought God's help in their predicament. In contrast, 16.9 percent of the Controls moderately and strongly agreed, while about 34 percent of the Cases moderately and strongly agreed. There is an indication that more of the Cases than the Control have belief in and sought God's intervention in their search for solutions to their health problems.

Seeking and believing in God for help also entails putting their trust in God's ability to meet such expectations. Among the Controls, about of 48.7 percent both strongly and moderately disagreed and a similar percent also in this group strongly and moderately agreed (44.9%) that their trust was in God. However, among the Cases, there was a percentage

difference of 17.4 per cent as 61.6 per cent strongly and moderately disagreed that their trust was in God.

For further clarification, respondents were asked if they found comfort in their religion and their current prayer life. Going by the percentage distribution in the above table, it will be observed that 50 percent of the Controls strongly and moderately agreed that they found comfort in their religion. However, an appreciable proportion (41.1%) among this group also indicated that they strongly and moderately disagreed that they found comfort in their religion. In contrast, about 53.9 percent of the Cases strongly and moderately agreed that they found comfort in their religion. Again a high proportion (53.9%), also indicted that they moderately and strongly disagreed that they found comfort in their religion.

Furthermore, respondents' were asked questions in order to better understand their religious coping measures. As such they were asked if they pray more than usual ever since the inception of their health problem. If there were delays in the expected healings or recoveries are not forthcoming, this might have affected the prayer lives of such sufferers. Among the Control, 43.6 percent strongly and moderately agreed that they pray more than usual, while about 40 percent also moderately and strongly disagreed that they pray more than usual as a result of their present health problem. The Cases were similar in their views, 30.8 percent strongly and moderately agreed that they now pray more than before, about 29 percent neither agreed nor disagreed, while about 40 percent moderately and strongly disagreed with the statement that they now pray more than usual.

In the final analysis, it is worthy to note that despite the similarities adopted in 'matching' the Cases and the controls, certain differences were observed in respondents characteristics that could have predisposed those in the Cases more to depression than those in the control group. The age categories of the respondents show that 48.7 percent of the Controls are

within the ages of 41-60years. This indicates that more than half of the Controls are likely to be working, economically independent and as well have a high level of social supports from their significant others such as their children, co-workers, relatives and among others. When the proportion of Cases within the age category of 41-60years is compared, it was observed that about 28.2 percent of them were in this age category. This implies a more proportion of Cases within age 18-40years (71.8%) and a reversal of some of the social resources that could minimise reactions to stressful life events when exposed to such events. It could be possible that many of the old adult (41-60 years) in the control group enjoy more social supports from their children, siblings and other significant others. Such social supports may not be available at the same quality to the young adults (18-40years) in the Case group who also accounted for the highest proportion of depressive cases.

Additional information on the Cases occupational status before illness revealed that 30.8 percent were Teachers, 21.8 percent were students and 17.9 percent were Civil Servants. When compared to the Control, there was a slight variation as traders accounted for about 25 percent; civil servants were about 24 percent and Teachers about 18 percent. Further information on respondents' perception on the influence of their life styles also indicated some levels of difference. Respondents were asked what they considered as unhealthy life style and the following responses were given: alcohol, lack of exercise, poor diet, and substance abuse. Among the Controls, 26.9 percent felt there was a link between depression and alcohol consumption, while about 21.8 per cent of those in the Case group also supported a link between alcohol and their illness. Lack of exercise was acknowledged by 24.4 per cent of the Controls, while about 32.1 per cent of those in the case group also perceived a link between their illness and lack of exercise.

Lastly, a higher proportion (23.1%) of the Controls perceived substance abuse to be associated with this illness than the 20.5 percent in the Case group that perceived such relationship. It appears that patients' in the Control group perceived a level of responsibilities patients should possess in safeguarding their health than those in the Case group. Based on this, it is assumed that patients in the Control group might have developed such perception as a result of accepting health caregivers' explanations on the aetiology of depression and therefore become more conscious of working towards good health condition than those in those in the Case group who in this study revealed a mixed orientation on their illness aetiology.

## 5.6 Test of Hypotheses

This section is focused on the testing of the study hypotheses. The major assumption in this study is that there are social stressors which predispose adults to depressive states. Therefore, the following hypotheses were tested:

**Hypothesis 1: A** higher proportion of younger adults are more likely to be depressed than older adults.

**Table 5.6.1: Percentage distribution of respondents by age groups and nature of health problem**

| Variable | Case | Control | Total | Sig. Test |
|---|---|---|---|---|
| 18-40years | 56(71.8%) | 40(51.3%) | 96(61.5%) | $X^2$ =6.933 P= 0.008 |
| 40-60years | 22(28.2%) | 38(48.7%) | 60(38.5%) | |
| **Total** | 78(100.0%) | 78(100.0%) | 156(100.0%) | |

**Source:** Filed Survey 2007.

Information relating to respondents age and nature of health problem as depicted in table 5.6.1 above indicates about 71.8 percent of the Cases within the ages of 18-40 years(young adults) account for well over two thirds (71.8%) of depression. Again, many respondents within this age group are also married with dependants to cater for. Interestingly, this age group also had a very high prevalence of depressive symptoms as earlier predicted. Generally, it is important to note that many of those within the age category of 18-40 years constitute a large proportion of the Nigerian youths, graduates who would be job seekers or

be in the workforce and most of them could end up to be government employees. In recent times, government and their employees have been on logger heads on the need to make workers wages commensurate with the economic and social realities of the day. Furthermore, among the Cases, old adults (41-60years) accounted for less than one third of the depressive cases reported. In contrast to the Controls, (51.3%) of the adults(18-40 years) had other health problems, while about 48.7 percent of the Controls were within the ages of 41-60 years. Although, young adults among the Controls also accounted for more than 50 percent of other health problems reported ,but the difference between the young and the old adults in the Control was minimal(3.6%) when compared to the difference(20.5%) observed between the young and old adults in the Cases.

When one compares the above results, it becomes obvious that the largest proportion of reported cases of depression at the teaching hospitals within the study period were found among the young adults within the ages of 18-40 years who accounted for over two thirds of the total number of cases sampled. Hence, an inference could be drawn based on the chi-square value = 4.35 and $P < .05$ above, that many young adults would have more depressive cases than old adults. The hypothesis that a higher proportion of young adults are more likely to be depressed than older adults is thus accepted.

**Hypothesis 2:** Adults on a higher socio-economic level (education and occupation) will suffer more depressive symptoms than those on a lower rung of the socio-economic ladder.

**Table 5.6.2: Percentage distribution of respondents by nature of health problem, level of education and occupational status before ill health.**

| Variable | | Case (N=78) | Control (N=78) | Total (N=156) | Sig. Test |
|---|---|---|---|---|---|
| Level of education | None/Low | 10(12.8%) | 12(15.4%) | 22(14.1%) | $X^2 = 0.212$ |
| | Minimum/High | 66(84.6%) | 68(87.2%) | 134(85.9%) | P= 0.645 |
| Occupation before ill health | Civil servant | 14(17.9%) | 18(23.1%) | 32(20.5%) | $X^2 = 7.944$ |
| | Clergy | 1(1.3%) | 1(1.3%) | 2(1.3%) | P= 0.439 |
| | Farming | 1(1.3%) | 1(1.3%) | 2(1.3%) | |
| | Retiree | 1(1.3%) | 4(5.1%) | 5(3.2%) | |
| | Self employed | 5(6.4%) | 8(10.3%) | 13(8.3%) | |
| | Student | 17(21.8%) | 12(15.4%) | 29(18.6%) | |
| | Teaching | 24(30.8%) | 14(17.9%) | 38(24.4%) | |
| | Trading | 13(16.7%) | 19(24.4%) | 32(20.5%) | |
| | Unemployed | 2(2.6%) | 1(1.3%) | 3(1.9%) | |

**Source:** Filed Survey 2007.

Table 5.6.2 reveals that a high proportion of the Cases (84.6%) and Controls (87.2%) posses minimum/high level of education. Only a small percent of Cases (12.8%) and Controls (15.4%) had none/low education, indicating a low patronage of the hospital by less educated adults. On the other hand, Cases (84.6%) and Controls (87.2%) with minimum/high level of education may find it relatively easier seeking treatments at the Teaching hospitals when confronted with health problems. However, it will be necessary to note that education alone may not be sufficient to be the only factor influencing the choice of treatment. There are other factors such as background of the patient, patient's perception of the illness and the social situation (DiMatteo & Friedman, 1982), in addition to other external factors such as access to such facilities.

Occupational distribution of respondents also shows three occupations, teaching (30.8%), Students (21.8%) and civil servants (17.9%) accounting for over one third of the health problem reported among the Cases. Among the Controls, 24.4 percent were traders, about 23 percent were civil servants, 17.9 percent were teachers and 15.4 percent were students. As earlier stated, many of the Cases (53.8%) and Controls (52.6%) had post secondary education at one level or the other. Many of the Cases with post secondary education that are teachers (30.8%) and civil servants (17.9%), are likely to be governments' employees who simultaneously are earning wages far below what could sustain them and their families. The students who also constitute 21.8 percent of the Cases on their parts may be exposed to different risk factors. Among the Controls Trading took the lead (24.4%) and was followed by the civil service (23.1%). It is obvious that a slight variation was found in the proportion of employees (48.7%) and students (21.8%) in the Cases than the Control group were employees were 41.0 percent and students were 18.6 percent. As such more of the Cases may

be having difficulty in meeting certain social obligations, but with little resources available to them especially as their earning powers and other social resources may also be closely tied to their occupational status before their ill-health.

From the foregoing, findings on occupational status and educational levels of respondents show that some of the Cases than the Controls are into some occupations that may be fetching them low social and economic resources. However, the Chi-Square values on level of education and health problem at 0.05 level of significance indicates $x^2$ =0.212, P>.05, while occupational status before illness also shows $x^2$ =7.944, P>.05. These imply that no statistical significant relationship exist between respondents socio-economic status (education and occupation) and the prevalence of depression.

**Hypothesis 3:** Depression will be more pronounced among married than unmarried adults.

**Table 5.6.3: Percentage distribution of Respondents by marital status and health problem**

| Variable | | Case | Control | Total | Sig. Test |
|---|---|---|---|---|---|
| **Marital status** | Married | 56(71.8%) | 60(76.9%) | 116 (74.4%) | Chi-square $X^2$ =.053 P = .463 |
| | Single/Unmarried | 22 (28.2%) | 18 (23.1%) | 40 (25.6%) | |
| | Total | 78 (100.0%) | 78 (100.0%) | 156 (100.0%) | |

**Source:** Filed Survey 2007.

Marital status of respondents was also investigated to gain better understanding on their socio-demographic characteristics. The above table shows that married (both males and females) were more than two thirds (71.8%) of the Cases and the unmarried were about 27

percent. There were about 76.9 percent of married adults among the Controls, while 23.1 percent were unmarried. Going by the earlier information on age groups of respondents it is not a surprise that over 70 percent of the Cases are married.

However, it becomes obvious that many of the Cases who are married possessed either post secondary or secondary education and were likely to be either teachers or civil servants. The occupational status of the Cases before illness as well as other factors such as the quality of marriage and quality of social networks of support, among other factors may have precipitated depression among them than the Controls. Furthermore, Chi-square test also confirms that there was no significant relationship between respondents' marital status alone and depression as the chi-square value $X^2 = .057$, P = .811 at 0.05 level of significance. It is important to note that although there was no significant difference between marital status and depression, however, married adults(71.8%) were predominant in the Cases and most of them are also females(58.6%) compared to the Controls were more were married(76.9%), but males were about 62.1 percent.

Findings from the in-depth-interviews also recorded that many psychiatrists who care for these patients also perceive a high preponderance of depression among married adults especially among females.



**Extract 5:In-depth interview with a female Psychiatric at Ile-Ife**

*… Well it is obvious in recent times that many of the patients with depression are married and many of them are usually females. Females by their biological make up have some hormones that distinguish them from males…*

*…However, it should be pointed out that depression aetiology cannot be traced to a single factor; but marriage could serve as precipitating event or protective event depending on*

*other factors (internal or external) acting on couple's experiences in marriage. Generally, some studies have confirmed a high prevalence among married females that have experienced negative marital events two to three weeks before their first episode…*

Hence, based on the above and the test of statistical significance, it may be difficult to conclude that marital status of the Cases have made some of them to be more prone to depression than the Controls. Furthermore, an explicit relation may be difficult to establish between marriage and depression. Marriage at time could serve as precipitating factor in the onset of abnormal behaviour or could also have cushioning effects to life stressors as well as marital stressors at times (Cockerham, 2000). In Kessler, Price and Worthman (1985) submissions, interpersonal conflict within a marriage can hardly be subsumed into a linear phenomenon as it is often in a web, and swings back and forth between bliss and misery.

**Hypothesis 4:** A higher proportion of the older adults will adopt religious coping mechanisms to depression than younger adults.

**Table 5.6.4: Percentage distribution of Younger and Older Depressed Respondents by Religious coping measures**

| Variable | Religious coping measures and depression | | | | | | |
|---|---|---|---|---|---|---|---|
| | Strongly agree | Moderately agree | Neither agree Nor disagree | Moderately disagree | Strongly disagree | Total | Sig. Test Chi-Square |
| **I seek God's help** | | | | | | | |
| 18-40 years **Case** | 18(32.1%) | 23 (41.1%) | 6(10.7%) | 8(14.3%) | 1(1.8%) | 56(100%) | $X^2$=6.5 P=.16 |
| **Control** | 11(27.5%) | 10(25.0%) | 5(12.5%) | 9(22.5%) | 5(12.5%) | 40 (35.7%) | |
| 41-60 years **Case** | 10(45.5%) | 11(50.0%) | - | - | 1(4.5%) | 22(100%) | $X^2$=8.5 P=.07 |
| **Control** | 7(18.4%) | 9(23.7%) | 7(18.4%) | 9(23.7%) | 7(18.4%) | 38(100%) | |

Source: Field Survey, 2007

**Table 5.6.4: Percentage distribution of Younger and Older Depressed Respondents by Religious coping measures**

| Variable | Religious coping measures and depression | | | | | | |
|---|---|---|---|---|---|---|---|
| | Strongly agree | Moderately agree | Neither agree Nor disagree | Moderately disagree | Strongly disagree | Total | Sig. Test Chi-Square |
| **I put my trust in God** | | | | | | | |
| 18-40 years **Case** | 5(8.9%) | 14(25.0%) | 4(7.1%) | 19(33.9%) | 14(25.0%) | 56(100%) | $X^2$=10.32 P=.03 |
| **Control** | 13(32.5%) | 14(25.0%) | 4(7.1%) | 19(33.9%) | 2(5.0%) | 40(100%) | |
| 41-60 years **Case** | 2(9.1%) | 5(22.7%) | 4(18.2%) | 4(18.2%) | 7(31.8%) | 22(100%) | |
| **Control** | 10(26.3%) | 7(18.4%) | 5(13.2%) | 8(21.1%) | 8(21.1%) | 40(100%) | $X^2$=2.38 P=.66 |
| **I try to find comfort in my religion** | | | | | | | |
| 18-40 years **Case** | 6(10.7%) | 19(33.9%) | 3(5.4%) | 15(26.8%) | 13(23.2%) | 56(100%) | $X^2$=11.46 P=.022 |
| **Control** | 15(37.5%) | 14(35.0%) | 4(10.0%) | 5(12.5%) | 2(5.0%) | 40(100%) | |
| 41-60 years **Case** | 3(13.6%) | 5(22.7%) | 4(18.2%) | 3(13.6%) | 7(31.8%) | 22(100%) | $X^2$=11.46 P=.08 |
| **Control** | 9(23.7%) | 9(23.7%) | 4(10.50%) | 7(18.4%) | 9(23.7%) | 38(100%) | |
| **I pray more than usual** | | | | | | | |
| 18-40 years **Case** | 4(7.1%) | 11(19.6%) | 14(25.0%) | 19(33.9%) | 8(14.3%) | 56(100%) | $X^2$=4.83 P=.30 |
| **Control** | 9(22.5%) | 7(17.5%) | 9(22.5%) | 11(27.5%) | 4(10.0%) | 40(100%) | |
| 41-60 years **Case** | 4(18.2%) | 5(22.7%) | 9(40.9%) | 1(4.5%) | 3(13.6%) | 22(100%) | $X^2$=11.18 P=.025 |
| **Control** | 6(15.8%) | 12(31.6%) | 4(10.5%) | 12(31.6%) | 4(10.5%) | 38(100%) | |

**Source:** Filed Survey 2007.

Table 5.6.4 above shows the use of religion as coping measures as a general phenomenon among the young and old adults in the Cases and Control group. All the respondents indicated their religious affiliation. Respondents' opinions in relation to religious coping measures were asked. On the average, about 73.2 percent of young adults (18-40years) in the Cases strongly and moderately agreed that they sought God's help for their situation. Similarly, more than 90 percent of the older adults (41-60years) in the same group also indicted that they both strongly and moderately agreed with the statement 'I seek God's help concerning my health situation'. Among the Controls, about 52.5 percent of young adults (18-40years) moderately and strongly agreed that they sought God's help for their situation. Similarly, about 42.1 percent of the older adults (41-60years) in the same group also indicted that they either strongly agreed or moderately agreed with the statement 'I seek God's help concerning my health situation'. Responses of the Cases and Controls to the above statement indicated an inclination to seeking God's help among the old adults in the Cases than the old adults in the Control group.

In further probing, respondents were asked to react to another statement, "I put my trust in God". Again, about 34 percent of young adults in the Cases strongly agreed and moderately agreed that they do, while above 30 per cent of old adults also strongly agreed and moderately agreed that their trust was in their God. Among the Controls, 57.5 of the young adults (18-40years) strongly and moderately agreed that they put their trust in God concerning their situation, while about 44 percent of the old adults in the same group said they did. Respondents were further asked to consider if they found comfort in their religion. In reaction to this, more than 40 percent of young adults among the Cases both strongly and moderately agreed, while 32 percent of old adults within the group strongly agreed and

moderately agreed with the statement. In contrast, a higher proportion (72.5%) of young adults indicated that they strongly and moderately agreed with the statement, while about 56 percent of old adults within the group strongly and moderately agreed.

Finally, respondents were asked questions relating to their prayer life. This was considered necessary to see if some of them are becoming weary due to delay in getting over their health problems or fear of relapse. It is obvious that quite a number of the respondents have perceived their prayer life to be diminishing. About 50 percent of the Cases that were young regarded themselves as not praying hard, while close to 50 percent of old adults among the Cases indicated that they were not praying more than usual. However, among the Controls, about 50 percent of both the young and old adults agreed that they were praying more than usual.

From the above findings, it is obvious among the Cases that a high proportion of the young adults' faith (58.9%) and prayer life (48.2%) may have become weakened when compared to that of the young adults (18-40 years) in the Control. This may not be unconnected with their previous experiences in search for solutions to their health problem. Previous success or failure in their quest for recovery could have affected their faith in such healing system including spiritual healing. The above findings are similar to Karp (1994) findings among severely depressed individuals. He argued that depressed individuals sense something wrong around them, but find it difficult to focus on what it is. They feel they must distance themselves from other people. They may try to offset their symptoms with exercise, meditation and different forms of spirituality. However, as soon as these efforts fail, a reinterpretation of the cause of their depression is sought and a resultant diminished optimism for cure.

However, a slight variation could be observed, among the Cases as old adults sought God's help than the young adults and the significance test also indicted a statistical relationship between the age of those in the study group and their decision to seek help from God ($X^2 = 22.59$, $P < .05$). A similar difference was also observed in their attitudes to prayers. More old adults were observed to be significantly different($X^2 = 11.18$, $P < .025$) from the young adults in the search for solutions to their health problem. Based on the above two findings, it may be statistically significant to conclude that there is a significant difference in the degree of religious coping measures of both young and old adults; thus, the hypothesis that more of the older adults will adopt religious coping mechanisms to depression than younger adults would be accepted.

**5.7 Discussion of the Major Findings**

The study showed that among the Cases a higher proportion of the adults were within the age group of 18-40 years (71.8%) than those within ages 41-60 years (28.2%). This finding is similar to the WHO sub-regional prevalence by age group of depressive episodes on Nigeria (see table 1, page 21). Unfortunately, adults within this social category also constitute a major share of the nation's labour force. However, factors such as high rate of unemployment, poor remuneration of government employees in Nigeria among others factors may have contributed to the sorrowful situation of young adults as they are socially expected to fulfil certain obligations without the necessary resources.

Among the Cases there was younger married adult's age 18-40 years (71.8%) compared with the Control group (51.3%). Related studies have partially attributed the variation in marital status, age and depression to how couples communicate and solve problems (Christensen & Pasch, 1993). Monroe (2001), had earlier argued that the newlywed phase

(where many of the married young adults fall into) may be more vulnerable to stressors during the early stages of marriage because their conflict resolution skills are more likely to be less developed compared to older couples.

The preponderance of depression among married adults in the study group (case) indicates that many Nigerian families are going through tough times and there appears to be a shrinking supply of the needed social support that could cushion the effects. The western ideology of individualism rather than the collectivism noted among the Cases is increasing as it shows in the preference for monogamous forms of marriage. Many of the Cases found it difficult to believe those around them as many preferred 'holding up' to 'opening up'. Marital status alone might not be sufficient to immune individuals from depression. Some studies have shown marital quality as an intervening factor: so it is not an issue of being married or not but the quality of the marriage (e.g. Cano & O Leary, 2000; Cano, 'Leary, 2000; Cano, & O'Leary, 2002; Christian- Herman, et al, 2001; Cano, O 'Leary, & Heinz, 2004; Cockerham, 2000; Kessler, Price & Worthman, 1985).

Again, it appears that civil servants, teachers and students are more in the study group (cases) than the Control. This indicates that many civil servants especially teachers amongst the Cases are going through hardships. Reasons for this may not be far from the poor remuneration of teachers in Osun State and Nigeria in general. Furthermore, previous and recent economic reforms may have impacted on some families negatively thereby predisposing some to depressive symptoms. The students like their teachers may also be going through series of hardships as poor funding of the Nigeria educational system has been widely reported. Scholarships and bursaries have become scarce and many of the essential materials to making learning more interesting are now luxury to students from poor economic background. The dilemma of the Nigerian students does not just end within the

four walls of the school. Those who succeed in graduating still have to conquer the fear of unemployment in the absence of social security.

Further findings revealed mixed interpretations of depression aetiology among the Cases. About 79.5 percent of the Cases indicated stressful life events, a similar proportion (79.5%) reported they had no idea, 40 percent attributed their health problem to genetic inheritance, and a similar proportion indicated unhealthy life style and perceived loss of spirituality (lack of contact with God,) as the factors responsible for their problems. Compared to the Control, about 43.6 percent attributed depression to stressful life event, while 38.5 considered the health problem as a product of unhealthy life style and a high proportion (48.7%) strongly and moderately agreed that they had no idea about the cause(s) of depression.

Finally the continuous relevance of patients' religious affiliation was again obvious as many of the Cases and Controls who adopted instrumental or social support measures still clung to religion to make their measures effective. Relatively, old adults among the Cases were found to be more inclined to religious measures as coping mechanisms than the young adults in the group, while such difference could not be found among the old adults in the Control group However, it was obvious that more of the young adults in the Case have lost faith in God and pray less than before compared to the young adults in the Control group. Religion is yet to be integrated into the care for mental health patients in many Nigerian teaching hospitals. This may be associated with the kind of orientation modern psychiatrist are given through training. While modern hospital system may not yield readily to incorporating patients' religious beliefs into their care, patients' perspectives remain crucial if effective care is seriously considered relevant. There is obviously a need for a more holistic health care system (particularly in the area of mental health and depression) which will emphasize patients' religion in the care process.

# CHAPTER SIX

# SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

The last chapter presents the study findings based on the quantitative and qualitative approaches adopted in generating the relevant data. Explanations on the research hypotheses were presented which informed the acceptance or rejection of some hypotheses. This last chapter, however, presented a summary of all the major findings, developed linkages between findings and current thinking on depression among adults in an emerging economy and the implications on health policy formulation. Recommendations are also provided in this direction on ways to further meet the increasing health demands and needs of adults in line with the increasing disease burden in Nigeria.



## 6.1 Summary

Modern health care delivery in Nigeria is fundamentally anchored on the western model of health care delivery. While some levels of achievement may have been attained in meeting the health needs of the Nigerian populace through this medical model, studies have shown that there is still a gross inequality in access to qualitative health across the country. The above background becomes worrisome when the increasing disease burden facing the Nigerian populace is examined. The disease burden facing many African nations have not only affected their economic growth and development, but has also incapacitated the continent in the search for solutions to the lingering problem of poverty which could be linked to poor health and low life expectancy. Depression has become prevalent in many developing nations among other diseases and it has been predicted that it will be the second

leading cause of morbidity and mortality globally by the year 2020(Global Burden of Disease Study Project, 2000).

The major objective of this study was to undertake a sociological investigation of adult patients with depression seeking treatment at the Obafemi Awolowo University Teaching Hospitals complex. Based on the above objective and a search through the literature, assumptions were made and hypotheses generated to examine the problem of depression from the patients' perspective, and that of the health care givers. Information was also obtained from patients' records. The assumptions are made with consideration to available evidence on depression and adulthood in an emerging economy. In reviewing the literature, adept attention was paid to the variations in the models on depression aetiology. The increasing relevance of the psychosocial and social stressor models in the illness aetiology was also described. These two models were used in describing depression aetiology, moderating variables as well as explaining illness behaviour and the process of recovery into sound health status.

The predispositions of patients to depression emanating from external factors such as socio-economic and cultural factors were given consideration. The social stressor model as well as the political economy theory were both integrated and employed in creating a theoretical base for explaining and interpreting depressive symptoms among adults. The assumptions of these two perspectives also influenced the primary thesis of this study, which is patients suffering from depression are predisposed to such states by external variables such as socio-cultural, economic and political and religious factors.

The methods of data collection included questionnaire, in-depth interviews and case notes of clinically diagnosed depressed patients. The primary data was collected personally by the researcher, assisted by four field assistants. The case notes of the Clinically Diagnosed

depressed Patients case notes were selected with the assistance of medical students in their clinical years.

### 6.2 Summary of the Major Findings

The study revealed that a higher preponderance of young adults (18-40 years) in the Case group accounted for about 71.8 percent of the depressive conditions reported, while among the Controls, young adults (18-40 years) accounted for about 51.3 percent of all other health problems reported under the study period. There were more married females in the Case group (58.6%) than in the Controls (41.4%). High proportions of the Cases (53.8%) and the Control (52.6%) had post secondary education, while, about 7 percent of Cases and 12 percent of Controls had primary education. Majority of the Cases (82.1%) and Controls (71.8 %) indicated Christianity as their religion, while 17.9 percent of the Cases and about 28 percent of the Controls indicted Islam. About 59 percent of the Cases and 69 percent of the Controls had monogamous families, while slightly above 14 percent of Cases and only 9 percent of the Controls practice polygyny. Occupation-wise, teaching was the predominant occupation (24.4%) among the two groups. Among the Cases, 30 percent were Teachers, while 17 percent were Teachers in the Control group. More Civil Servants (23.1%) were found among the Controls than the Cases (17.9%). On the average, about 45 percent of the respondents in both groups were employees.

Knowledge of the Cases on the aetiology and whether or not their health problem was curable varied. About (79.5%) of the Cases strongly and moderately agreed that there was a link between their illness and negative life events, while (43.6%) of the Controls also linked depression to stressful or negative life events. A higher proportion (79.5%) of the Cases than the Controls (48.7%) had no idea about the cause(s) of depression. Among the Cases (40%)

linked depression to biological factors, (39.8%) to unhealthy life style, and (34.6%) to loss of spiritual core, while (82.1%) of the Controls strongly and moderately disagreed that there could be a genetic link and about (52.6%) associated depression with unhealthy lifestyle. About 34.6 percent of the Cases viewed their health problem as being associated with losing touch with their spiritual core or faith in God. Again less than one quarter (11.6%) of the Controls moderately and strongly disagreed with the statement as regards this health problem. Up to 70 percent of the Cases moderately and strongly disagreed that there was a cure for their illness, while about 51.3 percent of the Controls felt otherwise. About 65 percent of the Cases considered drug use as burdensome; only (42.3%) of the Controls shared a similar view. Furthermore, respondents' views on chances of recovering from depression revealed that close to two thirds of the Controls strongly and moderately agreed that there was a cure for the health problem. On the other hand, more than two thirds of the Cases moderately and strongly disagreed that there was a cure for their health problem. This implies that about 78.5 percent of the Cases seeking treatments through orthodox medicine still felt unsure of regaining their health, although observations from the patients' case files showed that many of the Cases were brought to the hospitals by their significant others which may be against the patients' will at times.

Further probing showed that about 52.6 percent of the Controls moderately agreed that depression could be better treated in the hospital. Among the Cases, a high proportion neither agreed nor disagreed (59.0%). Respondents were also asked if they thought depression could be better treated through traditional medicine. Among the Controls, about 50 percent strongly and moderately agreed with the statement. For the Cases, less than one quarter strongly and moderately agreed that their health could be better treated through alternative medicine.

Among the Controls, overwhelming proportion reported regular drug use as 61.5 percent moderately agreed that they use their drugs regularly. Among the Cases, their attitude was indifferent as more than 70 percent also moderately agreed with the statement. Some of the respondents considered the use of some of their drugs as a stressful obligation. A relatively high percentage of the Controls strongly and moderately agreed (42.3%), while about 43.3 percent moderately and strongly disagreed that using some drugs was too stressful. However among the Cases, an appreciable percentage felt using some of their drugs were burdensome, as about 64 percent moderately agreed. These findings showed mixed feelings of respondents' perception of whether or not their use of prescribed drugs was burdensome. Further probing also showed that more of the Cases than the Controls have lost interest or hope in the efficacy of the drugs as an adequate measure of regaining their health, some still believed that their compliance to prescribed drugs through regular use could be of benefit to their health. Other findings also showed that about 26 percent of the Controls strongly and moderately agreed that they hated coming for clinical appointments. Slight variations were observed among the Cases, as about 51.2 percent strongly and moderately agreed that they hate going for clinical checkups. Findings on patients' information seeking and sharing indicated that quite a number of the Cases than the Controls were not prone to accepting information from those they knew and who have had similar health challenges like theirs.

On religious coping measures, it was found that more of the Cases than the Control have belief in and sought God's intervention in their search for solutions to their health problems. About 50 percent of the Controls strongly and moderately agreed that they found comfort in their religion. In contrast, about 53.9 percent of the Cases strongly and moderately agreed that they found comfort in their religion. Again a high proportion (53.9%), also indicted that they moderately and strongly disagreed that they found comfort in their religion.

## 6.3 Conclusion

From the foregoing, achieving leverage on the increasing disease burden especially the problem of depression among adults at the hospital setting will require consideration for patients' perspectives on their depression. Patients' perception of multi-causal factors especially the role of negative life events ,unknown factors, biological, unhealthy life style and loss of spiritual core as being responsible for their ill-health calls for a reconsideration of depression treatment modalities. Reckoning and implementing the values which old adults among the Cases have placed on religion may be achievable if incorporated into the treatment process. Although incorporating religion into the overall care for the depressed may be difficult to practise going by the secularity of the Nigerian populace, nevertheless, this is a reality that has come to stay.

Furthermore, the perception of drug use as burdensome by some of the Cases may influence negatively their compliance to drug treatment. In view of this, the use of multiple treatment modalities especially psychotherapy may serve multi functions towards patients' recovery. Similarly, the diminishing interest of the Cases in keeping to clinical appointments may have further implications on the relapse of depression in some circumstances as observed through the Cases medical records.



## 6.4 Policy Implications

Health care givers need to understand the complexity of the nature of depression as experienced by individuals and those who work with them towards resolving patients' concern. While prescription of drugs is relevant to gaining recovery, constant efforts should

be made to interact with patients especially when they visit for check up so that their experiences with some of the drugs can be aired.

Since drug treatment was frequently mentioned by the Cases and the Health Care givers relevant in the effective treatment of depression coupled with the absence of social securities for mood disordered patients, it may be paramount for the Government to subsidise the essential drugs needed by those suffering from one psychotic disorder or the other.

There is also an urgent need to address the economic hardships which teachers, students and civil servants are facing especially if the Nigerian government is serious about the health related goals of the Millennium Development Goals and reducing disease burden in Nigeria. Over the years most government policies including the ones affecting workers welfare have been done without consideration for any input from those who the policy is meant for. A good example is the incessant increase in premium spirit (petrol) price without adequate consideration for the likely effects on individuals and households in terms of affordability and access to quality health care service. Adequate funding of education is paramount. Scholarships and more bursaries may be helpful in minimising the financial burden on students. Although, this may not answer questions of substance abuse among students, it can be catered for by providing functional counselling services for students at all levels.

Lastly Marriage counsellors also need to be better informed on what aspiring husbands and wives should know about marriage. It is obvious that many marriages in Nigeria are contracted accidentally by virtue of unwanted pregnancy or other factors, thus making many young adults unprepared for marriage challenges; they thus easily fall prey to marital stressors when these begin to emerge.



### 6.5 Recommendations for Further Research

This study is focused on providing a sociological analysis of adult patients with depression at the Obafemi Awolowo University Teaching Hospitals. The study has revealed that more issues are still unclear. Obviously this study has some limitations such as sample size, time frame, finance and the type of population studied, necessary issues on depression and adulthood in an emerging economy cannot be covered by a single researcher.

In view of the above, there is need for further research based on a wider sample and possibly in other cultures of the Federation as the demands or societal expectations on men and women tend to vary across cultures. Such demands could put additional stress/burden on men and women.

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## APPENDIX 1

## QUESTIONNAIRE

**SOCIOLOGICAL ANALYSIS OF DEPRESSED PATIENTS IN OAUTCH, OSUN STATE, NIGERIA.**



Dear Respondents,

The researcher is a post-graduate student in the Department of Sociology/Anthropology. The study is focused on understanding depression among married adults from a Sociological perspective. It would be appreciated if you could spare some time. For emphasis, this research is been carried out for academic purpose alone. All information given will be treated in strict confidence.

Thank you for your cooperation and participation.

Yours faithfully,

Agunbiade Ojo.

Please kindly respond to the below questions by ticking were applicable, were not kindly supply further information.

**SECTION A: Socio-Demographic and Economic Characteristics of Respondents.**

1.Sex Male ( ) .Female ( )

2. Age of respondent…….

3a.Level of Education: None ( ) Primary ( ) Secondary ( ) Post Secondary ( )

3b.No years spent in school……

4a. Religion .Christianity ( ) .Islam ( ) .Traditional ( ) .Others please specify…….

4b.Level of religiosity. Very Committed ( ) Slightly Committed ( ) Committed ( )

Not committed( )

5. Type of marriage. Monogamy( ) Polygyny ( )

6. Occupation .Please specify……

7. What is your source of income? Please kindly specify…….

8. What is the nature of your health problem? Please specify…….

**Section B: Perceptions on causes and treatment of depression.** Using the scale below indicate the extent to which you believe each of the following factors is responsible for causing depression.

| | **Strongly agree** | **Agree** | **Strongly disagree** | **Disagree** |
|---|---|---|---|---|
| 9. Depression is as a result of a biological abnormality(for example chemical or hormonal imbalance) | | | | |
| 10. Stress or negative life experiences may cause depression. | | | | |
| 11. Loss of touch with ones my spiritual core or faith in God could cause depression. | | | | |
| 12a. Depression could arise from unhealthy lifestyle (for example, poor diet and lack of exercise). | | | | |
| 12b. Please kindly mention one unhealthy lifestyle you think affects ones health most. Please kindly specify…… | | | | |

| | | | | |
|---|---|---|---|---|
| 13.I do not have any idea about the cause(s) of depression | | | | |
| 14.There is a cure for depression | | | | |
| 15.There is no cure for depression | | | | |
| 16. Depression is better treated in the hospitals | | | | |
| 17. Depression is better treated through traditional medicine | | | | |
| 18. I am currently using both orthodox and traditional medicine | | | | |
| 19.I have used traditional medicine shortly before coming to the hospital | | | | |
| 20. I do not like using traditional medicine | | | | |
| 21. I do not like using orthodox drugs | | | | |

**Section C: Perceived Social Support scale-Friends and Family.**

**Directions:** The Statements which follow refer to feelings and experiences which occur to most people at one time or another in their relationship with **FRIENDS**, when thinking about friends; please do not include family members. For each statement there are five possible answers (1 through 4) ranging from "Strongly Agree" to "Disagree". Please tick the answer you choose for each item.

| | **Strongly Agree** | **Agree** | **Strongly disagree** | **Disagree** |
|---|---|---|---|---|
| 22. My friends give me the emotional moral support need. | | | | |
| 23. My friends are good at helping me solve problems | | | | |
| 24. When I confide in friends, it makes me feel uncomfortable. | | | | |
| 25. I don't have a relationship with a friend that is as intimate as other people's relationship with friends. | | | | |
| 26. I do not have anybody I could call a friend. | | | | |

| **Directions:** The statements which follow refer to feelings and experiences which occur to most people at one time or another in their relationship with **FAMILIES.** When thinking about family, please do not friends. For each statement there are five possible answers (1 through 4) ranging from "Strongly Agree" to "Strongly Disagree". Please tick the answer you choose for each item. | | | | |
|---|---|---|---|---|
| | **Strongly Agree** | **Disagree** | **Strongly Disagree** | **Disagree** |
| 27. My family gives me the moral support I need. | | | | |
| 28. My partner gives me the moral support I need. | | | | |
| 29. My family gives me the financial support I need. | | | | |
| 30. My partner gives me the financial support I need. | | | | |
| 31. I do not enjoy enough support from my partner like others do. | | | | |
| 32. I do not enjoy support from my family like others do. | | | | |

| **Coping Repertoires/Mechanisms.** Using the scale below indicate the extent to which you believe each of the following statements describe your coping measures | | | | |
|---|---|---|---|---|
| **A. Compliance to drugs usage/appointments/check up** | **Strongly Agree** | **Disagree** | **Strongly Disagree** | **Disagree** |
| 33. I use my drugs regularly. | | | | |
| 34. I make efforts to come for check up/appointment when due. | | | | |
| 35. I think is too stressful using some of the drugs. | | | | |
| 36. I think my situation will improve without using drugs. | | | | |
| 37. I hate coming for check up/appointments | | | | |
| **B. Seeking support for instrumental reasons** | | | | |
| 38 .I ask people who have had similar experiences what they did | | | | |
| 39. I try to get advice from someone about what to do | | | | |
| 40. I talk to someone to find out more about the situation | | | | |
| 41.I talk to someone who could do something concrete about the problem | | | | |

| **C. Positive reinterpretation and growth** | **Strongly Agree** | **Disagree** | **Strongly Disagree** | **Disagree** |
|---|---|---|---|---|
| 42. I look for something good in what is happening | | | | |
| 43.I try to see it in a different light, to make it seem positive | | | | |
| 44.I Learn something from the experience | | | | |
| 45.I try to grow as a person as a result of the experience | | | | |
| **D. Turn to religion** | | | | |
| 46. I seek God's help | | | | |
| 47.I put my trust in God | | | | |
| 48.I try to find comfort in my religion | | | | |
| 49.I pray more than usual | | | | |

50. Who would you say has been most supportive since this health problem started?

a. your spouse ( )

b. brother/sister ( )

c. mother ( )

d. father ( )

e. both parents ( )

f. any other (Please kindly specify)……

## APPENDIX II

### INTERVIEW GUIDE WITH HEALTHCARE GIVERS

**Date of interview…… Place of Interview……Time…….**

**Interviewer's Name…… Interviewee's Name……..**

**Respondent's identification number……**

**Sex 1. Male ( ) 2.Female ( ) Age at last birthday……..**

**Marital Status…….**

**Religious Affiliation…….**

**Highest qualification……**

**Present position on the job……..**

1. In your opinion what is depression?

2. As a professional in mental health what factors do you think are responsible for depression in married (i) men and (ii) women?

3. (I) How would you describe the social relationships of depressed patients?

4. Do you think there is a relationship between the number of years spent in marriage and depression among married adults?

6. Do you think the quality of marriage has any relationship with marriage and depression?

7. What coping measures do you think people suffering from depression can adopt?

8. How would describe these measures with respect to recovering from depression?

9. Is depression curable?

10. How can the problem of depression be better managed?

11. What forms of therapies do you give to those suffering from depression?

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# Mémoire de DEA

**THEME**

# Logiques, stratégies et pratiques autour de la mise en œuvre des Soins Obstétricaux et Néonatals d'Urgence (SONU) au Bénin

*(Etude réalisée dans la Zone Sanitaire de Tchaourou)*



*Présenté par* :
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*Sous la Direction d u* :
**Professeur Boubacar LY**

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# *Sommaire*

Résumé

La mortalité maternelle est un problème de santé majeure dans les pays en voie de développement. Au Bénin, les statistiques sanitaires affichent un taux de 498 décès pour 100.000 naissances vivantes en 1992. Dix ans après, ce taux n'a guère baissé malgré les différents programmes de lutte mise en œuvre dont les SONU (Soins Obstétricaux d'Urgence) constituent la principale composante. La nouvelle politique en cours après l'évaluation de 2003 et qui couvre la période de 2006 à 2015 est également basée sur la politique SONU. Or la mise en place au Bénin des SONU et de ses corollaires, s'est surtout focalisée essentiellement sur la formation des agents de santé notamment les sages femmes à l'identification et à la délivrance de soins obstétricaux d'urgence. Il s'agit du transfert d'un certain nombre de pratiques standards contenus dans des documents guides et que les professionnels doivent adopter.

L'application dans les maternités des leçons inculquées aux agents de santé, occasionne des dysfonctionnements dans le système notamment en ce qui concerne les interactions avec les usagers. Ce travail a consisté à saisir l'adaptabilité de la stratégie des SONU en rapport aux postures des acteurs en situation. C'est pourquoi il s'est intéressé aux logiques et pratiques des professionnels de la santé et des usagers qui affectent et remettent en cause l'efficacité pratique des SONU. Quels types de pratiques prônent ces normes et dans quel contexte ? Quelles en sont les modalités d'application ? Comment les acteurs s'organisent t-ils autour de cette réforme et comment ils se la réapproprient ? Quelles sont les stratégies développées et les nouvelles situations qui en découlent ?

Des données issues des investigations ainsi que l'analyse qui en découle, il ressort que les normes officielles des SONU sont réinterprétées c'est à dire mise en œuvre sur le terrain à la lumière des logiques et des stratégies propres aux acteurs. Les pratiques qui en découlent varient selon l'acteur en présence et l'objectif visé. Ainsi les uns préfèrent satisfaire les usagers au détriment du respect des normes ; tantôt à juste titre, tantôt avec des abus. D'autres par contre, appliquant avec zèle les normes avec les encouragements des supérieurs, sapent les attentes des usagers et occasionnent également des dérives. Tout ceci affecte les interactions entre agents de santé et usagers et engendre des "effets pervers".

Douleur, surmédicalisation, coût social, coût psychologique, coût économique sont le lot des usagers. Au fait les SONU qui selon l'appellation sont des soins réservés au cas urgents sont passés dans la routine des professionnels et sont automatiquement administrés à tous les cas d'accouchement.

# *Liste des sigles et abréviations*

| | |
|---|---|
| AQUASOU | Amélioration de la Qualité des Soins Obstétricaux d'Urgence |
| BONC | Besoins obstétricaux Non Couverts |
| CHD | Centre Hospitalier Départemental |
| CPN | Consultation Pré Natale |
| CS | Centre de Santé |
| DEA | Diplôme d'Etudes Approfondies |
| DSF | Direction de la Santé Familiale |
| EDS | Enquête Démographique et de Santé |
| GATPA | Gestion Active de la Troisième Phase de L'Accouchement |
| MSP | Ministère de la Santé |
| OMS | Organisation Mondiale de la Santé |
| PARSUON | Programme d'Amélioration de la Référence et des Soins d'Urgence Obstétricale et Néonatales |
| RU | Révision Utérine |
| SOE | Soins Obstétricaux Essentiels |
| SONU | Soins Obstétricaux et Néonatals d'Urgence |
| SOU | Soins Obstétricaux d'Urgences |
| SOUB | Soins Obstétricaux d'Urgence de Base |
| SOUC | Soins Obstétricaux d'Urgence Complet |
| UNFPA | Fonds des Nations Unies Pour la Population |
| UON | Unmeet Obstetric Need |
| ZS | Zone Sanitaire |

# *Introduction générale : contexte de l'étude*

Le choix du thème et du champ d'étude ne s'est pas fait ex nihilo. En effet, au cours de notre cursus professionnel à la Coopération Suisse au Bénin, nous avons eu (dans le cadre de l'appui à la zone sanitaire de Tchaourou) à participer à des débats sur la mise en œuvre de la stratégie des Soins Obstétricaux et Néonatals d'Urgences (SONU) dans la localité. Au cours d'une revue des indicateurs de résultats suivie de la restitution des résultats du monitoring du 1er semestre 2006 le 11 août 2006, il s'est avéré que dans la plupart des formations sanitaires périphériques de la zone, les taux de référence des urgences obstétricales vers l'hôpital de référence ont anormalement augmentés et dans certaines maternités, la fréquentation pour cause obstétricale a régressé. (Maternité de Bétérou 45% de taux de référence, maternité de Tchaourou, 25%, maternité de Kika, 18%).

Lors des débats, les professionnels de la Santé, notamment les sages femmes, ont justifié ces contres performances par l'avènement des SONU et GATPA dans la Zone et les activités afférentes. De même l'autorité en charge de la coordination de la zone a trouvé qu'il y a une coïncidence fâcheuse à ce niveau. Pour lui, les normes recommandent de ne pas dépasser 15% de taux de référence. Mais de plus en plus les nouvelles normes élargissent les indications de la césarienne ce qui augmente la référence. Ce sont ces débats qui ont inspirées les questions qui soutendent notre problématique dans le cadre de cette étude.

# *Première partie : Cadre Général et méthodologique*

# Chapitre 1 : Cadre Général

Ce chapitre concerne l'ensemble théorique de l'étude à savoir la problématique, les objectifs et les hypothèses, la revue de la littérature et le modèle théorique.

## 1.1 Problématique

Dans le monde, on évalue à plus de 500.000 le nombre de femmes qui, chaque année, décèdent de causes maternelles, et 99 % de ces décès surviennent dans les pays en voie de développement (De Brouwere et al, 1997). Au Bénin, le ratio de mortalité maternelle est estimé à 498 décès maternels pour 100.000 naissances vivantes. Le Ministère du Plan estimant ce ratio à 473, signale que la non communication probable de plusieurs cas signifie qu'il atteint environ 800 (EDS, 1996)[1]. Cependant en se référant aux différentes données, les indicateurs n'ont guère baissé malgré les politiques et stratégies mises en œuvre depuis 1992. L'Enquête Démographique et de Santé au Bénin de 1992 et le Recensement Général de la Population de 2002, montrent qu'il n'y a pas de différences significatives en matière de Santé de Reproduction entre les deux opérations : 498 et 474,4 pour 100.000 naissances vivantes, ce qui implique que sur 210 femmes qui accouchent, 1 femme meurt.

En 1999, une nouvelle méthodologie avait été élaborée pour fournir une autre vision de l'ampleur de la mortalité maternelle. Il s'agit de l'indicateur qui mesure les besoins obstétricaux non couverts (Bonc) ou Unmeet Obstétric Needs (UON). Cet indicateur s'obtient par le calcul des déficits en interventions obstétricales majeures pour des indications maternelles absolues. Le calcul de cet indicateur signale une répartition géographique des déficits favorisant ainsi l'identification des zones prioritaires pour l'action (Mongazi ; 2000).

Les études sur les besoins obstétricaux non couverts ont été réalisées au Bénin, et il s'est avéré qu'il y a entre autres, un énorme déficit dans le recours aux soins obstétricaux. Des disparités énormes sont relevées selon les régions et dans une même région, entre milieu urbain et milieu rural. Ainsi, le Borgou-Alibori présente un déficit global de 38% qui s'élève, dans certains milieux ruraux comme Karimama, à 96%. Même le milieu urbain n'est pas épargné dans ces départements, lorsqu'on considère les entités urbaines de Banikoara, Nikki, N'dali et Malanville qui présentent des déficits supérieurs à 70 %, laissant croire que ces hôpitaux ne remplissent pas leur rôle de structures de référence. Dans les Zou et Collines, le

[1] Enquête Démographique et de Santé

déficit est de 6% avec un pic de 36% à Zogbodomey. Même à Abomey où il y a le Centre Hospitalier Départemental (CHD), on constate un déficit allant jusqu'à 24%. L'Ouémé-Plateau affiche un déficit moyen de 36% qui va parfois à 63% avec la zone sanitaire Kétou-Pobè (Coopération Suisse au Bénin, 2002).

La lutte (si l'on peut parler en ces termes) contre la mortalité maternelle au Bénin n'a donc pas porté les fruits escomptés. En effet au Bénin, la lutte contre les décès maternels s'est traduit par l'adoption par le Ministère de la Santé Publique (MSP) des Politiques, Normes et Standards des Services de Santé Familiale, ainsi que des protocoles de Santé Familiale dont les SONU (Soins Obstétricaux et Néonataux d'Urgence), constituent une des composantes ; l'une des stratégies destinées à réduire les taux de mortalité maternelle et infantile.

Suites à une série d'évaluations réalisée en 2003, il s'est avéré que l'accès aux soins obstétricaux d'urgences dans les formations sanitaires souffre de trois principaux problèmes liées à leur disponibilité, à leur utilisation judicieuse par les différents acteurs et à leur qualité. Cette évaluation a suscité des questions sur la pertinence et l'efficacité des interventions et stratégies développées et mise en œuvre au Bénin depuis des décennies. C'est alors qu'une nouvelle Stratégie Nationale de Réduction de la Mortalité Maternelle et Néonatale 2006 – 2015 a été redéfinie et basée toujours sur la logique SONU (MSP/DSF, 2006) faisant appel à la demande et l'offre de soins dans un environnement sanitaire peu favorable soumis à des dysfonctionnements du système de santé et à des déviances de la part des différents acteurs. (Jaffré et Olivier de Sardan, 2003).

Selon les professionnels de la santé publique, les complications obstétricales sont aujourd'hui la cause majeure de décès pour les femmes en âge de procréer dans les pays en développement et constituent l'un des problèmes sanitaires les plus urgents et les plus difficiles à résoudre dans le monde.

Au cours des 10 dernières années, les priorités mondiales en matière de réduction de la mortalité et de la morbidité maternelles ont été réorientées. Dans le passé, les chercheurs et les praticiens pensaient qu'il était possible de déceler et traiter les grossesses à risque élevé et que les soins prénatals pouvaient prévenir de nombreux décès maternels. Ils ont aussi demandé que les accoucheuses traditionnelles soient formées à réduire les risques de décès ou de maladie durant la grossesse. Toutefois, ces deux interventions n'ont pas réduit la mortalité maternelle.

Aussi les professionnels de la santé et les décideurs s'accordent t-il désormais généralement à reconnaître que la plupart des décès maternels procèdent de problèmes qu'il est difficile de déceler ou dépister – toute femme pouvant connaître des complications durant la grossesse, l'accouchement et le post-partum – mais qui se prêtent presque toujours à un traitement, pourvu que des soins obstétricaux d'urgence de bonne qualité soient accessibles. Ils ont mis alors l'accent sur les interventions jugées les plus efficaces : donner aux femmes, un plus large accès à une assistance qualifiée durant l'accouchement; améliorer les centres dispensant des soins obstétricaux d'urgence, et l'accès des femmes à ceux-ci, pour traiter les complications de l'accouchement; et veiller à ce que des systèmes d'aiguillage et de transport soient en place pour que les femmes souffrant de complications puissent recevoir rapidement les soins nécessaires(UNFPA ; 2004).

La mise en place au Bénin des SONU et de ses corollaires[1], s'est surtout focalisée essentiellement sur la formation des agents de santé notamment les sages femmes à l'identification et à la délivrance de soins obstétricaux et néonataux d'urgence d'une part et aux problèmes liés à la référence d'autre part.

Pour ce qui concerne les formations, Il s'agit du transfert d'un certain nombre de pratiques standards contenus dans des documents guides et que les professionnels doivent adopter. Quant à la référence, les actions sont plutôt orientées pour la plupart vers la construction de centre de santé, la dotation d'ambulance, la réduction voire la gratuité des frais de transport, la mise en place de réseaux aérien de communication (RAC), etc..

De récentes observations sur le terrain dans des zones d'application des SONU révèlent que les formations sont entachées de beaucoup d'irrégularités et sont trop sélectives. Parfois elles ne visent pas la bonne cible. L'application sur le terrain, des leçons inculquées aux sages femmes, occasionne d'autres dysfonctionnements dans le système notamment en ce qui concerne les interactions avec les usagers. En effet, l'application stricte des standards SONU par les sages femmes des centres périphériques, entraîne entre autres, une augmentation du taux de référence vers les hôpitaux. Selon les propos d'une sage femme d'un centre périphérique, « depuis que j'applique les formations SONU, la population ne fréquente plus le centre car on nous a dit d'évacuer dès qu'il y a des signes associés à la grossesse tels

[1] à savoir SOE (Soins Obstétricaux Essentiels), SOUB (Soins Obstétricaux d'Urgences de Base), SOUC (Soins Obstétricaux d'Urgences Complets), sans oublier les sous programmes ou projets sectoriels plus ou moins ponctuels issus de ces derniers et les technologies médicales afférentes comme GATPA (Gestion Active de la Troisième Phase de l'Accouchement), PARSUON (Programme d'Amélioration de la Référence et des Soins d'Urgence Obstétricales et Néonatales), AQUASOU (Amélioration de la Qualité des Soins Obstétricaux d'Urgence),etc.

que la toux, la fièvre, etc. Et quand j'évacue à l'hôpital, les femmes finissent toujours par accoucher par voie basse soit à l'hôpital, soit dans le cabinet clandestin du village tenu par une aide soignante mettant ainsi en doute mes compétences. » (Discussion du 11-08-06).

La mise en place d'équipement pour la référence ne résout par non plus de façon systématique les problèmes d'accès rapide aux soins d'urgence.

Il est à remarquer que la mise en œuvre des SONU n'est ni détachée ni isolée de l'ensemble du système de santé et son succès dépend largement de l'ensemble dans lequel elle s'insère. Les trois retards qui fondent la stratégie SONU sont plus imputables au système et au personnel soignant qu'à la communauté et même les logiques et les positions de cette dernière sont largement influencées par les dispositifs en place et les pratiques des professionnels. Il s'agira pour nous dans le cadre de ce travail, de saisir l'adaptabilité de la stratégie des SONU en rapport aux acteurs en place. En d'autres termes, la pratique professionnelle des agents de santé en rapport à l'innovation que représente l'introduction des normes SONU.

C'est pourquoi nous nous intéressons à la logique des acteurs du système de santé (dans la mise en œuvre des SONU) qui font que l'accès aux soins obstétricaux d'urgences pose problème. De façon plus précise, il s'agit d'investiguer les pratiques et les stratégies des professionnels et des usagers qui affectent et remettent en cause l'efficacité pratique de la stratégie des SONU. Quels types de pratiques prônent ces normes et dans quel contexte ? Quelles en sont les modalités d'application ? Comment les acteurs s'organisent ils autour de cette réforme des SONU et comment ils se la réapproprient ? Quelles sont les stratégies développées dans la mise en œuvre des normes officielles et les situations qui en découlent ?

Il s'agit donc à travers ces questions, de décrire et d'analyser la mise en oeuvre de cette stratégie telle que pensée et vécue par les acteurs sur le terrain afin de faire ressortir sous un angle socio anthropologique, les éléments qui constituent des goulots d'étranglements durant le processus de mise en œuvre des normes des SONU. Ainsi identifiées, la connaissance et l'analyse de ces logiques propres aux acteurs en scène, pourront éclairer davantage les promoteurs de cette politique.

## *1.3 Objectifs de l'étude*

De façon générale, il s'agit d'investiguer les formes concrètes de la mise en oeuvre des SONU à travers les logiques et pratiques des différents acteurs en présence.

De façon spécifique,

- Décrire les grandes étapes de la lutte contre les décès maternels au Bénin ;
- Recueillir des vécus des soignants et des usagers en rapport avec la stratégie des SONU dans les maternités périphériques de la zone sanitaire de Tchaourou ;
- Décrire l'environnement d'application de la stratégie des SONU dans les maternités périphériques de la zone sanitaire de Tchaourou ;
- Identifier les stratégies et pratiques des acteurs qui transforment les principes théoriques des SONU ;
- Analyser les modalités d'application de la stratégie des SONU dans les maternités périphériques de la zone sanitaire de Tchaourou ;
- Dégager les implications des différentes applications.

## *1.4 Hypothèses*

Des réflexions issues de notre cadre théorique, nous avons identifié trois hypothèses :

Les normes officielles des SONU contenues dans les documents sont réinterprétées sur le terrain à la lumière des logiques et des stratégies propres aux acteurs ;

L'application des préceptes des SONU par les professionnels affecte les interactions entre agents de santé et usagers et engendre des "effets pervers" ;

La stratégie des SONU comme moyen de réduction de la mortalité maternelle est en contradiction avec les attentes des acteurs et l'environnement de l'offre des soins ;

## *1.5. Clarification conceptuelle*

*Logiques*

Le concept de logique en sociologie, a été utilisé par les tenants de la microsociologie suites aux travaux d'Olson et de Boudon. Ils parlent de logique sociale, de logique de l'action ou de logiques des acteurs. Selon Jean Marc Dutrénit dans le dictionnaire de Sociologie le Robert, « la Logique sociale est une suite d'évènements résultant de la combinatoire des stratégies des individus d'un ou plusieurs groupes régulée par la réciprocité ». La stratégie des acteurs et l'interactivité sont au cœur de cette définition. Selon Olivier de Sardan, l'exploration de logiques sous jacentes aux comportements des personnels de santé renvoie aux représentations, normes et stratégies relativement partagées par eux. (Jaffré et Olivier de Sardan, 2003). Dans le cadre de notre sujet, il s'agit des différentes rationalités qui soutendent les pratiques et les stratégies développées et qui sont propres aux différents acteurs en jeu. Nous voulons suivre et interpréter la manière de penser, de concevoir la politique des SONU propre aux différents acteurs notamment à travers les discours justificatifs avancés pour expliquer les stratégies et pratiques qu'ils adoptent vis-à-vis des SONU.

*Stratégies*

Pour Jean Marie Dutrenit dans le dictionnaire de Sociologie le Robert, la stratégie est un ensemble de moyens mis en œuvre par un ou des individus pour parvenir à leurs fins, dans un système dont les règles implicites sont formées par la combinaison de ces stratégies. Il s'agit ici des plans élaborés, les moyens mis en œuvre par chaque acteur pour négocier ou mettre en pratique sa conception de la politique des SONU.

*Pratiques*

La notion de pratique s'oppose à la connaissance abstraite. Selon Pierre Ansart dans le dictionnaire de Sociologie le Robert, étudier la pratique sociale, c'est renoncer à l'étude des lois, des institutions et de s'atteler aux conduites sociales concrètes. La pratique est alors définie comme le comportement ou l'activité sociale envisagés dans la manière dont ils sont exercés de façon habituelle par une personne ou un groupe.

Dans le cadre de ce travail, nous entendons par ce groupe de mots (logiques, stratégies et pratiques), un ensemble de postures, de décisions, de disposition d'esprit, de manœuvres, d'agissements, de manipulations, de tactiques et de bricolages adoptés par des acteurs ou

groupe d'acteurs en situation d'offre et de demande des SONU et qui influencent ces derniers. Nous mettons dans acteurs trois groupes de personnes. D'abord les agents des maternités : il s'agit des sages femmes, des infirmières ayant en charge des maternités, des aides soignants mais aussi tout autres professionnels de santé impliqués dans les soins obstétricaux d'urgence. Ensuite les parturientes, les accouchées et leur accompagnant ou visiteur au sein de la formation sanitaire. Enfin les agents du MSP impliqués dans la santé familiale et les partenaires au développement.

*SONU*

Les SONU sont les soins réservés aux femmes et aux nouveau-nés présentant des complications liées à la grossesse et aux suites de couches et exigeant une intervention d'urgence. En fait, les SONU constituent la stratégie majeure internationalement reconnue pour réduire la mortalité maternelle dans les pays en développement. Cette stratégie se base sur le postulat que les facteurs qui déterminent la mortalité maternelle et néonatale sont des facteurs liés au système de santé, concrètement sur la notion des trois retards: retard dans la prise de décisions de recourir aux soins, retard dans l'acheminement vers une formation sanitaire appropriée, retard dans la réception des soins adéquats. (MSP[1], octobre 2002). Cependant l'étude sera focalisée uniquement sur les complications de la mère qui d'ailleurs influent aussi sur la santé du nouveau né. L'aspect néonatal ne sera pas investigué. Nous allons nous intéresser uniquement aux formations sanitaires périphériques qui délivrent les soins obstétricaux d'urgence de base (SOUB). Mais pour les besoins de l'enquête, nous aurons de temps en temps à nous référer aux soins obstétricaux d'urgence complets (SOUC) au niveau du centre de référence. Ainsi c'est sur les SOU que mettons l'accent. Dans le cadre de cette étude.

*Mortalité maternelle*

On définit la mortalité maternelle comme « le décès d'une femme survenu au cours de la grossesse ou dans un délai de 42 jours après sa terminaison, quelle qu'en soit la durée ou la localisation, pour une cause quelconque déterminée ou aggravée par la grossesse ou les soins qu'elle a motivé, mais ni accidentelle, ni fortuite » (Dujardin, 1993). Il est à noter que les données sur la mortalité maternelle ne sont pas très fiables et ne révèlent pas la réalité du

[1] Ministère de la Santé Publique

phénomène. Plusieurs décès surviennent dans le cadre familial et ne sont pas pris en compte par les statistiques sanitaires. La complexité du phénomène a mobilisé plusieurs disciplines dont les sciences sociales qui explorent les pratiques médicales, sociales et psychologiques autour de la question. Notons également qu'en dehors de la mortalité maternelle qui mobilise les acteurs, il y a la morbidité maternelle qui peut ou pas entraîner la mortalité maternelle mais qui constitue également un fardeau pour les femmes.

## *1.6. Revue critique de la littérature*

Les différents auteurs qui ont abordé la question l'ont fait aussi bien sous l'angle de la Santé Publique que celui de la Socio Anthropologie. Les ouvrages consultés ont traité des causes et des déterminants du fort taux de mortalité maternelle mais aussi en partie des comportements des agents de santé dans le système sanitaire en général. Cependant il y a certains auteurs qui ont évoqué un pan des soins obstétricaux d'urgence et leur rapport avec les comportements uniquement des professionnels de santé.

Au cours de la dernière décennie, un certain nombre de forums internationaux (le Sommet Mondial sur les Enfants de 1990, la Conférence Internationale sur la Population et le Développement de 1994, la Conférence Mondiale sur les Femmes de 1995 et le Sommet du Millénaire de 2000) se sont notamment fixés pour objectif, la réduction de la Mortalité maternelle[1].

Ainsi Starrs et Hoopes-bender s'interrogent dans leur article "*Mourir pour la vie"* sur ce qui peut expliquer la stagnation du taux de mortalité dans les pays en développement. Ils affirment que « face à l'ampleur du phénomène, il existe dans la littérature, une certaine connaissance des causes et des mesures à prendre pour réduire de façon considérable le problème ; les décideurs savent comment empêcher les décès dus à la grossesse. Mais alors, pourquoi les femmes meurent elles plus que jamais ? Les causes les plus fréquentes de mortalité maternelle dans les pays en développement sont bien connus dans leur ensemble et peuvent être surmontés facilement par des interventions cliniques qui sont des pratiques standards dans les pays développés. La plupart des décès maternel (60%) surviennent [pendant] et après la naissance du bébé »[2].

Pour ces auteurs, si le problème subsiste, c'est parce qu'il n'y a pas une volonté politique, un engagement de la part des décideurs. Beaucoup de changements promis restent au stade des déclarations politiques sans atteindre celui de la mise en œuvre effective. Mais ce qu'ils n'ont pas exploré c'est la part des autres acteurs impliqués dans le processus. Ils sont restés réducteurs dans leur analyse en ne voyant la cause des décès maternels que sous l'angle d'un seul acteur mais aussi en considérant les approches de solutions uniquement sous l'angle

[1] Kenneth Hill et al, 2001 : « mesurer la mortalité maternelle à partir du recensement : guide pour les utilisateurs potentiels »
[2] A. Starrs et P.T. Hoope-Bender, 2004 "Mourir pour la vie" in Countdown 2015 : édition spéciale Bulletin de la Conférence Internationale sur la Population et le Développement (CIPD)

médical. Aussi ne comprennent t-ils pas qu'on ne puisse venir à bout d'un problème qui pouvait se régler par des gestes techniques standards.

Une telle approche des décès maternels, nous a permis de considérer que sur le plan médical, les problèmes sont définis à l'avance de façon globale et technique de même que les solutions préconisées. Ce que nous ne partageons pas dans le cadre de ce travail socio anthropologique.

Ces femmes qui meurent sont celles qui n'ont pas pu surmonter les péripéties qui jalonnent le trajet du recours aux soins obstétricaux d'urgence. Ces femmes qui n'ont pas pu résister face au circuit complexe du recours et de l'accès aux soins obstétricaux d'urgence. Car l'accouchement est comme l'ont dit les femmes rurales de Koutoukallé au Niger, "une bataille, une guerre ». [1]

Dans l'ouvrage collectif édité par Vincent De Brouwere et Wim Van Lerberghe « *Réduire les risques de la Maternité : Stratégies et Evidence Scientifique* », les auteurs analysent le problème en identifiant des causes liées au système de santé mais aussi aux comportements des agents de santé et des populations bénéficiaires. Aussi trouvent t-ils que « le déficit dans une localité cache un certain nombre de problèmes liés à toutes sortes d'accessibilité, à la qualité des soins, à la disponibilité des agents de santé, aux problèmes de références et à beaucoup d'autres situations telles que le boycott d'un centre de santé par les populations pour des raisons diverses : incompétence, mauvais accueil, contraintes socioculturelles, etc. » [2]

Mais pour palier ce déficit, Dujardin dans sa thèse d'agrégation estime qu'il ne suffirait pas de résoudre certains problèmes techniques telles que la formation du personnel de santé et la fourniture des techniques obstétricales nécessaire au niveau adéquat. Les problèmes, au delà du technique , découlent aussi d'une gestion inadéquate des services de santé et de stratégies non pertinentes d'une part, puis de la méconnaissance des logiques et des stratégies des patientes d'autre part[1]. C'est cette zone d'ombre que représente la

[1] Jean Pierre Olivier de Sardan et al,1999 : "L'accouchement c'est la guerre : de quelques problèmes liés à l'accouchement en milieu rural nigérien" in Bulletin de l'APAD n° 17 juin 1999

[2] Vincent De Brouwere, et Wim Van Lerberghe; 2001: « Réduire les risques de la Maternité : Stratégies et Evidence Scientifique »; Studies in Health Services Organisation Policy, 18,2001

[1] Bruno Dujardin, Février 1993: « Une Approche Globale pour Améliorer La Santé Maternelle »: Thèse d'Agrégation, Université libre de Bruxelles

méconnaissance des logiques et stratégies des patientes mais également celle des autres acteurs mais vue sous l'angle du processus d'offre et de demande des soins obstétricaux d'urgence qui nous intéresse dans cette étude.

Zoungrana et al. dans leur article sur "La Mortalité Maternelle au Burkina Faso : état des connaissances sur le sujet", démontrent que la persistance des taux élevés de mortalité maternelle dans les pays en développement, traduit entre autre l'insuffisance des programmes de santé qui ont été mis en œuvre depuis l'avènement des indépendances. Par ailleurs, l'ouvrage fait une classification des causes en distinguant les causes médicales et les causes non médicales. Ces dernières sont considérées comme la partie invisible du problème multidimensionnel qu'est la mortalité maternelle. Aussi affirment t-ils qu' « En réalité ce sont les facteurs logistiques ou ceux liés au fonctionnement des services de santé qui déterminent si une femme enceinte ou dont l'accouchement présente des complications vivra ou mourra »[2].

Dans un contexte plus général, Jean Pierre Olivier de Sardan et Yannick Jaffré, dans leur ouvrage collectif « *Une médecine inhospitalière Les difficiles relations entre soignants et soignés dans 5 capitales d'Afrique de l'Ouest »*, s'intéressent à l'environnement et à la nature des interactions qui ont cours dans l'espace sanitaire africain, les modèles organisationnels appliqués dans les formations sanitaires et les pratiques peu favorables des professionnels dans le processus d'offre de soins.[3]

Aucun de ces ouvrages ne s'est intéressé aux logiques de l'ensemble des acteurs face aux SONU c'est-à-dire depuis le choix de la stratégie jusqu'à la fourniture des soins en milieu hospitalier. Les études spécifiques sur la stratégie des SONU ne se focalisent pas sur les logiques d'acteurs en situation de mise en œuvre des SONU. Lorsque certains font ressortir des logiques d'acteurs, c'est surtout en rapport aux pratiques des agents de santé dans le système sanitaire de façon générale mais aussi en rapport au fonctionnement au quotidien des centres de santé. Cependant ces ouvrages ont le mérite d'aborder sous un autre angle, les questions relatives aux décès maternels. Ainsi en dehors des acteurs, la qualité du système de

[2] C.M. Zoungara. et A. Paré, 1999 "La mortalité maternelle au Burkina Faso : état des connaissances sur le sujet" in Santé de la mère et de l'enfant (exemples africains), Paris, IRD Editions, 1999, pp 82-107

[3] Y. Jaffré, JP.Olivier de Sardan, 2003 « *Une médecine inhospitalière :* Les difficiles relations entre soignants et soignés dans 5 capitales d'Afrique de l'Ouest, Paris : Karthala

santé intervient largement dans le débat sur la Mortalité maternelle. Les logiques et les pratiques des acteurs ne peuvent avoir de sens que dans un système donné.

May Post conseillère en santé publique dans son document *Prévenir la mortalité maternelle par le biais des soins obstétricaux d'urgence,* évoque les barrières rencontrées dans le processus des trois retards qui caractérisent les soins obstétricaux d'urgence. Au niveau des retards au centre de santé, elle incrimine "Les attitudes passives du personnel " notion utilisée par Mbaruku et Bergstrom, 1995. Ainsi, « La plupart des membres du personnel étaient convaincus que les décès maternels étaient liés à des circonstances n'entrant pas dans leur contrôle, tels que les retards pour arriver à l'établissement, les facteurs culturels et le manque de médicaments et d'équipement. Toutes ces raisons justifiaient une certaine passivité, surtout lorsqu'elles se conjuguaient à un moral assez bas du personnel lié à l'insuffisance du salaire. Le personnel avait tendance à oublier sa capacité éventuelle à résoudre les problèmes et peu, voire aucun effort n'était fait pour trouver des solutions appropriées à des problèmes évidents. »[1]

Traitées de passives, ces attitudes ne sont pas pour autant neutres et obéissent à des choix orientés par la manière dont les acteurs s'approprient les différentes stratégies. Au fait ce sont des attitudes chargées "d'actions".

Aussi Olivier de Sardan, dans *Anthropologie et Développement : Essai en socio anthropologie du changement social* affirme t-il que deux principes gouvernent les comportements des populations face aux opérations de développement (ici stratégie des SONU) : le principe de "sélection" et celui de "détournement". Le premier obéit au fait qu'aucune intervention n'est adoptée en bloc par les acteurs qui, opèrent dans cet ensemble, des choix qui occasionnent des "effets pervers" et neutralisent l'efficacité des améliorations proposées. Quant au second principe, il réside dans la dichotomie entre les raisons réelles d'adoption d'une intervention par les bénéficiaires et celles invoquées par les experts.[2]

Dans le même esprit mais sous un autre angle, dans l'article "La sage femme et le douanier : cultures professionnelles locales et culture bureaucratique privatisée en Afrique de l'Ouest", Jean Pierre Olivier de Sardan, en se référant aux comportements des membres de deux professions apparemment opposées, distingue ce qu'il appelle " la norme pratique" dont les principales composantes sont "la culture professionnelle locale" et "la culture

[1] May Post, 2007, « Prévenir la Mortalité Maternelle par le biais des Soins Obstétricaux d'Urgence » documents de synthèse du projet SARA, avril 2007
[2] Jean Pierre Olivier de Sardan, 1995, Anthropologie et développement. Essai en socio-anthropologie du changement social, Paris, Karthala

bureaucratique privatisée". En effet pour cet auteur, c'est une vision simpliste que de considérer que les écarts constatés entre normes et comportements relèvent essentiellement d'une mauvaise application des normes officielles ou d'une compréhension insuffisante de celles-ci. Les comportements des acteurs relèveraient plutôt d'autres normes non dites que sont les "normes pratiques" qui ne sont pas pour autant ni aléatoires ni nécessairement erratiques.[1]

Identifier et analyser ces non dits, normes réelles qui gouvernent les comportements des acteurs impliqués dans les soins obstétricaux d'urgences, constituent l'un des aspects de notre étude.



[1] Jean Pierre Olivier de Sardan, 2001 « La sage femme et le douanier : cultures professionnelles locales et culture bureaucratique privatisée en Afrique de l'Ouest », Autrepart, 20 : pp 61-73

## *1.7Modèle théorique*

Nous nous inspirons des théories de la microsociologie qui se focalisent sur les jeux des acteurs comme l'atome logique de l'analyse du social (Boudon, 1979). Les acteurs individuels pouvant être non seulement des personnes mais toute unité collective pour autant qu'elle se trouve munie d'un pouvoir d'action collective. Mais, c'est plus précisément à l'analyse stratégique de Michel Crozier et à l'interactionnisme de l'école de Chicago que nous faisons appel. Ainsi nous recueillerons les points de vue, les stratégies et pratiques des acteurs en situation de mise en œuvre de la stratégie des SONU. Sur le plan méthodologique, ce choix, signifie la rupture d'avec les enquêtes par questionnaires ou des traitements statistiques, pour privilégier l'observation et permettre de saisir comment dans et par l'interaction, les acteurs assignent du sens aux objets, aux situations et aux symboles (ici aux normes des SONU).

L'analyse stratégique postule que rarement dotés d'objectifs précis, les individus profitent davantage des opportunités qui se présentent à eux plutôt qu'ils ne mènent à bien un projet cohérent et mûri de longue date. L'organisation ne contraignant jamais totalement, quels que soit leur statut, tous les individus bénéficient toujours d'une marge de liberté et de négociation même la plus minime. Le comportement de l'acteur peut donc s'analyser comme l'expression d'une stratégie rationnelle dont le but est l'accroissement de gains personnels conquis grâce à des relations de pouvoir. Mais une telle pratique ne prend sens qu'à la condition de resituer cette dernière dans un système d'action concret. (Crozier et Friedberg ,1977)

L'interactionnisme symbolique quant à elle, nie toute conception holiste du social ; il ne reconnaît que la réalité individuelle comme niveau où puisse s'exprimer un sens. Autrement dit, les individus ne subissent pas les faits sociaux, ils ne cessent à l'inverse de les produire. En interprétant la situation dans laquelle ils sont plongés, les acteurs conçoivent et construisent leur action mais sans que celle-ci ne revête nécessairement un caractère extrêmement rationnel. (Blumer cité par Michel Lallement, 2000).

Par ailleurs nous nous inspirons des travaux d'Olivier de Sardan et de Jaffré[1] sur la socio anthropologie du Développement et les comportements des agents de santé et l'espace

[1] Jean Pierre Olivier de Sardan 1995, Anthropologie et développement. Essai en socio-anthropologie du changement social, Paris, Karthala.

psychologique sous jacent. Ainsi, en partant des choix politiques officiellement adoptés au niveau national concernant les SONU, nous allons à travers l'exploration du monde du développement sanitaire puis des logiques et stratégies mobilisées par les différents acteurs en situation, faire ressortir les pratiques de groupe qui en découlent et les effets qu'ils engendrent dans l'univers hétéroclite de la lutte contre les décès maternels.



Jean Pierre Olivier de Sardan 2003, « pourquoi le malade anonyme est-il si "mal traité" ? Culture bureaucratique commune et culture professionnelle de la santé» in Une médecine inhospitalière. Les difficiles relations entre soignants et soignés dans 5 capitales d'Afrique de l'Ouest, Paris : Karthala pp265 -294

Yannick Jaffré 2003, « la configuration de l'espace moral et psychologique des personnels de santé » in Une médecine inhospitalière. Les difficiles relations entre soignants et soignés dans 5 capitales d'Afrique de l'Ouest, Paris : Karthala, pp295 -337.

# Chapitre 2 : Cadre Méthodologique

Avant de décrire la démarche méthodologique qui a guidée cette étude, nous allons préciser le cadre spatial qui a inspiré la problématique.

## 2.1 Cadre géographique de l'étude

La zone sanitaire de Tchaourou est composée d'une seule commune située au sud de l'actuel département du Borgou. La commune est composée de 7 arrondissements et de 36 villages administratifs. Elle est limitée au nord par la Zone Sanitaire Parakou-N'dali et au sud par celle de Savè Ouèssè. Elle compte 121.692 habitants en 2005 pour une superficie de 6879 km². La couverture obstétricale est de 29% ; quant au ratio de décès maternel, il est égal à 251 pour 100.000 accouchements. La zone comprend 7 Centres de Santé d'Arrondissement (CSA)[1], 2 maternités isolées et 6 Unités Villageoises de Santé (UVS). Il s'agit des formations sanitaires publiques de Tchaourou, Goro, Alafiarou, Bétérou, Sanson, Tchatchou et Kika. Les deux maternités isolées se retrouvent à Goro et à Alafiarou. Au total, 9 maternités périphériques plus celle de l'hôpital de référence ont été pris en compte par notre étude.

On dénombre dans la zone une quarantaine de cabinets privés ouverts par des personnes de qualifications variables allant de médecins, infirmiers, aides soignants à des personnes dont la qualification reste difficile à prouver.

De par sa situation géographique (excentrique par rapport aux autres formations sanitaires) l'hôpital de référence de la zone communément appelé Hôpital Saint Martin de Papanè du nom du village où il est implanté, est accessible seulement à une partie de la population de la commune de Tchaourou. Seules les formations sanitaires périphériques de Tchaourou, Goro, Alafiarou y réfèrent leurs patients. Les autres réfèrent vers d'autres hôpitaux comme Boko et le CHD de Parakou. Par contre l'hôpital est accessible à une bonne partie de la population de la commune de Ouèssè dans la zone sanitaire Savè-Ouèssè. Aussi moins de 50% des populations de la zone de Tchaourou ont accès à l'hôpital de Papanè. La maternité périphérique la plus proche de l'hôpital dans la zone de Tchaourou est à 11 km et la

[1] chaque CSA est composé d'un dispensaire et d'une maternité

plus éloignée à 75 km. Voici la liste des différentes maternités suivie de la qualification et de l'effectif du personnel en service.

Liste du personnel en service dans chaque maternité

| Maternités | Personnel en service |
|---|---|
| Alafiarou | Une infirmière diplômée d'Etat + une aide |
| Bétérou | Une sage femme + 2 aides |
| Goro | Une infirmière de santé + 2 aides |
| Kika | Une infirmière de santé + une aide |
| Sanson | 2 infirmières de santé[1] + 2 aides |
| Tchaourou | 2 sages femmes + une infirmière diplômée d'Etat + une infirmière de santé + 3 aides |
| Tchatchou | Une sage femme + une infirmière de santé + 2 aides |
| Maternité Isolée Agbassa | Une infirmière de santé + 2 aides |
| Maternité Isolée Goro | Une sage femme + une aide |
| Papané | 5 sages femmes + 1 infirmière de santé + 3 aides |



Notons que l'hôpital de Papané est un hôpital confessionnel catholique de l'Archidiocèse de Parakou qui assure son administration. C'est depuis 2000, que l'Etat l'a érigé en hôpital de référence dans le cadre de la réorganisation de la base de la pyramide sanitaire. Au départ il a

[1] une des infirmières est formée à l'interne sur le tas.

été crée en 1972 comme un centre de santé de brousse qui se limitait à un bloc pour la chirurgie.

Cette étude revêt un caractère multi sites. Elle s'est déroulée dans la Zone sanitaire de Tchaourou plus précisément au niveau de l'hôpital de référence Saint Martin de PAPANE et dans les centres périphériques qui gravitent autour de lui ainsi qu'au niveau du MSP à Cotonou et auprès des partenaires au développement. Cependant les investigations ont été concentrées au sein des maternités des centres périphériques où s'administrent les soins obstétricaux d'urgence de base (SOUB). Nous avons fait ce choix en raison de la pluralité des interactions à la base de la pyramide sanitaire. De plus les soins commencent dans les centres périphériques pour se prolonger au besoin dans les hôpitaux de référence. Aussi les investigations faites au niveau de la maternité de l'hôpital de référence ont contribué à rendre plus compte de la pratique des acteurs du système de santé périphérique.

En outre compte tenu du caractère excentrique de l'hôpital vis-à-vis des centres de santé périphériques de son ressort territorial, nous y avons limité les investigations et privilégié tous les centres périphériques même ceux qui ne réfèrent pas à l'hôpital de Papané.

## *2.2. La démarche méthodologique*

La démarche adoptée s'est inspirée des références théoriques et des dispositifs méthodologiques de la socio anthropologie plus particulièrement ceux de la socio anthropologie du développement. Nous avons opté pour ce type d'étude afin de pouvoir pénétrer les logiques des acteurs puis les positions et les pratiques afférentes mais également de saisir les transformations qui en découlent. Ce choix nous a conduit « au décryptage des stratégies que les acteurs déploient » (Olivier De Sardan, 1995) sans pour autant faire appel aux "références paresseuses [à des] facteurs culturels".[1] En effet, nous ne nous inscrivons pas dans la logique qui se sert de la culture comme "bouche trou" susceptible d'expliquer tout car, « face aux écarts répétés entre les conduites prévues et les conduites réelles, face aux dérives que toute opération de développement subit du fait des réactions des groupes cibles, les "développeurs" tendent à recourir à de pseudo-notions sociologiques ou anthropologiques qui relèvent plus de clichés et de stéréotypes que d'outils analytiques ».[2]

C'est pour dire, dans le cadre qui est le notre, que sans ignorer l'accessibilité culturelle, elle n'est pas pour autant un élément justifiant les pratiques évoquées ci-dessous. Il s'agit donc d'une étude qualitative qui a fait appel à l'exploration documentaire, à l'entretien (entretiens individuels approfondis, conversations plus ou moins formelles, interviews libres), et à l'observation. Elle s'est réalisée en deux grandes phases que sont d'une part la recherche documentaire et les investigations sur le terrain puis d'autre part l'analyse des données.

### *2.2.1 La documentation*

Tout d'abord, nous avons passé en revue au niveau du Ministère de la Santé Publique (MSP), les différents documents de politiques et stratégies SONU et dérivés élaborés dans le cadre de la lutte contre la mortalité maternelle. Nous avons pris également en compte, des documents relatant des expériences de mises en œuvre de SONU sur le terrain. Cette exploration nous a permis de cerner la construction théorique officielle de cette stratégie, ses principes directeurs et les objectifs poursuivis avec quels acteurs et quels moyens ?

### *2.2.2 Les entretiens et les observations*

Sur le terrain, nous avons procédé à des recherches approfondies sur la base d'entretiens et d'observations.

[1] idem
[2] ibidem

Nous avons fait appel aussi à des témoignages à travers des situations concrètes d'application de cette politique sur le terrain. Les entretiens ont été réalisés auprès des acteurs du Ministère de la Santé Publique (MSP) et les partenaires au développement de cette politique de santé maternelle, les professionnels de santé appliquant la stratégie sur le terrain, puis les bénéficiaires c'est-à-dire les femmes, parturientes ou accouchées ayant bénéficié de soins obstétricaux d'urgence (ou leur accompagnants).

Auprès des acteurs du MSP et des partenaires au développement, nous avons recueilli des données relatives aux documents, aux grandes étapes de la lutte contre les décès maternels au Bénin, aux raisons de choix de cette stratégie, à la motivation du personnel de terrain, au positionnement des acteurs (MSP) vis-à-vis des partenaires appuyant la stratégie et vice versa, à leurs perceptions sur les autres acteurs, etc.

Les entretiens avec les agents de santé sur le terrain ont servi à comprendre la mise en œuvre réelle de cette stratégie sur le terrain, les facteurs bloquants, les interactions avec les bénéficiaires, les difficultés d'application et les bricolages, les stratégies et les logiques dont ils usent dans les processus d'offre des SONU, leurs motivations, leurs perceptions sur la stratégie, et le recueil de séquences biographiques professionnelles, etc. Quant aux entretiens avec les bénéficiaires, ils ont permis d'investiguer et d'apprécier leurs logiques, leurs réponses et attitudes face à l'offre de soins SONU.

Au total les entretiens ont pris en compte, de façon systématique, dans les formations sanitaires, tous les agents disponibles des maternités concernées (sages femmes ou infirmières responsables des maternités, les aides), les femmes ayant bénéficié de soins obstétricaux d'urgences ainsi que leurs accompagnants, les responsables administratifs et médicaux de la zone, les infirmiers, des agents de cabinets privés, des membres de comités de gestions, des commis de pharmacie. Nous avons réalisé en tout 92 entretiens avec 78 interlocuteurs répartis comme suit : 37 professionnels de santé dont 7 sages femmes, 15 infirmiers et infirmières, 15 aides soignants ; 29 usagers dont 16 Parturientes et accouchées et 13 accompagnants ; 8 responsables médico administratifs et partenaires au développement, 4 membres de comités de gestion.

Avec les observations directes in situ dans les centres de santé offrant des SONU, nous avons observé le déroulement effectif des activités issues de la mise en œuvre de cette stratégie sur des terrains spécifiques (les maternités périphériques de la zone) afin de saisir les acteurs en situations concrètes. Elles ont servi à approfondir et à recouper des informations

issues de plusieurs sources sur des cas d'agents de santé ayant développé des logiques propres dans la mise en œuvre de l'approche SONU, des cas de logiques de bénéficiaires, etc.

Tout en concentrant les investigations au niveau de la zone sanitaire de Tchaourou. Nous avons recueilli également des informations auprès d'acteurs à Cotonou et à Parakou.

### *2.2.3 Le traitement des données*

Pour l'analyse nous avons procédé d'abord à un dépouillement manuel et à la triangulation des données. Puis comme le dit Olivier de Sardan, « [essayer] de combiner en bonne rigueur méthodologique, la découverte des représentations et des logiques populaires et la mise en évidence des contraintes qui les régissent » Sardan op cit. Tout ceci en faisant un va et vient entre le modèle d'analyse stratégique et l'interactionnisme. Notons que la phase de terrain et celle de rédaction ne sont pas dissociées et ont été exécutées de façon simultanée.

Enfin il est à noter que tout au long des investigations et de la rédaction, nous avons fait le choix de privilégier les dysfonctionnements c'est-à-dire les aspects qui sont en contradiction avec les prescriptions des SONU et de rester dans une posture dite de "pessimisme méthodologique" afin de mettre l'accent sur ce qui pose problème dans l'application de ces normes. Cependant, ce choix n'est pas sans biais car il ne rend totalement pas compte de ce que nous pouvons appeler les "bonnes pratiques" des agents de santé.

# *2ème partie : Description et analyse des données*

# *Chapitre 3 : Politiques et stratégies de lutte contre les décès maternels au Bénin : choix nationaux ou directives internationales ?*

L'étude des logiques et pratiques des acteurs autour de la stratégie des SONU de réduction des décès maternels dans la zone sanitaire de Tchaourou, nécessite d'avoir une compréhension globale des choix faits au plan national et les modalités d'application.

## *3. 1 Les grandes étapes de la lutte contre la Mortalité maternelle au Bénin (théories et applications)*

La lutte contre la mortalité maternelle au Bénin a évolué au gré des tendances et choix impulsés par l'OMS et les autres organisations internationales. N'ayant pas adoptée une politique claire et précise, on a assisté plutôt à beaucoup d'errements. Ainsi selon un de nos interlocuteurs, spécialiste en santé publique :

> « Avant les SONU, c'était toujours la philosophie de l'OMS où on veut embrasser tout à la fois. Il n'y avait rien de concret qui se faisait. Tout a commencé par la conférence de Naïrobi en 1987 avec la Maternité à Moindre Risque.» Médecin Santé Publique entretien du 08-11-07

En 1997, le MSP a édité le document des standards des SOU qui décrivait juste les normes en matière de SOU. En 1998, il a adopté les Politiques Normes et Standards des services de santé familiale qui regroupaient des normes globales en faveur de la santé de toute la famille. En 2002, il y a eu le Programme National de Santé de la Reproduction 2003-2008 et le guide de formation en SONU. C'est en 2003 que le choix de la Gestion Active de la Troisième Phase de l'Accouchement (GATPA) a été fait. Mais c'est depuis 2006, que le document de stratégie nationale de réduction de la mortalité maternelle a été élaboré. Ainsi il y a eu beaucoup de documents écrits sans qu'une baisse des décès ne s'en suive.

Ces choix stratégiques décrits dans les documents sont introduits[1] par les partenaires au développement. Aussi les actions en faveur de la santé maternelle ont été fragmentées aussi bien dans le fond que dans la forme. Ceci parce que des options sont faites selon les objectifs de chaque partenaire et chacun d'eux intervient dans "sa zone" de façon isolée. Le MSP dans bien des cas ignore les actions entreprises sur le terrain. Ceci fait que dans chaque maternité

[1]Souvent une sous partie de l'ensemble

selon le partenaire en présence, la nature des soins offerts aux femmes diffère. A ce propos, un cadre du MSP déclare :

> « Avec les partenaires, c'est un peu difficile. Il y a des nuances dans la mise en œuvre sur les terrains. Chaque partenaire selon l'intérêt qu'il y trouve, choisit une partie des documents. Même nous au MSP, on a pas d'argent, donc on va directement aux cas urgents » entretien du 12-11-07

Notons que l'introduction du néonatal dans le concept SOU a entraîné assez d'ambiguïtés. Le plus souvent dans la mise en œuvre, ce sont les SOU qui prennent le dessus. Selon les spécialistes que nous avons interrogés, " à vouloir mettre la mère et l'enfant ensemble, on a tendance à sacrifier l'un au profit de l'autre."

## *3.2 L'avènement de la Stratégie des SONU au Bénin*

De l'avis d'un médecin de santé publique,

> « on a commencé par parlé des SOU au Bénin en 1996 , on en parlait mais cela n'accrochait personne. Puis en 1998, avec l'USAID on a parlé de SONU même si on réfléchissait comme SOU car en matière de néonatal, rien n'était élaboré en profondeur. C'est du document SOU qu'a été sortit le guide SONU qui n'est que l'aspect clinique» entretien du 08-11-07

Cependant selon un cadre du MSP,

> « Les SONU Y compris la GATPA sont des normes internationales qui ont été ramenées au Bénin sans aucune adaptation de notre part. Nous formons nos agents sur le terrain sur la base de ces normes et nous les évaluons avec sans tenir compte de l'environnement dans lequel l'application a été faite. Lorsque la Guinée a essayé d'adapter les SONU à son contexte, les concepteurs internationaux n'ont pas accepté. Ils ont trouvé que ce n'est plus SONU » entretien du 12 –11-07

Or il faut rester dans la lignée du concept tel que pensé et conçu pour bénéficier des mesures d'accompagnement.

Notons que la GATPA, pour la plupart des responsables maternité de notre zone d'étude, est un sous ensemble des SONU, un savoir faire relevant de la stratégie des soins d'urgence. Les prestataires de soins ont été formés[2] de façon successive par rapport à ces deux concepts (GATPA et SONU) par le même partenaire. Cependant leur version est en contradiction à ce qu'affirme un consultant de l'UNFPA :

> « GATPA est un nouveau concept, une nouvelle technique introduite au Bénin en 2003 qui relève de la prévention des hémorragies de la délivrance donc différent des SOU qui sont à vocation curative par exemple traiter cette hémorragie de la délivrance. Mais on mélange les deux. La dernière évaluation des GATPA a donné un taux de réussite de l'ordre de 22.8% ; ce qui prouve que les formations seules ne suffisent pas, » entretien du 08-11-07

Cependant, comme nous l'avons énoncé plus haut, ce n'est qu'en 2006, que le MSP reconnaît s'être doté d'un document de Stratégie Nationale de Réduction de la Mortalité Maternelle 2006-2015 basée sur les SONU. Pour l'un des rédacteurs

[2] Dans la zone sanitaire de Tchaourou, seules les responsables de maternité ( sages femmes et infirmières) ont bénéficié de la formation SONU. La formation GATPA a impliqué quelques aides soignantes des maternités en plus des responsables ; les protocoles de santé familiale sur la prise en charge des complications a visé 2 agents par maternité.

> « Nous avons élaboré la politique nationale de réduction de la mortalité maternelle basée sur les SOU mais personne, ni le MSP, ni les bailleurs ne s'intéresse à la mise en œuvre intégrale. Chaque partenaire tient à sa zone et continue ses actions comme il l'entend. Aucune action concrète n'est encore issu de la nouvelle stratégie ». Entretien du 08-11-07

Ainsi malgré le nouveau document, rien n'a changé côté application. De même il n'y a jamais eu une mise en œuvre globale et coordonnée de façon simultanée sur toute l'étendue du territoire. Or selon les médecins de santé Publique, les SONU constituent un concept global, un paquet d'élément qui ne concerne pas seulement le volet clinique. Il y a aussi le dispositif managérial, la disponibilité, l'accessibilité et la qualité des soins etc.

L'aspect des SONU qui intéresse le grand nombre de partenaire, est le volet clinique. Son financement se fait par le simple transfert des normes et pratiques afférentes aux professionnels des maternités notamment les responsables. En témoignent les propos d'un responsable de la Direction de la Santé Familiale (DSF)

> « Ce n'est que le transfert des compétences qui intéresse les partenaires. Il y a d'autres choses comme l'organisation des services. Au fait le Bénin n'a pas les moyens de faire seul les SONU mais c'est à nous d'orienter les partenaires. Actuellement pour la nouvelle stratégie de réduction des décès maternels, il n'y a que 7 zones choisis par nos partenaires sur les 34 ; donc on va commencer d'abord par là » entretien du 12-11-07

Même si les acteurs du MSP reconnaissent que les formations à elles seules ne peuvent venir à bout des décès maternels, ils affirment ne pas avoir les moyens d'imposer des actions intégrées et collectives. Car :

> « On dit qu'on forme les gens mais cela n'a jamais réduit les décès maternels et on continue. On n'anticipe pas, on ne tient pas compte de l'environnement (…) Si un partenaire nous dit qu'il n'a que l'argent de 3 jours de formation du personnel, je ne peux pas refuser sachant bien qu'il faut deux semaines, pour une bonne formation. » Entretien du 08-11-07 et du 12-11-07

Mis à part ces difficultés, nos interlocuteurs trouvent également que « les pays anglophones se retrouvent mieux avec ce concept SONU élaboré par des universitaires américains. Ainsi par exemple, il prône l'utilisation de la ventouse dans les accouchements difficiles or ce n'est pas enseigné dans les Etats francophones. »

Au delà de ces difficultés liées aux modalités d'application des SONU, il en existe d'autres qui résultent de la comparaison voire de la contradiction avec d'autres concepts qui relèvent aussi de la lutte contre la morbidité et les décès maternels

## *3.3. Une confusion dans les concepts et la mise en œuvre*

Selon un consultant du MSP,

> « en 1999 sur le plan international, il y a eu beaucoup de discussions entre les partisans des SOE (Soins Obstétricaux Essentiel) et ceux des SOU (Soins Obstétricaux d'Urgence. L'OMS a fait la gamme des SOE qui est claire et différente de SOU . Au fait dans les SOE se trouvent disséminés quelques gestes SOU comme la césarienne. Chacun des partisans pensait que l'autre concept était superflu pour réduire les décès maternels» entretien du 08-11-07

Au fait dans l'arène[1] de la lutte contre les décès maternels, s'est développé un certain nombre de projets/programmes qui véhiculent chacun un concept matérialisé par des sigles ou acronymes. Le contenu et les principes qu'ils prônent s'enchevêtrent et se chevauchent sur les terrains d'actions et parfois même au sein même des concepteurs. Dans l'ensemble, ces concepts ont pris le pas sur la mise en oeuvre et les résultats positifs.

Selon nos interlocuteurs, c'est du document SOU devenu entre temps SONU qu'ont été tirés les formations initiées par les projets PARSUON, AQUASOU et autres sous projets financés par les partenaires au développement. Pour les sages femmes qui ont bénéficié de formations dans le cadre de ces différents projets[2], les contenus révèlent parfois des nuances et des contradictions. A ce propos, un cadre du MSP affirme que: « Tous les acteurs n'ont pas la même vision de la stratégie. La Direction de la santé Familiale (DSF) a sa vision, les médecins coordonnateur de zone ont la leur de même que les partenaires au développement » entretien du 12-11-07

Aussi n'est il pas rare de trouver dans une même zone sanitaire, un ou plusieurs partenaires de la santé maternelle, introduire de façon simultanée ou successive, plusieurs concepts de lutte contre les décès maternels. A cet effet, les mêmes acteurs sont "formés" aux différentes méthodes et techniques afférentes. En outre ce sont souvent les mêmes personnes qui sont responsables des différentes équipes d'amélioration mise en place pour chaque concept. Ceci entretient des flous au niveau des acteurs sur le plan opérationnel.



[1] En sociologie politique dans ses analyses, Bailey cité par Bierschenk et Olivier de Sardan 1994, a utilisé le concept d'arène pour identifier la vie politique nationale qu'il compare à un jeu où se confrontent et s'affrontent les acteurs sociaux autour d'un leader et des factions. Pour ces auteurs, l'arène est un lieu de confrontations d'acteurs sociaux en interactions autour d'enjeux communs. Dans notre cas nous avons considéré comme arène, l'espace sanitaire de Tchaourou plus particulièrement les maternités périphériques.

[2] Compte tenu de la mobilité du personnel, certains agents peuvent bénéficier de plusieurs formations de partenaires différents.

Ainsi au cours de nos investigations sur le terrain d'étude, beaucoup de nos enquêtés ne se sont par retrouvés dans les différents concepts qui ont été introduits dans la zone sanitaire de Tchaourou par différents partenaires. Bien qu'ayant été "formés" sur chacun des concepts, ils avouent leurs difficultés à cerner leur contenu réel. Ainsi selon une sage femme enquêtée :

> « Ici à Tchaourou notre problème c'est SOE personne ne maîtrise SOE or on fait des réunions pour vérifier le remplissage des registres, on fait des diagrammes, c'est intéressant mais on ne comprend pas on dit que c'est SOE, c'est récent, c'est en 2005 après la formation SONU. Selon moi c'est un rassemblement pour pouvoir améliorer la qualité des soins et des prestations. On se regroupe pour faire la synthèse et débattre d'un cas et se donner des idées entre agents. Je crois que SOE c'est aussi GATPA et SONU. SONU c'est des gestes de sauvetage sur la femme par contre SOE c'est des discussions pour améliorer les SONU y compris GATPA » entretien du 7-8-07 tchaourou

Pour une autre sage femme cette fois ci responsable au niveau de la zone, « SOE est dans SONU il faut connaître l'essentiel avant de faire l'urgence même si on a été formé en SONU avant l'introduction de SOE » entretien du 9-8-07

Un responsable médico administratif de la zone de Tchaourou affirme avec mélancolie :

> « Notre zone était pris en compte par un partenaire américain pour bénéficier depuis des SOE à l'instar de deux autres zones sanitaires du pays mais un partenaire principal de la zone qui nous appuyait pour les normes de santé familiale en ce moment a refusé. C'est juste à cause de la guéguerre entre partenaire pour avoir de sphère d'influence, d'hégémonie. Actuellement on est en train d'essayer le modèle collaboratif AQ/SOE avec le Programme Suisse PSS » entretien du 12-08-07

Ces propos dénotent d'une "Balkanisation" du territoire par les partenaires et d'une monopolisation des différents concepts par chacun d'entre eux.

Au total, d'un côté il y a eu des normes officielles internationales transférer au plan national par plusieurs partenaires au développement ayant leur objectifs précis et ceci sur des terrains différents avec plus ou moins quelques nuances et de l'autre côté des prestataires de services de santé, à qui ces normes ont été transférées en vue d'une application en direction d'usagers avec lesquels ils sont en interaction.

La diversité des formations au profit des acteurs autour de différents concepts des Soins Obstétricaux d'Urgence, censés concourir aux même objectifs d'une part et l'absence

de synergie autour des actions d'un même partenaire et de tous les partenaires oeuvrant dans la résolution des complications obstétricales d'autre part, sont des éléments qui influent sur le jeu des acteurs au niveau opérationnel.

# *Chapitre 4 : Le jeu des acteurs dans la mise en œuvre des SONU*

Ce sont les logiques, les pratiques et les stratégies développées par les professionnels et les usagers pour s'adapter , apprivoiser en quelque sorte les normes contenues dans les SONU lors des interactions avec les usagers. Au sein d'une même catégorie professionnelle ayant reçu les mêmes formations autour de la politique SONU, les rationalités et les pratiques sont plurielles. Nous allons les évoquer en nous référant à certains éléments du processus d'offre de soins obstétricaux d'urgence de base notamment dans les centres périphériques. Il s'agit des actes de soins, des prescriptions médicales et des décisions médicales en rapport avec l'accouchement et la référence.

## *4.1. De quelques restrictions induites par les normes et les logiques afférentes*

La formation des agents de la maternité en soins obstétricaux d'urgence, a introduit des restrictions au niveau de certains gestes et actes médicaux autrefois apanage des agents des maternités périphériques. Ceci a entraîné une hausse des indications à la référence.
Ces restrictions les obligent donc à référer les cas indiqués vers l'hôpital de zone. L'introduction des normes SONU ont également permis au niveau de certaines phases du processus d'accouchement, l'utilisation de molécules et le recours à des gestes autrefois proscrits en périphérie.

Cependant tous reconnaissent qu'avec les nouvelles normes, il y a ce que les sages femmes et leurs aides apostrophent comme « un surplus de travaux élémentaires» évoquant ainsi la surveillance rapprochée de la parturiente prescrite avant pendant et après l'accouchement. La surveillance ici est perçue comme un acte à la fois fastidieux et secondaire qui incombe aux agents peu qualifiés.

En prise avec ces deux facettes (restrictions et permissions) de la nouvelle politique, les agents de la maternité se positionnent différemment. On distingue deux grandes tendances. Les choix vont de ceux que nos enquêtés appellent "les amis des patrons" ou "les chasseurs de félicitation" a ceux qui "ne respectent pas les normes".

La première catégorie d'acteurs considérés comme des zélés apparemment passifs, sont ceux qui s'appliquent à mettre en pratique à la lettre les normes SONU. Pour eux :

> « SONU nous amène à travailler moins. Avant, on se comportait comme des gynécologues, on gère tout comme des spécialistes or les SONU nous limitent et on ne commet plus de casse. Les protocoles te guident et tu n'as plus besoin de réfléchir. Avec ça nous sommes à l'abri ». Une sage femme, entretien du 07 –08-2007.

Ces propos témoignent d'un certain allègement des tâches et des responsabilités par les SONU en périphérie et qui est quelque part accommodant. On note également une fonction protectrice qui assure contre d'éventuelles complications du cas d'où la référence à temps. Cette attitude dénotent d'une certaine nonchalance, une tendance à se réfugier derrière les normes et comme l'a souligné May Post, une tendance à ignorer ses propres capacités et à ne pas chercher des solutions à des problèmes évidents. C'est cependant au niveau de cette catégorie d'acteurs qu'on retrouve les agents qui obtiennent les félicitations des partenaires au développement et des responsables administratives de la zone. Ils restent dans les limites des normes pour se faire féliciter. Par contre ces agents sont décriés dans leurs maternité par les usagers. A cet effet, un responsable administratif n'arrive pas à comprendre ce paradoxe :

> « la sage femme de la maternité X me demande chaque fois de l'affecter parce qu'elle est décriée par la population or elle est la plus appréciée de la zone par les différents partenaires lors des monitorings et supervision, à propos de l'application des normes. »Restitution monitoring du 11-08-2006

Les chapitres à venir vont davantage approfondir les manifestations de cette position.

Pour certaines de nos enquêtées, l'adoption de cette position a été temporaire. Juste le temps de constater que « nous sommes en train de perdre la face devant la clientèle » et "d'ajuster" à leur manière, les protocoles SONU. Aussi sur les 9 Maternités périphériques prises en compte, seulement une infirmière responsable de maternité et deux sages femmes ont affirmé respecter à la lettre les protocoles sans chercher à "tricher".

La seconde catégorie d'acteurs concerne ceux qui n'appliquent pas toujours à la lettre les guides SONU. Ils reconnaissent que :

> « C'est vrai que SONU nous aide mais avec ça, il ne nous reste plus d'actes importants à faire ; moi j'ai dit plus de références tout azimut car je finirai par perdre la main et personne ne fréquentera ma maternité (…) Il y a des choses frustrantes, on nous limite dans nos gestes juste parce que nous sommes à la périphérie ». une sage femme ; entretien du 08-08-07

L'une des logiques de cette catégorie de sages femmes, est de ne pas se laisser dépouiller de leurs malades lorsqu'on sait que leur crédibilité locale mais aussi leur survie

financière en dépend. Ainsi pour ces sages femmes, il s'agit de ne pas se limiter uniquement aux normes officielles, mais d'y adjoindre les "normes pratiques" identifiées par Olivier de Sardan (2001 op cit.) La logique de ces agents et les pratiques et stratégies afférentes, ne signifiant pas qu'ils ont mal assimilés les protocoles ni qu'ils les appliquent systématiquement de façon erratique. Mais souvent leur application dénote d'une réaction "judicieuse" en rapport à des situations précises. C'est dans les rangs de ces acteurs, que les usagers se disent satisfaits, le taux de référence moins élevé et plus de critiques de la part des superviseurs.

## *4.2 Durant le processus d'accouchement*

Le choix du processus d'accouchement se justifie par le fait de la concentration des décès maternels autour de cette période. Il est estimé que deux tiers des décès maternels se produisent à la fin de la grossesse et dans les 48 heures suivant l'accouchement (Abou Zahr 1998a cité par Graham et al. 2001). C'est donc la période la plus délicate qui exige plus de professionnalisme.

Avec les normes SONU, les sages femmes et les infirmières des maternités périphériques affirment qu'elles peuvent manipuler durant l'accouchement, l'ocytocine, pratiquer l'épisiotomie si besoin, prendre systématiquement l'abord veineux, etc. Nous allons évoquer au niveau de ce sous titre uniquement l'usage de l'ocytocine à cause des conséquences liée à une utilisation non judicieuse. L'abord veineux et l'épisiotomie seront pris en compte dans un autre ordre d'idée dans la suite du chapitre 4 et au chapitre 5.

Généralement les professionnels de la santé distinguent trois grandes phases dans le processus d'accouchement à savoir le Travail, l'Expulsion et la Délivrance. Si l'utilisation de l'ocytocine est permise en périphérie, les agents formés affirment que son utilisation est agréée voire obligatoire seulement durant la troisième phase de l'accouchement. A ce niveau il y a un paradoxe. En effet au cours des formations, toutes les sages femmes et infirmières sont initiées à l'usage de cette molécule à toutes les phases de l'accouchement indépendamment du lieu où elles exercent c'est à dire en présence d'un bloc opératoire ou non. C'est donc après la formation que la restriction est faite à l'endroit de celles qui exercent en périphérie où il n'y a pas de bloc opératoire. Voici ce qu'affirme une sage femme exerçant à l'hôpital de référence :

> « C'est à toutes les sages femmes qu'on a appris la règle d'administration de l'ocytocine pendant le travail.[…] même si la sage femme en périphérie sait comment régler les gouttes de l'ocytocine pendant le travail, elle ne doit pas en faire. » entretien du 9-8-07

Cette restriction au cours des deux premières phases de l'accouchement, n'empêche pas la disponibilité du molécule pour son usage systématique à la troisième phase. Pour une sage femme exerçant en périphérie, « avant les SONU, l'ocytocine n'était pas disponible de façon officielle dans les maternités périphériques et son usage n'était pas aussi répandu comme maintenant où c'est systématique avec toutes les femmes ». Pour une autre enquêtée cette fois ci aide soignante, « avant les SONU il y avait l'ocytocine mais de façon clandestine

car le centre n'en vendait pas. C'est avec SONU que c'est officiel à la pharmacie du centre » entretien du 11-08-07

L'aptitude acquise au cours des formations, la disponibilité du molécule, ajoutées aux logiques dans lesquelles les acteurs se trouvent, occasionnent des applications multiples en rapport aux prescriptions. Les mesures introduites sont réappropriées par les agents de santé en tenant compte des contraintes locales, des ambitions personnelles, des antécédents avec la hiérarchie sanitaire, du statut professionnel[1] mais aussi du souci de sauver la face devant le malade et les jugements de l'entourage. Ainsi selon une sage femme de l'hôpital de référence, « les sages femmes en périphérie sont obligées de tricher pour ne pas passer pour incompétentes devant la communauté mais elles ne mentionnent pas cela dans le registre ». De façon plus détaillée, une infirmière de la périphérie explique sa stratégie:

> « la disponibilité nous amène à tricher et à l'utiliser pendant le travail dans les cas exceptionnel pour aider certaines femmes comme les anémiées. Mais on ne le mentionne ni dans le registre ni dans le carnet. On prescrit cela à la femme comme si c'est pour gérer la troisième phase de la grossesse or c'est pour le travail. C'est pourquoi on prescrit plus que les 10 unités recommandées pour la troisième phase. On sait comment gérer cela car si par malheur une équipe de supervision passait… » Entretien du 12-9-07

Cette attitude ne garantit pas la fiabilité des données sanitaires et ne permet pas également une appréhension directe des faits dans les maternités. Il faut des séjours longs, une intégration du milieu avant de déceler la réalité concrète qu'une simple supervision avec son caractère parfois menaçant ne saurait saisir. Or c'est avec les résultats de ces supervisions évaluations que les normes sont révisées ou conçues.

Pour d'autres responsables de maternités périphériques, ces choix se justifient par des mesures de prudence mais aussi par le fait que les normes ne cadrent pas toujours avec les expériences pratiques qu'elles ont acquises sur le terrain. Ainsi :

> « SONU a bien dit de ne pas utiliser les ocytocines pendant le travail d'accouchement en périphérie où il n'y a pas de bloc opératoire. Mais dans certains cas c'est à dire chez certaines femmes, la théorie et la pratique sont opposées. Voilà qu'avant que la tête du fœtus n'appuie le col pour que la dilatation soit complète, l'ocytocine fait réagir vite l'utérus et la femme accouche. C'est parce que beaucoup de sages femmes ne savent pas s'y prendre qu'on nous dit de laisser. C'est pourquoi il n'y a plus de références intempestives de ma maternité. » Entretien du 8-8-07

[1] Selon qu'on soit agent permanent de l'Etat, agent contractuel de l'Etat ou agent contractuel du centre de santé c'est-à-dire ayant pour employeur direct, l'autorité sanitaire locale.

Cependant, même l'utilisation prescrite de ce produit durant la troisième phase de l'accouchement, occasionne des utilisations autres.

« on attend plus après l'expulsion ; automatiquement on met l'ocytocine et on sort le placenta, c'est 10 Unités mais on va parfois à 20 unités lorsque avec la première dose, le placenta ne décolle pas » une sage femme, entretien du 08-08-07

En somme, il serait difficile voire impossible de contrôler l'usage d'un produit disponible et accessible en périphérie et d'en limiter l'application à une seule des différentes phases de l'accouchement. Lorsqu'on sait que c'est tout le processus de l'accouchement que peuvent conduire les sages femmes ou celles qui en font office.

En se référant aux discours de nos interlocuteurs, le recours à l'ocytocine pendant les périodes proscrites, est souvent justifié par le refus de référer les femmes selon les indications des normes.

## *4. 3 Autour de la référence*

La stratégie SONU repose essentiellement sur la référence à travers la notion des trois retards qui empêcheraient les femmes d'accéder aux soins d'urgences. En mettant l'accent sur la référence, elle suppose qu'à chaque palier de la pyramide sanitaire, correspond un paquet d'activités à l'endroit des usagers. Aussi les agents des maternités, selon le niveau où ils se situent devraient fournir juste le nécessaire de soins permis et référer dès que les normes ne les autorisent plus à continuer les soins face au tableau que présente le cas. Lors d'enquêtes précédentes[1] nous avons pris connaissance avec les obstacles à la référence qui vont des plaintes des usagers concernant les références dites expéditives à but punitif aux plaintes des agents de santé sur les refus des usagers d'accepter les décisions de référence. Sans oublier aussi les nombreux problèmes liés aux transports et aux autres coûts de la référence.

Sur notre terrain d'étude actuel, nous nous intéressons aux décisions et pratiques des sages femmes périphériques en face des restrictions des normes SONU qui exigent une référence.

Selon certaines sages femmes, en suivant les normes, elles n'auront rien d'autre à faire que de référer tous les cas d'accouchement de la périphérie vers l'hôpital de référence. En témoignent ces extraits d'entretien :

> « En suivant SONU, il ne nous reste plus beaucoup de choses à faire. C'est pourquoi nous même on choisit : si la fièvre n'est pas associé au travail, on gère nous même. Avant, on gérait la hauteur utérine élevée puis avec SONU on nous dit de référer à 40 cm mais nous ne respectons pas à tout moment. On essaie d'apprécier peut-être la femme a du paroi et ça marche» entretien du 7-09-07 une sage femme responsable de maternité.

Les agents de santé affirment que ces choix sont guidés par le souci de satisfaire les usagers en leur évitant les nombreux coûts qu'occasionne une référence. « On nous a juste appris les gestes d'urgence avant de référer. Mais si on réfère, c'est qu'on ne veut pas travailler pensent les usagers d'autres disent que tel agent est PAPANE[1] et on l'étiquette

[1] Il s'agit d'une première étude sur "Itinéraires et Vécus des femmes ayant bénéficié d'une Intervention obstétricale majeure à l'hôpital De Zone de Dassa" Coopération Suisse au Bénin décembre 2001 puis d'une série d'enquêtes réalisées dans le cadre du programme multidisciplinaire AQUASOU au niveau des centres périphériques de Cotonou et d'Abomey Calavi qui réfèrent vers l'HOMEL et la CUGO( septembre 2003 à février 2004 : LASDEL - CREDESA- IRSP- Coopération Belge) ; une série d'entretiens et d'observations dans le cadre professionnel lors des appuis de la Coopération Suisse au Bénin

[1] du nom de l'hôpital de référence qui accueille les référés

comme cela parce qu'il réfère beaucoup. » une Infirmière diplômée d'Etat entretien du 7-8-07.

Par contre certains agents affirment qu'ils respectent les normes et réfèrent la femme dès que les indications l'exigent. Ainsi au cours de la séance de restitution du monitoring du premier semestre 2007 le 10 août 2007, séance à laquelle nous avons pris part, certains représentants de la communauté ont fustigé l'attitude des sages femmes qui réfèrent à tout moment. En effet, les exposés ont montré que 3 des 7 maternités monitorées affichent des taux de référence allant de 20 à 35%. Un président de COGEC trouve qu'« en suivant les protocoles, vous allez perdre vos compétences » parlant des sages femmes. Il trouve également que « ces sages femmes se cachent derrière les protocoles sans aucune conscience professionnelle pour faire des références expéditives » et estime comme l'affirme cet infirmier, qu'

> « En dehors des normes, nous pouvons mieux faire comme ce qu'on a appris à l'école pour pouvoir soulager les patientes de la référence qui est un problème pour elles. Il faut ajouter nos propres connaissances car tu vas référer et c'est quelqu'un qui a fait la même école que toi qui va finir par traiter la femme. Il faut se demander pourquoi je réfère ; est ce à cause des normes ou parce que le cas me dépasse ? Et si ce sont mes parents qui sont référés comme cela est ce bon ? » Restitution monitoring du 10-08-07

Une sage femme qui a un taux de référence peu élevé dans sa maternité, renchérit :

> « SONU dit de référer si dans le tracé du partogramme[2], la phase de latence dure plus de 8 heures mais si toi qui est devant le cas tu trouves qu'en faisant ci ça peut marcher (…). Je jauge le cas. A cause de cela j'ai eu une vive discussion au CODIR avec mes supérieurs. Au fait tant que la sage femme est disponible, il ne doit pas y avoir beaucoup de cas référés. Le taux de référence élevé chez certaines collègues est dû au savoir faire de chacun. Quand tu réfères trop, au regard de la communauté c'est que tu ne connais rien. Au début je référais aussi mais depuis que j'ai pris les choses en main, la fréquentation qui avait baissé a augmenté et les références ont diminuées » entretien du 07-08-07

Autres stratèges utilisés par les sages femmes pour empêcher ou retarder la référence tout en se mettant à l'abri de quelconque représailles en cas de problèmes, consistent en deux procédés qui se trouvent détaillé dans les extraits d'entretiens suivants

[2] Lorsqu'on sait l'usage qui est fait des partogrammes outil d'aide à la décision, dans les maternités. Très peu servent à cette fonction car ils sont tracés après l'accouchement juste pour la cause des supervisions.

> « L'un des constats, c'est l'écart entre l'heure d'arrivée et l'heure du traitement définitif. Avec SONU, c'est au plus 15 minutes pour le traitement initial et 2 heures pour le traitement définitif sinon on réfère. Donc les sages femmes jouent avec ça pour ne pas référer et se mettre à l'abri. Ainsi si après un premier traitement il n'y a pas de résultat dans les 2 heures qui suivent, elles inscrivent une autre heure d'arrivée et un autre traitement. » Entretien du 9-8-07 une sage femme responsable au niveau de la zone sanitaire de Tchaourou

> « En périphérie, par exemple pour rester dans les normes, nous appelons l'ambulance et on profite du temps de trajet de l'ambulance pour mettre les soins en retardant l'évacuation et souvent on arrive à sauver la femme et l'ambulance retourne bredouille » une sage femme à la séance de restitution du monitoring du premier semestre 2007 le10-08-07

Cependant, les sages femmes justifient le non respect strict des normes par la crainte des jugements émis par les usagers mais aussi au regard de la frustration qui découle de l'incapacité d'achever un accouchement entamé. Ainsi :

> « En tant que sage femme tu surveilles la grossesse et le travail puis c'est une autre sage femme comme toi qui va procéder à l'accouchement et à la délivrance. C'est pourquoi c'est frustrant de référer. Tu fais le gros lot du travail et une personne vient simplement dégager. Devant la population, c'est celui qui sort l'enfant qui a fait l'accouchement » entretien du 8-8-07

Par contre de l'avis d'un responsable médico administratif de la zone, « les sages femmes doivent référer car nous n'avons pas obligation de résultats mais plutôt de moyens. Elle a à faire ce qu'on doit faire. S'il faut référer et tu ne réfères pas, c'est là qu'on va t'attaquer » entretien du 09-08-07

C'est pour dire que la sage femme n'est pas notée sur la base de l'issue favorable de l'accouchement mais plutôt au regard des procédés dont elle a recours pour exercer. Est ce des procédés en rapport avec les normes ? Même si l'application stricte de ces normes ne rencontre pas toujours l'agrément des utilisateurs.

## *4.4 Les différentes positions des usagers face à l'introduction des SONU*

Les usagers qui ont fait l'objet d'entretiens au cours de nos investigations, ne connaissent pas le concept SONU et n'en ont jamais entendu parlé. Aussi avons nous travaillé en tenant compte de cadres temporels. Les usagers évoquent "la période d'avant" et "la période actuelle" qui remonte à 2 ans. Des entretiens que nous avons eu avec ces utilisatrices des maternités, trois catégories de pratiques professionnelles découlent de la mise en œuvre des SONU qui cadre avec "la période actuelle" . Ces pratiquent posent problèmes à leur niveau et les limitent dans l'accès aux services. Il s'agit de la fréquence des décisions de référence, des actes de Révision Utérine et de la prescription systématique de molécules et consommables médicaux. Seule la fréquence élevée de la décision de référer, concerne quelques maternités plus précisément celles de Kika et de Tchaourou. Quant aux deux autres pratiques, elles sont communes à toutes les maternités prises en compte par l'étude.

### *4.4.1 la référence*

Dans deux des maternités où la référence est en hausse, les statistiques ont montré une baisse de la fréquentation. Il s'agit des maternités de Kika et de Tchaourou. Ainsi selon un infirmier à la maternité de Kika, les accouchements sont passés de 16-20 à 6 voire 4 par mois. Néanmoins les femmes de cette maternité viennent faire les Consultations prénatales à la maternité et accouchent dans le cabinet privé d'à côté mais parfois chez l'aide soignante de la maternité publique. Dans ce cadre précis, l'aide soignante, agent de santé public, devient pour la circonstance à domicile, agent de santé privé. Les restrictions n'existent plus alors et les interactions avec les usagers ne sont plus les mêmes que celles qui ont cours dans le centre de santé publique. Centre de santé publique dont la responsable maternité fait partie de celles qui font une application stricte des normes SONU.

Les usagers expliquent : « dès qu'un petit problème surgit, on te dit d'aller à Parakou en ville à plus de 20 km ». En se référant à un cas récent, l'infirmier raconte :

> « La dernière fois l'échographie a révélé une grossesse gémellaire avec présentation de siège et la responsable de la maternité a dit à la femme de ne pas venir au centre si le travail commence mais d'aller directement à l'hôpital de référence. En face de cette interdiction de venir à la maternité du village, la dame a accouché à la maison et la sage femme à dit que c'est à cause des protocoles SONU » propos recueillis lors de la restitution du monitoring du 10-08-07

Notons qu'au cours des investigations, une accouchée à la maternité du Centre de Santé de Tchaourou explique :

> "Pour cet accouchement, j'avais été référée et j'ai refusé. Ils ont dit que c'est à mes risques et périls et j'ai dit oui. Ils ont alors prescrit un produit qu'ils m'ont administré et quelques minutes après j'ai accouché. Il y a des sages femmes qui te donnent du courage pour supporter la douleur» entretien usagers du 07-08-07

Une accompagnante évoquant la fréquence des références, ajoute : « les agents du centre de Tchaourou ne veulent plus aider, elles ne sont plus audacieuse comme avant ».

Au niveau de ce centre, aussi bien les usagers que le personnel de l'hôpital de référence s'accordent pour reconnaître qu'il y a un abus des décisions de référence même au delà des prescriptions SONU.

Selon l'une des sages femmes qui reçoivent les cas référés à l'hôpital de zone,

> « il arrive qu'on reçoive des cas de Tchaourou où aucun diagnostic n'est posé. Par exemple un monsieur m'a dit que dès que la sage femme a su que sa femme attendait des jumeaux, elle les a référé vers l'hôpital. Il faut savoir ce qu'on met dans les SONU » propos lors de la restitution du monitoring du 10-08-07

Les agents de ces maternités apostrophées, justifient leurs actes par le fait que tous les services qui interviennent dans la prise en charge correcte des femmes ne sont pas disponibles en même temps. Mais aussi parce que les normes affirment de ne pas recevoir plus de 5 femmes par jour si on veut faire de la qualité. Il est à noter cependant que ce ne sont pas seulement les nouvelles normes qui gouvernent toutes les pratiques des agents de santé.

### *4.4.2 La Révision Utérine (RU)*

« Avant il n'y avait pas autant de révision utérine. Avec mes deux derniers accouchements elles me l'ont fait or c'est très douloureux. Ma sœur qui vient d'accoucher a refusé et la sage femme a dit que c'est obligatoire pour éviter les hémorragies ». Entretien du 07-08-07. Ainsi parlait une de nos interlocutrices, accompagnante dans une maternité.

C'est le caractère douloureux de cet acte qui fait qu'elle a retenu particulièrement l'attention des usagers. Pour celles qui ont eu droit à cet acte, « on ressent des douleurs comme une grande plaie dans le ventre ». Même les agents de santé reconnaissent son

caractère douloureux « c'est vrai que c'est très douloureux mais c'est pour les sauver. » une aide soignante entretien du 20-08-07

Au fait la Révision utérine est un acte qui se pratiquait dans les maternités bien avant l'avènement des normes SONU. Mais avec ces dernières, les indications pour la pratiquer sont revues à la hausse dans le but de prévenir les hémorragies. Ainsi selon une sage femme, « si il y a plus de RU c'est parce qu'on fait beaucoup plus attention et les indications pour le faire ont augmenté.» entretien du 8-8-07

De façon plus précise, les normes SONU selon une Infirmière responsable d'une maternité,

> « exigent l'examen systématique du placenta. Dès que le placenta ne sort pas en intégralité même si la femme ne saigne pas, on fait la RU. De même si il y a intégrité du placenta et la femme saigne, on fait RU. C'est pourquoi la fréquence de ce geste est élevé» entretien du 10-08-07

Cependant, la non disponibilité de certains instruments sont également à la base de la fréquence de cet acte en périphérie car

> « Avant de faire la RU, il faut l'examen sous valve pour vérifier si ce n'est pas le col qui saigne mais n'ayant pas les instruments en périphérie pour le faire, les agents vont directement à la RU ce qui fait croire qu'on en fait trop.» une sage femme de l'Hôpital de Zone entretien du 9-8-07



### *4.4.3 Les prescriptions de consommables médicaux*

Les normes SONU dans leurs mises en œuvre, ont entraîné l'utilisation accrue d'un certain nombre de consommables médicaux dont le coût repose sur les usagers. Il s'agit des gants, de l'ocytocine, du cathéter, des solutés et du perfuseur. De façon systématique pour tout accouchement, ces produits et consommables sont prescrits aux femmes dans un but curatif mais le plus souvent préventif. Ainsi l'exigence de la prise d'un abord veineux systématique pour la femme en travail, exige la prescription du cathéter. De même l'importance donnée à la surveillance occasionne l'emploi de plusieurs gants à usage unique. En effet « La surveillance est plus accrue et chaque heure il faut le toucher donc changer de gant à chaque étape » une infirmière, entretien du 10-08-07.

Ce sont surtout les prescriptions des gants qui suscitent les réactions des usagers. En témoignent les extraits d'entretiens suivants :

> « une fois j'ai acheté 18 paires de gants et pourtant la sage femme n'a pas pu me faire accoucher et m'a référée à Papané où j'ai encore acheté d'autres gants. Ils font du gaspillage, parfois, ils portent plusieurs gants à la fois » un usager à la maternité de Tchaourou entretien du 07-08-07.

> « on achète pour chaque CPN trois paires de gants ce qui fait 300 F en plus de 350F pour la consultation ou 450F lorsque c'est la première fois. C'est après qu'il y a les médicaments qui font en moyenne 2000 F si tu n'est pas malade.» un usager du CS de Tchaourou entretien du 12-08-07.

Ces versions sont approuvées par les agents de santé eux même qui trouvent que pour les usagers, SONU a occasionné l'usage de beaucoup de consommables « les gants, l'abord veineux, tout ça revient cher aux usagers ». Entretien du 09-08-07

Au cours d'un entretien, une sage femme affirme :

> « Moi par exemple je prescris plus parce que je double mes gants et à chaque fois j'enlève pour écrire ce que j'ai remarqué car je ne confie pas aux aides soignantes et je fais cela au moins chaque heure. L'utilisation des gants dépend de la durée du travail d'accouchement. Avec 10 heures de travail, plus la surveillance post partum, ça fait au moins 20 paires de gants pour les sages femmes qui les doublent. » Une sage femme de l'hôpital de zone entretien du 9-8-07

Eu égard à ce

*Chapitre 5 : Les transformations induites par la politique SONU et le jeu des acteurs*

U en voulant soulager les

ersé le processus d'offre

## *5.1 Vers une surmédicalisation ?*

En se référant aux pratiques des professionnels autour de l'accouchement, Buekens avait attiré l'attention sur "la surmédicalisation des soins aux mères dans les pays en voie de développement". Pour cet auteur, « la pratique de la césarienne, de l'épisiotomie et l'utilisation de l'ocytocine durant l'accouchement sont en nette progression dans les pays en voie de développement. Si il n'y a pas d'indication d'une augmentation des taux de césarienne en Afrique, les chiffres sont déjà supérieurs à 5 % dans beaucoup de régions urbaines » (Buekens 2001). Cependant une étude de la représentation de l'OMS au Bénin à estimé en 2006 le taux de césarienne rapporté à la population du département de l'Atlantique et du Littoral, à 12% . Les normes fixent le taux normal pour couvrir les urgences obstétricales à au moins 5% et au plus 15%.(Bulletin trimestriel de la représentation de l'OMS au Bénin, 2006).

Sur notre site d'investigation, les statistiques donnent à l'hôpital de zone, un taux de césarienne de 11% en 2004 et 8 % en 2005 (rapport césarienne effectuée à l'hôpital sur l'ensemble des accouchements de la zone).

Parlant de l'épisiotomie acte autorisé en périphérie, n'ayant pas assez de données la-dessus, nous ne pouvons pas qualifier la pratique qui en résulte même si Buekens[1] parle de 87,4% de son application chez les primipares au Nigeria avec toutes les conséquences qui en découlent.

Ce qui nous intéresse surtout, c'est l'analyse sur l'usage de l'ocytocine. L'utilisation des ocytociques fait partie de l'ensemble des soins obstétricaux d'urgence de base recommandés par les organismes internationaux. (Donnay cité par Buekens 2001)

Au cours des descriptions antérieures, nous avons évoqué la disponibilité de l'ocytocine dans les maternités périphériques et les différents usages afférents. Ces usages sont motivés d'une part par les prescriptions de la politique SONU, mais aussi par les normes qui relèvent de "cultures professionnelles locales et privatisées". L'on ne saurait donc affirmer de façon catégorique que c'est seulement avec l'avènement des SONU que ces pratiques autour de l'accouchement ont vu le jour. Mais l'on peut avancer que loin de réduire

[1] Idem

ces pratiques (l'utilisation de l'ocytocine), ces normes les ont exacerbées tout en les rendant quelque peu officielles.[1]

Ainsi l'utilisation de cette molécule, au lieu d'être réservée uniquement dans des cas où le risque est grand, est passée dans la routine. Mieux, elle est passée de la clandestinité au grand jour. A plusieurs reprises, nous avons entendu des sages femmes et même des aides soignantes, banaliser son emploi « Si l'utérus est vide on peut donner ce qu'on veut d'ocytocine. Dès que l'enfant est déjà sorti on peut mettre ce qu'on veut pour réussir la délivrance » une sage femme, entretien du 9-8-07. De même « Après la RU, si l'utérus ne se rétracte pas, on remet l'ocytocine » une sage femme, entretien du 8-8-07

Selon un responsable du MSP, les agents de santé ne mesurent plus les conséquences que peuvent entraîner de tels abus sur les femmes car :

> « Au fait la mort ne suit pas tous nos gestes. Il y a aussi les séquelles qui comptent 30 fois plus. C'est à dire que pour un décès maternel, on a 30 femmes qui ont des séquelles à traîner toute leur vie et qui augmentent le risque de décès maternel pour des grossesses ultérieures. Il faut donc multiplier le Ratio de mortalité maternelle par 30. » Entretien du 12-11-07

il continue en ces termes :

> « l'ocytocine utilisée en amont c'est à dire pendant le travail d'accouchement, par voie veineuse va directement dans le sang, entraîne plus d'hémorragie chez la femme car après cette administration continue d'ocytocine, l'utérus se relâche et c'est cela qui entraîne les hémorragies. » entretien du 12-11-07

Ce discours rejoint celui de Buekens qui affirme que la fréquence avec laquelle l'ocytocine doit être utilisée au cours des périodes d'effacement, de dilatation et d'expulsion, est un sujet plus controversé(…) L'administration d'une dose excessive d'ocytocine peut causer une hyper stimulation et même une hypertonie utérine (Dujardin et al. Cité par Buekens, 2001)

Quant à son utilisation au cours de la troisième phase, même si elle présente des risques moindres, elle n'est pas toujours recommandée. Une revue systématique de quatre études comparant l'attitude active (y compris l'injection d'ocytociques) à l'expectative au moment de la délivrance, a montré que la gestion active de la délivrance en routine était supérieure à l'expectative, en termes de pertes de sang, d'hémorragie du post-partum,

[1] Il serait souhaitable d'investiguer dans des stratégies visant la réduction de ces pratiques autour de l'accouchement.

d'hémorragies sévères du post-partum, de besoin de transfusion sanguine au cours du puerpérium, et d'anémie du post-partum (Prendiville et al. cité par Buekens 2001).

Au Bénin également de pareils constats se font aussi. En réalité, « la GATPA soulage la sage femme mais c'est une fausse assurance car elle croît éviter systématiquement les hémorragies. Mais au fait elle évite seulement 60 % des hémorragies du post partum. Et les 40% restant ? Il faut donc surveiller. » Un médecin de santé publique, entretien du 12-11-07

Déjà certains de nos interlocuteurs sur le terrain, en ont fait l'expérience : « quand la GATPA échoue, c'est des complications graves comme l'hémorragie qu'on arrive pas à gérer » une responsable de maternité périphérique, entretien du 11-08-07.[1]

Les sages femmes, n'ayant pas eu au cours des formations, des informations sur les limites des normes dans la résolution ou la prévention des complications, elles y placent toute leur confiance. En témoignent ces utilisations à tout vent. Mais pour certains responsables, ces sages femmes se réfugient plutôt derrière les normes pour camoufler leur incompétence.



[1] Voir infra sous titre 3.2 où nous avons parlé de l'évaluation de cette technique au niveau national qui a montré que seulement 22% des GATPA réalisées sont bien faites.

## *5.2 L'exigence de la qualité avec des ressources limitées*

### *5.2.1 Des ressources humaines*

Au cœur des normes SONU se retrouve le souci d'offrir aux femmes, des soins de qualité. Pour ce faire, l'accent est mis sur la qualification des agents[2] qui doivent fournir les soins. Cependant, l'étiquette "professionnelle seule ne peut suffire à décrire la capacité technique ou la compétence, et que nous ne devons pas considérer seulement la réduction du risque mais aussi l'augmentation du risque de mort maternelle en présence d'un personnel "professionnel" non qualifié (Gray 1997 cité par Graham et al. 2001). Aussi est il exigé que ça soit la sage femme ou l'infirmière tenant lieu qui fournisse les soins aux femmes. Les aides soignantes ne devant jouer que des rôles secondaires.

Pour plusieurs raisons (que cette étude n'a pas pris en compte), ce n'est pas toujours ce que nous avons observé dans les maternités de notre site de recherche. Il nous est arrivé d'observer un aide soignant prendre seul la garde. Cet aide affirme : « moi je ne suis formé ni en GATPA ni en SONU mais je fais ce que je peux car je reste de garde seul » aide soignant de Sanson entretien du 11-08-07

Pour les responsables de maternités, ce sont des contraintes surtout lors des

> « CPN où on dit que c'est la sage femme qui doit tout faire même prendre la tension et que va faire l'aide soignante ? Moi j'ai formé mon aide à prendre la tension. Le tout dépend de comment nous avons pris notre SONU » une sage femme, entretien du 8-8-07

Même de l'avis des responsables, ce n'est pas faisable vu l'effectif du personnel en service dans les maternités périphériques. Selon l'un d'eux,

> « En périphérie, une sage femme ne peut pas rester 365j sur 365 donc l'aide fait des gestes de Sage femme par exemple beaucoup d'aides administrent l'ocytocine pour la GATPA » entretien du 9-8-07

En témoigne une aide soignante « je fais aussi les RU, la GATPA, l'abord veineux, la tension, » entretien du 11-08-07.

Dans le cadre toujours de la disponibilité, l'impossibilité d'assurer la présence permanente du seul agent qualifié de la maternité, entraîne également l'interruption de l'offre

[2] Même si nous pensons qu'il faut plutôt associer la compétence à la qualification, les deux n'allant pas toujours de paire. Il y a eu dans la littérature assez de controverses sur l'efficacité d'une assistance qualifiée dans la réduction des décès maternels. Cf. à cet effet, GRAHAM et al. 2001

de soins. Ainsi donc, « un seul gynécologue ou une seule sage femme ne peuvent assurer la permanence des soins 24 heures sur 24. Or c'est ce qui leur est souvent demandé dans les maternités périphériques (…) ceci entraîne la démotivation du personnel, l'abandon des structures de soins et des pratiques frauduleuses » (Prual 2004).

Toujours dans le même ordre d'idée concernant les ressources humaines, le même auteur peint ce tableau qui n'est pas loin des réalités de notre cadre d'étude : « Les rares personnels qualifiés, démotivés par des salaires très bas, des conditions de travail difficile, une absence de reconnaissance, des décisions arbitraires de la hiérarchie, fuient littéralement vers le secteur privé lucratif tout en restant officiellement dans la fonction publique où se font recruter par ces mêmes organismes qui se plaignent de l'insuffisance du personnel qualifié dans les maternités. Les maternités publiques sont désertées par les personnels qualifiés qui restent pourtant présent en théorie.[1] »

Les agents de santé en situation vont plus loin en ce qui concerne la disponibilité des soins. Pour eux, même en présence de l'agent de santé, il arrive que les femmes n'aient pas accès aux prescriptions SONU :

> « Avec un seul agent, l'application des SOU à toutes les femmes est impossible. Si il y a deux femmes qui accouchent en même temps, il y a une qui ne peut pas bénéficier ni de GATPA ni d'une surveillance accrue. je laisse l'autre faire sa délivrance naturelle et si il y a problème, je fais recours à la référence. Avant l'accouchement il faut une surveillance toutes les heures et après la délivrance, toutes les 15 minutes, il faut prendre la température, la tension artérielle, vérifier la couche et ce durant 6 heures. Aussi une femme sera délaissée au profit de l'autre. Même avec une seule femme qui accouche, on ne peut surveiller à la lettre. Il faut du personnel pour appliquer cette politique. » Un aide soignant et une infirmière, entretien de groupe du 11-08-07

La permanence des soins exige également la disponibilité des services aussi pour une sage femme de la maternité de Tchaourou, « Si parfois on dit aux femmes de partir à PAPANE, c'est parce que tous les services ne sont pas disponibles en même temps. Comment faire albuminurie à minuit ? » Entretien du 10-08-07

### *5.2.2 Des ressources matérielles*

[1] Idem.
Concernant la part des organismes d'appui à l'absentéisme dans les formations sanitaires, on peut citer également les nombreuses invitations à des séminaires, ateliers et formations dont l'efficacité reste à démontrer.

On ne saurait parler de l'application des normes sans s'intéresser à l'environnement matériel dans lequel évoluent les acteurs. Dans la zone sanitaire de Tchaourou, les ressources sont limitées aussi bien au niveau des maternités qu'au sein des usagers. Les ressources limitées des maternités ainsi que le faible pouvoir d'achat des populations entraînent des accommodations qui réduisent la qualité des soins. Par exemple, « SONU dit d'utiliser les gants stériles pour les soins, l'accouchement et la RU mais faute de moyen en périphérie, on utilise les gants propres » entretien du 16-8-07. Il arrive également des ruptures de molécules dont l'ocytocine. Ainsi « en 2006, il y a eu rupture d'ocytocine pendant 7 mois et on se débrouillait avec les spécialités des officines privées ce qui revenait plus cher aux usagers » une infirmière, entretien du 18-08-07.

L'insuffisance de ressources fait que l'application des normes n'est pas également réparties dans les maternités. Ainsi selon un responsable médico administratif, « trois maternités n'ont pas de frigo pour garder l'ocytocine donc n'appliquent pas officiellement GATPA » entretien du 9-8-07. Mais de par nos observations, nous avons constaté l'utilisation de l'ocytocine dans l'une de ces maternités.

L'un des éléments qui expriment la limitation des ressources, est la référence vers l'hôpital. Comme nous l'avions dit plus haut, toutes les maternités de la zone de par la distance qui les sépare de l'hôpital de PAPANE, n'y réfèrent pas leurs cas. Ainsi malgré la gratuité des évacuations instaurée en 2005, tous les cas n'y ont pas accès.

## *5. 3 Les coûts supportés par les usagers*

Au cours des entretiens, tous nos interlocuteurs notamment les usagers, ont déploré l'augmentation du coût des services et soins liés au suivi de la grossesse et à l'accouchement depuis l'avènement des SONU. Si il faut désormais acheter « gants, sérum, cathéter, perfuseur, ocytocine et autres», il faut remarquer aussi qu' « avant, les gants n'étaient pas à usage unique ».

Selon une sage femme en périphérie,

> « tout produit engendré par les urgences sont systématiques et avec SONU les coûts augmentent, les consultations coûtent plus chères, pour faire un accouchement maintenant, c'est entre 4000 et 7000 f, l'abord veineux revient à 1500f et les gants à raison d'une moyenne de 10 par femme font 1000 f », entretien du 7-8-07

Les usagers quant à eux, révisent ce prix à la hausse : « l'accouchement avec les médicaments varient entre 9500F et 15000F or avant c'était 5000F» un groupe d'usagers, entretien du 11-08-07.

Certes, ces choix obéissent à un souci de la qualité. Mais on ne saurait atteindre la qualité sans y impliquer les expectatives des usagers. Toute normes doit associer efficacité clinique et satisfaction du client.

Dans le domaine de la santé reproductive, la qualité signifie « offrir toute une gamme de services sûrs et efficaces qui répondent aux attentes et préférences des clients » (Kols et Sherman, 1998 cité par Beninguisse & al., 2005).

Face à ce dilemme coût qualité, certains agents de santé préfèrent sacrifier les normes pour garder leur clientèle. A cet effet, une responsable de maternité périphérique déclare :

> « L'une des difficultés de SONU, c'est le pouvoir d'achat du paysan. Si en tant qu'agent de santé tu veux appliquer à la lettre les protocoles, ton prix sera élevé et ce sont les cabinets privés qui vont drainer tes patients. La première CPN seule coûte déjà 1500F. Même le prix de la mutuelle a été légèrement augmenté à cause des SONU » entretien du 11-08-07

Mais de l'avis d'une aide soignante, « le coût dont parle les usagers, c'est surtout la référence et les gants » entretien du 11-08-07

Si pour les gants, il s'agit juste d'un coût économique, pour la référence, les coûts sont multiples. Ils vont du socioculturel à l'économique en passant par le psychologique.

Du point de vue socioculturel évoqué par certains auteurs, la référence est perçue comme un malheur, une malédiction voire l'incapacité pour la femme d'accomplir normalement sa fonction reproductive qui est une conjugaison harmonieuse du naturel (c'est-à-dire du « proprement physiologique ») et
du spirituel, (Beninguisse, 2003 ;Lallemand, 1991 ; Erny, 1988, cité par Beninguisse et al., 2005.)

Aussi lorsqu'il s'avère qu'un agent de santé fait le diagnostic d'une évacuation, c'est qu'il annonce un pronostic sombre, un mauvais présage pour l'enfant et la mère. C'est pourquoi les usagers préfèrent les centres de santé où les décisions de référence ne sont pas fréquentes, afin de ne pas subir un étiquetage voire une stigmatisation de la part de l'entourage. De plus, la référence vers l'hôpital est synonyme d'un accouchement par césarienne. Or « dans beaucoup de cultures, la césarienne est considérée comme un échec de la reproduction[1]. Il y a beaucoup de risques que ces femmes ne reviennent plus pour un accouchement institutionnalisé (qui risque de devoir se faire par voie haute) et accouchent à domicile, avec un risque augmenté de rupture utérine » (Bergström 2001).

Les traumatismes psychologiques émanant d'une référence sont incalculables et ont des répercussions sur la santé de la mère et de l'enfant. La peur de l'inconnu, l'angoisse, le sentiment de culpabilité, sont des états qui rongent les femmes et la famille à l'annonce d'une référence.

Le coût économique de la référence concerne non seulement le transport mais surtout le séjour à l'hôpital de référence loin des activités économiques quotidiennes. Ces séjours reviennent chers sur le plan médical, alimentaire, etc. Souvent la femme et sa famille ont eu à faire face déjà à des dépenses pour des soins au premier niveau.

Tous ces éléments doivent être pris en compte par les prestataires afin d'encourager et de garantir la fréquentation des maternités c'est à dire le recours aux soins obstétricaux.



[1] Cette conception se vérifie au Bénin par la publicité de certains guérisseurs dans les médias à propos de remèdes anti césariennes pour les femmes enceintes. Cependant, tout usage du terme "culture" ne doit jamais oublier qu'on a affaire à des dynamiques permanentes de transformation des représentations et des normes c'est à dire de tout ce qui donne un sens concret au terme de "culture" (Sardan,1995) Cf. Infra chap. Méthodologie.

# *Conclusion Générale*

Tout au début de la conception de cette étude, nous avons voulu étudier uniquement les logiques et stratégies des acteurs. Mais tout au long des recherches, nous avons constaté que les logiques et stratégies des acteurs font appel à des pratiques spécifiques sur le terrain. De même ces pratiques prennent sens dans un contexte donné, un environnement (humain et physique) qui les favorise. Au cours de l'analyse des données, bien que nous ayons mis l'accent sur les stratégies et les pratiques des acteurs, nous avons débouché sur les conséquences éventuelles de certains abus aussi bien sur les usagers et le système de santé que sur les normes elles mêmes. Mais avant, nous nous sommes intéressée à cette politique au plan national et comment son transfert est fait au niveau local.

L'application des normes SONU dans la zone sanitaire de Tchaourou, révèle les tendances suivantes :

Les normes officielles des SONU contenues dans les documents sont réinterprétées c'est à dire mise en œuvre sur le terrain à la lumière des logiques et des stratégies propres aux acteurs. Les pratiques qui en découlent varient selon l'acteur en présence et l'objectif visé. Ainsi les uns préfèrent satisfaire les usagers au détriment du respect des normes ; tantôt à juste titre, tantôt avec des abus. D'autres par contre, appliquant avec zèle les normes avec les encouragements des supérieurs, sapent les attentes des usagers et occasionnent également des dérives.

L'un dans l'autre, quelle que soit la logique ou le choix qui guide les professionnels des maternités, l'application des préceptes SONU affecte les interactions entre agents de santé et usagers et engendre des "effets pervers".

L'autre constat qui découle de notre analyse est que l'offre de soins SONU se fait dans un environnement incompatible avec ses principes directeurs mais aussi contre les attentes des usagers. Douleur, surmédicalisation, coût social, coût psychologique, coût économique sont le lot des usagers avec les applications qui en sont faites. Au fait, les SONU malgré leur rapport aux cas urgents, sont passés dans la routine. Les SONU sont plutôt administrés de façon systématique à toutes les femmes en périphérie d'où les dangers de la surmédicalisation.

Une hypothèse non prévue mais qui se retrouve vérifiée, est que les normes en elles mêmes portent des germes d'échec de la stratégie en ce sens que dans la conception[1], nous sommes en face d'une politique qui facilite la circulation de produits à usage délicat et comptant aussi sur la référence à temps vers l'hôpital dans un contexte où la dégradation des conditions élémentaires de vie, les coûts d'une prise en charge hors du lieu de résidence, l'association référence et incompétence de l'agent de santé, intériorisée par les usagers, sont autant de facteurs bloquant l'expression des normes SONU. Une attention particulière doit être accordée à la référence en tant qu'élément majeur des soins obstétricaux d'urgences de base, afin qu'elle ne demeure pas un fardeau, un frein à la politique des SONU au point de nous faire conclure que "c'est la référence qui tue la stratégie de la référence".

Autre élément d'attention est l'usage de l'ocytocine autour duquel aussi bien les normes que les professionnels ne s'accordent clairement.

L'augmentation des coûts que les nouvelles normes ont engendré, limite l'accessibilité des femmes. L'accessibilité financière devient un enjeu majeur aussi bien pour les usagers que pour les agents de santé car « pour assurer les coûts de fonctionnement des maternités, chaque équipe essaie de trouver des solutions, bien souvent en dehors de tout contrôle et de toute transparence ce qui laisse libre cours au débordement » (Prual, 2004 op cit).

Au total, plusieurs goulots d'étranglement côtoient au quotidien la mise en œuvre des SONU dans la zone sanitaire de Tchaourou : ressources humaines peu qualifiées et peu compétentes, ressources matérielles insuffisantes, problèmes économiques limitant l'accessibilité financière, les comportements stratégiques des agents de santé et des usagers, le caractère peu réaliste de certaines directives des SONU, etc.

Admettons enfin que trop de références mettent en cause l'efficacité du niveau Centre de Santé d'Arrondissement (CSA). Aussi ne serait il pas bien de promouvoir les interventions d'efficacité avérée mais aussi de renforcer ce niveau des soins plus accessible aux populations ?



[1] Faite in muro dans un contexte international

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