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HEALTHCARE PROVIDERS' EXPERIENCE OF NON-LINGUISTIC BARRIERS TO HEALTHCARE PROVISION FOR OFFICIAL LANGUAGE ILLITERATE PATIENTS IN FAR-NORTH CAMEROON HEALTHCARE CENTERS: A CONTRIBUTION TO INTERCULTURAL COMMUNICATION IN HEALTHCARE PROVISION

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ABSTRACT
Non-linguistic barriers have significant impacts on healthcare provisions. Drawing data from questionnaires administered through simple random sampling to 487 healthcare providers in 45 healthcare centers of the Far-North region of Cameroon, this paper sets out to study healthcare providers' experience of non-linguistic barriers to healthcare provision for official language illiterate patients (i.e. patients who lack complete communicative skills in official languages of Cameroon (English and French)). More precisely, the work investigates non-linguistic barriers to healthcare provision in Far-North Cameroon healthcare centers and discusses some remedial strategies. Campinha-Bacote's (2002) Cultural Competence of Healthcare Delivery has served as the theoretical framework for the study and the approach of analysis is both quantitative and qualitative. Findings reveal that religious barriers; cultural beliefs, practices, taboos and witchcraft; overdependence on traditional medicine, traditional doctors and soothsayers and exacerbated patriarchy constitute serious hindrance to healthcare provision in the healthcare centers in this region of Cameroon. Current trends and suggestions to limit these barriers include the following: informing, educating, communicating and counselling; familiarization of healthcare providers to the cultural practices of the community; gender-sensitiveness with regard to the caring of patients; referring some patients to colleagues of other healthcare centers; priority to female healthcare providers in women health services; recruiting healthcare providers who are of the locality in which healthcare centers are found and getting substitute product for blood during blood transfusion. It is argued that in addition to these current strategies, a more efficient approach to limit these barriers should incorporate intercultural competence. The paper intents to contribute to the domain of intercultural communication in the context of healthcare provision for official language illiterate patients in multicultural contexts.

Keywords: Far-north cameroon; healthcare providers; healthcare provision; non-linguistic barriers; official language illiterate patients

INTRODUCTION

Healthcare provision in multiculturally diverse contexts has not always been easy both to healthcare providers and patients. It is important to point out that there are some cultural and religious realities on the side of patients which have to be taken into consideration by healthcare providers while administering care. Failure to take into consideration these realities might negatively impact healthcare provision. Therefore, healthcare providers' familiarity with patients' elements of their culture and religion might facilitate healthcare provision and contribute to better health care. The Far-North region of Cameroon is a multicultural and multiethnic diverse region. Also, it is the Cameroon's region which has the highest rate of illiteracy. As a consequence, many patients in healthcare centers cannot communicate in the country's official languages (English and French) and consequently cannot communicate with healthcare providers as they have received their training in official languages (English and French) and in other foreign languages as it is the case of some medical expatriates. It will be therefore very difficult for healthcare providers who cannot communicate in the patient's home language to inquire from them culturally- and religiously-related health information. Despite the fact that cultural and religious barriers to healthcare is a global concern as they are attested in various sociocultural contexts, the forms that they take and the responses to them vary from one setting to another. Cultural and religious barriers to healthcare provision is one of the main concern of scholars

interested in bridging the gap between healthcare providers and patients. Various cultural barriers to healthcare provision have been found in previous studies, namely shame and insufficient sociocultural support, little attention to the culture of disability and discrimination, reluctance to provide health services and disrespect (Soltani et al (2017), and low cultural competency of healthcare providers (Almutairi 2015). Previous research has established that cultural beliefs play an important role in shaping people's attitudes and behaviors, including how they approach health care, influence how patients perceive health, illness, and the role of health care providers. Furthermore, cultural beliefs can also impact how patients interact with health care providers (Mcleod 2023) and result to health inequity (Jie-Li Li (2017). It is found that access to mother and infant health services in Far-North Cameroon is hindered by many gender and culture-related barriers such as unequal gender power relations, financial dependency on the husband, low male involvement in pregnancy-related health services, lack of respect and confidentiality by health providers, traditional treatments (Nudelman et al 2019).

Barriers to healthcare among Muslim women include the following: modesty and privacy among Muslim women, gender preference for providers, family involvement in care, fatalism and predestination, maintaining religious practices during illness, low health literacy and language proficiency, preference for traditional remedies, fear of stereotype and discrimination (Sean Tackett (2018). In fact, the care of Muslim patients provides challenges for many non-Muslim healthcare providers. Islamic faith can influence decision-making, family dynamics, health practices, risks, and the use of healthcare (Attum et al 2024). Moreover, it has been established that islamophobia has severe consequences on healthcare provision (Laird 2007). It is worth pointing out that these non-linguistic barriers (cultural and religious) though present in various sociocultural environments take various forms and are experienced differently by healthcare providers. As a consequence, the response to these barriers will also vary from one sociocultural setting to another.

The present study differs from Nudelman et al (2019) in the sense that it analyses barriers to healthcare from the healthcare providers' perspective and is oriented toward intercultural communication. This paper investigates from the healthcare providers' perspectives how these non-linguistic barriers to healthcare provision are manifested in Far-North Cameroon' healthcare centers as well as healthcare providers' response to this phenomenon. Lastly the paper makes some suggestions for improvement. The following questions are therefore addressed: What are the cultural and religious barriers to healthcare provision in Far-North Cameroon healthcare centers? What are healthcare providers' responses to these barriers? How can the situation be improved upon? The work intents to contribute to intercultural communication in the domain of healthcare provision in multicultural Cameroon and is discussed from the vantage point of Campinha-Bacote's (2002) Cultural Competence of Healthcare Delivery. The Model is based on the following five assumptions:

1. Cultural competence is a process, not an event.
2. Cultural competence consists of five constructs:
   a. Cultural awareness (it is a process of self-examination and in-depth exploration of one's own cultural and professional background which involves the recognition of one's biases, prejudices, and assumptions about individuals who are different. Cultural awareness prevents cultural imposition on the part of healthcare providers (i.e. the tendency of an individual to impose their beliefs, values, and patterns of behavior on another culture).
   b. Cultural knowledge (It consists in seeking and obtaining a sound educational foundation about diverse cultural and ethnic groups by focusing on the integration of three specific issues: health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy).
   c. Cultural skills (cultural skills refer to the ability for healthcare providers to collect relevant cultural data regarding the client's presenting problem as well as accurately performing a culturally based physical assessment).

d. Cultural encounters (process that encourages the health care provider to directly engage in cross-cultural interactions with clients from culturally diverse backgrounds. By interacting with clients from diverse cultural groups healthcare providers refine or modify their existing beliefs about a cultural group and prevent possible stereotyping that may have occurred).
e. Cultural desire (it has to do with the motivation of health care providers to *want* to, rather than *have* to, engage in the process of becoming culturally aware, culturally knowledgeable, culturally skillful, and familiar with cultural encounters).

3. There is more variation within ethnic groups than across ethnic groups (intra-ethnic variation). 4) There is a direct relationship between the level of competence of health care providers and their ability to provide culturally responsive health care services.
4. Cultural competence is an essential component in rendering effective and culturally responsive services to culturally and ethnically diverse clients.

As this work focuses on barriers to healthcare provision in a multicultural context, Campinha-Bacote's (2002) notions of cultural competence, cultural awareness, cultural skills, cultural encounters and cultural desire will be helpful in data analysis and discussion of findings. The subsequent sections of the paper are entitled as follows: method (Section 2), results (Section 3), discussion (Section 4) and conclusion (Section 5).

METHODS

The data analysed are drawn from the project on language and healthcare provision in health centers in multilingual Far-North Cameroon carried out at the Netherlands Institute for Advanced Studies in the Humanities and Social Sciences . Details about research sites, research population, age ranges of participants, distribution of the proportion of healthcare providers, longevity of healthcare providers in the profession, healthcare providers' in-service longevity in the Far-North Region of Cameroon, data collection and processing are provided in the following section.

Forty-five healthcare centers of the 6 divisions of the Far-North Region of Cameroon were involved in the study. A research authorisation[1] from the Regional Delegate of Health of the Far-North Region was obtained prior to the data collection process which was carried out from June 22, 2023 to September 1, 2023.

Table 1.
healthcare centers which constitute research sites

Healthcare centers
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.

The research population consists of 487 healthcare providers selected on a simple random sampling basis. They include Care assistants, nurses, medical doctors, midwives, medical and sanitary agents, pharmacists, dieticians, physiotherapists, psychologists, psychomotor therapists, psychiatrists,

psychosocial counsellors, lab technicians and x-ray technicians. The most considerable proportion of informants (91 per cent) received their medical training in French while 9 per cent of them were trained in English. Fig. 1 provides the distribution of proportion of informants according to their occupation.

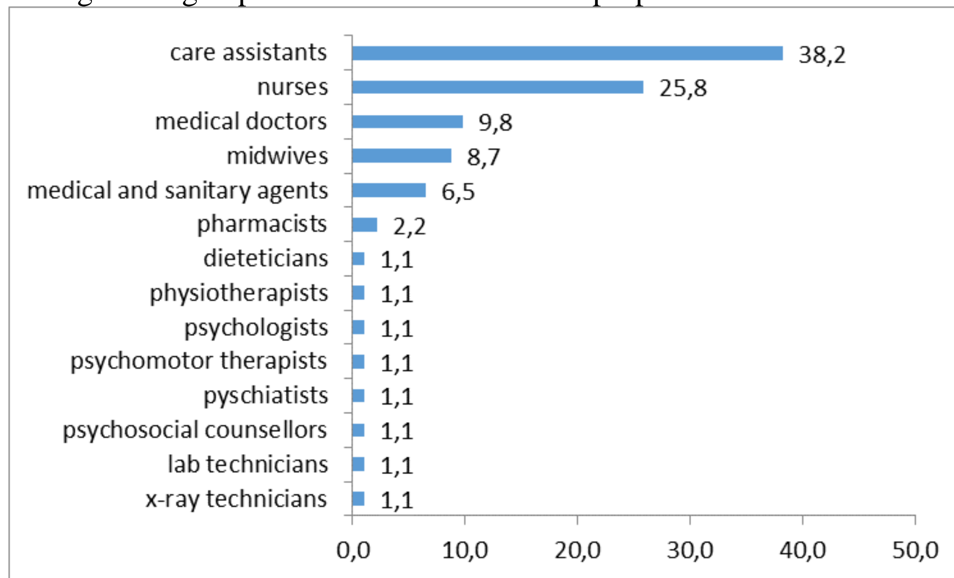

Fig. 1. Distribution of proportion of informants per occupation

The age range of informants varies between 20 to 50 + years. More precisely 20-25 years (16.8 per cent), 25-30 years (30.2 per cent), 30-35 years (28.5 per cent), 35-40 (8.3 per cent), 40-45 (14.5 per cent), 45-50 (0.4 per cent), 50 and above (1.3 per cent). So, the most significant proportion is relatively young. Their gender distribution is almost balanced. More precisely 50.1 per cent are male and 49.9 per cent are female. With regard to their religious affiliation 25 per cent are Muslims, 74.8 are Christians and 0.2 per cent are animists. Their longevity is situated between less than one year to 25+ years: less than 1 year (23.3 per cent), 1-5 years (33.5 per cent), 5-10 years (22.0 per cent), 10-15 years (9.3 per cent), 15-20 years (5.1 per cent), 20-25 years (3.6 per cent), 25 years+ (3.2 per cent). Details about their longevity in the Far-North Region are provided below: less than 1 year (24.8 per cent), 1-5 years (37.1 per cent), 5-10 years (21.7 per cent), 10-15 year (7.2 per cent), 15-20 years (5.5 per cent), 20-25 year (1.7 per cent), 25+ (2.1 per cent). From these statistics it can be noted some sort of correspondence between healthcare providers' longevity in the profession and their in-service longevity in the Far-North Region of Cameroon.

The data was collected via a questionnaire structured into three parts: namely Part I: demographic information, Part II: Communication with patients and Part III: Assessing communication strategies. Part I elicits from healthcare providers' demographic information such as health district, health center, sex, age ranges, religion, profession/rank/function and longevity in the profession. Part II inquires about healthcare 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 of work in the Far-North region, their familiarity or not with official language illiterate patients, their estimated frequency of attendance to such patients, the verbal repertoire of official language illiterate patients, insights into their verbal repertoire concerning the languages of the Far-North region and the strategies they make use of in order to overcome linguistic barriers. Part III elicits information related to the current strategies used to overcome linguistic and non-linguistic barriers to healthcare provision, information about people carrying out interpretation in health centers, the presence of absence of professional interpreters in the centers, their views about the necessity or not of training home language healthcare interpreters so as to overcome language barriers in healthcare and the suggested strategies to overcome

language barriers between official language illiterate patients and healthcare providers in Far-North Cameroon healthcare centers.

The data collection process was done in three steps, namely pilot testing of the questionnaire, the administration of questionnaire, the filling-in of questionnaires by respondents and the collection of the filled-in questionnaire. For the pilot testing, I distributed 10 questionnaires to healthcare providers so as to check whether or not the information expected from informants was elicited adequately and unambiguously. At the end of this pilot testing stage, I had to adjust some questions in the questionnaire on the basis of their observations and print the final version of the questionnaire to be administered. The administration of questionnaire was done on a simple random sampling basis so that each healthcare provider in the healthcare centers had equal chances of participating in the study. The number of questionnaires in each healthcare centers was determined by the size of healthcare providers in the center. With the help of a healthcare provider in each center, I administered the questionnaires. Explanation of the purpose and contents of the questionnaire were given to each head of healthcare centers and also to healthcare providers and deadline for filling in questionnaire was set. I requested participants' informed consent for processing their responses and publishing the findings of the study. Questionnaires were filled in by healthcare providers and given back to the healthcare staff that I designated to collect the filled-in questionnaires. From time to time I contacted them to have information about the evolution of the filling in of questionnaires. Once the deadline was reached, the filled-in questionnaire were collected. As a whole, 520 questionnaires were recovered out of the 600 that was distributed in all the healthcare centers.
The processing of data was done in three stages, namely checking and validation, keying-in of information from the questionnaire and lastly editing of the keyed-in information.
Checking and validation of filled-in questionnaire
The 520 filled-in questionnaires were collected and the information provided by informants were checked. Questionnaires with were less than half-filled in were left aside. At the end of this checking activity, 487 questionnaires were retained.

Keying-in of information from the questionnaire
The information got from questionnaires were keyed in a template designed on the google form software. It is a survey administration software. In this study, this software has helped in data collection. Given the socioeconomic context of the Far-North Region and internet connection problems, almost all questionnaires were filled in manually. The information from questionnaires were keyed in a google form so as to keep the data in electronic form for easy manipulation. The data from the google form template were treated using SPSS 18.0 (Statistical Package for the Social Sciences) and Excel was used to draw diagrams which was used for quantitative analysis.

Editing and coding of the keyed-in information
The keyed-in information was finally edited and typographical errors were corrected in the database. After editing the data, I coded them so that the required information from the data base can easily be generated for data presentation and analysis. The coding of the data was done in three steps. The first step has consisted in extracting the data from the data base, reading through them; secondly, grouping the information provided and giving them labels; thirdly, assigning codes to each label. The codes were attributed respectively to items which fell under each label.

RESULTS

The results are presented in the following four subsections, namely religious barriers, cultural beliefs, practices, taboos and witchcraft, overdependence on traditional medicine, traditional doctors and soothsayers and exacerbated patriarchy.

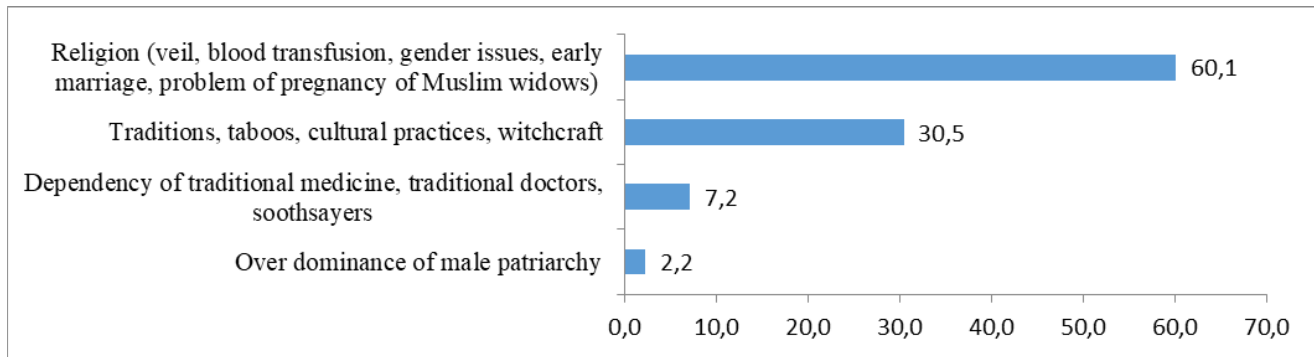

Fig. 2. Distribution of non-linguistic barriers to healthcare provision

Religious barriers are found to be the most significant non-linguistic barrier to healthcare provision in the Far-North region of Cameroon. Some practices associated to some religions and cultures constitute a hindrance to healthcare provision. As pointed out by an informant, "some patients refuse blood transfusion on religious grounds and also because of custom and tradition" (Nurse Mokolo 23). For instance, in the Jehovah Witness religion, blood transfusion is forbidden. Therefore, patients who are of Jehovah witness obedience do not accept to receive blood. This refusal can be nefarious to their health situation in case of extreme necessity during medical care. In addition to these, religion has been identified as a factor of discrimination in many healthcare centers in Far-North Cameroon: "Some Muslim patients would like to be attended to only by Muslim healthcare providers" (HR Maroua 65, nurse). This is concurred by another informant who points out that "in Kolofata, for instance, with the Kanuri people, if a healthcare provider is not Muslim, he cannot touch their wives" (Nurse, Doukoula A).

Such a preference might be accounted for by the fact that a patient of Islamic obedience is certain that a Muslim healthcare provider will abide by Muslim religious principles while administering care. However, due to the shortage of healthcare providers, it is not always obvious that healthcare providers of Muslim obedience will be available for Muslim patients. Furthermore, the faithful of some born again churches resort to prayers as a means of treating some diseases rather than receiving medical care. This point is buttressed by Nudelman et al (2018:3) when they point out that "for some Christian revival churches, the treatment is through prayers. Thus, the faithful can obtain a cure to HIV through their belief and confidence in God". Also, early marriage is very commonplace in the Muslim community in the Far-North regions of Cameroon. This practice has nefarious consequences on healthcare. Some of which are "physical and psychological problems (high-risk pregnancy and childbirth, physical illnesses, depression, and emotional distress" (Yoosefi Lebni 2023:1). It has been pointed out by respondents that in the Muslim religion, a woman should be pregnant only if she is married. It is therefore a taboo for an unmarried Muslim woman or Muslim widow to be pregnant unless she has got married after the death of her late husband. As a consequence, many of them commit abortion as they are ashamed to go for antenatal consultations and also of the reaction of members of the religious community.

In addition to these religious beliefs, the use of veil among Muslim women constitutes a hindrance to healthcare provision. Some Muslim women refuse to unveil during medical consultations and this might limit healthcare providers' physical examination of patients especially when the part of the body to be examined is veiled. The situation is more difficult with Muslim women who veil themselves completely as pointed out by a healthcare provider: "women who cover themselves from head to toe with veil (…) are difficult to handle during medical consultation" (Midwife, HR Maroua 1). This situation renders more difficult the work of healthcare providers. Furthermore, as indicated by a

healthcare provider, “some men prohibit their wives to be consulted by male healthcare providers” (CNPS 3, Care Assistant). This situation is very commonplace with patients of Islamic obedience. As a result, it is a common habit for Muslim women to refuse to be attended to by male healthcare providers, especially when their consultation will require that they are naked. Unless in the presence of their husband, they are reluctant to allow male healthcare providers to see their nudity. Similarly, “some patients refuse to be taken care of by female healthcare providers simply on the grounds that the healthcare provider is a woman” (Mokolo 52, midwife). It is worth mentioning that the reluctance to be naked in the presence of the healthcare providers also applies to some male patients. In fact, “some patients do not want to be naked in front of healthcare providers as they carry with them traditional devices/amulets” (care assistant, Guidiguis 15). It is worth stating that many healthcare providers who are not familiar with these religions and gender restrictions will face difficulties administering care to these patients.

In addition to religious barriers, cultural ones are the most important non-linguistic barriers to healthcare provision in Far-North Cameroon. Healthcare provision in the Far-North region of Cameroon is also hampered by cultural beliefs, practices, taboos and witchcraft. With regard to cultural beliefs, the cultural perceptions of the etiology and treatment of some diseases constitute a hindrance to access to modern healthcare. For instance, in some communities “mental diseases are considered as madness or devilish” (Mokolo 15, psychologist). As a consequence, local population will opt more for a traditional medicine treatment than for modern medicine so as to cure this disease. In addition to this, in some communities, the etiology of some diseases is explained by supernatural factors. For instance, the etiology of cholera which is scientifically a waterborne disease is not perceived as such. In such communities (e.g. Doualare, Maroua II) it is believed that “cholera is caused by punishment from ‘god’ ”. This belief is a blame on the patient for failing to please ‘god’. As a consequence, many villagers consult soothsayers who will direct them to perform rituals such as offering food to ‘god’ (commonly known in the local language as ‘sadaka’) to prevent and/or cure cholera; and thus, delaying seeking proper care at health facilities. (Ngwa et al 2017:3).

Moreover, some healthcare providers have noted that people of some communities reject some medical practices such as “the insertion of nasogastric tube, insertion of urinary catheter” (Mokolo 70, Nurse), use of “oxygen-therapy, amputation of body parts” (Medical Doctor, CNPS 13). This situation constitutes serious barriers to healthcare provision especially if healthcare providers do not have other alternative solution to the problem of the patient. Looking for alternative solution is time-consuming and consequently delays healthcare provision. Moreover, as mentioned by an informant, “there is a tendency for patients to get cured at home and only resort to hospital treatment when there are complications ” (Mokong 2, care assistant). In other words, many patients who abide by the above-mentioned restrictions first opt for traditional medicine and only go to healthcare centers when the traditional medicine treatment has not cured the disease and more often they arrive at the hospital when there are complications.

Overdependence on traditional medicine, traditional doctors and soothsayers, exacerbated patriachy

Far-North Cameroon population’s overreliance on traditional medicine, traditional doctors and soothsayers negatively impact healthcare provision. In fact, as a result of these cultural and supernatural beliefs, people in the community tend to resort to traditional treatment, consult soothsayers and native doctors or practice auto-medication so as to get cured of some diseases. Also, the adherence to cultural norms and practices can also be observed by women resorting to traditional birth practices rather than modern ones. Women prefer delivering their children at home with traditional attendants rather than doing it in a modern healthcare center. In the study carried out by

Nudelman et al (2018:4) a female participant explains how she put to bed as follows "I never go to the hospital for delivery. I do it like going to the toilet (squatting) and I deliver. Why is it important to go to the hospital? (woman, Guidiguis)". The cultural beliefs that people in some communities in the Far-North region have towards some diseases can also be perceived in their perception of pharmaceutical drugs. This is commented by Ngwa et al (2017:4) as follows:

Beliefs against pharmaceutical medicines: beliefs about the consequences of consuming pharmaceuticals and the healing power of traditional medicine hinders receptivity of public health messages: there is a belief that too much consumption of pharmaceutical products destroys human organs, reduces his life span, and leads to white hair, decreases fertility and increases premature aging. As such, traditional medicine is believed to be superior. In addition, there is rural-urban mentality confrontation and the former wins because the people have more confidence in traditional medicine, (FGD, men only group, Doualare, Maroua II) The overreliance of populations to traditional treatments is a serious impediment to healthcare provision in Far-North multicultural Cameroon. Many communities in the Far-North region of Cameroon are patriarchal. Patriarchy is "a form of social organization in which fathers or other males control the family, clan, tribe, or larger social unit, or a society organized in this way ". For Levy (2022) patriarchy literally translates as the "rule of the fathers" and is most commonly understood as a form of social organization in which cultural and institutional beliefs and patterns accept, support, and reproduce the domination of women and younger men by older or more powerful men. In many communities in Far-North Cameroon, patriarchy is exacerbated and men are extremely domineering. Women have to seek for the approval of their husband for whatever they want to do, even receiving healthcare. It is uncommon for women to receive healthcare without their husband consent no matter the gravity of the disease. As indicated by an informant, "a woman should get permission from her husband if she wants to go to the hospital for medical attention" (Mokolo 30, midwife). Failure to do so without the approval of their husband is considered as a sign of disrespect which is sanctioned by community norms.

Strategies to overcome non-linguistic barriers

A quantitative analysis of the data reveals that various strategies are used by healthcare providers in the Far-North region of Cameroon in order to overcome non-linguistic barriers, viz: informing, educating, communicating and counselling; familiarization of health care providers with the cultural practices of the community; being gender-sensitive as concerns the caring of patients; referring some patients to colleagues of other health centers; giving priority to female healthcare providers in women health services; recruiting healthcare providers who are natives of the locality in which the healthcare center is found; getting substitute products for blood during blood transfusion.

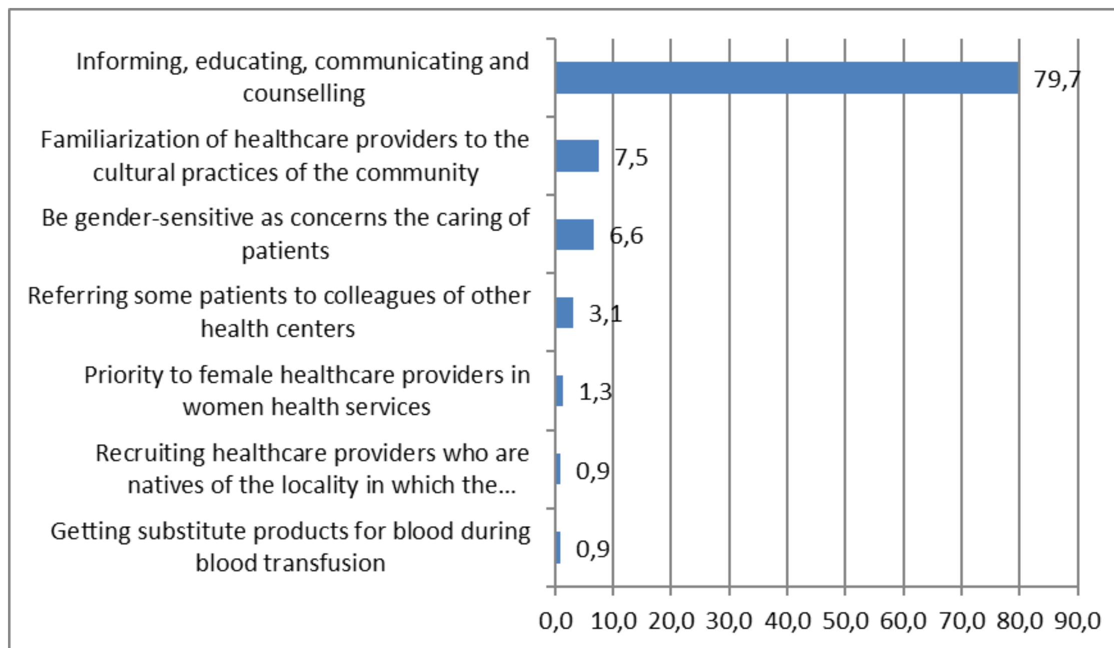

Fig. 3: Trends in overcoming non-linguistic barriers to healthcare provision in Far-North Cameroon health centers.

Informing, educating, communicating and counselling

The organisation of activities such as health awareness campaigns, workshops, seminars, etc. should be more and more recurrent so as to inform, educate and counsel populations about health issues. These activities can help them update their knowledge on health-related issues. Such events can help improve or change their beliefs about some diseases and provide them with additional benefits of modern healthcare practices. Communicative events can also be helpful in the fight against stigma and discrimination with regard to some patients suffering from some diseases (e.g.: AIDS), promote gender-equity in the communities and limit religious misconceptions with regard to health issues. Such initiatives should be encouraged by government authorities, local authorities, traditional authorities, quarter heads, religious and community leaders in order to increase the participation of populations. Efforts should also be made towards communicating about health issues in the various local languages of the region. Community radios should develop and broadcast health programmes in local languages so as enable official language illiterate populations to have access to health information. Community health relays should be trained during workshops and sent to remote communities so that they can sensitise populations who live in remote areas about health-related issues. NGOs who are concern with health issues should continue educating populations.

Familiarization of health care providers with the cultural practices of the community

As pointed out earlier, the Far-North region is one of the most multiculturally diverse areas in Cameroon. In order to develop efficient strategies to overcome cultural barriers, healthcare providers should acquaint themselves with the various cultural practices and beliefs of the community "by adapting to the realities of the field, by trying to be versed with the culture and religion of patients and more importantly by communicating with patients explaining to them the advantages of what healthcare providers are doing (Mokolo 21, CSI Minawao, Nurse). It is suggested by some researchers that "training and collaboration with traditional birth attendants could have a significant impact on maternal health (e.g. cf. Kayombo, 2013). This can also be done either individually or through

sensitisation. Nudelman (2018:6) underscores the benefit of healthcare providers' sensitisation when she points out that "health provider sensitisation is essential to enhance culture and gender sensitive health care".

Be gender-sensitive as concerns the caring of patients

Gender issues constitute an important barrier to healthcare provision in Far-North healthcare centers and dealing with them can be challenging to healthcare providers as revealed below:

We try to explain to the female patient that we do not have female healthcare provider to attend to her and we ask her to change her decision and accept to be attended to by male healthcare providers. Sometimes we lose female patients because we have only male healthcare providers and the female patient refuses to be attended to by male healthcare providers (HRMaroua, Physiotherapist)

Taking into account the socio-cultural realities of Far-North Cameroon, healthcare providers should be sensitive to gender-specific issues of the region in their daily practice while dealing with patients. For instance, healthcare providers and health center officials' awareness of the fact that many patients, especially Muslim ones, do not want to be attended to by healthcare providers of the opposite sex can help them anticipate on the measures which can be efficient in such situations.

Referring some patients to colleagues of other health centers

It is common practice for some healthcare providers who are neither familiar with the language nor with cultural practices of official language illiterate patients' community to refer these patients to colleagues of other healthcare centers who are more versed with the language and/or cultural practices of these patients.

Giving priority to female healthcare providers in women health services

In order to overcome-gender related barriers in women health services, the trends in many healthcare centers in the Far-North region is to give priority to female healthcare providers in this service. It has been found that many women, especially pregnant ones, prefer to receive healthcare in maternity ward dominated by or which comprise only female healthcare providers. It was pointed out by many healthcare providers that women healthcare's services such as maternity wards in which there are male healthcare providers were rarely visited by patients. A healthcare provider points out that in the healthcare center in which she is working, "to overcome the problem of female patients' preference of female healthcare providers to male healthcare providers during child delivery, only female healthcare providers have been posted to maternity ward" (CSDK 5, Maroua, Nurse). However, this situation will be very difficult to handle in healthcare centers which have very few female healthcare providers.

Recruiting healthcare providers who are natives of the locality in which the healthcare center is found

Given the multicultural diversity of the region and the necessity to overcome non-linguistic (e.g. cultural) barriers, it is important to make sure that some healthcare providers who hail from the locality in which the healthcare centers are found among the staff of the healthcare centers. It is assumed that healthcare providers who originate from the community in which the healthcare is found are very versed with the cultural beliefs and practices of people of the community and can therefore be better place to explain the behaviors of some patients to other healthcare providers of the healthcare center. These healthcare providers who are natives of the locality can act as intercultural mediators between patients and other healthcare providers. Intercultural mediators help to reduce cultural and even linguistic barriers in healthcare centers (Verrept 2019:6).

Getting substitute products for blood during blood transfusion

As discussed above, religious and cultural barriers are great impediments to healthcare provision. It is

found that some patients of some religious background (e.g. Jehovah Witnesses) because of the exigencies of their religion do not accept blood transfusion. Furthermore, as indicated by an informant, patient refuse blood transfusion because of cultural restrictions. These find illustration in the verbatim of an informant who notes that "some patients refuse blood transfusion on religious grounds and also because of custom and traditions" (Mokolo 23). Moreover, "people who accompany patients to hospitals refuse to donate them blood." (Mokolo 66, nurse). In order to overcome such problems, blood substitute can be an alternative for patients who are in need of blood. In the literature some benefits of blood substitute have been identified. It is found that "a suitable blood substitute would eliminate the need for cross matching, reduce risk of pathogen transmission, increase availability in remote regions and be storable for longer periods of time" (Jahr 2022:3).

DISCUSSION

Findings reveal that non-linguistic barriers constitute a serious impediment to healthcare provision in Far-North multiethnic Cameroon. These barriers are linked to religion, cultural practices and beliefs, taboos, witchcraft, overdependence on traditional medicine, traditional doctors and soothsayers and exacerbated patriarchy. In the literature of healthcare provision, "culture [and religion] have been identified as significant variable in how people experience, perceive, construct, and understand health" (Bennet 2015:4). As pointed out by Attum et al (2024) "cultural and religious background influence an individual's attitudes, behaviors, and beliefs toward health, illness, and the provision of healthcare may present obstacles to the healthcare this population receives. It is worth stressing the fact that these elements constitute barriers to healthcare provision due to the fact that the Far-North region of Cameroon is a multicultural diverse area and as a consequence is home to people with diverse cultural practices and beliefs which are not necessarily familiar to healthcare providers. In healthcare encounters, as pointed out by Bennett (2015:4), there are broadly generally two cultures, namely, the culture of medicine represented by the healthcare provider and that of the healthcare receiver representing the lay culture no matter whether or not both hail from the same nation.

The trend for healthcare providers is to consider the medicine culture superior to the lay culture. In addition to the medicine culture, healthcare providers as members of an ethnic group have also acquired the culture of their community which might not be the same as that of their patients. Taking into account the cultural and religious diversity of the Far-North region of Cameroon, it is argued that the response plan to overcome these non-linguistic barriers should incorporate intercultural communication. In fact, healthcare providers in these healthcare centers should acquire cultural competence. These cultural differences, if not well handled, are breeding grounds to conflicts and misunderstandings. Therefore, in addition to the current strategies used to overcome these barriers, it would be crucial for health authorities and healthcare providers in Cameroon to integrate in their response plan what Campinha-Bacote (2002) calls cultural competence which is obtained via cultural awareness, cultural knowledge, cultural skills and cultural desire. Their development of cultural competence will prevent them from imposing their beliefs, values, and patterns of behavior on another culture (patients' culture), thereby avoiding cultural imposition (cultural awareness), enable them obtain a sound education about the various health-related beliefs, practices and cultural values of the ethnic communities in Far-North Cameroon (cultural knowledge) and collect relevant cultural data about ethnic communities of the region (cultural skills), constantly interact with diverse cultural groups so as to refine or modify their existing beliefs about these cultural groups and prevent possible stereotyping (cultural encounters). Developing cultural competence will require from these healthcare providers some sort of motivation that will make them want to, rather than have to engage in the process of becoming culturally aware, culturally knowledgeable (cultural desire) Campinha-Bacote's (2002).

As pointed out by Care Rohini Anand and Indra Lahiri (2004:387) “a major challenge for today’s health care providers around most of the world is that culturally diverse groups comprise the largest growing segment of the patient population”. Furthermore, as the region with the highest level of illiteracy rate in the country, it comprises many official language illiterate patients. Such a situation does not facilitate interactions with healthcare providers and official language illiterate patients who do not necessarily share the same cultural and religious background. It is also noted that current trends in overcoming these barriers are more targeted on patients and populations than on healthcare providers. The imbalanced proportions provided in the diagram above are instructive in this respect: 79 % for informing, educating, communicating and counselling (patients and populations) Vs 7.5 % for familiarisation of healthcare providers with the cultural practices of the community.

According to the Office of Minority Services (2000:80865) intercultural competence, also commonly referred to as cultural competence, may (…) be defined as the ability to deliver “effective, understandable, and respectful care that is provided in a manner compatible with [patients’] cultural health beliefs and practices and preferred language”. In fact, “intercultural competence has emerged as a movement in healthcare and is accepted as an essential strategy to deal with cultural differences in healthcare in a proper manner” (Bennett 2015:6). It is worth pointing out that current trends to overcome cultural and religious barriers in healthcare in various parts of the world is to make healthcare providers culturally and religiously competent i.e. by providing them with religious and culturally relevant knowledge which will help them be culturally and religiously competent in healthcare provision across culturally and religiously diverse contexts (cf. Swihart et al 2023, Attum et al 2024). In order to be “interculturally competent in the delivery of healthcare, healthcare providers need to recognize and respect cultural differences and develop cultural knowledge”(Bennett 2015:6).

Healthcare authorities and healthcare providers in Cameroon in general and in the Far-North region in particular should align to this trend. Therefore, provision should be made by government and health authorities so that these healthcare providers acquaint themselves with various aspects of local culture so as to develop cultural knowledge and be sensitive to the specificities of religions practised in their community. As stated by Care Rohini Anand and Indra Lahiri (2009:388) “interculturally competent care is a necessity for successful patient outcomes”. An intercultural competent healthcare provider discusses with patients (via the interpreter) to arrive at the healthcare option that takes into consideration patients’ cultural and/or religious specificities while dealing with the health issue (medication, treatment plans, dietary restrictions, etc.). Another positive aspect of developing intercultural competence for healthcare providers is that it prevents them from developing medical ethnocentrism . Developing intercultural competence will be very instrumental for healthcare providers in overcoming cultural and religious barriers in Far-North Cameroon health care centers. This cultural and religious knowledge will help them not only to develop awareness in the trends concerning traditional medical practices and beliefs of indigenous populations but also provide them with insight into the taboos of some communities as well as the exacerbated patriarchal nature of the many communities in the region. These clues will certainly help them improve on healthcare provision to these underprivileged populations.

CONCLUSION

As a whole, the study has revealed that cultural and religious barriers hinder healthcare provision to official language illiterate patients in Far-North Cameroon healthcare centers. Current trends in overcoming these barriers include the following: informing, educating, communicating and counselling; familiarization of health care providers with the cultural practices of the community, being gender-sensitive as concerns the caring of patients, referring some patients to colleagues of other health centers, giving priority to female healthcare providers in women health services, recruiting

healthcare providers who are natives of the locality in which the healthcare center is found and getting substitute products for blood during blood transfusion. The findings have revealed that the majority of informants has suggested informing, educating, communicating and counselling patients and populations as main strategy to overcome non-linguistic barriers in healthcare provision in the Far-North Cameroon, but that is not enough and does not necessarily respect the religious and cultural diversity of the population. It is therefore argued that a more efficient approach will consist in including in the response plan Campinha-Bacote's (2002) five assumption of Cultural Competence of Healthcare Delivery. It is an intercultural competent model in healthcare which is very suitable for limiting barriers in culturally and religiously diverse contexts like the Far-North region of Cameroon. It is therefore suggested that provision be made to healthcare providers in Cameroon in general and in Far-North Cameroon in particular so that they become culturally competent through the acquisition of a cultural awareness, cultural knowledge and cultural skills of the various communities where they work and also strive to engage in cross-cultural encounters with their patients.

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