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The journey of tuberculosis patients in Douala-Cameroon in the context of the drug crisis

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Abstract
The fight against tuberculosis has been going on since the dawn of time. However, humanity still seems vulnerable to this disease. At the international and national levels, health surveillance policies have been developed to eradicate it. It has been rightly noted that several factors stand in the way of its elimination. This study was conducted in four (04) health facilities in the city of Douala with thirty (30) people, using a qualitative approach. The data collection techniques used were interviews and observation. Social representations were used as an analytical framework. This research describes the difficulty of accessing anti-tuberculosis drugs. It warns of the lack of seriousness in the management of the disease, which increases the risk of endemicity. The results show that the patients interviewed were not aware of the symptoms of this disease beforehand. This lack of knowledge justifies the use of self-medication as the first line of treatment and delayed referral to hospital. Biomedical treatment is found to be inadequate due to continuous shortages of medication. When medication is unavailable, patients are referred to the street, where they are likely to consume products of dubious quality. In this context, patients are monitored without medical supervision. In addition, they no longer follow the treatment protocol, do not check for acid-fast bacilli, and do not change molecules.

Keywords: tuberculosis, drug crisis, patient journey, Douala-Cameroon

Résumé
La riposte contre la tuberculose se fait depuis la nuit des temps. Cependant, l'humanité semble toujours vulnérable à cette maladie. À l'échelle internationale et nationale, des politiques sanitaires de veille ont été élaborées pour son éradication. Il a été donné à juste titre de constater que plusieurs facteurs se dressent en obstacle pour son élimination. La présente étude s'est déroulée dans quatre (04) formations sanitaires de la ville de Douala auprès de trente (30) personnes, privilégiant la démarche qualitative. Les techniques de collecte des données convoquées sont l'entretien et l'observation. Les représentations sociales ont été mobilisées comme grille d'analyse. Cette recherche décrit la difficulté d'accès aux antituberculeux. Elle alerte sur la légèreté dans la prise en charge, ce qui accentue le risque d'endémicité. Les résultats obtenus montrent que les patients interrogés ne connaissaient pas les symptômes de cette pathologie bien avant. Cette méconnaissance justifie le recours à l'automédication comme première itinéraire thérapeutique ainsi que la sollicitation tardive de l'hôpital. Pour ce qui est du traitement biomédical, il ressort qu'il est approximatif à cause des ruptures continues des médicaments. Quand ceux-ci manquent, les malades sont référés dans la rue où ils sont susceptibles de consommer les produits de qualité douteuse. Dans ce contexte, le suivi du malade se fait sans le contrôle du médecin. En plus, il n'observe plus le protocole de soins, ne fait pas de contrôle des *bacilles acido-alcoolorésistants* et ne change pas de molécule.

Mots-clés : tuberculose, crise du médicament, périple du malade, Douala-Cameroun

I. Introduction

Tuberculosis (TB) is one of the leading causes of death worldwide (WHO 2021: 1). In 1993, the WHO declared it a "global public health emergency." Current health policies aim to eradicate it by 2030. To achieve this goal, the organization has prioritized monitoring patients and facilitating access to care. Each member country of this institution has established a national TB observatory. Known as the National Tuberculosis Control Program (PNLT), it is responsible for distributing anti-tuberculosis drugs (L'Union, 2019: 35). Diagnosis and treatment centers (CDTs) have also been set up in certain health facilities. To achieve the goal, it has been agreed that: *"Treatment must be free for anyone diagnosed with tuberculosis"* (L'Union, ibid: 31). The response to tuberculosis has slowed down due to the emergence of COVID-19 (The Global Fund 2023: 36). In 2019, the number of people diagnosed with tuberculosis worldwide was approximately 7.1 million. In 2020, 5.8 million cases were reported. In 2021 and 2022, there has been an increase in diagnoses. Data shows

that 6.4 and 7.5 million people were reported to have tuberculosis during these years.

Other factors listed regularly influence TB management in Cameroon. These include difficulties in releasing drug stocks from the port (PNLT, 2019: 4), inadequate infection prevention and control measures in treatment units, and late and irregular purchases of anti-tuberculosis drugs (WHO-Cameroon 2019: 43). The above-mentioned causes usually lead to stock shortages. They contribute to the shortages of anti-tuberculosis drugs observed in hospitals in Douala. These drug shortages increase the risk of tuberculosis becoming endemic due to the incomplete treatment of diagnosed cases and the disorientation of patients from the formal circuit to the informal network. These factors are likely to lead to the development of ultra-resistant strains in Cameroonian society in general and in Douala in particular. This work is structured around three (03) main areas: methodology, presentation of results, and discussion.

1. Data collection methods and tools

This research was conducted in Douala. It took place in certain health areas in the city's districts. For confidentiality reasons, we have kept the centers where the surveys were conducted anonymous. The four hospitals visited for the study are Douala North, South, East, and West. Informants were selected from among patients undergoing treatment and healthcare personnel working in the CDTs. The ages of the participants ranged from 22 to 56. The research was conducted from February 2024 to May 2025. For data collection, we used direct observation, semi-structured interviews, and group interviews (Angers 2009, N'da 2015). This is a qualitative study (De Sardan 2013; Zagré 2013) that puts into perspective social representations of tuberculosis and treatment pathways.

II. Theoretical framework

The theoretical framework is based on social representation theory (Abric 1987; Jodelet 1989; Rateau and Lo Monaco 2013). This refers to the "*products and [...] processes of mental activity through which an individual or group reconstructs the reality they are confronted with and attributes a specific meaning to it*" (Abric, op. cit.: 188). The latter posits that all representations are the product of a social construct. It thus favors the emic approach. Their understanding is rooted in cultural endosemy (Mbonji Endjèguèlè 2005), meaning that their comprehension is relative to the consideration of indigenous meaning. As a sociocultural product, social representations are defined as: *"a symbolic, culturally determined universe where spontaneous theories, opinions, prejudices, decisions to act, etc. are forged"* (Garnier and Sauvé, 1999: 1). They are removable, constructed, deconstructed, reconstructed, structured, and evolve *"at the heart of the interaction with the object apprehended, even though the interaction with the object is determined by the representation that the subject constructs"* (Garnier and Sauvé, ibid: 1). The idea that individuals have of tuberculosis therefore depends on the information circulating in their environment. This information determines the interpretation of the symptoms of ill health revealed by the body and justifies therapeutic choices.

III. Presentation of results and discussion

The presentation of results serves to highlight the ethnographic data. The discussion consists of applying the theoretical framework to the results in order to make the information gathered understandable.

3.1. Results

Several themes serve as the basis for this work. It starts with the experience of the symptoms of the disease and the search for medication.

3.1.1. Experience of the disease

This section discusses patients' preconceived ideas about tuberculosis and their behavior upon confirmation of BK infection.

3.1.1.1. Pre-diagnosis interpretation of tuberculosis symptoms

Popular knowledge about a disease is based on preconceived ideas. In some cases, it also comes from personal experience. In other cases, it is acquired from the experience of those around them. It is in these circumstances that patients most often form their ideas about a condition. Tuberculosis has claimed countless victims and caused countless deaths over the centuries. To this day, it is little recognized at the family level. Even some healthcare professionals are still unaware of its symptoms. This lack of knowledge about the early signs of tuberculosis explains why patients' first therapeutic reflex is to self-medicate.

"I thought it was just a cough. When it started, I had malaria, so I treated it. Then I got the cough, bought some antibiotics, took them, and it went away. I just kept losing weight. When I got to the meeting, my friends asked me why I was losing weight. I told them I didn't know. That's when they advised me to go to the hospital." (Chanceline, 33, sick, East Douala).

"When I started coughing almost two and a half years ago, it would come and go. It wasn't constant. I could cough for four days straight and then it would go away. It would come back again even three months

later. All this made me think it was just a simple cough or that I was allergic to something I was eating" (Rose, 31, patient, North Douala).

"At first, I didn't pay much attention to my cough. Then I started feeling cold. One morning, I was washing myself and that's when I lost consciousness. They took me to a hospital in the neighborhood, where they did what needed to be done, and I calmed down a little. Then they took me to Cité des Palmiers, where I had tests done. When I coughed up blood, I didn't know what was wrong with me" (Claude, 25, patient, Douala East).

The conclusion that emerges is that despite the various symptoms (fever, cough, coughing up blood, and weight loss), none of the victims suspected they had tuberculosis. However, these signs clinically describe the infection. This raises the issue of ignorance of the symptoms of tuberculosis. The first therapeutic action taken by patients is self-medication. They first resort to biomedical pharmacopoeia. It has been observed that patients seek hospital care after attempts at self-treatment have proved unsuccessful. One informant explains: *"At first, I thought it was just the flu. I took the remedy (traditional medicine). When I saw that it wasn't going away, I came to the hospital"* (Emile, 29, patient, North Douala). Self-medication leads to delayed recourse to the healthcare system, which involves diagnosis, clinical examination, counseling, medical prescription, and patient follow-up.

The general findings are that, firstly, none of the patients suspected tuberculosis at the onset of infection. Secondly, the decision to go to hospital was made under pressure from those closest to them. For others, it was the worsening of symptoms that motivated the decision. After diagnosis, we observed a difference in behavior among people who tested positive for tuberculosis when the results were communicated to them.

3.1.2. Ambivalence in accepting infection between HIV-positive and HIV/AIDS-untested individuals

When the sputum test results were returned, the behavior of those who did not know their serology status was not the same as that of those who were HIV/AIDS-positive after confirmation of tuberculosis infection. The former contested the results, while the latter gave the impression of not being surprised by the new diagnosis.

3.1.2.1. Consternation among people who doubt their serology

Most people believe that tuberculosis is a symptom of AIDS infection. Paramedical staff are no exception to this belief. *"In most cases, tuberculosis is a co-infection with HIV/AIDS"* (Mireille, 41, nursing assistant, South Douala). This perception is one of the reasons why people who have not been tested for HIV and are diagnosed with tuberculosis appear despondent. They say that tuberculosis is *"a disease you get when you have AIDS*" (Mélanie, 24, patient, West Douala). *"We were taught at school that generally when you have HIV, there is a high chance that you will have tuberculosis. So I have always linked tuberculosis to this disease"* (Pélagie, 23, patient, West Douala). These representations justify the weariness of many newly diagnosed patients when waiting for and receiving the news of their infection. Some bedridden patients shed tears at this moment. *"I even cried because it was my first time dealing with an illness like this. I was really uncomfortable... it frustrated me a lot. At that moment, in my head, I thought I had AIDS"* (Justine, 43, patient, North Douala). The paramedical staff interviewed also reported the asthenia of patients in the same circumstances and for the same reason.

"Patients are very depressed when they are told they have tuberculosis. Some even cry. Many refuse to accept their illness. In their minds, they already have AIDS. They need a lot of counseling, a lot. When I call them on the phone to tell them to come and get their tuberculosis results, they say, 'How is it? ' I simply tell them to come and collect their results. They say, 'Tell me if it's positive.' Before, when I was still new to the CDT, I would rush to tell them it was positive, and I saw that I could lose one patient a month" (Victorine, 47, CDT major, North Douala).

The use of clinical examinations is an expression of the enthusiasm of the patient or those around them to discover or identify the unknown entity that is consuming them, destroying them, wasting them away, threatening their existence, isolating them, and frightening their loved ones. The moment of certification of infection, instead of being a time of joy, is perceived by patients as the pronouncement of a sentence. This resonates with the victim as the consequence of a "mistake" they made at some point in their life. The person feels at that moment that they are condemned to live forever with the AIDS virus in their blood. The behavior of patients who refrain from finding out the results of their sputum tests stems from the same apprehension. In the same circumstances, the majority of patients who are already aware of their HIV status are more serene when the infection is confirmed than those with tuberculosis.

3.1.2.2. "Indifference" among HIV-positive individuals

The fear that drives tuberculosis patients when they receive their test results is more common among individuals who, without having been tested for HIV, believe that their symptoms are those of AIDS. Most TB patients who already know their HIV status readily accept their second diagnosis. This acceptance can be attributed to the counseling provided by AIDS activists. However, other reasons cited by informants shed light on their confidence. For many, apathy stems from the fact that tuberculosis is a benign disease. It is less stressful than AIDS. In addition, patients are not condemned to live with it for the rest of their lives because treatment is known and accessible. *"Tuberculosis is a disease like any other. My daughter was affected by this disease. At the time, people said it was a dangerous disease. When I was told I had tuberculosis, it didn't affect me as much as when I was told I had AIDS. I accepted my illness* (tuberculosis) very quickly" (Ruth, 46, patient, West Douala).

Most informants co-infected with AIDS/tuberculosis admit to having accepted the infection that is worse and incurable. Consumption, which can be treated, is less serious. It is rightly referred to as a "minor illness." This representation shows that an individual's acceptance of an illness is proportional to the health difficulties they are already enduring or experiencing. For these patients, being infected with BK is not a death sentence because:
"I already have something more serious. If I have been able to accept and live with an incurable disease, it's not a minor illness like tuberculosis, which can be treated, that's going to bother me. Some people in my condition will see it as inevitable, but for me, that's not the case. I'm going to follow the treatment and it will be over. Since I've been taking medication for the other one (AIDS), is it over? You see!" (Paul, 37, sick, South Douala).

While co-infection is not viewed negatively by many HIV-positive individuals, some patients in this category find their condition very difficult to cope with. They consider the double infestation to be a form of punishment. They feel that tuberculosis, which comes on top of AIDS, is the invisible hand of a third party who wants to see them suffer more by afflicting them with tuberculosis. Some of these patients, feeling sorry for themselves, prefer to seek treatment first through traditional African medicine and only as a second resort through conventional medical care. *"I have to go to the village first because my life is complicated. It's not just tuberculosis. Someone's hand is involved. I have to get to the village first before continuing treatment. I don't understand why I'm the only one suffering from all these diseases"* (Robert, 47, patient, North Douala).

It should be noted that the choice of treatment regimen is based on the interpretations of the patient and sometimes those around them.

3.1.3. Clinical management of tuberculosis

The treatment of tuberculosis depends on the patient's profile. Whether sensitive to rifampicin or ultra-resistant, in either case, the patient is subject to almost the same requirements for recovery.

3.1.3.1. Subordination of recovery to prohibitions

Patients with tuberculosis who are undergoing anti-tuberculosis treatment must comply with a set of requirements. Certain dietary and sexual behaviors are prohibited. Some say: *"I must not smoke, I must not drink alcohol, I must not have sexual relations with women. I must not eat after a certain time. I must not eat after 9 p.m."* (Mohamadou, 23, patient, South Douala). Others mention the ban on cold drinks and the prescription of barrier measures[1].

"I was told not to drink ice-cold water and to wear a scarf to avoid spreading the disease to others. I was told to follow the treatment carefully because it is a treatable disease. I shouldn't worry. I was asked to take the large tablets for two (02) months. If I test negative after that, we'll change. I was also told to take the medication as prescribed" (Justine, 43, patient, North Douala).

For paramedical staff, the purpose of these restrictions is to prevent patients from developing resistance to rifampicin. The sexual ban is not permanent during treatment. This restriction must be observed:

"[...] because the patient does not have enough breath. It is also a measure to break the chain and reduce the risk of spreading the disease. The patient can resume sexual activity after the results of the first Baar test show that the patient has made a good recovery" (Abel, 32, paramedical staff, West Douala).

Compliance with the restrictions imposed on patients serves a threefold purpose. It prevents the risk of patients developing resistance to the anti-tuberculosis drug to which they have been shown to be sensitive, optimizes recovery by temporarily ruling out sexual intercourse and sports, and contains the disease by

[1] These barrier measures involve: wearing a face mask, isolating the sick person, individually assigning spoons, glasses, plates, and even the bed for fear of contaminating those around them.

instructing patients to resume sexual activity only after the risk of infecting their partner has been eliminated. Before initiating the patient on anti-tuberculosis drugs, the CDT gives them a talk aimed at reassuring them.

3.1.3.2. Patient adherence to treatment

The discourse on deprivation accompanies the enticing words. CDT majors encourage patients to psychologically integrate the satisfaction that taking medication will bring them while complying with the requirements of the medical protocol. *"I was told that I have to take a lot of medication. I also have to eat a lot. The doctor told me that if I take my medication, I'll be fine"* (Aïcha, 21, patient, East Douala). Similarly, another patient recalled: *"I was told that if I take my treatment normally for six (06) months and there are no interruptions, I could recover"* (Justine, 43, patient, North Douala). The obligation to eat well justifies the systematic prescription of vitamin B complex to patients observed in a CDT. The advice to take the treatment properly refers to taking the medication daily while respecting the timing adopted at the first dose as well as the various recommendations. The treatment must be taken for six (06) months or more, depending on whether the patient is sensitive to rifampicin, multi-resistant or ultra-resistant.

During the first phase of treatment, patients emphasize that it is painful. However, others do not get discouraged. They manage to adapt and overcome the undesirable side effects experienced at the beginning of treatment with Rifampicin, Isoniazid, Pyrazinamide, and Ethambuthol (RHZE). *"When you first take these drugs, you could die. It affected me so badly that I had trouble getting out of bed. When I took them, I coughed a lot. At one point, I even had chest pain. It hurt. As I drank more, it calmed down"* (Rosaline, 55, sick, West Douala).

The tuberculosis treatment process has two stages. The first is an intensive phase involving the use of RHZE. This ends when the Baar test returns a negative result. The first test is clinically recommended at the ninth week of anti-tuberculosis treatment. The second stage involves taking rifampicin and isoniazid (RH) with check-ups in the fifth and sixth months. When the last check-up proves negative, patients are recommended to have a chest X-ray. This is to confirm complete recovery, which is confirmed by the disappearance of cavities in the lungs, as seen on the X-rays.

3.1.4. Scanning the routine use of RHZE in CDTs

The treatment of tuberculosis is ongoing after the patient has taken the first dose of medication. Medical staff make sure to reiterate this to the patients they see. The message is as follows: The treatment of tuberculosis is ongoing after the patient has taken the first dose of medication. Medical staff make sure to reiterate this to the patients they see. The message is as follows:

"The treatment is for six (06) months without interruption. After two (02) months of RHZE, you will take the red ones I give you for two (02) months. After that, I will check to see if the Baar levels have dropped. Check means sputum check. If the Baar levels have dropped, I will switch to RH. These are small tablets that you will take when you have finished with the red ones. While you are taking these small tablets, in the fifth month, I will do the second check. Following the second check, if the Baar are still negative, you will continue the treatment until the sixth (06) month. After the sixth month, you will have an X-ray and a final sputum check. If the result is negative, then you will stop the treatment. When you are on RHZE, the appointment is every two (02) weeks. When you are on HRT, the appointment is after one (01) month" (Amandine, 54, Major CDT, West Douala).

The comments made by the patients interviewed are no different from those made by the healthcare staff. They confirm that during counseling, they are told about the continuity of treatment. Once on treatment, patients can no longer afford to interrupt it or even go a day without taking their medication. Patients report that: *"For the treatment, I was told to take four (04) tablets a day and not to skip any. If you skip a dose, you have to start the treatment all over again. You have a set time at which you take the medication and you wait two hours before eating. I take my medication every day at 5 a.m."* (Jacqueline, 57, patient, North Douala).
"I was told that for all new TB cases, treatment lasts a minimum of six (06) months. For older cases, treatment can last from six (06) to nine (09) months. The medication must be taken every day at 5 a.m. on an empty stomach. Under no circumstances should they be combined with another antibiotic without the doctor's advice" (Flore, 33, patient, South Douala).

In general, following tuberculosis treatment is difficult for patients. Not only is it long, but it also requires a certain amount of discipline on the part of the patient, who is caught between deprivation and

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custom[2]. For some patients, the routine or repetitive nature of treatment is the reason for discontinuing it. They report that they find it difficult to adapt to the regularity, repetition, and same behavior every day.

The duration of treatment is therefore one of the main factors explaining why patients undergoing anti-tuberculosis treatment voluntarily abandon it. In addition, there are cases of involuntary non-adherence to treatment. This second type of abandonment is based on the unavailability of medication. *"After the diagnosis, I was given medication for two (02) weeks. At my next appointment, I was told that there was no more medication"* (Jules, 41, patient, Douala East). While some patients are lucky enough to have the precious product for a few weeks after diagnosis, others are not so fortunate. *"After I was told I had tuberculosis, what I was told next was that there was no medication available at the moment. I would have to manage on my own"* (Emile, 29, patient, North Douala). *"The day I was diagnosed positive, there wasn't even any medication. Five (05) days later, she (Major CDT) called me to come by quickly. She gave me two (02) packs. When the two (02) packs were finished, I went back, but there was no more. She gave me enough for only three (03) days"* (Carole, 63 years old, patient, Douala South). In Cameroon in general, and in Douala in particular, access to anti-tuberculosis drugs is very poor. Newly diagnosed patients are not always put on treatment immediately. Those already under medical supervision find it difficult to comply with the treatment protocol.

3.1.5. The quest for healing during periods of anti-tuberculosis drug shortages

In the context of drug shortages, we note that in Douala, the quest for health takes place on the streets. The lack of drugs in hospitals often leads patients to feel that death is certain and caregivers to question their "power" to heal.

3.1.5.1. The journey of patients: from the hospital to the streets.

Patients' access to anti-tuberculosis drugs in Douala is questionable. Permanent shortages of these drugs result in poor adherence to treatment by infected individuals. The unavailability of medication hinders the quest for optimal tuberculosis treatment. Individuals who value their lives must gather information on RHZE supply points from certain health personnel and/or other patients.

"At the hospital, they gave me a prescription to go and buy the medicine. After the diagnosis, I waited five (05) days before I could get the treatment. I don't know how it works yet. My daughter is going to go to the pharmacy to find out. At the moment, I don't even know how much the medicine costs. I was told to go to the Douala pharmacy, the Degaulle pharmacy, and the La Rive pharmacy. Those are the three pharmacies" (Carole, 63, patient, South Douala).

The conclusion that emerges is that during the shortage, tuberculosis treatment is not free. One informant lamented the profiteering caused by the crisis: *"Normally, it's the hospital that should supply patients with anti-tuberculosis drugs"* (Rebecca, 46 years old, CDT, Douala East). The solution envisaged by some practitioners during this period of shortage is: "*We send patients home to wait*" (Vincent, 33, CDT major, South Douala). The option of sending patients home to wait for the medication to become available prompts some of them to go to the central level to demand the medication in order to restore their bio-social well-being[3], which has been compromised by BK.

"I went to Bonanjo (Regional Health Delegation) to see the people who distribute medicines throughout the city. They told me that if I couldn't find it, it would be better for me to go to the grasslands. Because they might have it there. I bought the pack for 2,500 at the market. The shortage really bothers me. It was the first time there had been a shortage during my treatment. I went to find the medicine at the market (Rodolphe, 23, patient, South Douala).

For other people infected with tuberculosis, it is at the hospital that they are directed to the street. *"At the hospital, they told me I could go to the grass to find it. I wondered how there could be a shortage at the hospital when they sell it at the grass! "(*Chanceline, 33, patient, East Douala). The observation is that the previous" recovery" of a close relative in the informal sector, as well as the recurring unavailability of RHZE, encourage some people to legitimize the use of the illegal branch of the drug to the detriment of the official one. *"I never took the*

[2] Custom, in the context it is used, does not refer to religious acts. It is used in the sense of habit, systematization, and repetition of the gesture.

[3] Bio-social well-being here reflects physiological, somatic, and mental health on one hand, and social harmony on the other. Tuberculosis patients often face social exclusion, which manifests as the isolation of the patient to limit the spread of the bacteria.

medication at my center. They gave me the names of the medications to pay for, and I went to the Nkoulouloun market. I took the paper they gave me with me. When I got there, they gave it to me. Especially since a colleague had already advised me to go there " (Emile, 29, patient, North Douala). In the same vein, another interviewee stated: *"I never took the medication at the hospital. I always buy it. My mother had to treat my little brother. She knows where the medication is sold"* (Sandrine, 28, patient, North Douala). While the informal medicine sector is indeed a lifeline for patients and a rescue route for hospitals during RHZE shortages, tuberculosis treatment no longer follows protocol during the medicine crisis.

IV. Discussion

Tuberculosis is one of the oldest diseases known to humankind. However, its symptoms are still misunderstood by many people. When infection first occurs, people often interpret the symptoms as a simple cough. Some say it is a manifestation of HIV/AIDS, while others believe it is a curse. We can therefore see that, in the quest for health, the first course of action for those who consider the symptoms to be a passing cough is self-medication. Those who believe it is a curse first turn to traditional medicine. The purpose of this therapeutic choice is to break the spell of the disease and lift the mystical veil that hinders any physio-psychosomatic treatment. Once the cosmic dimension of the disease has been addressed, biomedical effectiveness is conceded. Called upon as a follow-up treatment, conventional medicine thus manages to restore the lost silence in the life of the organs (Leriche 1936 cited by Simpore, 2013: 45) taken over by the Koch bacillus. In this approach to care, there is no antagonism between biomedicine and ethnomedicine (Jaffré, 1999: 10). Just as we speak of the disease-state on one hand and the disease-object on the other, each respectively reflects the state of the subject-body and that of the object-body (Bénoist, 2002: 5). The multi-interpretive aspect then leads to saying that the disease is: "*anthropo-socio-cosmo-biological*" (Mbonji Edjenguèlè, 2009: 68). Affection as a signifier is a universe of senses. It is subject to different interpretations and reinterpretations. The variation in the meanings of a legitimate condition thus leads to the plurality of therapeutic pathways for its victims. It highlights the popular representations of tuberculosis as a spiritual assault on one hand and a bacterial one on the other. Interpreted as a symptom of AIDS, this naive representation explains the fear of being diagnosed, involving factors such as: family pressure, the worsening of symptoms to prompt a doctor's consultation.

In hospitals, the discourse used by healthcare staff encourages patients to abandon the various representations of tuberculosis mentioned above and to adhere to treatment. Furthermore, one of the first obstacles that arises is the shortage of anti-tuberculosis drugs. When this occurs, the treating physician finds himself helpless and without a solution. This shortage reshapes the perception of the caregiver/patient relationship, transforming it into a commercial partnership in which the former is the seller, the latter is the customer, and the free medication is the merchandise. This reconfiguration of the relationship leads to the formation of two categories of patients in terms of access to care. The privileged category consists of individuals whose financial resources allow them to purchase treatment, while the disadvantaged category consists of people whose recovery depends on free care. It is the latter who go to the hospital seeking recovery and return home with no hope. They must return to wait, continue to consume, die, and spread the infection. In the caregiver/patient relationship, we also note that when faced with crying patients, healthcare workers absolve themselves of responsibility for the shortage. The healthcare system also shirks responsibility for the suffering of victims. The idea of certain death that crosses the minds of infected people is reinforced. The unavailability of "pills" contributes to the problems observed in patient/caregiver and/or clinic interactions. It confirms the notion that medication is the only tool through which therapists can express their competence and on which their authority is based (Desclaux and Lévy, op. cit.: 15). In the absence of medication, clinicians and their institutions become ineffective in the face of the disease. Hospitals cease to be preventative facilities. The streets become the patients' sanatoriums and convalescent homes.

In the context of disruption, tuberculosis crises remove patients from the control of established healthcare professionals and deliver them into the hands of those involved in the drug trade. We can therefore see that when shortages occur, the much-criticized network of informal pharmacists (Jaffré, op. cit.: 9) or gazon [4](Wogaing, 2013: 1) takes on a contrasting representation (Desclaux and Lévy, 2003:

[4] In the Cameroonian context, gazon refers to informal drug seller.

15). For patients, it is the obligatory route insofar as it is the only possibility that guarantees them access to treatment. For the legal biomedical circuit, it becomes the concession route because the latter yields its priorities to it. In this uncontrolled treatment circuit, it appears that victims are exposed to counterfeit or expired drugs. They are no longer monitored, Baar checks are ignored, and the transition from the initial phase of treatment to the so-called intensive phase is not observed. In addition, patients decide on their own recovery, far from biomedical certification. From this perspective, there is cause for concern in Douala, a society on the brink of a tuberculosis explosion. A metropolis haunted by the specter of its population's hyper-contagiousness to different strains of Koch's bacillus. It is well known that poor therapeutic follow-up is a risk factor for the outbreak of an incurable tuberculosis epidemic. As Batchong Ekono (op. cit.: pp. 62-63), a lax approach to treatment is likely to encourage the development of severe forms of drug-resistant TB and, in addition, give rise to ultra-resistant strains that cannot be treated. This suggests that the drug crisis is worsening, while the response to the disease in Cameroon is characterized by underreporting of actual TB cases (WHO-Cameroon, 2019: 43).

V. Conclusion

In summary, this study focused broadly on the experience of tuberculosis care during the drug shortage in Douala. It put into perspective the level of popular knowledge about this disease through social representations.

The results obtained show that both patients and caregivers are struggling to cope with the anti-tuberculosis crisis. When shortages occur, the streets replace hospitals and become sanatoriums. Some caregivers turn to selling these drugs to ensure continued access to treatment for those who can afford it. This behavior results in discrimination in access to healthcare.

In light of certain determining factors, it appears that the monitoring and treatment of tuberculosis in Cameroon in general, and in Douala in particular, needs to be reconsidered. It is important for the government to monitor the circulation and distribution of anti-tuberculosis drugs. In addition, given the population's lack of knowledge about the early symptoms of this disease, it is essential that the authorities in charge increase awareness and education about tuberculosis. Cameroon can only achieve the goal of eradicating this infection if it is fully aware that it is real and that it has so far underestimated its endemicity. The information obtained on the difficulties of monitoring patients until they are cured therefore requires caution to be exercised with regard to controlling the chain of infection on the one hand and ensuring that patients receive complete treatment on the other.

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