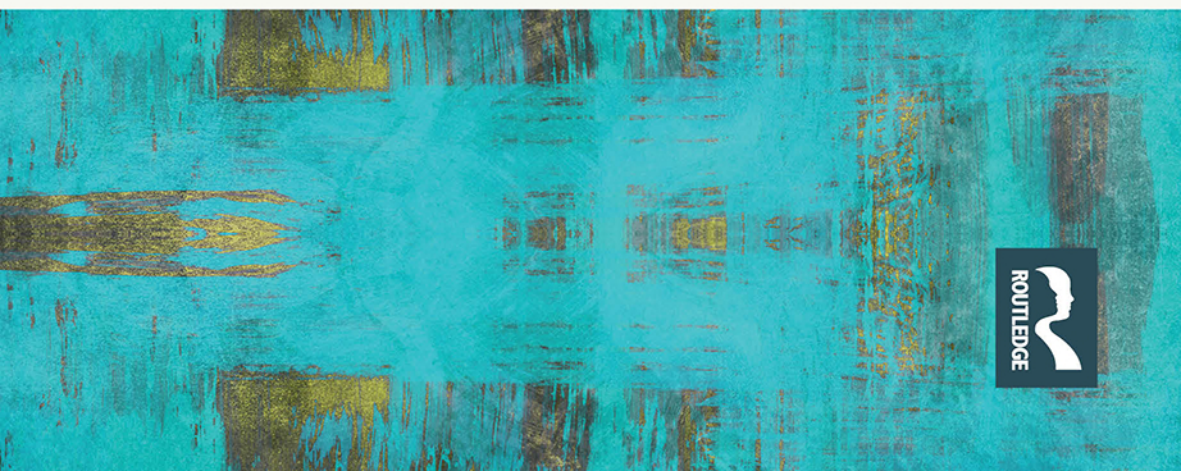
Routledge Research in Health and Healing in Africa and the African Diaspora

PUBLIC HEALTH AND SPIRITUAL AFFLICTIONS IN AFRICA AND THE DIASPORA

EPISTEMIC POLITICS OF PLURAL HEALING WORLDS

Edited by
Boris Koenig



"*Public Health and Spiritual Afflictions in Africa and the Diaspora* provides a nuanced look into the complex relationships between public health and a wide range of spiritual healing practices from across sub-Saharan Africa and its diaspora. Never content to accept simple appeals to inclusion or collaboration at face value, the authors draw on detailed ethnographic cases to explore how epistemic legitimacy is produced and negotiated within and beyond institutional boundaries."

China Scherz, *Professor of Global Affairs, Keough School of Global Affairs, University of Notre Dame, USA.*

"A fascinating and profound set of cases written by a marvellous combination of star-studded and emerging scholars, *Public Health and Spiritual Afflictions in Africa and the Diaspora* reveals links of co-creation among belonging, exclusion, and public health structures in conditions of medical pluralism. Taking the social dynamics of spiritual insecurity seriously, it proposes new means to address epistemic dialogue among states, healers, patients, and kin, aiming to improve African and African-diasporic experiences of health and care by reshaping global health's epistemic foundations."

Pamela Feldman-Savelsberg, *Broom Professor of Anthropology and Social Demography, Carleton College, USA.*

Public Health and Spiritual Afflictions in Africa and the Diaspora

This book examines the paradox whereby spiritual afflictions (conditions attributed to ancestors, jinns, spirits, witchcraft, and other intangible entities) remain central to everyday therapeutic worlds in Africa and the diaspora, yet are routinely sidelined or rendered invisible in official public health policies and global health agendas.

Drawing on ethnographic research in Cameroon, Congo, Côte d'Ivoire, Ghana, Mozambique, South Africa, Tanzania, Zanzibar, and African diasporic communities in Europe, the book's contributors analyse how people navigate intertwined therapeutic worlds in which invisible forces and biomedical logics coexist, collide, or bypass one another. It conceptualizes public health as a domain of ongoing epistemic struggle, examining how policies, legislation, and clinical encounters enact limited recognition and integration that keep spiritual healing subordinate even when they claim to include it. At the same time, the chapters illuminate vernacular governance, popular epistemologies, and informal infrastructures of care through which communities negotiate forms of accountability, regulate healers, and sustain therapeutic legitimacy beyond the clinic and the state. Ethnography is positioned here as an epistemic infrastructure in its own right, capable of unsettling dominant assumptions and opening space for more equitable, plural public health futures.

The book speaks to scholars and students in anthropology, political science, and public health, as well as clinicians, policymakers, and practitioners in global health and development. It offers conceptual and methodological tools for rethinking what counts as evidence, legitimate care, and public health expertise, inviting readers to imagine health institutions that are attentive to plural epistemologies and responsive to the lived realities of those navigating diverse therapeutic worlds.

Boris Koenig is an FNRS postdoctoral fellow at UCLouvain and a former SSHRC postdoctoral fellow at the University of Michigan (Department of Afroamerican and African Studies). He has conducted long-term ethnographic research in urban and rural Côte d'Ivoire since 2012. His current work examines the intersections of public health, spiritual healing, and the digital transformation of plural therapeutic worlds in Africa and its diasporas.

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Public Health and Spiritual Afflictions in Africa and the Diaspora

Epistemic Politics of Plural Healing Worlds

Edited by Boris Koenig

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Introduction

Reimagining Public Health's Epistemic Infrastructures from the Lived Realities of Spiritual Afflictions

Boris Koenig

The following ethnographic vignettes show some ways in which spiritual perspectives on health and illness intersect with or remain invisible within public health institutions.

In a Ghanaian psychiatric clinic, a young woman's brother fervently contests her diagnosis of psychosis, asserting that the voices she hears are not pathological hallucinations but spiritual visitations marking her as a future healer. Their refusal of medication lays bare the fraught tensions between biomedical authority and spiritual frameworks of well-being, animating a struggle over whose knowledge counts in guiding recovery. While in this particular Ghanaian clinic, psychiatric staff do not necessarily reject these spiritually infused interpretations, they often choose not to engage with them. Instead, they maintain the institutional boundaries of psychiatric care even as they tacitly acknowledge the limits of what can be recognized and addressed within the psychiatric unit.

Across the continent in Zanzibar Town, women mobilize Quranic recitations and healing rituals to confront afflictions often linked to envy, social tensions, or suspected sorcery—practices that blend devotion, aesthetics, and moral authority. Enacted within the intimacy of the household and often timed to avoid public scrutiny, these rituals reflect the gendered, strategic, and socially negotiated nature of healing in everyday life. Although Zanzibar's 2008 Traditional and Alternative Medicine Policy opened pathways for healer integration in public health facilities, spiritual healing practices continue to thrive largely in everyday, non-clinical settings. They persist not as residual traces awaiting inclusion, but as therapeutic and moral infrastructures tied to lived Islam and the relational politics of care.

Meanwhile, in Parisian oncology wards, West African immigrant women weave together ritual healing and herbal therapies with biomedical cancer treatment to address the spiritual dimensions of their suffering. These plural care itineraries are rarely acknowledged within French clinical settings. The biomedical emphasis on bodily pathology and communicative transparency often overlooks how illness is experienced relationally, spiritually, and cosmologically. The structural invisibility of non-biomedical healing frameworks within clinical settings, coupled with the absence of dialogue around coexisting but sometimes incommensurable modes of care, contributes not only to delayed diagnosis but also to

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ruptures in treatment, mistrust, and disengagement. In the absence of such recognition, miscommunication and deep divergences in how illness is understood have, in some cases, culminated in preventable deaths, underscoring the high cost of silencing different epistemologies within clinical governance.

Among the Babanki of Northwest Cameroon, families facing illness often initiate ceremonies to repay spiritual debts and hold these rituals as vital for restoring well-being and disrupted relations with the ancestral world. Even as they turn to biomedical care, many explain that healing ultimately depends on satisfying ancestral or spiritual demands. While such non-biomedical approaches are both significant and widely practiced, they receive little formal engagement in public health systems. As a result, families navigate intertwined but institutionally segregated systems of ritual and biomedical care, each structured by divergent logics of efficacy and care, and rarely recognized as coexisting in daily life within state-sanctioned public health systems.

These vignettes expose a persistent paradox at the heart of this volume.[1] Spiritual healing practices are profoundly woven into the fabric of social life and shape how countless individuals and communities make sense of illness and suffering, yet they remain largely excluded by national health policies, marginalized within biomedical institutions, and often regarded with ethical wariness in mainstream public health narratives. These exclusions persist even though spiritual forces are understood within communities not as symbolic abstractions but as lived dimensions of health and well-being, deeply rooted in local aetiologies, forms of reasoning, and relational understandings of affliction. It is in this context that this volume foregrounds the issue of spiritual afflictions, understood as conditions and illnesses attributed to invisible forces such as ancestors, demons, jinns, spirits, witches, and other intangible entities.

Engaging with the spiritual dimensions of illness and healing may, first of all, require recognizing the everyday presence and significance of the idioms through which people interpret and seek healing from such afflictions. These include widely circulating expressions across Africa and its diaspora such as "sent illness" (*maladie envoyée*), "bewitchment" (*ensorcellement*), "kindoki" (*sorcellerie/witchcraft*), "uganga" (sorcery), "spiritual blockage" (*blocage*), or "mystical illness" (*maladie mystique*), expressions one might hear in everyday conversations, whether in the street, at home, in markets, workplaces, or clinics alike. Such idioms, together with the practices, relationships, and cosmological understandings they are part of, illuminate diverse frameworks of affliction and healing, frameworks that biomedical and government-mandated public health systems frequently overlook or fail to seriously engage. This disjuncture between lived experiences of spiritual affliction and the governing logics of these nationally directed health systems is not merely theoretical; as the introductory vignettes suggest, it has tangible and often severe consequences, including delayed diagnoses, disrupted therapeutic paths, preventable deaths, misallocated resources, and deep emotional as well as economic strain on individuals and their families.

This paradox demands a new analytical lens. Rather than conceiving public health as a supposedly unbiased or partially inclusive domain, it is more

precise and constructive to approach it as an active arena of ongoing epistemic struggle, constantly shaped by institutional logics that govern which kinds of knowledge, affliction, and healing are recognized as legitimate and authoritative. In this regard, the collection invites readers to move beyond surface-level descriptions of policy "inclusion" and instead address the deeper question of how therapeutic legitimacy is constructed, negotiated, and contested within everyday life. By highlighting these dynamics, the contributions make clear how regulatory gestures and formal recognition, regardless of how progressive they may seem, often serve to entrench existing epistemic hierarchies. At the same time, authority over health and care is continually reconfigured from below: through the improvised work of mediation, everyday relational responsibility, and vernacular governance enacted by individuals and communities as they navigate uncertainty and multiple therapeutic possibilities. Such transformations expose the persistent tensions between lived pluralism and the limits of what official public health frameworks can recognize or sustain. In so doing, the volume collectively challenges any notion of uncomplicated progress towards public health systems attuned to plural therapeutic realities.

As a first step, the collection calls for an epistemic rebalancing: a recognition that the foundational assumptions underpinning global and national health governance must be opened to scrutiny. Building on the strengths of biomedical knowledge while addressing its limits, this perspective insists on the need for critical engagement with diverse therapeutic worlds as equally deserving of serious institutional consideration. Such a shift requires confronting a series of complex but essential questions: Who has the authority to define legitimate knowledge about health, healing, and well-being? Under what circumstances are spiritual healing practices recognized or rendered invisible? And how might public health policies and programmes take seriously multiple health knowledge traditions, rather than settling for tokenistic inclusion?

To address these questions, this volume draws extensively on immersive ethnographic fieldwork conducted across rural villages, urban neighbourhoods, and transnational settings in a diverse range of countries and territories—including Cameroon, Congo, Côte d'Ivoire, Ghana, Mozambique, South Africa, Tanzania, Zanzibar, and African diasporic communities in France. Bringing together disciplinary expertise from anthropology, public health, political science, and history, the contributors offer a nuanced perspective on the politics of knowledge surrounding spiritual healing. Through sustained participant observation and deep engagement, they approach the everyday worlds of spiritual affliction and healing not as peripheral curiosities, but as central, constitutive terrains where health, well-being, and the fabric of social life are actively shaped, contested, and negotiated.

Ethnography here is positioned not only as an epistemic disruption but as an intentional intervention into how care and healing are institutionally imagined. Far from merely documenting cultural difference, ethnography challenges the reductionist impulses of biomedical frameworks by bringing to light the relational, moral, and cosmological dimensions that animate healing practices in

diverse communities. This methodological commitment enables the volume to amplify the voices, strategies, and struggles of those too often rendered invisible within institutionalized forms of public health. By positioning ethnography as a form of epistemic infrastructure and transformative practice, it generates situated knowledge capable of unsettling dominant assumptions, clarifying the lived complexities of therapeutic pluralism, and opening new pathways towards more inclusive and equitable approaches to public health.

Beyond cataloguing alternative practices, providing technocratic fixes, or incrementally appending marginalized realities to prevailing paradigms, the chapters collectively interrogate fundamental assumptions about evidence, authority, and inclusion in global health. They encourage readers—among others, policymakers, public health practitioners, scholars, and students—to recognize the persistent, often unacknowledged forms of spiritual affliction and healing that exist beyond the horizons of dominant biomedical models, and to seriously engage with the question: What might public health look like if it were not circumscribed by biomedical norms, but instead attuned to the experiences of those navigating plural therapeutic worlds?

This introduction unfolds in three parts, each advancing the central argument that public health is a domain of ongoing negotiation over knowledge and legitimacy. First, it examines how biomedical paradigms and global health governance enact forms of epistemic capture, marginalizing spiritual healing and delimiting the scope of therapeutic pluralism. Second, it explores the creative, often informal, and socially embedded forms of health governance from below, demonstrating how individuals and communities generate recognition, shape responsibility, and maintain therapeutic alternatives outside or in productive tension with institutional frameworks. Third, it considers potential institutional and policy futures—asking what it would mean to design pluri-epistemic public health institutions, rather than systems confined to forms of inclusion that remain symbolic in practice. Together, these three lines of inquiry illuminate both the persistent constraints and emergent possibilities for building public health infrastructures attuned to the lived experiences and therapeutic needs of diverse populations.

Governing the Invisibilized: Spiritual Healing and Global Health Politics

Whether before or after the consolidation of biomedicine, relationships between the material and spiritual realms have long played a central role in how health and affliction are understood (see, among others, Feierman and Janzen 1992; Last 1996; Bernault and Tonda 2000; Moore and Sanders 2001; Larsen 2008; Winkelman 2009; Mpofu et al. 2011; Dhar et al. 2013; Geschiere 2013; Basu and Steinforth 2017; Josewski et al. 2023; Pemunta and Tabenyang 2023). In Africa, and more broadly across the globe, biomedical services have never existed in isolation; they have long coexisted with a dense ecology of spiritual therapies addressing ailments attributed to ancestors, spirits, jinn, witchcraft, or divine agency. Yet public health policies

and regulatory frameworks, both colonial and post-colonial, have largely equated progress with the expansion of biomedical infrastructures, framing therapeutic pluralism as a problem of access, regulation, or "modernization" (Lock and Nguyen 2010; Prince and Marsland 2014; Olsen and Sargent 2017). Contrary to widespread assumptions that spiritual healing would disappear with the global advance of biomedicine, such predictions have proven inaccurate: as Lock and Nguyen (2010) observe, rather than disappearing, healers have adapted and continue to operate as vital and evolving actors in contemporary therapeutic landscapes. This biomedical default nonetheless continues to shape what governments fund, measure, and deem credible, even as many citizens often pursue healing pathways that unfold well beyond clinical settings.

As the chapters in this volume demonstrate, the vitality of spiritual healing in contemporary Africa cannot be reduced to mere gaps in biomedical coverage, structural adjustment programmes or to unequal distributions of wealth (Pfeiffer and Chapman 2010: 156). These practices persist because they align with locally grounded aetiologies, that is, interpretations in which misfortune, illness, and social dynamics are habitually read through spiritual lenses. What unites the contributions here is the argument that the marginalization of spiritual healing is not incidental but systemic: public health systems enact recognition only when spiritual practices can be rendered legible to governing institutions, made administratively manageable, and aligned with dominant biomedical frameworks. This conditional inclusion is less an embrace of therapeutic diversity than a mechanism of containment and reduction—one that reinforces global hierarchies of therapeutic legitimacy.

These marginalizing dynamics are particularly visible in African contexts, where struggles over therapeutic standing unfold within legally ambiguous and institutionally plural environments. The settings explored in this volume are not peripheral but central to challenging dominant global health logics, serving as sites where these tensions are not only exposed but actively negotiated in daily life. In such contexts, state recognition of spiritual healing is most often conditional, granted only when such practices can be translated into institutionally sanctioned medical categories, though in uneven ways. This selective legibility constrains more than it includes, reducing different epistemologies to those fragments deemed acceptable within formal public health frameworks. Beyond Africa, comparable tensions are evident in Indigenous health movements across the Americas or in plural medical systems in Asia. Yet the African cases highlight, with particular clarity, the entrenched structural barriers and profound ethical stakes involved in designing public health systems capable of supporting multiple therapeutic worlds without suppressing them.

From Recognition to Reduction: How Health Policy Frames Spiritual Healing

Interrogating how spirituality is addressed within public health policy brings into focus the unresolved frictions between biomedical governance and alternative therapeutic logics. Spiritual healing practitioners—once repressed by

colonial administrations and still frequently confined to legal grey zones in many African, European and North American countries—have, over the past three decades, become subjects of emerging public health policy. These national policy shifts follow the World Health Organization's (WHO) long-standing calls to promote, regulate, and integrate complementary, nonconventional, and traditional medicine into the formal infrastructures of state-led public health systems (Akerele 1984; World Health Organization 2000, 2013, 2019, 2024; Kasilo et al. 2010; Abrams et al. 2020).

Healers have been the subject of two dominant discourses within these initiatives (Peng-Keller et al. 2022). The first envisions them as an auxiliary workforce to address biomedical shortages, a framing that expanded after the Alma-Ata Declaration in 1978. Here, the objective is not to embrace multiple therapeutic registers but to extend the reach of biomedicine, while treating the spiritual dimensions of healing as incidental, non-essential, or even obstructive to public health goals. The second adopts a commercial logic: pharmacopoeias are reframed as reservoirs for economic growth and global markets for alternative therapies.

Following the WHO's calls since the 1980s, many national health authorities, particularly in Africa, have adopted legislative frameworks to formalize the use of healers' remedies (such as animal, plant, and mineral-based treatments) through biomedical evaluation protocols. While often justified as measures for safety and efficacy, these policies deploy selective validation mechanisms that marginalize the core spiritual worldviews of many therapeutic traditions. Critics have noted how this dynamic contributes to the broader medicalization of healing traditions, eroding their cultural and epistemological richness (Dozon 1987; Ashforth 2005a; Langwick 2011; Bruchhausen 2018; Nichols-Belo 2018). This reflects what Ashworth and Cloatre (2022) describe as the production of "depoliticized alterity," where bureaucratic rationality neutralizes the relational or subversive dimensions of non-biomedical healing and thereby reduces their ontological depth while aligning them with dominant public health models.

As the scientific paradigm continues to condition how most governmental health authorities perceive and regulate non-biomedical practices, contributors to this volume highlight that the degree of openness of official public health approaches and legislation towards spiritual healing varies significantly across countries. It ranges from maintaining the activities of spiritual healers in a legal or regulatory vacuum (as observed in Cameroon, Congo, and France), failed attempts to bureaucratize and institutionalize spiritual healing practices (South Africa), outright delegitimization and prohibition of spiritual healing (Northern Tanzania), initiatives aimed at collaboration between healers and biomedical health practitioners (Ghana), and intercultural therapeutic dialogues in biomedical facilities (Canada) to the adoption of health legislation that aims to integrate spiritual healing practitioners within health systems (Côte d'Ivoire, Zanzibar).

Exploring these contextualized differences, this volume examines the extent to which national health authorities regulate spiritual healing practices and

construct public health policies intended to be inclusive and receptive to the plurality of health, healing, and well-being practices. Each contributor provides an overview of the recent legislative developments concerning the regulation of spiritual healing practitioners and the modalities of their potential integration into the formal public health system in the countries where they have conducted empirical research. These contextual analyses shed light on the formal boundaries of recognition and the logics that underpin them, providing a necessary foundation for understanding how inclusion is structured, negotiated, and contested within distinct national public health frameworks.

Yet this volume moves beyond purely descriptive accounts of legal frameworks and regulatory gestures. It probes the deeper logics that underlie such policies, examining how they operate as instruments of governance and as vehicles for shaping which forms of knowledge, practice, and legitimacy circulate in public health. Accordingly, the chapters bring to the fore the performative dimensions of policy: what public health directives actively materialize in the world, not simply what they permit or restrict. Public health legislation and global directives thus do more than organize existing practices; they actively produce social realities and institutionalize knowledge hierarchies. These hierarchies determine which therapeutic approaches are affirmed within institutions, which become eligible for resources and formal recognition, and which are marginalized or dismissed—typically privileging biomedical models over alternative ones. In this light, health policy should be understood as a form of infrastructural design, setting the boundaries of what is institutionally imaginable, articulable, and put into practice within state-sanctioned public health. This foundational logic recurs throughout the volume and is taken up again later in the introduction.

Fragile and Epistemically Contained Integration: The Global Politics of Health Pluralism

The cases assembled in this volume expose a broad spectrum in state–healer relations, spanning from outright suppression or regulatory indifference to modes of symbolic endorsement and sporadic collaboration, and, in some instances, to experiments in more formal incorporation. Yet even when states institute seemingly "integrative" strategies, these rarely guarantee equal standing of different forms of knowledge. As the illustrations provided below demonstrate, these modalities of what could be termed fragile integration may grant spiritual healers an uncertain position within the official health sphere, but their acknowledgement remains conditional, temporary, and frequently restricted to urban or pilot programmes. In such environments, a pattern we identify here as epistemically contained integration surfaces whenever acceptance hinges on adapting or modifying spiritual healing practices to satisfy dominant biomedical standards. In doing so, the overt diversity of therapeutic approaches conceals a more enduring persistence of biomedical dominance, with alternatives recognized only under strictly controlled and often utilitarian

circumstances. Throughout this continuum—from complete exclusion to unstable, conditional inclusion—these arrangements almost unfailingly reinforce the principles of hierarchy and restriction.

In this perspective, Geschiere's chapter brings into focus some deep contradictions that can undermine any durable integration of spiritual healing into institutionalized public health frameworks. Drawing on long-term ethnographic research in Cameroon and on the regulatory dilemmas highlighted by South Africa's Ralushai Report, he demonstrates how state efforts to distinguish "legitimate" healers from "witches" repeatedly founder, both conceptually and in practice. In the local cosmology, the power to heal is inseparable from the power to harm—legitimacy and suspicion are always intertwined. As a result, even as healers are sometimes recognized or incorporated, such inclusion is always precarious, contingent on the state's hope that spiritual forces can be rendered institutionally manageable. Yet the efficacy of these forces inevitably evokes ambivalence and anxiety, exposing the limits of any project of epistemic containment. As such, fragile and epistemically contained integration is less a failure of policy than a symptom of the state's inability to fix boundaries without erasing the complexity of local understandings of healing and danger.

While Geschiere emphasizes ambiguity, Nichols-Belo's chapter shows how ambivalence can be replaced by strict institutional control. Focusing on Northern Tanzania, she demonstrates that spiritual healing practices were not simply marginalized but actively suppressed by state authorities. This suppression forced spiritually rooted healing practices into covert settings, reducing both their accessibility and therapeutic effectiveness for local communities. Even after some practices were legalized, their official recognition remained conditional: healers were required to adhere to biomedical protocols that are fundamentally at odds with the tacit, spiritual, and relational foundations of their expertise. The Tanzanian example thus sharply illustrates epistemically contained integration: when spiritual healing cannot be translated into biomedical terms, efforts at inclusion can swiftly revert to exclusion.

Côte d'Ivoire provides a seemingly more progressive instance of formal integration. Healers have been officially recognized as "health agents," and transnational spiritual healing NGOs acknowledged as leading health organizations in the fields of addiction, mental health, and the social reintegration of marginalized populations (Koenig 2016; Koenig and LeBlanc 2023). However, hundreds of Christian and Islamic rural healing centres, where therapeutic care often extends over long periods in precarious conditions, remain absent from regulatory frameworks and excluded from substantive institutional engagement (Koenig, this volume). Here, inclusion operates through a dual register: political gestures project an image of inclusive pluralism to national and international audiences, while everyday practices of care, especially those rooted in informal, long-term therapeutic settings, remain structurally marginal.

A parallel dynamic appears in Zanzibar, where the Ministry of Health has granted legal status to healers and established formal clinics that combine biomedical and spiritual healing under the same roof in an officially recognized

institutional setting (Larsen, this volume; Baylor 2015). Yet administrative recognition remains partial and uneven, constrained by persistent resource shortages and a lack of trained personnel. In both Côte d'Ivoire and Zanzibar, symbolic recognition may sustain the appearance of inclusive policy. However, such initiatives often falter when confronted with limited institutional follow-through, chronic under-resourcing, and hesitant political commitment. They also remain on the margins of global health circles, where openness to radically different models of health and well-being beyond the biomedical paradigm has yet to gain secure footing.

The tensions observed in Africa find close parallels elsewhere: in most contexts, the formal "integration" of spiritual healing proceeds only insofar as it aligns with dominant biomedical frameworks. China is often cited as a success story: since the 1950s, traditional Chinese medicine (TCM) has received sustained state support, and by 2021 over 95% of general hospitals had established TCM departments. Yet, as Zhou et al. (2024) demonstrate, this development reflects a strategy of selective translation in which alternative ontologies are incorporated into biomedical systems through modalities that prioritize pharmacological efficacy and standardized diagnostics. In the process, core cosmological logics, such as qi flows, spirit-mediated diagnosis, and relational theories of health, are pushed to the margins. Ongoing tensions among Chinese medicine practitioners in Hong Kong further expose these fault lines: while some advocate a return to classical theoretical foundations, others seek biomedical legitimacy through scientific reframing (Tian and Zhang 2024).

A similar pattern appears throughout South and North America, where post-colonial histories inform divergent health policy frameworks. In Bolivia, intercultural health programmes such as the Tinguipaya project seek to bridge Indigenous and biomedical logics; however, biomedical staff maintain predominant control over clinical spaces, thereby marginalizing Indigenous cosmologies (Torri and Hollenberg 2013). In British Columbia, Canada, provincial policies purport to support Indigenous-led mental health services, yet mainstream biomedical standards continue to shape both contractual requirements and clinical authority (Josewski et al. 2023). As a result, relational and spiritually rooted Indigenous approaches are often pushed to the margins within urban practice settings.

The same trend is evident in Brazil, whose national policy on Integrative and Complementary Health Practices (PNPIC) embodies the region's participatory approaches and formally embraces therapeutic plurality. In practice, however, it elevates modalities such as phytotherapy that align with biomedical evidentiary standards, while displacing the spiritual and metaphysical dimensions of Afro-Brazilian and Indigenous healing traditions to the edges of public services (Gallego-Pérez et al. 2023; Hoenders et al. 2024). As Gallego-Pérez et al. (2023) observe, this dynamic transcends Brazil: across much of Latin America, policies that affirm therapeutic pluralism in principle still struggle to accommodate the relational and ontological dimensions of non-biomedical medicine within dominant health systems.

Read together, these cases illustrate that what appears to be the fragile integration of spiritual healing practices within health systems is neither isolated nor exceptional, but part of a broader, transnational pattern of epistemic containment. Behind the rhetoric of pluralism, integrative medicine, and interculturality, persistent knowledge hierarchies continue to define what qualifies as legitimate care. Far from disrupting biomedical dominance, these forms of inclusion consolidate it: reducing complex cosmological systems to a narrow set of recognizable or measurable practices, curating therapeutic diversity under controlled terms, and perpetuating the marginalization of non-biomedical knowledge.

Epistemic Freedom in Global Health

The illusion of therapeutic pluralism, however, conceals what Ndlovu-Gatsheni (2018) has called a more profound deficit: the persistent lack of epistemic freedom—the capacity for communities to define, legitimize, and institutionalize their own modes of knowing. Without such inclusion, pluralism reflects not merely a shortfall in policy recognition but a continuation of the asymmetries embedded in the coloniality of knowledge. From this vantage point, the central challenge addressed in this volume lies not in integrating diverse forms of healing, but in reshaping the knowledge foundations upon which global health systems rest.

In this regard, the chapters in this volume offer two critical forms of disruption. First, they challenge the entrenched binary between "evidence" and "belief," demonstrating that biomedical rationality is neither universal nor neutral, but culturally and morally contingent (Good 1994; Lock and Nguyen 2010; Abadia-Barrero 2022). Ashforth (this volume; 2011), from a different vantage point, critiques the category of "belief" itself, advocating for a relational realist approach that treats spiritual experience as engagement with real agents, not as irrational conviction. Viewed through this lens, the chapters in this volume trace an important range of diagnostic and therapeutic repertoires: divine revelations, embodied testimonies, Qur'anic and other divinatory readings, multisensory ritual ceremonies, administrative and relational interventions, psychiatric consultations, pluralistic treatment negotiations, and selective uses of biomedical technologies. Each of these, as the chapters show, constitutes a situated regime of truth-making—responding simultaneously to spiritual, moral, and biomedical needs, and mediating vulnerability, harm, and care across the spheres of spirituality, law, clinical medicine, and everyday life. Recognizing their coexistence not only clarifies the limits of biomedical authority but also opens space for more equitable relations among divergent ways of knowing.

Second, the chapters bring to the fore what Nyamnjoh (2001) calls "popular epistemologies"—ordinary people's lived, situated, and relational understandings of knowledge, healing, and reality. Unlike the pejorative connotations of "folk belief" or "superstition," this concept highlights an epistemological order

that refuses the dichotomies of dominant western epistemological frameworks, instead marrying the visible and the invisible, the rational and the relational, within a framework where individual agency is always embedded in collective life. This perspective resonates with a wide body of ethnographic studies on spiritual experience and extra-human agency, revealing the diverse healing practices upon which people rely in daily life (Jackson 1989; De Boeck and Plissart 2004; Ashforth 2005b; Van Beek and Peek 2013; Blanes and Espírito Santo 2013; Pemunta and Tabenyang 2023). Building on these insights, the contributors to this volume approach discourses on spiritual afflictions and healing not as figurative or metaphorical, but as literal and factual claims about spiritual forces understood to influence bodily and social experiences (Ashforth 2005b). They emphasize that the role of intangible entities in everyday life and healing is not considered socially "supernatural" or "extraordinary" but ordinary, even banal, integral to the empirical reality lived by many across the globe (Olivier de Sardan 1992; Jackson 1996; Ashforth 2005b). This ethnographic stance explicitly recognizes the intangible as part of empirical reality, destabilizing entrenched binaries and revealing the deep entanglements between spiritual and physical worlds in shaping health, illness, and well-being.

Taking this recognition as a point of departure, the following sections call for a fundamental rethinking of public health infrastructures that seriously engage with the diverse ways communities understand and address illness. This goes beyond cultural inclusion or simple adaptation; it is a question of epistemic justice, which, as Fricker (2007) suggests, involves acknowledging and actively redressing the ways in which certain knowledge systems, including those animating therapeutic lives, are excluded or marginalized within dominant institutions. Advancing such change necessitates questioning entrenched forms of authority and engaging the politics of recognition that determine whose knowledge and practices count. In moving towards this perspective, the focus shifts from formal health systems to informal, community-based infrastructures that constantly reshape what counts as legitimate healing and care, questioning prevailing models and presenting new possibilities for more equitable forms of health governance.

Public Health from Below: Vernacular Governance and Plural Healing Worlds

Beyond official public health policies and programmes, the social integration and recognition of spiritual healing have historically been driven by locally rooted therapeutic initiatives and community-based informal networks. Across diverse contexts, individuals and communities have developed their own approaches to health and healing, often operating alongside, or entirely outside, official public health systems. Far from being marginal or improvised, these practices form enduring parallel systems that confer therapeutic credibility and sustain access to care beyond formal infrastructures. Instead of replicating biomedical rationalities, they follow alternative logics, affective, moral, religious, or spiritual, deeply embedded in everyday social life and anchored in long-standing

communal institutions. This does not signal a lack of structure or validity; rather, such informal health practices frequently embody distinct forms of organization and authority, directly challenging the dominant order in public health.

Exploring these dynamics, we note that, alongside governmental authorities, ordinary people in Africa and elsewhere have long played significant roles as organizers of public health, actively contributing to the social integration of non-biomedical therapeutic forms (Chrisman and Kleinman 1983; Feierman and Janzen 1992; Last 1996; Baer 2022). Health seekers and their social networks have experimented with and evaluated non-biomedical therapies, endorsing some over others based on perceived efficacy, cultural resonance, and moral legitimacy, and extensively sharing knowledge about the most effective practices for specific health issues. From this perspective, public health emerges as co-produced at the community level, through the integration and social regulation, by the population itself, of a plurality of non-biomedical therapeutic practices. This view centres the agency of health seekers, practitioners, and local communities in producing, regulating, and legitimizing therapeutic approaches, offering a direct counterpoint to dominant, expert-driven models of state-sanctioned health governance.

The Politics of Invisibility in Spiritual Healing

As the chapters in this book show, the positioning of healers within local therapeutic landscapes—and the pathways taken by those experiencing spiritual afflictions—depend simultaneously on partial national regulation and on informal, personal, and often secretive practices that unfold in semi-public spaces and daily interpersonal relations. The configuration of this formalized–informalized interface varies across settings, yet is frequently structured by two interrelated forces: the dominance of the biomedical paradigm, which, as shown above, marginalizes practices that elude standardized scientific validation; and the influence of certain religious movements that openly denounce spiritual healing. These religious critiques are not new: since the colonial period, missionary and revivalist movements in multiple contexts have worked actively to drive such practices out of public view, portraying them as theologically deviant or morally dangerous. Together, these forces have shaped not only public discourse and institutional policy, but also pushed spiritual healing to more private arenas, rendering it less visible, less legible, and less legitimate in public and institutional imaginaries.

The politics of spiritual healing's invisibility is not confined to formal institutions or religious authority; it permeates everyday interactions and intimate relations, shaping how people navigate their socio-spiritual lives. Spiritual healing trajectories and personal approaches to "spirituality," understood as "the everyday ways ordinary people attend to their spiritual lives" (McGuire 2008: 98), are rarely discussed even among close relations in most African and African-diasporic contexts. This reticence reflects the widespread prejudice still