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## **Linguistic and Cultural Pitfalls of Patient-carer Communication in the Official Health Care Structures of North Cameroon<sup>1</sup>**

*Abstract:* North Cameroon displays nearly sixty local languages for an estimated 3,500,000 people. Such a multilingualism is offset by the use of a major trade language, Fulfulde or Fula (spoken by Fulbe or Fulani), which allows basic exchanges to take place in many settings. Owing to increased rates of school attendance, French has been taking on a greater but still limited role in interethnic communication. The question of language comes immediately to the fore in any medical consultation, yet there are also prior cultural factors in play which have a strong impact on the procedure.

*Keywords:* Cameroon, health, multilingualism, cross-cultural communication

### **1. The linguistic situation in the Far North of Cameroon**

The sociolinguistic situation in the region discussed here, North Cameroon, is remarkably complex. In 2010, nearly sixty local languages were spoken by an estimated 3,500,000 people (17.9% of the country's total population) in the Far North alone. Most of these languages pertain to the Central branch of the Chadic family. The sec-

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ond group is formed by Adamawa languages (a Niger-Congo family). Quantitatively less important are the Kanuri (Nilo-Saharan) and the Shuwa Arabic (Semitic) languages. In addition to these local languages, one finds a variety of other languages spoken by inhabitants native to other parts of the country and by foreigners, mostly Chadians and Nigerians. Cameroon also has two national languages, French and English. The Far North is in francophone territory, though there is a small minority of English speakers.

This omnipresent multilingualism is offset by the use of a major trade language, Fulfulde or Fula (spoken by Fulbe or Fulani), which allows basic exchanges to take place in many settings. Owing to increased rates of school attendance, French has been taking on a greater but still limited role in interethnic communication, though the local standard fluctuates and often diverges from the more widely used forms of the official language.

## **2. Where to go for medical consultation**

There are currently (2016) 3 regional hospitals, 29 provincial hospitals, 18 local medical centers and 359 health stations in the region.<sup>2</sup> Many of the latter are in fact underused because people hesitate to visit them. To improve this situation at least insofar as mother and child care is concerned, a project called “H4+” has recently been put into operation in seven of the region’s health care districts. It relies on community health agents, one of whose objectives is to get mothers to go regularly to the health stations.

On arrival, patients go to the administration desk of the hospital or other health center where they are asked to show their health book (if they do not have one, they must pay a fee to buy one), and their weight, height, age and blood pressure are recorded. They are asked the reason for their consultation and then oriented towards a member of the health care staff. After the visit, if tests are required, they are sent to a laboratory if one exists, and are invariably sent to the offi-

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cial pharmacist to buy any prescribed medicines. The patients must thus state their needs in three or four different contexts: to the administration, to the health care provider, to the pharmacist and, when applicable, to the laboratory personnel. Of these, the crucial phases are the administration and the consulting room since patients will go to the laboratory and the pharmacy with a prescription in hand which they can simply show without explanation.

### **3. Health care staff**

For the entire Far North, there are 80 doctors (equivalent to one for 45,000 people), and around 300 registered nurses, 30 midwives, 700 primary care aides and 30 laboratory technicians.

Health care providers, whatever their category, are generally called *doktor* locally, or one of the numerous phonetic variants of this word: *dofta*, *dokta*, *dokter*, *dopta*, *doptor* or *ndopta*. Wearing a white blouse earns a person this title and confers upon him the ensuing role functions. Most of the staff of the various types of health care centers are actually nurses, whose functions are practically those of a general physician, and aides who provide basic care. There is also maintenance staff whose job is to keep the premises clean.

Patients have been known to approach cleaning staff addressing them as “doctor” because they were inappropriately attired in a white blouse, and get medical prescriptions from them in the absence of qualified staff. Each category of carer is supposed to have a distinct uniform to avoid this kind of confusion but outsiders are not necessarily acquainted with this dress code and the prerogatives associated with each type of apparel.

## **4. The cultural factor in medical consultation**

### **4.1 Local notions of disease**

The question of language comes immediately to the fore in any medical consultation, yet there are also prior cultural factors in play which have a strong impact on the procedure. Indeed, from a biomedical standpoint, the causes of most diseases are clearly defined and include pathogenic germs (protozoa, bacteria, viruses, micro-

scopic fungi), risk-augmenting behavior (in food intake, sexual activity, etc.) and psychic disorders, all of which have scientifically proven effects.

The world as speakers of Fulfulde see it is quite different (Hampshire 2004: 658-659; Tourneux *et al.* 2007: 373-383). In the sphere of Fulani influence in North Cameroon, diseases are divided into two main classes: “worm diseases” (*nyawu marngu gildi*) and “wormless diseases” (*nyawu bilaa gildi*). One should not jump to the conclusion that “worm diseases” are those that are propagated by a vector and “wormless diseases” are non-transmissible. While diabetes and cataracts are indeed included among the wormless diseases, so are malaria, leprosy, cholera and mycotic affections though the latter four are biomedically vectorial.

Both of these major classes, worm and wormless diseases, can also be called “God’s diseases”. This label covers both ordinary diseases (those whose cause is thought to be known) and diseases with no known cause, the latter being part of the set of wormless diseases. God’s diseases are in turn set over against diseases caused by witchcraft or evil eye. These are called “hand” diseases (*nyawu junngo* – the hand being the witch’s), or “sent” or “aimed” diseases (*nyawu neldaangu*), whose “sender” is always a witch. These sent diseases are also a subset of wormless diseases. It should not therefore be concluded that all wormless diseases are sent by witchcraft, only that the witch chooses among them the ones he wants to send. Fever (*pabbooje*), dizziness (*giilol*), diarrhea (*doggere*) etc. are all sendable wormless diseases. This is also true of madness (*ginnawol*).

A final class, also a subset of wormless diseases, is that of diseases caused by jinns (*ginnaaji*, Tourneux 1999). These include nervous affections such as epilepsy and psychic disturbances.

#### **4.2 The setting for medical consultation**

The material surroundings of hospitals and health care centers make a strong impression on patients who are not always accustomed to setting foot in modern installations where they find unfamiliar smells and hear metal objects clink as they are laid on trays. They may be

nervous about entering a consulting room where they have no idea of what awaits them on the other side of the door.

Patients, whether alone or not, will avoid looking the “doctor” (man or woman) directly in the eyes and, even when they understand the questions asked, will be reluctant to reveal their mind and reply in the shortest possible way. They will be less reluctant, however, if the “doctor” speaks their language. The timidity of a woman patient will always be greater than a man’s, whatever the “doctor’s” gender. Many patients only turn to a health care center as a last resort when a traditional treatment, Islamic or otherwise, is already felt to have failed.

## **5. Medical consultation and the language factor**

### **5.1 Absence of verbal exchange**

In the worst, but far from the least frequent case, there is practically no verbal exchange between the patient and the care provider. This may be due to the nonexistence of a common language, further complicated by the lack of an interpreter. The consultation is then unfortunately akin to veterinary medicine.

### **5.2 Intervention of an interpreter**

Somewhat more favorable is the situation where there is no direct communication between patient and carer, but the patient has come with an interpreter (friend or relative) who translates the carer’s questions to the patient and the latter’s replies. The resulting limitations are nevertheless easily envisaged: the required confidentiality of the exchange is lacking and the patient cannot give frank expression to his feelings, thereby reducing the possibility of accurate diagnosis. There is a second risk, to which we will return below, namely that of incorrect translation.

### **5.3 Direct communication**

It may happen that patient and carer share a language: (a) a common first language, (b) a trade language or (c) French.

With increasing school attendance, more and more patients have had instruction in French about health and hygiene (Tchuenkam 2016). This introduces them to a biomedical vocabulary which is bound to conflict with what they hear at home in their everyday surroundings. There is however no guarantee that the either interlocutor in such case has a true command of any shared second language.

## 6. Diagnosis

The examples below are taken from instances where Fulfulde is spoken. The kind of situations observed will however be the same, *mutatis mutandis*, in any of the other languages spoken in the region.

### 6.1 The disease named or described by the patient in a local language corresponds to any of several biomedical conditions

A patient comes speaking of suffering from *pabbooje*. This is a plural noun derived from the verb *fabbugo* meaning ‘take, spend a long time’. Etymologically, the noun therefore properly means ‘things that last’. The patient may use it to designate any fever that lasts longer than a couple of days. Such a fever may result from any of a number of factors which often cannot be determined with certainty without laboratory analyses. Failing these, the diagnosis is almost automatically forthcoming as malaria. It could, however, easily be a typhoid or paratyphoid fever requiring a completely different, antibiotic treatment.

The term *pabbooje* is thus systematically taken to mean ‘malaria’ and a patient with this complaint will be treated accordingly. Here, the health care providers are themselves the ones who have restricted the word to this meaning.

### 6.2 The disease named or described by the patient in a local language is just a symptom of any of a range of possible diseases

Fulfulde has a word *sawoora* whose meaning is practically the same as French *jaunisse* ‘jaundice’. It refers to a set of symptoms, the primary ones being a yellow coloring of the sclerotic membrane and the urine. This may be a manifestation of hepatitis (whose forms are avowedly multiple), a bile duct condition or a kind of malaria.

Traditionally in French, *jaunisse* is spontaneously understood as involving a liver complaint. Bile duct problems as such do not come immediately to mind.

As the Fulani see it, *sawoora* is latently present in every individual. It can be activated or reactivated in specific triggering circumstances. This apparently leads us far away from the pathologies that biomedicine associates with these symptoms.

### **6.3 The disease named or described by the patient in a local language corresponds to nothing particular in biomedicine**

There is a Fulfulde term that patients often use, *caayoori*. This is a noun derived from the verb root *saay-* meaning ‘disappear without a trace’. *Caayoori* without qualification refers to a generalized internal condition which is believed to move constantly about the body and cause local ailments such as toothache, earache, sore throat, boils, etc. Its primary manifestation is a feeling of heat and pain in one organ or one (internal or external) part of the body or another. Excessive cold, like excessive heat, will bring *caayoori* out of dormancy. It can appear on the outer surface of the body as swelling or even boils. Some traditional healers take *caayoori* to be an allergic reaction to eating catfish (*Clarias*). Others attribute it to “worms” that circulate inside the body.

This word is systematically translated into French as ‘inflammation’. According to Quevauvilliers *et al.* (2007 :481), inflammation is a “set of reactions that occur in the organism in response to irritation or aggression by one or more factors. These reactions are characterized primarily [...] by four symptoms: reddening, tumors, heat and pain”.

It is thus evident that ‘inflammation’ as a translation of *caayoori* inaccurately captures the sense of the notion in Fulfulde.

Another case in which local and biomedical notions are at odds is when an affection is thought to be caused by witchcraft or occult forces. Let us take the case of *garsa* which, according to D. Noye (1989:132b) is a “[...] generalized weakness in a small child caused by its being made the object of too much attention from other people”. The word probably originates from Tamasheq: in Jeffrey

Heath's 2006 *Dictionnaire touareg du Mali*, we indeed find "[gàrsha] mauvais œil, mauvaise langue". The condition is caused by being looked at too tenderly (*gite gidooje*) or too insistently. Worse even than general weakness, this disease can cause crippling. It appears initially in the eyes without causing either rheum or redness (though interviewees' opinions may vary on these two points). Rarely, this nonfatal disease may affect adults causing paralysis of the legs. There are many charms for protecting babies from this affection. Kohl can also be used to draw a small black line between the eyebrows. In the health centers, the tendency is to restrict the meaning of this word to "conjunctivitis". There are however later stages of the disease which affect (1) the neck, the mouth and the tongue and (2) the bones. In (1), the body parts involved are deformed (the neck becomes twisted) while (2) causes sporadic pain in the bones.

One does not need to be a doctor to see that the symptoms attributed to *garsa* might originate from any of a variety of pathologies. In any case, for those who diagnose *garsa*, it is clear that this is not the kind of pathology that can be successfully treated by biomedicine. A suitable solution can only come from traditional medicine.

#### **6.4 The patient cites a French name for his affection and communicates in French with the care provider.**

When the parties communicate in an official language (here French), both the patient and the care provider will tend to incorporate traditional notions into biomedical terminology. All the observations made in above examples apply here as well. Thus, when a patient speaks of "malaria", he has *pabbooje* as his underlying conception.

### **7. Implications of the existing situation**

#### **7.1 For national and international health programs**

What then are the implications of this situation in terms of communication, both within the framework of national and international health programs and, on the ground in the villages and the quarters of larger towns, for hospitals and health care centers?

Nurses, health care aides and community health agents are quick to adopt a biomedical terminology that they have not necessarily mastered fully. They may well try to make it jibe with local notions, thus giving rise to an uncertain syncretic mode of thought.

Sectorialized projects (AIDS, tuberculosis, cholera, malaria, mother and child protection, etc.) come along one after another, but the time devoted to training the agents who are to carry them out is often insufficient. It is also rare that agents' knowledge at the end of a training program be evaluated.

We have had occasion to speak with a community agent who is taking part in the H4+ project and can be recognized from the fact that he rides a blue bicycle marked UNICEF. He told us his job was to spot "undernourished children" over the different parts of town. As he saw it, since undernourished children did not get enough to eat, any children who were thin were undernourished. This erroneous notion may well be without untoward consequences for the children identified as undernourished since the community agent is not himself responsible for the final diagnosis; this is rather the task of the staff of the health care centers. Still, the mother of the child involved is likely to feel herself to be stigmatized for not feeding her child well, and this may lead her to mistrust public health services in general.

## **7.2 How the situation can be improved**

How can specialists in intercultural communication help to improve the quality of communication? Will it be enough, for example, to assign interpreters to work with health care providers? How can the level of distortion between the intended message, the message as it is expressed, and the message as it is perceived be minimized?

First of all, we suggest that all actions of mass communication be preplanned to take account of local notions, whether they be expressed in French or in local languages. Word-for-word translations of documents published by the WHO or other agencies must be avoided. With foresight, the communicational gap between patients and health care providers can be progressively reduced by creation of

a common language that will correspond even better to reality than the one learned at school.

There are many but not countless widespread pathologies. It would therefore be extremely helpful to have written information on each of them in a variety of languages, two at least. Such documents could then be used as a basis for radio and television broadcasts for the general public. We have tried to apply this procedure by drafting a guide to communication on HIV infection (Tourneux *et al.* 2011) in two French and two Fulfulde versions, standard and simplified in each language.

The list of subjects that require this kind of treatment can easily be established: malaria, tuberculosis, cholera, intestinal parasites, diabetes, pregnancy, child nutrition, and so on.

### **7.3 What are the implications for training health care personnel (doctors and nurses)?**

We feel that this situation, which is far from specific to just one part of Cameroon, should be taken up as part of the curriculum in schools of medicine and nursing. There should be more initiatives like the Darrah & Froude's (1975) manual of Hausa medicine for Western doctors. It will be enough to aim such manuals not just at Western doctors but at everyone who gets medical training in a non-African language (English, French, Spanish, Portuguese, Arabic, etc.).

While an acquaintance with local medical notions is indispensable, attention must also be focused on gaps in local knowledge: there is indeed "the importance of knowing about not knowing" as Murray Last (1981) remarked. We may refer here to an instance of nonmedical biology which nonetheless provides a good illustration of our point. For the peasants of North Cameroon, there are no aphids. What entomologists designate by this term are for them "caterpillar eggs". Obviously, for as long as one remains unaware of the existence of something, one cannot be concerned with or by it.

### **References:**

- Bouvier S., 1999, "Du ventre à la tête. A propos de quelques maladies ordinaires à Timba, Fouta-Djalón", in: Y. Jaffré, J.-P. Olivier de Sardan (dir.), *La Construction sociale des maladies: Les entités nosologiques populaires en Afrique de l'Ouest*, Paris: PUF (Les Champs de la santé).
- Darrah, A. et Froude, J., 1975, *Hausa medicine for Western doctors*, Mimeographed booklet, Zaria: Ahmadu Bello University.
- Feierman, S. et Janzen, J. M. (eds.), *The Social Basis of Health and Healing in Africa, Comparative studies of health systems and medical care*, Berkeley-Los Angeles-Oxford: University of California Press.
- Hampshire, K. R., 2004, "Fulani", in: Carol R. Ember et M. Ember (eds.), *Encyclopedia of Medical Anthropology Health and Illness in the World's Cultures, vol. II: Cultures*, New York-Boston-Dordrecht-London-Moscow: Kluwer Academic/ Plenum Publishers.
- Jaffré, Y. et Olivier de Sardan, J.-P. (dir.), 1999, *La Construction sociale des maladies : Les entités nosologiques populaires en Afrique de l'Ouest*, Paris: PUF (Les Champs de la santé).
- Last, M., 1981, "The importance of knowing about not knowing", *Social Science & Medicine. Part B: Medical Anthropology*, 15 (3), 387-392.
- Last, M., 1992, "The importance of knowing about not knowing: Observations from Hausaland", in: S. Feierman et J.M. Janzen (éd.), *The Social Basis of Health and Healing in Africa, Comparative studies of health systems and medical care*, Berkeley-Los Angeles-Oxford: University of California Press.
- Noye, D., 1989, *Dictionnaire foulfouldé-français*, Garoua: Procure des Missions, Paris: P. Geuthner.
- Quevauvilliers, J., Somogyl A. et Fingerhut A., 2007, *Dictionnaire médical*, Paris: Masson.
- Le Marcis F., 1999, "Keefi, une maladie peule", in: Y. Jaffré et J.-P. Olivier de Sardan (dir.), *La Construction sociale des maladies: Les entités nosologiques populaires en Afrique de l'Ouest*, Paris: PUF (Les Champs de la santé).

- Tantchou, J., 2010, “Personnels de santé et discours sur le sida”, in: H. Tourneux et L. Métangmo-Tatou (dir.), *Parler du sida au Nord-Cameroun*, Paris: Karthala.
- Tchuenkam, M., 2017, *L’analyse des discours sur la santé dans les manuels scolaires de sciences et d’éducation à la citoyenneté au Cameroun*, Thèse de Doctorat/Ph.D., Université de Maroua.
- Tourneux, H., 1999, “Les animaux supports de génies chez les Peuls du Diamaré”, in: C. Baroin et J. Boutrais (eds.), *L’homme et l’animal dans le bassin du lac Tchad*, Paris: Éditions IRD.
- Tourneux H., avec la collaboration de Boubakary A., Hadidja K. et Fakh O., 2007, *Dictionnaire peul du corps et de la santé (Diamaré, Cameroun)*, Paris: OIF/Karthala.
- Tourneux H., 2010, “Traditional healing of fevers as practiced by the Fulani of Northern Cameroon”, *Folia Orientalia* 45-46, 331-340.
- Tourneux H., Boubakary A., Hadidja K., 2011, *Communiquer en Afrique sur l’infection par le VIH, français-fulfulde*, Marseille: IRD Éditions.
- Tourneux H. et Métangmo-Tatou L. (dir.), 2010, *Parler du sida au Nord-Cameroun*, Paris: Karthala.