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Healthcare Providers' Views on the Teaching of Home Languages in Medical Schools in Cameroon as a Means of Overcoming Language Barriers Between Health Care Providers and Patients Who Do not Speak Official Language(s): Torn Between Sociolinguistic Reality, Pedagogic Necessity and Language Policy

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Abstract

Using data from questionnaires administered to 487 health care providers from 45 health centers in the Far North Region of Cameroon, this paper explores the views of health care providers on the teaching of home languages1[1] in medical schools as a way of limiting communication barriers between health care providers and patients who are not proficient in the official language(s). The work is discussed in the light of Postcolonial Linguistics (Warnke, 2017; Makoni et al., 2023) and the data are analysed both quantitatively and qualitatively. The findings show that although the majority of healthcare providers (74%) have positive views of home language teaching in medical schools, a smaller proportion (26%) have negative views of home language teaching in such institutions. Positive views are justified by the fact that teaching these languages will facilitate communication between healthcare providers and patients who do not speak official languages [2] (French and English), strengthen trust between patients and healthcare providers and improve the performance and quality of healthcare provided by healthcare providers, contribute to the preservation of native languages, diversify healthcare providers' knowledge of native languages and strengthen national integration, and limit the presence of intermediaries in the interaction between patients and healthcare providers and contribute to the preservation of medical confidentiality. Negative views are based on the difficulties of teaching the more than 200 Cameroon home languages, the heavy workload of medical students, the possibility for health care providers to learn home languages informally in the community where they work, the need to limit home language teaching to primary, secondary and high schools, and the non-availability of didactic materials for teaching Cameroonian home languages. The paper argues for the empowerment of home languages in the medical domain in Cameroon in general and for their teaching in medical schools in particular.

Key words: Healthcare providers; Teaching; Home languages; Medical schools; Medical training schools

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[1] Languages used to interact with other family members for everyday interactions at home (Neokleous, Park, & Krulatz, 2020, p.19). They are often referred to as first language, mother tongues. They are different from official languages (English and French) which are used to conduct the affairs of the State (administration, judiciary, education, etc.).

[2] French and English are the two official languages of the Repubic of Cameroon. According to the language policy of the country, these are the languages used for teaching in the educational system of the country from nursery, primary, secondary, high school and in the tertiary level of education as well as in training schools (eg. medical schools). They are also taught as subjects in these schools. It was in 2011 that the State of Cameroon launched the teaching and promotion of national/home languages and cultures in the teachers' training schools. (Nkenlifack, et al, 2011). Since then home languages have been being timidly taught in primary, secondary and high schools but not in training schools (e.g. medical schools).

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1. INTRODUCTION

The impact of language barriers on healthcare has been extensively discussed (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; Röysky, 2015; Qanbar and Saqer, 2019; Hunter-Adams and Rother, 2017; Narayan, 2013; Van Rosse, et al, 2015; Kamwendo, 2004). There are various strategies that can be employed to overcome language barriers. One strategy which is advocated for multilingual African contexts (e.g. Nigeria and South Africa) consists in incorporating home language teaching in the training of healthcare providers (cf. Olajuyin, et al, 2022; Hamad, 2023). However, there is no consensus among healthcare providers on the efficiency of the implementation of this strategy to overcome language barriers in healthcare centers in Africa. This is due to the multilingual and multicultural situation in many African countries, official language policies and the state of development of many African languages. Language barriers are a common problem in healthcare centers in Cameroon, especially in the Far North Region, where the rate of illiteracy[3] is the highest in the country. As a result, many patients who are illiterate in official languages face significant challenges in communicating with healthcare providers. These providers have been trained in French and/or English which are European languages adopted as the country's official language through colonisation. Additionally, up to date, there is no room for the teaching of home languages in these medical schools. We must therefore ask ourselves whether the teaching of home languages in medical schools in Cameroon can overcome language barriers between healthcare providers and official language illiterate patients. This paper will investigate healthcare providers' views about the teaching of Cameroon home languages in medical schools as a means of limiting language barriers between healthcare providers and patients who are not proficient in the official languages of the country.

It is clear that healthcare providers' training in medical schools in western countries relies on their mother tongues as the primary language of instruction. In contrast, their training in many African countries still relies almost completely on European languages and pay little or no attention to the teaching and learning of African home languages. In other words, the training of healthcare providers in African countries is confined to English, French, Spanish and Portuguese (cf. Hamad, 2023) and Africans have become accustomed to this situation. Indeed, most medical students and faculty members in medical schools have come to prefer English as the language of instruction for medical education. They do not believe that teaching medicine in Arabic should be sought as a future goal (Alrajhi, et al, 2019). This situation does not render efficient healthcare providers' communication with patients. After all, these providers will not administer care in the patient's home language(s). It is crucial to highlight that incorporating indigenous language training into the medical school curriculum in many African countries is essential to overcome language barriers in clinical practice (Olajuyin, et al, 2022). It is clear that healthcare providers' lack of communicative abilities in Afrikaans (35.3%) and Xhosa (67.2%) represents a significant barrier to patient communication, as medical students in South Africa have identified (Mohamed, 2019). This underscores the urgent need to decolonise medical education in African countries (Hamad, 2023).

[3] The North and Far-North regions of Cameroon have the highest illiteracy rates in the country. Only half of school-age children are actually educated. In the Northern Province and Adamawa, the rates are even higher (60% in Adamawa, 68% in the North Province and 76% in the Far North Province) (Cameroonian-Canadian Foundation, 2022) (https://camerooniancanadianfoundation.org/our-work/education/building-schools-incameroon/#:~:text=The%20northern%20and%20far%20northern,North%20Province)%20%5B1%5D)

2. METHOD

The data analysand for this paper were drawn from the research project on language and healthcare provision in Far-North Cameroon that I carried out at the Netherlands Institute for Advanced Studies in the Humanities and Social Sciences within the framework of a 2023-2024 individual research grant. This section provides detailed information about the research sites, research population, instrument of data collection, method of data presentation and analysis.

2.1 Research sites

The data collection process was conducted in forty-five healthcare centers across the six divisions of the Far-North Region of Cameroon (Diamare, Mayo-Kani, Mayo-Danay, Logone-et-Chari, Mayo-Sava and Mayo-Tsanaga). The healthcare centers comprise both rural and urban ones, government and private. Also the criterion of patients' demographics was considered in the choice of these healthcare centers: It was deemed necessary to include both referral hospitals where patients' turn out is very high and non-referral ones where patients' turn out is relatively low. So, for data representativeness, a balance was stricken between geographical, demographic and government – private criteria. Prior to the data collection activity, which took place from 22 June to 1 September 2023, the Regional Delegate of Health of the Far-North Region granted the research authorization. More details on the research sites are presented below (cf. Table 1).

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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.

2.2 Research population

A total of 487 informants (healthcare providers) were selected on a simple random sampling basis to participate in the study. This research population is very diversified and comprises healthcare providers of various occupations, including 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 majority of informants (91%) received their medical training in French, while 9% were trained in English. Fig. 1 shows the distribution of these informants by occupation.

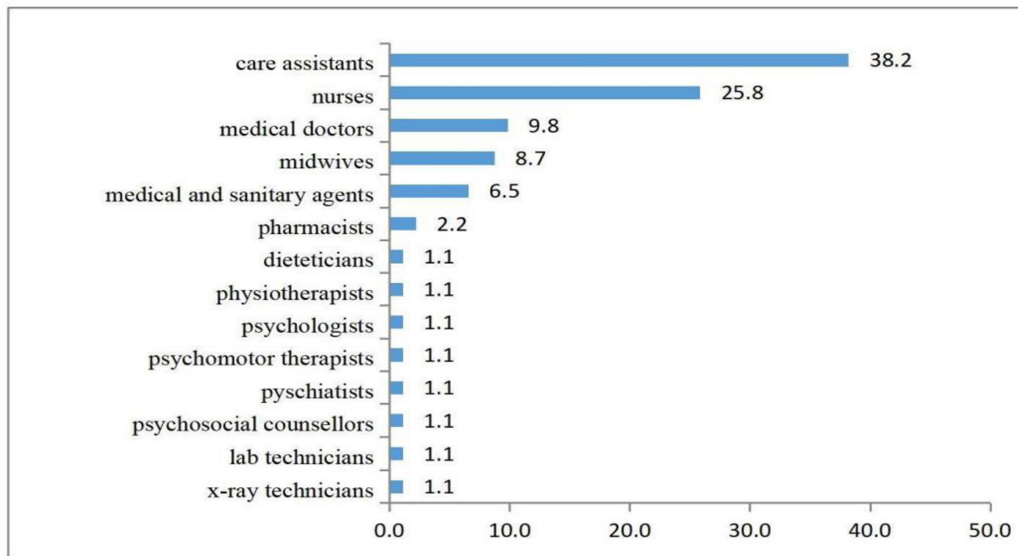

Figure 1
Distribution of proportion of informants per occupation

The age range of informants is between 20 and 50+. To be precise, the age range is as follows: 20-25 years (16.8 %), 25-30 years (30.2 %), 30-35 years (28.5 %), 35-40 (8.3 %), 40-45 (14.5 %), 45-50 (0.4 %), 50 and above (1.3 %). The most significant proportion is relatively young, with a gender distribution that is almost balanced. In fact, 50.1 % are male and 49.9 % are female. As for their religious affiliation, 25 % are Muslims, 74.8 % are Christians and 0.2 % are animists. The number of years of service is between less than one year and 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+ (3.2 %). The following details about the term of service in the Far-North Region 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+ (2.1 %).

2.3 Research instrument and data collection

The data were collected via a 28-item questionnaire structured as follows: Part I: Demographic information, Part II: Communicating with patients and Part III: Assessing communication strategies (cf. the appended questionnaire). In Part I, we elicited informants' demographic information such as health district, health center, sex, age ranges, religion, profession/rank/function and longevity in the profession. Part II gathers information about healthcare providers' first official language, their language of training, the languages they speak, the home languages of the Far-North Region they speak, if any; their number of years of service in the Far-North region, their familiarity or lack thereof with the official language, and so on. We also consider the estimated frequency of attendance to language illiterate patients, their verbal repertoire, the languages of the Far-North region and the strategies they make use of in order to overcome linguistic barriers. Part III looks at the current strategies used to overcome linguistic and non-linguistic barriers to healthcare provision. It also covers the presence or absence of professional interpreters in health centers, as well as the views of those working in the centers about the necessity or otherwise of training home

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language healthcare interpreters to overcome language barriers in healthcare. Finally, it inquires about strategies to overcome language barriers between official language non-proficient patients and healthcare providers in Far-North Cameroon healthcare centers.

The data collection process was carried out in three clear steps: pilot testing of the questionnaire, administration of the questionnaire, and collection of the filled-in questionnaires. For the pilot testing, I distributed 10 questionnaires to healthcare providers in 5 healthcare centers each to ensure that the information expected from informants was elicited adequately and unambiguously. Once the pilot testing stage was complete, I made adjustments to the questionnaire based on my observations and printed the final version to be administered. I used simple random sampling to ensure that each healthcare provider in the healthcare centers had an equal chance of participating in the study. The number of questionnaires in each healthcare center was determined by the size of the healthcare providers in that center. I administered the questionnaires with the help of a healthcare provider in each center. I explained the purpose and contents of the questionnaire to each head of healthcare centers and also to healthcare providers, and set a deadline for filling in the questionnaire. I requested participants' informed consent for processing their responses and publishing the findings of the study. The healthcare providers filled in the questionnaires and handed them back to the healthcare staff I had designated to collect them. I contacted them from time to time to find out how many questionnaires had been completed. Once the deadline had passed, I collected the completed questionnaires. In total, 520 questionnaires were recovered out of the 600 that were distributed across all the healthcare centers.

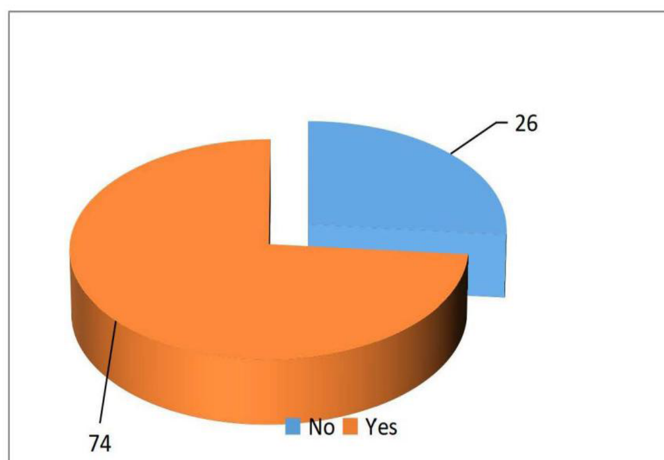
2.4 Data processing

The data was processed in three stages: checking and validation, keying in the information from the questionnaire, and editing the keyed-in information. After the checking activity, 487 questionnaires were retained. The information from the questionnaires was keyed in a template designed on the Google Form software. This is survey administration software. In this study, this software helped with 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 the questionnaires was keyed in a Google form to keep the data in electronic form for easy manipulation. The data from the Google form template was treated using SPSS 18.0 (Statistical Package for the Social Sciences) and Excel was used to draw diagrams 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 it so that the required information from the database can easily be generated for data presentation and analysis. The coding of the data was done in three steps. First, I extracted the data from the database, read through it, and grouped the information provided. I then assigned codes to each label. The paper draws on insights from Postcolonial Linguistics, specifically Warnke (2017) and Makoni et al (2023). This theoretical paradigm focuses "on how language is and was integral to the colonial matrix of power and the orders of knowledge in the postcolonial era (Warnke 2017) as well as the "problems connected to the management of multilingualism by postcolonial elites or the ways in which former colonial powers have used […] language to legitimize continued influence" (Heller 2010, p.105 as quoted by Makoni et al 2023:487). This theoretical backdrop aligns with the view which advocates for a status planning of languages in multilingual Africa by empowering the functionality of home languages in various domains in postcolonial Africa.

3. RESULTS



26. Do you think that the State of Cameroon should make the teaching of some mostly spoken home languages a component in the training of healthcare providers in Cameroon?

Figure 2
Healthcare providers' estimated proportion of official language illiterate patients

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The diagram above (cf. Fig.1) shows that a significant proportion of healthcare providers (74 per cent) are in favour of the teaching home language in medical schools in Cameroon, while 26 percent of informants are not in favour of this. The figures below provide reasons for these views.

■**Positive views**

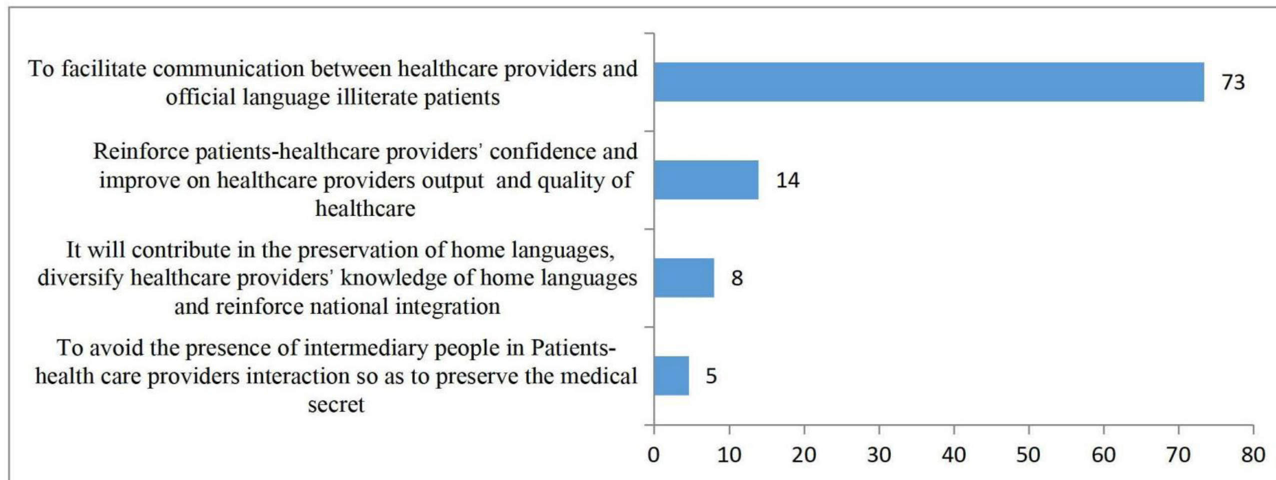

Figure 3
Healthcare providers' positive views about the teaching of Cameroon home languages in medical schools

-To facilitate communication between healthcare providers and official language illiterate patients

A significant proportion of informants' positive views towards the teaching of Cameroon home languages in medical schools is supported by the argument that this teaching will facilitate communication between healthcare providers and patients who are not proficient in the official languages. As an informant rightly pointed out, teaching home languages in medical schools will equip medical students with the skills they need to communicate effectively with patients who do not understand official languages. Furthermore, if healthcare providers can communicate in the patients' home languages, it will significantly reduce the need for interpreting, as they will be able to communicate directly with patients without the need of an interpreter. Teaching home languages in medical schools in Cameroon will undoubtedly increase the verbal repertoire of medical students, thereby limiting language barriers with official language non-proficient patients. The choice of the home language to teach in these schools should be made either on the basis of a need analysis in each region of the country or following the geographical distribution of languages in each region.

- Reinforce patients-healthcare providers' trust and improve on healthcare providers' output and quality of healthcare

Teaching home languages in medical training schools in Cameroon is essential for medical school students. It will enable them to develop fluency in those languages and facilitate communication with patients who are not proficient in official languages. It will also contribute to establishing trust between healthcare providers and patients. In fact, "communicating with a patient in his/her home language is more reliable and helps establish trust" (Mokolo 95, Nurse). It is clear that healthcare providers' communication in the patients' home language(s) creates familiarity between the two and is conducive to the development of trust between both parties. This established trust has positive outcomes on healthcare providers' output as well as on the quality of healthcare. Mutual intelligibility between both parties facilitates the diagnostics of patients and limits medical errors linked to language barriers. Furthermore, communicating in patients' home languages helps to "avoid the leaking of information concerning the health situation of patients" (Guidiguis 45, medical and sanitary technician). When there is no intermediary between both parties, the probability of divulging information about the patient situation is very limited.

- It will contribute to the preservation of home languages, diversify healthcare providers' knowledge of home languages and reinforce national integration

In addition to facilitating communication between healthcare providers and non-proficient official language patients, establishing trust between patients and providers, and limiting communication barriers, the teaching of Cameroon home languages in medical schools will contribute to the preservation of Cameroon home languages, diversify healthcare providers' knowledge of home languages and reinforce national integration. As an informant stated, "the preservation of our home languages will be achieved through the integration of our home languages in the training (Moutourwa 18, medical doctor). It is crucial to acknowledge that with the advent of globalization, many African languages, including Cameroonian home languages, are increasingly

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neglected for European languages due to the lack of instrumental motivation associated with these languages as compared to foreign ones, such as English, French, and Chinese. Cameroonians clearly prefer to learn foreign languages such as English, French, Chinese, etc. over Cameroonian home languages. This is because the knowledge of these foreign languages offers numerous opportunities and advantages on the job market. As a result, home languages are being forgotten, and some are even on the brink of extinction. The teaching of home languages in Cameroonians' training schools in general and in medical schools in particular will increase the value of these languages, enrich the linguistic repertoires of medical students so that they are proficient at least in one Cameroonian vehicular language. The teaching and learning of home languages in medical schools in Cameroon will undoubtedly contribute to the reinforcement of national integration.

- To avoid the presence of intermediaries in patients' healthcare interactions so as to preserve the medical secret

The more healthcare providers are proficient in their patients' home languages, the less they seek the help of health interpreters. In other words, when providers can communicate in the home language of the non-proficient official language patients, there is no need to get the help of interpreters. As indicated by a healthcare provider "there will be no need to train interpreters who will be intruders in the domain of health" (CNPS 9, Lab technician). This will be very positive for health care providers who have negative views towards the practice of interpreting in healthcare in these healthcare centers, as it is carried out by untrained interpreters. Providers' communicative skills in the patients' home language "will prevent the leaking of information about patients' illnesses, create confidence between healthcare providers and patients" (Mokolo 27, Nurse). Furthermore, it was noted that the presence of a non-medical staff member during medical encounters leads to patients being reluctant to open up. Moreover, it has been noted that in these healthcare centers, there is a shortage of ad hoc interpreters in the patients' home language and interpreting by healthcare providers is sometimes considered by them as a disturbing and time-consuming activity which delays the communication of information from healthcare providers to patients and vice versa during interpreting.

It therefore goes without saying that a significant proportion of healthcare providers (76 per cent) express the view that teaching home languages in medical schools in Cameroon will help to limit language barriers between healthcare providers and official language non-proficient patients. However, there is a less significant proportion who are very pessimistic about the necessity of teaching these home languages in medical schools in Cameroon for various reasons.

■Negative views

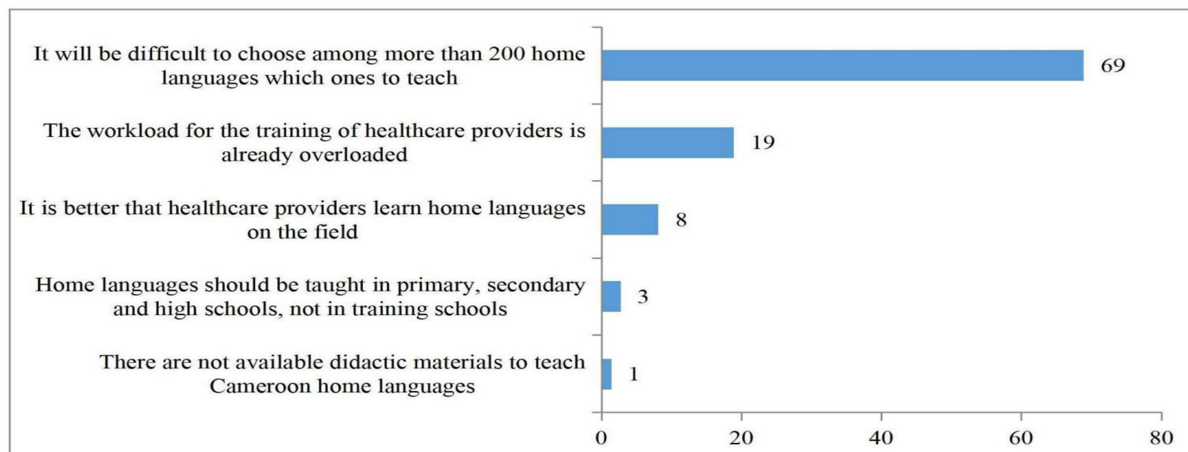

Figure 4
Healthcare providers' negative views about the teaching of Cameroon home languages in medical schools

-It will be difficult to choose among more than 200 home languages which ones to teach

As shown in the diagram above (see Figure 4 above), one of the reasons given by health care providers to explain their pessimism about the teaching of Cameroonian home languages in medical schools is the large number of home languages attested in Cameroon. As one healthcare provider pointed out, "there are too many home languages attested in Cameroon and each tribe would like their language to be taught in those schools (HR Maroua 65, Nurse) and "…failure to teach a language will constitute a problem (HR Maroua 67). In fact, there are 247 home languages (Echu, 2004) in Cameroon and, according to the respondents, it will be very difficult to implement the teaching of all these languages in medical schools due to various factors, namely their large number, which will therefore require a lot of human resources (trained teachers), financial resources (recruiting and paying more teachers), pedagogical and didactic resources (producing textbooks

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for learning all these mother tongues) in a context of scarce financial, human and material resources. Another factor mentioned by the informants to explain this pessimism is the criteria for selecting the languages to be taught. As one informant put it, "...which ones to choose as all home languages are equal?" (Mokolo 43, nurse). Another reason given by informants to account for their negative views on the teaching of these home languages in medical schools in Cameroon is the fact that there is not necessarily a correspondence between the mother tongue(s) studied in medical school and the place in the country where the medical school graduate will work as a health care provider. For these reasons, some informants reject the idea of teaching home languages and instead suggest that "the posting of healthcare providers should be done on the basis of their home language. For instance, a Guiziga healthcare provider should be posted in a healthcare center of the Guiziga community (Moutourwa 10, Lab technician). They also point out that the "training of interpreters so as to overcome such types of difficulties are sufficient (HR Maroua 11, Care Assistant).

-The workload for training health care providers is already overloaded

In addition to the above mentioned reasons, some health care providers justify their pessimism about the teaching of home languages in Cameroonian medical schools as a means of reducing language barriers between health care providers and patients who do not speak the official language by the fact that the workload in medical school is already very heavy. As one informant said, "There are already too many courses in the training of doctors. It will be unbearable. It would be better to train interpreters in health centers to overcome these language barriers". (CNPS 13, Medical doctor). As a result, adding more courses to the workload of training health professionals will make training more tedious and difficult for medical students.

-It is better for health workers to learn local languages in the field

Many health care providers do not value the importance of teaching native languages in medical schools in Cameroon, preferring instead that health care providers working in a context of high official language illiteracy learn informally the native languages of the community in which they work. As one informant said, 'depending on the situation, local languages can be learned on the field' (Clinique du Sahel 1, Medical doctor). This view also points to the value or importance that many Cameroonians in general, and health workers in particular, attach to the teaching and learning of Cameroonian home languages. To paraphrase this viewpoint, there is no point in teaching Cameroonian home languages, just as there is no point in teaching them in medical schools. In other words, there are more important subjects to teach in medical schools than Cameroonian home languages. Consequently, health workers should learn them in the community during their practice.

-Home languages should be taught in primary, secondary and high schools, not in training colleges

Many Cameroonians do not really see the importance of teaching and learning Cameroonian home languages. This may be reflected in some health providers' perceptions of the teaching of these languages. According to many health care providers, the teaching of Cameroonian home languages should be limited to primary, secondary and high schools. According to them, home languages should not be taught at tertiary level in Cameroon, let alone in medical schools. In other words, home languages are so meaningless that they do not deserve to be taught in either tertiary institutions or training schools in Cameroon. Their teaching and learning should be confined to the lower levels of education. Some even go so far as to say that even if it is taught, "there will be no consideration for home language teachers in medical schools" (CMK 6, Nurse) because it is "a waste of time" (CMK 8, Nurse).

- There are no didactic materials for the teaching of Cameroonian home languages

The non-availability or scarcity of didactic materials for teaching these home languages is another reason given by health care providers to explain their pessimistic view. As explicitly stated by one informant, "there are no didactic materials available to teach these home languages, healthcare providers can easily learn these mother tongues in their station (the area where they work)" (Fotokol A, psychiatrist). If it is true that there is a problem with the development and availability of didactic materials for the teaching of many Cameroonian home languages, it is nonetheless true that some efforts are being made by many Cameroonian linguists to solve this problem. In fact, with the recent introduction of the teaching of Cameroonian languages and cultures in secondary and higher schools, many didactic materials (textbooks for teachers and students, course contents, etc.) are being produced for the teaching of Cameroonian home languages and cultures. It should be noted that continuous efforts should be made to develop these didactic materials. Many Cameroonians who do not work in the field of education, as is the case with health care providers, are not aware of the efforts being made to develop didactic materials for the teaching of Cameroon's home languages and cultures, and this may explain the opinion expressed above. As mentioned earlier, some vehicular languages[4] (e.g. Fulfulde, Ewondo, Bulu, Ghomala, Medumba, Fe'fe, etc.) for which didactic materials have been developed can be taught as elective courses in medical schools in the country. Much attention

[4] Language used for communication between people who speak different home languages

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should be paid to the vehicular languages spoken in regions with high illiteracy rates. This is the case of Fulfulde in the northern part of Cameroon (Adamawa, North and Far North regions).

4. DISCUSSION OF FINDINGS

The above findings have highlighted the views of healthcare providers on the teaching of home languages in medical schools in Cameroon. The majority of informants emphasised the importance of teaching home languages in medical schools because it facilitates communication between providers and patients who do not speak the official language, builds trust between patients and providers and improves providers' performance and quality of care, helps to diversify providers' knowledge of home languages, and limits the presence of intermediaries in patient-provider interactions. These findings corroborate those of previous studies conducted in other multilingual African contexts. The study by Olajuyin et al (2022) on the use of indigenous languages in clinical placements found that 73.7% of medical students in Nigeria supported the inclusion of indigenous language training in the medical school curriculum and agreed that teaching home languages in medical school would improve communication skills. A study conducted in South Africa showed the benefits of health care providers using indigenous languages in health care. It was found that providers' knowledge of indigenous languages limits misinterpretation, reduces infant mortality and improves maternal health, ensures public safety, contributes to prevention and reduplication of treatments, etc. (Mphasha and Lebese 2015). It is worth noting that the education system in many African countries is still based on Western models. In fact, "Africa showed the lowest dependence on the mother tongue; medical education in Africa is confined to English, French, Spanish and Portuguese" (Hamad, 2023) and this dates back to the colonization period since "most postcolonial societies have retained ex-colonial languages as the language of economic, social and institutional power. The dominance of the ex-colonial language as the official language has contributed to the maintenance of colonial cultural hegemony. In some cases, this has contributed to a lack of legitimacy for home languages chosen by postcolonial governments as an important element of nationhood" (Rassool 2007:247). Despite the fact that the majority of healthcare providers have a positive views towards the teaching of home languages in medical schools in Cameroon, a less significant proportion still expresses negative views about it. These negative views can be accounted for by the language myth developed by Africans towards European languages. This myth views European languages such as English and French as the sole or most appropriate languages to be used in the domain of education, science and technologies. This is in consonance with Ngugi Wa Thiong'o (1986) who points out that one of the effects of colonisation of Africans is the loss of their cultural identity and self-esteem. The domain of education is very illustrative in this regards. The paper is in line with the discourse of postcolonial linguistics, which moves away from the view according to which only Western languages are the only languages that can be used in the fields of education, health, technology, etc. in Africa and argues for the functionality of African languages in these domains and stresses linguistic decolonization of education in medical schools in Africa in general and in Cameroon in particular. This point is in line with the decolonisation of the mind as propounded by Ngugi Wa Thiong'o (1986). It is worth stressing the fact that African languages, like European languages, have the potential of being used in the domains of medecine, education, economy and culture. Olajuyin et al (2022), in a study conducted in Nigeria, found that most medical students (70.8%) used Yorùbá in their clinical clerkships, despite studying medicine in English and only 16.0% of these students relied on interpreters. This suggests that Yoruba, an African language, can be used to convey medical knowledge in the same way as other European languages such as English, French, Portuguese, etc. The paper therefore argues for a readjustment of the language policy in the medical education system in post-colonial multilingual Africa in general and in Cameroon in particular, in order to adapt to the realities faced by health care providers in their daily practice. In other words, in addition to learning foreign languages, medical students should also be taught home languages so that they can provide care in the home languages of their patients. This is part of the overall process of linguistic decolonisation of medical education in Africa.

Negative attitudes towards the teaching of home languages in medical education in Cameroon are based on the feasibility of teaching more than 200 home languages, the availability of didactic materials for these mother tongues, and the heavy workload of training medical students. Instead, informants who hold this view opt for the training of interpreters and the learning of home languages by health care providers in the community in which they work. According to them, the teaching of home languages in Cameroon should be limited to primary, secondary and high schools, but not in higher education institutions or training schools.

It should be noted that although there are 247 home languages attested in the country, there are vehicular languages/lingua francas (i.e. languages used for communication between people or different ethnic groups who speak different languages). The teaching of home languages in these medical schools can start with the teaching of these vehicular languages (e.g. *Fulfulde* in the Far-North, North and Adamawa regions; *Ewondo* in the Center Region; *Bulu* in the South Region), Ghomala' (in

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the West Region) and gradually extend to the teaching of other home languages. In addition to the official languages (English and French), students in medical schools may be asked to choose as an elective one of the vehicular languages other than their home language.

It is important to note that the education system in Cameroon has never made the teaching of home languages a priority. This is why, it is 49 years after Cameroon's independence in 1960 (i.e., in 2009), that the State of Cameroon launched the ""recruitment of 40 students in the Department in charge of teaching and promoting national languages and cultures in Higher Teachers Training College in Yaoundé" (Nkenlifack, et al, 2011)". Moreover, many Cameroonians are not very eager to invest their time and resources in learning Cameroon's home languages. This can be accounted for by the fact that knowledge of home languages does not offer comparable opportunities to knowledge of European languages such as English, French, German, Spanish, Chinese and Italian. As a result, the instrumental motivation for teaching and learning these home languages is very low. This can also be accounted for by the fact that many Cameroonians do not see the importance of teaching home languages in schools, as some of them believe that they can only be learnt in the community outside formal education. Regarding the non-availability of didactic materials, it should be noted that efforts are being made to develop them with the introduction of the teaching of Cameroonian home languages and cultures in secondary and higher schools nationwide.

5. SOME POLICY RECOMMENDATIONS FOR THE TEACHING OF HOME LANGUAGES IN MEDICAL SCHOOLS IN CAMEROON

Communication barriers is a significant jeopardy to healthcare provision in Cameroon healthcare centers, especially in Priority Education Zones (ZEP)[5] of the country. The study has scored the importance of teaching home languages in medical schools in Cameroon as a means to overcome communicative barriers between healthcare providers and patients who are not proficient in official languages. It is worth stating that in other multilingual countries in Africa, for instance in South Africa, home languages are successfully taught in medical schools (cf. Matthews & Van Wyk, 2016). Below are provided some policy recommendations for the implementation of home language teaching in medical schools in Cameroon.

a) The Minister of Higher Education and the Minister of Health should co-sign an order which introduces the teaching of home languages in medical schools in Cameroon.

b) The choice of the home languages to be taught can be established either on a need analysis or on the geographical coverage basis of the languages.

c) Didactic materials (both print and audiovisual) and syllabi should be worked out by Cameroonian linguists for this purpose as it is done for the teaching of these languages in secondary and high schools in the country.

d) These home languages for a start can be taught as elective courses but compulsory and students should be encouraged to choose a home language in which they are not fluent. This will help them increase their verbal repertoire.

e) Higher teachers' training schools should increase the quotas of student-teachers to be admitted in the department of Cameroonian languages and cultures so as to increase the number of trained teachers in these home languages.

6. CONCLUSION

The study has revealed that despite the fact that the majority of healthcare providers are optimistic about the teaching of home languages in medical schools as a means of overcoming language barriers between healthcare providers and patients who do not speak the official language, a smaller proportion are pessimistic about this solution as a means of bridging this language gap. If it is true for the former that the teaching of Cameroonian home languages in medical schools will facilitate communication between health care providers and patients who are not proficient in the official language, increase trust between patients and health care providers and improve the performance and quality of health care provided by health care providers, help to diversify health care providers' knowledge of home languages, and limit the presence of intermediaries in the interaction between patients and health care providers, it is nonetheless true that the latter question its feasibility in a multilingual context such as Cameroon i.e. feasibility in the context of coexistence of more than 200 home languages, non-availability of didactic materials in these home languages and the heavy workload for the training of medical students. Instead, they opt for the training of interpreters and the informal learning of home languages by health care providers in the community in which they work. In their view, the teaching of home languages in Cameroon should be limited to primary, secondary and high schools, but not in higher education or training institutions. The importance of home languages in health care in Cameroon is a fact, and it is paramount that government policy makers develop strategies to strengthen these languages and teaching them not only in secondary and high schools but also in training schools will contribute in giving more value to these languages.

[5] The term priority education zones (ZEP) was adopted by the Cameroonian government in 2005 to refer to regions of the country which need special social support due to the high level of illiteracy of populations. These include the Adamawa, North, Far-North, North-West and South-West regions.

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