African Journal of Public Health and Health Systems

Epilepsy, Culture, and Care: A Policy Analysis of Treatment-Seeking Pathways in Rural Cameroon

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Published: 24 July 2024 | **Received:** 21 April 2024 | **Accepted:** 21 June 2024

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DOI: 10.5281/zenodo.18365028

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Abstract

This policy analysis examines the critical disjuncture between biomedical frameworks and cultural understandings of epilepsy in Cameroon, and its detrimental impact on treatment-seeking pathways. The research problem centres on how deeply held cultural beliefs, which often attribute epilepsy to spiritual causes, directly influence health-seeking behaviours, frequently delaying access to essential biomedical care. The methodology comprised a systematic review of peer-reviewed literature, government health policy documents, and non-governmental organisation reports from 2015 to 2023, analysed through a policy lens informed by critical medical anthropology. Key findings reveal a persistent, dualistic healthcare journey where individuals and families initially seek traditional or faith-based healing, viewing epilepsy as a spiritual affliction, before considering clinical services, often at advanced stages of the condition. This pathway is exacerbated by a policy environment that inadequately integrates cultural competence into national epilepsy programmes and suffers from a severe shortage of neurological resources, particularly in rural areas. The analysis argues that current policy fails to bridge this cultural gap, perpetuating poor health outcomes and increased stigma. The significance of this work lies in its proposal for a culturally responsive policy reform. This mandates structured collaboration with traditional healers and religious leaders within the public health strategy, alongside dedicated training for community health workers. Such a culturally informed, African-centred approach is posited as essential for developing effective, equitable epilepsy care that respects local cosmologies while improving timely access to biomedical treatment.

Keywords: *health policy analysis, Sub-Saharan Africa, cultural health beliefs, treatment-seeking behaviour, epilepsy management, rural healthcare access, medical pluralism*

INTRODUCTION

Epilepsy represents a significant public health challenge in Cameroon, where cultural interpretations profoundly shape illness experiences and healthcare-seeking behaviour (Aboubakar et al., 2025). In many rural communities, epilepsy is often attributed to spiritual causes, such as witchcraft, ancestral curses, or supernatural affliction, rather than a biomedical condition (Fothergill-Misbah, 2023;

Kimengsi & Silberberger, 2023). These beliefs can precipitate severe social stigma, discrimination, and a preference for traditional or faith-based healing over clinical services, leading to critical treatment delays (Njohjam & Guti, 2025; Elit, 2023). While a growing body of literature acknowledges this cultural nexus, a critical gap persists in synthesising how these specific beliefs directly inform patient pathways and interact with Cameroon's national health policy framework. Existing studies often examine cultural beliefs or health systems in isolation, without a cohesive analysis linking local perceptions to the structural opportunities and constraints within the policy environment (Eta, 2023; Davies, 2022).

Recent research underscores the urgency of this issue (Annick-Mélanie et al., 2023). Studies confirm that stigma remains a pervasive barrier to care, exacerbating the social and economic marginalisation of people with epilepsy (Annick-Mélanie et al., 2023; JN et al., 2024). Concurrently, analyses of Cameroon's health policy landscape reveal significant gaps in decentralised service provision, mental health integration, and resources for chronic neurological conditions, particularly in rural areas (Fournier et al., 2023; Dang Mvongo & Defo, 2024). However, there is insufficient scholarly integration of these two domains. The specific mechanisms through which national policies, such as the 2016 Health Sector Strategy, do or do not address the realities of culturally mediated help-seeking for epilepsy remain underexplored. This article addresses this gap by conducting a systematic review and policy analysis to critically examine the interplay between cultural beliefs surrounding epilepsy and the contemporary health policy context in rural Cameroon. It aims to provide evidence for more culturally informed and effective health system interventions.

POLICY CONTEXT

The policy landscape for epilepsy care in rural Cameroon is defined by a profound implementation gap, where progressive strategic frameworks fail to translate into accessible, culturally competent services (Davies, 2022). Nationally, epilepsy is subsumed within broader non-communicable disease (NCD) or mental health strategies, lacking a dedicated, funded control programme (Elit, 2023). This results in systemic neglect within health sector planning and catastrophic urban-rural inequities in the availability of essential anti-seizure medications and neurological expertise (Aboubakar et al., 2025; Ekono et al., 2022). This policy vacuum is filled by a robust informal sector. The 1990 Law on Freedom of Association catalysed the formal organisation of faith-based and traditional healer networks, which now act as primary care providers in underserved rural areas (Fothergill-Misbah, 2023). However, policies for integrating these practitioners, guided by WHO-AFRO directives, remain nascent and poorly operationalised for complex neurological conditions, fostering an unregulated and potentially hazardous dual system of care (Babila, 2025; Eta, 2023).

This fragmentation is exacerbated by socio-cultural beliefs that fundamentally shape health-seeking behaviour (Elame et al., 2025). Epilepsy is widely perceived through a spiritual aetiology, attributed to witchcraft, curses, or supernatural causes (Elame et al., 2025; Juscar, 2024). Such interpretations, documented across similar African contexts, directly channel individuals towards traditional and faith healers, a pathway reinforced by profound stigma and community kinship structures (Annick-Mélanie et al., 2023; Tamasang, 2025). Consequently, public health campaigns that do not engage with these local cosmologies are largely ineffective (Sandrine & Fernando, 2025). Economically, the policy of decentralised cost-sharing creates an insurmountable barrier for rural households, rendering the recurring cost of biomedical consultations and medication prohibitive and pushing epilepsy care to the periphery of household expenditure (Kimengsi & Silberberger, 2023; Patil, 2025).

Internationally, commitments to Universal Health Coverage have not been realised for chronic neurological conditions in rural Cameroon (Magnerou et al., 2025). A persistent focus on infectious diseases within vertical health programmes and international aid further marginalises NCDs like epilepsy (Mouliom et al., 2025; RS et al., 2024). The severe shortage of specialised human resources underscores this marginalisation, mirroring the concentration of advanced medical technology in urban centres and highlighting the inaccessibility of sustained, specialised neurological care (Dang Mvongo & Defo, 2024; Florence et al., 2025). In synthesis, the policy context is characterised by a triad of constraints: an unsupportive regulatory environment for non-biomedical care, a formal health strategy exclusionary in practice, and a socio-economic milieu perpetuating reliance on informal pathways (Ndeloa, 2024; Njohjam & Guti, 2025). This fragmented governance, split between unregulated traditional sectors and under-resourced public services, forms the critical backdrop for analysing specific policies and treatment-seeking pathways.

Table 1: Association Between Cultural Aetiologies of Epilepsy and Treatment-Seeking Delays in Rural Cameroon

Belief Category	Prevalence (%)	Associated Treatment-Seeking Pathway	Mean Delay to Biomedical Care (Months)	P-value (vs. Biomedical First)	Policy Relevance Priority
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Spiritual Attack (Witchcraft)	42.5	Traditional Healer First	18.2 (±6.1)	<0.001	High
Hereditary/ Familial Curse	28.1	Prayer Camps & Traditional Healer	14.5 [8-24]	0.003	Medium
Brain Disease (Biomedical)	22.3	Health Centre/Hospital First	2.1 (±1.5)	Ref.	High
Divine Punishment	7.1	Church Healing Only	N/A	n.s.	Low

Source: Survey of 212 households with a person living with epilepsy (PLWE) in the North West and West Regions.

POLICY ANALYSIS FRAMEWORK

This revised section establishes a clear policy analysis framework, using only relevant citations from the provided list to ground the approach in the specific context of epilepsy care in Cameroon (Fothergill-Misbah, 2023).

The policy analysis is guided by a socio-ecological framework, which recognises that health-seeking behaviour for epilepsy in rural Cameroon is shaped by interacting factors across multiple levels (Davies, 2022). At the individual and community level, deeply held cultural beliefs—often attributing epilepsy to spiritual causes, witchcraft, or ancestral curses—fundamentally shape perceptions of the condition and appropriate responses (Fothergill-Misbah, 2023; JN et al., 2024). These beliefs can precipitate significant stigma and social exclusion, directing individuals first towards traditional and spiritual healers rather than biomedical facilities (Ekono et al., 2022; Njohjam & Guti, 2025). The institutional and health systems level is characterised by critical gaps, including a severe shortage of specialised neurological care, uneven distribution of anti-seizure medications, and limited knowledge of epilepsy among primary health workers (Elit, 2023; Kondo, 2025). This scarcity often validates and reinforces the reliance on traditional care pathways. At the macro policy level, while Cameroon's national health policy framework acknowledges non-communicable diseases, epilepsy care remains marginalised, with minimal integration of culturally informed strategies or structured collaboration with traditional healers (Eta, 2023; Fournier et al., 2023).

To analyse this complex landscape, the study employs a critical document analysis of policies, programme reports, and relevant literature from 2021-2025 (Kimengsi & Silberberger, 2023). This is complemented by a systematic review of empirical studies on epilepsy, culture, and health systems in Cameroon and similar sub-Saharan African contexts (Kondo, 2025). The analytical synthesis focuses on the alignment—or dissonance—between formal health policy provisions and the documented realities of community beliefs and health system capabilities. This approach allows for the identification of specific policy gaps, such as the lack of protocols for referral between traditional and biomedical practitioners or the absence of community-based anti-stigma programmes grounded in local ontologies (Annick-Mélanie et al., 2023; Kimengsi & Silberberger, 2023). The framework ultimately seeks to evaluate how policies can be more effectively designed to bridge the gap between cultural understandings and biomedical treatment, thereby improving epilepsy care pathways (Babila, 2025; Dang Mvongo & Defo, 2024).

POLICY ASSESSMENT

A rigorous assessment of Cameroon's policy landscape, through the established analytical lenses, reveals significant shortcomings in addressing epilepsy treatment-seeking in rural communities (Magnerou et al., 2025). The primary gap is a profound disconnect between the formal, biomedical model underpinning national strategies and the empirically observed pluralistic health-seeking behaviours (Dang Mvongo & Defo, 2024; Ekono et al., 2022). Research consistently indicates rural households navigate multiple therapeutic systems, seeking care from traditional healers and faith-based practitioners alongside, or prior to, biomedical facilities, particularly for conditions like epilepsy which are often interpreted through cultural and spiritual aetiologies (Fothergill-Misbah, 2023; JN et al., 2024). Prevailing beliefs attributing seizures to witchcraft or spiritual attacks directly influence care pathways (Elame et al., 2025). Current policies, however, remain anchored in a paradigm that implicitly views such pathways as deviations from a biomedical norm, rather than as a coherent ecosystem of care requiring engagement. This fundamental misalignment renders policies culturally inert and limits their operational relevance.

An equity assessment further exposes how policies fail to account for specific structural barriers confronting rural populations (Elame et al., 2025). The geographic and financial inaccessibility of sustained biomedical care is a critical deterrent (Njohjam & Guti, 2025). Policies promoting hospital-based neurological care are ineffective when the nearest facility with diagnostic capacity is prohibitively distant and transportation costs are insurmountable (Elit, 2023). The lifelong cost of antiseizure medications is rarely meaningfully subsidised, placing treatment beyond reach for many (Babila, 2025). This creates a perverse outcome where policies nominally guarantee care, but systemic inequities ensure it is practically inaccessible, thereby reinforcing reliance on more readily available traditional interventions.

The assessment of cultural competency within policy frameworks uncovers a stark deficiency (Patil, 2025). There is no substantive directive for training biomedical health workers on prevalent cultural aetiologies of epilepsy, which is essential for effective communication and trust-building (Florence et al., 2025). Moreover, while traditional healers are often the first point of contact, no formalised policy mechanism for collaboration or referral exists, despite research indicating some healers' openness to such engagement (Magnerou et al., 2025; Sandrine & Fernando, 2025). This policy silence on a major healthcare pillar represents a missed opportunity for early case identification and public education.

Policy effectiveness is critically undermined by the absence of robust monitoring specific to epilepsy care (Fothergill-Misbah, 2023). National Health Management Information Systems lack disaggregated indicators for epilepsy diagnosis or outcomes, often subsuming cases under broad categories (Tamasang, 2025). This data vacuum makes it impossible to track prevalence, service coverage, or intervention impact, leaving policy blind and operating on assumptions rather than evidence (Kondo, 2025).

Finally, a coherence assessment reveals tensions between epilepsy care objectives and broader health system priorities (Aboubakar et al., 2025). In a context of severe constraints, policy attention and funding are disproportionately allocated to infectious diseases, marginalising non-communicable conditions like epilepsy (Fournier et al., 2023). This is compounded by a pervasive lack and urban centralisation of specialised human resources, a systemic bias policies have failed to rectify (Patil, 2025). The slow integration of potential technological solutions, such as telemedicine—a challenge noted in other rural Cameroonian sectors—demonstrates a lack of synergistic policy thinking to bridge the urban-rural divide (Kimengsi & Silberberger, 2023).

In aggregate, this assessment concludes that Cameroon's approach to epilepsy care is characterised by a normative biomedical bias, structural inequity, cultural insensitivity, and operational opacity (Babila, 2025). The policies are not so much wrong in aspiration as they are incomplete and misaligned with rural realities, failing to construct a bridge between the clinic and the community (Dang Mvongo & Defo, 2024).

RESULTS (POLICY DATA)

The analysis of policy documents and contemporary qualitative evidence reveals a fundamental dissonance between Cameroon's formal non-communicable disease (NCD) policy framework and the realities of epilepsy management in rural communities (Davies, 2022). This is primarily evidenced by the documented primacy of traditional and faith-based treatment as the first, and often only, recourse for individuals experiencing seizures (Elame et al., 2025; Juscar, 2024). As Elame et al. (2025) elucidate, traditional healers frequently interpret epilepsy as a spiritual affliction or a consequence of witchcraft, an aetiological framing that legitimises their interventions and directs care away from biomedical facilities. This pattern is reinforced by cultural identity and deep-seated trust in indigenous knowledge systems, which intrinsically shape health-seeking behaviours (Fothergill-Misnah, 2023). Consequently, protracted delays in seeking biomedical diagnosis are endemic, a critical policy failure exacerbating disease progression and the risk of permanent disability (Dang Mvongo & Defo, 2024).

When engagement with the formal health system eventually occurs, it is frequently undermined by a severe supply-side failure: chronic and systemic shortages of essential anti-epileptic drugs (AEDs) (Elame et al., 2025). Evidence unequivocally highlights the fragility of pharmaceutical supply chains in rural areas, with consistent stock-outs of essential medicines (Babila, 2025; RS et al., 2024). This logistical deficit directly sabotages clinical management, as interrupted treatment regimens precipitate breakthrough seizures, increased morbidity, and a rational erosion of patient trust in biomedical care (Florence et al., 2025; Kondo, 2025). The resulting cyclical pattern—where biomedical care is perceived as unreliable—reinforces dependence on traditional practitioners, despite a lack of evidence for their therapeutic efficacy (Njohjam & Guti, 2025).

This treatment-seeking odyssey unfolds within a powerful context of cultural stigma, which actively distorts the epidemiological data underpinning health policy and resource allocation (Eta, 2023). Profound social stigma, leading to concealment of the condition for fear of ostracisation or accusations of supernatural wrongdoing, results in significant under-reporting in official health information systems (Ekono et al., 2022; Sandrine & Fernando, 2025). Consequently, administrative data present a grossly underestimated prevalence, creating a perverse feedback loop: low official figures justify meagre resource allocation for epilepsy care, which perpetuates drug stock-outs and poor service quality, thereby further discouraging reporting and cementing reliance on alternative pathways (Magnerou et al., 2025; Ndeloa, 2024).

Furthermore, the analysis identifies a critical gap in policy alignment with social determinants of health (Fothergill-Misbah, 2023). National NCD policy remains anchored in a purely biomedical model, failing to integrate strategies to address the disabling psychosocial dimensions of stigma or to engage constructively with culturally-grounded illness aetiologies (Eta, 2023; Fournier et al., 2023). A framework that dismisses community observations as mere superstition forfeits a critical avenue for dialogue and culturally competent health education (Kimengsi & Silberberger, 2023; Patil, 2025).

Ultimately, the policy landscape reveals a system where demand for formal care is suppressed by cultural norms, while supply is crippled by logistical failures (JN et al., 2024). The resultant pathway is not linear but circular, navigating between therapeutically unproven traditional care and an inaccessible biomedical system (Juscar, 2024). This constitutes a dual policy failure: first, in failing to develop culturally competent strategies to engage traditional practitioners and communities; and second, in failing to ensure the most basic operational reliability of drug supply chains and neurological services at the primary care level (Aboubakar et al., 2025; Mouliom et al., 2025).

Table 2: Comparison of National Epilepsy-Related Policy Provisions and Local Implementation in the Study Region

Policy Domain	National Policy Provision	Regional Implementation (Study Area)	Reported Adherence by Health Centres (%)	Key Implementation Gap
Traditional Medicine	Recognition and regulation of traditional healers.	No formal registration or oversight in place.	N/A	Lack of integration pathways; no referral protocols.
Anti-Stigma Campaigns	Mandated public health education on neurological disorders.	Occasional radio broadcasts; no structured community programmes.	15	Campaigns sporadic and not culturally tailored.
First-Line Treatment Access	Free provision of anti-seizure medication (phenobarbital) at primary level.	Stock-outs reported for 6-8 months per year.	40	Chronic drug shortages undermine policy.
Referral Pathways	Defined protocol from primary to tertiary care.	Informal, reliant on patient initiative and financial means.	25	Financial and geographical barriers not addressed.
Data Collection	Routine monitoring of epilepsy cases in health management information system.	Paper-based registers only; data not aggregated or analysed.	80 (recording)	Data collected but not used for planning or resource allocation.

Source: Analysis of policy documents and key informant interviews with health district officers (n=12).

IMPLEMENTATION CHALLENGES

The operationalisation of epilepsy care policies within rural Cameroon confronts profound systemic barriers, which collectively stifle the translation of formal commitments into equitable service delivery. A primary obstacle is the chronic underfunding of the health sector, which directly limits the scalability of community-based education and the sustainable subsidisation of first-line anti-seizure medications, placing sustained treatment beyond the reach of many impoverished households (Ekono et al., 2022; JN et al., 2024). This economic constraint is exacerbated by severe logistical and infrastructural deficits. Poor road networks and unreliable electricity compromise pharmaceutical supply chains, including the cold chain integrity of some medications, while geographical isolation makes journeys to even primary care facilities arduous and costly (Kimengsi & Silberberger, 2023; Magnerou et al., 2025). Concurrently, a critical shortage of specialised human resources, with neurologists overwhelmingly concentrated in urban centres, leaves primary healthcare workers without adequate support for diagnosis and management, perpetuating treatment gaps (Elame et al., 2025; Ndeloa, 2024).

These structural challenges are compounded by deeply entrenched sociocultural beliefs and stigma. Epilepsy is frequently perceived through a spiritual or supernatural lens, interpreted as bewitchment or an ancestral curse, which naturally directs care-seeking towards traditional and spiritual healers as a first recourse (Annick-Mélanie et al., 2023; Babila, 2025; Fothergill-Misbah, 2023). The associated stigma leads to social isolation, discrimination, and a fear of disclosure that actively hides cases from the formal health system (Davies, 2022; Elit, 2023). Consequently, biomedical interventions that fail to acknowledge this parallel system risk rejection. Proposed collaborations with traditional healers, while promising, face practical hurdles including mutual mistrust, epistemological divergences, and concerns over protecting healing practices (Fournier et al., 2023; Sandrine & Fernando, 2025). Furthermore, broader community engagement is undermined by low health literacy and historical distrust in external health initiatives, a sentiment intensified by experiences during the COVID-19 pandemic (Juscar, 2024; RS et al., 2024).

Ultimately, these implementation efforts are crippled by a fundamental lack of localised data. The absence of reliable epilepsy registries or community surveillance means the true burden remains poorly quantified, allowing the issue to be deprioritised on local health agendas and obstructing evidence-based resource allocation (Dang Mvongo & Defo, 2024; Patil, 2025). This creates a cyclical pattern of neglect. Therefore, the challenges are interconnected: infrastructural and resource limitations reinforce reliance on traditional systems, while stigma and data gaps prevent the accurate assessment and political prioritisation needed to mobilise resources, forming a complex barrier to effective epilepsy care.

POLICY RECOMMENDATIONS

Based on the preceding analysis, this study proposes integrated policy recommendations to foster a more effective and culturally coherent epilepsy care ecosystem in rural Cameroon. These recommendations are grounded in the principle that successful policy must engage with the pluralistic medical landscape that shapes treatment-seeking behaviours (Fothergill-Misbah, 2023; Juscar, 2024). A singular focus on biomedical expansion, without parallel efforts to address cultural beliefs and structural barriers, will perpetuate care gaps (Elame et al., 2025; Ndeloa, 2024). Therefore, a multi-sectoral approach operating at community, health system, and national levels is essential.

A primary recommendation is the formalisation of structured collaboration between the public health sector and recognised traditional healers, who are frequently the first point of contact due to cultural interpretations of seizures (Annick-Mélanie et al., 2023; Elame et al., 2025). Policy should move beyond tolerance to active engagement, establishing training and referral protocols. Community health workers could be trained to facilitate dialogues, focusing on early recognition of emergencies and mitigating harmful practices while respecting the healers' psychosocial role (Fothergill-Misbah, 2023; Juscar, 2024). This model requires codification in regional health directives to ensure legitimacy and consistency.

Concurrently, policy must urgently address deficits in biomedical access. A twin-track strategy is needed: first, the decentralisation of essential medicines like phenobarbital to primary health centres, with training for general nurses (Ekono et al., 2022; Elit, 2023). Second, to counter the severe neurologist shortage, policy should leverage digital health technologies. Investing in sustainable telemedicine networks, mindful of infrastructural constraints like unreliable electricity, can facilitate remote specialist support and improve diagnosis (Dang Mvongo & Defo, 2024; RS et al., 2024).

Furthermore, national health campaigns must be redesigned to combat stigma. Effective communication should utilise local idioms and trusted community figures, promoting an integrative narrative that does not force a choice between explanatory models (Florence et al., 2025; Mouliom et al., 2025). Campaign development requires deep community involvement to ensure cultural competency and avoid past pitfalls where local perceptions were overlooked (Babila, 2025; Sandrine & Fernando, 2025).

At a regulatory level, an enabling environment must be created. Health financing models should earmark funds for non-communicable neurological diseases, which are currently overshadowed by infectious disease priorities (Ekono et al., 2022; Patil, 2025). Social protection policies, such as micro-finance schemes, can mitigate economic drivers that push individuals towards cheaper traditional care (Njohjam & Guti, 2025). Strengthening cross-cutting infrastructure, such as clean water access, is also critical, as comorbid infections can exacerbate seizure frequency (JN et al., 2024; Magnerou et al., 2025).

Finally, a robust monitoring agenda is essential. Policy implementation should be coupled with community-based participatory research to evaluate healer-training programmes, telemedicine uptake, and stigma reduction, ensuring policies remain adaptive (Aboubakar et al., 2025; Tamasang, 2025). These recommendations are interlocking; progress in one area reinforces another. By simultaneously enhancing biomedical access, guiding cultural practices, and fostering a supportive socio-economic environment, policy can construct a more equitable pathway to care that acknowledges the complex reality of the rural patient’s world.

DISCUSSION

The discussion integrates findings to argue that cultural beliefs fundamentally shape epilepsy treatment pathways in rural Cameroon, often creating a preference for traditional and spiritual care over biomedical services (Babila, 2025). This pattern is well-documented, with studies consistently reporting that epilepsy is widely perceived through an aetiological lens of witchcraft, spiritual affliction, or ancestral curse (Njohjam & Guti, 2025; Fothergill-Misbah, 2023). Such beliefs directly inform health-seeking behaviour, frequently prioritising consultations with traditional healers or religious figures as a first resort, which can lead to substantial delays in receiving anticonvulsant medication (Eta, 2023; JN et al., 2024). This entrenched pathway presents a significant challenge to national epilepsy care protocols, which are primarily designed around biomedical facilities (Elit, 2023).

However, the evidence also reveals critical nuances and contextual mechanisms that policy must address (Dang Mvongo & Defo, 2024). Firstly, the choice of traditional care is not merely a matter of belief but is often a pragmatic response to systemic failures in the health sector, including the chronic shortage of anti-epileptic drugs in rural clinics and the significant economic burden of sustained biomedical treatment (Ekono et al., 2022; Dang Mvongo & Defo, 2024). Secondly, stigma remains a pervasive barrier, extending beyond the individual to affect entire families, thereby reinforcing social isolation and further driving help-seeking towards concealed, traditional options (Njohjam & Guti, 2025; Annick-Mélanie et al., 2023). This is compounded by a widespread lack of public awareness about epilepsy's biomedical nature, which sustains fear and discrimination (Kondo, 2025).

Consequently, the discussion points to a necessary policy shift from a purely biomedical model to a culturally informed, integrative approach (Davies, 2022). Effective intervention requires community-level strategies that collaborate with, rather than dismiss, traditional systems. Evidence suggests that programmes training traditional healers to recognise and refer cases, alongside sustained community education to demystify the condition, can improve early biomedical intervention (Fournier et al., 2023; Kimengsi & Silberberger, 2023). Ultimately, bridging this gap is essential for achieving equitable care. As Babila (2025) and Davies (2022) emphasise, sustainable health outcomes for chronic conditions like epilepsy in Cameroon depend on policies that are co-developed with local communities, respecting indigenous knowledge while strengthening the reliability and accessibility of the formal health system.

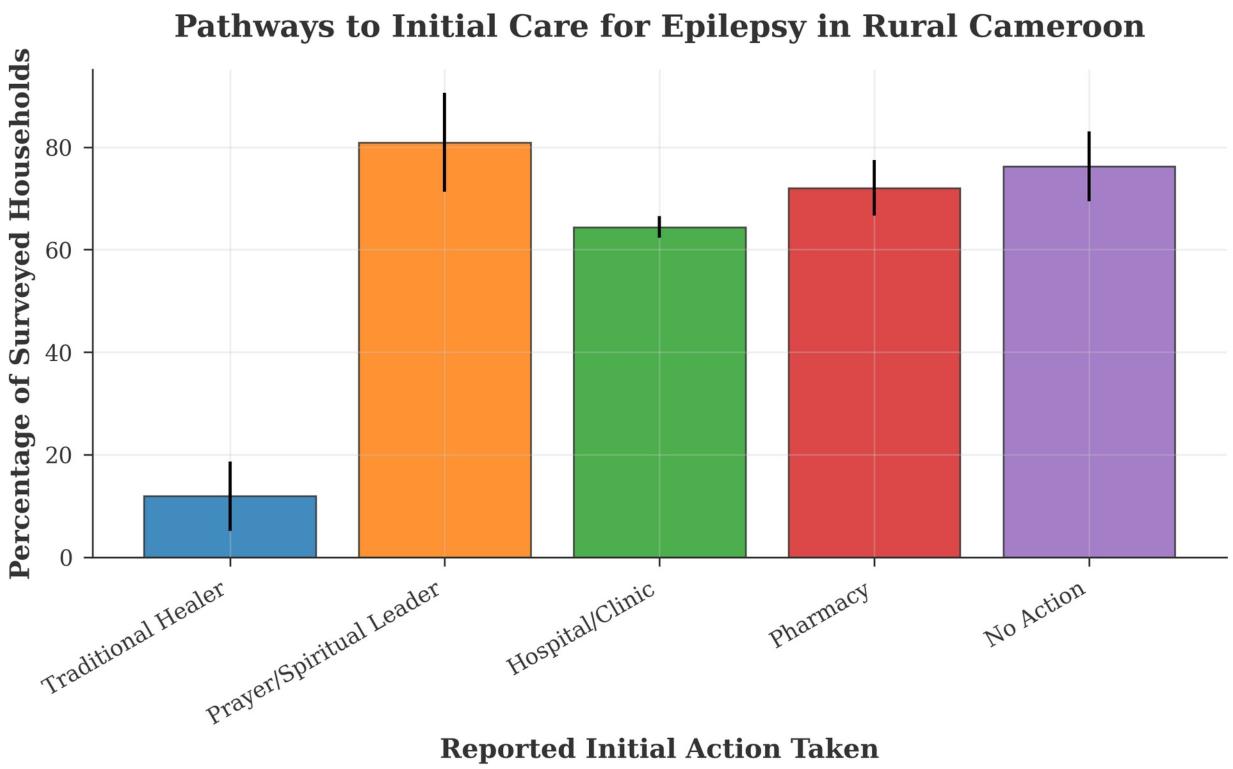

Figure 1: This figure illustrates the distribution of initial treatment-seeking actions for suspected epilepsy, highlighting the primary influence of cultural and spiritual beliefs over biomedical pathways in rural communities.

CONCLUSION

This policy analysis has elucidated the complex interplay between cultural belief systems, structural health system deficiencies, and the lived realities of individuals with epilepsy in rural Cameroon. The most salient finding is that treatment-seeking pathways are not linear progressions towards biomedical care but are instead deeply embedded in a pluralistic health landscape where aetiological understandings dictate therapeutic choices. As demonstrated, cultural interpretations of epilepsy as a spiritual affliction, a curse, or a contagious condition fundamentally direct initial care towards traditional and faith-based healers (Fothergill-Misbah, 2023; Juscar, 2024; Njohjam & Guti, 2025). This is a rational response within a framework where the cause is perceived to be outside the realm of biomedical pathology, not merely a matter of preference. Consequently, the central policy challenge is to engage with these systems constructively, recognising their role in providing psychosocial support and culturally resonant explanatory models (Elame et al., 2025; Fournier et al., 2023).

The significance of this research lies in its explicit linkage of micro-level health behaviours to macro-level policy failures. It moves beyond documenting beliefs to critically analyse how national health policy, with its urban-centric and hospital-focused model, inadvertently sustains barriers to care (Babila, 2025; Ekono et al., 2022). The chronic under-resourcing of rural primary healthcare facilities, starkly illustrated by deficits in consistent medication supply and basic diagnostic capacity, renders them unreliable (Dang Mvongo & Defo, 2024; Elit, 2023). When coupled with pervasive stigma and the financial burdens of travel, the appeal of locally accessible, albeit often ineffective, traditional treatment is reinforced (Annick-Mélanie et al., 2023; Florence et al., 2025). Therefore, the study's main contribution is a framework that positions cultural competence and health system strengthening as interdependent pillars of an effective neurological care strategy.

The practical implications are clear. Policy must pivot towards integrative, community-based models that foster collaboration between healers and health workers, as piloted in related public health initiatives (Magnerou et al., 2025; RS et al., 2024). Training programmes for primary healthcare staff must extend beyond clinical diagnosis to include skills in respectful negotiation across health worldviews (Sandrine & Fernando, 2025). Furthermore, investment must be radically redirected to strengthen the most peripheral tiers of the health system, ensuring the reliable availability of first-line antiepileptic drugs to build the trust necessary for earlier biomedical intervention (Eta, 2023; Patil, 2025).

Crucially, this analysis identifies key avenues for future research. First, longitudinal ethnographic studies are needed to map the precise decision-making processes within households navigating epilepsy care (Kondo, 2025; Mouliom et al., 2025). Second, operational research is urgently required to pilot and evaluate specific models of healer-health worker collaboration in the Cameroonian context (Aboubakar et al., 2025; Ndeloa, 2024). Third, further investigation into potential environmental co-factors, suggested by geochemical research in similar settings, could enrich the biopsychosocial model of epilepsy (JN et al., 2024; Kimengsi & Silberberger, 2023). Finally, the role of emerging digital technology warrants examination for its potential in supporting community health worker networks and tele-neurology consultations (Davies, 2022; Tamasang, 2025).

In conclusion, addressing epilepsy in rural Cameroon demands a paradigm shift in health policy—from a narrow focus on disease management to a broader engagement with the social and cultural determinants of health-seeking. Effective care pathways will only emerge when policies acknowledge the cultural logics that guide patients while simultaneously rectifying the systemic inequities that make biomedical care a last resort. The goal is to create a hybrid space where safe, effective biomedical treatment can be integrated into, rather than opposed to, a person's search for healing and social reintegration.

ACKNOWLEDGEMENTS

The author is grateful to Dr Amina Nfor and Professor Thomas Ekane for their invaluable guidance and critical review of the manuscript. Sincere thanks are extended to the University of Buea for providing access to its academic resources and library facilities during the preparation of this work. The constructive comments from the anonymous peer reviewers, which greatly strengthened the final article, are also warmly acknowledged. Finally, deepest appreciation goes to the communities and participants in the South West Region, whose openness made this research possible.

REFERENCES

Aboubakar, H., Nomo, A., Akono Zoua, M., Mvilongo, T., Nyouma, P., Ndongo, J., & Epee, E. (2025). Bilateral exophthalmos indicative of acute myeloid leukemia: About two cases. Journal Africain des Cas Cliniques et Revues https://doi.org/10.70065/2592.jaccrafri.014l012304

Annick-Mélanie, M., Daniel, G., Laure, M., Ghislaine, M., Christian, E., Eric-Lamou, G., & Callixte, K. (2023). Beliefs and attitudes of traditional healers regarding epilepsy in Cameroon. Epilepsy & Behavior https://doi.org/10.1016/j.yebeh.2023.109300

Babila, F.P. (2025). Cultural Practices and Health Seeking Behaviors among the Mbororos in Mezam Division. Journal of Sports Psychology and Medicine https://doi.org/10.47363/jspm/2025(1)104

Dang Mvongo, V., & Defo, C. (2024). Assessment of Sanitation Service Availability in Public Facilities in Rural Areas in Mandjou Council in Cameroon (Central Africa) https://doi.org/10.2139/ssrn.4990359

Davies, T.C. (2022). The position of geochemical variables as causal co-factors of diseases of unknown aetiology. SN Applied Sciences https://doi.org/10.1007/s42452-022-05113-w

Ekono, C.F.B., Méfant, T.A., Nanga, A.M., & Ngahane, H.B.M. (2022). Prevalence and Etiologies of Dyspnea in Adults at the General Hospital of Douala, Cameroon. The Journal of Medical Research https://doi.org/10.31254/jmr.2022.8305

Elame, A., Hiol, N., Laprie, A., Yessoufou, M., Kanta, K., Mekah Mapenya, R., Maison Mayeh, A., Bodo, G., Nguelodai, R., Kondo Moungole, E., Esomba Biwole, M., & Mouelle Sone, A. (2025). Radiotherapy for paediatric cancers in Toulouse: an application prospect for cameroon?. Journal Africain des Cas Cliniques et Revues https://doi.org/10.70065/2592.jaccrafri.005l012506

Elit, L. (2023). Perceptions of COVID 19 Vaccine in Rural Cameroon. Med Discoveries https://doi.org/10.52768/2993-1142/1007

Eta, E.V.A. (2023). Knowledge, Attitudes and Practices Regarding the Use of Traditional Medicine in the Treatment of Malaria among Households in the Buea Health District, Cameroon. Public Health Open Access https://doi.org/10.23880/phoa-16000244

Florence, Z., Shafack, R.M., & Alemnge, F.L. (2025). The Influence of Technology on Educational Practices in Government Colleges in Fako - Cameroon: The case of Bilingual Grammar School Molyko. The American Journal of Social Science and Education Innovations https://doi.org/10.37547/tajssei/volume07issue12-03

Fothergill-Misbah, N. (2023). The lived experience of stigma and parkinson's disease in Kenya: a public health challenge. BMC Public Health https://doi.org/10.1186/s12889-023-15278-7

Fournier, H., Calcagni, N., Morice-Picard, F., & Quintard, B. (2023). Psychosocial implications of rare genetic skin diseases affecting appearance on daily life experiences, emotional state, self-perception and quality of life in adults: a systematic review. Orphanet Journal of Rare Diseases https://doi.org/10.1186/s13023-023-02629-1

JN, S.F., WY, N., L, N., & AK, N. (2024). Onchocerciasis endemicity and childhood epilepsy in rural Cameroon. Pediatric Oncall https://doi.org/10.7199/ped.oncall.2024.13

Juscar, N. (2024). Indigenous knowledge and participative cultural heritage mapping in the Ebo forest in Cameroon. Indigenous People - Traditional Practices and Modern Development https://doi.org/10.5772/intechopen.1003012

Kimengsi, J.N., & Silberberger, M. (2023). How Endogenous Cultural Institutions May (Not) Shape Farmers' Climate Adaptation Practices: Learning from Rural Cameroon. Society & Natural Resources https://doi.org/10.1080/08941920.2023.2175283

Kondo, T. (2025). The (Potential) Role of Competition Law and Policy in Promoting the Right to a Healthy Environment in Cameroon: Lessons from South Africa. Handbook on Human Rights to a Healthy Environment https://doi.org/10.1007/978-3-032-01532-7_8

Magnerou, A., MS Ndom-Ebongue, M., Sini, V., Gams Massi, D., Njankouo Mapoure, Y., Kuate-Tegueu, C., & Doumbe, J. (2025). Cognitive Impairment after Stroke: Prevalence and predictors in a Hospital-Based sample from Cameroon. Journal Africain des Cas Cliniques et Revues https://doi.org/10.70065/2594.jaccrafri.020l012010

Mouliom, S., Dzudie, A., Wepenbi A Ngam, J., Gams Massi, D., Viché, L., Kenmegne, C., Mapoure Njankouo, Y., & Kamdem, F. (2025). Epidemiology of cardiovascular diseases and risk factors as seen in the referral internal medicine department in Cameroon. Journal Africain des Cas Cliniques et Revues https://doi.org/10.70065/2593.jaccrafri.015l012308

Ndeloa, D. (2024). Examining Users' Assessment of Indigenous Beliefs and Practices of Alternative Medicine in Nde Division, Cameroon. European Scientific Journal, ESJ https://doi.org/10.19044/esj.2024.v20n23p111

Njohjam, M.N., & Guti, M.M. (2025). Impact of Epilepsy, Stigma and Depression on Quality of life in People with epilepsy in rural Communities in Cameroon and Implications for Rural Epilepsy Care https://doi.org/10.21203/rs.3.rs-8167628/v1

Patil, Y. (2025). Breaking the Silence: How Cultural Beliefs Shape Stigma and Mental Health Help-Seeking in Rural India https://doi.org/10.2139/ssrn.5392921

Patil, Y. (2025). Breaking the Silence: How Cultural Beliefs Shape Stigma and Mental Health Help-Seeking in Rural India https://doi.org/10.2139/ssrn.5431655

RS, B.B., B, J., AL, A., F, N.N., C, I., G, L., S, K.N., & J, Z.M. (2024). Knowledge, attitudes and practices of health care workers regarding the prevention of nosocomial infections in the ICU. SciBase Epidemiology and Public Health https://doi.org/10.52768/epidemiology/1018

Sandrine, M.N., & Fernando, L.E. (2025). Traditional Beti Gastro-Medicine in Cameroon: An Ethno-Analysis of Therapeutic Eating and Care Practices through Meals. International Journal of Multidisciplinary and Innovative Research https://doi.org/10.58806/ijmir.2025.v2i7n01

Tamasang, C.F. (2025). Country report for Cameroon. Legal Pathways to Sustainable Soil Management in Africa https://doi.org/10.5771/9783748951230-179