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Original Research Article

The Urgent Need to Rethink Health Systems in Africa *An Anthropological Reading of Therapeutic Pluralism: Profiles of Neglected Patients and Pathologies Overlooked by the Health System, Across Several Regions of Cameroon*

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Abstract: ***Objective*****:** This article argues for a reorganization of health systems in Africa, and Cameroon in particular, that brings together biomedical and local knowledge rather than treating them as opposites. ***Introduction*****:** African health systems remain built on an imported biomedical model grounded in Western positivism and determinism, which prioritizes investment in so-called dominant pathologies. Documentation on the profile of patients currently underserved by the health system reveals conditions such as mystical illnesses, cardiovascular diseases, psychological disorders, home births, HIV/AIDS, epilepsy, tuberculosis, and non-communicable chronic diseases across five major zones of Cameroon. Most patients appear to navigate a system that, in practice, has made no provision for their health problems beyond symptomatic care. Stroke, mystical illnesses arising from failure to honour the last wishes of the deceased, and epilepsy fall within a witchcraft-related register, whereas HIV/AIDS, tuberculosis, and chronic diseases reveal more material system failures. ***Methodology*****:** A descriptive and analytical study using a qualitative approach was conducted from January to August 2024 in eighteen health areas spread across the six health districts of the Noun Subdivision (West Region). Data collection combined semi-structured interviews, focus group discussions, and participant observation with patients, caregivers, health personnel, traditional healers, and health authorities, supplemented by a literature review and a comparison across five major socio-cultural and health zones of Cameroon. ***Results*****:** Therapeutic pluralism emerges as a structural fact: patients follow multiple therapeutic pathways combining traditional healers, exorcists, religion, and biomedicine. A tripartite typology of causes (natural, individual mystical, and ancestral), identified through the case of *Yiémum* (or hemiplegia) in the Noun Subdivision recurs in varying forms for epilepsy, malaria, infant malnutrition, and chronic diseases. The current health system, structurally oriented towards dominant pathologies, leaves aside a significant proportion of patients whose ailments fit none of the categories it recognizes. ***Discussion*****:** The work of Olivier de Sardan and Ridde (2014) and Ridde *et al*., (2023) on medical pluralism, together with the frameworks of Kleinman (1980) and Massé (1997), converge to show that health reforms fail when they ignore patients' actual practices. Two limitations are highlighted: the risk of idealizing local recourses, and the difficulty of imposing from above a uniform articulation between care systems across heterogeneous regional contexts. ***Conclusion*****:** The urgent need to rethink health systems in Africa, and in Cameroon specifically, calls for a differentiated refoundation according to context, one that explicitly acknowledges the profile of currently neglected patients and pathologies overlooked by health investment, and that brings together biomedical knowledge and local epistemologies rather than opposing them.

Keywords: Health Systems, Neglected Patients, Overlooked Pathologies, Therapeutic Pluralism, Decolonization of Knowledge, Medical Anthropology, Africa, Cameroon, Noun.

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INTRODUCTION

Context and Observation

According to the World Health Organization (WHO), health is 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.' This definition appears in the Preamble to the WHO Constitution (adopted in 1946 and entered into force in 1948). It introduces a holistic approach to health, moving beyond the purely medical to incorporate psychological and socio-economic dimensions. A health system is defined as 'all the organizations, institutions, resources and people whose primary purpose is to improve, restore or maintain health'. According to the WHO, a well-performing health system rests on six fundamental building blocks: service delivery, which consists of providing safe, effective, and quality care; the second pillar, having a sufficient, well-trained, and equitably distributed health workforce; the third pillar, health information systems, producing and analysing data to guide decisions; the fourth, medical products, vaccines, and technologies, ensuring equitable access to safe and affordable products; the fifth, health financing, mobilizing funds to prevent health expenditure from causing financial hardship (universal health coverage); and finally, the sixth, governance, ensuring effective stewardship and appropriate regulation.

In its recent strategic orientations, the WHO has reaffirmed and updated its vision of health systems through two major levers: the World Report on Universal Health Coverage (UHC), which prioritizes equitable access to essential care without the risk of financial impoverishment for populations; and the Astana Declaration on primary health care, which recognizes primary health care as the cornerstone of a resilient and inclusive health system. The strategic framework for health system resilience was developed in the wake of recent global health crises to strengthen pandemic preparedness, sustainable financing, and the digitalization of care. It comprises technically trained personnel, appropriate infrastructure, adequate equipment and medicines, and a clearly defined philosophy of care. Most sub-Saharan countries, Cameroon foremost among them, having undergone Western colonization, have consequently embraced a health architecture grounded in logical positivism, determinism, and Cartesianism. This logic has driven strong specialization in the medical field and a prioritization in the management of so-called dominant pathologies to cope with the economic constraints structuring African health systems. Yet anthropological studies have consistently demonstrated the existence, in the African context, of other causes of morbidity and mortality that go beyond Western rationality alone. It emerges that a significant proportion of patients in Africa navigate a health system that has made no provision for their health problems beyond symptomatic care, whose primary effect is often to further impoverish the patient while awaiting complications and an approaching death.

This article aims to describe, on the one hand, the profile of these patients left on the margins of the current health system, and on the other, the pathologies for which this system shows the least inclination to invest. It also seeks to convey the lived experiences of populations who suffer from this situation or bear, directly or indirectly, the failures of an entire health system. It is from this observation that an urgent need arises to rethink health systems in Africa towards a broader vision and, consequently, greater diagnostic and therapeutic effectiveness.

METHODOLOGY

This article is based on a descriptive and analytical study using a qualitative approach, conducted from January to August 2024 in the health districts of the Noun Subdivision, West Region of Cameroon. This area constitutes a privileged research site owing to the coexistence of biomedical practices and therapeutic traditions deeply rooted in Bamoun cultural life. Three health areas were selected in each of the six health districts, for a total of eighteen health areas out of the seventy-one that make up the Subdivision. Data was collected using several complementary techniques to allow for the triangulation of information. Semi-structured individual interviews and focus group discussions were conducted with patients, caregivers, health personnel, traditional healers, and health and community authorities to gather their experiences, perceptions, and collective representations regarding the causes of illness, therapeutic pathways, current health systems, care practices, and the relationship between modern and traditional medicine.

Documentary research covered national health policies, institutional reports, scientific publications, and prior work relating to African health systems, medical pluralism, and the anthropology of health. Finally, participant observation was carried out within certain health facilities and, where ethical conditions permitted, alongside traditional healers; this immersion fostered a better understanding of the interactions between caregivers, patients, and families, as well as the therapeutic practices observed. The qualitative data underwent thematic content analysis following an inductive approach. Interviews and focus group discussions were fully transcribed, coded, and grouped into analytical categories allowing key emerging themes to be identified. The analysis rests on a comparative approach highlighting the pharmacological and clinical principles mobilized by traditional therapists alongside biomedical reference frameworks, assessing their convergences, specificities, and fields of application in addressing health problems.

Clifford Geertz's interpretive anthropology made it possible to understand the cultural meanings attributed to illness, therapeutic practices, and the behaviour of actors by situating them within their social and symbolic contexts. The combination of these two

approaches offered a reading that was both organizational and anthropological regarding the mechanisms that foster or limit the effectiveness of health systems within the socio-cultural context of the Noun Subdivision and other zones of Cameroon.

For the nine regions other than Noun, in the absence of the author's own fieldwork conducted simultaneously in each of them, the analysis draws on a targeted literature review mobilizing works in the anthropology of health, sociology, and public health published over the past twenty years, as well as reports by international and humanitarian organizations for the zones most difficult to access. This acknowledged methodological asymmetry calls for complementary fieldwork in the regions not directly covered, identified in the conclusion of this article as an avenue for future research.

RESULTS

Literature Review

Anthropology of Public Health Policies in Africa

Olivier de Sardan (2015) shifted the analysis of African health policies away from representations of illness alone and towards the study of "practical norms" the informal regulations by which public officials, in their daily routines, depart from official rules. This analytical framework was applied directly to the health sector by Olivier de Sardan and Ridde (2014) in their study of free healthcare policies in Burkina Faso, Mali, and Niger implemented since the early 2000s for pregnant women and children under five, following the continuity of the 1987 Bamako Initiative. The same dynamic is found in the edited volume by Bierschenk and Olivier de Sardan (2014), States at Work, devoted to African bureaucracies.

Decolonizing Knowledge and Global Health

Gaudillière and Chabrol (2023) trace the colonial origins of global health and the resistance of colonized peoples to the occupier's health policies between 1870 and 1960. Ridde, Fillol, Kirakoya-Samadoulougou, and Hane (2023) explicitly call for the decolonization of global health in the face of epistemic injustice mechanisms linked to systems of economic and political domination. Lachenal (2014), in his study of a colonial pharmaceutical scandal, shows how certain health interventions presented as saving Africa reproduced relationships of domination.

Health Systems in Cameroon

Batibonak S., a socio-anthropologist at the Evangelical University of Cameroon, works on African epistemologies of health and on the market for divine healing in Cameroon. "Therapeutic efficacy in the market for divine healing is not a matter of simple credulous illusion; rather, it stems from a local rationality in which physical affliction is inseparable from its relational, spiritual, and cosmological dimensions. So to speak: treating the body without addressing the mystical etiology is akin to patching a leak without turning off the tap." "For an African epistemology of health, the objective is to break away from biomedical ready-to-think frameworks that marginalize endogenous knowledge. Disease is not merely a biological alteration; it is a social language that must be deciphered at the intersection of the visible and the invisible." Batibonak, S. (2023).

Nsangou Moustafa Moncher, a researcher at the Centre for the Development of Good Practices in Health, directs his work towards the sociology and anthropology of health, as well as health policies and systems in Africa. "Analyzing health systems in Central Africa requires going beyond a purely institutional reading to observe practical norms. In the field, care delivery is reconstructed daily at the intersection of failing public policies, the informal private sector, and the coping strategies of users facing the burden of illness." "Therapeutic pluralism is not a dysfunction of the Cameroonian health system, but rather its actual operating mode. Patients' care trajectories reveal a pragmatic navigation between the hospital, street pharmacies, traditional chieftaincies, and prayer camps." Nsangou, M. M. (2018).

This work, together with that of Nzhié Engono on comparative sociology, argues for contextualizing medical ethics within African soil and for a closer alignment between the medical and social sciences. "Medical ethics cannot be a mere importation of abstract universal norms. It must find its societal grounding in African soil, integrating community solidarity, local representations of personhood, and collective responsibility in the face of suffering." "The dialogue between medical and social sciences is not an academic luxury, but an epistemological requirement. Medicine heals the organ, but only sociology makes it possible to understand the individual in context and the social structures that condition their access to care." Nzhié Engono, J. (2018).

Mental Health

According to WHO-Africa (2023), the African region, which accounts for more than 10% of the world's population, remains marked by a persistent shortage of mental health personnel. A study conducted in Guinea (2019) likewise highlights low coverage of specialized services as a major challenge for the continent's health systems. Petit (2015), in her work on Senegal, shows that patients navigate between several recourses (biomedical care, family self-medication, and unevenly distributed psychiatric provision) within a context of therapeutic pluralism and persistent stigmatization.

Maternal and Child Health

Studies conducted in Côte d'Ivoire (2020) confirm that financial barriers hinder access to maternal and child health services, while fee-exemption measures represent a lever for reducing morbidity and mortality.

Ouattara (2023) further links poor maternal health indicators to the broader precarity of the health system. Lemouogue (2019), in her study conducted in two isolated villages of Cameroon's Littoral region (Nzobi and Ediengo, Melong subdivision), shows that the persistence of home births reflects an adaptation to structural constraints on access to care rather than a simple traditional attachment.

Extending the Scope to Other Pathologies: HIV/AIDS, Epilepsy, Tuberculosis, Chronic Diseases

Beyond *Yiémum* (hemiplegia), several other pathologies documented in Cameroon confirm this same diagnosis. Regarding HIV/AIDS, Laborde-Balen (2020) shows that nearly a third of people on antiretroviral therapy in Cameroon experience therapeutic failure. The author analyses how these failures are socially and culturally reconstructed, redefining the relationship between caregivers and patients. Vidal (2014) situates these dynamics within the broader context of associative activism and civil society in Cameroon in the face of AIDS. Tantchou and Gruénais (2009) further document the specific difficulties involved in recruiting new lay actors into hospital-based HIV care in Cameroon.

Epilepsy constitutes a particularly illuminating case, insofar as it shares with *Yiémum* the same inscription within the register of witchcraft and possession. The launch of a national epilepsy control project in the Mbam-et-Kim Subdivision, one of the main foci of the disease in Cameroon, gave rise to public testimony on the twofold suffering of patients, both physical and social who are frequently confronted with a society that sees in their condition nothing but manifestations of witchcraft. This reading aligns with the work of Geschiere (1997, 1995) on witchcraft as an explanatory grammar for misfortune in contemporary Cameroon.

Tuberculosis illustrates another dimension of the health system's structural shortcomings: according to a recent report, only 48% of estimated cases in Cameroon are detected, and only 83% of diagnosed patients complete their treatment within a context marked by social stigmatization and patient isolation. Finally, non-communicable chronic diseases such as hypertension and type 2 diabetes, whose prevalence reaches 32.1% and 5.8% respectively in Cameroon, pose a challenge of a different nature: that of long-term adherence, in a context where the absence of a generalized health insurance system places the entire financial cost of chronic treatments on patients and their families.

Taken together, this body of work concerning hemiplegia but also HIV/AIDS, epilepsy, tuberculosis, and non-communicable chronic diseases converges on a single diagnosis: African health systems, and the Cameroonian system in particular, cannot be effectively reformed without seriously taking into account actual practices, local knowledge, and the circulations that traverse them, whatever the pathology under consideration.

Universal Health Coverage and Community Health Mutual Funds

Ridde and colleagues (2018) show that community health mutual funds, sustained by voluntary membership and community management, have largely disappeared from the international agenda since the 2010s, despite their persistence in certain countries such as Senegal or Mali. This literature emphasizes that solidarity, presented as one of the cardinal virtues of these mutual funds, has come up against progressive erosion as Africa enters the era of globalization.

Religious Healing and Therapeutic Pluralism

Bamba (2019), in his work on rural Côte d'Ivoire, shows that priests, priestesses, and healers continue to play a central role alongside biomedical provision. Lado, Félicien, and Azetsop (2018) document the proliferation of Christian healing camps since the 1980s, in continuity with the prophetic movements that emerged at the start of the twentieth century. Sarr (2008) shows how witchcraft-based explanations of illness are recomposed upon contact with Christianity rather than disappearing under its influence.

Medical Migration and Therapeutic Mobilities

Bochaton (2019), Kaspar (2019), and Sakoyan (2012) define therapeutic mobilities as the circulation of people, knowledge, products, and technologies within the field of health, breaking with older notions of "medical tourism" (Holliday *et al.*, 2015; Wilson, 2011) or "therapeutic immigration" (Guillou, 2009). Hoyez (2012), in her work on Maghrebi patients in France, shows that recourse to traditional care in the country of origin is explained as much by patients' social trajectories as by cultural adherence.

Inter-Regional Comparison of Health Indicators in Cameroon

From this perspective, the work of Nkouongnam (2025) suggests that the causes of morbidity recognized by certain African communities can be grouped into several categories: biological causes, witchcraft attacks, the anger of ancestors linked to failure to honour the last wishes of the deceased, human malice, the violation of taboos, and forms of social or moral disorder. These various causes of morbidity identified in Africa, and in Cameroon in particular, sometimes lead patients to spend money needlessly at health facilities when the treatment they seek belongs to an entirely different register.

Without calling into question the effectiveness of biomedicine for pathologies within its field of intervention, this classification highlights a mismatch between the nosological categories mobilized by health institutions and those mobilized by segments of the population across different Cameroonian zones.

Sudano-Sahelian Zone (Far North, North, Adamawa)

This zone accumulates the country's most worrying health indicators. A report by the International Organization for Migration (2026) notes the existence of endogenous mental health support practices among crisis-affected communities in the Far North. This structural fragility has been compounded since 2014 by the conflict with Boko Haram: according to ALIMA (2018), several health facilities in the region were abandoned before the arrival of international medical teams. Gruénais (2003), in his study of the health system reform of the former Far North province, shows how the state struggles to bring national primary health care policies to fruition at the local level.

The available literature converges around the fight against malaria, the region's major endemic disease. Mouliom Moungbakou (2014) shows that in the Far North, traditional and biomedical therapeutics are in direct competition in malaria management, and that the first-line recourse often remains traditional medicine, particularly among certain segments of the population—a configuration set within a context marked by strong demographic pressure and an insufficiently distributed biomedical supply.

Kouokam Magne (2016), drawing on fieldwork conducted along the Chad–Cameroon border, documents the lay reasoning underlying the refusal or under-use of certain biomedical prevention tools, notably insecticide-treated mosquito nets, perceived as uncomfortable, and highlights the role of vernacular preventive practices (fumigation, plant-based repellents) that coexist with institutional prevention campaigns against cholera. This dynamic of medical pluralism, shaped less by outright opposition than by pragmatic trade-offs grounded in perceived comfort and accessibility, is found in a different form in the analysis of *Yiémum* in Bamoun country.

Anglophone Zone in Crisis: North-West, South-West

The Anglophone regions offer a limit case in which therapeutic pluralism is no longer merely a matter of representation, but a direct consequence of the material collapse of the health system. Since the outbreak of the conflict in 2017, Médecins Sans Frontières (2023) documented a drastic reduction in the number of functioning health facilities in the North-West and South-West. The suspension of its own activities in the North-West by Cameroonian authorities in December 2020 deprived tens of thousands of people of access to vital care, according to Human Rights Watch (2022). Nearly one health facility in five is no longer operating in these two regions because of the crisis (MSF, 2021).

In this context, recourse to traditional healers, exorcism, religious practices, or self-medication ceases to be a simple cultural choice: it becomes, for part of the displaced population, the only option available in the absence of an accessible, functioning facility, which invites us to distinguish in this zone specifically between a chosen pluralism and an imposed one.

Forest and Coastal Zone: Littoral, South, East

Ngwen (2018), drawing on national data, statistically confirms that the residents of Yaoundé and Douala have proportionally greater recourse to traditional healers and private facilities than those of the Littoral and South-West. Monteillet (2016), in her study of the healthcare system in Nkoteng, shows that the absence of recourse to care facilities is explained more by problems of physical and economic access or perceived quality of services than by a systematic culture of self-medication. Baxerres and Desclaux (2015) link this more broadly to global pharmaceutical markets and the commodification of health in countries of the Global South.

Mpondo and *al.* (2012), drawing on an ethnobotanical survey conducted in three villages in the Douala region, document the extent of recourse to medicinal plants (48 species recorded, drawn primarily from home gardens and fallow land rather than deep forest), reflecting a traditional medicine that is largely domesticated and integrated into daily life rather than confined to exceptional ritual use.

Socpa (1995), in his work on street pharmacies in Douala, documents the emergence of informal strategies for accessing medicines in urban settings. A dissertation devoted to the Essoh-Attah of the South-West on the socio-cultural representations of epilepsy highlights the deficit of social science research on this pathology in Cameroon, even though its mystical representations (possession, transmission) partly overlap with those observed for *Yiémum*.

Western Highlands Zone: West/Noun, North-West

It is in this zone that the fieldwork proper of this study is anchored: *Yiémum* among the Bamoun of Noun, where illness is situated within an etiological repertoire combining witchcraft and a disruption of relations with the invisible world, alongside other pathologies (psychological disorders, home births, infant fevers) giving rise to plural therapeutic pathways among traditional healers, churches, and biomedicine. Nguimfack (2016) analyses, drawing on his clinical practice with Cameroonian families, how certain psychological or behavioural disorders in children are attributed to famla, a form of witchcraft specific to Bamileke country whereby a relative mystically 'sells' a child for enrichment purposes, a mystical family-based etiology distinct from the malicious spell cast by a third party described for Yiémum, which enriches the causal typology with an intra-family dimension.

This mismatch between institutional categories and community categories helps explain the simultaneous recourse to hospitals, traditional healers, religious leaders, and therapists. Far from being a mere

phenomenon of cultural resistance, this therapeutic pluralism constitutes a pragmatic strategy allowing individuals to seek responses suited to the different biological, psychological, social, and spiritual dimensions of their suffering. Studies published in global health journals show that combined recourse to several therapeutic systems remains common in several African countries and constitutes an essential element of access to care.

Centre Region: Yaoundé

Yaoundé, Cameroon's political capital located in the Centre Region, presents a configuration opposite to that of the preceding zones, marked by a concentration of care supply rather than a generalized shortage. The country's major national referral hospital facilities are gathered there alongside the majority of the country's specialists, while rural areas suffer from a chronic shortage of qualified personnel. This asymmetry fuels internal medical migration towards Yaoundé. Kouokam Magne (2016), a lecturer-researcher at the Catholic University of Central Africa in Yaoundé, situates precisely in this city a significant share of Cameroonian anthropological research on health, religion, and HIV. A mapping of traditional healers in the Centre Region further shows a distribution of traditional medicine practitioners according to the pathologies treated and highlights the obstacles to their institutional recognition despite their role as a first-line recourse for part of the population.

The documentary review of these five zones shows that therapeutic pluralism and the shortcomings of health systems take different forms depending on the context: enclosure and armed conflict in the North and Far North, security collapse in the Anglophone regions, the informal drug market in urban and forested zones, witchcraft and local cosmology in Noun, and concentration of supply together with internal migration around Yaoundé. Yet they all converge on a single finding: the Cameroonian health system, like most African health systems, remains structurally ill-suited to the diversity of geographic, security, and cultural contexts it is supposed to cover uniformly.

This comparative reading suggests that popular etiological classification does not proceed disease by disease, but according to cross-cutting criteria, notably: suddenness of onset, visibility of symptoms, impairment of motor function or consciousness, and the failure of initial biomedical treatments, which together determine the degree of 'mystification' attributed to a given pathology. Epilepsy, for example, is frequently attributed to a register of possession very close to that described by the healer of Kourom in the Noun subdivision for *Yiémum*, which explains, in both cases, the priority recourse to traditional healers rather than biomedical facilities, at least in the first stage of the therapeutic pathway. Conversely, pathologies with a more immediately legible bodily manifestation, such as malaria or cholera, tend to be attributed more directly to natural or environmental causes, although the mystical register is not entirely absent, as the repetition or unusual severity of an episode can tip the interpretation towards a curse or witchcraft.

Several pathologies documented in Cameroon illustrate this tension in different forms: *Yiémum* (a form of hemiplegia recognized among the Bamoun of Noun), curses that have been cast, and epilepsy (widely present in the Mbam-et-Kim Subdivision) are inscribed within an etiological repertoire mobilizing witchcraft and social transgression. HIV/AIDS, tuberculosis, and non-communicable chronic diseases (hypertension, diabetes) reveal, for their part, other shortcomings less tied to representations than to the material architecture of the care system: access, financing, and long-term adherence. This finding calls for a reorientation of how African, and indeed Cameroonian, health systems are viewed.

Profile of Patients the System Fails to Cover

It is no longer simply a matter of documenting the coexistence of several explanatory registers of illness, but of focusing specifically on the profile of patients who, in practice, escape the coverage that the current health system claims to offer. These patients are not necessarily those who lack access to a care facility, insofar as most do in fact consult a health centre or hospital. Rather, they include those for whom the biomedical response, once obtained, does not resolve what they themselves identify as the true cause of their affliction.

They also include those whose pathology, deemed secondary or marginal considering national and international health priorities, receives only limited investment in training, specialized personnel, and diagnostic resources. This coexistence of two explanatory regimes, biomedical and vernacular, raises the central question of this article: to what extent can African health systems, as they are currently structured and administered, continue to dispense with a serious consideration of local interpretive frameworks of illness without compromising both the effectiveness of care and the legitimacy of health institutions among populations?

In other words, should we not question the very relevance of a health system conceived in the abstract, imposed on socio-cultural realities that it ignores or marginalizes, rather than a system conceived from within Africa, drawing on its own epistemologies of the body, illness, and care? The comparative study of several pathologies *Yiémum* (hemiplegia), morbidity linked to failure to honour the last wishes of the deceased, and epilepsy for the witchcraft-related register; HIV/AIDS, tuberculosis, maternal health, and chronic diseases for the material shortcomings of the system across five zones of Cameroon serves here as the empirical foundation for interrogating this imperative to rethink health systems.

This article thus pursues a threefold objective: first, to describe the profile of patients not adequately accounted for by the current health system, as well as the pathologies for which this system shows the least investment; second, to document and analyse, from an anthropological perspective, the logics of perception, naming, and management of several pathologies in Cameroon (hemiplegia, epilepsy, HIV/AIDS, tuberculosis, maternal and child health, non-communicable chronic diseases) across five major zones of the country; and third, to convey the lived experiences of the populations concerned and, on the basis of these combined findings, to argue for a scientific and structural reorganization of health systems in Africa that brings together biomedical and local knowledge rather than opposing them.

Medical Pluralism and Therapeutic Pathways

The articulation of several registers of causation (natural, mystical, ancestral) for a single pathology falls within the conceptual framework of medical pluralism, understood as the coexistence, within a single social space, of several care systems (biomedical, traditional, religious) to which individuals have non-exclusive recourse, following a pragmatic logic of seeking effectiveness rather than a single doctrinal allegiance (Benoist, 1996). This approach shifts the analysis away from a binary opposition between 'modern' and 'traditional' medicine towards the study of patients' concrete pathways.

This is precisely what the notion of the *therapeutic itinerary* allows us to grasp coined by Janzen (1978) from his fieldwork in Lower Zaire to designate the set of journeys, choices, and trade-offs, often collective in nature and involving the family as much as the patient, that structure recourse to care. Kleinman (1980) complements this framework with the concept of *explanatory models*, which accounts for the way patients, families, and caregivers construct divergent interpretations of a single morbid episode, each shaping specific therapeutic expectations. Massé (1997), for his part, proposes the notion of *therapeutic pathways*, emphasizing the processual and evolving dimensions of these care journeys, which are liable to be reoriented based on the perceived failure or success of a previous stage.

A verbatim account collected in Bangourain, in the Noun Subdivision, where hypertension and diabetes are simultaneously recognized as physiological causes and attributed to divine will, illustrates this coexistence of non-exclusive rather than contradictory explanatory models: "*The doctor says it is blood pressure, and we believe him. But we also know that nothing happens unless God allows it. Both things are true for us at the same time.*" (Focus group discussion, Bangourain). Applied to the Cameroonian context, this framework invites us not to treat the etiological typology of *Yiémum* as a mere local ethnographic curiosity, but rather as a regional manifestation of a pluralistic mode of health management that recurs, in reconfigured forms, across all socio-cultural and health zones of the country.

Etiological Typology of *Yiémum* in Bamoun Country

Interviews conducted in Noun reveal a tripartite typology of causes attributed to *Yiémum*: a natural cause, recognized in particular when the illness is associated with arterial hypertension or a stroke; an individual mystical cause, corresponding to a spell cast by a malicious third party; and an ancestral cause, linked to a transgression or a failure of duty toward ancestors. A healer in the village of Kourom summarized the second category as follows: "*When the spirits enter you, the arm or the leg no longer responds. It is not the blood that is blocked; it is the person themselves who has been struck by someone who wished them harm. The hospital can soothe the body, but it cannot send back what was sent.*" (Interview with a traditional healer, Kourom village). Within the Bamoun context, recourse to mystical explanations does not necessarily imply a denial of natural causes: several individuals combine different explanations, viewing an illness as natural in its bodily expression while interpreting it as linked to a social or spiritual event. This logic of causal plurality explains the diversity of therapeutic recourses observed: an illness perceived as mystical calls for an intervention capable of acting on the invisible register (prayers, religious practices, specialized consultations, rituals to restore balance), whereas an ailment regarded as natural leans toward biomedical treatments or pharmacopoeia.

This plurality constitutes an essential element to consider when building African health systems better suited to the socio-cultural realities of populations. Delays or failures in certain health programs do not stem solely from a lack of infrastructure; they may also arise from a mismatch between the institutional definition of illness and the way communities interpret misalignment that directly contributes to creating the profile of neglected patients overlooked by the current health system.

Profile of Neglected Patients and Pathologies Overlooked By the Current Health System

Beyond describing therapeutic pluralism, this section characterizes more precisely which patients the health system leaves on the margins and which pathologies receive the least investment from this system.

Profile of Neglected Patients

Three profiles of neglected patients emerge from the survey conducted in the Noun Subdivision and from the inter-regional comparison:

Patients with Unmapped Pathologies: Individuals whose ailments find neither a diagnosis nor a stabilized protocol within the biomedical system. This includes forms of morbidity linked to the failure to honor the last wishes of the deceased, treatment-resistant epilepsy,

atypical psychological disorders, or idiopathic complications, even when the patient's family holds a coherent explanation drawn from mystical or ancestral frameworks.

Structurally Margined Populations: Patients for whom material access to a care facility is compromised, including populations displaced by conflict in the Anglophone regions and the Far North, isolated rural households, and families unable to bear the costs of travel or long-term treatment.

Patients with Chronic or Stigmatized Pathologies: Individuals affected by chronic or stigmatized conditions (notably tuberculosis, HIV, epilepsy, and psychological disorders) for which long-term follow-up, therapeutic adherence, and social acceptability pose challenges that a system centered on acute episodes handles poorly.

According to testimonies collected during the survey, it is not uncommon for patients affected by pathologies idiopathic to Western medicine to see their condition deteriorate within the family setting to a critical stage before experiencing complete remission, often described by families as unexplained. Several interlocutors attribute these remissions to talking therapies or healing practices specific to traditional chieftaincies. This type of account, while frequent in the narratives collected, has not been subject to systematic scientific documentation and must be approached with methodological caution: the aim here is not to assert the clinical efficacy of these practices (the evaluation of which exceeds the scope of this anthropological study), but to note that their lack of documentation contributes to the health system's inability to account for the full range of illness and healing trajectories observed by populations.

Pathologies Overlooked by Health Investment

Several categories of pathology appear structurally under-invested in by the Cameroonian health system:

Mental Health Disorders: The national shortage of specialized personnel documented by WHO-Africa (2023) deprives a large share of the population of access to psychiatric diagnosis or follow-up.

Epilepsy: Management remains confined to sporadic, one-off initiatives (such as those observed in Mbam-et-Kim) without lasting integration into local care networks.

Tuberculosis: The national detection rate remains capped at 48% according to recent data.

Non-Communicable Chronic Diseases: The absence of universal health coverage transforms lifelong treatment into an unbearable financial burden for many households.

This implicit hierarchy of health investment is not unique to Cameroon; it reflects international prioritization logics historically centered on infectious diseases with high epidemic potential and maternal/child health. While legitimate, these priorities structurally sideline chronic diseases, mental health disorders, and conditions whose etiology does not readily fit international public health frameworks.

Felt Experiences in the Face of Health System Failures

Interviews and focus groups reveal a widespread sense of abandonment in the face of pathologies for which the health system offers only "partial or symptomatic responses." This sentiment does not reflect a rejection of biomedicine which is widely recognized as indispensable for technical interventions, diagnostic examinations, or acute complications but rather the repeated experience of a system that fails to meet the demand for meaning and comprehensive care when illness is interpreted through mystical or social lenses.

This sentiment is particularly pronounced among families of chronic or stigmatized patients, who report a lived experience of social isolation compounding the ordeal of illness itself (a dynamic well-documented for tuberculosis, HIV, and epilepsy). It is similarly pronounced among families in the Anglophone regions and the Far North, where the collapse or remoteness of biomedical provision transforms non-biomedical recourse into a necessity experienced with ambivalence caught between trust in local practices and regret over being unable to access legitimate public health services.

Traditional Therapists: Between Empirical Knowledge and the Need for Scientific Validation

Cameroonian therapeutic practices rest on several categories of actors and knowledge. Among them are empirical practitioners, notably herbalists and medicinal plant specialists whose knowledge relies on long experience with natural resources. These practitioners master various techniques for extracting and preparing plant-based substances:

- **Infusion:** Placing leaves or bark in a container before adding boiling water and filtering.
- **Decoction:** Boiling plant matter to extract active principles.
- **Maceration:** Soaking crushed plants in room-temperature water prior to filtration.
- **Fumigation:** Utilizing vapors produced by burning specific plants.
- **Incineration:** Using ash resulting from the combustion of plant parts.

These practices demonstrate the existence of structured local pharmacological knowledge built through experience and transmitted across generations. However, integrating these practices into a modern health system requires a scientific framework capable of identifying active principles, determining therapeutic indications, assessing dosages, and guaranteeing safety. The objective is not to oppose traditional pharmacopoeias to modern medicine, but to develop

interdisciplinary research capable of enhancing local therapeutic resources while mitigating the risks of non-standardized preparations.

Despite their social importance, traditional care settings present significant challenges: precarious accommodation conditions, the absence of institutional recognition mechanisms, and a default role as a last resort for patients abandoned by official health networks. Addressing this reality requires establishing mechanisms for oversight, training, collaboration, and scientific evaluation rather than excluding actors whose social role remains vital in underserved rural areas.

DISCUSSION

The results of this research show that African health systems must evolve toward a model capable of integrating multiple forms of knowledge. The persistence of recourse to traditional healers demonstrates that populations continue to place significant value on local knowledge. This aligns with Ngũgĩ wa Thiong'o's (1986) work on the colonial domination of knowledge systems: colonization did not only target territories; it established a hierarchy that devalued African knowledge. Applied to health, this analysis prompts a reexamination of the status accorded to pharmacopoeias, therapeutic practices, and local representations within public health policies, without falling into an uncritical idealization of traditional practices.

These findings also align with Pfeiffer and Chapman (2010), who demonstrate that health interventions in Africa encounter difficulties when international biomedical models fail to account for local social practices and health representations. In Noun, hospitals are recognized as indispensable for technical procedures (e.g., medical examinations, infusions, emergency care). However, when illness is interpreted as a mystical attack or a social failure, biomedicine alone appears insufficient. This does not undermine the scientific value of modern medicine; rather, it underscores the need for a health model that incorporates the cultural dimensions of illness.

These results confirm Charles Leslie's (1976) framework on medical pluralism, which posits that societies do not operate around a single dominant system, but mobilize several medical traditions depending on circumstances, beliefs, prior experience, and patient expectations. Traditional healers in this study rarely claim exclusivity; many recognize their limits and refer patients to hospitals when technical skills are required. This aligns with research by Broom *et al*., (2021) on hybrid medical systems, where contemporary patients combine multiple medical traditions rather than choosing one exclusively. This hybridization is evident in the discourse collected in the Noun Subdivision: hospitals are called upon to treat physiological dimensions, while traditional healers intervene when causes are interpreted as mystical or social. This existing community-level complementarity should be formally recognized and organized by health policies, in line with recommendations from WHO (2019) and Kasilo *et al*., (2019), which advocate for institutional mechanisms enabling information exchange, training, and collaboration between traditional practitioners and biomedical professionals.

Ultimately, these results invite a rethinking of African health models based on local realities. The issue is not the existence of biomedicine, which remains indispensable but the inadequacy of a system that recognizes only a single form of therapeutic rationality, structurally leaving behind an identifiable share of patients and pathologies. This aligns with Boaventura de Sousa Santos's (2018) *epistemologies of the South*, which advocate for recognizing diverse forms of knowledge without accepting them uncritically. African therapeutic knowledge must be treated as a subject capable of undergoing rigorous scientific analysis. As Mbembe (2021) emphasizes, contemporary African societies must build their own development models by integrating historical experiences, cultural resources, and social realities.

Finally, our findings align with Didier Fassin (1996), who argues that health cannot be reduced to a technical issue: health policies are embedded within specific social, historical, and political contexts. The introduction of biomedicine during the colonial era was accompanied by the marginalization of local therapeutic knowledge. Similarly, Paul Farmer (2004) demonstrates that health disparities are shaped by structural violence, economic inequalities, and historical dynamics of domination. In Noun, recourse to traditional therapists is driven not only by cultural beliefs, but also by practical constraints related to accessibility, cost, and trust in local actors.

Expanding the field of observation across the ten regions of Cameroon confirms that therapeutic pluralism is not a residual cultural trait, but a structural response to systemic shortcomings. In the Sudano-Sahelian zone, Gruénais (2003) documented the limits of local primary health care reforms, a situation worsened by the Boko Haram conflict, as highlighted by ALIMA (2018) and IOM (2026). In the Anglophone regions, Human Rights Watch (2022) and Médecins Sans Frontières (2023) show that the material collapse of health infrastructure transforms non-biomedical recourse into a necessity, confirming Olivier de Sardan and Ridde's (2014) thesis that health policies fail when they ignore practical implementation conditions.

Conversely, the forest and coastal zones nuance an overly culturalist reading: Monteillet (2016) shows that non-recourse to care facilities in Nkoteng is driven by access barriers and perceived quality rather than self-medication traditions, while Ngwen (2018) establishes

that recourse to traditional healers and private clinics is proportionally higher in urban centers like Yaoundé and Douala than in certain rural areas. Finally, the Centre region presents a different dynamic: care seeking is shaped not by scarcity, but by the heavy concentration of health infrastructure in Yaoundé, driving internal medical migration and generating asymmetries in health knowledge production. This regional comparison highlights two important caveats:

- **Contextual Heterogeneity:** The diversity of regional situations rules out uniform generalizations; a health policy designed for conflict-affected Anglophone zones cannot be applied directly to the Centre region.
- **Localized Translation:** The integration of care systems cannot be dictated uniformly from Yaoundé. It requires contextual adaptation tailored to specific local constraints security-related in the North-West and South-West, economic/informal in the Littoral, cosmological in Noun and Mbam-et-Kim, logistical in the Far North, and financial for chronic illnesses.

CONCLUSION

This study moves beyond the classic dichotomy between modern biomedicine and local therapeutic traditions. The primary challenge facing African and specifically Cameroonian health systems is not choosing between exclusive models but establishing an organizational framework capable of addressing the holistic dimensions of human health while ending the systemic marginalization of specific patient profiles and pathologies. Refounding African health systems requires an intercultural approach grounded in complementarity between validated biomedical science and local knowledge. However, this openness must not translate into the uncritical acceptance of all practices; the integration of traditional knowledge into public health policy must occur within ethical, scientific, and regulatory frameworks that guarantee patient safety. Starting from the localized case of *Yiémum* among the Bamoun of Noun, this national comparative analysis shows that therapeutic pluralism reflects a broader structural issue: health systems designed independently of the geographic, economic, security, and symbolic realities of the populations they serve. Addressing these challenges calls for differentiated, region-specific health reforms rather than top-down, uniform policies. Effective health systems must look beyond biological diagnostic categories to understand how communities conceptualize suffering, healing, and well-being. Only under these conditions can health systems in Cameroon and across the African continent achieve both clinical efficacy and social legitimacy.

Limitations and Avenues for Future Research

This study has several limitations that should be explicitly acknowledged:

Methodological Asymmetry: Primary fieldwork was conducted in the Noun Subdivision, whereas data for the remaining nine regions relies on secondary literature.

Scope and Coverage: The selection of regions and pathologies studied is non-exhaustive.

Unverified Clinical Claims: Testimonies regarding unexplained remissions or traditional cures reflect anthropological perceptions rather than clinically validated outcomes. These limitations point to key avenues for future research:

- Conducting empirical fieldwork in regions currently documented primarily through secondary literature.
- Carrying out longitudinal studies tracking patient therapeutic itineraries over extended periods.
- Initiating pharmacological, clinical, and toxicological evaluations of traditional preparations as a prerequisite for health system integration.
- Developing comparative studies with neighboring countries in Central and West Africa.

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