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**| RESEARCH ARTICLE**

**Exploring experience of the practice of French/English- home language interpretation for patients who are not proficient in the official language in Far-North postcolonial multilingual Cameroon: a healthcare providers' perspective**

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**| ABSTRACT**

As the Far North of Cameroon has the highest illiteracy rate in the country, a significant proportion of the population is unable to communicate in the official languages, English and French. As these two exoglossic languages are used in all areas of public life, many patients who are not proficient in them face language barriers in health centers. As Official Language non-proficient patients (OLNPPs), they are unable to communicate with health professionals who are trained in these languages. It is common practice to use interpreters to bridge this communication gap though the outcomes are not always satisfactory. Based on data from questionnaires administered through random sampling to 487 healthcare providers in 45 healthcare centers in the Far North Region of Cameroon, this study aims to explore the experiences of healthcare providers with French/English- home language interpreting in these centers. In addition to a quantitative analysis (using SPSS 18.0 (Statistical Package for the Social Sciences)), a qualitative analysis was carried out using a thematic approach. The work is discussed from the perspectives of the cultural competence model (Brach & Fraser, 2000) and Postcolonial Linguistics (see Makoni, 2011; Arnke, 2017; Anchimbe, 2018; Levisen & Sippola, 2019). The findings reveal that the practice of French/English home language interpreting in health centers in the Far North Region of Cameroon faces several challenges. Furthermore, it is found that healthcare providers are divided on the need to train French/English home language interpreters to limit language barriers in healthcare centers. While some healthcare providers view the training of French/English-home language interpreters positively as a means of overcoming language barriers between patients who do not speak the official language and healthcare providers (the Satisfied Group), others view it negatively (the Unsatisfied Group).

**| KEYWORDS**

*Illiteracy, interpreting, official languages, patients, healthcare providers, communication gap, Far North Region of Cameroon.*

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**1. Introduction**

The importance of mutual understanding between healthcare providers and patients in the context of healthcare delivery cannot be overemphasised. This means that both groups of people should speak the same language or code, or use strategies to bridge communication gaps, in order to ensure effective and successful communication. Failure to do so can have dire consequences for patient care and treatment (cf. Bowen 2015; De Moissac and Bowen 2019; The Disparities Solutions Center 2012; CMC (Center for Medicare and Medicaid services 2017); Meuter et al 2015; Rösky 2015; Qanbar and Saqer 2019; Hunter-Adams and Rother, 2017; Narayan, 2013; Van Rosse et al 2015, Hankoni Kamwendo, 2004). Given that the Far North Region of Cameroon is the region with the highest illiteracy rate in Cameroon(cf. Cameroonian-Canadian Foundation 2022; United Nations for Development Programme 2002; Commission Nationale pour l'UNESCO (2008); Banque Africaine de Développement 2011; Ministry of Basic Education 2015), many patients lack full communication skills in French and/or English, the official languages of the country;

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these are the languages in which almost all health care providers working in the country have received their training, with the exception of those trained abroad and expatriate health care providers working in non-governmental organisations (e.g. Médecins Sans Frontières).

As a result, both patients and healthcare providers who are not proficient in the official language face communication barriers. In order to bridge this communication gap, the current trend is to rely on ad hoc interpreters (nurses, other patients, patients' family members or relatives) and bi/multilingual health professionals and community health workers to communicate from French/English into home language and vice versa, as the country does not train home language health interpreters. However, this communication practice faces several challenges: despite the fact that it allows information to be transferred from health care providers to patients who do not speak the official language, and vice versa, many health care providers are still not satisfied with the practice and are very doubtful about its effectiveness in a context where there are no professional health care interpreters and where there is a multiplicity of mutually unintelligible home languages in the region.

## 2. Previous studies

The use of interpreters in healthcare has received considerable attention in the field of language and healthcare. It has been found that in South African health centers, the use of ad hoc interpreters in interpreter-mediated health care has some shortcomings, as their level of competence is not sufficient to ensure optimal health care delivery; hence the need for language access services and trained interpreters, as the continuous use of untrained interpreters compromises the effectiveness of mental health care and could lead to adverse health outcomes (Hagan et al. 2013, Hagan et al. 2020). However, other studies (in the Australian and New Zealand contexts) have shown that the practice of using untrained interpreters was rated positively by clinicians as working well 88% of the time for OTD (On this Day) consultations and 36% of the time for booked consultations. Working with in-house interpreters (28% of consultations) was rated as working well 100% of the time.

The practice of interpreting in health care is very sensitive. Therefore, several factors need to be taken into account when preparing for an interpreting session, namely the type of interpreting (trained professional interpreter, ad hoc interpreter or bilingual healthcare worker as interpreter), the mode (face-to-face, telephone, video-remote or web-based translation software) (Hadziabdic et al 2020, Habib et al 2023), the interpreter's ethnicity, religious background, gender, language or dialect, social group, dress, appearance and attitude. In addition, interpreters should follow the recommendations in the Guidelines for Interpreters (Hadziabdic et al 2020). It should be added that the use of interpreters requires clinical judgement about the type of interpreting required (Gray et al 2011a, Gray et al 2012). Furthermore, in the Wellington area of New Zealand, it was found that clinician awareness of the policy on how to obtain interpreters and the increased clinical risk of not using them when needed did not lead to high levels of interpreter use for patients with limited English proficiency (Gray et al 2011b).

Previous studies on interpreting in health care have tended to focus on case studies of patients with limited proficiency in a language, usually English, but who have had formal education and therefore have literacy (at least reading and/or writing skills) in a language other than the language spoken by the health care provider. Furthermore, such studies focus on areas that are sociolinguistically and socioeconomically different from the one examined in this paper. The present study focuses on patients who are not proficient in the official language in the Far North region of Cameroon, a region with an illiteracy rate of 76 per cent. These underprivileged patients have no formal education. This paper therefore aims to explore the experiences of healthcare providers with the practice of French/English-home language interpreting in health centers in the Far North region of Cameroon. More specifically, the paper addresses the following research questions: What are the challenges facing the practice of French/English-home language interpreting in the healthcare centers of Far-North Cameroon, as experienced by healthcare providers? What are the views of health care providers in Far North Cameroon on the need to train health care interpreters to overcome language barriers in health care centers?

This work is discussed from the perspective of an eclectic framework that includes the Cultural Competency model (cf. Brach and Fraser 2000) and postcolonial linguistics (cf. Makoni 2011, Arnke 2017, Anchimbe 2018, Levisen & Sippola 2019).

The cultural competence model is a theoretical model that proposes techniques to help reduce barriers in health care. Proponents of this model have identified the following eight main cultural competency techniques, some of which will be helpful in the data analysis and discussion: interpreter services, recruitment and retention policies, training, coordination with traditional healers, use of community health workers, culturally competent health promotion, involvement of family/community members, immersion in another culture, and administrative and organisational accommodations. Postcolonial linguistics (which focuses on what language is and how it has been integral to the colonial matrix of power and orders of knowledge in the postcolonial era [(Warnke 2017)]) will be helpful in analysing some practices and misconceptions of language use in postcolonial contexts by deconstructing some 'segregationist paradigms' (Makoni 2011) and language myths in postcolonial Africa.

### 3. Methodology

This section provides details about the research sites, research population, research instruments, data collection and processing.

#### 3.1. Research sites

The data for this study were collected from 45 health centers in 29 health districts in the 6 divisions that make up the Far North Region of Cameroon. Research permission was obtained from the Regional Delegate of Health of the Far North Region before accessing the research sites.

**Table 1: healthcare centers which constitute research sites**

<b>Healthcare centers</b>
HRA Mokolo, CSI Minawao, Intermediare, Zidini, Clinique Ophtamologique de Mokong, Clinique du Sahel, CMS/CNPS, Clinique du Vivre-Ensemble, HD Makary, HR Guider, HR Yagoua, HD Guere, CSC Bangana, CSPC Gobo, HD Roua, CSI Roua, CSI Madakwa, Pette, HR Maroua, Clinique Maroua Kaliao, SSD Mogode, SSD Maga, HD Hina, SSD Bourha, SSD Bourha, DS Koza, HD Bogo, HD Kolofata, CMA Logone Birni, Hôpital de Doukoula, HD Kaa-hay, HD Vele, HD Meri, HD Fotokol, SSD Mindif, HD Guidiguis, CSI Guidiguis, HD Mindif, HD Moutourwa, SSD Moutourwa, HD Kaele, CSI Kaele, HD Tokombere, Centre de Sante Djarengol Kodek, CMA Mozogo.

#### 3.2. Research population

The research population consists of health care providers (n=487) selected by simple random sampling. They include medical doctors, nurses, nursing assistants, midwives, laboratory technicians, radiographers, psychosocial counsellors, psychiatrists, pharmacists, psychomotor therapists, psychologists, physiotherapists and dieticians. Most of these informants (91%) received their medical training in French, while 9% were trained in English. The distribution of the proportion of informants according to their profession is shown below (see Table 2).

Table 2: Distribution of proportion of informants according to their occupation

<b>Occupations</b>	<b>Proportion (in percentage %)</b>
care assistants	38.18
nurses	25.82
medical doctors	9.82
midwives	8.73
medical and sanitary agents	6.55.
x-ray technicians	1.09
pharmacists	2.18
lab technicians	1.09
psychosocial counsellors	1.09
pyschiatrists	1.09
psychomotor therapists	1.09
psychologists	1.09

physiotherapists	1.09
dieticians	1.09

The largest proportion of informants who participated in the study are care assistants (35%), nurses (34.8%), doctors (9.4%), midwives (8.5%) and medical and sanitary assistants (5.5%) (see Table 2). The gender distribution of the informants is almost balanced. More precisely, 50.1% are male and 49.9% are female. In terms of religious affiliation, 25% are Muslims, 74.8% are Christians and 0.2% are animists. Their age ranges from 20 to 50+ years. More precisely, 20-25 years old (16.8%), 25-30 years old (30.2%), 30-35 years old (28.5%), 35-40 years old (8.3%), 40-45 years old (14.5%), 45-50 years old (0.4%), 50 and over (1.3%). This means that the largest proportion is relatively young.

The length of time informants have been working in the health sector ranges from less than one year to more than 25 years: less than one year (23.3 %), 1-5 years (33.5 %), 5-10 years (22.0 %), 10-15 years (9.3 %), 15-20 years (5.1 %), 20-25 years (3.6 %), 25 years and more (3.2 %). Details of the length of time they have worked in the Far North are as follows: less than 1 year (24.8%), 1-5 years (37.1%), 5-10 years (21.7%), 10-15 years (7.2%), 15-20 years (5.5%), 20-25 years (1.7%), 25+ years (2.1%). Most of these health workers were trained in the southern parts of the country.

### 3.3. Research instrument

The data collection instrument used in this study was a questionnaire. It was divided into three parts, namely - Part I: Demographic information, Part II: Communication with patients and Part III: Evaluation of communication strategies. Part I elicits demographic information from healthcare providers such as health district, health center, their gender, age, religion, occupation/rank/function and longevity in the profession. Part II asks about the providers' first official language, their language of training, the languages they speak, the local languages of the Far North Region they speak, if any, their longevity in the Far North Region, their familiarity or not with OLNPP, the estimated frequency with which they see such patients, the verbal repertoire of OLNPP, insights into their verbal repertoire regarding the languages of the Far North Region and the strategies they use to overcome linguistic barriers. Part III collects information on the current strategies used to overcome language barriers, information on the people who interpret in the health centers, the presence or absence of professional interpreters in the centers, their views on the need or not to train home language health interpreters to overcome language barriers in health care, and their proposed strategies to overcome language barriers between OLNPP and health care providers in Far North Cameroon health centers.

### 3.4. Data collection

The data analysed in this paper was collected from 22 June 2023 to 1 September 2023. I collected these data for the research project that I carried out from Sep. 2023-June 2024 at the Netherlands institute for advanced Study in the Humanities and Social Sciences. Part of the data for the project was analysed in previous publications (cf. Meutem Kamtchueng 2024, 2025& 2026).

The data collection process was carried out in three steps, namely pilot testing of the questionnaire, administering the questionnaire, respondents completing the questionnaires and collecting the completed questionnaires. For the pilot testing, I distributed 10 questionnaires to health care providers to check whether the information expected from the informants was adequately and unambiguously elicited. At the end of this pilot testing phase, I had to adjust some questions in the questionnaire based on their observations and print the final version of the questionnaire to be administered, as most of them filled it in by hand. The questionnaire was administered using simple random sampling, so that each provider in the health centers had an equal chance of participating in the study. The number of questionnaires in each health center was determined by the number of health care providers in the center. I administered the questionnaires with the help of one health care provider in each center. The purpose and contents of the questionnaire were explained to the head of each health center and also to the health providers, and a deadline was set for completing the questionnaire. I obtained participants' informed consent for their responses to be anonymised and for the results of the study to be published. The questionnaires were completed by the health care providers and returned to the health care staff I had appointed to collect the completed questionnaires. I contacted them from time to time to check on their progress in completing the questionnaires. When the deadline was reached, the completed questionnaires were collected. In total, 520 of the 600 questionnaires distributed in all the health centers were collected.

### 4. Data processing

Data processing was carried out in three stages, namely checking and validation, entering information from the questionnaire and finally editing the information entered.

■ **Review and validation of completed questionnaires**

The 520 completed questionnaires were collected and the information provided by the informants was checked. Questionnaires that were less than half completed were discarded. At the end of this checking process, 487 questionnaires were kept.

■ **Keying in the information from the questionnaires**

The information from the questionnaires was keyed into a template designed on a Google form for survey administration to facilitate analysis. Due to the socio-economic context of the Far North region and problems with internet connectivity, almost all questionnaires were completed manually. The data from the Google form template was processed using SPSS 18.0 (Statistical Package for the Social Sciences) and Excel was used to create graphs based on the quantitative analysis.

■ **Editing and encoding the information entered**

Finally, the keyed information was edited and typographical errors in the database were corrected. Once the data had been edited, I coded it so that the necessary information could be easily generated from the database for data presentation and analysis. The coding of the data was done in three steps. The first step was to extract and read the data from the database; the second step was to group the information provided and label the groups; the third step was to assign codes to each label. The codes were assigned to the items that fell under each label.

**5. Data presentation and analysis**

This section presents and analyses the data obtained from the questionnaire. It is divided into three sub-sections, namely the proportion and frequency of OLNPP visits to health centers in the Far North of Cameroon, the challenges facing the practice of French/English mother-tongue interpreting, and the health providers' views on the need to train health interpreters to overcome language barriers in health centers.

**5.1. Estimated proportion (%) of OLNPP among healthcare providers**

As shown in Figure 1, almost all healthcare providers who participated in the study have experienced patients' lack of proficiency in official languages.

Have you ever attended to patients who do not speak any of the official languages?

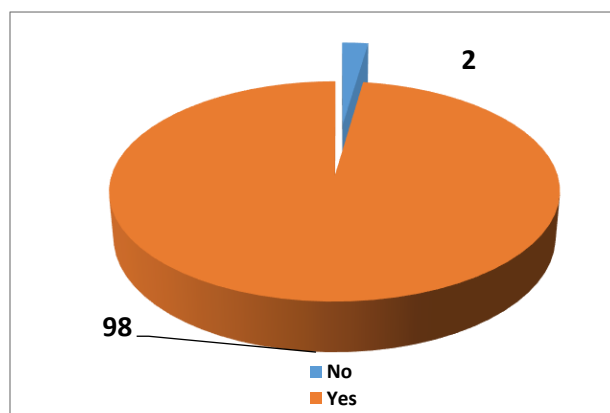


Fig. 1: estimated proportion of healthcare providers' encounter with official language non-proficient patients

From the graph it can be seen that 98% of the informants had experience with patients who were not proficient in any of the official languages. Only 2 % of the informants had no such experience. Regarding the frequency of caring for these patients (see Figure 2), the results show that 35 % of the informants place this frequency between [0.20], 14 % between [20-40], 16.8 % between [40-60], 25.3 % between [60-80] and 8.9 % between [80-100].

How often (%) do you come across such patients?

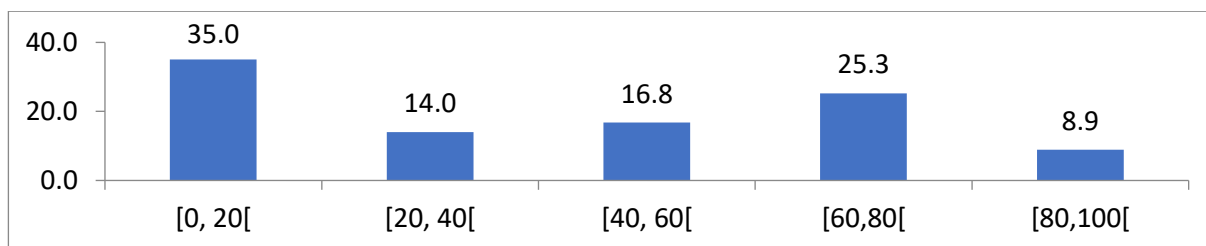


Fig. 2: Healthcare providers' estimated frequency of encounter with OLNPP

These statistics show that patients' lack of knowledge of the official languages is very common in health centres in the Far North of Cameroon. It can be noted that there is a correlation between patients' lack of proficiency in French and English and the illiteracy rate in the Far North Region of Cameroon, which is estimated at 76% according to a report by the Unesco Institute for Lifelong Learning (2014). This poses a real challenge not only for healthcare providers, but also for this group of patients, who can be considered socially disadvantaged because they cannot communicate in the official languages.

## 5.2. Challenges facing the practice of French/English home-language interpreting in Far North Cameroon health centres

The challenges facing the practice of French/English-home language interpreting in Far North Cameroon health centres were identified and discussed under the following headings: the practice of French/English-home language interpreting in health care by untrained interpreters, the reluctance of patients to open up in the presence of non-medical staff, the problem of the availability of ad hoc interpreters, the practice of interpreting by health care providers being seen as a time-consuming activity, and the delay in the communication of information from health care providers to patients and vice versa during interpreting (cf. Figure 3).

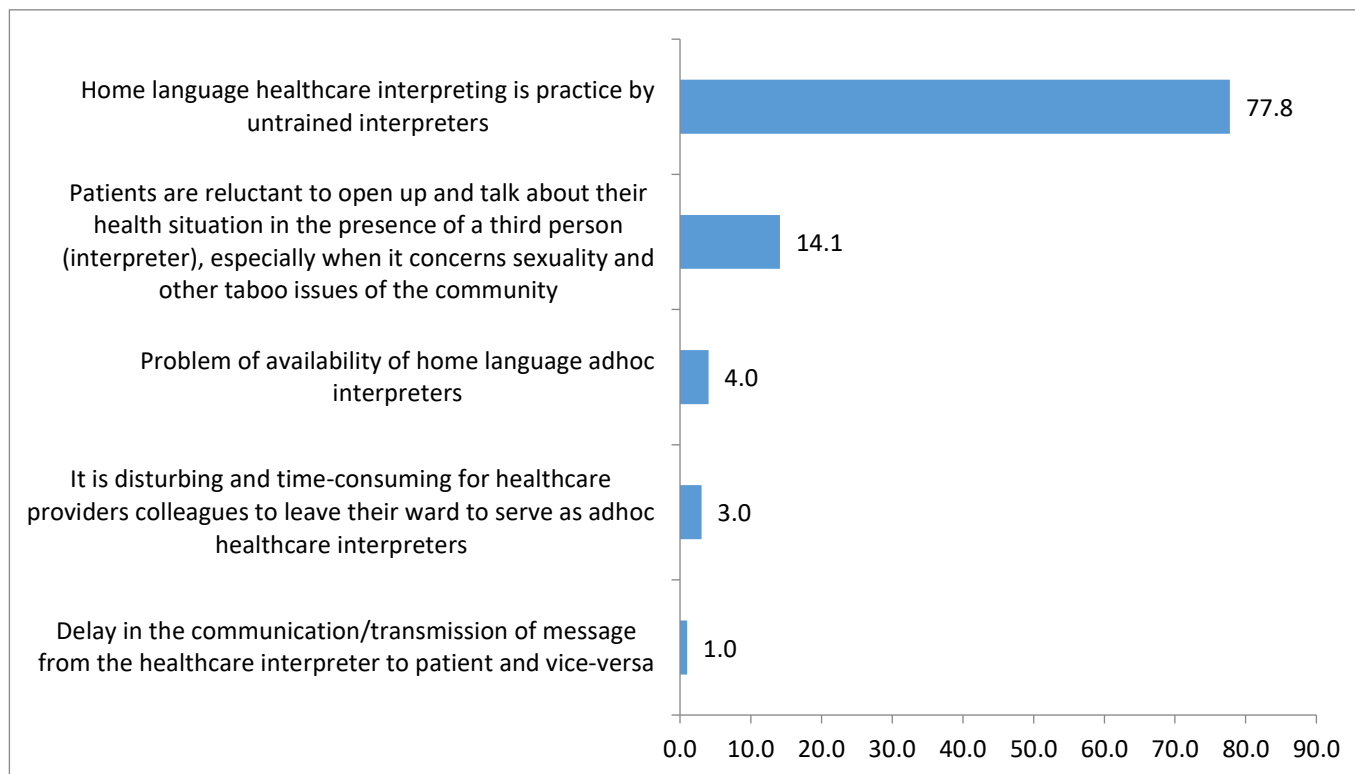


Fig. 3: Distribution of the challenges facing the practice of French/English-home language interpreting in Far-North Cameroon healthcare centers

### 5.2.1. The practice of home language interpreting by untrained interpreters

The practice of French/English-home language interpreting in these health centres is essentially carried out by non-professional interpreters. They are either ad hoc interpreters (family members, friends, relatives, patients' guardians), community health workers or bi/multilingual health care providers. According to health care providers, in their experience, interpretation provided

by untrained health care interpreters, especially ad hoc interpreters and community health workers, is not reliable. Many health care providers point out that they have often found that the message conveyed to patients by interpreters was not well understood because it was poorly interpreted as illustrated below:

"I noticed that very frequently, the interpretation provided by the recruited health community interpreter working with me did not match patients' reactions to my questions and statements. I told the director of the hospital that I did not want to work with that interpreter anymore [my translation]" (Health care provider, Bogo District Hospital Maroua).

For this reason, health care providers suggest that they "would like to have well-trained health interpreters in the health centres in order to communicate successfully with patients" (Mokolo 23, CSI Minawao, nursing assistant)[...] because "the presence of an interpreter, even if he/she is from the medical corps, generally prevents patients from opening up and saying what is on their minds (Clinique du Sahel 1, Maroua, doctor). As a result of the unreliability of interpretation by untrained interpreters, many health care providers prefer either to work without interpreters or to refer OLNPP to their colleagues who can communicate in the patients' mother tongue.

### **5.2.2. Patients' reluctance to open up in the presence of non-medical staff**

In addition, the presence of these non-medical staff during medical encounters with patients is most often risky from a medical ethics perspective. Healthcare providers' experience of the presence of non-medical staff during medical encounters shows that patients often do not open up fully to them, as explained in the following quote: "because some interpreters are not trained in health ethics and deontology, they reveal patients' medical information to people (HR Maroua 2, Care Assistant). This is because patients are afraid of revealing medical information about their health, especially if they suffer from diseases that are stigmatised in society. This is the case with sexually transmitted diseases such as AIDS, hepatitis, syphilis, gonorrhoea, etc. There is therefore a high probability that working with untrained interpreters will compromise doctor-patient confidentiality. In other words, they can easily disclose patients' medical information to people in the community, and therefore "patients cannot tell these interpreters everything about their health situation" (Mokolo 38, HRAM, IDEP). As a result of this reluctance to open, health care providers may not know some important details about patients' health information in the presence of non-medical staff.

### **5.2.3. Lack of ad hoc home language interpreters**

Given the multilingual context of Far North Cameroon, it is not always easy to find ad hoc interpreters in health centres who can translate from French/English into a patient's home language and vice versa. For this reason, health care providers always stress to OLNPP the importance of coming to hospitals with an accompanying person who is fluent in French and/or English and the patient's mother tongue to act as an interpreter. This saves them the trouble of running up and down the health center looking for an interpreter in their own language. The extent of the shortage of ad hoc home language interpreters varies from one home language to another and from one community to another.

### **5.2.4. Interpreting by health care providers perceived as disruptive and time-consuming**

In addition to the shortage of ad hoc interpreters, another challenge involved in the practice of interpreting in Far-North healthcare centers is, as there are no interpreters trained and posted in healthcare centers, the high demand on ad hoc home language interpreters. Many bi/multilingual health care providers are asked by their colleagues to act as interpreters, especially when they know that the colleague can communicate in the patient's home language. As a result, some of these bi/multilingual healthcare providers have to leave their offices to go to their colleagues' offices to interpret. It may happen that the bi/multilingual healthcare provider is also busy providing care to other patients. The healthcare provider in need has to wait for his/her colleague to finish caring for his/her patients before he/she can be provided with interpreting assistance. This situation is seen as inconvenient and time-consuming not only for the health care provider who needs interpreting assistance, but also for the OLNPP who is receiving health care. This state of affairs leads to a delay in the provision of information both to health care providers and OLNPP and, of course, causes the delay in the treatment of patients.

### **5.2.5. Delays in communicating information from healthcare providers to patients and vice-versa during interpreting**

Interpreting is also seen as a time-consuming activity by many healthcare providers, not only because of the shortage of people who can act as ad hoc interpreters, but also because interpreters have to go back and forth between healthcare providers and the OLNPP. This situation can lead to a delay in getting information from the interpreter to the healthcare provider and the patient. As one provider pointed out, "it is difficult to understand each other through interpretation and it is very time-consuming" (HR Maroua 17, nurse). The interpreters could ask either party to clarify a point to make it easier to understand. Also, there are some medical terms that are easy to explain in European languages, but which may not have direct equivalents in the home languages and, as a result, may be difficult to explain in the home languages, especially if the healthcare interpreter is not

trained to interpret in these home languages. The same applies to the names of some diseases. An untrained interpreter may lack the appropriate lexical items to refer to these, or may need time to think of the most appropriate lexical items or constructions to express these realities in the mother tongue. All of this could take more time and cause a delay in information.

In this situation, training French-English home-language interpreters and placing them in different health centres in the region could be the most appropriate solution to limit language barriers.

### 5.3. Health care providers' views on the training of home language health care interpreters to overcome language barriers between OLNPP and health care providers

From Figure 4 and the analysis, it can be seen that the practice of French/English-home language interpreting faces several challenges, the most prominent of which is the fact that it is carried out by untrained interpreters. Can the training of home-official language healthcare interpreters be a long-term solution to bridge the communication gap between healthcare providers and patients who are proficient in official languages?

#### ■ Positive views

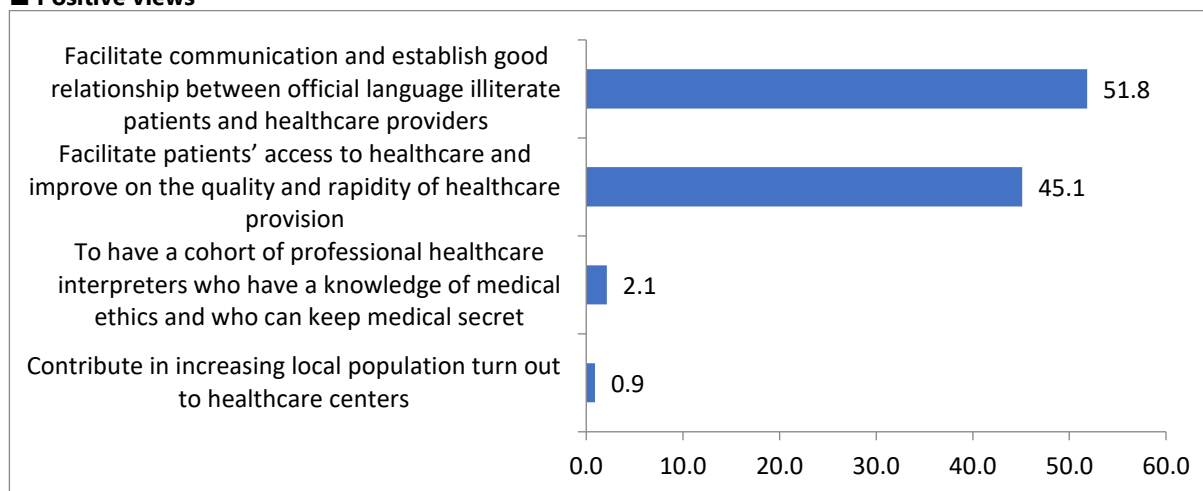


Fig. 4: Positive views of Far-North Cameroon's healthcare providers on the necessity of training health interpreters to overcome language barriers in healthcare centers

#### a) To facilitate communication and establish a good relationship between patients who are not proficient in the official language and healthcare providers

Interpreting is one of the most commonly used strategies in health centres to overcome language barriers. When interpreting is done by professional interpreters, it not only facilitates communication between health care providers and OLNPP, but also establishes a good relationship between both sides: interpreting helps to bridge the communication gap between both parties in such a way that both health care providers and patients are on the same wavelength. Once they understand each other, a relationship of trust can be established.

#### b) To facilitate patients' access to health care and to improve the quality and speed of health care.

It should be noted that patients' lack of communication skills in the official languages (English and French) in health centers in the Far North of Cameroon significantly limits their access to health care, as they have difficulty interacting with health care providers, especially when both parties do not have a common language in their repertoire through which they can communicate (e.g. Fulfulde language). Language thus becomes a barrier that prevents patients from accessing healthcare. The use of professional interpretation is therefore a means of overcoming this barrier and enabling OLNPP to access healthcare. In addition, when done well, interpretation contributes to improving the quality and speed of health care by enhancing safety (limiting medical errors related to communication barriers), timeliness (reducing waiting times and minimising harmful delays) and equity (no discrimination on the basis of language).

#### c) A cohort of professional healthcare interpreters who have knowledge of medical ethics and who can maintain medical confidentiality.

As mentioned above, one of the complaints of health care providers in the Far North Health Centers is that those who interpret there are not trained interpreters, which casts doubt on the reliability of their interpretation. In addition, some health care

providers are reluctant to use ad hoc interpreters because they are untrained, unfamiliar with medical ethics, and may, for example, divulge medical information about patients. Therefore, working with trained interpreters increases health care providers' confidence in the professionalism of interpreters and therefore their ability to maintain the confidentiality of medical information about patients.

**d) Helping to increase the number of local people attending health centres**

In addition to limiting access to health care for patients who are proficient in the official language, language barriers such as those observed in the Far North of Cameroon also reduce patient attendance at health facilities. In fact, according to health care providers, some people in Far North Cameroon are reluctant to go to health centres because they cannot express themselves in one of the official languages (French and English) unless they are accompanied by someone who can act as an interpreter for the health care provider.

As a result, they turn to traditional medicine. This situation reduces attendance at health centres. The availability of trained French/English mother-tongue interpreters "increases the attendance of the local population at health centres" (Nurse, HR 65). In other words, the availability of these interpreters will encourage these unprivileged patients to go to health centres because they will be sure that what they say will be understood by the health providers.

While it is true that some healthcare providers believe that the training of French/English-home language interpreters will be a solution to the problem of language barriers, it is nonetheless true that other health care providers, for various reasons, do not see this as a solution to overcoming language barriers in health centres in the Far North of Cameroon.

**■ Negative views**

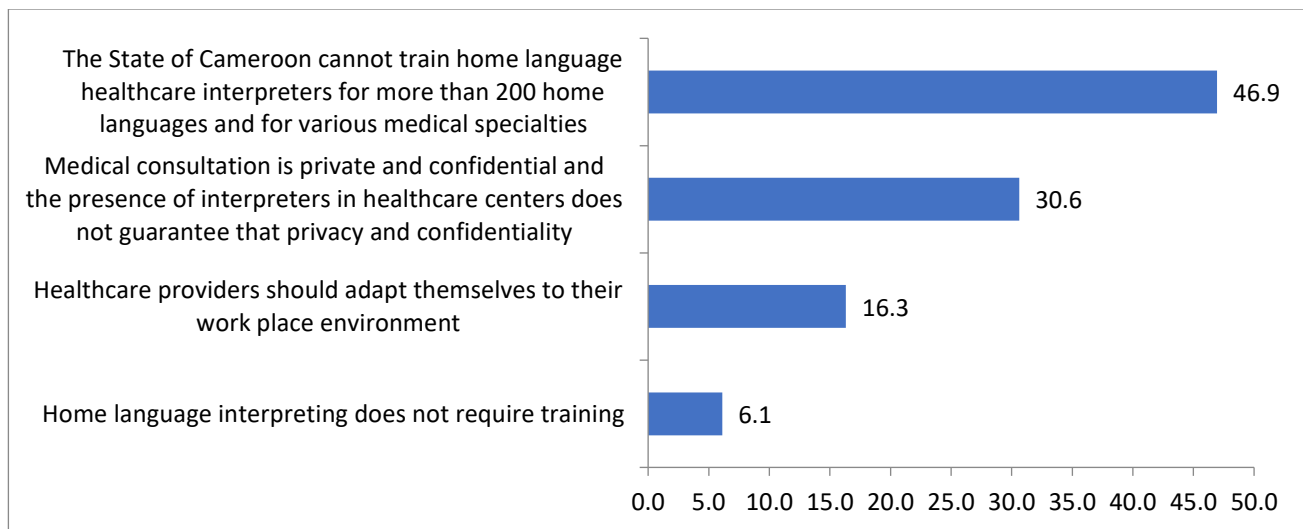


Fig. 5: Negative views of Far-North Cameroon's healthcare providers on the necessity of training health interpreters to overcome language barriers in healthcare centers.

**a) The State of Cameroon cannot train home language health interpreters for more than 200 home languages and for different medical specialties.**

Given the complex multilingual situation in Cameroon, where there are 247 home languages, many health care providers question the practicality of training French/English –home language health care interpreters for such a large number of languages. For them, it will be impossible to train health interpreters in such a large number of languages. In addition, they stress the difficulties in choosing the Cameroonian home language to be used for health interpreting. It should be noted that in the northern regions of Cameroon (Adamawa, North and Far North), the proportion of people who are not proficient in official languages is very high due to the high illiteracy rate. In other regions of Cameroon (West, Littoral, Centre, South, etc.), this problem is not very pronounced, although it does exist. It should be noted that despite the multiplicity of home languages in

Cameroon, there are vehicular languages in each region and in the North of Cameroon, Fulfulde is a vehicular language. The choice of language in health interpreting can be made on the basis of these criteria.

**b) Medical consultations are private and confidential and the presence of interpreters in health centers does not guarantee privacy and confidentiality**

The practice of interpreting requires the presence of an interpreter who acts as an intermediary between the health care provider and the patient. In order to do their job successfully, they need to fully understand the message being conveyed by both parties and will inevitably end up learning something about the patient's medical information by interpreting for them. Some healthcare providers stress the fact that interpreters, whether trained or not, can reveal medical secrets. Instead, they prefer to use their colleagues as interpreters whenever possible, or to communicate in the patient's home language. They go on to say that medical consultations are private and confidential and that the presence of a third party, unless he/she is a healthcare provider, does not guarantee the privacy and confidentiality of the patient's medical information.

**c) Health care providers should adapt to their working environment**

A large number of health care providers point out that training French/English- home language interpreters is not an effective strategy for overcoming the language barrier between health care providers and patients who do not speak the official language in the multilingual Far North of Cameroon. Instead, healthcare providers should adapt to the linguistic and socio-cultural environment of the region by learning the local language(s) and familiarising themselves with the cultural realities of the area. It is worth noting that most health care providers, especially general practitioners and specialists, are not from the area and have not worked there for many years. By learning the native languages of the community, it will no longer be necessary for health care providers to look for interpreters to facilitate communication between them and patients who are illiterate in the official language. As one informant pointed out, "everyone can make an effort to adapt to speak the local language" (HR Maroua, nurse 7). Some health care providers stress that "it is important for health care providers to learn the most spoken local language of the area where they work" (HR Mokolo 33, midwife), given the multiplicity of mother tongues in the Far North region of Cameroon.

**5. Discussion of the findings**

From the above analysis, it can be seen that health care providers have divided experiences and opinions (see Table 3) about the practice of French/English - home language interpreting in health care centres and the need to train these interpreters as a means of overcoming communication barriers between health care providers and the OLNPP. This split of opinion has led to the identification of two main groups, namely the Unsatisfied and the Satisfied Groups. The Unsatisfied Group does not see the importance of training French/English-home language health care interpreters as a means of overcoming communication barriers in this setting. Furthermore, they consider interpreting, whether or not it is done by a trained interpreter, to be an unreliable and inefficient communication practice that does not guarantee the privacy and intimacy of patients. According to them, the linguistic complexity of the country, which has 247 home languages, makes it unrealistic and even impossible to train French/English - home language interpreters for all these languages. More realistic strategies should therefore be adopted, namely the provision of facilities for health care providers to learn the home language(s) of the community where they practise so that they can communicate with the OLNPP in their home languages (s), and the recruitment in health centres of health care providers from the community in which the health center is located.

**Table 3: Healthcare providers' dis/satisfaction about French/English-home language interpreting**

Unsatisfied	Satisfied	
Interpreting is unreliable, inefficient and does not guarantee the privacy and intimacy of patients	<b>Conditionally satisfied</b>	<b>Unconditionally satisfied</b>
	Interpreting is efficient and recommended in overcoming linguistic barriers between healthcare providers and OLNPP provided interpreters are trained (professional).	They are optimistic about its practice. It is an efficient and recommended strategy in overcoming linguistic barriers between healthcare providers and OLNPP

The Satisfied Group appreciates the importance of training French/English-home language interpreter to bridge this communication gap. Two sub-groups can be identified, namely the Unconditionally Satisfied and the Conditionally Satisfied. The Unconditionally Satisfied Group appreciates the importance of healthcare interpreting. They see interpreting as an effective and recommended strategy to overcome language barriers between healthcare providers and OLNPP. For the Conditionally Satisfied Group, interpreting is efficient and recommended in overcoming language barriers, provided that the interpreters are trained (professional).

The use of trained interpreters in interpreter-mediated health care encounters has produced various positive outcomes in other multicultural contexts. For example, in South Africa, another multiculturally diverse African country, it was found that "trained interpreters improve the quality of healthcare, clinical outcomes and patient satisfaction [...], whereas untrained bi- or multilingual staff, family members or friends pose serious ethical and medical challenges" (Habib et al 2023:1). Ad hoc interpreters have been found to have inadequate language skills and to be prone to making frequent errors during interpretation (Van den Berg 2016, Hagan et al 2013). As it is the case in South Africa, the use of trained interpreters in Far North Cameroon health centers can be very helpful in bridging the communication gap between health providers and OLNPP.

It is important to emphasize the absence of technology with regard to interpreting in health centres in the Far North of Cameroon. It should be noted that with the increasing development of new information and communication technologies, coupled with the development of telemedicine, translation and interpreting software applications have been developed (Cf., for example, xprompt-multilingual assistance (cf. Albrecht et al. 2013), Canopy Medical Translator, Universal Doctor Speaker and Vocre Translate (cf. Khander et al. 2018)) and their use in other countries has yielded satisfactory results. Further findings on the use of translation and interpreting apps in healthcare with positive results can be found in Panayiotou (2019), Kaliyadan and Gopinathan (2010); Albrecht (2013); Beh and Canty (2015); Nguyen-Lu et al. (2010), Patil and Davies (2014). The development of such interpreting applications may be useful in multilingual health centres in Cameroon.

This study highlights the issue of the continuing hypercentrality of exoglossic languages (French and English) in the social life of post-colonial multilingual Africa. It is unrealistic and regrettable that, more than sixty years after independence, many Africans still face difficulties in accessing social needs because they cannot communicate in exoglossic languages. Health domain is a case in point. The situation of the OLNPP, whose access to health care in their home country (e.g. Cameroon) is limited because they cannot communicate in the language of the colonisers, should lead to a readjustment of language policy in Cameroon, especially in social domains (health, education, etc.). As pointed out by Thiong'o (1986), the mind of Africans is colonised and there is an urgent need to decolonise their mind. Linguistic practices in healthcare setting in many sub-saharan African countries are a case in point. The exclusive use of exoglossic languages (English and French) is a factor of exclusion to healthcare access in a context of high official language literacy. This point concurs the findings of Kayum Fokoue (2013), Akumbu and Di Carlo (2021) and Good (2017) according to which the restriction of health communication to the official languages (French and English) in Cameroon is nefarious because it limits the population's access to health information, especially during health crises such as epidemic (e.g., cholera) and pandemic (Covid-19) outbreaks. It is therefore of paramount importance to make access to healthcare more linguistically inclusive. It is worth stressing the fact that the exclusive use of English and French for communication in health centres in Cameroon is very disadvantageous for populations, especially in rural areas and in parts of the country where the illiteracy rate is very high, as is the case in Northern Cameroon.

In other words, providing health care to indigenous people exclusively in a foreign language can be detrimental to the recipient. For example, it has been found that "people in South Africa are vulnerable to human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS), malnutrition, measles, diarrhoea and other health problems, partly because important information is not provided in their own languages and in a culturally sensitive way" (Mphasha & Tsakane Lebeso 2015:91). Therefore, the use of indigenous languages in health care has been shown to have significant positive outcomes: reducing child mortality and improving medical health, public safety, preventing duplication of treatment, etc. (Mphasha & Tsakane Lebeso 2015:91-93).

It is worth noting that continuing to consider exoglossic languages as the sole languages of health is tantamount to perpetuating Western universalism and politico-cultural imperialism in the social life of Cameroonians. Given the impossibility of erasing our historical past and the importance of English and French in the Cameroonian education and health systems, a more linguistically inclusive approach to communication in health centres will better serve the needs of the population. This approach challenges and breaks away from the linguistic myth that European languages are the only languages to be used in formal contexts in postcolonial Africa. Health care in postcolonial Africa should not rely solely on exoglossic languages.

This is what I call an **exo-endonormative approach to communication in health centres**. A successful implementation of the approach will consist in:

- a) identifying the home languages spoken in the areas where the rate of official language non-proficiency is very significant,
- b) developing home language literacy material in these languages starting with vehicular languages,
- c) developing programs for the training of French/English- home language healthcare interpreters,
- d) training medical interpreters starting with French/English- home language healthcare interpreters laying emphasis first on the training of medical interpreters into vehicular languages (eg. French – Fulfulde) and gradually extend it to other home languages,
- e) developing softwares for translation and interpreting from French into home languages and vice-versa,
- f) creating multilingual language access services in hospitals (starting with referral hospitals),
- g) training more teachers of Cameroon home languages in higher teachers' training schools,
- h) integrate the teaching of some Cameroon vehicular languages in medical schools.

The advocated approach is linguistically inclusive. Its inclusiveness lies in the fact that, while recognising the importance of French and English in the health domain in Cameroon, it empowers the use of home languages. It is therefore of paramount importance to improve not only the development of health literacy, but also the "dissemination of social skills" (cf. Bakume Nkongho 2018) in home languages in Cameroon, both in printed and digitalised forms, to change some of the constraints on mother tongue or indigenous language education in Cameroon (cf. Anchimbe 2006), invest more human, financial, pedagogical and infrastructural resources in the teaching of Cameroonian home languages and cultures, and raise awareness among health care providers and authorities about the importance of disseminating health information in both official and home languages.

## Conclusion

From the foregoing study, it is clear that the practice of French/English mother-tongue interpreting in health centres in the Far North of Cameroon faces several challenges: lack of trained interpreters, patients' reluctance to open up in the presence of non-medical staff, lack of ad hoc mother-tongue interpreters, interpreting is seen by some health providers as a disruptive and time-consuming activity, delays in the transmission of information from health providers to the OLNPP. It was also found that health care providers are divided on the need to train French/English mother tongue interpreters as a means of reducing language barriers in health care centres. While it is true that some health care providers are optimistic about the need to train French/English mother tongue health care interpreters as a solution to overcome language barriers between OLNPP and health care providers (the satisfied group), it is also true that other health care providers are very pessimistic about training French/English mother tongue health care interpreters in multilingual Cameroon as a solution to overcome language barriers.

This study has brought to the fore the nefarious aspects of restricting the provision of healthcare to indigenous populations in exoglossic languages in postcolonial Cameroon, more than 60 years after independence. The paper argues for an exo-endonormative language policy in multilingual health centres in Cameroon. This approach emphasises the importance of linguistic inclusiveness for communication in health centres in Cameroon in general and in the North of Cameroon in particular. It will definitely be of paramount importance to empower home languages in the Cameroonian health system.

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