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Original Research Article

Normative Logics and Therapeutic Negotiations: A Study of Dengue Fever in Bingerville

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Abstract: This sociological study analyses the normative regimes and heterogeneous logics of action mobilised by carers and patients in the management of dengue fever at Bingerville General Hospital. It examines power relationships, social imaginations and medical devices in a context of biocrisis. Based on a methodological triangulation (interviews, participant observation, documentary analysis), the study highlights dissonances between biomedical norms and lay knowledge. These discrepancies compromise the co-production of care. The analysis thus calls for therapeutic protocols to be reconfigured to incorporate local rationalities, with a view to more reflexive, situated and intersubjectively negotiated health governance.

Keywords: Normative logics, popular rationalities, dengue management.

INTRODUCTION

The empirical data collected reveal a complex interweaving of institutionalised care systems and culturally situated regimes of representation, structuring both healthcare professionals and patients at Bingerville General Hospital. Caught up in a logic of compliance with biomedical injunctions, carers frequently find themselves confronted with local epistemologies of illness and care, expressed through vernacular therapeutic practices. This lay knowledge, perceived as dissonant or even disqualifying by medical professionals, is nevertheless part of a symbolic economy of health that is legitimate in the eyes of patients. This friction reveals a latent conflict between hegemonic rationalities and subaltern knowledge.

The central paradox revealed by this study lies in the coexistence, indeed the intertwining, of pragmatic adherence to biomedical treatments and the persistence of traditional symbolic matrices structuring patients' health behaviours. While biomedicine operates according to a logic of normalisation and standardisation of practices, it is confronted with locally rooted regimes of meaning, which reconfigure the appropriation and legitimacy of the care prescribed. This epistemological tension calls into question the capacity of the medical field to consider the dialogical articulation between scientific knowledge and popular rationalities in the management of endemic pathologies, within a fundamentally plural therapeutic space.

The aim of this study is to examine the interactional configurations between established healthcare systems and vernacular representations of the disease, by shedding light on the negotiation logics that unfold at the intersection of these heterogeneous rationality regimes. More specifically, the aim is to analyse the effects of these intersecting rationalities on the concrete ways in which dengue patients are cared for, while examining the tactical adjustments made by healthcare workers in the face of paradoxical injunctions from the field. By mapping the areas of dissonance and mutual translation, the study suggests ways in which therapeutic co-construction can be contextually intelligible and culturally situated.

The scientific scope of this research is based on a desire to decipher the socio-cultural configurations that shape medical practice in the African context, particularly in areas of hybridisation where biomedicine and endogenous therapeutic knowledge are articulated. The aim is to provide a detailed understanding of the interactions between institutional norms and popular rationalities, in order to rethink the governance of healthcare in epidemic crisis situations. From a socio-operational point of view, the study aims to outline intervention strategies rooted in local realities, promoting a more inclusive and co-constructed approach to care. It is part of a burgeoning scientific field in which contemporary research is mobilising a variety of critical approaches to analyse the logics of appropriation, negotiation and resistance within infectious disease management systems.

Epidemiological investigations, enriched in particular by contributions from the WHO (1998) and Andries (2015), have made it possible to define dengue as an acute viral infection with a strong febrile component, whose typical symptomatology includes headache, diffuse pain, skin rashes and leukopenia. When it worsens, the disease can develop into a severe haemorrhagic form, combining persistent fever, signs of bleeding, liver damage (hepatomegaly) and, in critical cases, haemodynamic changes leading to a syndrome of hypovolaemic shock induced by massive plasma leakage. This clinical picture, known as 'dengue with shock syndrome' (DSS), is a life-threatening emergency.

Dengue fever is currently a major public health problem, due to the gradual extension of its transmission zone and the significant increase in severe forms. First described in its haemorrhagic form in the Philippines in 1953, the disease has since conquered new territories. Any region where the virus is circulating is potentially exposed to high-intensity outbreaks. Although data on haemorrhagic manifestations of dengue fever are still incomplete in Africa and the Mediterranean, a number of epidemiological indicators point to a worrying expansion trend.

On the African continent, endemicity is well established in tropical areas, with sporadic incursions into temperate regions, particularly in North Africa and around the Mediterranean. Since the 1960s, many African countries have been the scene of documented viral transmissions: Côte d'Ivoire, Burkina Faso, Angola, Senegal, Nigeria, DRC, Kenya, Mozambique, Madagascar and the Comoros, among others. Some outbreaks have reached critical thresholds, such as the 1993 Comorian epidemic linked to serotype I, which affected almost 60,000 people, or the 1994 epidemic in Pakistan, the first confirmed outbreak of dengue haemorrhagic fever in the region. As the threat intensifies, health monitoring mechanisms need to be strengthened and there needs to be greater access to diagnostic tools tailored to local conditions, to ensure an efficient, contextualised response to epidemic crises.

The results of research coordinated by the World Health Organization (2013) and the recent work of Ayroulet (2022) are evidence of a structured international effort to refine our understanding of the clinical and biological markers associated with the severity of dengue infections. A prospective, multi-centre study was carried out in various endemic areas under the aegis of the WHO's TDR programme, with financial support from the European Union. This approach made it possible to draw up a discriminatory grid for prioritising cases according to their severity, based on objectively verifiable indicators.

With this in mind, a reclassification of non-severe forms has been proposed, distinguishing cases with warning signs likely to herald an unfavourable outcome from those without. However, it would appear that the apparent benignity of certain clinical pictures does not protect against rapid deterioration, particularly in subjects with vulnerability factors. Hence the need for reinforced hospital surveillance as soon as warning symptoms emerge, or in the presence of high-risk profiles.

The WHO's 2009 revision of the classification broadened the parameters of vulnerability to include variables related to age (infants, the elderly), physiological status (particularly pregnancy in the third trimester, which is correlated with unfavourable perinatal outcomes), and specific co-morbidities. These include obesity, diabetes, chronic kidney disease, haemolytic disorders such as sickle cell anaemia, and certain autoimmune diseases. The 2013 update completed this framework by including arterial hypertension and heart failure as potential cofactors of worsening, thus reconfiguring clinical triage and therapeutic prioritisation in an endemic context.

1. Theoretical and methodological background

This study can be informed by several sociological theories. The first theory, that of Max Weber (1922) on rationality and social action, is distinguished by its analysis of the types of rationality that guide human actions. According to Weber, people's behaviour is guided by instrumental rationality (driven by efficiency) or axiological rationality (driven by values). In the context of treating dengue fever, this theory helps us to understand how healthcare staff, guided by professional imperatives, adopt a rationality based on clinical efficiency, while patients, influenced by cultural beliefs or social perceptions, adopt a rationality based on the search for personal meaning. This represents a scientific breakthrough, as Weber proposes a distinction between substantial rationality (based on value) and formal rationality (oriented towards efficiency), a point of convergence that is essential for analysing the different modes of care in hospitals.

The second theory is that of Émile Durkheim (1897), in his work 'Le Suicide', which highlights the way in which social norms influence individual behaviour within an institutional framework. Durkheim argues that individual behaviour is structured by collective norms that shape social interactions. Applied to Bingerville General Hospital, this theory enables us to examine how hospital norms, treatment protocols and social expectations shape both healthcare staff and patients in their management of dengue fever. The scientific breakthrough here lies in taking account of social regulation through institutional norms, which govern the interaction between patients and healthcare staff. The point of convergence with Weber lies in the idea that the rationality of individuals (carers and patients) is not only individual, but also shaped by a collective normative framework.

Finally, the third theory, that of Pierre Bourdieu (1992) and the notion of 'field', particularly in his work 'La Distinction', enables us to analyse the way in which different forms of capital (cultural, economic, social) influence power relationships and social interactions. In the hospital context, the 'fields' of medicine and patients' social lives intersect, with each actor (doctors, nurses, patients) carrying a certain amount of symbolic capital that determines the dynamics of relationships. The scientific breakthrough lies in the study of the relationships of power and domination that operate within the hospital environment, where patients may be subjected to care logics imposed by carers, but may also resist or adapt according to their own cultural or social capital.

These theories converge in their recognition of the complex interactions between rationality, norms and power relations in the management of dengue fever in hospitals.

Using a triangulated qualitative approach, the case study at Bingerville General Hospital was based on a rigorous methodology. Participants were selected according to specific criteria: healthcare workers (doctors, nurses) and patients who had been treated for dengue fever, thus offering a diversity of viewpoints. The sampling technique used was purposive sampling, allowing key players to be targeted according to their role in the care process. Data collection tools included semi-structured interviews and participant observation, to gather information on the practices and perceptions of carers and patients. The data was analysed using a thematic approach, coding the responses and identifying recurring trends in the participants' discourse. However, methodological limitations can be identified, such as subjectivity in the interpretation of the interviews and potential bias in the selection of participants, which could limit the generalisability of the results. Despite these limitations, the study provided an in-depth understanding of the social and normative dynamics influencing the management of dengue fever in a hospital setting in Côte d'Ivoire.

RESULTS

2.1. Cultural capital and asymmetries of knowledge: dynamics of medical socialisation between carers and dengue patients

The survey of dengue patients revealed a profound lack of knowledge about the disease among the population surveyed. In fact, the majority of patients stated that they were unaware of the very nature of the disease from which they were suffering, demonstrating a structural information deficit. When questioned by the interviewers, the individuals interviewed found themselves unable to formulate a coherent response about dengue fever, reflecting limited access to biomedical knowledge in the public arena.

This lack of information manifests itself at several levels. While some of those interviewed mentioned a rough knowledge of the disease, it was still far from sufficient to provide an informed understanding of the health issues involved. According to the testimonies gathered, the lack of awareness campaigns in the commune of Bingerville and, more specifically, in the neighbourhoods where the patients come from, is a major factor in this lack of knowledge. The invisibility of dengue fever in institutional communication systems reinforces the lack of awareness among the populations at risk.

Moreover, the hospital environment itself does not seem to compensate for this lack of information.

When patients come to the general medicine department in Bingerville for treatment, they do not come across any signposting or didactic devices designed to provide them with basic knowledge about the disease. This lack of educational mediation in the hospital setting illustrates a biomedical approach that focuses on the cure to the detriment of prevention, contributing to the reproduction of inequalities in access to health knowledge and to the structural vulnerability of populations to emerging vector-borne diseases.

This comment illustrates the point: ***"I don't know, afterwards I'll do my research, but otherwise I've heard people talking like that in the streets, but I haven't learnt anything ".***

The analysis of the statement can be illuminated by the contemporary theories of two major sociologists: Pierre Bourdieu and Bruno Latour. In his book La Distinction (1979), Pierre Bourdieu highlights the way in which individuals navigate through systems of knowledge and meaning as a function of their cultural and social capital. The individual making this statement seems to be distancing himself from academic or institutional knowledge about dengue fever, contenting himself with superficial information conveyed by the social environment (the 'streets'). This attitude can be understood through the prism of cultural capital: the individual does not seek to delve deeper into the issue, preferring to rely on his own experiences and limited resources, which reflects a low level of cultural capital in relation to specialised knowledge. Furthermore, the distancing expressed here can be seen as a mechanism for reproducing social inequalities, where the information available in working-class environments (the 'streets') is often fragmented and not very formalised.

For his part, Bruno Latour, in Science in Action (1987), develops the idea that knowledge is not a finished product but a process that is constructed through interaction with other actors and devices. The individual in this quotation seems to refer to partially constructed knowledge, which is born of informal interactions (‘I heard people talking in the streets’) but which remains unfinished and uninstitutionalised (‘I didn’t retain anything’). This Latourian approach highlights the fact that knowledge about dengue fever, in this case, is a form of knowledge that has not yet been fully integrated into a network of scientific and medical certainties, and remains in a state of potential. The gap between the perception of the phenomenon (heard in the streets) and the desire to ‘do research’ indicates a divide between popular knowledge and institutionalised knowledge, resulting from a process of disconnection between the two types of knowledge. This analysis helps us to understand how health-related knowledge, such as that relating to dengue fever, is partially integrated into society, often fragmented and disconnected from the health authorities, and only becomes fully operational through a process of hybridization between this knowledge and concrete actions of research or understanding.

In addition, the survey revealed that the interaction between GPs and dengue patients highlights a marked asymmetry in access to medical knowledge. Treatment is mainly limited to prescribing diagnostic tests (dengue RDTs), with no effective transmission of knowledge about aetiologies, symptomatology or preventive measures. This lack of educational communication produces an information deficit that keeps patients in a state of uncertainty and anxiety about their condition, revealing a breakdown in the biomedical socialisation process.

Analysis of the social trajectories of the patients interviewed shows that this lack of knowledge about the disease is not solely linked to their position in society, but cuts across different categories of cultural capital. Whether they were shopkeepers, secondary school students, housewives or even those with higher levels of cultural capital, they all expressed a structural lack of information about dengue fever. This finding suggests that the spread of medical knowledge does not just follow the classic pattern of socio-educational inequalities, but is also the result of a structural deficiency in institutional health mediation.

As a result, the lack of information about dengue makes patients cognitively and health-wise vulnerable. This reduces their ability to adopt preventive behaviours or to interpret their symptoms correctly, exposing them to fragmented care trajectories and increased dependence on medical prescriptions, without acquiring autonomy in terms of health. This phenomenon is indicative of a biomedical approach to care that focuses on curative measures, overlooking the educational and interactional dimensions of care, which are essential in the fight against emerging vector-borne diseases.

2.2. Social representations and asymmetries of knowledge in the management of dengue fever

The management of cases of dengue fever by GPs at the general hospital reveals an implicit hierarchy of pathologies in which malaria is the dominant diagnostic prism. When faced with a febrile patient, the first step taken by GPs is to carry out a rapid diagnostic test (RDT) for malaria. If the result is positive, the anti-malarial treatment protocol is immediately applied, while a RDT for dengue fever is only considered if the first test is negative. This sequential approach to diagnosis, which is far removed from the official guidelines advocating simultaneous testing for malaria and dengue fever, leads to a form of institutionalised cognitive bias.

This decision-making pattern can be explained by the structural importance of malaria in the health history of Bingerville. Operating in an endemic area, doctors have developed a professional routine shaped by the prevalence of malaria, leading to a diagnostic inertia that tends to make other emerging febrile conditions such as dengue fever invisible. This inertia reinforces a framing effect whereby dengue is only considered retrospectively, often after the failure of anti-malarial treatment or recurrent consultations with the patient.

Ultimately, this procedure resembles a form of diagnostic lottery, in which recognition of dengue fever is conditional on the prior exclusion of malaria, leading to delays in treatment. This process illustrates a structuring of medical practices based on professional habits shaped by cumulative experience of malaria, to the detriment of an integrative approach in line with current recommendations.

This statement explains: ***"The symptoms are often fever and headache, often starting with an infection syndrome, so when we see this, because we're used to it and we're in an endemic area, we think directly of malaria, even though it's not always malaria, you see a patient who comes in with a fever headache and all that, you ask for a malaria test, it comes back positive, you prescribe a treatment, then they come back, the patient comes back again complaining of the same symptoms, you ask for a dengue test, it comes back positive, so it's a bit like the signs there, there are several signs, there's a good fever headache, chills, all that, it's a bit confused with malaria, both that ... but it's different ".***

Analysis of this medical discourse reveals a diagnostic bias rooted in the professional habits of healthcare workers in malaria-endemic settings. The doctor's spontaneous statement illustrates a way of thinking in which cumulative experience of malaria structures the perception of febrile pathologies. Symptoms are recognised according to a pre-established pattern, in which fever and headache are automatically associated with malaria because of their high prevalence in the region. This diagnostic reflex is based on a form of cognitive and pragmatic routine which guides therapeutic decisions even before biological confirmation. The absence of a systematic differential approach to febrile syndromes thus reflects a form of pathological reductionism, in which the statistical probability of malaria takes precedence over the need for simultaneous investigation of other possible aetiologies, particularly dengue.

This phenomenon leads to inertia in the recognition of cases of dengue fever, which often only emerges in the event of treatment failure, when the patient returns with persistent symptoms. The emergence of the diagnosis of dengue fever in this account is therefore part of a logic of ‘failure to reveal’, where the persistence of symptoms after anti-malarial treatment becomes the trigger for a new diagnostic hypothesis. This dynamic illustrates an implicit hierarchy of diseases in the local medical arena, with malaria occupying a hegemonic position, relegating dengue fever to belated recognition. This process of late differentiation of febrile diseases highlights an asymmetry in the construction of local medical knowledge, where certain diseases are socially and medically over-invested to the detriment of others, which are becoming increasingly prevalent.

Indeed, the medical care of febrile patients at Bingerville General Hospital is deeply influenced by a pre-constructed diagnostic schema, where malaria occupies a central place in the social imagination of caregivers. As soon as the patient describes the symptoms, doctors develop, on the basis of a professional habitus shaped by the historical prevalence of malaria, a clinical reasoning oriented towards this pathology. This diagnostic reflex leads to systematically favoring the antimalarial treatment protocol and prescribing sometimes costly biological tests, thus reinforcing a routine approach to care. Far from being a simple clinical approach, this posture reveals a structural bias in the management of febrile syndromes, where the experience of malaria eclipses any other etiological hypothesis in the initial phase of diagnosis.

This nosological reductionism has direct consequences on the care pathway of patients, who, in the absence of improvement after antimalarial treatment, return for consultations with the same persistent symptoms. It is often at this stage that dengue fever is finally considered, revealing an implicit hierarchy of diseases that delays its recognition. The conflation of malaria and dengue fever is all the more evident in the discourse of healthcare providers, for whom these two pathologies remain largely undifferentiated due to the similarity of their clinical manifestations. This epistemic confusion directly influences medical judgments and care pathways, illustrating a form of care where the social perception of diseases weighs as much as biomedical knowledge in defining therapeutic protocols.

This statement exemplifies***: "Generally, it's fever, headaches, body aches, persistent fevers, that's it... well, generally, the... well, what I know, there are some who have mistaken it for malaria. They come first to do the RDT, the malaria test, and when they see that it's negative, since it persists now, they try to do something else, it's logical."***

This statement illustrates a sequential diagnostic pattern structured by a dominant framing effect of malaria. The physician describes a clinical reasoning where malaria constitutes the initial hypothesis when faced with feverish symptoms. This modus operandi reflects a collective cognitive bias, where the cumulative experience of malaria prevalence spontaneously directs the diagnostic approach of caregivers towards this pathology. This phenomenon is rooted in a medical habitus shaped by the local epidemiological context, where malaria is historically overrepresented in hospital care. Thus, until the malaria RDT test invalidates this hypothesis, other diagnoses, such as dengue fever, remain pending.

The logical argument used by the physician to justify this sequential approach reveals a naturalization of medical practices, where the order of tests does not stem from a protocol-based approach based on official recommendations, but from an implicit hierarchy of diseases in the local biomedical imagination. This backward methodology, where dengue fever is only considered in cases of malaria diagnosis failure, reflects a pathological reductionism that limits the effectiveness of early case detection. More broadly, this decision-making sequence illustrates a dynamic of relative invisibility of emerging diseases, where the historical weight of a dominant pathology conditions access to care and the recognition of other conditions in the local medical field.

The biomedical management of dengue cases in hospitals is based on a decision-making process structured by the diagnostic dominance of malaria. Upon admission to the consultation, general practitioners prioritize a malaria rapid diagnostic test (RDT), designed to detect the presence of specific antigens of malaria parasites in the blood of febrile patients. This preeminence of the malaria test reflects a structural bias in the clinical approach, where the first diagnostic hypothesis is systematically oriented toward malaria, regardless of symptomatic variations that may suggest other etiologies. In the event of laboratory confirmation, an antimalarial treatment protocol is immediately implemented, and only in cases of failure, i.e., when symptoms persist despite initial treatment, is a dengue RDT considered as a secondary diagnostic hypothesis.

Physicians justify this prioritization of tests by the historical and epidemiological roots of malaria in Bingerville, an area where this disease remains endemic and constitutes, in local clinical experience, the reference febrile illness. This routinization of diagnostic practices, shaped by years of almost exclusive exposure to malaria cases, has led to a naturalization of medical procedures where malaria becomes a dominant diagnostic reflex, relegating dengue to a status of deferred diagnosis. This dynamic illustrates a logic of institutional inertia, where the resurgence of malaria serves as a structuring framework for medical decisions, to the detriment of an integrative and simultaneous approach to fever syndromes. Thus, far from being a simple clinical procedure, the primacy of the malaria RDT reflects a social construction of diagnosis, influenced by local health history and the logic of normalizing diseases in the medical space.

The diagnostic approach adopted by some general practitioners when faced with dengue fever reveals an institutionalized resistance to official protocols, demonstrating a gap between biomedical standards and actual field practices. Although management guidelines recommend the simultaneous performance of a malaria RDT and a dengue RDT in all cases of fever, some practitioners question the usefulness of the dengue test, arguing that it provides little decision-making value. This stance reflects a logic of pragmatic rationalization, in which the dengue RDT is perceived as a redundant tool, as its results alter neither the clinical diagnosis nor the therapeutic strategy, which is essentially symptomatic. Thus, the refusal to systematically integrate this test into the diagnostic process is based on a biomedical conception in which the value of an examination is measured by its impact on therapeutic management, and not by its epidemiological function or its role in nosological differentiation.

This reluctance of healthcare providers to apply the official protocol is also rooted in a specific perception of post-infectious immunity to dengue, which reinforces the marginalization of this disease in the hierarchy of medical concerns. The idea that a primary infection confers lasting immunity, except in the event of exposure to another stereotype of the virus, fuels a view that dengue, although recurrent, does not require systematic diagnostic surveillance comparable to that of malaria. This representation of the immune cycle helps to put the urgency of screening into perspective, thus reinforcing a clinical approach based on symptom management rather than formal identification of the pathogen. This phenomenon illustrates a logic of diagnostic triage based on an implicit hierarchy of diseases, where medical management adapts to local perceptions of health risk rather than to the protocol standards dictated by health authorities.

This statement illustrates: ***"even the RDT doesn't say that there is no malaria unh aah I don't ask for it because it doesn't bring me anything at all it's a rapid screening test that only explores Plasmodium falciparum malaria it doesn't recognize Vivarte ovarian and malaria so that means it doesn't bring me anything at all if I do my RDT it tells me that I don't have Plasmodium falciparum malaria but it doesn't say that I don't have Plasmodium ovarian and malaria malaria so what does it bring me so so I don't ask that, that doesn't bring me anything today there is dengue well dengue is.. well even if we say there is dengue and then what is there a treatment for dengue there isn't the treatment it is simply symptomatic the treatment is the symptoms we treat the signs We don't treat like we treat, we give malaria medication, it doesn't exist, and then there are four stereotypes for dengue fever: if I get dengue fever, I come out immune to that stereotype, but if I encounter the same stereotype, I no longer get the disease, because I've developed immunity, but if I encounter stereotype 2, I still get the disease, to which I'll still come out immune, so you'll encounter stereotype 3, stereotype 4, well, maybe steriotype 4 to be immune, that's all."***

The analysis of this medical discourse highlights a pragmatic and differentiated vision of diagnosis and treatment, shaped by the local experiences of caregivers, as well as by a specific perception of dengue and malaria, which deviates from institutional recommendations. According to the physician interviewed, the malaria RDT is considered insufficient and partially obsolete, as it only detects Plasmodium falciparum, while excluding other forms of malaria, such as those caused by Plasmodium ovale and Plasmodium malariae. This limitation of the diagnostic tool is perceived as an obstacle to comprehensive care, which pushes the practitioner to neglect this test in favor of more intuitive practices more directly oriented towards the patient's symptoms. This rationalization of diagnostic tools is linked to what Pierre Bourdieu (1979) calls "habitus," a set of enduring patterns of perception, appreciation, and action that influence medical decisions in specific contexts. According to Bourdieu, social agents, here doctors, act according to their experiences and practical capital, which is based on tacit knowledge from their professional practice and their environment. The reluctance to use certain screening tests thus illustrates a logic of local rationality, where care is organized around what seems most useful in the given context, even if this deviates from formal recommendations.

Furthermore, the physician's assessment of dengue treatment questions the place of immunity in clinical practice. The symptomatic nature of the treatment and the idea that immunity is acquired after infection with a given stereotype of dengue fever refer to an immune understanding that stems from a more biological than epidemiological approach. This discourse can be illuminated by the work of Michel Foucault in "The Birth of Biopolitics" (2004), where he shows how medical and scientific discourses, while formulated in biological terms, are largely shaped by social practices and logics of power. Here, the physician, by resorting to an immune vision centered on stereotypes, transforms medical knowledge into mechanisms for interpreting the local health experience, leaving aside the epidemiological and social dimensions of diseases. This logic is also part of a dynamic in which medical knowledge, both practical and epidemiological, is filtered through the lived experience and personal interpretation of practitioners, as Harold Garfinkel emphasizes in his work on social norms and practices (1967), where social rules and norms influence decisions even in technical fields such as medicine.

In short, this discourse demonstrates how medical practices are shaped by a dynamic exchange between formal knowledge and local experiences, and how this knowledge is filtered by logics of pragmatic efficiency which, although effective in certain contexts, can lead to decisions that deviate from global recommendations and scientific standards.

2.3. Interactional Configurations and Relational Dynamics in the Dengue Case Management Process

Interactions between general practitioners and dengue patients are part of an asymmetrical negotiation dynamic in which patients, often in situations of socioeconomic vulnerability, adopt strategies of supplication to influence the terms of their care. This negotiation is not reduced to a simple transactional exchange, but mobilizes discursive and emotional tactics aimed at reconfiguring the treatment protocol according to the patients' financial constraints. It thus initiates a process of staging the living conditions and economic precariousness of patients, structuring the caregiver-patient relationship around a moral economy of health. These negotiated adjustments are reflected in particular in the reduction of drug prescriptions or the suspension of certain diagnostic tests.

This statement illustrates: ***"yes of course, often there are patients who come you tell them this is what he had you prescribe him medication he will say aaah doctor you prescribed us too much medication unnnh but doctor they will... But you depending on that... you are a doctor you do what you have to do and then after in any case you tell this person that in any case this is what I saw this is what I saw this is what I prescribed what I should do I did now him because there are patients you prescribe them you explain to them after they don't buy the medication they don't do... not so I didn't come... because the patients they are a bit smart you prescribe a medication or an examination they will... you tell them do this do that they will say aaah doctor I have no money they wait for you to tell them good do both hoonhonn I tell you do this is what there is to do you do now after that also It depends on the patient who does or doesn't do it, in any case, as a doctor, I do what needs to be done."***

This statement by the physician highlights an implicit power struggle in the therapeutic interaction, where medical prescriptions clash with the patients' economic and strategic rationales. From a sociological perspective, it reveals several central dynamics in the process of caring for patients with dengue fever:

A tension between biomedical knowledge and lay rationales: the physician asserts his scientific and normative authority by emphasizing the prescriptive nature of his role: "As a doctor, I do what needs to be done." However, this stance clashes with the logic of patient appropriation of care, who are not content to simply receive prescriptions but also exercise the power of negotiation, adjustment, and sometimes resistance.

A relational asymmetry modulated by negotiation: the physician highlights a recurring practice where patients contest, negotiate, or minimize prescriptions ("Doctor, you have prescribed too much medication"). This reaction illustrates a process of implicit commodification of care, where the patient does not passively receive the diagnosis, but evaluates it in light of their own financial constraints and survival strategies. The healthcare professional, although possessing legitimate knowledge, must deal with these strategies and sometimes adjust their decisions based on the patient's economic situation.

A perception of patients' cunning and strategic calculation: the doctor's use of the term "clever" suggests a moralistic interpretation of patients' behavior, perceived as being cunning with medical prescriptions. This judgment reflects a form of dissonance between the biomedical model, which is based on scientific rationality and the objectification of care, and the practices of patients who integrate economic and pragmatic rationalities into their disease management. This perception of the patient as a strategic actor illustrates the tensions between normative medicine and healthcare users who are reconfiguring the therapeutic relationship through negotiation tactics. The moral economy of care and the fragmentation of access to care: the doctor's statement highlights a structural inequality in access to care, where patients, faced with economic constraints, must choose between different prescriptions ("do both there hoonhonn"). This situation reflects the fragility of health systems where access to care is conditioned by the financial capacity of individuals. Thus, care is not based solely on medical criteria, but is part of a moral economy of care where medical decisions are modulated by ethical, economic and relational considerations.

In conclusion, far from being a simple vertical relationship between caregiver and patient, the interaction described by the physician reveals a space of negotiation where patients attempt to reconcile therapeutic imperatives and economic constraints, while the physician oscillates between scientific authority and pragmatic adaptation. This dynamic highlights the limitations of a biomedical model based on unilateral prescription and underscores the need for a more integrated approach that takes into account the social and economic determinants of health. In this same perspective, a general practitioner in charge of managing dengue cases at the Bingerville general hospital declared: "there are people who have cried here unh that's clear we meet them everywhere today how many people are insured there is the CMU but there are lots of medicines that don't go through the CMU unh and then not everyone is on the CMU also unh even with the insurances when you leave they say that we don't take so much we don't take so much certain insurances restrict products to be able to earn at the expense of the population so the tears during my years of service he had plenty of tears there is even a gentleman who once to whom we had prescribed medicines he told me how much these medicines cost I have barely 7000 francs but he is a gentleman who has houses but all these houses are problems it is up to the justice the tenants do not pay themselves.. I told him everything was done 7000 francs he started to cry I gave him the money he went to get treatment he said thank you doctor I am retired house who gave me a little money is in court but meanwhile he lives how well that is average case but problem but the others you don't talk about it he has others you prescribe they disappear they can't pay that's it there are lots of things we don't meet people who express their things it's sad unh but well let's say that that's our societal side. So often he doesn't have the means so that's a bit of our reality what the reality is that there are people who can't pay for their medication.

This statement by the doctor highlights the structural precariousness of the healthcare system. It is marked by inequalities in access to care and a moral economy of care. Medical decisions are not strictly biomedical, but influenced by economic and social considerations:

a. ***Health as a marker of social inequalities:*** The doctor mentions the difficulty of accessing care due to the cost of medications and the limitations of health insurance systems, particularly Universal Health Coverage (CMU). He emphasizes that "not everyone is covered by CMU" and that "many medications do not pass through CMU," thus revealing a segmentation of the healthcare system that reproduces social inequalities. This situation illustrates a fragmentation of social protection, where the state struggles to guarantee effective health coverage for the entire population, giving way to individual and family strategies to finance care.
b. ***The Moral Economy of Care and Patients' Dilemmas:*** The physician's testimony highlights a moral economy of care in which patients must decide between their medical needs and their financial resources. The example of the patient who owns a home but is experiencing financial difficulties illustrates a paradoxical situation: although he has assets, he finds himself unable to meet his healthcare needs due to legal disputes and cash flow problems. This situation highlights the economic vulnerability that is not limited to the most vulnerable groups but also affects middle-class individuals experiencing financial instability.
c. ***The asymmetry of relationships between patients and insurance systems:*** The doctor also criticizes the role of insurance companies, which "restrict products in order to profit at the expense of the population." This observation illustrates a dynamic of commoditization of healthcare, where the profit motives of insurance companies conflict with the health needs of the population. The refusal of insurance companies to cover certain treatments creates a double bind for patients, forced to choose between forgoing care or finding alternatives, often informal and costly.
d. ***The doctor's emotional burden and informal compensation:*** The doctor highlights the emotional impact of the distressing situations he encounters daily: "There are people who have cried here," "there have been plenty of tears." This emotional burden sometimes transforms the caregiver-patient relationship into an interaction of solidarity, where the doctor occasionally takes on a role of economic assistance, as evidenced by the fact that he gave money to a patient so that he could buy his medication. This type of action highlights the limitations of the social security system and the need for individuals to rely on informal forms of support, where compassion and individual solidarity compensate for structural shortcomings.
e. ***Medical care under economic constraints:*** In short, the doctor's statement highlights a form of forgoing care: "There are others, you prescribe, they disappear, they can't pay." This observation reflects a well-documented phenomenon in the sociology of health: patients' self-exclusion from care due to costs. This medical forgoing, which primarily affects populations in precarious situations, contributes to a deterioration in general health and reinforces health inequalities.

This testimony illustrates the tensions between the biomedical principles of care and the socioeconomic realities that influence access to care. It reveals a medicine under constraint, where healthcare professionals are confronted with ethical dilemmas when dealing with patients in economic distress. Far from being a neutral space, the hospital thus becomes a place where social inequalities are replayed and materialized, exposing the limits of public health policies and the need for a more integrated approach that takes into account the social determinants of disease.

DISCUSSION

The study results highlight a clear tension between institutional norms and local perceptions of illness, which profoundly influences the dynamics of collaboration between caregivers and patients. Healthcare institutions, particularly hospitals and clinics, operate according to codified norms, often referring to universal biomedical models, where illness is primarily viewed through the lens of standardized biological and diagnostic processes. However, these norms can conflict with local conceptions of illness, often shaped by cultural beliefs, social values, and individual patient experiences. Thus, the way illness is perceived by patients and their families does not always correspond to pre-established clinical categories. This dissonance can lead to mutual misunderstandings, where patients do not always identify with the medical terms used, and caregivers may perceive local approaches to illness as irrational or inconsistent with medical recommendations.

This divide between institutional norms and local perceptions has significant consequences for patient-caregiver collaboration, a central element in successful treatment. When patients and caregivers lack a shared framework for understanding the disease, trust, treatment adherence, and communication are often hampered. Patients may feel marginalized or misunderstood, which can hinder their engagement in the care process. For their part, caregivers, confronted with cultural practices that are outside their clinical training, may experience difficulties establishing an effective care relationship, which can affect their practice and their own professional well-being. Thus, the interaction between institutional norms and local perceptions of the disease is a major issue in building a harmonious patient-caregiver relationship, where recognition of each person's perspectives is essential to successful care.

In light of the results presented above, we employ a discursive economics approach. This analytical approach goes beyond the simple reiteration of the elements contained in the results matrix, promoting a critical and interpretive perspective on the underlying dynamics. Thus, our analysis focuses on: ***"Cultural Capital and Knowledge Asymmetries: Dynamics of Medical Socialization Between Healthcare Providers and Dengue Patients."***

This result can be illuminated through the work of Pierre Bourdieu and Michel Foucault, two sociologists who have extensively analyzed the dynamics of power and knowledge in social relations. In his book Distinction (1979), Pierre Bourdieu explores how cultural capital, which he defines as the set of knowledge, skills, and dispositions acquired within a particular culture, plays a central role in social interactions. In the context of medical care, this cultural capital is manifested by the mastery of biomedical knowledge of caregivers, who possess scientific knowledge, and the perceived ignorance of patients, who may not have access to this knowledge. Bourdieu thus shows that inequalities in the possession of cultural capital reinforce power asymmetries between individuals, here between doctors and patients, and that these inequalities profoundly influence interactions within the medical field.

Michel Foucault, for his part, in his work The Birth of the Clinic (1963), offers an analysis of power relations through the prism of medical knowledge and practices. Foucault argues that medical knowledge is intrinsically linked to power and that clinical practices are organized in such a way as to reinforce the domination of caregivers over patients. In the context of dengue fever, this perspective allows us to understand how asymmetries of knowledge can translate into a power relationship where the caregiver, as an expert, imposes their knowledge on the patient, often without taking into account local experiences or knowledge relating to the disease. Foucault also shows that the medicalization of the disease, in this specific case, renders invisible other forms of knowledge, such as popular or traditional knowledge, which may be meaningful to patients. The asymmetry of knowledge is therefore not only a question of unequal access to information, but also a question of the validation of legitimate knowledge.

From this perspective, the dynamics of medical socialization between caregivers and dengue patients reveal how cultural capital and knowledge asymmetries influence interactions. Caregivers, often from professional backgrounds where scientific and medical knowledge are valued, may consider their own knowledge more legitimate than that of patients, which is sometimes rooted in local or community traditions. This hierarchical nature of knowledge creates tension in the caregiver-patient relationship, where the patient may feel devalued or excluded from treatment decisions. This results in difficulties in communication and mutual understanding, which can affect patient adherence to treatment and the quality of the care relationship.

Thus, analyzing these dynamics through the prism of Bourdieu and Foucault sheds light on the social mechanisms underlying medical interactions. Inequalities in knowledge, linked to both cultural capital and power relations, shape the way care is provided and received. Healthcare providers, as holders of medical knowledge, are in a position to impose their conceptions of illness and treatment, while patients, often ignorant of medical logic, can find themselves in a position of subordination. To improve these interactions, it would be necessary to rebalance these asymmetries, recognizing the legitimacy of local knowledge and encouraging a more collaborative and inclusive approach to patient care.

CONCLUSION

This study examined the normative configurations and intersecting rationalities that structure the interaction between healthcare staff and patients in the context of dengue fever treatment at Bingerville General Hospital. Using a qualitative approach based on semi-structured interviews and on-site observations, we highlighted the co-presence of biomedical, economic, and emotional rationales in the therapeutic relationship. Far from being a unilateral process, treatment reveals itself to be a space of negotiation, where institutional norms of medicine are articulated with the coping strategies of patients, often constrained by limited financial resources. This dynamic illustrates a structural tension between public health imperatives and the social realities of healthcare provision, thus shaping a moral economy of care where stakeholders continually adjust their practices according to contextual constraints.

The analysis of the results highlights the existence of multiple rationalities in the management of dengue treatment. On the one hand, healthcare providers assert a stance based on biomedical rationality and institutional protocols, while incorporating pragmatic flexibility in the face of patients' economic constraints. On the other hand, patients, faced with the costs of care and the limitations of health insurance, develop discursive and strategic tactics to influence medical prescriptions, thus revealing a form of micro-negotiation of care. These relational adjustments reflect not only an adaptation by stakeholders to the limitations of the healthcare system, but also a redefinition of the boundaries of medical power through logics of appropriation and circumvention of established therapeutic norms.

From a scientific and social perspective, these results call for a rethinking of institutional arrangements for the treatment of infectious diseases by integrating a sociological perspective attentive to the sociocultural logics of patients and the pragmatic adjustments of healthcare providers. It appears essential to coordinate public health policies with a detailed understanding of the social determinants of the disease in order to reduce inequalities in access to care. In this sense, we recommend strengthening social support systems for patients in precarious situations, better consideration of economic constraints in the development of therapeutic protocols and training of caregivers in the management of therapeutic interactions under constraint. Finally, continuing research on the impact of social and economic dynamics on the management of infectious diseases in hospitals would allow us to refine these analyses and develop more inclusive health policies adapted to local realities.

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