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Publication date

2018

Document Version

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Citation for published version (APA):

Cremers, A. L. (2018). *TB truths: Patients' experience with tuberculosis and healthcare in sub-Saharan Africa*. [Thesis, fully internal, Universiteit van Amsterdam].

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Exploring processes of boundary-making and the concept of medical pluralism in Lambaréné, Gabon

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Submitted

ABSTRACT

The topic medical pluralism fuels interesting discussions about how healers position themselves and their healing practices within a therapeutic landscape, and how patients navigate between a vast array of therapeutic traditions. Based on fieldwork in Lambaréné, Gabon, this paper examines discursive practices of tuberculosis patients and healers indicating that therapeutic traditions were kept separate. Attention is given to a national programme of the Gabonese government which fosters traditional medicine and potentially informs boundary-making processes between therapeutic traditions. They reinforce traditional healers' position within the Gabonese therapeutic landscape and additionally aim for collaboration between traditional medicine and biomedical medicine. This paper confirms popular paradigms of boundary-making within the medical pluralism debate wherein boundaries are produced and crossed to contrast, strengthen, purify, and divide the therapeutic landscape. Additionally, I differentiate between formal, state-sponsored and local discursive practices. I introduce the concept *conventional boundary-making* describing the reluctance reflected in patients' and healers' discursive practices regarding the notion of fluid or adaptive boundary-making processes within the therapeutic landscape.

Jadougou had brought his wife, Adeline, to a hospital in Lambaréné, Gabon, because she had felt very ill for months. Here, she was diagnosed with extrapulmonary tuberculosis (TB). Adeline was hospitalized for several weeks and put on first-line antituberculous drugs, but did not seem to recover. During my visits at the hospital, Adeline was too ill to converse, so I mostly talked to Jadougou. He continuously expressed his troubles regarding the care of his wife. He feared that her TB was magical; that someone had bewitched her, but struggled with the taboo of using different therapeutic traditions simultaneously. Their church leader had approved this hospital visit, yet condemned consulting a traditional healer as such healing practices were associated with work of the devil. However, in case of bewitchment, treatment from the hospital could not cure his wife. During several visits he admitted that he was planning on visiting a traditional healer:

'If my wife is still ill after some time, we might go to the traditional healer. We, Protestants, are not supposed to go there. [...] The church doesn't like it if two different religions are combined. But you have to do something to get healed'

(Informal conversation, husband of TB patient Adeline, Jadougou).

Jadougou carefully expressed that he could only justify a switch to another therapeutic tradition if it was certain that the biomedical treatment would provide no cure. Unfortunately, Adeline died after four weeks leaving Jadougou devastated and with mixed feelings about his own care-taking behaviour. On the one hand He regretted that he had not done everything to save Adeline's life. However, on the other hand he described feeling relieved at not having engaged in different therapeutic traditions at the same time.

Jadougou's carefully plotted care seeking behaviour and his changing decision points over time, raises the question how medical pluralism is shaped and organized in Lambaréné, Gabon. In this article, I focus on TB patients and their healers in Lambaréné, Gabon who resort to discursive practices to explain how they navigate a plural medical field while acting on TB. With discursive practices, I refer to discourse that not merely reflects the existence of a reality, but additionally defines the social rules that construct this reality.¹ Moving away from literal actions or behaviour, this study analyses the idea of conceptual boundary-making processes that are principally constructed within speech. Within the field of medical anthropology, encounters with different therapeutic traditions have often been discussed in the light of notions of boundary-making processes.

The idea of fixed, static boundaries between different therapeutic traditions has shifted to theories of how the variety of illness perceptions and therapeutic traditions intermingle and interact in people's practices while searching for a cure.^{2,3} The reproduction and the crossing of boundaries are mutually constitutive acts, as no boundaries are to be crossed if there are none produced and the other way around.⁴ Boundary-making practices between therapeutic traditions are often presented as being fluid and continually reconfigured.^{4,5}

Whilst explaining the functioning of medical pluralist societies and associated practices of boundary-making, various authors have referred to the role of the state, predominantly in Eastern^{6,7} or Western countries.^{8,9} States may impose a discourse that purposely excludes biomedical explanations and practices to professionalise and strengthen the position of traditional medicine within society. Their campaigns may prompt processes of negotiation and redefinition of both traditional and modern medicines.⁷ Luedke and West⁴ describe how boundaries are created to define and delineate traditional healing, but at the same time can be crossed, challenged, and shifted.

Likewise, in Gabon, boundary-making practices within the Gabonese therapeutic landscape have changed and shifted through colonialism and nationalistic political programmes. TB patients negotiate treatment decisions in a context where the national political programme fosters the traditional cult and same-named religion *Bwiti* and associated traditional therapeutic practices. *Bwiti* has been given a lot of emphasis, because the Gabonese government claims that it represents Gabonese tradition. Scholars describe *Bwiti* as a political project to reunify the various ethnic groups of Gabon defining what is 'authentically' Gabonese.^{10,11} Traditional medicine is one of the important elements embedded within this politicised traditional *Bwiti* culture. A state-imposed campaign fosters traditional healing and may produce processes of boundary-making by acknowledging the position of traditional healers in the therapeutic landscape. Moreover, their campaign breaks boundaries down by encouraging collaboration between healers. Such a therapeutic discourse of boundary-making and -breaking can achieve local and national relevance informing the medical plural landscape and the position of its actors.

Within this debate about medical pluralism and boundary-making, I would like to add an additional concept, *conventional boundary-making*. This concept is derived from my respondents' discursive practices which portrayed a separateness between therapeutic traditions. Both healers and patients explained that boundaries were crossed at times, a practice that is extensively discussed in the literature. However, boundaries were not shifted or reconfigured. Similarly, Orr¹² briefly notes that in contrast to contemporary theories, he had hardly encountered a blurring of boundaries between therapeutic traditions in southern Peru. One of the examples in which discursive practices reflected notions of conventional boundary-making was the case of Jadoungou who explained a preference to engage in therapeutic traditions subsequently and not simultaneously.

To elucidate notions of conventional boundary-making, I draw on five months of fieldwork in Lambaréné, Gabon. This study has been part of a larger health study on TB in Lambaréné, hence this explains why the focus of fieldwork has been narrowed down to TB patients and their healers. Nevertheless, study results go beyond the theme of TB, as patients and healers often discussed healing practices and navigation of the therapeutic landscape in general. In this article, I discuss some of the vast array of literature concerning medical pluralism with a focus on conceptualisations of therapeutic traditions. After, I will introduce this study and the main therapeutic traditions encountered in the field. I draw on notions of conventional boundary-making to present TB patients' and healers' discursive practices in response to their experiences of navigating the therapeutic landscape. I do not claim that the notion of boundary-making is new, neither that medical pluralism does not occur. Instead, I aim to describe a variant of boundary-making processes that manifests in discursive practices and in which a reluctance towards boundary-reconfiguration is embedded. In other words, boundaries are said to be crossed but not challenged and shifted. Finally, I will speculate why discursive practices of such boundary-making practices occur and how these could be related to theories of state power^{13,14} and Gabonese therapeutic identity politics.^{10,11,15}

MEDICAL PLURALISM AND PROCESSES OF BOUNDARY-MAKING

In the seventies, Leslie¹⁶ represented the variety of biomedical, traditional, and alternative health care in India and China as *medical systems* acknowledging their well-developed and sophisticated nature. This idea formed a sharp contrast with previous studies that described traditional medicine merely as part of traditional religions. The representation of medical pluralism as equal to medical systems strengthened traditional healers' positions and recognized their ability to compete with biomedical systems.^{5,17} Kleinman¹⁸ further questioned the ubiquity of biomedical interpretations by introducing a differentiation between the social construction of *disease* and *illness*. He advocated recognition of both biomedical diagnoses and of patients' experience of illness. Within the idea of an individualised illness experience, scholarly attention was increasingly given to the influence of specific sociocultural, political, and economic contexts, leading to a wide range of models to explain illnesses and health care.⁵

The notion of *multiple explanatory models*¹⁸ evoked discussion about patients' responses to an environment in which a variety of therapeutic traditions were present. Theories started off with the idea of fixed, parallel systems with sharp boundaries, used by patients either sequentially or simultaneously.^{18,19} This paralleled the popular multiculturalism theories of the nineties in which minority groups maintained their identities and practices and were not expected to assimilate into a dominant cultural group.²⁰ Yet, the representation of closed medical systems with their own internal logic, homogeneous group of practitioners

and patients, and structured treatment regime became criticized. Last³ referred to a spectrum of de-systemized and scattered medical practices from which patients would choose when it was considered appropriate. He presented patients as pragmatic, i.e. patients who would engage in pluralist health strategies in order to get healed as soon as possible. Several anthropologists described trial and error practices as a common part of decision-making processes regarding therapeutic traditions. Failed treatment in one tradition would trigger the patient to seek health care from another therapeutic tradition.^{2,21} The associated taxonomy of therapeutic traditions often applied by anthropologists became widely rejected.²³ Rejection of a certain hierarchy should be seen in the context of the modernization debate in which the superior position of modern culture and the presumption of a linear evolutionary development into modernity was replaced by processes of cultural maintenance and interplay between *modern medicine* and *traditional medicine*.²² African therapeutic traditions did not seem to be destroyed through colonialism or replaced by biomedicine, but appeared adaptive and resilient.²³ Conversely, Europeans likewise adopted and internalised elements of African therapeutic traditions, such as herbal remedies.²⁴ Following these ideas, later approaches presented biomedical and traditional therapeutic traditions in a more symmetrical fashion leading to a reconsideration of the latter and its importance for patients. Moving beyond the idea of systems within certain hierarchies, various authors have offered looser frameworks, such as the term *therapeutic traditions*.²⁵

Nowadays, anthropologists have repeatedly demonstrated the problematic conceptualization of processes of entanglement between different therapeutic traditions and explanatory models. A variety of processes have since been described, including *bricolage*, *hybridism*, *syncretism*, *assemblage*, *eclecticism*, *selection*, and *adaptation*.⁵ In addition, various concepts came into use, such as *circulation*²³ and *indigenization*²⁶ to describe how actors in the therapeutic landscape crossed, shifted, and reproduced boundaries by adopting each other's therapeutic elements. In the last decade, yet another perspective which emphasises the fluid and continually changing nature of boundaries between therapeutic traditions, has gained popularity.^{4,5}

The notions of multiple explanatory models and *boundary-making* are closely related to debates of power strategies, as boundaries are generally considered arbitrary yet always powerful.²⁷ The maintenance and crossing of boundaries within the medical landscape are described by many as a tool to empower therapeutic traditions.⁴ For example, biomedical professionals may aim to maintain sharp boundaries with alternative therapeutic traditions in order to prevent competition and to confirm their superiority.²⁸ Similarly, faith healers have been observed to create a boundary by stressing how divergent their healing approaches are compared to other approaches.²⁹ Nevertheless, many contemporary ethnographers discuss how actors (mainly from the traditional or religious therapeutic traditions) transgress imposed boundaries, using this

action as a tool of resistance against taken-for-granted hierarchies in the therapeutic realm.³⁰ Studies have described how traditional and faith healer categories seem to mix and entangle leading to healers representing a variety of healing traditions and combining healing techniques.²⁸ Some traditional healers transgress boundaries by incorporating biomedical practices³¹ or creating institutions.²⁸ Boundary transgression fuels reinforcement of their medical expertise, authority, and legitimacy to heal.

Boundary-making processes can similarly be imposed by states generating powerful realities. The state can have an important influence on the development of a medical pluralist society and the maintenance or crossing of symbolic boundaries between therapeutic traditions. Most plural medical studies that focus on the role of the state, explore co-existence and processes of intertwinement between therapeutic traditions. Consequently, the literature often describes an integration of traditional medicine into national health systems.^{6,8,9} Zhan⁷ describes how the state aimed to scientificize Chinese medicine to enable competition with biomedical science. As a consequence of traditional medicine success, biomedicine and traditional therapeutic traditions were woven together, intermingling, interchanging and adapting. Zhan analysed-Chinese state-imposed discourses regarding traditional medicine and its relationship with national identity politics, but argued that the position of traditional Chinese medicine within the therapeutic landscape remained marginal.

This brief overview of medical pluralism with a focus on processes of boundary-making and the role of the state therein, scratches only the surface of the enormous plethora of available literature. However, it provides a framework for exploring and understanding the findings of my study.

METHODS AND SETTING

In 2012, I conducted four months ethnographic fieldwork in and around Lambaréné, Gabon with assistance from Grace Bikene, a local researcher. Aiming to explore how TB patients navigated a medical plural landscape, I approached thirty patients who were following TB treatment at the Albert Schweitzer Hospital (ASH), the governmental regional hospital, or the governmental ambulatory health care centre for HIV and TB (GAHC). Recruitment took place with the help of researchers from a TB epidemiology cohort study (PanEpi) at the ASH in Lambaréné. We visited patients multiple times at their homes and interviewed them and their family members in French about their experiences with TB and the associated (medical plural) care they engaged in. All interviews lasted one to two hours, were in-depth and semi-structured, and were complemented with various informal conversations. Additionally, we approached faith healers (N=8), biomedical healers (N=10), and traditional healers (N=5) to understand how they positioned themselves within the medical plural landscape of Lambaréné and its surroundings. I intentionally approached one

traditional healer outside of the research area, in the capital Libreville, because he was well-known to most respondents as a healer who combined both biomedical and traditional healing practices. Two focus group discussions were organized with around eight TB patients each, one at the ASH and one at the GAHC to discuss perceptions about TB and health care seeking behaviour. I conducted extensive participant observations at patients' homes and villages, the biomedical hospitals, during nocturnal traditional healing practices, and during exorcist sessions conducted by faith healers in various churches (Pentecost, Protestant, Catholic, Christiansme Celeste, Christianisme du Réveil).

In order to understand the position of the state regarding the therapeutic landscape and traditional healing, I visited the governmental Institute of Pharmacology and Traditional Medicine (IPHAMETRA) in Libreville, Gabon's capital. I conducted participant observation, and several in-depth interviews with its director and traditional healers (N=5) to discuss the role of traditional healing in Gabon. As stated earlier, *Gabonese traditional identity* is officially represented by the political construction of the Bwiti,³⁰ yet there are many other traditional societies and healing practices such as the *Ndokwe*, *Mekum*, and *Ndjembe*. These have received less political attention compared to Bwiti.³⁵ The website of IPHAMETRA merely referred to the broad term *traditional healing* and did not particularly specify Bwiti as the bringing together of a wide variety of traditional healers regardless of their cult or religion.

For analysis of ethnographic data I used a grounded theory approach leading to the emergence of five main themes of conventional boundary-making: dichotomy between medicine from the *Blacks* and *Whites*, a taboo of combining therapeutic traditions, justifying a change of therapeutic tradition, the danger of combining two therapeutic traditions, and therapeutic traditions in their essence being the same. Some themes may be familiar as they confirm older literature discussing the classical natural-supernatural dichotomy presented in African literature on health care³² and the secrecy surrounding traditional healing.³³ In the context of increased interest in shifting and reconfiguration of boundary-making between therapeutic traditions, these themes may take on a new meaning. Moreover, the latter three themes may shed some alternative light on how and why patients navigate between therapeutic traditions and may provide additional perspectives for the medical plural debate.

MEDICAL PLURALISM IN LAMBARÉNÉ

In Lambaréné, medical pluralism manifested in the vast array of therapeutic traditions available. I will, for the sake of convenience, loosely divide this medical plural landscape into three distinct categories: traditional healers, faith healers, and biomedical healers. In order to present a more symmetrical conceptualisation of these therapeutic traditions, I will refer to each of them as *healers* in this section. However, in the results section these terms will be

used interchangeably with the terms used by my respondents. Interestingly, respondents often referred to biomedical healers as doctors or medical doctors. However, one could argue that all categories can be considered as medical and all healers as doctors. Therefore, I have chosen to nuance this category with the term *biomedical*. The three categories of healers are based on a combination of the literature from Gabon, my observations during this ethnographic fieldwork, and the framing of healers and patients.

In order to understand the construction of *the traditional healer* in Gabon and the socio-political processes involved, traditional healing needs to be situated within the history of Bwiti. Around 1890, the ethnic group Fang incorporated the masculine initiation cult Bwiti and its similarly named religion Bwiti from the ethnic groups Mitsogo and Apindji in their own culture. With the arrival of colonist- and missionary influences in the same episode, Bwiti developed into a syncretic religion in which God, ancestors, and nature spirits were equally recognised. Many subcategories of Bwiti arose for different functional specialisations (*le Bwiti Disumba*, *le Misoko*, *le Ngonde*, *le Myobe*), varying rituals (*le Ndea*), or schismatic innovation (*le Sengedy*).³⁴ Samorini³¹ refers to inter-ethnic marriages, travel and local migration in order to explain how a wide variety of Bwiti interpretations was spread and practiced by a majority of ethnic groups. In addition, Ngolet³⁵ stresses that variety occurred because of different responses to economic and social problems encountered in Gabon.

Christians generally perceived the Bwiti religion and its followers as diabolic, because of their rich history of human sacrifices, anthropophagy, sorcery, and communication with the deceased. With support of the French colonial government, they aimed to eradicate this religion by killing Bwiti leaders and destroying their temples. This persecution and weakening of traditional knowledge invoked Bwiti to become a collective tool of resistance against colonial rulers meanwhile enhancing social cohesion among the Gabonese. In 1948, several important spiritual Bwiti leaders started a popular movement to reunify the different (Bwiti) cults and to strive for recognition by the Gabonese government.^{30,35} In 1960, Gabon became independent with its first president Léon Mba being a Bwiti initiate. After years of persecution, Bwiti came to symbolise a national and anti-colonial sentiment and '*the birth of the new Gabon Republic*'.³⁵ Nowadays, Bwiti is a fully recognised religion in Gabon and an important aspect of national identity, which secures traditional values. The therapeutic traditional values are promoted by IPHAMETRA. Interestingly, IPHAMETRA only represents herbal traditional healing and excludes traditional healing on a spiritual level.

Faith healers are not part of IPHAMETRA's assortment of traditional specialists despite the fact they have a prominent role in Gabonese society. In the literature, faith healers are often classified as the third type of traditional healer (alongside herbal and spiritual traditional healers), because of their similarities in therapeutic beliefs and practices. Both faith and traditional healers included

in this study explained TB as the involvement of evil spirits and were seen as authorities on witchcraft and sorcery. Whilst traditional healers were oftentimes additionally Christians, faith healers responded defensively after pointing out these similarities. They often stressed the fact that no linkages existed between them and traditional healers, because they condemned their work as practices of the devil. I will elaborate on faith healing practices in the context of Gabon's rich history, because they were presented as inseparable positioned within the Gabonese therapeutic landscape.

Processes of religious diversification in Gabon were not only apparent in traditional societies, but also within Christianity. New religious sects raised social and political issues and advocated an Africanization of the church. Their approach criticized the existing church policy for their sole focus on moralistic and religious issues, because of their state sponsorship. The proliferation of different churches, such as *Christianisme Celeste*, paralleled the emergence of new healing practices.³⁵

Biomedical medicine was introduced in Gabon during the colonial era and the arrival of missionaries. In 1913, Albert Schweitzer founded the first hospital in Lambaréné.³⁶ Nowadays, the hospital's colonial image with foreign sponsorship and foreign biomedical healers and nurses has progressed into a partially state-sponsored biomedical service with almost all the staff being Gabonese. It has developed into one of the three main biomedical facilities in this area. Biomedical healing has become more acceptable and accessible in the area, but is not universally trusted nor considered appropriate for all illnesses or conditions.

MEDICAL PLURALISM AND TUBERCULOSIS

The number of TB patients is alarmingly high in Gabon and many pass away because of this disease.³⁷ Despite my use of the term tuberculosis throughout this article, I do recognise the existence of a variety of diagnostic labels for this disease.

The traditional healers approached for this study used different names for TB but recognised its biomedical synonym. They treated TB patients with herbs, and some additionally used spiritual healing. Traditional healers formed a scattered, disconnected group, because of the variety of sources for their traditional healer knowledge and skills (e.g. through a dream, training of a spiritual father). Yet, there were some similarities as all healers were initiated in a traditional cult (three were Bwiti initiates), carried the name *nganga* (meaning healer in Bantu languages), and used the hallucinogen plant *iboga* as a central element in their (TB) healing practices. *Iboga*, by respondents referred to as *le Bois Sacré* (holy wood), was firstly used by the Pygmies who are seen as the original inhabitants of Gabon^{34,35} and is a symbol for Bwiti healing practices.³⁵ Moreover, these traditional healers were connected by a state-imposed campaign that professionalised traditional healing and each obtained a IPHAMETRA issued certificate to confirm their expertise in traditional healing.

Of the numerous Christian churches in Lambaréné, many engaged in faith healing of patients, using a power derived from the Holy Spirit. TB was often described as an illness bringing spirit and healing was represented in many different forms ranging from prayers to individual or communal exorcism sessions during which patients were released of evil spirits. Some faith healers additionally made use of herbal medication, holy water, or advised fasting. Various faith healers informed their patients of the option to additionally follow treatment at the hospital, but most condemned attending traditional healers.

Biomedical tuberculosis treatment at the included hospitals consisted of a first-line four-drug therapy to cure patients in six months. The Gabonese National Tuberculosis Programme (NTP) provided treatment without costs, but hospitals faced repeated drug stock-outs,^{38,39} which sometimes persisted for several months up to a year. At the time of this study, there were no diagnostic facilities to diagnose resistance against first-line TB drugs, and second-line drugs were not available.

Gabon's rich history of medical pluralism with its wide spectrum of traditional, faith, and biomedical therapeutic traditions, raises the question about what discursive practices are used by TB patients and healers regarding their own position while navigating this plural therapeutic landscape in search for a cure? In Lambaréné, notions of conventional boundary-making between therapeutic traditions were reflected in my respondents' descriptions of navigating the medical plural landscape of Gabon indicating how therapeutic traditions were kept separated.

DICHOTOMY BETWEEN MEDICINE FROM 'THE BLACKS' AND 'THE WHITES'

My research assistant's mother, Joessabe, was a traditional healer in one of the villages in the surrounding area of Lambaréné. On a daily basis, patients visited her house, often accompanied by their family members. Joessabe's important position as traditional healer within this village and the importance of traditional healing for the people living in the area was emphasised during various discussions and also observed during my many visits. While discussing traditional healing practices, they placed emphasis on terms, such as *tradition* and *real Gabonese*. Most framed it as '*this is what we have done for generations*' or '*what we have, is the medicine from the Blacks*'. Joessabe and the other traditional healers explained how their practices did not contain any Western elements, and illustrated their sole reliance upon traditional Gabonese resources, such as herbs, fetishes, and connection with their ancestors. These discursive practices reflected processes of boundary-making in which a distinction was made between *the medicine from the Blacks* as opposed to *the medicine from the Whites*.



Photo 1 Traditional healers during healing ritual using amongst others iboga and fetishes.

The hospital, described as a facility of the Whites, was considered *un-African* referring to the anonymous policy in the hospital whereby doctors did not know their patients and family members could only visit during strict visiting hours. Moreover, they explained that the traditional way of healing was considered *normal* for this country and its people; for *the Blacks*. This di-

chotomy between the hospital and traditional healers, between *the Whites* and *the Blacks*, seemed to play a central role in most of my conversations with both T B patients and traditional healers. Sometimes this topic was closely intertwined with stories of distrust towards doctors in which accusations of stealing blood for witchcraft and keeping Black people dependent on medication by not instantly curing their T B (and HIV) were voiced despite the availability of medication. Moreover, the hospital was perceived by many as a place where people died and therefore some people were reluctant to seek care in this place.

In general, traditional healers were the first point of care when falling ill for many Gabonese people. The majority of Gabonese people were initiated in a traditional cult, marking the transition into woman- or manhood, and additionally protecting you against evil spirits that might bring diseases. Udagudu, one of Joessabe's T B patients, explained what the consequences would be if someone was not initiated in a cult, '*Because [if you are not initiated] you are not protected against evil spirits and more importantly, you are not part of the group.*' Members of this group were expected to seek help from their traditional healer first and foremost. For many the hospital was not an accepted choice to seek healing, or at least not considered as an adequate first point of care.

At the governmental institute IPHAMETRA, the presentation of traditional medicine formed a sharp contrast with those accounts described above. Instead of a *Black* and *White* dichotomy, discursive practices reflected a merging of therapeutic traditions. Biomedical terms, such as *consult*, *prescription of medication*, and *written instructions* were combined with traditional terms. This mixing was also visible when I went to visit the IPHAMETRA centre in what appeared to be a big, sterile, white building with traditional healers wearing white coats, and the presence of both a laboratory and a pharmacy with herbal medications. This collection of biomedical elements gave the traditional healing institute the impression of a hospital. Additionally, the employees of IPHAMETRA underlined the need for traditional healers to professionalize and to collaborate with medical doctors.

The state's Bwiti campaign and IPHAMETRA's efforts to professionalize or enhance corporation between traditional and medical healers seemed to have little impact in Lambaréné. On hospital territory biomedical traditions dominated formal discourse from which traditional healing was excluded. Various biomedical doctors explained that for many Gabonese people the first point of care were traditional healers or faith healers. As a consequence, many patients attended the hospital when they had developed a very advanced stage of TB and were therefore seriously ill. At times patients were close to dying. In general, patients were very reluctant to discuss previous visits to faith healers or traditional healers with their medical doctors. Doctor Jean explained that this was problematic:

*'It is so important to know what healing they have done before coming to us. So I say: tell me, because I can see you are traditional.'*¹ *But even then patients will deny they have done any traditional healing practices.'*

(Interview biomedical doctor Jean)

Some doctors and nurses explained that the choice of healer often depended on a person's religion. Camilla, one of the nurses, expressed firmly, *'You can't combine different sides. That is not good. That is a taboo. You can go to the hospital or to the traditional healer.'*

During an in-depth interview at the home of TB patient Omelia, we discussed the topic of secrecy regarding traditional healing in hospitals. Bikene and Omelia explained that TB patients and health workers in the hospital were reluctant to straightforwardly admit usage of other therapeutic traditions, as doctors would scold or ridicule them. The corrections or jokes made people often feel ashamed. Moreover, patients were aware that doctors wield considerable power and were afraid that this might negatively influence their TB treatment. These boundary-making processes between biomedical healing and traditional or faith healing were enforced by biomedical healers because they often viewed the latter as problematic, due to the number of TB patients who delayed seeking urgently-required medical health care. Patients additionally engaged in boundary-making processes induced by attitudes of secrecy as they were aware that usage of traditional and faith healing was not considered appropriate at the hospital. Many patients did however engage in various therapeutic traditions. The way they navigated this medical plural landscape and boundary-making processes that arose from these practices, will be discussed below.

1 Being 'traditional' or part of a traditional cult, could be observed in initiation scars or certain clothes or accessories.

Patients regularly mentioned the need to put faith into one therapeutic tradition at a time. The case of Cedric is a good example of turning to different sorts of health care subsequently. I met him at the Albert Schweitzer hospital where he had received his first package for TB treatment and I offered him a ride home. We needed to drive for two and a half hours by car, take a canoe to cross a river, and walk for half an hour. In contrast to Cedric's initial claim that everyone in his village goes straight to the hospital when falling ill, he later elaborated about the role of different therapeutic traditions within his village:

'When I fell ill my uncle tried to heal me with medical herbs from the jungle. In every family there is someone with herbal knowledge, so that is the first thing to do. When this didn't work, I went to the pharmacy. I kept coughing and then I turned to four different traditional healers. [...] If a traditional healer can't heal you, you try another one, and so forth.'

(Interview TB patient Cedric)

Cedric explained that when a traditional healer had given up on him, he was advised to go to the hospital, *'[The traditional healers I attended] gave me the diagnosis "Tuberculosis of the Hospital". That meant they could not do anything for me anymore.'* Cedric subsequently visited four traditional healers and only decided to go to the hospital when he was assured that none of them was able to heal him. Cedric explained that he had lost confidence in the effectiveness of traditional treatment, which triggered him to try out *the medicine from the Whites*. By not engaging in multiple therapeutic traditions simultaneously, this boundary between the therapeutic traditions seemed to be maintained.

The choice of following only one healing practice at a time can be linked back to the often-heard phrase that it was very important to have faith in a treatment. TB patients Fussala, emphasised the power of having confidence or faith in a singular treatment:

'If you believe it [your treatment], you will get cured, but if you don't believe in it, it won't work. That's how it is. For the traditional healer and for the hospital too. For all different healing methods.'

(Interview TB patient Fussala)

She explained that a patient turning to different explanations for TB at the same time would hinder his own healing. Various patients and healers highlighted that believing in one singular treatment not only stimulated treatment compliance, but additionally enhanced the healing process on a spiritual level.

Besides faith or spiritual considerations, there were also physical reasons mentioned for engaging in a singular treatment at a time. I was introduced to Jack, a nurse from the hospital, whose sister was following TB treatment at his hospital. His sister lived next door with her husband who was a traditional healer. Jack, and with him many other biomedical health workers, had to navigate a pluralistic therapeutic landscape manifesting within their own family. Jack talked with respect about the work of his brother-in-law and described how his sister followed traditional treatment for eight months using herbs and plants from the jungle, but was not getting better. Her decision to attend the hospital, made her stop taking traditional treatment. Jack explained that the two treatments should not be combined, because the body was not strong enough to deal with two strong treatments at the same time. Similarly, most biomedical doctors described how they always advised patients to not combine treatments as they feared negative drug interactions.

There appeared to be a fine line between traditional and biomedical therapeutic traditions in the case of a biomedical doctor in Libreville, who was at the same time a traditional healer. However, instead of an ostensible intertwining of therapeutic traditions, the doctor stated that healing traditions were strictly separated, *'You should not combine the different healing practices. So we have different consults for them.'* The therapeutic traditions he engaged in were carefully separated in space, practice, and in speech. It was not considered *'good'* to combine two powerful healing traditions. Yet, it was accepted to first attend his biomedical consult at his biomedical consulting room and after treatment continue with a traditional approach in his traditional consulting room. The healing traditions were considered too powerful to be used simultaneously. A time restriction was maintained resulting in the use of different therapeutic traditions subsequently and requirement of having a biomedical consult first.

This boundary-making processes within time and the connection to the danger of combining powerful traditions were similarly presented during interviews with faith healers. Despite the fact that the church's doctrine condemned traditional healing and prohibited communication with the deceased (ancestors), most faith healers accepted the position of traditional healers within the therapeutic landscape. Aruna explained that even though it was *'wrong'* to



Photo 2 faith healer exorcizing TB-bringing spirit.

combine faith and traditional healing, everyone in Gabon would follow 'his roots' and additionally make use of traditional healing. He explained:

'We are in Gabon, in Africa. It is part of where we are and who we are.' [...] Everyone attends the traditional healer, you can never stop that. And some are able to heal TB. [...] But you should never combine two big forces, then it is better to choose [between traditional or faith healing].'

(Interview faith healer Aruna, church Christianity de Reveil)

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T B TRUTHS

They made a clear distinction between themselves and traditional healers stating that, *'We don't use herbs from the jungle. We leave that to the traditional healers. They do healing on another spiritual level.'*

THE THERAPEUTIC TRADITIONS IN THEIR ESSENCE THE SAME

An often mentioned statement was that that healing from the Whites and from the Blacks was in their essence the same. It depended on the choice of the patient where s/he preferred to go, either to the traditional healer or to the hospital. Dala explained how therapeutic traditions were seen as in their essence, the same:

'The Africans, [...] the plants they use from the jungle, those are used by the whites as well. The Whites are in a way using the knowledge of the Blacks. [...] They only compress it in tiny, balanced pills. In contrast, the Blacks cook a big pot full of medication and tell you that you should drink everything. But in fact, it is the same thing, exactly the same medication. [...] So it wouldn't make sense to use both. [...] Patients choose one healing.'

(Informal conversation, TB patient Dala)

The idea that traditional and biomedical healing is in their essence the same, was in some way mentioned by biomedical doctors who explained that their pills consisted of plants from the jungle. Yet, they did stress the importance of laboratory-made pills and the careful balancing of ingredients. This idea reflects a blurring of boundaries between therapeutic traditions, but triggers boundary-making processes when patients ought to make a choice between therapeutic traditions. Joessabe emphasised, *'You either go to the hospital or you go to the traditional healer. It is your own choice.'*

DISCUSSION

Describing accounts of my fieldwork in Gabon, I illustrate how TB patients' and healers' discursive practices regarding their navigation of therapeutic traditions reflect processes of *conventional boundary-making*. This is distinct to the

concept of *boundary-work* in which boundaries are often framed as arbitrary, permeable, and flexible. In recent anthropological literature in general,^{40,41} and in medical pluralism literature specifically,^{4,5,23,26} boundaries are often described as being maintained, crossed, changed, shifted, and reproduced. Rather, with the notion of conventional



Photo 3 Albert Schweitzer Hospital

boundary-making, I do refer to the maintaining and crossing of boundaries, but additionally describe a reluctance towards the reconfiguration of boundaries and the protection of the purity of therapeutic traditions. This notion of boundary-making processes resonates with theories on multiculturalism. According to various authors, many people resist the dissolution or shifting of old boundaries in order to protect the purity of their cultural identity.⁴² Along the same lines, many anthropologists have been concerned with the notion of boundaries to describe how ethnic groups mobilize typification systems to define who they are and who they are not.⁴³

Conventional boundary-making processes are created through an interplay of personal choices of health care, relational processes between therapeutic traditions and healers, and are intertwined with notions of purification, distinction, credibility, and authority. The way these processes influence connections, separations, and alignments within the therapeutic landscape, affects how therapeutic traditions are defined and positioned in Gabonese society. The findings of this study suggest that boundary-making processes exists in various forms and carry disparate values and meanings. Respondents intentionally stress the difference between therapeutic traditions and associated medication with the prominent and often-mentioned dichotomy Medicine from the Blacks versus Medicine from the White. (Synonyms for this dichotomy mentioned by respondents were: disease of Blacks vs. disease of Whites, disease of God vs. disease of witchcraft, and disease of the hospital vs spiritual disease. The terms resonate with the classical natural-supernatural dichotomy presented in African literature on health care.)³² Consequently, this dichotomy roughly divides the therapeutic landscape and its actors, notwithstanding each bounded ascriptions representing a wide variety of therapeutic traditions.

This boundary-making process has spatial and discursive dimensions as it influences what topics can be discussed in which areas. For instance, it is a taboo to discuss matters of traditional healing on hospital territory, and for patients who are initiated into a specific cult it is not considered appropriate

to (first) consult a biomedical doctor. The latter was sometimes enforced by discursive practices about conspiracy theories in which the Whites try to suppress the Blacks by not providing them with an instant cure for their TB and by the belief that they potentially steal their blood for witchcraft. These stories reflect and negotiate certain concerns and anxieties regarding biomedical health workers and hospitals, places that are often conceived as a place where people die. Likewise, Saethre and Stadler⁴⁴ describe various tales of white malice in the field of public health that exist throughout sub-Saharan Africa. Beyond this Black-versus-White dichotomy, faith healers' discursive practices similarly reflected taboos informing boundary-making processes, as they condemned patients who went to traditional healers accusing them of working with the devil.

Exploring the idea of taboo, this boundary-making can be linked to underlying power strategies. Both healers and patients' discursive practices reflect clear distinctions between the pure therapeutic traditions, leaving no space for processes of syncretism, bricolage or eclecticism. The various healers mostly present themselves as being purely biomedical, traditional/Gabonese, or Christian to pursue a pure and authentic position within Gabonese society. (This purification can be slightly nuanced as all traditional healers identified themselves as Christians, hence this may indicate some form of shifting or blurring of boundaries. However, traditional healers did explain their healing practices differed completely from those of faith healers.) Besides boundary-making processes on a discursive and spatial level, there are additionally discursive practices illuminating boundary-making processes that seem to influence how patients navigate the therapeutic landscape over time. Temporal boundaries compel patients to negotiate the variety of therapeutic traditions in a certain way: patients are not supposed to engage in different therapeutic traditions simultaneously, but can make use of a variety of traditions subsequently. These boundaries are constructed on individual levels, as it is deemed necessary for patients to fully commit to a therapeutic tradition in order to achieve cure. If patients have exhausted all means of one therapeutic tradition and consequently have lost faith, it is socially acceptable to move to another therapeutic tradition. The choice of therapeutic tradition depends heavily on the patient's religion and associated faith, but is not a static preference as patients are allowed to change and adapt their faith in a therapeutic tradition overtime. Another form of a temporal boundary that is closely related, derives from discursive practices about '*the danger of combining two different therapeutic traditions at once*'. Using therapeutic traditions simultaneously would accumulate excessive power and could have damaging (physical or spiritual) consequences for patients. Crossing this boundary by mixing therapeutic traditions would not cure patients, yet choosing one after the other would avoid premature death. Through this boundary-making process, each therapeutic tradition is considered very powerful, thus, claiming its own space and legitimization within the therapeutic landscape.

Discursive practices about '*all healing being in their essence the same*' seems at first to contrast boundary-making processes described above. Because therapeutic traditions that are *the same* and obtain a similar level of credibility, would indicate that boundaries become blurred and consequently lose their value. In contrast to the literature, this blurring of boundaries is not caused by a transgression of boundaries by traditional healers who are copying biomedical aspects.³⁰ Respondents simply explained how biomedicine is rooted in traditional medicine, as both their medications originates from the same plants in the jungle. (It is interesting to note that faith healers are not mentioned within this argument, amongst others because most faith healers practice healing methods on a spiritual level and do not use plants or biomedical medication). However, this blurring of boundaries does trigger boundary-making processes on an individual level for patients navigating therapeutic traditions. Their choice depends on a personal preference for a certain therapeutic tradition, because it does not make sense to try different therapeutic traditions if they are essentially the same thing. According to this reasoning, individual health care decisions and thus boundaries between therapeutic traditions, determine how patients should navigate the therapeutic landscape. This can be related to the often-mentioned idea of '*having faith in one therapeutic tradition at a time*'. However, individual boundary-making processes informed by the idea that therapeutic traditions are the same, omit a temporal division as a change of therapeutic tradition even later in time is difficult to justify. Therefore, a change of therapeutic tradition is often explained with a change of TB aetiology and consequently the need for a new therapeutic approach.

On the governmental level, discursive practices reflect processes of negotiation, interchange, and redefinition of traditional medicine shifting and recreating boundaries. The aim of IPHAMETRA's to professionalise traditional healing is reflected in their presentation of laboratories, biomedical devices, and distribution of certificates to professional traditional healers. They do not only transgress boundaries between traditional and biomedical therapeutic traditions, but additionally create new boundaries by presenting traditional healing as merely an herbal and not a spiritual practice. Meanwhile, they strive for collaboration between traditional and biomedical healers, which breaks down boundaries between therapeutic traditions (again faith healers are not mentioned within this discourse despite the fact that faith healers behold a prominent position within Gabonese therapeutic landscape).

Comparing discursive practices of boundary-making of IPHAMETRA's employees with those discursive practices of patients and healers shows various differences. Despite the potential of a state to influence boundary-making processes between therapeutic traditions, IPHAMETRA's reconfiguration and reproduction of boundaries is not reflected in the discursive practices of healers and patients in this study. In contrast, as described above, discursive practices show processes of boundary-making in which intertwining of medical practices

and the recreation of therapeutic traditions not only does not occur, but is even considered a taboo. Both patients and healers deploy discursive practices that clearly separate the various therapeutic traditions and stress in multiple ways that mixing and combining therapeutic traditions is not considered appropriate. Similarly, Herzfeld⁴⁵ describes the often found incongruence between formal, state-sponsored versus local discourse about identity and boundaries.

In sum, this study confirms several components of the debate surrounding medical pluralism, such as patients' and healers' boundary-making processes and the transgression of boundaries. However, I would like to introduce the concept of *conventional boundary-making* to additionally illustrate how my respondents' discursive practices reflected the need to keep different therapeutic traditions separate. This neither entailed rethinking of local illness explanatory models nor the creation of a new syncretic model wherein different therapeutic practices were combined. Boundary-making processes were intentionally enforced to contrast, strengthen, purify, and to divide the therapeutic landscape in time, space, and speech. Meanwhile, these processes may guide patients in their navigation of this space and their search for cure and may additionally confirm healers' place and authority in the therapeutic landscape.

Whilst creating conceptual parameters for the medical pluralism debate with the notion of conventional boundary-making processes, I underline that this research focused on discursive practices as opposed to actual behaviour. Following this argument, discursive practices reflecting boundary-making do not necessarily reflect practices. Indeed, given that my research merely focuses on discursive practices, no conclusions regarding respondents' daily activities can be drawn. However, respondents did give the impression that they literally kept therapeutic traditions separate while navigating the therapeutic landscape and that therapeutic healers aimed to maintain and practice a pure therapeutic tradition. Therefore, it would be interesting to further explore patients and healers daily practices and how and why they are compelled to navigate the disparate therapeutic traditions in Gabon during future ethnographic research. Moreover, as respondents of this study tended to discuss the medical plural landscape and their navigation in more general terms, future research could narrow its focus down on the particularities of TB within the context of medical pluralism.

EPILOGUE

Lastly, I would like to speculate why discursive practices of conventional boundary-making are deployed. Looking at literature about Gabon's therapeutic landscape, the state-imposed discourse regarding therapeutic traditions provides an extra layer of context while analysing boundary-making processes. In Gabon, state-imposed identity politics could play a role in the formation of power division within the therapeutic landscape.^{10,11,15} This is particularly interesting

within a post-colonial timeframe where social orders often get contested.¹³ For example, the state's amplification and maintenance of '*the traditional*' can create a strong and authentic position within a country augmenting political power as a contra-movement to colonial rule.¹¹ Diving into political literature about Gabon, these processes of boundary-making may be read as being part of a larger political process.

Explaining the underlying reasons for national identity politics and the focus on 'Bwiti' in Gabon, scholars have referred to contrasting arguments. Samorini¹¹ and Swiderski¹⁰ describe how imagined ecumenism of a Bwiti society is supported by the Gabonese state and functions as an empowerment of the Gabonese people and traditional medicine against colonial powers. Ngolet describes that the state proclaims the purpose of unification of the Gabonese people with an emphasis on their tradition or 'Bwiti', and pre-eminence (*Gabon d'abord*, translation: Gabon first, one of Omar Bongo principles written in his famous Little Green Book). However, according to Ngolet, the main reason for this state's identity politics is to convince the Gabonese of perfect leadership and to stay in power. Meanwhile, most of Gabonese society remains poor and obtains a marginalised position in society. Ngolet explains that this political strategy to enhance false thinking elicited a counter-reaction of the disillusioned Gabonese people against the state transforming Bwiti (and other emerging traditional societies and religious sects) into their own instrument to reject this post-colonial hegemony. Consequently, this provided a new space for a wide variety of therapeutic traditions.

Following Ngolet's line of reasoning, the question arises whether patients' and healers' discursive practices reflecting boundary-making can be seen as part of this strategy to rebel against the powerful position of the post-colonial government. Resorting to the purity of therapeutic traditions might be considered a remedy to deal with 'associated societal problems like political and economic marginalization, disturbed social order, and an associated sentiment of frustration'.¹⁵ This is specifically interesting while looking at tuberculosis, one of Gabon's major health concerns^{37,46} and described as a 'disease of the poor'.⁴⁷ Social scientists focused on tuberculosis often refer to theories of structural violence⁴⁸ as this disease mainly hits the most marginalized and vulnerable people with a low socio-economic position in society due to social structures of inequality and poverty. More research is needed to explore this extra dimension of why boundary-making processes may occur within discursive practices of both TB patients and their healers in Gabon.

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