

The Practices of the Traditional Caring Culture and Western Nursing Culture in Cameroon



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STATEMENT OF AUTHORSHIP

I hereby declare that this thesis is my own work and contains no material that has been accepted for the award of any degree or diploma from any tertiary institution. To the best of my knowledge and belief, this thesis contains no material previously written or published by another person, except where due reference is made in the text.

Signed:

Date

Emmanuel Aoudi Chance

9th April 2015

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ABSTRAKT

I arbeidet mitt som sykepleier i Norge går tankene ofte til Kamerun og omsorgskulturen der. Folk oppsøker sykehus for behandling der også. Men mange prøver i første omgang å behandle seg selv hjemme eller i landsbyen, eller de søker tradisjonelle healere. Hensikten med denne oppgaven er å forstå praksis både innenfor tradisjonell omsorgskultur og vestlig sykepleie i Kamerun.

Denne oppgaven ser på hvordan tradisjonell omsorgskultur og vestlig sykepleie påvirker hverandre ved å observere praksisen til agentene som hører hjemme i både tradisjonell og vestlig pleie. Den teoretiske oversikten vil bli presentert først, deretter en beskrivelse av folks praksis, levemåter og tidsbruk, knyttet opp mot de teoretiske perspektivene.

Det er gjort intervjuer, tatt notater, tegnet og tatt bilder. Det er også gjort en beskrivelse av settingen; først landet, så landsbyen og deretter sykehuset der forskningen ble gjort.

Ved å bruke Bourdieus nøkkelbegreper *kapital*, *habitus* og *felt* ((Boudieu, 1990b; Bourdieu & Wacquant,1992), prøver jeg å forstå omsorgens praksis og hva omsorg betyr i de ulike settingene. For Bourdieu (1977, 1990) er praksis mer enn bare en vane; det er et praktisk ”mastership” innarbeidet i folks kropp, som leder dem til å handle uten å vite hva de egentlig gjør. Hva som fører til handling/praksis er ubevisst og irrasjonelt ut fra sunn fornuft, men likevel tilstrekkelig og adekvat under de gitte omstendighetene.

For å konstruere habitus og kapital i feltet, beskriver oppgaven:

- posisjonen til respondentene, det vil si hvor de kommer fra og fra hvilken posisjon de snakker - for eksempel sykepleier, sjef, tradisjonell healer, lege eller administrator
- disposisjoner som fremmer praksis;

- *økonomisk kapital* - for eksempel penger, eiendom og eiendeler
 - *kulturell kapital* - for eksempel kompetanse, ferdigheter, kvalifikasjoner og utdanning
 - *sosial kapital*, som er "summen av ressursene, faktiske eller virtuelle, som tilfaller en person eller en gruppe i kraft av å ha et varig nettverk av mer eller mindre institusjonaliserte relasjoner av gjensidig bekjentskap og anerkjennelse" (Bourdieu & Wacquant, 1992) - for eksempel sosiale relasjoner og sosial opprinnelse
 - *symbolsk kapital* - for eksempel prestisje, ære, oppmerksomhet og ressurser
- posisjonering - for eksempel mening, uttalte tanker og handlinger

Synet på det å være syk i deres samfunn og stamme blir presentert og diskutert, samt informasjon om hvordan helsearbeidere håndterer de syke.

Studien fokuserer på omsorgspraksis og ser på muligheten for konvergens mellom den praksisen som foregår i tradisjonelle omsorgskulturer og vestlig sykepleie i Kamerun. Analysen av funnene viser sammenheng mellom de to praksisene; praksis og enkelte kjennetegn ved tradisjonelle healere har fellestrekk eller overlapper med praksis i det vestlige omsorgssystemet.

Systemene er komplekse og eksisterer side om side. Samtidig finner vi - innenfor noen medisinske områder - et samarbeid som er formelt godkjent av Kameruns regjering.

I studien brukes refleksivitet som et viktig aspekt for å transcendere dualiteten mellom objektivisme og subjektivisme og for å belyse omsorgspraksisen som tilbys av tradisjonelle healere, sykepleiere og leger i Kamerun. Dette øker forståelsen av praksisen i den tradisjonelle omsorgskulturen og den vestlige sykepleieomsorgen.

Nøkkelord: Omsorg, praksis, tradisjonell omsorgskultur, vestlig sykepleie, praksisologi, habitus, felt, kapital, agenter, praksislogikk.

ABSTRACT

While working as a nurse in Norway, my thoughts were always in Cameroon, a caring culture in which many patients and their relatives at one time chose to go to hospitals for treatment, but are now trying to treat themselves at home or in the village or are being treated by traditional healers. The intention of this thesis is to understand the practices within the traditional caring culture and western nursing care.

Using Bourdieu's key constructs of *capital*, *habitus*, and *field* (Bourdieu, 1990b; Bourdieu & Wacquant, 1992), the ideas discussed in this thesis were formed from what caring means in that setting. Set in the context of Cameroon, this research determines the impact of traditional caring culture on current approaches to western nursing care that health professionals provide. It examines how the practices of traditional caring culture influence the current state of nursing care practices provided by nursing professionals who have received an education and are part of both traditional and western tradition and settings. Following this theoretical overview, the respective agents practices are described and analyzed. For Bourdieu (1977, 1990), a practice is more than just a habit; it is a practical mastery incorporated in people's bodies that guides them to act without complete or explicit knowledge. What led them to these actions/practices is unconscious and irrational in the common sense but adequate under the given circumstances. For this research, everyday social practices of agents were observed, interviews were given, field notes and pictures were taken, and drawings were made. The study began with a description of the setting; the country, the village, and the hospital where the research was done.

To construct the habitus and capital of agents in the field, the research described

- the position of respondents, meaning from which place, profession do they speak (e.g., nurse, chief, traditional healer, doctor, and administrator);
- the dispositions to enact practice;
 - *economic capital* (e.g., money, property, and assets);

- *cultural capital* (e.g., competencies, skills, qualifications, and educations);
 - *social capital*, which is “the sum of the resources, actual or virtual, that accrue to an individual or a group by virtue of possessing a durable network of more or less institutionalized relationships of mutual acquaintance and recognition” (Bourdieu & Wacquant, 1992) (e.g., social relationships and social origin);
 - *symbolic capital* (e.g., prestige, honor, attention, or resource);
- positioning (e.g., meaning, thought in word, and actions).

Next, the views of respondents about being sick in their society, tribe, and community were investigated, and their ideas on how healthcare workers handle sick people were elicited and analyzed. This study focus on the provision of caring practice and the possibility of convergence between the practices of western nursing and traditional caring cultures in Cameroon. There is a relationship between the practices of traditional caring culture and western nursing. The practices and certain characteristics of traditional healers have some aspects in common with the practices of the western caring system. These two caring systems are complex; they coexist and cooperate in some health areas and are formally accepted by the Cameroonian government.

Reflexivity is used as an important aspect of transcending the duality between objectivism and subjectivism and unveiling the reality of care provided by traditional healers, nurses, and doctors in Cameroon. This improves the understanding of how healthcare is provided and practices services in Cameroon.

Keywords: Caring, care, practices, traditional caring culture, western nursing, praxeology, habitus, field, capital, agents, logic of practice.

SUMMARY OF CHAPTERS

In Chapter I, the fundamentals and the overall rationale behind the conducted research are discussed, specifically in addressing the question of whether the practices of traditional caring culture have a relationship with western nursing practices in Cameroon. Additionally, the chapter highlights the researcher's goals and objectives for the study. The research aims to describe and understand caring practices in Cameroon and, particularly, the relationship between traditional caring cultural practices and western nursing practices. The researcher's background and interests are also presented.

Chapter II presents the field in which the research was conducted. The field is described as: "It is networks of social relations, the field of cultural production, structured systems of social positions within which struggles or maneuvers take place over resources, stakes and access." (Bourdieu, 1983, 1990a) The field represents the broader social context, another social terrain. The described field represents the contexts in which agents interact and refer to both physical and social spaces. The focus is on power, domination, and class.

Chapter III provides the reader with an overview of the healthcare practice types in Cameroon. This chapter introduces the health system model that operates in Cameroon as a dual healthcare system with a predominant biomedical health facility (the western health-practices system), a modern influenced ministerial side and an overwhelming presence of traditional medicine (the traditional care system), a traditional pre-modern side. This chapter is about the understanding of cultural practices in relation to the cultural meanings applied to illness.

Chapter IV discusses the theory of practice developed by Pierre Bourdieu, a distinguished French anthropologist. This theory of practice is simultaneously a critique of the methods and postures of social science and a general account of how human action should be understood. According to Bourdieu, the concepts of habitus, field, and capital are interdependent and should not be used separately (Bourdieu &

Wacquant, 1992). In the theory of practice, Pierre Bourdieu transcends the dichotomies between objectivism and subjectivism, which have shaped theoretical thinking about the social world with his central concept of habitus, the principle that negotiates between objective structures and practices. The theory of practice is used to provide an understanding of practices in Cameroon based on what people have, do, and say. Habitus is embodied, enduring, and dynamic, and according to Bourdieu, (1990a), p.70, it is expressed through durable ways “of standing, speaking, walking, and thereby of feeling and thinking.” The interaction of habitus, cultural capital, and field generates the logic of practice.

Chapter V presents the discussion on the research methodology and the approaches used in this thesis. The research is praxiological-oriented, which further notes Bourdieu’s concepts of understanding, reflexivity, and interviewing as foundations of the overall methodology. Further, it highlights the sampling method, population size, data analysis, limitations, and ethical research considerations.

Chapter VI presents in detail the articulation of practices. It increases understanding of the relationship between the practices of the traditional caring culture and western nursing practices in Cameroon. It presents how agents choose their healthcare system, the factors and dispositions that likely influence health-seeking decisions. In addition, this chapter details the field, habitus, and capital of the agents. The presented perceptions of agents increase our understanding of traditional caring cultural practices. This chapter also presents the analogy between the traditional caring cultural practices and the western nursing practices in Cameroon.

Chapter VII concludes the thesis. Many aspects of the practices of traditional caring culture can be linked to the practices of western nursing. The two systems coexist and have a relationship to each other despite several differences. Both systems refer patients to the alternative when appropriate. Practitioners incorporate some of the ideas and practices employed by their counterparts, thus improving their own practice. These two systems have different views regarding illness etiology and treatment

methods. Doctors, nurses and traditional healers, and patients' relatives are constantly exposed to the traditional caring culture and modern medicine creating challenges in the caring functions they provide to their patients. The understanding of these two health systems as symbols of the society also help us in respecting both systems as value contributing to people health and as the way agents care for each other due to their history, tradition, culture and possibilities for the benefit of people.

1. CHAPTER I: INTRODUCTION

1.1. Introduction

Traditional caring culture and western nursing are two healthcare forms formally accepted in Cameroon. They live and work alongside one another. This thesis focuses on the understanding of the dichotomy and the similarities between the practices of the traditional caring culture and western nursing practices in Cameroon. The exchange of ideas between these two forms of care concerning health and illness is no simple matter. The description of practices in each of these forms provides a richer context for understanding the relationship between the practices of traditional caring culture and western nursing in Cameroon.

People's ideas of sickness, health, and cure differ and are associated with fundamental principles of beliefs. Patients and relatives bring with them to the hospital traditional medicines and occult caring practice. In Cameroon, cultural beliefs result in greater use of traditional medicine than of western medicine. The question then becomes, what are the practices within the traditional caring culture and western nursing and how do they relate to each other?

Pierre Bourdieu's notion of habitus aims to precisely capture the learned mastery that is natural and underestimated by the agents. Through this term, we can better understand the temporal, relational, and embodied nature of caring, and analyze how care arises and operates in the physical and social environment or the field.

1.2. Research Background

Tension and discord still exist between the practices of traditional healing and western medicine due to lack of trust and mutual understanding. Traditional health practices are still very common in rural areas even though modern western cultural health practices are offered in public healthcare facilities. Preference for traditional healers has been attributed to the cultural and economic similarities that are said to exist between patients and their traditional healers (Tembon, 1996). According to the World Health Organization (WHO) (2002; 2003), in Africa, there is one traditional healer per 200 people, thereby covering 80–90% of healthcare. In Cameroon, it is estimated that there are more than 20, 000 traditional healers serving both the rural and urban population (Agbor & Naidoo, 2011). The reasons for the

presence of this high numbers of traditional healers are consistency with local cultural values and beliefs, better healer/patient practices, proximity, and lower costs compared to western health-practices facilities. The cultural beliefs and health practices are embodied in people. Culture cannot change overnight as a result of agents (habitus). New habitus can be created by changing the structure and the dispositions of the agents (economic, social, and cultural). Habitus changes when the character of the field and the struggles over capital in the field change. The African nation of Cameroon is already pushing forward in its effort to accept both cultures, resulting in them living side by side and interacting through traditional and modern medical practices.

Despite government efforts to make possible a collaborative work within these two health systems and to make these systems work together, there is a lack of humility on the part of western health professionals when it comes to understanding that traditional caring culture can have something to offer in the medical field. Doctors and nurses perceive the practices of traditional caring culture as being very poor. Some traditional healers may refer patients and their relatives to modern medicine, but the reverse is rare. According to De Smet (2000), there is a tendency in the western-oriented biomedical tradition to focus on risks and downplay indigenous medicine and the expertise of traditional healers. The etiology of diseases between western medicine and traditional healing differs. Most patients perceive the practices of traditional caring culture as being consistent with cultural values and beliefs. Other patients perceive it as being equal to western nurse practices. Conversely, there is a significant group of patients who perceive traditional medicine as being very primitive.

1.3. Research Access and Questions

This master's thesis is supported by the Praxeology Research Group at the Department of Public Health and Primary Health Care, Faculty of Medicine and Dentistry in the University of Bergen. Praxeology is defined as empirical and theoretical studies of human action; it is a science that explains practice. Bourdieu agrees with Durkheim that "In each of us, in varying proportions, there is part of yesterday's man; It is yesterday's man who inevitably predominates in us" (Bourdieu 1977, p79; Sales, 2012, p 70). The individuals we are today are shaped and directed by the experiences of our past. People create meaning through their history and practice. Bourdieu argues that while people do have an intent or purpose in their behavior, our behavior also carries an objective character of the family we come from and the

community that surrounds us. Imprinting behavior is stored in our bodies as a practical sense or knowledge of how to emerge and position ourselves in the social space—a knowledge that we, according to Bourdieu, are social, not conscious. These are statements that form the background of Bourdieu's theory of practice (Callewaert 1992, pg. 42–58 pg. 146). In praxeology, Bourdieu's theory of practice and methodology is central. Bourdieu's concepts of habitus, field, and capital are applied to construct an explanation to the question of this research.

The key research question asked to apply and extend Bourdieu's theory is:

What are the practices within the traditional caring culture and western nursing and how do they relate to each other?

Additional, secondary questions are as follows:

- How do patients and healthcare professionals perceive the healthcare practices systems in Cameroon?
- To whom do patients go when seeking healthcare?
- How is caring described, understood and practiced in Cameroon?
- What factors influence a patient's choice of healthcare providers?
- How are nursing practitioners exposed to the traditional culture of care?
- What are the challenges posed by the coexistence of the practices of traditional caring culture and western caring?

Pierre Bourdieu's notion of habitus is used to construct an explanation of the areas of practice.

The structuration of habitus includes these aspects as follows:

- *Position* (profession—doctors, nurses, nursing assistants, healthcare administrators)
- *Disposition* (capital—economic, cultural, and social)
- *Positioning* (meaning—opinions thought in word and actions)

1.4. Purpose of the Study

Assessing the perceptions and experiences of patients and healthcare professionals with regard to the practice of traditional caring culture in Cameroon, including the practices of western nursing, is important as this determines the impact that the traditional approaches to care have on the nursing practices provided by health professionals.

One main purpose of this study is to contribute to understanding the practice of traditional caring culture and western nursing in Cameroon. This study provides a description of agents' practice in regard to caring. In addition, this thesis focuses on exploring the convergence between the cultures of western health practices and traditional health practices in Cameroon.

This research is highly significant to the medical field as western cultural-based nursing is a profession anchored on the value of caring for all patients. Traditional caring culture could positively or negatively influence the level of nursing practices that western nursing professionals provide to patients.

To summarize, the purposes of this study are:

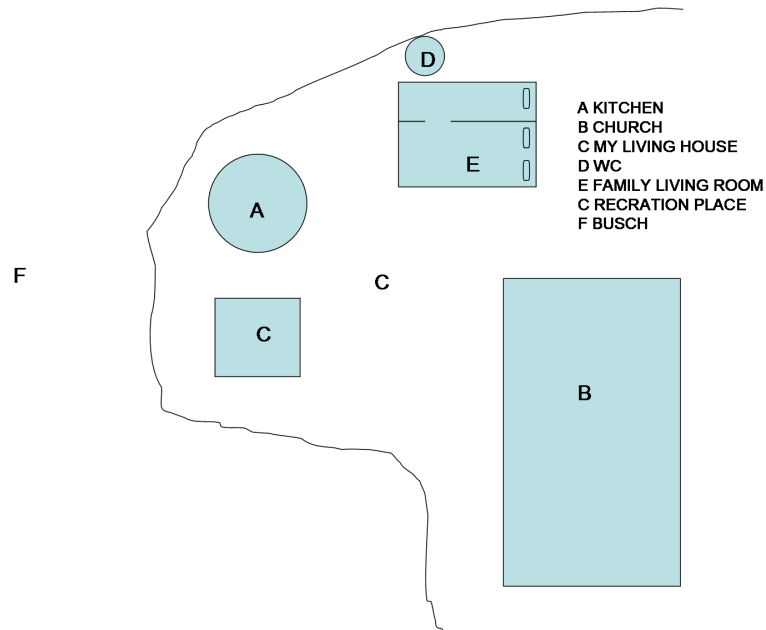
- to describe, understand, and explain the actions of agents and how these actions are formed into practice in Cameroon;
- and to determine how the practices of western nursing, modern healthcare, and traditional caring culture in Cameroon converge or diverge.

1.5. Researcher Background: Capital, Habitus, and Field—Auto-Socio-Analyze

The auto-socio-analysis is an attempt to objectify myself, my own position in the social space and as a nurse. All research is affected by the habitus (Cf. appendix A) and life experiences of researchers. I am an individual (with dispositions), formed by the world that surrounds me. The background and interests of the researcher are always important, especially when conducting qualitative studies (Lipson, 1991) with an ethnographic approach. Therefore, using reflexivity is essential to reflect on the research process and to challenge my own perceptions and influence on the subject studied as a researcher. According to Lipson (1991), reflexivity requires critical self-reflection on the ways in which the researcher's social background, personality, personal assumptions, position, and behavior can impact on the research process, particularly the collection and analysis of the data.

I am a black Cameroonian man from a middle tribe born in 1970 who is married to a Norwegian woman from the middle class. She is a schoolteacher since 1985. My own habitus (a set of dispositions that generate practices and perceptions) can be constructed from my experience growing up in a very poor Christian family. My father was catechist and my mother was a housewife. I grew up in a rural area, was one of 15 children, and attended a Protestant urban school, followed by a government-run high school. My grandfather and grandmother had no western education. It was difficult for them to accept sending their children to school. When white Baptist missionaries established their school around 1844 in south Cameroon while Germans likewise established a school in the north of Cameroon around 1905 as a product of colonization (Tourneux & Iyébi-Mandjek, 1994), going to school became an obligation from ages 5 to 17. They went from house to house to enroll children from the villages. My dad had to walk several kilometers (taking approximately 2 hours each way and every day) to school in 1945. He went to school for 6 years and often went without having eaten food.

Figure 1: The Researcher Background: Living Environment from 1970 to 1992



I grew up in a small village as illustrated in Figure 1, in a poor family that faced significant economic challenges. My father worked as catechist and my mother took care of us in addition to working in farming. Nevertheless, we were an academically-oriented family. Early in our lives, it was assumed that we would attend college and graduate. The reason we wanted to study and to get an education was that we learned from our parents that schooling is valuable and that it enables us to attain a good life; a salary, a house, food for ourselves, as well as the possibility of creating and sustaining a family. We saw that people who were well educated in our village had better lives. We learned that education is the way to success and the key to understanding others and being understood. It could bring hope and change to our local community. My father had a limited educational background, meaning 5 years of primary school, which for his time was a valid and good intellectual background, whereas my mother had no formal education. The education my father received did not translate into economic viability. My parents' knowledge derived from being in the world. My mother was a caretaker and a housemaid. My dad is a householder. They have land, goats, chickens, and a dog. They sometimes received food from grandparents to feed us. Both are well respected in society because they have learned to read and write. In our community, we consider ourselves to be poor.

I came to Norway in 1996 because of my marriage to a Norwegian woman whom I met in Cameroon where she worked as a schoolteacher for a missionary organization and I worked as a gardener. When I arrived to her home country Norway, I needed first to learn her language to achieve my goal of completing higher education. I underwent 500 hours of Norwegian language courses offered by the municipality. I also took some courses at Folkeuniversitetet and at the Cathedral School. Altogether, I spent two years studying Norwegian. In 1998, I also started a foundation course in Christianity at 1998. By 2002, I had finished language school, a course in Christianity, and a nursing minor, and received a Bachelor's degree in Nursing. From 2002 to 2007, I worked as a nurse in the orthopedic ward at Haukeland University Hospital in Bergen, Norway, the largest hospital in the West coast of Norway. I then pursued specialist training in intensive practices from 2007 to 2008 and completed a part-time master's degree in this field. I currently work full-time in a postoperative ward. I would love to return to live in my home country, but my wife is Norwegian, and I feel sometimes that a move would not be viable because of the poverty and corruption. I also think that I should return and help to create a better world with my education. My education here has given me something to share with others and tools to participate in the development of my village and my country. Being in Norway enables me to raise support and money and to focus on building skills and facilities in my ancestral home, which at the moment is the only way I can contribute to my homeland and family.

As a catechist, my father did not have enough money to feed us or send us to school. With 15 children in our family and a salary of just 3000 Cameroon Francs a month (equivalent to approximately 13 U.S. dollars), life was not easy. In addition, his monthly salary was not always guaranteed. I remember from my childhood how hard it was to find something to eat in our home. He would move us from village to village every two to three years to serve a new church. This inflicted challenges and difficulties, especially in establishing a good farm, which was needed to feed our family. To supplement his income, my father was forced to take work as an assistant nurse in different villages. Before being a catechist, he was trained as a nursing assistant. According to my father, he left this training because of a disturbing incident when he and his brother were in a river close to his training school. They found a stomach in the river. They were hungry and thought that it was edible so they took the stomach and cooked it. Before they began to eat, one of my father's friends approached them and told them that it was a human stomach that came from the dispensary that was close to the training school. Since that day, my father felt uneasy and left the nursing assistant training

program. However, his limited education in health allowed him to work clandestinely, deferring to modern medicines, like antibiotics. He travelled from village to village to meet with patients and to treat them. The patients he met were people with financial problems, and because of this, they were unable to get to a hospital. For them, my father became a “healing angel.” In exchange for his services, people offered him food like cereal known as “*mil*” or “*sesam*” or small amounts of money. His efforts helped us survive. My mom was responsible for preparing the food. She had fields of “*mil*” and groundnuts. In addition, she made “*beignets*” and cakes. All these things were our economic capital as shown in Figure 2. I remember how as children, my siblings and I often ventured down the long village streets to sell her baked goods. To catch people’s attention, we would repeatedly shout aloud “*Maccala, maccalla*” and the price of the cakes. My mother was a frugal woman who knew how to save money. She managed to scrape together enough of the money she earned to pay for our school fees.

My mother died when I was around 11 or 12 years old. I do not remember her age. She had become sick after the birth of one of our little brothers. She was paralyzed down one side of her body. She could not speak or express herself. The illness and the death of my mother led to disagreements within our family. In part, this was because in Cameroonian culture, people believe that illness is the direct result of a supernatural phenomenon, such as witchcraft. They promote prayer or other spiritual intervention in an effort to counter the presumed destruction caused by these powerful forces.

When mom was sick, members of her family visited a traditional healer or “*voyeur*.” They were led to believe that she was sick because people did not like her and because she did not help one of her cousins who was sick and paralyzed. Other “*voyeurs*” inferred that my father was the cause of my mother’s illness. As children, we did not know what to say or do. All we knew was that we loved our parents and they loved us; we did not judge them like the others.

Since the death of my mother, I have always worked hard to pay for my own studies, as well as to pay the school fees for my brothers, who were 6, 7, 8, 10, and 14 years of age. I worked to pay school fees for my sisters. According to tradition, it was important to support my brothers so they could have the opportunity to have a stable life-situation, whereas my sisters were supposed to get married and be supported by their husbands. My brothers were my responsibility since I had received so much that I wanted to share as a result of my Norwegian

education and marriage status. It was instilled in us early in life that we must support each other. I was one of two in my family that had well-paying jobs. We got these jobs because we were loved by the missionaries and they wanted to support us. In Cameroon, I worked as a gardener for the missionaries. I worked in maize fields to help us survive. At home, I was responsible for preparing food for my brothers. After school, my brothers and I would frequent the bush to hunt antelopes, herisons, and rabbit. We also fished near a river close to our house. Sometimes, we returned with a herison or a rabbit; other times we resorted to collecting edible insects. When we came back home with food, it was a great day. Other days were much more difficult. I remember some days when, because of the lack of food, we ate bitter cassava—a bark and leaves from the trees you can prepare and cook for food that is very rich in protein. Sometimes we spent nights without food because we had no other choice.

Figure 2: The researcher Background: Food and Hunting



We struggled at the poverty line, my brothers (8, 12, and 19 years of age), sisters (10, 13, 15, and 17), and I worked hard for money to use toward school and to buy food.

I am a western-trained nurse and I work at Haukeland University Hospital in Bergen, Norway. Knowing how and what nursing practice is in Norway and having an interest in understanding the practice in Cameroon has motivated me to do ethnographic research regarding this issue. When my mother was seriously ill, she was admitted to the Protestant hospital. Traditional healers were also contacted. My father's and my mother's sisters were also responsible for

tending to my mother's every need and providing her with food. They were there almost all the time. It was not easy for them. My mother received both hospital medicine and traditional medicine. The traditional medicine was given to her in secret when the nurses and my father were not present. I aim to gain more knowledge and understanding on the practices within the traditional caring culture and nursing practices in Cameroon.

Understanding how difficult it was to dig a farm has motivated me to think about helping people in my village. Being in Norway has given me the opportunity to financially help others in need. My brother and I have purchased five tractors (Figure 3) to help people in our village produce more crops and fight against hunger. When I am in Cameroon, I feel I am at home; I am from Cameroon and I grew up in this culture. I have a historical relationship with this country. In Cameroon, in Mbé, I own a house, cows, and many properties. I see myself as both an "insider" and an "outsider." For Bourdieu (1990), the insider is someone whose mental and bodily dispositions (*habitus*) have been acquired within and, thus, fit into a specific space.

Figure 3: Emmanuel in Agriculture in Mbé in Cameroon 2013



After 18 years of living in Norway, I perceive myself as an outsider because I do not completely belong in either a sociocultural or political sense to Cameroon now. In Norway, I own an apartment and a car. I work at Haukeland University Hospital in Bergen as an intensive practice nurse. I have family and friends. My mental and bodily dispositions have evolved. I feel culturally out of place both in Norway and in Cameroon. Since being away from Africa for so long, people in Ngaoundéré and in my village Mbé, Cameroon, call me "the outsider" the moment I enter their space. I am a stranger to them in many ways. I approach my group as a newcomer willing and able to share the present and the future with them under all circumstances. I remain excluded from such experiences of its past. I am seen

as a man without a history. I am no longer permitted to see or to consider myself to be the center of my social environment. Idioms, technical terms, jargon, and dialects remain a challenge. Sometimes I am called ungrateful because I have difficulties acknowledging the cultural patterns that granted me shelter and protection.

According to Simmel (1976), a stranger is identified as a person that is far away and close at the same time. Simmel suggests that because of their peculiar position in the group, strangers often carry out special tasks that the other members of the group are either incapable or unwilling to carry out. The stranger is close to us in that we share common features of a national, social, occupational, or generally human, nature. The stranger is also far from us in that these common features extend beyond him or us and connect us only because they connect a great many people. The stranger is perceived as being in the group but not of the group. The stranger, he says, comes today and leaves tomorrow. The stranger is a member of the group in which he lives and participates and yet remains distant from other “native” members of the group. In comparison to other forms of social distance and difference (such as class, gender, and even ethnicity), the distance of the stranger has to do with his “origins.” The stranger is perceived as extraneous to the group, and even though he is in constant relation to other group members, his “distance” is more emphasized than his “nearness” (Karakayali, 2009). As a stranger and liminal person, I feel ambiguities and paradoxes that characterize my social situation. I see myself between two positions. According to Victor Turner (1969), pg 94-95 “Liminal entities are neither here nor there; they are betwixt and between the positions arranged by law, custom, convention and ceremonial.”

By choosing to explore this field, I, as a stranger, will better understand and describe the ways of practicing that define actions, rather than accepting naïve explanations that have been historically imposed on people and situations. Knowledge of my background assists readers to understand the practice within the context. My background provides experiences to interpret and analyze the research data.

2. CHAPTER II: THE CAMEROONIAN SETTING

Before discussing the theoretical framework of this thesis, the social terrain is described, and outlines of Cameroon, the Protestant Hospital of Ngaoundéré (HPN), and the village of Mbé are presented to give readers a sense of the context from which I have drawn my material, along with some understanding of how the material was obtained.

2.1. History of Cameroon

Figure 4: Map of Cameroon



Cameroon is located in Central Africa, bordering the Bight of Biafra, lying between Equatorial Guinea and Nigeria. Cameroon shares borders with several other countries: Central African Republic has a shared border distance of 797 km, Chad 1,094 km, Republic of Congo 523 km, Equatorial Guinea 189 km, Gabon 298 km, and Nigeria 1,690 km (CIA, 2013).

The name Cameroon was derived from the Portuguese word *camaroes*, which means shrimp (Ardener, 1962; Fonlon, 1969; Pondi, 1997). A Portuguese sailor, Ferdinando Poo, arrived at the River Wouri in Douala in 1472 and discovered so many shrimp in the river that he decided to call it Rio Dos Camaroes (River of Shrimp, in Portuguese). It was from this word that the territory derived its name, which is now spelled in various forms: the Spanish spell it Cameroes; the Germans, Kamerun; the English, Cameroon; and the French, Cameroun. Cameroon is the axis or the hinge of Africa (Ardener, 1962; Kouega, 2007). Geographically, Cameroon has several indications of recent and prior volcanic activity. In the north lies Mount Cameroon, which is still an active volcano. Cameroon's coastline stretches from the Bight of Biafra that borders Nigeria toward Equatorial Guinea to the south (West, 2008, 2011). The Central African Republic of Equatorial Guinea, Nigeria, Congo, and Chad are countries that share Cameroon's borders. It has a total land area of 475,440 sq km, with a climate range and terrain governed by its tropical coastal areas with lush vegetation and a swampy mangrove up to the savannah grasslands of the northern areas. The country's natural resources include hydropower, timber, iron ore, bauxite, and petroleum (Kouega, 2007; KPMG International, 2012).

It has been suggested that the Bakas (Pygmies) were the earliest inhabitants of Cameroon (Mbaku, 2005). The forests of the eastern and southern provinces were inhabited by these pygmies, who speak Bantu and originated in Cameroon's highlands. However, they left when other settlers moved in (Mbaku, 2005; West, 2008, 2011). In the late 1770s and early 1800s, a pastoral Islamic populace from western Sahel invaded the majority of the area that is now known as northern Cameroon. They were reputed to be powerful and displaced the huge community of non-Muslims during that time (KPMG International, 2012).

Despite the fact that the Portuguese arrived on Cameroon's coast in the 1500s, it was malaria that drove the Europeans to conquer and settle in the innermost parts of the region up until the late 1870s when the supply of quinine, a malaria suppressant, became available in large volumes. Until that time, the Europeans' sole purpose in occupying Cameroon was to acquire slaves and conduct coastal trading. Cameroon's northern area was the site of the Muslim slave trade network until the middle of the nineteenth century when the slave trade was widely curtailed. By the end of that century, Christian missionaries had established themselves in Cameroon and began to play an influential role in the lives of the Cameroonians (KPMG International, 2012).

Historically, the German colony of Kamerun, including some surrounding areas, neighboring countries, and all of modern-day Cameroon, appeared on the map in 1884, with its capital city first being Buea and later Yaoundé. After World War I, on June 28, 1919, the colony was divided between France and Great Britain under the mandate of the League of Nations (Mbuagbaw et al., 1974; Ngongo, 1982). It was France that gained the larger geographical share, along with the outlying regions near French protectorates and the remaining areas in Yaoundé. Britain's center of power became Lagos, and British territory covered a strip that borders Nigeria from the sea toward Lake Chad, with almost the same population as the French colony (KPMG International, 2012).

In 1955, a group known as the Union of the Peoples of Cameroon (UPC), which was composed of a large number of members of the Bassa and Bamileke ethnic groups, started an armed struggle to liberate the French part of Cameroon (Awasom, 2000). Even after the region gained independence, the rebellion did not subside. The death toll increased from tens of thousands to hundreds of thousands. In 1960, French Cameroon became independent and was named the Republic of Cameroon (Gros, 1995). In 1961, the southern parts of the neighboring British Cameroon merged with the newly installed Republic and together they formed the Federal Republic of Cameroon. In 1972, the United Republic of Cameroon as a unitary state replaced the federal state through its new constitution (Nghoh, 1990; Julius, 1990; Le Vine, 1964). Until then, the country had been stable and enjoyed progress in agriculture, infrastructure, and petroleum. Its political power, despite its many ups and downs, stood firm under the leadership of President Paul Biya (KPMG International, 2012).

2.2. Culture and Religion

Cameroon is home to speakers of approximately 250 languages (Mbaku, 2005). These include 55 Afro-Asiatic languages, 2 Nilo-Saharan languages, and 173 Niger-Congo languages. This last group is divided into 1 West Atlantic language (Fulfulde), 32 Adamawa-Ubangui languages, and 142 Benue-Congo languages (130 of which are Bantu languages) (Fonlon, B. 1969; Echu, G. 2004; Kouega, J. P. 2007; and Connell, 2009; and Kwintessential, 2014). English and French are the nation's official languages—a heritage of Cameroon's colonial past as a former colony of both the United Kingdom and France from 1916 to 1960. The nation strives toward bilingualism but, in reality, very few Cameroonians speak both English and French and many speak neither. The government has established several

bilingual schools in an effort to teach both languages more evenly. Cameroonian Pidgin English is the common lingua franca in the Northwest Province, the Anglophone part of Cameroon. Fulani is used in North Cameroon as the language of business. Cameroon is a member of both the Commonwealth of Nations and La Francophonie.

As for its culture, Cameroonians are known to reside in remote villages, but in recent times, they have increasingly moved to developing urban centers like the highly populated city of Douala. Much of Cameroon's culture is rooted in social inequality with regard to gender, age, caste, and access to political and academic power (Fonjong, 2005).

The extended family is the focus of the social system and includes grandparents, cousins, aunts, uncles, etc. These family members are as close knit as nuclear families in the West. Family obligations take precedence over almost everything else in life. Individuals achieve recognition and social standing through their extended family, the young are expected to practice care for elderly members of the extended family, and retirement homes are an alien concept. As with many family-orientated cultures, nepotism does not have a negative connotation in Cameroon. In fact, hiring relatives is part of the cultural context since it not only provides for the family but also ensures that Cameroonians work with those they know and trust.

Respect for age, gender, and social title are important in social interaction. Forms of address and behavioral signs of respect, such as bending down, averting one's eyes, talking through one's hands, especially among men of title, have an important role in the power hierarchy.

Fathers are the heads of their families; they generally work in the wage-labor sector, grow cereal, and engage in a variety of entrepreneurial activities. In this society, women assume almost the entire responsibility for food production (farming), providing for the household, and child-care. Traditional title-holders, like the Lamido, practice polygamy. Muslim and other households also practice polygamy (Fonjong, 2005; Gondje, 2011). Husbands and wives usually have separate sleeping quarters and seldom eat together. Children perform a variety of household tasks from an early age, including practicing care for their younger siblings, carrying water, fetching firewood, running errands, and later on helping on the farm. Infants are exposed to a dense social network of caregivers, including parents, siblings, relatives, grandparents, and neighbors. Mothers are still the primary caregivers. Fathers are rarely at home and, therefore, play a minor role in daily communication with their children when they are young. Women usually leave for the farm early in the morning and only return

to the compound late in the afternoon or at dusk. Babies are taken to the farm strapped to their mothers' backs (Yovsi, 2014). Preschoolers may accompany their mothers and help in the practice of care for the babies of the family, while older children are sent to school. In the evenings, women prepare food, nurse their babies, and exchange news with visitors and with their husbands if they are present. Music, dance, social gatherings, and storytelling are an integral part of Cameroonian society. Traditional dances are intricately choreographed. Children sleep in the same bed as their mothers and fathers until they are weaned, and older siblings usually sleep in the same room; therefore, small infants are in close physical contact with their mothers and other caregivers both day and night.

Cameroonians who have a common background tend to organize themselves into small groups commonly called associations. Individual members refer to themselves as sons and daughters of the community. Associations handle two major financial activities. A "trouble bank" is a special assistance fund to which every member contributes money at regular intervals and from which money is given to members who fall victim to misfortune. A "*njangi*" is a financial institution similar to a bank based on mutual trust, which gives loans to unemployed but hard-working association members who do not own property or real estate (Fonjong, 2002).

A key element of Cameroonian social network is social status. Even though the traditional political framework is associated with socio-cultural factors, the deeply entrenched patrilineal networks remained the basis for identifying land usage among the various ethnic groups and village organizations. In determining the social status of the people inhabiting the growing cities, the rich urban elite are recognizable through the houses they dwell in, their language, and their way of dressing. Other significant factors that determine social identity are religious beliefs, which also have an impact on control and networking. Cameroon's leading religions include the indigenous belief systems, Islam, and Christianity (Trevino, 2011). In Cameroon, fear of divine retribution, the power of occultists, and ostracism from the community are strong governing forces.

The region's day-to-day life is like that of a communal society where daily living takes place in open community spaces, such as open-air markets and residential courtyards. The villagers and their descendants consider themselves as brothers and sisters who share a universal bond, which involves their social identity. A form of societal control has been sustained via informal networks due to beliefs like their shared fear of voodoo, angering ancestors,

witchcraft, ostracism, and gossip (Stewart, & Strathern, 2004; Ngambouk Vitalis, 2013). Social networks among family and friends are demonstrated through the exchange of gifts between urban and rural networks, entertainment, and shared meals. Thus, people tend to form cultural associations based on the traditional background they share or have founded, which are originally bound by a common ethnicity. Such cultural associations have been instrumental in aiding the progress and development of their community infrastructure, in maintaining the link between the rural ancestry and the urban migrants, and in organizing ethnic festivities that help preserve their traditional culture (Trevino, 2011).

About 40% of the population of Cameroon is Christian, 40% have indigenous beliefs, and 20% are Muslim (Gam & Gam, 2009).

2.3. Education System

In 2011, Cameroon's expenditure on education was 3.2% of its gross domestic product (GDP) (CIA, 2013). Education in Cameroon is given a high priority but is also considered quite expensive. Education is not free, which means that if one is incapable of paying the tuition fee, then one cannot attend school. Reportedly, it costs approximately \$50 to \$60 or 30,000 francs a year to study in a public school (Gam & Gam, 2009).

A majority of parents are unable to afford secondary school fees (Classbase, 2013). Parents are further expected to pay for uniforms and books, which also contributes to the low national literacy rate.

Schools primarily teach in English and French. Cameroon's education system is divided into primary school (six compulsory years), middle school (five years), secondary or high school (two years), and tertiary education (university) (Mbaku, 2005). The academic year runs from September to June, when written end-of-year examinations are held. Both the Ordinary and Advanced levels of the General Certificate of Education (GCE) are the two qualifying exams in the Anglophone part of Cameroon. There are two different secondary schooling systems: one is based on the French colonial system and the other runs on the British colonial system. In broad terms, the secondary phase comprises lower-level school (middle school) and upper-level school (high school) (Mbaku, 2005). Students who graduate from a five-year secondary school program have to take GCE Ordinary Level exams, and those who graduate from a two-

year high school program have to take GCE Advanced Level exams (Mbaku, 2005). The GCE Advanced Level and the Baccalaureate (the French equivalent of academic attainment) are the two main entrance qualifications for institutions of higher learning. After secondary school, there is the possibility of undertaking vocational studies—courses aimed at unemployed people and delivered under the responsibility of the Ministry of Employment (Classbase, 2013; CIA, 2013). In Cameroon, there is equality of opportunity for access to education. Education is compulsory through the age of 12 years (Mbaku, 2005). Primary school education has been free since 2000; however, fewer girls enroll in primary school in Cameroon than boys. Tuition and fees at the secondary school level remain unaffordable for many families (Amin, & Awung, 2008; Boyle, 1996).

2.4. Politics

Cameroon is a unitary multiparty republic. Cameroon reintroduced multiparty politics in 1990. The multiparty politics was abandoned in 1966 as a result of former President Ahidjo convincing leaders of various political parties to dissolve their organization and form a single party called the Cameroon National Union (Mbaku, 2005). On January 1996, Cameroon adopted a new constitution creating a unitary, decentralized, and multiparty state with a semi-presidential regime. The constitution allows for separate executive, legislative, and judicial branches of government. These three government branches (executive, legislative, and judiciary) run as one. The president of the Republic of Cameroon is the head of the state, head of government, and is elected by universal adult suffrage to serve a term of seven years and for many terms. Executive power is exercised by the government. President Paul Biya has dominated politics in Cameroon since 1982 when, as the prime minister, he was appointed president of the one-party state following the unexpected resignation of President Ahmadou Ahidjo (Mbaku, 2005). As president, he is considered a symbol of unity and was given responsibility for determining national policy, safeguarding the constitution, overseeing the smooth operation of the state, and making certain that Cameroon adheres to or complies with all international treaties and convention. The prime minister is appointed by the president and is the head of government. The president also appoints his cabinet. The legislative power is held by the parliament consisting of the National Assembly and the Senate. Parliament enacts laws and monitors the activities of the government. The National Assembly consists of 180 elected members, elected by direct and secret universal suffrage to serve a term of five years.

Justice is administered by a judiciary system headed by the Supreme Court. The president also appoints all judges and officers of the courts (Mbaku, 2005). He appoints governors in province or region. Regions follow rules and laws created by the assembly (Gam & Gam, 2009). In terms of administrative divisions, Cameroon has ten regions: Adamaoua, Centre, East (Est), Far North (Extreme-Nord), Littoral, North (Nord), North-West (Nord-Ouest), West (Ouest), South (Sud), and South-West (Sud-Ouest) (Mbaku, 2005; CIA, 2013).

2.5. Economic System

With plentiful oil reserves and agricultural resources, Cameroon is one of the best-endowed regions of sub-Saharan Africa. This means that Cameroon should be able to create a well-developed infrastructure to attract investments (CIA, 2013). Despite this, the region has a stagnant per capita income, along with inequitable income distribution and unfavorable business enterprise. There are also significant issues of corruption.

Cameroon's natural resources are oil, timber, hydroelectric power, natural gas, cobalt, and nickel. Its agricultural products are timber, coffee, tea, bananas, cocoa, rubber, palm oil, pineapples, and cotton (Arnold, 2014; Abdulai & Shamshiry, 2014). In terms of industry, Cameroon has petroleum production and refining, aluminum production, food processing, production of light consumer goods, textiles, lumber, and ship repairing (Mbaku, 2005).

2.6. Healthcare System

The healthcare system in Cameroon is interesting, especially in terms of how it was developed. According to the Central Intelligence Agency (CIA), in 2010, Cameroon spent 5.1% of its GDP on health (2010). Cameroon's population growth rate is 2.04%; its birth rate is 31.93 births per 1,000 population members, and its death rate is 11.51 deaths per 1,000 population members (CIA, 2013 est.). Life expectancy (in years) at birth as of 2012 was 52.1 (UNDESA, 2011).

The population of Cameroon is 20,129,878 (estimate as of July 2012) (Time, 2014; Gadinga, 2013). There is approximately one doctor for every 10,000 people, which explains why most healthcare providers are nurses. Nurses in Cameroon have always been involved in assessing, diagnosing, and prescribing treatments to a far greater extent than in Western Europe and

other developed countries. This is because Cameroon has fewer medical practitioners, and there is a culture of accepting and seeking treatment from nurses. Because of this culture, the healthcare system is structured so that people can consult nurses or those trained in handling basic health problems and go on to see doctors only for serious illnesses (CIA, 2013).

In Cameroon, when a patient is admitted to a clinic or hospital, it is like admitting his or her entire family (Chichom et al., 2013). The patient's family and friends are responsible for all the cooking and washing of clothes and floors (Mbanya et al., 2001), financial support (Earley, 2010), and other tasks; most even stay overnight to help with the patient at all hours. As families are very close knit and because many close friends are considered immediate family, this can add up to a lot of people in one hospital room (Fleischer, 2007; Cameroon, 1987).

Health services are largely provided by the government, voluntary agencies, independent people, and private companies, and are structured by the Ministry of Health. Dispensary services are the lowest level of this system, staffed by nurses, nursing assistants, and midwives managing some beds and basic medical equipment (Fokunang et al., 2011). There is a governmental hospital and private hospitals in each region. Cameroon's Integrated Health Care Centers focus on preventive medicines and often initiate a number of community programs. The government also dynamically pursues public health improvement, and their efforts have paid off in the success of programs such as the reduction of sleeping sickness, leprosy, and other endemic diseases. However, there is a high and constant demand for modern healthcare equipment, along with the need for modernizing some clinics and outdated medical tools. Other issues facing Cameroon's health system are the illegal import of medical equipment (Van der Geest, 1982) and the high incidence of malaria among adults in the southern forests, the coastal regions, the basin of Lake Chad, and the Bénoué River Valley. Other serious diseases include water-borne diseases, like schistosomiasis and sleeping sickness, which are spread by the tsetse fly (KPMG International, 2012).

2.7. The Protestant Hospital of Ngaoundéré (HPN)

Figure 5: Field of Research



Figure 6: Protestant Hospital of Ngaoundéré Buildings



This thesis draws its data partly from the Protestant Hospital of Ngaoundéré (Figures 5 and 6), Cameroon. This is a private hospital located in Ngaoundéré in Cameroon. Ngaoundéré is the capital of the Adamawa Region of Cameroon and has a population of 231,357. It lies at the northern end of the railway line to Yaoundé and is also home to an airport. The city as it is today was founded around 1835 by the Fulani leader Ardo Njobdi and had previously been the Mbum capital (Lode, 1990). The name Ngaoundéré is a composite word in the Mbum language meaning Navel-Mountain, where “Ngaou” means mountain and “ndéré” means navel. The town is named after a nearby mountain on the Ngaoundéré Plateau. The Fulani became the ruling caste of the area following their invasion in the nineteenth century (Lode, 1990). Being the largest city in Adamaoua, Ngaoundéré draws a significant number of settlers from the surrounding rural areas, including Dii from further north, Gbaya from the Meiganga area, and Pere from the west. Most people in Adamaoua continue to use traditional medicine.

The Protestant Hospital of Ngaoundéré was founded in 1957 by Norwegian missionaries belonging to the Norwegian Missionary Society. The first missionaries to this area were Norwegian Lutheran missionaries Mr Endressen, a pastor, and his wife, a nurse who arrived in 1923 (Lode, 1990). It was through their efforts that the idea, funding, and building of the hospital took place. It was funded by a wealthy American donor in Cameroon and by the Evangelical Lutheran Church of Cameroon, with the hospital having been in full operation since 1957.

2.8. Education of Nurses and Services in HPN

The formal education of nurses and nurse assistants began in June 1954 (Lode, 1990). The first teacher was Ada Kopstad who was also Norwegian. The duration of their course of education was three months. To qualify for nurse training, the candidates needed to have completed at least one year of education at an average primary school, be a communicant member of the church, and have a written recommendation from the mission. The first candidate in 1954 who received this nursing education was a woman. She was the only one that joined the program at first. In 1955, the program was attended by five additional candidates (Lode, 1990).

Today, the Protestant Hospital of Ngaoundéré employs over 127 people and offers medical services, such as medical imaging (X-ray, ultrasound, mammography, endoscopy), maternity services, maternal and child health, laboratory services, operating theaters, a department of surgery, a department of pediatrics, reanimation service, a burns unit, emergency services, physiotherapy, hospital chaplaincy, social service, a pharmacy, biomedical maintenance service, service statistics, maintenance, a support unit for people living with Human immunodeficiency virus infection and acquired immune deficiency syndrome (HIV/AIDS), prevention of mother-to-child transmission (PMTCT), an anti-tuberculosis program, and an expanded immunization program (Oeuvre de Santé de Église Évangélique Luthérienne du Cameroun 2008; Lode, 1990).

The hospital has 200 beds and plays an important role in providing health practices for the city and its surrounding areas. The Christian belief has been central for more than 50 years at this hospital.

2.9. Nurse Education and Nurses in Cameroon

Only a limited amount of research addressing the role of nurses in Cameroon is available. One researcher, Fongwa (2002), acknowledged the important role that nurses and the other health sector personnel in Cameroon play in both healthcare as well as in shaping society. According to the author, like in other countries, trained nurse assistants and birth and dispensary attendants in Cameroon are part of the health-practices system and are considered to be health practices providers.

Nowadays, entering nursing school in Cameroon requires a Baccalaureate degree (Baccalauréat de l'Enseignement Secondaire) or a junior high school diploma (Brevet d'Études du Premier Cycle du Second Degré). After completing nursing training, students receive their Diploma of Advanced Nursing Care (Diplôme en Soins Infirmiers Supérieures), making them eligible for work in Europe. Prior to nursing training, candidates must complete one of the following streams of education: four years after advanced-level GCE, a BSc from a university, and two or three years with a state registered nurse (SRN) (Fongwa, 2002).

If nurses wish to specialize in midwifery, reproductive health pediatrics, mental health, or anesthesia, it takes an additional two years of training following the SRN. The credential given before this specialty is “state certified.” In Cameroon, they are not considered

professional nurses and are, therefore, not eligible for registration; however, they can register with the association as associate members. A licensure examination is not conducted, but all professionals have an obligation to be registered with the National Association for Nurses, Midwives, and Health Technicians (NANMHT). Approval of training programs is given by the Ministries of Public Health, Higher Education, and other Vocational Education. However, there are many clandestine schools offering certificates that are not recognized by the state. Nurses are waiting for the day they will be given the mandate to do this themselves. Also, most of the registered nurses in the area have completed their education up to the diploma level.

Cameroon is a major destination for the training of healthcare personnel. There are “10 training centers for nurses and nurse aids; 7 schools for assistant nurses; 7 for state registered nurses (SRNs, same as RNs); 3 post-basic schools for nurse-midwives, psychiatric nurses, and nurse anesthetists; and a university health center for the training of medical doctors, senior nursing officers, and medical specialists” (Fongwa 2002, p. 327).

The training of doctors is carried out in a university setting, after they have received an Advanced Level certificate in the sciences, with a focus on chemistry and biology. It takes future doctors six to seven years to earn their first degree, followed by specialist courses that take another two to four years. Nurses are trained at professional schools and universities, most of which are state owned and require four years of professional training.

The core subjects taught during nurse training are anatomy, physiology, and microbiology. Some examples of such core nursing courses are Introduction to Nursing Practice Course, a Pathophysiology, Pharmacology, and Health Assessment. The Introduction to Nursing Practice course is an introductory course for students who wish to enter the field of nursing. Its main focus is the history of nursing and the theories and skills relevant to the profession. The course on Pathophysiology provides instructions on the results of illnesses in otherwise well-functioning human bodies. Students taking this course study almost all common sicknesses and an array of illnesses to understand the procedures of disease and remedial care. Students also examine the habits of sick patients that nurses should be able to modify. The course on Pharmacology focuses on drug therapy and its connection to the profession of nursing. Students of this course study frequently used therapeutic drugs, learn how medicines affect physical schemes, and are shown the impact of typically recommended medicines. The Health Assessment Course shows students how to evaluate the whole patient, including both

biological and psychosocial components. Students also study how to collect information on their patients' medical histories.

There are also specialist nursing courses, which include the option to complete Masters- and PhD-level programs. In addition, there are assistant nurses who require one year of training at a professional school, and their qualifications correlate to those of licensed practical nurses in industrialized countries. Many assistant nurses are actually doing the work of nurses in Cameroon because of a high demand for nursing care.

Religious groups like the missionaries also offer nurse training for Cameroon's 218 hospitals and health centers. Nurses face several problems, such as the uneven distribution of jobs and the need for better training. There are more female than male nurses (Yoder-Wise, 1999). The ranks of nurses and doctors are affected by the general and common desire of nursing school graduates to better opportunities outside Cameroon. Despite this, nurses are widely acknowledged for their contribution to improving the health-practices system in collaboration with doctors and other health-practices professionals (Fongwa, 2002).

Nurses at the Protestant Hospital of Ngaoundéré do not use evidence-based practice (EBP) in the narrow sense as in Western medicine and nursing knowledge, but they use judgment and, in that sense, evidence (Martinsen & Boge, 2004) for their practices. EBP is the collection, evaluation, and integration of valid research evidence, combined with clinical expertise and an understanding of patient and family values and preferences, to inform clinical decision making (Sackett et al., 2000). According to Stevens (2009), recognizing that EBP is the foundation of excellent patient care, western nurses established national consensus on competencies for EBP in nursing in 2004. EBP is also a new approach in many western countries. In the Protestant Hospital of Ngaoundéré, poor information technology (IT), such as the lack of a computer with reliable Internet access, as well as the lack of time and poor awareness of the barriers of EBP hinder its effective implementation.

Nurses in the Protestant Hospital of Ngaoundéré have several levels of professional titles based on education and responsibility. The hierarchy of nursing titles is as follow:

- Major and Nurse Officer are titles given to nurses with considerable experience in the profession.
- Chief Nurse (Infirmary chief) is a nurse with more education and training.
- Midwives and Nurse Anesthetists are nurses with specializations.

- Nurse assistants are those with two years training; they can perform tasks such as injections, give patients body washes, and measure blood pressure, etc.

Nurses wear white nursing uniforms embroidered with their title and name on the shoulders. The embroidered titles indicate their level of education and responsibilities.

2.10. Description of Mbé

I was also in Mbé to meet and interview some traditional healers about their practice. Mbé is located just north of Ngaoundéré on the road to Garoua (along the paved road between the two big cities in the region, Ngaoundéré and Garoua), north of the plateau at about 700 m above sea level, and is characterized by high temperatures (27 to 40°C). Mbé is a well-known place and a large Dii town “*Plaine dii*” (Muller, 2002). Formerly known as Duru, the Dii in Mbé inhabit the Adamawa Plateau. Adamawa is the “*Chateau d'eau du Cameroun*” because many rivers take their sources from the region areas, including Benoue, and it is one of the ten administrative regions of the Cameroon Republic.

The Dii ethnic group (I belong to this ethnic group and I speak dii) is comprised of approximately 150 villages called “*kaa*” that exhibit similar and nearly similar structures. There is a chief “*gbanaa*” in each village (Muller 2000 p.41). The Dii speak dii, a language of the Adamawa group of Greenberg’s classification (Greenberg, 1948). The Dii form one linguistic group with several dialects. Dii chieftaincy is based on an explicit contract between the ruling family and the autochthons and the latter have the duty to select the chief from within some restricting limits. A chief to be elected should be the son or the grandson of a chief who has effectively reigned. The choice is also based on the best candidate who is always described as a man who is patient, listens to people, is generous, and is sympathetically interested in what people think, say, and do. According to the Dii, a chief has to be a hard-working man and should listen to his advisors and make his decisions based on the wishes of the majority (Muller, 1996). They have strong beliefs on tradition. Dii people are known as the easternmost population to cultivate yams and sorghum. The Dii are patrilineal and are estimated to approximately 50,000 in population (DeLancey & DeLancey, 2010).

This is my family’s living place and the birth-place of my father. The setting is quite traditional. The town is situated 70 miles north from Ngaoundéré. People in this village are

in the business of agriculture and hunting. Every year in the month of May, the village people celebrate “*Sion*” (a big ceremony where traditional medicine and practices are applied for the treatment of women who suffer from chronic diseases of the stomach) and “*Don*” (the ceremony of traditional circumcision). In this second ceremony, a masque, “*Guoek*,” or the “*Faa*” Mask (the wife” of the *Guoek*,) must be present as a symbol of power (Muller, 1996, 2001, 2002) (Figure 7). The importance of this is a rite of initiation, turning young boys into men and making them Dii. This ceremony is intended to control the body and demonstrate respect of the elders by accepting pain that follows the circumcision and the teaching that follows. All details concerning the circumcision are hidden from the female Dii (Muller, 2002). Boys are followed for two to three months, they learn from elders how to care, how to cure, and how to find and use traditional medicine. They do not have contact with women during this period. Circumcision is also connected to the knives used by the circumciser and by the blacksmith. The knives are regarded as divinities or spirits (Muller, 2001). There are Christians, Muslims, and followers of indigenous religions in Mbé, all of whom are circumcised. It is common to count a percentage of 40% Christians, 40% animists, and 20% Muslims (CIA, 2013).

Circumcision in the western medicine style in Cameroon is done in a hospital and is a simple surgery, without traditional ceremony (Muller, 2002). Boys are followed for just two to three weeks. Unlike traditional circumcision, a woman can bring the child in to be circumcised in the hospital. In this case, boys do not receive traditional training. Mothers provide practices and they are in permanent contact with these boys. This is called “*Don nassaa*,” meaning western circumcision (Muller, 1996, 2001, 2002). Some people choose this western circumcision because it is cheaper than traditional circumcision. Money is paid to a local healer to have a big party for the whole village.

Sacrifices are important practices as they ensure fertility while the sorghum is still not ripe and represent the most important public communication between the male Dii and God. They cut the throat of a white ram, pour the blood into a hole in the ground, and address their invocations to God, asking for a good harvest, good health, many children, good luck for the hunters, and good production for the blacksmiths (Frobenius 1987: 142). Washing and painting the skull of the last *gbanaa* to please the ancestors are done on the altar of the *gbanaa* to secure the harvest (Drønen, 2007; Muller 2000: 41).

The traditional religion of the Dii contains many of the central aspects and beliefs that are shared by the majority of sub-Saharan traditional religions (Bah, 1993). Great social changes occurred from 1934 to 1960. The Norwegian missionaries introduced the Dii people to Christianity in 1934 (Drønen, 2007). The alliance with the missionaries was considered as a means to gain increased political independence, to receive western education, and to strengthen their ethnic identity. Today, an overall majority of the Dii present themselves as either Christians or Muslims.

Western missionaries from Europe and America in Mbé have greatly challenged the traditional practicing culture by equating traditional healing and other parts of the indigenous world with evil practices and condemning everything tribal as devilish.

Most patients in Mbé go to the hospital or are taken to the hospital when they become critically ill, although sometimes the critically ill are taken out of the hospital by family members in order to seek traditional healing provided by witchdoctors called medicine men (Hardy, 2008) or “*Mbangam*.”

Figure 7: Masque in Ceremony of Circumcision



3. CHAPTER III: HEALTH PRACTICES AND CULTURE

At the heart of this study, Pierre Bourdieu's notion of practical sense and concept of practice are used to better explore the research question:

What are the practices within the traditional caring culture and western nursing and how do they relate to each other?

In addition, Arthur Kleinman's explanatory model of illness is used to reveal the cultural meanings applied to illness and to lead people to seek care.

3.1. Understanding Culture and Cultural Meanings Applied to Illness

3.1.1. Understanding Culture

Agents' explanations about practice in Cameroon are culture-specific. In "Outline of a theory of practice," Pierre Bourdieu (1977) defines culture "as a map: it is an analogy which occurs to an outsider who has to find his way around foreign landscape and who compensates for his lack of practical mastery, the prerogative of the native, by the use of a model of all possible routes." In *La Distinction*, 1984, Bourdieu wrote: "There is no way out of the game of culture..." Culture is one of the defining characteristics of the human condition. Culture is enacted by everyone in the field. It is a game in which there are no non-participating spectators. It is a *huis clos* from which no one is excluded and from which there is no escape. The term "culture" appears in medical literature as a way to denote non-western cultures. Culturally appropriate health practices emerge as an umbrella concept that encapsulates the importance of health-practice workers being sensitive to the disparities of health status and inequalities in the quality of health-practices experiences between social class cultural differences in health practices and understanding.

The work of Pierre Bourdieu has served as a substantial source of inspiration for researchers working in the fields of medical anthropology, health policies, and social technologies. The Bourdieuan concept of practice and the practical sense are tools that help describe how people act and what they do. This helps to better understand culture. Pierre Bourdieu's theory of practice tries to escape the objectivism of action viewed as a mechanistic reaction devoid of

the agent. According to Bourdieu, what people say seldom is completely the same as what they actually do. The sociology of culture described by Pierre Bourdieu emphasizes the “primacy of relations” in which the analytic concepts of field and habitus provide the objective structures shaping the subjectivity of experience. Bourdieu and Wacquant, (1992, p. 97) stated that: “To think in terms of field, it is to think relationally: In analytic terms, a field may be defined as a network, or a configuration, of objective relations between positions.” A field is a space of power. Field is also a space of conflict and competition (Bourdieu, 1996). Bourdieu’s notions of habitus, field, and capital are important for understanding health practices in Cameroon. Habitus, according to Bourdieu, is a system of dispositions integrating past experience and enabling individuals to cope with a diversity of unforeseen situations—dispositions that agents acquire either individually, through family and the education system, or as a group, through socialization. Habitus is a form of transcendental historic, a socialized body, a structured body, a body that has incorporated the immanent structures of this world and that, in response, structures perception and action in this world. The habitus is a “system that is socially constituted of structured and structuring dispositions that are learned through practices” (Bourdieu, 1992: 97). Habitus is composed of agents’ thoughts, tastes, beliefs, interests, and their understanding of the world around them. Habitus is created through agents’ primary socialization into the world through family, culture, and the education environment.

3.1.2. Cultural Meanings Applied to Illness

The cultural meanings applied to illness are also of considerable importance to agents in the field of caring or health. According to Kleinman (1975), illness is culturally shaped in the sense that how people perceive, experience, and cope with disease is based on their explanations of sickness, specific to the social positions they occupy and systems of meaning they employ. Cultural beliefs influence people’s expectations and perceptions of symptoms (Kleinman, 1978). The eruption of an illness leads patients and those close to them to ask questions about what is happening, and to call into question ordinary explanations. Quests for meaning appear. People ask: Why me? Why now? Where does this illness come from? What is the reason for my illness? When illness occurs, decisions on where and when to seek care, how long to remain in care, who will provide care, and how to evaluate treatment are made. Cultural beliefs also affect how people communicate about their health problems, the

manner in which they present their symptoms, when and to whom they go to for care, how long they remain in care and practice care, and how they evaluate that care. In Cameroon, traditional healers and western healthcare providers seek to provide a meaningful explanation for illness and a good way to care when the patient's condition worsens (Hardy, 2008; Agbor, & Naidoo, 2011). Caring activities rely on doxa, a fundamental assumption of why things are done the way they are. Habitus is formed and informs the everyday practice of individuals, thus constituting a practical logic and also the organizing principle of caring action. The habitus operates in everyday contexts to shape attitudes and behaviors.

People within the cultural group also believe in a holistic practice of health and vitality. Culture influences people's expectations of what constitutes illness or disease. People distinguish two causes of diseases: diseases associated with spirits (ancestral spirits) caused by witchcraft or sorcery and diseases related to morality, like sexual abuse, killing, or stealing. In this practice of care, they have to address forces in both the natural and the spiritual world. Vitality means the energy to sustain life. The restoration and the preservation of health are impossible without life forces manifested in everything living or non-living. God, ancestral spirits, plants, animals, mankind, and all phenomena and objects that have biological life are considered. God is the ultimate force, source, and controller of vital forces, while the spirits have access to some of these forces. Priests, witches, and medicine men have the knowledge and ability to tap, manipulate, and use this vital force. Witches' roles are to address and control the negative powers. Witches can cause or cure a curse given to a person, an animal, or a location. Priests and traditional healers help people to appease the gods by performing rituals and making sacrifices. Animals, plants, and environments are interrelated. The healing art consists of the application of natural products, such as extracts or concoctions from leaves, roots, oils, fats, animal parts, or insects, and appeals to spiritual forces involving incantations, symbols, and sacrifices, among other rituals.

3.2. Health-practices Systems in Cameroon

The healthcare system model that operates in Cameroon is a dual health system: a predominant biomedical (western) health facility, and an overwhelming presence of traditional medicine. The biomedical health facility is composed of doctors, nurses, nurse

assistants, and many other health practitioners that practice western health care. This is a western influenced. The traditional medicine is practiced by traditional healers.

3.2.1. The Western Health-Practices in Cameroon

The biomedical health facility is part of the national health system that comprises both the private and public sector. The principal provider of health services is the public sector. This sector comprises a university teaching hospital, three central hospitals, ten provincial hospitals, health districts, district hospitals, and many medical centers. The private sector is made up of faith-based, private for-profit health facilities and non-governmental organizations (NGOs), including private clinics, pharmacies, drug retailers, and doctors' clinics. There are multiple financing sources in this sector. The government, public enterprises, foreign aid donors, private enterprises, households, religious missions, and NGOs finance this sector. This sector is dominated by the Catholic and Protestants Missions.

Healthcare activities in Cameroon are supervised and facilitated by the Ministry of Public Health. The development of healthcare has been marked by a mixture of good and bad results. During the early 1970s and during the oil boom of the 1980s, several factors brought progress to the modern western healthcare structures in the country. In particular, there were more than 1000 government-operated health facilities across the country in 1997. According to Ntangsi (1998), the Cameroonian health system has two important features. First, its health system is considered pluralistic because it is characterized by various sources of financing and various providers. Sources of funding for the operation of these facilities include government, public enterprises, foreign aid donors, private enterprises, households, religious missions, and NGOs; the providers are government health facilities, health clinics, health facilities of religious missions and NGOs, private clinics, pharmacies and drug retailers, and traditional healers. Second, it is described as a vertical system because the owners of its financial resources deal directly with the providers without passing through a series of intermediaries or financing agents (Ntangsi, 1998, 2013).

Despite such progress in the network of health systems in Cameroon, the country is still facing challenges. The country faces a shortage of modern western medical and healthcare professionals. Based on statistics (Nationmaster, 2014), there are fewer than 0.7 western doctors for every 10,000 people. Because of the shortage of doctors available to provide care

for patients, services in the country are often provided by western trained (English and French) nurses. These nurses are trained in basic healthcare, delivery of preventive programs, and providing education on hygiene, nutrition, and HIV/AIDS. In addition, despite the variety of funding resources for the healthcare facilities, funding is still inadequate, with a mere 6% of government expenditure being allocated to health (Poverty and Health Care, 2013). Such challenges lead to a turning point that necessitated integration of the modern healthcare system with the traditional systems of providing care.

In Cameroon, modern or western medicine is considered scientific and ultimately efficacious for patients (Kong-Ming, 1977).

3.2.2. Traditional Health Practices in Cameroon

Although some western health practices in Cameroon are provided in public health centers and institutions at no cost, patients in rural areas mostly continue to treat themselves or seek the help of traditional healers. Traditional healers use traditional medicine to treat patients (Hardy, 2008; Agbor & Naidoo, 2011). This medicine was the only healthcare available for centuries in Cameroon. The traditional culture of Cameroon believes that to maintain the health and vitality of human beings and to cure illness, they have to address both spiritual and natural forces (Agbor & Naidoo, 2011). They prevent, diagnose, and treat social, mental, and physical illnesses. Traditional medicine in Cameroon plays a crucial role in combating multiple and complex health problems. Since colonial times and despite massive stigmatization (practices were categorically condemned as witchcraft or sorcery and banned), traditional medicine in Cameroon continues to thrive.

Even before the modern or western philosophy of healthcare was introduced in Cameroon, traditional practices of caring had existed across the country. In Africa, the practices of traditional caring culture and systems are still very prevalent. As Darshan and Bestus (2000) asserted, most of the African cultures have a coherent or unified belief system when it comes to health and efforts to sustain life. This perception involves five key entities:

- God;
- superhuman beings and ancestral spirits;

- mankind;
- biological life forms (e.g. plants and animals); and
- phenomena and objects that do not have a biological life (e.g. rocks, moon, and the sun).

Traditional medicine and practice offered and performed by traditional healers are very popular in most regions of Sub-Saharan Africa. Cameroon still embraces traditional caring practices, including traditional medicine and traditional healers. According to Hillenbrand (2006), in Cameroon, poor people are more likely to rely on traditional healers and traditional medicine than rich people. There are similarities with the practices in the West where upper-class individuals often find their own way when it comes to choosing alternative means of treating diseases, such as cancer. The difference is in cultural codes and understanding of a meaningful and worthwhile life, but the practices of both traditional and western healthcare systems cut and do surgeries. However, the integration of the practices of traditional caring culture, most importantly in the context of the role of traditional healers, is still facing obstacles as resistance to it is evident. Many perceive and claim that traditional practitioners, sometimes referred to as “charlatans,” are pretenders. As noted by the head of the AIDS-Cameroon Program, collaboration between western or modern healthcare and traditional caring practices and methodologies is doubtful, mainly because the majority of healers are likely to be unreliable. “Out of 100, you might only have five who are really good traditional doctors. The rest might be fake, going around saying they can cure AIDS. We need to work on this before we can embark on any sort of collaboration” (Tzortzis, 2003). Western medicine used to postulate that they can heal all diseases, but cancer treatment for example is still a challenge.

4. CHAPTER IV: THE LOGIC OF PRACTICE

4.1. Pierre Bourdieu's Concepts of Field, Habitus, and Capital

The logic of practice emphasizes the importance of practices within the social world and focuses on the theorization of how agents do what they do and how we are to understand the world they construct in so doing (Ritzer, 2004). Practice is what people do. It is activities embodied in individuals mind and body. Practice is the action in which agents are engaged in the making of their work. According to Bourdieu (1990b), the interaction of habitus, cultural capital, and field generates the logic of practice. The logic of practice is a toolkit for this research that helps to provide social explanation of everyday life of the agents studied.

The theoretical framework for this thesis stems from Bourdieu's core concepts. Bourdieu's foundational framework rests on his concepts of field, habitus, and capital (Bourdieu, 2002; Broady, 1991). Bourdieu's framework or concepts have different elements that are difficult to isolate and to extract. According to Bourdieu and Wacquant (1992, p.96), "habitus, field, and capital can be defined, but only within the theoretical system they constitute, not in isolation. [... They] are designed to be put to work empirically in systematic fashion."

4.2. The Praxeology Tradition

Praxeology is a discipline that explains the individual action within the context of practice. Bourdieu is one that founded the tradition of praxeology (Cf. Appendix A). In an attempt to transcend the duality of objectivism (structuralism) and subjectivism (phenomenology, interpretivism), Bourdieu introduces three key concepts as the foundation of his theory of practice: capital, habitus, and field (Bourdieu & Wacquant, 1992). Bourdieu's "theory of practice" states that the "social practices" of "agents" tend to reproduce existing "objective structures." In his theory of practice, Bourdieu tries to balance the influences of both "structure" and "agency" in social practices. Bourdieu also highlights the concept of "field," the social space where "agents" engage in "struggles" to survive/enhance their position.

Pierre Bourdieu is known for his analysis of how society's classes are maintained and reproduced despite the notion of similarity. According to Petersen (1995), in the historical epistemology, Bourdieu's work is empirical, methodological, and theoretical with regards to

themes. The term “structure” is important here as it is both the medium and outcome of the reproduction of practices. Constructed objects are seen as more true and real than those encountered through direct human experience (Petersen, 1993, pp. 36–37). It is a central theme of this knowledge tradition that science constructs its object (Petersen, 1993, p. 36). Bourdieu explores the actions of agents in a given social context with the goal of constructing a theory of practice—the theory of praxeology (Petersen, 1995, 1995b). The word practice is about all concrete human activity that necessarily takes place in the social world. Practice may correspond to very basic activities: food people eat and most of all how they eat, the sports they like and how they practice it, their political opinions and how they express them, the work they achieve, and the stakes they pursue.

Pierre Bourdieu (1 August 1930–23 January 2002) was born into a working-class family in Denguin, a small village in Southern France. He became a French sociologist, anthropologist, and philosopher. He was raised in a remote mountain village in the Pyrénées where his father was an itinerant crop-picker with temporary post office work. His mother was a housewife who raised the family (Grenfell, 2011). At the close of the 1940s, he moved to Paris to study at the prestigious *École Normale Supérieure*, at a time when philosophy was the queen of all disciplines and the obligatory vocation of any aspirant intellectual (Grenfell, 2011).

After receiving his doctorate in 1958, Bourdieu took a teaching position in Algiers, Algeria. Algeria was at that time a French colony, but a war was underway between France and the Algerian independence movement. During this time, Bourdieu undertook ethnographic fieldwork among the Kabyle, Algeria’s largest indigenous group. In the *Outline of a Theory of Practice*, 1977, (*Esquisse d’une théorie de la pratique*), Bourdieu developed a theory of practice that is simultaneously a critique of the methods and postures of social science and a general account of how agents or human action should be understood. This book is well described by Staf Callewaerts eg. in *Praxeologisk sygeplejevidenskab, hvad er det* (Petersen & Callewaert, 2014).

Bourdieu’s rising reputation as a leading social theorist landed him the position of Director of Studies at the *École Pratique des Hautes Études* and later, in 1981, the Chair of Sociology at the Collège de France (Bourdieu & Passeron, 1990). At the Collège de France, he quickly grew dissatisfied with the “philosophy of the subject” exemplified by Sartrean existentialism—then the reigning doctrine—and gravitated toward the “philosophy of the concept” associated with the works of epistemologists Gaston Bachelard, Georges

Canguilhem, and Jules Vuillemin, as well as toward the phenomenologies of Edmund Husserl and Maurice Merleau-Ponty (Bourdieu, 1993; Grenfell, 2007; Jenkins, 2013).

However, shortly after graduation from the elite *École Normale Supérieure*-Paris, Bourdieu turned his back on a projected study of affective life mating philosophy, medicine, and biology and converted to social science, as other illustrious theorists, such as Émile Durkheim and Maurice Halbwachs, had done before him (Robbins, 2002; Swartz, 2005).

Starting from the role of economic capital for social positioning, Bourdieu pioneered investigative frameworks and terminologies, such as cultural, social, and symbolic capital, and the concepts of habitus, field or location, and symbolic violence to reveal the dynamics of power relations in social life. His work emphasized the role of practice and embodiment or forms in social dynamics and worldview construction, often in dialogue and opposition with universalized Western philosophical traditions. He built upon the theories of Ludwig Wittgenstein, Maurice Merleau-Ponty, Edmund Husserl, Georges Canguilhem, Karl Marx, Gaston Bachelard, Max Weber, Émile Durkheim, Erwin Panofsky, and Marcel Mauss. A further notable influence on Bourdieu was Blaise Pascal, after whom Bourdieu titled his *Pascalian Meditations* (Bourdieu, 1990, 2000).

Pierre Bourdieu was a prolific academic writer with more than 25 books and over 400 articles and essays published throughout his career (Santoro, 2011; Reed-Danahay, 2002). Bourdieu was also a leading public intellectual in France, speaking out and organizing protests against what he saw as the unfair and exploitive aspects of neoliberal economic policy and globalization. By the time of his death in 2002, Bourdieu was known as one of France's greatest scholars and one of the most influential social theorists in the world (Reed-Danahay, 2002).

One of his contributions was his introduction of the theory of practice. This theory seeks to explain individual and group actions in the social world. Bourdieu recognized that the actions of social groups cannot be explained simply as the aggregate of individual behaviors, but rather as actions that incorporate influences from cultures, traditions, and objective structures within the society (Jenkins, 1992). Such influences are incorporated into his theory through the concepts of field, capital, and habitus (Cf. Appendix A), ensuring that the theory is fully representative of the social world.

Simply, the theory of practice describes the interaction of these three concepts: field, capital, and habitus. Such interaction, as noted in Bourdieu (1984, p. 101), is explained using the following equation. Action is seen as the outcome of a relationship between habitus, capital, and field.

$$\text{Practice} = [(\text{habitus}) (\text{capital})] + \text{field} \text{ (Bourdieu 1984, p. 101)}$$

4.3. The Significance of Bourdieu's Theory of Practice

As stated previously, Pierre Bourdieu book, *Outline of a Theory of Practice*, (1977) based on his work in Algeria during the Algerian War of Independence, represents his formulation of practice theory applied to empirical data gathered through ethnography. In the *Outline of a Theory of Practice*, Bourdieu is attempting to move beyond objectivism without relapsing into subjectivism taking account of the need to break with immediate experience while doing justice to the practical aspects and character of social life (Rutz & Balkan, 2013; Bourdieu, 1991). Social life consists of individual acts, social structures, traditions, moral codes, institutions, and established ways of doing things that can be changed when people start ignoring them, replacing them, or reproducing them differently. Through the theory of practice, we learn that practice is the repetition of the individual agent's acts that reproduces or subverts the social structure. The main concern of Bourdieu's conception of social action and practice is based on the interrelationship between society and societal development. Practice is what humans do (Bourdieu, 1977, 1990; Jenkins, 2013). The meaning of this concept is twofold: it suggests action as opposed to philosophical speculation and it implies that a fundamental characteristic of human action is material production to meet basic needs.

We also learn from the *Outline of a Theory of Practice* that a person acts on the natural world or works, and only secondarily thinks about it. Human action occurs on the natural and social world, and there is a life-changing nature of action and the priority of action over thought (Öztürk, 2011; Bourdieu 1990a). Practice is more than social action that is seen as an isolated event. Practice is an activity by which human individuals produce and reproduce society in its cultural, social, and economic dimensions (Swidler, 1986, Jenkins, 2013, p.59). Practice has both a mediary role between individual human action and societal development and has a mediatory link between individual and collective action and social structure (social organization of the production and reproduction of society). The individuals' practice is part

of societal development. According to Petersen (1996), the importance of the *Outline of a Theory of Practice* is to explain social practice. This theory contributes to the understanding of human action and the way in which agents internalize the outside world and how this affects what they really do. She adds that “one can in principle not study nursing or care, but one can study the praxis, that some people do, and that in their self-understanding is called nursing and/or practices” (Petersen, 1996). Bourdieu’s theory of practice teaches that through practice, people produce and reproduce their social structure, culture, and economic wealth (Öztürk, 2011). This production and reproduction process is according to Pierre Bourdieu (1998a, 1990a) in relation with overall organization of economic production and reproduction.

4.4. Field, Habitus, and Capital Theories

Bourdieu’s theories of practice are composed of three concepts that aim to understand and explain individual and group actions while ensuring the representation of the social world (Rhynas, 2005). Also, the social groups’ actions, as emphasized by Bourdieu, are not merely justifiable by the aggregates of behaviors but by its incorporation of culture, traditions, and objective structural influences (Jenkins, 1992). These concepts of the theory are known as field, capital, and habitus.

Lynam et al. (2007, p. 29), emphasize Bourdieu’s usage of these concepts for drawing analysis on the “different types of intergroup relations, social relations, individual experiences, social structures and processes of influence.” The authors state that these concepts are to be used for the verification of certain features and also focus on the distinct aspects of the procedures influencing the means by which “social relations are constituted and experienced” (Lynam et al., 2007). With the concept of habitus, field, and capital, Bourdieu sought to bridge subjectivism (the individual) and objectivism (society) using a perspective called *constructivist structuralism* or *structuralist constructivism* (Bourdieu, 1989).

The focus of structuralism is to look at the objective structures of language and culture that give shape to human action (Bourdieu, 1990). Bourdieu’s constructivist structuralism looks at the social genesis of schemes of perception, thought, and action. His concepts are an attempt to examine the social construction of objective structures with an emphasis on how people perceive and construct their own social world, but without neglecting how perception and construction are constrained by this disposition. These three concepts forming the theory of

practice—field, habitus and capital—are converging, intersecting, and relational and direct the analyst to focus on different forms of influence on social relations and the social conditions that shape them (Bourdieu, 1990a, 1990b, 1998). The dynamic in this relationship is characterized with the ability of individual agents to invent and improvise within the structure of their routines.

4.4.1. Field

Bourdieu's concept of field is the objective complement to the idea of habitus. A field is defined as a network of social relations among the objective positions within it (Calhoun, 1993). For Bourdieu and Wacquant (1992, p. 77), the field is an arena of forces and struggles. In the field, agents and institutions are engaged in struggle. Agents want to increase their position in the field through the accumulation of capital. These capitals are economic, cultural (degrees, knowledge of cultural codes), social (networks and social relations), and technical (Bourdieu & Wacquant, 1992). The hierarchy of power relationships serves to structure all other fields described in politics. The influence of the field is crucial as the action is both constrained and given meaning by the context in which it takes place. Field is stated to represent a setting in which agents and their social positions are located, while some regard it as the acquisition of geographic boundaries, comparing it generally to social terrain. Fields also pertain to both physical and social spaces and, at the same time, to the means of interaction with people (Dumais, 2002; Calhoun, 1993). Fields are built, structured, and organized through time. They are the product of a history. This concept also directs analysis to concentrate on procedures like "gaining entry and navigating the social terrain of relationships" (Lynam et al., 2007). Whereas habitus is supported by home fields, there are other unfamiliar fields that can test and foster reflection on the habitus. This may, in turn, need to be changed in terms of participating in activities or in the reconciliation of the evident challenges to the usual and expected means of being.

Field cannot be regarded as a set of interactions or intersubjective ties among individuals; it is like a magnet that is attracted to someone because of the agent's position, dispositions, and positioning (habitus). A variety of semi-autonomous fields, such as art, religion, and education, represent the social world. The field is the symbol of a competitive marketplace in which economic, cultural, social, and symbolic power are used (Bourdieu, 1996).

It is very important to understand the relationship to the political field when analyzing fields. The researcher must map the objective positions within a field and the nature of the habitus of the agents who occupy particular positions. These agents act strategically, depending on their habitus, to enhance their capital.

4.4.2. Habitus

Habitus interacts directly with capital as individual actors work in pursuit of capital. Habitus refers to the tacit features of culture that mainly occurred during the earlier evolution of Bourdieu's research undertaken in the Kabyla society in Algeria. This set the origins of the habitus, prior to emphasizing the means by which culture is "embodied and lived" (Reay, 2004; Bourdieu, 1986). Habitus pertains to the individual's attributes or features, physical dispositions, and viewpoints in navigating the social world. Habitus is the set of dispositions generating practices. The concept of habitus consists of a system of dispositions formed throughout the life of a person (Bourdieu, 1986; Nash, 1999). It refers to the embodied or incarnated impressions that are also reflected in a person's way of thinking, physical posture, and disposition to act in a certain way (Lindh & Dahlin, 2000). Habitus is constructed, mobilized, and restructured during and for practice. Bourdieu's writings referred to habitus as the "comfort zone," which meant the "physical places and social spaces that do not push humans to 'look for clues' to know how to participate" (Lynam et al., 2007). Moreover, this concept is basically obtained in the home context, although it encompasses "a range of social environments and the relationships that typify them" (Lynam et al., 2007).

Bourdieu's habitus represents the mental structure through which people deal with the social world. It can be thought of as a set of internalized schemes through which the world is perceived, understood, appreciated, and evaluated. Habitus is perceived as the result of the long-term occupation of a position acquired in the social world. According to Pierre Bourdieu (1991, p.86), "Habitus provides a practical mastery of situations of uncertainty and grounds a relation to the future which is not that of a project, as an aiming for possible outcomes which equally well may or may not occur, but in relation of practical anticipation" (Bourdieu, 1991 p.86, 2005).

According to Bourdieu, habitus produces and is produced by the social world. People internalize external structures, and they externalize things they have internalized through

practices. When talking about habitus, Bourdieu often used sports metaphors, for example, referring to it as a “feel for the game” (Bourdieu, 1990).

In *The Logic of Practice* (1990, p. 53), Bourdieu defines habitus as follows:

“Systems of durable, transposable dispositions, structured structures predisposed to function as structuring structures, that is, as principles which generate and organize practices and representations that can be objectively adapted to their outcomes without presupposing a conscious aiming at ends or an express mastery of the operations necessary in order to attain them. Objectively ‘regulated’ and ‘regular’ without being in any way the product of obedience to rules, they can be collectively orchestrated without being the product of the organizing action of a conductor.” Habitus is the roots of common sense, or “doxa.”

4.4.3. Capital

This is the third concept with a range of resources in several forms: social, material, cultural, and symbolic. Capital is a resource that seeks to obtain field access to navigate the social world (Bourdieu, 2006, 2008). Through social processes, value is assigned to capital that can either be positive or negative. The procedures of assigning value and the chapter where capital is recognized are said to be important aspects of Bourdieu’s viewpoints. There are various forms of capital (Bourdieu, 2008, p 281): (1) economic (money, material wealth, commodities, and physical resources, property); (2) social (the networks or connections to people an agent can mobilize or draw resources from)—social capital is considered to be the powers and the resources that stem from networks of relationships; and (3) cultural (a variety of competencies more fully described below)—cultural capital is the culturally valued way of being, knowing, and acting. The concept of capital means values, assets, or resources that can be of both economic and cultural character.

It is this insightfulness of Bourdieu’s concept that was used to explore how agents conceptualize patients and their conditions and it is related to this work. Relating to these three concepts, Bourdieu’s theory of practice is used as a theoretical framework. The practice of agents in their social world are the outcome of complex interrelationships between habitus, various forms of capital, and their field. To understand the different agents’ actions, their

practical mastery within a field, their habitus must be constructed (e.g., the agents' practice within the tradition of modern western medicine in Cameroon, both patient and professional, and the political system government's rules and regulations within the field). This thesis uses Pierre Bourdieu's concepts to construct and reflect the complexities of social practice and that which it comprises.

As previously mentioned, Bourdieu's concepts of capital, habitus and field were used to frame the understanding of my research topic. According to Petersen (1995; 2008), habitus is a theoretical construction of people or of agent acting. The term practical sense refers loosely to what people do and how they act and the practical ability to interact with others on a daily basis. When a nurse meets a patient and that nurse reaches out her hand and places it mid-air in front of a patient, the patient knows exactly what to do. He stretches out his arm, holds the nurse's hand, and gently shakes. There is nothing universal about a handshake, but because patients and nurses are socialized from the birth in their society to know how to respond to one, that action becomes a part of their practical sense. It is something that is second nature and they do it without reflection and without thinking. People do not always know what they do even if we ask them. They can only tell us what they believe they do. As researchers, we have to find out what they actually do and why. Therefore, it is needed to construct an explanation by asking them and by studying the structures that are present and effect how and what can possibly be done.

5. CHAPTER V: METHODOLOGY

Pierre Bourdieu's notion of an "epistemological break," as described in *The Craft of Sociology* (Bourdieu, 1991), is the basis of the methodological approach used in this research. With this notion, Bourdieu highlights the importance of breaking with own presupposition when doing research. Based on my personal desire to make such an epistemological break, I considered my research objectives with a new gaze, a sociological eye, which implies a break in the ordinary research attitude toward the world. More precisely, I break with spontaneous thinking and with focusing only on my immediate experience. I break with my existent preconceptions by instead focusing detailed attention on method and description, and above all, I avoid using *clichés*. The reflexivity process of breaking with my presuppositions as a way to understand the social world involved a rupture from the primary experience as well as a rupture from my presuppositions.

5.1. Research Approach

Bourdieu's praxeological approach was used as the principle research method, in which observational research and 25 semi-structured interviews were conducted.

The main objective of the study is to understand the social practices in the traditional caring and western nurse care that influence participants' experiences and to shape their opinions and their daily life. Research interviews (cf. appendix interviews) were used to determine the perceptions and experiences of patients, relatives, nurses, traditional healers/practitioners, and healthcare administrators. Since it was only through research interviews, observations of agents' practices, and description that I was able to pursue and immerse myself in the topic, such a methodology was employed as the study's primary means of research inquiry. I focused my attention on those elements of practice that would seem to have the greatest relevance to understanding both traditional practices and western nurses' practices.

Such a research method involves the researcher in collecting open-ended and emerging data, along with the primary aim of developing themes from the data.

The praxeological approach enabled me to not only observe the culture and describe people's actions, but also to discern and understand the patterns of behavior that function in that specific culture, and so to gain new knowledge about the communities and field. I conducted

a systematic observation in the field. I interviewed agents and carefully recorded what I saw and heard, as well as how things were done.

Ethnography places the researcher in a unique position in which descriptive writing is encouraged. I documented the culture, the perspectives, and practices of the people in their native settings. The aim was to thoroughly “get inside” the way each group of people, the agents, *see* (Hammersley, 1992) and *act* in the world (Bourdieu, 1977). Ethnographic research allows the researcher to become immersed in the specific setting, thereby generating rich insight and understanding of social practices, and their subtleties in different contexts. This method provides opportunities to gather empirical insights into the social practices that are normally “concealed” from the public gaze. I used ethnographic research methods for identifying the emic knowledge, namely significant human experiences, and the etic perspective that refers to objective or outsider accounts. An etic point of view is one for which the analysis of behavior and cultural systems is built on the perspective of one who does not participate in the culture being observed (Harris, 1990). This view point is one of an “outsider.” Both the etic and emic perspectives are discussed for better understanding of agents’ practices. Ethnographic research is a means of focusing on understanding the field in a broader socioeconomic and political context, as well as sociocultural contexts (households and families, formal and informal networks, organizations, groups, dyads, institutions and relationships of the wider community, society, and intersocietal linkages), sociocultural processes (interactions of individuals with and within their significant social systems), and sociocultural meanings (social systemic relationships, the physical environments) within cultural systems (Whitehead, 2005).

5.2. Gaining Admittance to the Field

The key events that stood out for me as gateways to my gaining admittance to the research field were the discussions that I had with the director of Hospital Protestant Ngaoundéré and the representative of the traditional healers in Mbé. The vital discussions involved my getting to know them both as individuals and as group representatives, as well as explaining my interests and research focus. Ultimately, these two people were the ones who had the authority to either let me inside or not. The director is a scholar, a person with high formal

education, who values both the theoretical and practical orientations. The representative of the traditional healers is a traditional-practitioner with deep and profound knowledge of the local culture. From the start, they were both positive toward and highly supportive of my work.

To gain insight into the social practices and to understand the emic and etic aspects, I used Pierre Bourdieu's concept of *understanding* (Bourdieu, 1999). As stated previously, the investigative methods employed in this thesis included observing people and describing the field, habitus, and capital of people, as well as in-depth qualitative interviews. I obtained permission from the director of Hospital Protestant of Ngaoundéré and the representative of the traditional healers in Mbé to do my research.

Bourdieu's empirical work reveals a highly eclectic orientation, relying on questionnaires, interviews, fieldwork, observational studies, and document analyses (Prasad, 2005). Bourdieu's praxeology calls for rigor in reflexivity, theoretical coherence, and careful attention to data. Reflexivity is an important aspect of transcending the duality between objectivism and subjectivism and, therefore, to unveil the reality of practices in Cameroon. Reflexivity is central for Bourdieu because of its usefulness in overcoming three types of common researcher bias: social bias, field bias, and intellectual bias (Prasad, 2005). Social bias arises from a researcher's identity (age, gender, nationality, ethnicity, occupation, and membership) and influences the researcher's interpretation of any situation. Field bias arises from the researcher's position in his academic field (whether he or she is a novice researcher or an experienced scholar) and determines the choice of the researcher's focus and degree of investment. Intellectual bias is driven by the demands of the profession and the researcher's desire to be recognized as a leading scholar, a prominent intellectual, or an expert social scientist (Bourdieu & Wacquant, 1992). According to Prasad (2005), Bourdieu's tradition of praxeology remains an excellent way for researchers to bring the micro subjective world of social actors together with the macro world of objective structures. The micro-subjective deals with individuals, their work, and their experiences. To highlight the micro-subjective world of social actors, I gathered data by interviewing, observing, and describing the agents' practices in their social setting and in their social context. I observed the traditional practices and the western nursing practices that agents, as individuals, live every day—interacting with other agents in their field. Each agent's activities are at the microlevel to the world outside. This microlevel is a mirror of the macrolevel. The macrolevel refers to the collective of the agents' actions. My study was done in the Protestant Hospitals of Ngaoundéré and in the

village Mbé. I examined the historical and structural forces alongside the individual and group strategies of social positioning. With the concept of habitus, I linked the global with the local and the local with the global. I mediated the link between the social structure (macro) and the individual action (micro).

One of the instruments used in this study for data gathering was the semi-structured interview. I have already explored the research questions through a review of Bourdieu's theories of capital, habitus, and field. Following this theoretical overview described in chapters 3 and 4, I constructed the respondents' habitus and context by describing what people did when acting as nurses, traditional healers, relatives, and patients in the field of Cameroon and from where their actions arose. I analyzed the social conditions where their actions were generated and whether those conditions rendered their actions adequate due to the reality of the situation in Cameroon.

5.3. Construction of Agents' Different Habitus and Operative Capital

As mentioned, Pierre Bourdieu's theory of practice, as well as the concepts of reflexivity and understanding, were used as research tools. They were expressed through the description of the position of respondents (i.e., from which position in the field do they speak?). The dispositions that lead to practices are also important. Dispositions generate individual practices, perceptions, and attitudes. We all have dispositions (preferences or tastes, abilities to distinguish between subtle differences, ideas of success or life goals, and one's practical sense) socialized into us at a young age, and our habitus is that part of ourselves where our dispositions lie. These dispositions are also produced by a particular class of conditions; we are all socialized in different ways depending on the society or class in which we were born (Martin, 2014, pg. 74). Asymmetrical access to privilege, authority, and capital are forms of relational domination and practices. It is also important to consider positioning when constructing the habitus of agents in the field.

I construct the agents' different habitus as follows:

- Their position (nurse within the traditional culture, nurse within western culture or a combination of the two).
- Their dispositions (I asked respondents questions such as *Do you have any children, friends?* or *Where did you get your education?*).

- Their capitals:
 - Economic (salary, money, house, flat, bicycle, or cows).
 - Social (married, children, friends, or parents).
 - Cultural (school, education, specialization, and nation of origin).
- Their positioning (what they think and what kind of attitude they have toward their situation).

I construct the answers of my research questions (cf. research questions from Appendix B) from what they say, tell a story and how they see things. The answers are analyzed as data and my theory is constructed based on what is going on in the field.

5.4. Bourdieu's Reflexivity, Understanding, and the Semi-Structured Interview

Social proximity and familiarity both had a powerful impact on my research process as they facilitated a deeper understanding of agents' practice in the field. Bourdieu's approach to understanding is thoroughly described in *The Weight of the World: Social Suffering in the Contemporary Society*. Bourdieu argues that to effectively engage in scientific investigation, one must learn how to make use of one's own presuppositions. Bourdieu compares this to a scientific investigation in which it would be ideal if the researcher, armed with knowledge on what is being constructed, strives to master the very methods of construction (Bourdieu, 1999). Bourdieu states that the only way to explore communication in general is to focus on the simultaneously practical and theoretical problems that emerge from the particular interaction between the investigator and the person being questioned.

Bourdieu further emphasizes that the investigator must do all it takes to reduce any form of symbolic violence that may arise from the investigator/investigated relationship. I tried to achieve this by listening actively and methodically during the interviews so that the interviewees' thoughts, language, and feelings were properly understood. For Bourdieu, it is very important that the investigator knows how to act on the very structure of the relationship, as well as the choice of the respondents and the interviewers (Bourdieu, 1999).

Scientific questioning excludes the intention of exerting any type of symbolic violence that could affect responses. I did everything possible to avoid any kind of distortion (distorted questions and facts) becoming embedded in the very structure of the research relationship. Otherwise, distortions have to be understood and mastered as part of the practice, which can be reflective and methodical without being an application of the method or the

implementation of a theory (Bourdieu, 1999). Through interaction, the respondents and I were always actively engaged in constructing meaning. This required continuous reflection regarding one's own role in the interview. According to Pierre Bourdieu, "Only ... a reflex reflexivity based on a craft, on a sociological "feel" or "eye" "non-problem", allows one to perceive and monitor on the spot, as the interview is actually taking place, the effects of the social structure within which it is occurring" (Bourdieu et al., 1999, p. 608). To engage in the scientific investigation of presuppositions, I tried to make reflexive use of the findings of social science to control the effects of the survey itself and to engage in the process of questioning with a command of the inevitable effects of that process.

To illuminate the respondent's representation of the situation, my cultural background was important in terms of understanding the things that were being said by the respondents, including those things that they held back and did not utter. I constructed the rules of the game so that the relationship between the agents and myself was well established and I made sure to provide them with all necessary information. It was crucial for the research relationship to be as close to the ideal limit as possible.

As mentioned, social proximity and familiarity provide two of the conditions for non-violent communication. However, there are limitations to the social categories that are obtainable under the optimal conditions of familiarity. According to Pierre Bourdieu, "no interviewer can ever forget that objectifying the respondent means objectifying oneself" (Bourdieu, 1999, p. 611). By adjusting the way I formed my questions, for example moving from the objectivizing "you" to "one," I was effectively objectifying myself. Despite this, I protected the interviewees against reductionism and provided agreement on how nonverbal signs and verbal utterances were to be interpreted.

In terms of the spiritual exercise, Bourdieu claims that all of the procedures we use to reduce the distance between the interviewer and the interviewee have their limits. For my project, I handled this distance by inviting the agents to have coffee or dinner. At the same time, I was able to create a proper distance when we talked because I knew the cultural cues; I respected their religion. When I was unsure about their answers, I respectfully asked them to clarify their answers. I tried to put myself in the place of the interviewees to better understand them. Questioning the interviewees and taking their part does not affect the phenomenologists' projection of oneself into the other. Instead, this gives a generic and genetic understanding of who these individuals are based on their grasp of the social conditions of which they are a

product. It requires the interviewer to understand the circumstances of life and the social mechanisms that affect the entire category in which any individual belongs. Here, understanding and explaining are the same thing. My interview was conducted as a spiritual exercise in which I broke with my presuppositions. Thus, my work was based on objective reality, with objective meaning the knowledge of the truth of which is not influenced by any individual. Such knowledge is public and can, in principle, be validated from sources other than the respondents. I gave the respondents unconditional opportunity to speak free from all coercion. I avoided influencing the interview in any distorting direction. This helped the respondents to move over from the private to the public sphere to explain themselves and to construct their own viewpoint. Researchers must be able to recognize their own experiences and understand them completely, while also considering the possibility that their presence as a researcher may likely alter the research setting or even the participants' responses (Robson, 2002).

The semi-structured interview guide for this study was modified during/between interviews where necessary to benefit the information-gathering process. The qualitative research interviews were focused on agents, field, habitus, and capital. The interviews covered a range of social and information-oriented topics, with some questions being more focused on the issue of practice. I conducted the interviews by: (1) defining the research question; (2) creating the interview guide; (3) recruiting participants; and (4) actually carrying out the interviews. Each interview was scheduled at a time and place suitable for ensuring minimal interruption. The informed consent and confidentiality (cf. Appendix C) requirements were explained to each informant and were signed by both parties. With the agreement of each individual informant, the interviews were electronically/audio recorded. Hand-written notes were taken when this was not possible.

The interviews were conducted, when possible, in French, Fulani, or Dii, according to the informant's preference. The informants were given an unconditional opportunity to speak and they were free from all coercion.

At the conclusion of each interview, the informants were again assured of the confidentiality of the proceedings and they were thanked for participating and, when possible, permission was obtained to contact each informant for follow-up purposes as needed.

5.5. Population and Sampling

The total population for the study comprised of patients, relatives, traditional healers, doctors, and healthcare administrators in Ngaoundéré. A total of 25 participants was pre-screened to qualify for the research interviews. Specifically, the study used five traditional healers, five patients receiving western or modern health practices, five relatives, and five healthcare administrators. The sampling technique employed was convenience sampling, in which the researcher selects any participant or subject available to participate based on proximity, accessibility, and possession of qualifications that match the criteria necessary for the study (Crossman, 2013). A collective understanding of all 25 participants in the field was necessary to construct their habitus based on their position and positioning and because of their dispositions (capitals). According to Pierre Bourdieu (1990b, p. 82), it is important to recognize that individuals contain within themselves their past and present position in the social structure at all times and in all places, in the form of dispositions, which are so many marks of social position.

The following are the criteria for respondents in this study:

Study Respondent #1: Nurses and Nursing Assistants

Over 20 years old, male/female.

Must have served as a nurse or nursing assistant in the Protestant Hospital Ngaoundéré in Cameroon.

Study Respondent #2: Patients

Over 20 years old, male/female.

May or may not have been a regular patient in Cameroon (either in hospital or as an outpatient).

Must be familiar with western nursing practices/traditional practicing culture being provided in Cameroon.

Study Respondent #3: Relatives/Family Members of Patients

Over 20 years old, male/female.

Must be a relative/family member of a patient (either in hospital or an outpatient) in Cameroon.

Must be familiar with western nursing practices/traditional practicing culture being provided in Cameroon.

Study Respondent #4: Local Healthcare Administrators

Over 20 years old, male/female.

Must be serving as a local healthcare administrator in Cameroon.

Must be familiar with western nursing practices/traditional practicing culture being provided in Cameroon.

Study Respondent #5: Traditional Healers

Over 20 years old, male/female.

Must be serving as local traditional healers.

Must be familiar with the traditional healer practices/traditional practicing culture being provided in Cameroon.

My status as a nurse and my cultural background helped me to secure the trust of the interviewees. I presented myself as an independent researcher aiming to understand healthcare and the relationship between traditional care culture and western nursing practices. The sample was constituted in an on-going way and stopped at saturation, when it appeared that a new case would bring no additional relevant information.

The interviews were captured using two audiotape-recorders as a means of keeping the information gathered safe and to record details and the native expressions verbatim. The interviews lasted from 20 minutes to 40 minutes. Every interview was transcribed within 24 hours and transmitted to my assistant for validation, which also allowed me to raise comments, new questions, and discussions.

The data collection was based on constructing explanations that go beyond people's personal experiences. The fieldwork lasted four weeks and involved the researcher acting as

interviewer/observant. The Protestant Hospital is not used to hosting researchers in the nursing field.

5.6. Observation of the Field

Two weeks were spent in the Hospital Protestant of Ngaoundéré and two other weeks in Mbé. Before entering the field, I refamiliarized myself with the local norms. In the hospital, I was introduced to agents by the director and in the village by the chief of the traditional healers. I presented myself as a scholar interested in learning and explained the aim and scope of the research project. I created some contact files with relevant agents and made a plan to contact them. The position of respondents in the field was also identified. Being present for 4 to 5 days a week, I was allowed day-to-day observation within the organization. There have been many informal talks with people (both interviewees and other people) during coffee-breaks, lunchtime, and at social events, as well as in private homes, all of which helped me to understand their perspectives. Notes and remarks were written every day in a journal. I took pictures, made drawings, and observed and described what people did and said. Documents as plans, methods, and field notes were used to understand the context of the organization, but some also served as data.

I observed the agents' appearance in terms of their clothing, age, gender, and physical appearance by taking note of anything that might indicate their membership of groups or in sub-populations of interest to the study, such as profession (nurse, relatives, etc.), social status, socioeconomic class, religion, or ethnicity. The observation also included their verbal behavior and interactions (who speaks to whom and for how long; who initiates interaction; languages spoken; tone of voice) by noticing the gender, age, ethnicity, and profession of the speakers. These factors constituted the agents' dynamics of interaction. I observed the physical environment, behavior and gestures (what people do, who does what, who interacts with whom, who is not interacting), and described the place where the interaction occurred and noted how the agents used their bodies and voices to communicate different emotions. Personal space issues (how close people stand to one another) is described by taking note of what individuals' preferences concerning personal space suggests about their relationships. I observed the human traffic (agents who enter, leave, and spend time at the observation site) and described where agents enter and exit; how long they stay; who they are (ethnicity, age, gender); whether they are alone or accompanied; and the number of people. I observed people who stood out (the identification of agents who receive a lot of attention from others).

The description focuses on the characteristics of these agents/individuals; what differentiates them from others; whether agents consult them or they approach other agents; whether they seem to be strangers or well known by others present.

5.7. Data Analysis

The analysis was designed to uncover the structure of my field of study. Pierre Bourdieu (1989a, p.7) states that “the task of sociology is to uncover the most profoundly buried structures of all various social worlds which constitute the social universe, as well as the mechanisms which tend to ensure their reproduction or their transformation.”

Data analysis was an ongoing process that began with the first interview. My interview texts, observation notes, and conversations formed the units of analysis for the study. I translated the information collected from those who responded and transcribed my audiotapes. I read the transcribed interviews several times to check their accuracy and to capture the overall picture in the text (cf. interview text).

I also undertook constant comparison to identify categories of information. During all phases of my study, the data were coded into categories as a way to identify themes and patterns. Furthermore, in the process of coding my data, I created some tables and figures to link similar themes across various phases of my research project. I grouped my data based on agents: position, disposition, positioning, cultural capital, economic capital, social capital, and symbolic capital. For example, I coded:

Cow, bicycle, etc. -> economic capital

Sisters, brother, father -> social capital

Chief -> position

Education -> dispositions etc.

During the analysis process, I identified the meaning of units and then condensed them. I labeled the condensed meaning of units with relevant codes, grouped these codes based on their similarities and differences, and then formulated the themes.

Examples of meaning of unit, condensed meaning of units, subcategories, categories, and theme are as follows:

Meaning of unit: When I feel sick, it's my family and I who have to decide what to do and where to go to ask for help for my health. If I want any help, it's my family who goes to some doctors or traditional healers or finds plants to cure me. It's often my family who has to say what I want and need.

Condensed meaning of unit: It's my family and I who have to decide and select the kind of treatment.

Code: It is our responsibility to seek health assistance.

Subcategory: It is our responsibility to seek Western expertise, traditional expertise, or home medicine.

Category: Taking on responsibility to select treatment

Theme: There is a common responsibility and need for care to be given.

5.7.1. A Relational Analysis of Social Tastes and Practices

To understand the dynamic relationship between structure and action, I conducted a relational analysis of social tastes and practice. I concentrated on three concepts: positions, position-taking (practices), and dispositions (habitus). I observed the position (occupation, education, proximity to power) that agents occupy in their social space relative to another's position. I also observed their position-taking (*Prises de position*), which refers to the choices that agents make to signal their positions to one another in symbolic terms (style of dress, choices of leisure activities, actions, possessions, lifestyles, other tastes, or anything that differentiates the agent from others). Finally, I observed the way in which agents physically manifest their social position. I studied the disposition as the site of interplay between structure and practices. Habitus mediates between position and position-taking. Habitus is the basis of dispositions that enable one to define the social group and social classes (those who occupy similar positions (e.g., nurses and doctors, may have the same habitus). Through habitus, an agent's personal social position turns into position-taking, according to the agent's individual dispositions or preferences. I outlined the "social space" of positions and the symbolic space of position-takings, and I showed how they map onto one another. I used this as a guide to construct the collective habitus of key sets of agents in their field. This relationship mapping

was used for studying the positions occupied by practicing agents or institutions that compete for the legitimate form of specific authority in this field (Bourdieu & Wacquant, 1992).

5.7.2. Field, Habitus, and Capital

I analyzed the position of the field in relation to the field of power, mapped the objective structure of the relations between the positions occupied by agents who compete for a legitimate form of specific authority, and analyzed the habitus of agents based on the system of dispositions that they have acquired.

I described what they did in their arenas of struggle for control over valued resources (capital) and explored the setting in which agents and their social positions were located. I gathered information on agents' social positions: their occupation and profession (medical doctor, traditional doctor, nurse, priest, etc.), family (parents, siblings, etc.), and hobby (member of various clubs and organizations). I constructed and described the objects of study and defined these objects in terms of where they are situated within a relational system. I determined how the fields constituent agents, differently positioned as they are within their field in respect to the distribution of capital (or capitals) operative therein. This involved consideration of how the agents perceive themselves, their competitors, and the field as a whole regarding all its opportunities and challenges. I configured the objective relationship between positions. I also examined their individual interests, shared interests, concerns, and ultimate beliefs.

Further, Bourdieu stated that the field of positions is methodologically inseparable from the field of stances or position-takings as, for example, the structured system of practices and expressions of agents. It is, therefore, important to analyze the spaces of both objective positions and stances. The field was analyzed in terms of objective relations by describing it; I did this by examining the hierarchy of position (doctors, nurses, traditional healers, patients). I specifically examined the space of power relations by collecting information on their capital (salary, network, assets). The space of positions can command the space of position-takings (Wacquant, 1989). Agents and groups of agents are defined by their relative positions within the space. The position of a given agent within the social space is defined by the positions he/she occupies in different fields (i.e., the distribution of the powers that are active within each of them). These are, principally, economic capital (bicycles, cows, house, etc.), cultural capital (formal and informal education, intellect, style of speech, dress, physical appearance, etc.), and social capital (friends, family, colleagues, neighbors, and other contacts), as well as

symbolic capital (titles such as Governor and Chief), which is commonly called prestige or reputation.

The disposition analysis was based on the construction of the habitus of agents, for example, agents' actions and practices, such as cleaning their room, washing patients, feeding, and visiting, as acquired by internalizing their determinate type of social and economic condition.

I also focused on the perception, appreciation, and personal experiences of the social agents. The habitus was constructed by describing what agents do, what they say, and the struggles they experience.

5.8. Ethical Considerations

This research project did not require clearance by the Regional Committee for Medical Research Ethics in Western Norway REK (Cf. Appendix D) because it did not involve interference in people's bodies. It was, however, cleared by the data protection official for research, the Norwegian Social Science Data Services (NSD) (Cf. Appendix E) and was accepted and approved by the director of the Protestant Hospital of Ngaoundéré.

Participants were chosen on the basis of their willingness to cooperate and undergo the research process. Information sheets and consent forms (Cf. Appendix C) were created to formalize the research processes. Participants were asked to attend individual, tape-recorded, unstructured interviews. The use of the tape recorder was discussed with each participant and they were able to decline its use if they found its presence to be intimidating. The unstructured interview is a flexible and adaptable method of finding out about a given subject, in this case the perceptions and experiences of patients, relatives, nurses, traditional healers, and healthcare administrators with regard to traditional practicing culture and nursing practices in Cameroon. Unstructured interviews were used to make the participants feel comfortable enough to speak freely. All appropriate steps were taken to negate any form of symbolic violence and violent communication that may have arisen from the interviewer/interviewee relationship.

The participants gave their informed consent regarding the use of notes and recordings from sessions, as well as their own written materials, for research purposes (Cf. Appendix D). Confidentiality was guaranteed by the researcher undertaking not to disclose any details or

circumstances that could contribute to the identification of participants. Further, ethical considerations have been honored during discussions with the participants throughout the project, as well as in the presentation of findings to safeguard the participants' dignity. As a result of these considerations, quotations are presented as group data and not related to specific individuals.

5.9. Limitations of the Study

The interviews were mainly conducted in French and Dii (the local language) and occasionally in Fulani. The transcription of these interviews proved difficult. Transcribing and analyzing interviews while also having to translate from one language to another results in some limitations. Language structures, idioms, grammatical strategies, and vocabularies are very culture-specific. During the translation and transcription processes, inaccuracies were difficult to avoid. Moreover, in the analysis of these transcripts, some subtle and hidden meanings might potentially have remained undetected (cf. Appendix E for a fully transcribed interview and observation).

The researcher's limited understanding of Fulani also caused concern during periods when relatives talked with patients rather than with the researcher. These conversations would have certainly provided useful information that could have further enriched the analysis, so not being able to understand what was being discussed was a significant limitation to this research. The researcher is familiar with the field, is fluent in French and Dii, and had some background knowledge on traditional practices and nursing practices in the geographical area studied. The setting corresponds to the social context, the habitus in which the participant group grew up, so relationships and interactions are crucial to ensure field validity. Therefore, the study of the discourses that surround the respondents would provide valuable insights into practicing culture.

Concerning generalizability, the data collection comprised 20 to 40 minutes of interview with a focus on the individual informant's professional life, actions, and also life history. The sample for this study was drawn from the Protestant Hospital of Ngaoundéré and from Mbé, and, therefore, generalizing the findings to non-represented nurses and traditional healers in Cameroon may be challenging. However, the interactional patterns identified in this study are consistent with other ethnographic descriptions and empirical studies. Additionally, the present study did not aim at examining the quality of practices, but was instead interested in

the underlying relationship between traditional practicing culture and western nursing practices in Cameroon.

Therefore, the research aim is not to make claims that are representative on a national level. The claims made in this study refer primarily to the local contexts in which the study was conducted. Moreover, the findings can be considered to be transferable to other contexts that are culturally similarly organized. Comparison with studies in similar contexts would thus allow for further generalization.

6. CHAPTER VI: THE ARTICULATION OF CARING PRACTICES

In this chapter, the practices or “the practical sense” within the traditional caring culture and western nursing culture and how do they relate to each other are explored. The agents’ activities in their field are also discussed. This research focuses on what agents do in the field, what activities agents are involved in and where agents are positioned. It is also a description of the dynamics and relationships in field allowing to recognize the game and its stakes. Agents have a feel for the game; they have the game under their skin, they have a sense of the history of the game (Widin, 2010, p. 34; Bourdieu & Wacquant 1992: 81). This research analyze both the structure of the distribution of species of capital, which tends to determine the structure of individual or collective stances taken through the interests and dispositions it conditioned (Bourdieu &Wacquant, 1992, p. 114). It also discloses the structure that tends to find and legitimize people to enter the field (Bourdieu &Wacquant, 1992, p. 107).

Individual acts, the social structures, traditions, moral codes, institutions, and the established ways of doing things are important elements for understanding the practice of agents (Boudieu, 1977, 1990; Jenkins, 2013). Articulating caring practices are attempts to unmask and unveil social reality and its many nuances that are hidden by presumptions and merely concealed behind a veil of common sense understandings, discourses, and narratives (Jenkins, 1992). The logic of practice is used to better understand the relation between the practice of the traditional caring culture and western nusing. The articulation of practice is based on what agents really do in their social field.

This chapter is aimed to the understanding and the description of the practices of the traditional caring culture and western nursing. This part is also based on the comparative analysis of the practices of care. This chapter scrutinizes the practices of care field. It contains the description of the differences and the similarities in the practices of care and the challenges posed by the coexistence of the practices of traditional caring culture and western care.

6.1. Health-Seeking Decision: Traditional, Modern, or Both?

Selecting appropriate treatment when illness occurs is the common practice agents face every day. Figure 8 shows the steps patients take when seeking care and outlines the influencing

factors, personal perceptions, and dispositions concerning their health needs. This provides insight to the possibility of integrating the cultures of traditional care and modern/western nursing for patients and healthcare practitioners. Cameroonians of all ranks, cultures, and backgrounds depend on traditional medicines for their healthcare needs. Traditional medicine is formally recognized in Cameroon. According to Agbor and Naidoo, (2011), the official recognition and integration of traditional medicine into the Cameroonian health system was established in 1981. The Presidential decree no. 95-040 of July 3, 1995 authorizes traditional healers in Cameroon to create associations at both provincial and national levels to manage their caring activities (Republic of Cameroon, 1995; Agbor, & Naidoo, 2011). The majority of Cameroonians still rely on traditional healers. Most people believe that traditional healers share their culture, beliefs, and values and understand their expectations of health care.

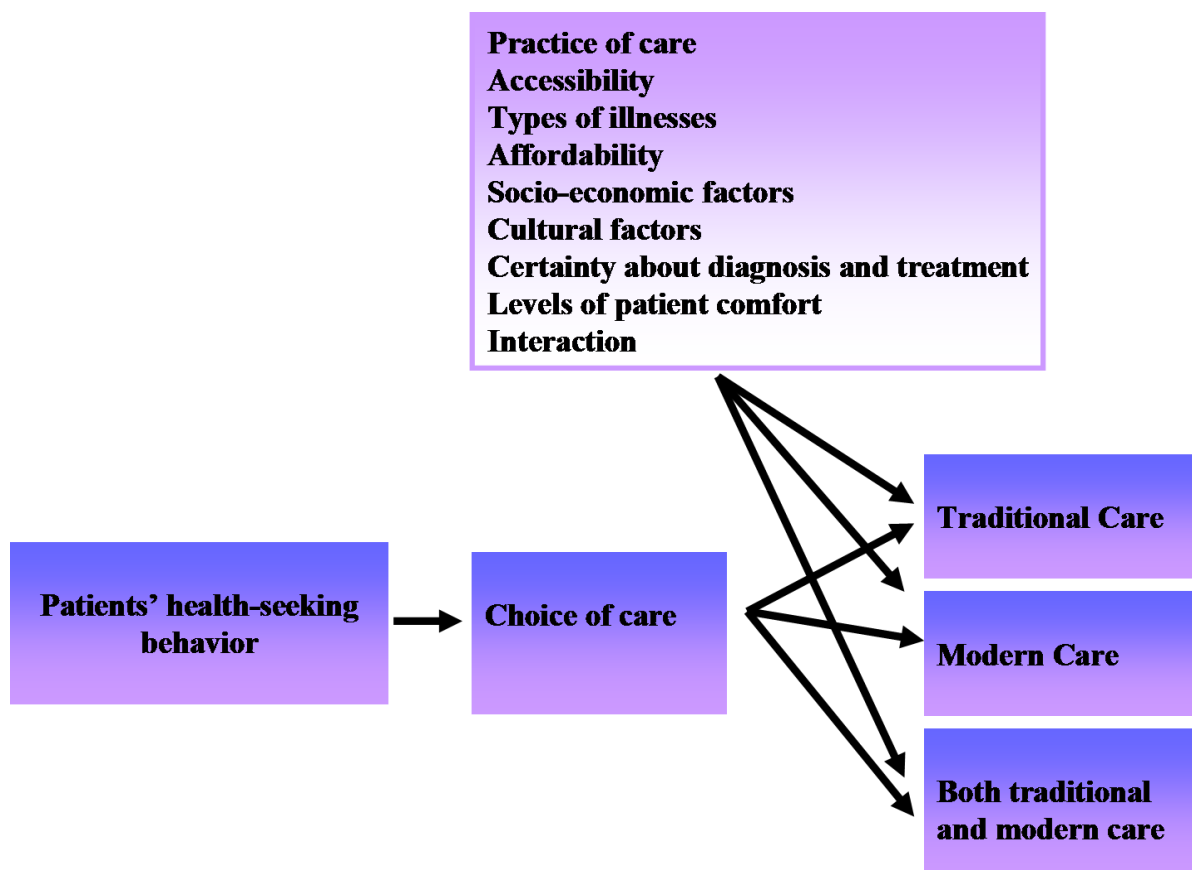
When illness occurs, people choose between western medicine and traditional medicine. In many villages in Cameroon, when there is an outbreak of acute diarrhea, for instance, people tend to suspect a spiritual cause first, and, therefore, resort to a traditional healer. Patients and their families also present hospitals with evidence of their caring culture, their familiarity with traditional medicine, and the values related to health and illness. Their cultures have systems of health beliefs that allow them to understand the human body. They have their own explanations of what causes illness, how it can be cured or treated, and who should be involved in this process. The way they perceive, experience, and cope with disease or illness is based on their explanations of sickness, and these explanations are specific to the social positions they occupy and the systems of meaning they employ. “I have quarreled with neighbors, they are the cause of my illness” or “somebody has thrown me a worm causing sickness in my body” are other typical examples based on local beliefs. This explains how they report symptoms, their expectations of how healthcare will be chosen and delivered, and their beliefs concerning medication and treatments.

Traditional healers’ treatment is considered to be affordable and accessible to the vast majority of Cameroonians. According to Lantum (1978, p 79), traditional healers understand the social problems and cultural experience of their communities. “They use this knowledge in their diagnosis to better treat the invalids, to whom they are very close. If a sick person tells [the healer] that he was beaten all night in his bed, the indigenous healer will understand him and help him chase away the spirits.”

Rich/educated people rely on traditional healers as well as poor and low educated people. The choice of healthcare providers is driven by patients' healthcare-seeking culture and behavior. This choice reflects considerations as to when and what patients seek when it comes to their health. When people seek healthcare, the nature of their beliefs about health and illnesses influence their choices. Much has been written about these beliefs from the standpoint of particular cultural groups and even from subcultures of dominant groups (e.g., working-class beliefs versus middle-class beliefs) (O'Guinn, Faber, & Imperia, 1986). There are different cultural beliefs, personal dispositions, and perceptions that aid in the choices patients make regarding healthcare providers.

Figure 8 illustrates the way patients and relatives choose traditional caring or modern medicine. This selection of treatment is based on the practice of care and the quality of the interaction of patients with traditional healers or western nurses and doctors. It is also based on the certainty about diagnosis and treatment, socio-economic factors, affordability, types of illnesses, levels of comfort, confidentiality, and interaction.

Figure 8: Factors and Dispositions Meaning Habits, Beliefs, Values, Tastes, Bodily Feelings, and Thoughts that Likely Influence Health-Seeking Decision



6.2. The Environment Where the Practices of Care are Articulated

The practices of western nursing itself take place in the Hospital Protestant of Ngaoundéré (HPN), as shown in Figure 9. The hospital is divided into a variety of distinct arenas or “fields” of practice. Each arena has its own unique set of rules, knowledge, and types of capital.

Figures 9 and 10 show the field where agents receive treatment when illness occurs. This field has various social and institutional arenas in which agents express and reproduce their dispositions. Agents in this field compete for the distribution of different kinds of capital (Gaventa, 2003, p. 6). Figure 9 is showing the modern western hospital in Ngaoundéré.

Figure 9: The Modern Western Biomedical Field—Hospital Protestant of Ngaoundéré

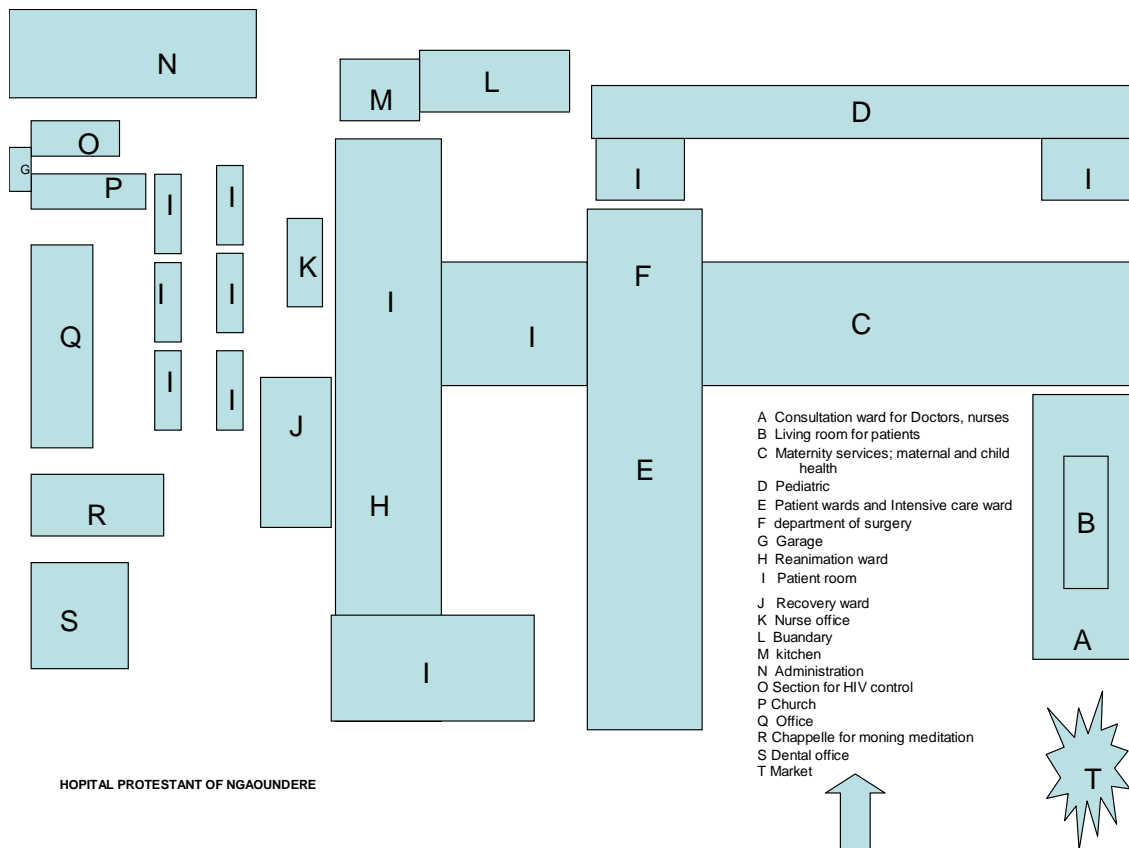


Figure 10: Traditional Healer Field



Figures 9 and 10 show the fields of social activity, where the practices of care and the interaction between agents occur. The practice of traditional healers can usually be observed in villages. Most traditional healers use banners. Figure 10 shows a banner with the following message: “Traditional Healer for All Your Needs!” Patients and their relatives may choose to be treated for their health in the modern western biomedical field (Figure 9) or in the traditional healer’s field (Figure 10). In these fields, agents relate and struggle through a complex number of connected direct and indirect social relationships.

The objectives of the traditional healer banner in Figure 10 are to clearly deliver the message about his activities, to create awareness of his healing power and products, to confirm his credibility, to connect his target prospects emotionally, to motivate people to visit him in his location, and to build loyalty. By using this banner, he wants to increase personal image and position, to stay in peoples’ minds and to make money. Traditional healers use banners to increase their professional visibility and to be seen as well-known, popular, and trustworthy traditional practitioners. People use to choose to go to such traditional healers when they need treatment.

As shown in Figure 11, the patients’ wards looked as if they were built in the 1920s out of cement. Above the door, the patients’ relatives are seated on a spread-out mat. The door is made of iron. There is a little space of approximately 16 square meters with four beds and one patient in each bed. Under each bed are bags and food since the patient (or their relatives)

should provide their food and do their laundry. The patients' beds are also used as chairs for visitors.

Figure 11: Patient Wards, Church, and Relatives in Hospital Protestant of Ngaoundéré



During my visit to a patient ward, I met two visitors sitting down in the same bed as a patient and seven relatives sitting on the floor. They talked and gesticulated. One of the patients was trying to eat. She was unable to eat without help so her relatives assisted her. The relatives advocated for the patients and received information on the patient during medical ward rounds. They often performed roles similar to those of nurses observing a patient's vital signs and trends in their condition. They acted like advisers and qualified nurses but lack formal education. The medical ward rounds group was composed of a doctor, two nurses, two nurse assistants, and three nurse assistant students. After the doctor prescribed medicine, the relatives were charged with going and buying the prescribed medication if they had enough money. To administer the medicine, they made contact with the nurse assistants. A nurse assistant then administered the medicine.

The interaction between agents is characterized by caring practice. The interaction influences people's behavior, motivation, and mood regarding care. Further, the field consists of arenas of caring action, social networks, and social support. The social networks include the

structural aspects of social relationships, such as the unlimited number of families, friends, colleagues, group members, and representatives of the village who come to the hospital to visit their patients and stay for an extended period of time. In this social relationship, the agents are connected to one another. The ties are based on group structures, such as work, neighborhood, and homogeneity. Some aspects in this network include the frequency of contact and visits, and reciprocity. Social support refers to the various types of capital used and assistance received from their social networks, such as instrumental (e.g., money, food, and feeding patients), emotional (e.g., being there and encouraging patients, giving hope, and greeting), and informational (e.g. informing that they know someone in the village who can treat illness, and giving medical advices).

6.3. Understanding of Agents' Daily Activities—Habitus

In the social environment, the concept of caring habitus is constructed and expressed through the agent's daily practices. Agents' everyday practices, as shown in Tables 1, 2, and 3 are repetitive, routinized, and mundane activities; they are interwoven activities in the social environment. According to Pierre Bourdieu, habitus is "society written into the body," "a state of the body" comparable to "motor schemes and body automatisms" (1990a: 68–9, 104). The practice of caring is related to culture. Caring and culture are intertwined and inseparable. The practice of caring involves nurses, patients, relatives, traditional healers, family, and the patient's community. Caring takes place in the relationship between agents in the field. The relationships of these people in the social environment are conveyed in a range of activities, including visiting, eating, greeting, speaking and gesturing, interacting, cleaning the room, and washing the patient. The agents' habitus in Hospital Protestant of Ngaoundéré (HPN) and in Mbé is also related to social practices. According to Bourdieu (1990a, p.70), habitus is expressed through durable ways of standing, speaking, and walking and, therefore, of feeling and thinking. Pierre Bourdieu defines habitus as embodied in individuals and enacted (Weick, 2007) in social interactions. Habitus is understood with this expression: "That's just how things are done here." Habitus shapes what people think, how people act, what is feasible to imagine, and what is considered possible and acceptable in practice in the social environment. Habitus is central to generating and regulating the practices that make up social life. Habitus expresses itself in the innumerable mundane everyday practices (Webb et al., 2002). Tables 1, 2, and 3 present agents' habitus.

Table 1 continues

Time Every day	Activities	Agents	Researcher commentaries
9:00-15:00	Doctors check patient's documents and check the results of blood analysis. Ask patient or their relatives' questions about how he/she (patient) feels.	Doctor, nurses, nurse assistants, and "auxiliaries." Patients, patients' relatives.	Nurse decides and rejects patient's view. Caring is giving instructions, diagnosing, administering. Less hands-on care. Elevate voice when talking to patients. Difficult working structure, things are not clear. Education (knowledge, skill, competence) administration (economic, political, legal, and structures) social and other factors influence caring. Caring as nurse and nurse assistant activities means: talking to and assisting patient with diet and with position, comfort, trust, advocacy, touch, authentic presence, and respect.
15:00-17:00	Administer medicine. Ward attendants.		These activities are not practiced properly and daily because of unpaid salaries. Nurses are not motivated to provide a good quality of care. The hospital has its own pharmacy. Patients must buy drugs before they can get treatment. Caring is to give recommendation, direction.

The agents begin the day with a prayer or meeting in the church every morning at 7:30. Table 1 shows what the doctors, nurses, and nurse assistants in HPN do and how they act daily. They do it by practical sense; they do not know what they do even if I ask them. They can only tell me what they believe they do. Nurses have only a practical sense of what they are doing. For example, when they give a blood transfusion to patients they place it in vena. Nurses place spoon in the mouth of patients when given a peroral medicine. They intuitively anticipate the position of vena or the patient's mouth. These actions are based on practical aptitudes nurses have picked up through past experiences. They can tell what they do but cannot explain from where their actions - what they do - are generated from.

The daily activities of agents involve receiving and giving night reports, praying and singing in the church every morning (Christians), managing care, gathering patients' documents, and finding out the results of blood analyses. They collect instruments for measuring blood pressure, temperature, and glucose in blood. They visit patients (medical ward rounds). The doctors check the patients' documents and check the results of blood analyses. They ask the patients or their relatives questions about how the patient feels. They assess and diagnose by asking "tell me your symptoms." They treat any conditions; they prescribe and administer treatment and follow-up care for the patients. They sign prescriptions and documents.

Table 1 also shows that caring is prescribing medicine, giving instructions, diagnosing, administering, and providing recommendations and a direction. Caring is not closeness. There are, in some ways, some differences to caring that I have learned from being with patients at the most intimate and difficult times of their lives. The increasing speed of the recovery of patients is a shared responsibility between relatives, nurses, and doctors. *Habitus* restores the picture and the caring action of the social agents as embedded in history.

6.3.2. Nurses' Practices in the Hospital

To further describe nurses' practices in the hospital, various definitions were derived from the responses of the participants. The words "effective" and "adequate," were mentioned by many respondents. Both terms describe how nursing should be delivered, not just by nurses, but also by other healthcare professionals whose careers are simply to provide nursing services to their patients.

One of the health administrators stated, “It [nursing] should provide effective plans [and interventions] that help achieve positive results for the patient.” Considering the increasing demand for accountability, nurses must demonstrate the effectiveness of the treatment in aiding in the achievement of favorable outcomes. This goes to show that nursing practices, including all its objectives and consequent care plans, should be effective enough to ensure care goals are met.

Nursing care is characterized by adequate interventions and care plans that aid patients in their various treatments. The practice entails the delivery of sufficient and satisfactory healthcare through a series of tasks. The nurses’ tasks as observed include:

- Assessment of patients
- Establishing diagnosis
- Anticipating outcomes
- Planning for intervention strategies
- Implementation of an intervention plan
- Evaluation of patient’s progress

These responsibilities are a set of duties and tasks performed on a daily basis in their workplace. In regard to the main task, one respondent stated, “We initially observe or interview them [the patients] to get [a] brief background of the patient [as well as] their condition.” They collect samples and relevant data on the patient, then evaluate the patient’s situation and create a diagnosis. After the outcome identification is performed, they design plans for treatment or nursing care intervention. As noted by the participants, “We conduct the plan for the patient based on the patient’s physician’s suggested treatment” and “most importantly, we do counseling for the patient, discussing many things from psychological counseling, etc.”

6.3.3. Patients and Relatives' Daily Activities in Hospital Protestant of Ngaoundéré (HPN)

Table 2: Patients and Relatives' Daily Activities in Hospital Protestant of Ngaoundéré (HPN)

Time Every day	Activities	Agents	Researcher commentaries
6:00-9:30	<p>Wash/clean patients.</p> <p>Go to marketplace close to hospital and buying bread, sugar, coffee and so on.</p>	<p>Patients.</p> <p>Relatives.</p>	<p>Relatives have a lot of time to care, body contact. Caring is to be there.</p> <p>Caring is relatives' activities: patterns of love, dignity, and concrete caring actions.</p>
7:30-9:30	<p>Make food or get food from relatives.</p> <p>Patients eat or get help from relatives to eat.</p> <p>Visit anytime.</p> <p>Relatives talk.</p> <p>Patients and relatives are ready for the doctor's ward rounds.</p>		<p>Too many visitors and visits (some receive visits from their congregation)</p> <p>They may contact traditional healers. Combined care from nurse, doctors and from traditional healers.</p> <p>Have limited knowledge of modern medicine.</p> <p>First try traditional medicine given by traditional healer, and if it does not help then they go to hospital.</p>
9:30-12:00	<p>Answer questions asked by doctors.</p>	<p>Doctor, nurses, nurse assistants, and "auxiliaries."</p>	<p>They use home-based treatments and use them earlier in the treatment sequences. They often use traditional healers.</p> <p>Most choose traditional medicine first because they believe in the power of witchcraft and homeopathy.</p> <p>Modern medicine seems prohibitively expensive for many.</p>

Table 2 continues

Time Every day	Activities	Agents	Researcher commentaries
12:00-06:00	<p>Some relatives wash patients' clothes.</p> <p>Make dinner.</p> <p>Patients eat or sleep or receive new visitors.</p> <p>Buy medicine prescribed by the doctor.</p> <p>Contact nurse assistant to administer medicine.</p> <p>Control IV medicine and inform nurse assistant when empty.</p>	Patients, relatives.	<p>Caring is closeness, caring is to give patient hope that he/she will be well and that he/she is not an economic burden.</p> <p>Caring is being there, encouraging the patient.</p> <p>Physical contact.</p> <p>Apply instructions given by doctors or traditional healers.</p> <p>Delaying initial treatment, using various home remedies or pharmaceuticals, going to a government clinic or private hospital, and consulting a traditional healer.</p> <p>Many patients' relatives in a small room.</p> <p>They sleep at the bedside, on the floor, or camp nearby in the open air on hospital grounds. They sit vigil, bathe their loved one, run to the pharmacy to buy medicine if they can afford it, make meals, and feed them to the patients. They keep an eye on intravenous bottles. They wash patients.</p>

Table 2 shows the patients and relatives' daily activities in HPN. The relatives wash and clean the patients. Some relatives wash the patients' clothes. The relatives go to the marketplace close to the hospital and buy bread, sugar, coffee, and other items. They make dinner and prepare food or get food from other relatives. Some patients eat without help;

others get help from their relatives. There are no visiting hours, so people come and go as they want. They sleep at the bedside or on the floor, or at a camp nearby in the open air on hospital grounds. They sit vigil, bathe their loved ones, and run to the pharmacy to buy medicine if they can afford it. They keep an eye on the intravenous bottles. They give traditional remedies to patients and administer them in addition to western medications. The relatives of the different patients talk and share experiences. The patients and relatives prepare themselves for the doctor’s ward rounds and answer all questions asked by the doctors. Communication is a one-way process. The relatives buy the medicine prescribed by the doctor, contact the nurse assistant to administer the medicine, and control the IV medicine and inform the nurse assistant when the IV is empty.

Table 2 also shows that caring is based on love, dignity, and concrete actions. Relatives have a lot of time to care and practice body contact. They are always there. Caring is closeness; caring is giving the patient hope that he/she will be well and that he/she is not an economic burden. Caring is being there and encouraging the patient. It is physical contact. Caring is applying the instructions given by the doctors, nurses, or traditional healers. Relatives talk to and assist the patient with diet and with physical position and comfort, and provide trust, advocacy, touch, a familiar presence, and respect. The patients’ relatives have the power and the freedom to delay initial treatment, use various home remedies or pharmaceuticals, go to a government clinic or private hospital, and consult a traditional healer.

6.3.4. Traditional Healers’ Daily Activities in Mbé

Table 3: Traditional Healers’ Daily Activities in Mbé

Time	Activities	Agents	Researcher commentaries
Every day			
01-06	Activities may vary. Pray (Muslim). Go to the forest to harvest medical plants.	Traditional healers, patients, relatives. Patients, relatives.	Family as a factor that influences the traditional healer/patient relationship. Pray to get supernatural caring power from God and ancestors spirit. Caring is a relationship involving the patient’s family and traditional healers. Caring involves relationship with God, and belief in ancestors.

Table 3 continues

Time Every day	Activities	Agents	Researcher commentaries
06-24	<p>Diagnose patients.</p> <p>“I’ll tell you what’s causing your symptoms.”</p> <p>Give instructions.</p> <p>Give medical and therapeutic, psychosocial, and lifestyle information.</p> <p>Administer medicine, treat with herbs, plants, and so on.</p> <p>Pray.</p>	Traditional healers	<p>To diagnose, traditional healers use supernatural methods such as reading a chick, egg, or fowl. Mystical and certain symbolic activities are used as well.</p> <p>They sleep at the bedside, on the floor. They keep an eye on the patients. They wash the patients.</p> <p>Life experience, knowledge acquired from ancestors, parents, grandfathers, culture structure, social, and other factors influence caring.</p> <p>Caring as traditional healer activities means: talking to and assisting patients with diet and with position, comfort, trust, advocacy, touch, authentic presence, and respect.</p> <p>Some drawbacks of traditional medicine, such as incorrect diagnosis, imprecise dosage, lack of hygiene, lack of written records about the patients, and the secrecy of some healing and caring methods.</p> <p>Cheap and expensive services. Traditional treatments are expensive, take longer, and more often include inpatient treatment. Other traditional healers offer treatment at lower costs and are easier to reach.</p> <p>Poor and less educated people as well as educated people seek care from traditional healers.</p>

Tables 3 continues

Time	Activities	Agents	Researcher commentaries
Every day	They speak, interact	Traditional healers	<p>Caring is giving instructions and checking up.</p> <p>Patient-centered in several aspects: psychosocial topics, issues of daily life, asks for patient’s opinion and frequently discusses patient’s concept of illness, talks about issues that matter in real life, talks about the concept of illness during consultations and by thoroughly exploring their beliefs.</p> <p>Encourages patients and relatives.</p> <p>They interact differently with their patients. They try to approach their patients by talking about issues that matter in real life and by thoroughly exploring their beliefs.</p>

Table 3 shows the traditional healers’ daily activities. Traditional healers’ daily activities may vary. As Muslims, they pray daily, five times per day. They go to the forest to harvest medical plants (extracts or decoctions from roots, oils, leaves, etc.) or to find some animal parts or insects. Healing and divination are practiced by traditional healers. They have power to deal with spiritual realm. Some rituals are also used to recreate the adequate spiritual conditions for a healthy life. When they have patients, they diagnose them by saying “I’ll tell you what’s causing your symptoms.” To diagnose, traditional healers use “supernatural methods,” such as reading a chicken, stone, bone, egg, or fowl. Certain symbolic activities such as rituals and rites are also used. They give medical and therapeutic instructions, plus psychosocial and lifestyle information. They administer medicine and treat with herbs, plants, tortoises and ceremonial smoking of herbal preparation. Caring is guiding the patients to consult the right healers or to give recommendations to the patients to go to the hospital when traditional medicine cannot help them. Most traditional healers’ compensation is dependent on the discretion of the patients.

Table 3 also shows that caring is done by the patient's family and traditional healers. Caring involves a relationship with God and a belief in ancestors. Traditional healers sleep at the bedside or on the floor and keep an eye on the patients. They wash the patients. Caring practice is influenced by life experience; knowledge acquired from ancestors, parents, and grandfathers; the culture's structure, social network and interaction, and other factors. They talk to and assist patients with diet and with their position and comfort, and provide trust, advocacy, touch, authentic presence, and respect. They give instructions and follow up with their patients. They practice patient-centered caring in several aspects: psychosocial topics, issues of daily life, asking the patient's opinion, frequently discussing the patient's concept of illness during consultations, and by thoroughly exploring their beliefs. They encourage the patients and relatives. They interact differently with their patients than doctors and nurses.

6.3.5. Story of One Traditional Healer

Robert, a traditional healer born in 1947, speaks about his individual life history:

I learned to be a healer from my father, who learned it from my grandfather. Before making a trip to the bush, I first of all ask for God's guidance and protection. Just like my father, I draw some grains of millet under the trees before cutting them.

Patients who come to me for healing are normally received with respect and kindness. I receive and treat patients with a lot of care. I care in a deep and meaningful sense. After the reception of a patient, I diagnose with the help of a chick. I place a chick on some sensitive part of the patient's body until this chick dies. When the chick has died, I operate to discover the contaminated parts, which are immediately transferred and related to the patients. At times, the kidney is swollen to look like a tortoise or a chick without wings. This kind of illness is called the "tortoise" illness. There are two kinds of illnesses: tortoise and chick illnesses. Most of these illnesses are spiritually given. I tell the patients and family what's causing their symptoms to help them understand the illness. I do regular checkups. Patients that have already been diagnosed can either stay in my house to be treated, I have a room for them, or they can return home and wait for me to come and treat them. For treatment, a dose of two cups a day repeatedly for seven days is prescribed. This is done in a way that it does not tire the patient. I treat typhoid quicker than the hospital can and I do it for free. I also treat mental diseases. I have a bucket of traditional drugs and herbs with me every day. Compensation from patients is either verbal (they thank me) or in the form of a gift or money. The money earned is used to send my children to school. I have two wives, five children, goats, a bicycle, and a small farm. I started healing in 2005 when I was already old and unable to do tedious farm work. Originally from Mazadou, my parents and I migrated to Mbé to do agriculture. My father was also an elder in this social class. I used roots and leaves and ritual ceremonies (bone-setting, blood-letting, and foreign object extraction) to heal my patients. I assist women when they have babies. I am happy being a traditional healer. I have schooled up to CE1 and read "Mamadou et Bineta," and I have gone to Quran school.

I advise other healers to be cautious and very careful when dealing with patients. I equally say that if illnesses are difficult to manage by traditional healers, as traditional healers we must refer the patients to the hospital.

This story illustrates how Robert accumulated his capital and how that capital supported the development of his habitus as a traditional healer. Robert's habitus as a traditional healer and caregiver originated from his life experiences acquired in the social environment. His caring habitus is composed of trips to the bush, praying to ask guidance and protection, and drawing grains. He diagnosis illnesses by placing a chick on the body of patients and operates this chick to localize the health problem. He performs checkups and treats his patients by using roots and leaves. He assists women, advises other healers, and refers patients to the hospital.

This story presents three forms of capital: (1) economic (money, house, gift, goats, bicycle, and farm); (2) social (grandfather, wives, children, patients, patients' relatives, and others healers); and (3) cultural (Schooled up to CE1, Quran School, experiences from his father).

Robert's story is similar to other traditional healers' stories. This story describes common practice among the traditional healers in Mbé. They use chickens to diagnose patients' health problems and medicinal plants, roots, herbal remedies, and bone to treat diseases.

6.3.6. Behaviors of Nurses or Traditional Practitioners that Inhibit or Stimulate Patient Participation

The practices of care are related to the behaviors of caregivers. The behaviors of nurses or traditional practitioners can inhibit or stimulate patient participation. Patients and relatives are fully focused on the behaviors of caregivers as important factors for caring process and well being.

Table 4: Behaviors of Nurses or Traditional Practitioners that Inhibit or Stimulate Patient Participation

	Behaviors of nurses and doctors	Behaviors of traditional healers
Stimulating patient participation	Accessible	Accessible
	Confirms	Active communication with patients
	Listens and asks	Expresses opinion
	Gives necessary explanations	Gives explanations
	Gives written material	Acts directly
	Acts as intermediary for contacts	Gives medical and therapeutic, psychosocial, and lifestyle information
	Gives tips about self-care	Gives tips about self-care
	Discusses and makes agreements	Makes and shows agreements
	Hands over responsibility	Hands over responsibility
Inhibiting patient participation		Closeness
		Supportive during consultation and treatment
	Withdraws from the patient	Give poor health and medicine
	Non-supportive during the medical ward rounds	information, they keep things secret
	Disparages with baby talk	Does not make notes
	Makes ironic remarks about an experience	Problems with dosage
	Decides herself and rejects views of patients	Risk for harm
	Answers abruptly	Long treatment duration
	Neglects making notes in records	Infection
	Many complications reported	

Table 4 presents what traditional healers are able to do. They communicate with their patients and are close to patients; they give tips about self-care and are supportive during caring. The suffering of patients affects traditional healers directly and traditional healers' practices are associated with closeness to a person's vulnerabilities. This supports the moral importance of closeness and immediacy of traditional healers. They are good at expressing their opinions,

giving explanations, acting directly, making agreements, and giving medical, therapeutic, psychosocial, and lifestyle information. They are very close to their patients. From the perspective of modern/Western medical practitioners, traditional healers give poor medical information. They cannot even tell what they give as medicine to their patients. They do not make notes or read because they never attended school. They practice the art of remembering everything.

Compared to traditional healers, nurses and doctors tend to withdraw from patients and they are not supportive during medical ward rounds. They talk about everything. They make ironic remarks. They decide on their patients' treatment and reject the views of their patients. They are used to answering abruptly. They sometimes neglect to make notes in the records. They take notes and are able to give just necessary explanations.

6.3.7. Practices of Care and Reputation of Agents

The practices of care are the essence of nurses, doctors, and traditional healers. Agents' reputation, competences, title, and position play considerable role in the practices of care.

Table 5: Practices of Care and Reputation of Agents

Characterizing field - Bourdieu likens field to game or kind of market	Elements of field Traditional place	Elements of field Hospital
Place	Village: Mbé	Institution in town: Protestant Hospital of Ngaoundéré
Titles	Farmer "Paysant," traditional healers, chief	Nurses, nurse assistants, and so on
Honors/honored titles	Chief Traditional healers "Marabou"	Healthcare administrator, doctors, priest, "Surveillant General," and so on
Positions (symbolic capital - hierarchy of position in the form of prestige, personal authority, renown, reputation)	Traditional healers	Nurse, major nurse, healthcare administrators
Structure consisting of the distribution of goods and power they afford	Chief, "Dogari," traditional healers, and so on	In hospital: director, human resources manager, medical chief, bursar, nurse assistant, nurse students, ward attendant, chief cleaner, cleaner, and so on

Table 5 shows the characteristics of the field. In this field, both dominant and dominated positions can be seen. There is a competition for prestige. Prestige refers to a good reputation or high esteem. Some traditional healers see their roles not in terms of setting standards but in becoming a successful healer in the caring practice. Others seek to provide nursing practices, and they attract and retain patients by saying they deal with all kinds of illness: "traditional healer for all your needs." Many traditional healers have embraced merit on low or high treatment cost as a way of boosting their prestige and reputation.

Formal education, competences, and practices of nurses and doctors are ways of boosting prestige and reputation. The nursing profession gives public recognition, position, power in the society, and increases expectations of patients. The nursing profession focuses on skills and knowledge needed for preventing disease and disability, managing and eliminating symptoms caused by illness, enhancing end-of-life, and palliative care. These practices of care make nurses symbols of good caregivers and agents with higher authority.

Table 5 also presents the titles and positions of the agents, in addition to the structures consisting of the distribution of goods and power. Prestige, honor, and attention are symbolic capital constituting the crucial source of power. Skills, knowledge, and abilities are required to occupy any position in the field.

6.3.8. Dispositions and Competence Generating and Shaping Action

Disposition is, according to Bourdieu (1977 p. 214), “a way of being, a habitual state... a tendency, propensity, or inclination.” Dispositions are corporeal in that they are embodied in human beings and converted into motor schemes and body automatisms, which, in practice, materialize as postures, gestures, and movements. Habitus consists of dispositions and forms of know-how and competence, all of which function below the threshold of consciousness enacted at a pre-reflective level.

Table 6: Dispositions and Competence Generating and Shaping Action

	Traditional caring culture in Cameroon	Western nursing practices in Cameroon
Dispositions generating and shaping action	Physical care Traditional skill Regular checkups Attention Good behavior Keeping privacy Caring with compassion Practice through comforting Practice through respecting patient's belief and culture Authenticity in practice Demonstrating understanding Kindness Going to church, mosque	Physical care Nursing skill Regular checkups Attention Good behavior Keeping privacy Practice with compassion Practice through comforting Practice through respecting patient's belief and culture Authenticity in practice Demonstrating understanding Kindness Going to church, mosque
Competence generating and shaping action	Experience from ancestors Going to Quran school (They are well educated. Their education is different from western medical education.)	Skill, school, university, high school

Table 6 shows that traditional healers and nurses, doctors, and patients' relatives are all embedded in a habitus with many dispositions for how they care for patients. I found that the presented dispositions are similar. The dispositions are related to regular checkups, attention, good behavior, confidentiality, practice with compassion, practice through comforting, practice through respecting the patient's beliefs and culture, authenticity in practice, demonstrating understanding, kindness, and going to a church or mosque. These elements will be reviewed one by one later.

Table 6 also shows that the practice competence of traditional healers is generated from accumulated experiences from ancestors, families, friends, and from attending Quran school. Doctors and nurses' competences are received from western education (university, high school).

6.4. Capital of Agents Enabling the Practices of Caring

Capital is resource enabling the practices of care and is a factor that defines positions and possibilities of various agents. It represents a resource in the social struggles that are carried out in the field. These resources help agents to maintain a position in the status hierarchy of society. People with illnesses and a lack of money will have less power to make decisions about their care or to change their situation. Cultural capital plays a central role in societal power relations in which caring is exercised, as this “provides the means for a non-economic form of domination and hierarchy, as classes distinguish themselves through taste” (Gaventa, 2003). The causes of inequality may come from the shift from material to cultural and the symbolic forms of capital.

Within the traditional caring culture and western nursing, there are various capitals that enable agents to practice caring, to exercise domination, and to resist domination in the practices of care. Agents with capital are able to cover the full cost of care. Those with less capital do not get proper treatment. They do not have money to buy medicine. Being poor means that you do not have money for treatment and are not valued by others. Doctors, nurses, and traditional healers have better economic capital than patients with no academic background. Capital represents a symbol of domination constantly under challenge by the dominant class as academics and professionals. Caring is taste representing the heart of these symbolic struggles.

Table 7: Types of Capital Enabling the Practices of Caring within administrators, nurses, relatives, traditional healers, and patients

Type of caring capital	Healthcare administrator's caring capital Examples of caring capital	Relatives and Patient's caring capital Examples of caring capital	Nurse's caring capital Examples of caring capital	Healer's caring capital Examples of caring capital
Economic Capital	<p>Have better lifestyle, earn more than nurses and nurse assistants. Have money</p> <p>Salary</p> <p>Own computer, mobile phone</p> <p>Cars</p> <p>House</p>	<p>Cow</p> <p>Farm/agriculture (fruits, legumes, ignam (yams), and so on)</p> <p>Business, house</p> <p>Economic support from family members or village</p> <p>Loan</p> <p>Herbal medicine</p>	<p>Salary</p> <p>House</p> <p>Agriculture</p> <p>Motorcycle</p> <p>Bicycle</p> <p>Do not have computer, lack of instruments to monitor patients. Irregular salaries</p>	<p>Have house, cow, plants, bicycle "gris gris," agriculture, farm.</p> <p>Don't have a caring record system for patients</p> <p>Make money when they treat</p>
Social Capital	<p>Lead and manage all business activities in hospital</p> <p>Delegate responsibilities to nurses and so on</p> <p>Share some information with colleagues and nurses</p> <p>Exercise power</p> <p>Responsible for salary</p> <p>Promote and control caring activities</p>	<p>Share love, empathy, closeness</p> <p>Observe and report vital signs to nursing assistants, nurses, doctors</p> <p>Families, siblings, ethnic group, and so on are present</p> <p>They are advocates for the patient</p>	<p>Work in collaboration with doctors, nurse assistants, and others</p> <p>Receive advice from doctors</p> <p>Go to church each morning</p> <p>Singing in choir</p> <p>Use knowledge acquired from his professional education to care</p> <p>Not so close to patients - lack of time</p>	<p>Receive knowledge and experiences from fathers, grandfathers</p> <p>Test medicine on own family</p> <p>Use traditional medicine to heal and cure people in the village</p> <p>Visit patients in their private houses</p> <p>Receive recognition and respect from people in village and some receive recognition from the local authorities</p>

Table 7: *continues*

Type of caring capital	Healthcare administrator's caring capital Examples of caring capital	Relatives and Patient's caring capital Examples of caring capital	Nurse's caring capital Examples of caring capital	Healer's caring capital Examples of caring capital
Social Capital			Motivate patient and rude way to deal with patients (communication, tone, empathy)	
Embodied Cultural Capital	Greeting Are competent with academic degrees, have meetings every day to discuss issues regarding hospital Work continuously for quality care	Greeting Visits Acquired from ancestors, grandfathers, grandmothers, rituals, and ceremonies as part of identity Take on the role of caring Care daily	Greeting Welcoming patients Do not maintain quality care Administer medicine, do not check on or control the patient Some of them apply their best efforts to all duties while others practice complaining Do not take enough into consideration when patient is feeling pain	Greeting Visit Committed to being good at caring Do all they can for the well-being of the patients Encourage patients Use all their experiences and knowledge received from ancestors, grandfathers, and fathers. Holistic care Try many different traditional medicines

Table 7: continues

Type of caring capital	Healthcare administrator's caring capital Examples of caring capital	Relatives and Patient's caring capital Examples of caring capital	Nurse's caring capital Examples of caring capital	Healer's caring capital Examples of caring capital
Embodied Cultural Capital			Lack of dealing with pain Some maintain quality caring learned from school Difficulties in practicing holistic care Lack of standard for caring Complicated system of record-keeping	
Cultural Objectified Capital	Academic degree Promoted to major or administrator	Provide good caring Traditional caring competence Communicate with patients, do observations and report verbally to caregivers Use information provided by caregiver	Describe and diagnose very easily Some try to make efforts to meet the required standard imposed by the hospital while others do not	Use incorrect diagnosis, imprecise dosage, lack of hygiene, lack of written records about the patients Protects secrecy of some healing and caring methods Experiment and said to deal with many diseases

Table 7: *continues*

Type of caring capital	Healthcare administrator's caring capital Examples of caring capital	Relatives and Patient's caring capital Examples of caring capital	Nurse's caring capital Examples of caring capital	Healer's caring capital Examples of caring capital
Cultural Objectified Capital			Receive information, guidance Need training	Have difficulties explaining the negative side of their treatment Earn money, have food Provide guidance and information
Cultural Institutional Capital	Higher education Higher degree	Learned caring through experiences Some have formal education and others do not	Bepc, Baccalaureat, Diplom d'infirmier: * Infirmier diplomé d'etat	Non-formal education Respected in the society Life history is important

Table 7 shows the types of agents' capital in the field: economic, capital, embodied cultural, cultural objectified, and cultural institutional. The agents' capital differs according to their positions and their education (formal or nonformal) in the field. These types of capital also play a large role in enabling each agent in the field to exercise and resist domination in their social relations. Capital helps agents to maintain a position in the status hierarchy of society, the "organizing principle."

Economic capital (money, cows, and bicycle), social capital (network), and cultural capital (skills, education, and knowledge) are necessary resources for providing and receiving care and promoting health. Agents have almost the exact same cultural and social capital. Each agent owns several types of capital. Patients with higher educational attainment have more capital and easier ways to get health help. They have easy access to western medicines and can be treated very fast since they have money. Economic capital combined with social

capital and cultural capital illustrates the potential means to explain the puzzle of caring activities. Many of the respondents said, “We feel happy and at ease when people visit us, when they spend time and tell jokes to us.” This illustrates that social capital plays a particularly important role in the recovery process of patients. Family members, friends, and gospel choirs give food, money, and moral support when they visit patients in the hospital.

6.5. Power Relationships between Agents in the Practices of Care

Figure 12: Power Relationships in Cameroon’s Healthcare and Traditional Care System

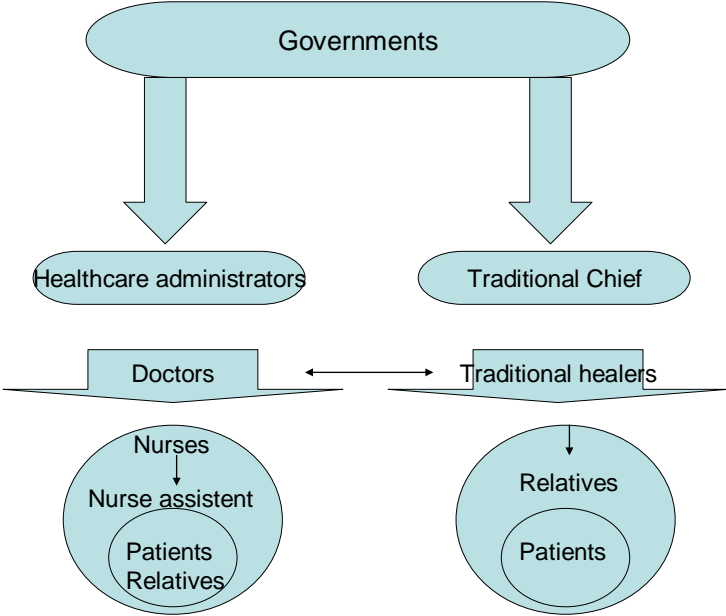


Figure 12 shows the hierarchy of power relationships among the agents in the field. Nurses, nurses assistant, and doctors use medical gaze to “see” diseases that lie deep within the body and communicate directly with diseases instead of patients. Each agent operates according to an implicit practical logic—a practical sense—and bodily dispositions. Agents act according to their “feel for the game” (the “feel” being, roughly, habitus, and the “game” being the field). They are also in competitive and self-perpetuating hierarchies of domination. The Cameroonian government is the head of these two care systems and supervises the practice of care.

The traditional chiefs have power over the traditional healers. The traditional healers must respect the traditional chiefs. The traditional chiefs have legitimate power and cultural power over the population.

Figure 13: Traditional Chief (“*lamido*”) in His Field



Figure 13 shows a traditional chief seated in a comfortable chair with a cane in front of him. The cane is a symbol of power and kingship, ferocity, caring, danger and royalty. The cane is a scepter, like what the kings have in western societies and a scepter is a symbol of power. Kings with a scepter have the right to speak and define the situation (Broady, 1984, 1998). Figure 13 shows that Guards surround the chief. The chief has power and serves as the justice and caregiver coordinator. He is concerned with overall development issues and activities taking place in his jurisdiction. Figure 13 illustrates the tribal king's royal status and the power and honor that a traditional chief (“*lamido*”) has in his field. Guards are also traditional healers. These traditional healers have great power over the population. They participate in the care of the population, and, in many cases, they collaborate with western doctors and nurses for treatment of certain diseases when modern medicine cannot help, for example, in mental illness or snakebites. There are specific kinds of snakebites for which modern medicine does not have anti-venom. Traditional healers are considered somewhat similar to western doctors and nurses. The healers look for the cause of a patient's illness in

the relationship between the patient and his natural, social, and spiritual environment. They have “healing hands,” which are seen as a gift from the gods. Traditional healers prescribe appropriate health behavior and prohibit actions that may threaten health. Traditional healers are more related to the local people, whereas modern medicine is related to the bureaucratic political system. As shown in Figure 12, as the representative of the government and the head of healthcare in the country, Cameroon’s Ministry of Public Health is responsible for the maintenance of all public health services. Relatives, patients, nurse assistants, nurses, healthcare administrators, and traditional healers are agents that act strategically, depending on their habitus, to enhance their capital. Some positions within each field can perpetrate symbolic violence on less powerful agents. Cultural mechanisms, such as education and social status, impose a dominant perspective on the rest of the population to legitimize their power. Nurses are under doctors and healthcare administrators but have more power than patients and their relatives. Patients are often the players with the least capital. Patients, relatives, nurses, and healthcare administrators have different habitus and capital at the Protestant Hospital of Ngaoundéré. Traditional healers have significant power in the village. These power relationships in Cameroon’s healthcare system have an impact on the traditional caring culture and on western nursing care. Traditional healers interact directly with patients and are used to communicate about psychosocial issues. These healers have a concept of illness that match their own and their patients’ understanding. Dance and music, medicine, food and clothing, masks, statues, and other artifacts are all parts of traditional caring culture. Traditional healers interact directly with patients in “*Siong*”: a dance to cure women from stomach illness.

Society is hierarchically structured. This is characterized by the traditional centrality of both the chieftain “*lamido*” and the government. Title and rank are emphasized as significant political attributes. Titles and offices are important as symbolic capital. Traditionally, most important titles are hereditary and are obtained through lineage. Government titles are obtained as per one’s level of education; for instance, governors, assistant divisional officers (sous-prefets), and district heads (chefs de district), are titles obtained based on the level of education. These leaders are charged with implementing the will of the president, reporting on the general mood and conditions of the regions, administering the civil service, keeping the peace, and overseeing the heads of the smaller administrative units.

6.6. Emic and Etic Approaches to Agents' Dispositions

The emic approach refers to viewpoints and perspectives obtained from agents, whereas the etic approach refers to viewpoints and perspectives from the outside, meaning the observer. The emic approach helps to understand how agents perceive and categorize their world, their rules for behavior, what has meaning for them, and how they imagine and explain things. According to Kottak, (2006), the emic approach investigates how local people think and the etic approach helps emphasize what is considered important in the field. Emic and etic approaches are important for understanding the acts of agents in a situation according to an individual's habitus.

As we have seen and presented in table 6, agents consider physical care, nursing skill, regular checkups, attention, and good behavior important aspects of the care practice. These are discussed and analyzed independently below from an emic and etic perspectives.

6.6.1. Physical care and closeness

Nurses and traditional healers' duties are also to provide physical care and closeness. Most patients feel that the nursing staff are likely not to feel responsible for the cleanliness of patients and closeness between them and patients. Nurses have less hand contact than patients' relatives and traditional healers. They wash or touch patients infrequently. Personal hygiene is ignored in the practice of physical care in some cases. One patient stated, "I feel that they just ignore me when I am about to go to the toilet or take a bath. If they help, I feel like they do not feel such responsibility as a nurse to help me wash my hands and legs daily when I am in need with regards to such things." In Cameroon, the practice of physical care is the duty of the relatives and families. After a time of silence, the patient added, "Fortunately, as patients, we are accompanied by siblings, parents, spouses, children, or other companions when we come to hospitals or go to traditional healers. They are at the bedside taking turns throughout the hospitalization. They sleep at the bedside, on the floor next to the bed, or by the ward's door, or camp nearby in the open air on the hospital grounds. They sit vigil, bathe their loved ones, run to the pharmacy to get medicine if they can afford it, make meals, and feed them to the patient. Our relatives are deeply involved in the practice of physical care." Traditional healers practice physical care and closeness as do patients' relatives.

Another patient said to a nurse, “Please don’t go. Be here. I am afraid, please hold my hand.” Based on my observation, I noticed that nurses perform less “hands-on” practices of care than traditional healers. The patients perceive the nurse as being the person who will look after their physical needs, talk to them, and hold their hands when they are in the hospital. Modern health-practices in Cameroon are very technical, losing some of the aspects of care, such as the respect of the person’s preferences, values, needs, support, and interaction. The nature of practice has become impersonal. Closeness, professional bonding, and emotional bracketing are vital attributes and practices required in the field.

6.6.2. Nursing skill

When informants expressed dissatisfaction with the competence and technical skills of the nurses who took care of them and asked why, responses included:

“The nurse could not get the ‘dextrose thing’ [IV device—intravenous device] right away which is very painful and discomforting.”

“It was very painful when my nurse had difficulty getting the injection [needle] into my arm [vein] to get blood. I told her [to go] get someone who could do the procedure easily.”

Interpersonal skills were also seen as having an impact on the satisfaction of the patients, which partly characterizes the nurses and nursing care providers as skilled and competent. However, despite the importance of such elements of the nursing skill set, one patient complained about the poor interpersonal skill his nurse had, stating “my nurse did not tell me what she injected me with, which I really don’t know.” According to the patient’s perception of nursing, characterizing it as “skilled” not only depends primarily on the success of every insertion or extraction procedure the nurse is performing, but also has something to do with the nurse’s interpersonal skills and how the nurse communicates while performing such procedures. I found that the majority of nurses speak loudly to their patients as do traditional healers. Often, I had the impression that the patients were startled. In another ward, the communication between the patient and nurse was rude: “You must take the prescribed medication.” When I asked the patient how he felt about the way the nurse was talking to him, he answered, “It’s always like this, we are afraid when they visit us, we have to give them all respect.” When I asked the nurse what he thought about his way of speaking to

patients, he answered, “It is important to elevate the voice here to be understood, if not they do not understand.”

This responses reflect the social class the nurses are recruited from, their economic capitals (salary), social capital (family), cultural capital (education) and their positions within the fields (the medical field and healing field).

Although the majority of the research respondents were dissatisfied with their nurses during their stay at their respective healthcare facilities, one respondent provided high satisfaction with his nurse, stressing her competence and knowledge. She noted, “I am happy with my nurse, Samira, in being excellent in taking care of me,” and further noted that “she is the best, she knows what to do, has great contact with me, and has a good sense of humor... she listens, advocates for me, and anticipates my needs.” The communication style of traditional healers does not differ from the western nurse’s communication style. Sometimes, they have an aggressive communication style with verbal characteristics, such as emphasizing blame, using a firm voice and a sarcastic, cold, or harsh tone, and threatening to make a patient do something. Other times, they use an assertive communication style with a firm, relaxed voice that is fluent with few hesitations, and they use sincere, clear, and cooperative phrases, for example, “What are your thoughts about this?”

6.6.3. Regular Checkups

Caring from traditional healers is very similar to western nursing care even though the nurses are positioned under the medical doctor in the western system. Traditional healers fill multiple roles as healer and nurse. One person act in several roles. Relatives also often take the place of the nurses and check up on patients. Traditional healers treat certain physical and mental diseases as nurses do. As nurses, they also review the patient’s vital signs. Traditional healers practice regular checkups and bedside visits just as western nurses do. They do that to identify risk factors and problems before they become serious. They share the same room and sleep there with patients. They have time as they only care for a few patients. Traditional healers practice regular check-ups and give advice to patients with high blood pressure, diabetes, lifestyle and medication. Compare to nurses who use modern equipment, such as stethoscope, heart monitor, pulse oximeter, traditional healers use animal parts, leaves, barks, rituals, incisions, incantations sacrificial offerings, as equipment to conduct check-ups and physical examination on patients. The practice of checking up is described by one respondents as follows: “When my mother was ill with a strong stomach pain, my grandfather

advised my father to perform a ritual and to make some offers to check up if she was possessed by demons or devil. He would have taken her to the hospital otherwise.”

6.6.4. Attention

While doing interview during my observational study, the term “attention” was identified, discussed and appreciated. The interviewed patients had some negative experiences when it came to the amount of attention the patient needed from their nurses and the nursing care staff. Based on the findings, the majority of the respondents, accounting for approximately 80%, were “slightly satisfied” with regards to the amount of attention they received. Some of the reasons why the satisfaction level decreased included the response as follows:

“There was a time when I requested something from my nurse, and she said she would address my request. However, I waited for about five hours for the nurse’s reply. When she visited me for a routine checkup, I asked her about my request. And she said she forgot about it. I was disappointed about this.”

The unit was small. All the intensive care patients were in this unit. There was only one nurse and one assistant nurse with more than 20 patients under her care. Each patient in that unit had one or two relatives sitting near their bed, were responsible for washing, giving meat, and giving trust and assistance, such as keeping an eye on IV bottles, and giving bed baths. I met one of the relatives who was washing her family member and when I spoke with her, she said, “We would like the nurses to teach us to wash our patients properly. We try to wash our patients in our traditional way. Often, we find that the nurses are so far away from us. When they are here, it is to measure blood pressure, take the temperature, and remove the infusions.” When asking the nurse how he cares, he replied, “Fortunately, the unit is full of relatives able to care, we do not need to sit near the patients...the patients or relatives can call us if necessary. When our monitor’s alarm sounds, we can go and check. We do not always need to go around and check our patients’ condition.”

Nurses’ attentiveness to their patients constitutes a major factor that influences patients’ satisfaction. Patients who reported a high level of satisfaction had been influenced, to a significant degree, by how much attention their nurse paid to them. Care receivers regarded consideration and attentiveness on the part of the nurse as a necessary condition for satisfaction with nursing care. This, in turn, enabled the nurses to use their intuition to

understand the patient's unexpressed questions and needs. The more attention the nurse paid to the patient, the greater the perception of satisfaction.

6.6.5. Good Behavior

Patients generally expressed "good behavior" from nurses/healers as important when considering their practices of care. The understanding of what is good behavior in the practice of care differs within the different groups because each group has its own habitus constructed from their life history, their positions within the field, their dispositions (capitals) and their positionings (meaning, attitude in action and word). Patients and relatives come from different social groups within the field and sometimes their habitus matches and other times it does not, so sometimes they share values with one another and sometimes not. Within groups, there are different ways for understanding what is good behavior in the practice of care.

More than half of the total respondents comprising the research sample of patients and relatives of patients were "extremely satisfied" with the "good behavior" of their nurses, doctors, and traditional healers who took care of them. These satisfied patients and relatives are agents with good capital and position. Their position in the society allow them to appreciate the practice of care. Some respondents claimed that their nurses were polite and good listeners. One patient noted that "despite the fact that I was having a hard time in one of the treatment procedures, my nurse was still positive and motivated me that I could do it." This attitude shows that patients value the practice of care based on good behavior. Good behavior is important attitude allowing agents to make decisions about their daily lives. Another respondent described the traditional healer as "a man with great patience and sympathy... he cared with respect and he made me smile." This description shows that the desire to help patient, exhibiting good manners, kindness, empati, sympathy, respect are behaviors that are good in social situations. Therefore, the patience of the nurses and the traditional healers constitutes a major characteristic of the concept of "good behavior." Good behavior is socially and culturally acceptable. Nurses or other nursing care staff, traditional healers who possess and display good behavior impact positively on the patient and by extension, the level of satisfaction and timely progress of the treatment. Traditional healers - and nurses displaying "good behavior" can stimulate patient participation in the practice of care. Conversely, displaying bad behaviors can inhibit patient participation. Patients and relatives face good behaviors or misbehaviors each day. There are behaviors of nurses and traditional healers that either stimulate or reduce patient participation. The behaviors that

stimulate patient participation are cautiousness, pleasant, listen when others are talking, show respect for agent with high position and good capital. The behaviors that reduce patient participation are abusive, angry, abrasive, anxious, boorish, cowardly, crazy, creepy, cruel, dangerous, defiant, erratic, flashy, flippant, foolish, furtive, mysterious, obnoxious, outrageous, panicky, secretive, unsuitable, and vengeful. Agents described “good behavior” as an expression of feelings, a body language to be used in the practice of care and important term to use to perceive and appreciate the practice of care. Agents practice good behavior by showing respect, being available to practice care, greeting and listen.

6.7. Preferences and Tastes

The emic and etic approaches illustrate that agents’ dispositions also include tastes and preferences, abilities to distinguish between subtle differences, ideas of success or life goals, and one’s practical sense. Preferences and tastes are shaped by the practice of care. What agents prefer, like, or dislike depends in part on their socialization into their particular field. Agents make a virtue out of necessity with physical care, regular check-ups, attention, good behavior, and confidentiality. These acts are what agents are forced to do as a result of their life circumstances as if it were both something they chose or desired and something virtuous. These parts also illustrate agents’ abilities to distinguish between subtle differences. Differences in agents’ attention depend on how agents have been socialized. Physical care, nursing skill, regular check-ups, attention, and “good behavior” are also important parts in a practical sense of caring, an articulation of the essence of the way in which nursing is practiced. These refer to the practical ability that agents must interact appropriately or inappropriately with each other on the everyday basis. The concept of practical sense reported include language, ways of speaking between nurses, patients and relatives, ways of carrying one’s body and each agent’s idea of what counts as reasonable or common sense. This shows the significance of speaking proper language in proper settings and also the ability to do a task. Nurses tend to stand closer while talking and patients and their relatives stand further apart. Patients tend to be more reserved with their way of speaking. Nurses and doctors are considered as holding very high positions with great power and professional caregivers deserving honor, respect, and admiration. This difference justifies the significance of the positions occupied by agents in society when we look at the positions collective as a position within the field. There are also differences within each group of nurses, doctors,

traditional healers and relatives when looking each position separately. “Good behavior”, attention, regular check-ups, and physical care are reasonable acts or elements of common sense fostering the well-being of patients in the social class.

6.8. Agents Perspectives on the Practices of Care

The practices of traditional caring culture and western nursing are expressed and supported by the research participants’ views and judgments of the nature of care in the field. Common themes are drawn upon from my empirical data to present the concepts underlying the definition of the practices of traditional care culture and western nursing from a Cameroonian point of view:

6.8.1. Practice of Care with Compassion

The empirical study of my data shows that the practice of care with compassion is one of the key characteristics of traditional care and western nursing. Statements such as “it’s all about showing compassion to others” and “the practices of traditional caring culture and western nursing mean compassionate caring for others”, signify that traditional care culture and western nursing elucidate caring with “compassion”. Such statements from the participants in my study support the understanding and importance of compassion to the practice of western nursing and the practices of traditional culture. My study shows that the practice of care with compassion requires nurses and traditional healers to go deeper and to go beyond hands-on skills and techniques and to focus on alleviating suffering and pain through empathetic concern.

Emotion, inherent regard, and respect for others as fellow human beings were clearly present. Being present in the moments of another’s despair was very important in the practice of traditional caring culture and western nursing culture. Patients’ friends, relatives, and others are also present. The everyday practice with compassion entails helping to end the suffering of others with a smile, telling someone something sweet, visiting each other, sharing news and giving advice on where and how to find appropriate care. This supports the assertion of one of the local health authority employees interviewed who noted that the practices of traditional caring culture and western nursing are being “emotionally and physically attached in giving care.”

6.8.2. Practice of Care through Comforting

As mentioned earlier in section 6.8.1, “compassion” was noted as a major facet in a practice of traditional caring culture and western nursing. Nurses and traditional healers have to be attentive and to practice care wholeheartedly for people who are going through difficult health problems. As a participant noted, the practice of traditional caring culture and western nursing involve “care, comfort, and compassion.” It is stressed that the art of “comforting” is highly critical to the development, implementation, and delivery of care. The study of my empirical data shows that “comforting” is the first and the last consideration by caring agents when caring for patients.

In taking care of patients, the short-term goal of “comforting” is to basically ease the burden patients are experiencing in their current state, relieving the patients’ discomfort, and assisting them in enduring pain. In addition, it is also stressed that it helps the patient obtain long-term health, even if smaller discomfort has to be endured along the way. In spite of the discomfort and distress experienced by patients, the act of “comforting” could help speed recovery and prevent complications, thus aiding in reducing future distress and promoting well-being. Traditional caring culture and western nursing both highlight the importance of the act of comforting.

The practice of care through “comforting” include touching, talking, listening, and other body gestures. Touching and talking were said to be two of the most critical components given that these two were found to have distinct and unique characteristics according to the relationship between the comforter (nurse, doctors, or traditional healers) and the person being comforted and the perceived needs of the person. Such components are a way to establish a “meaningful and deeper relationship between patient and nurses or between patient and traditional healers,” as noted by one of the participants.

6.8.3. Practice through Respecting the Patient’s Beliefs and Culture

The response by participants of “having sensitivity toward the beliefs of the patients during caring” also provides a key theme that describes what traditional care culture and western nursing mean. Religion and spirituality are central to many patients experiencing a crisis (Koffman et al 2008; Siegel et al 2001; Belcher et al, 1989). The spiritual beliefs and needs of patients are tremendously diverse. Respect for all religious faiths and practices are priority goals. Like traditional healers, nurses appreciate the need for scripture reading, prayer, and

other expressions of faith. Nurses and traditional healers understand that spiritual distress can occur when individuals are disconnected from their religious or cultural ties. Patients will express these concerns to nurses and traditional healers. If solutions are possible, they are implemented early. Nurses write goals and specific plans of care to manage the spiritual needs of patients. Traditional healers speak out in favor of religion. These may include assessing beliefs and preferences, informing patients of spiritual resources, and creating an environment conducive to free expression. Spirituality was a dimension reported consistently in many of the stories told by respondents. Both nurses and traditional healers recognize spirituality and religion as important aspects of the holistic patient care practice. Nurses and traditional healers have the same practice of spiritual care. They practice spiritual care activities, such as sharing the reading of scripture passages, praying with patients, singing, listening, and counseling patients about spiritual concerns.

6.8.4. Authenticity and Genuineness in Practice of Care

Another well-noted and emphasized theme when describing traditional care culture and western nursing involve the terms “authenticity” and “genuineness.” Most of the participants defined the practices of traditional caring culture and the western nursing as “authentic” and “genuine”. By definition, authenticity in care concerns sincerity, devotion, and intentions in the practice of care. Genuineness is characterized as the self-awareness of one’s feelings as they happen within a relationship, as well as the capacity to communicate such awareness. In a broader sense, the term reflects the ability to establish a therapeutic relationship. It is conveyed by actions, such as listening to and communicating with others without distorting their messages, and being clear and concrete in communication with patients. Genuine helpers do not take refuge in the role of a “nurse,” “clinical practitioner,” or “traditional healer.” This reflects one of the responses from the participants, stating that “traditional care and western care are caring in a deeper and more meaningful sense and not just caring because it’s your responsibility to provide care as a nurse, traditional healer or any care provider.”

6.9. Relationship between the Practices of Traditional Caring Culture and Nursing Care in Cameroon

In Cameroon, the traditional caring culture is an ever present reality. Traditional healers, doctors, and nurses constitute a source of healthcare. The sociocultural identity and traditional medicine are an integral part of people’s cultural heritage. The variety of the

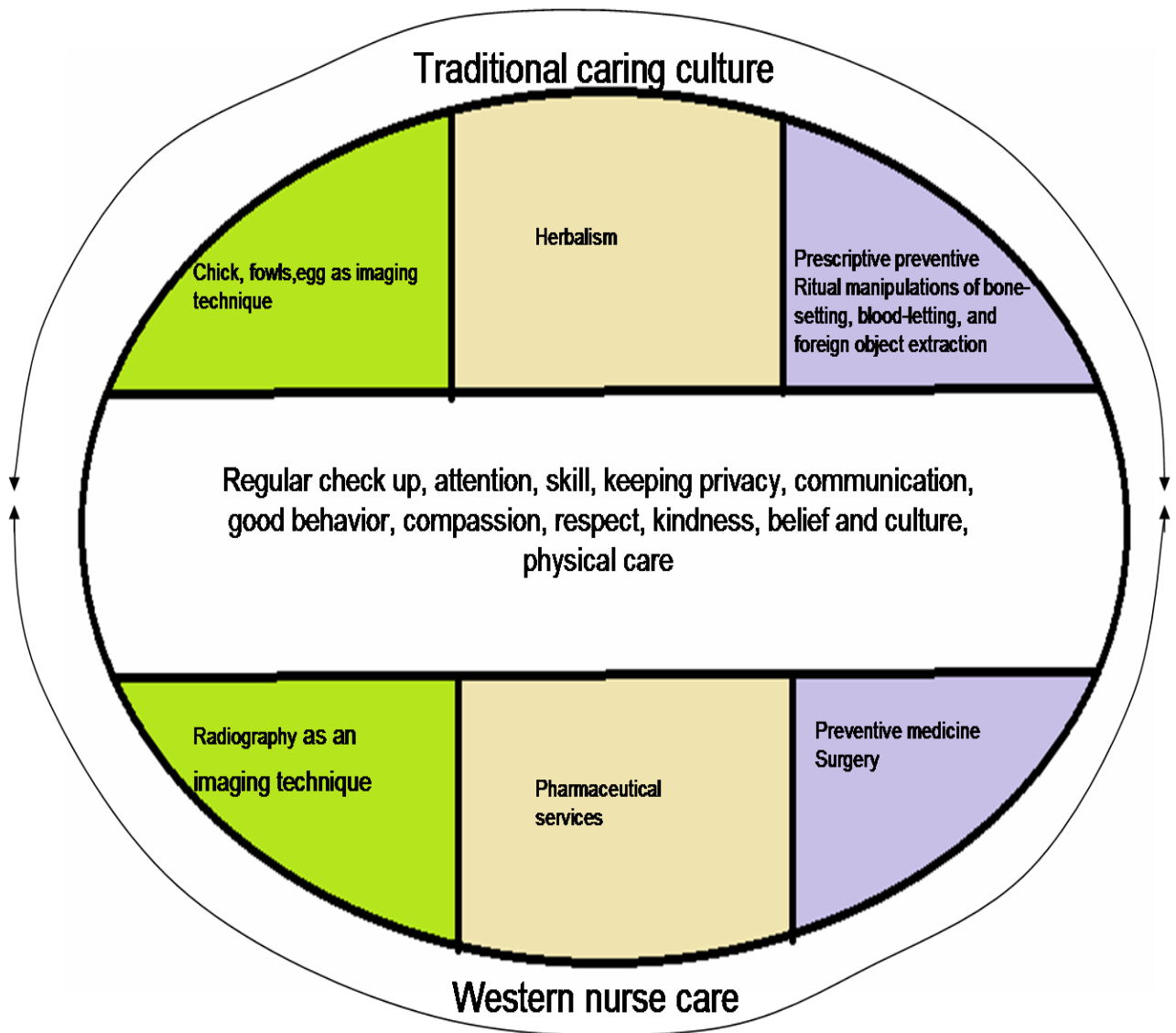
capital among the agents constituted a great challenge that forced authorities to establish a syncretic national healthcare delivery system. It can be noted that the government has made an effort to integrate the training of health practitioners. This illustrates that a relationship between traditional caring culture and western nursing care exists. The two systems co-exist as two independent sectors with emphasis on respect for the uniqueness of the other. To some extent, they also complement each other. As shown in Figure 14, many aspects of traditional caring culture may be linked to western nursing care. It can also be noted that the counterpart of herbalism used in traditional caring is found in pharmaceutical services, whereas traditional midwifery corresponds to the area of maternal and child health. The use of chickens, eggs, and fowl by traditional healers corresponds to radiography examinations in the hospital. The surgical aspects of modern medicine correlate with the traditional manipulations of bone-setting, blood-letting, and foreign object extraction. Prescribing appropriate health behavior, ritual activities, and prohibiting actions that threaten one's health correspond to the preventive health measures in the modern medical system. The practices of traditional caring culture have existed for a longer period than the practice of western nursing. The western medicine and the local traditional system treat and care for people differently but with similar approach to patient well being. The practices of traditional caring culture have accumulated a lot of experience and wisdom and this practice has a significant contribution to the practice of western nursing. For example, the creation of synthetic drugs is based on flora, fauna, and traditional knowledge. Massage treatment or therapy is practiced both in traditional caring culture and western nursing. Traditional healers use their hands or limbs to practice manipulation on the surface of the body. Western nursing also makes tremendous breakthroughs. For massage treatment, nurses and doctors use hand and synthetic oil from plants. The effect of these two practices is to activate blood and disperse stagnation, which improves malformation and smooths tendons.

Therefore, many aspects of traditional caring culture may be linked to western nursing care. The two systems practice mutual referrals, a form of cooperation that improves the quality of care for the patients. The traditional health system operates to a lesser extent side-by-side with the western healthcare system.

People visit traditional healers since they are an integral part of their cultural heritage. One relative stated, "We take our patients home to traditional healers when the treatment in hospital doesn't help" or "We understood that the health of our daughter went worser and worser, we decided to bring her in the village to try our traditional medicine." Another family

said, “We saw that our father was dying in the village, we decided to get him to the hospital.” A traditional healer said, “The government knows who I am. I am a national accredited traditional healer...and there are many recognized healers as me.” All these responses support the various studies that describe the relationship between traditional care culture and nursing care.

Figure 14: Liaison between the Practices of Traditional Caring Culture and Western Nurse Care



The practices of traditional caring culture and western nursing relate to each other. These healthcare practices are becoming part of Cameroon’s own tradition. Nurses, doctors, and traditional healers value the cultural competence and respect for each others practices, gaining patients’ trust, and dignity of all patients. The practices of western nursing and the traditional

caring culture advocate for patients. Doctors, nurses, and traditional healers refer patients to each other sometimes. For example, it is often difficult to have medicine against a venom of some particular snake at the hospital when a person is bitten by a poisonous snake so the doctor sends the patient to a traditional healer for treatment. Often, traditional healers send their patients to the hospital for treatment when they are in front of diseases they cannot handle.

Nurses, doctors, and traditional healers have an understanding and recognition that culture influences a patient's behavior, attitude, preferences, and decisions around health. The practices of western nursing have tremendous influence and contributions on current and future practices of traditional caring. For example, to disrupt the transmission of microorganisms to patients, some traditional healers begin to practice hand hygiene.

These two systems co-exist despite some differences. According to Neba (2011) and Ndenecho (2008), normally, people consult both systems, though for different reasons and during different stages of the disease. The Cameroonian government approaches the health challenge by establishing a syncretic healthcare delivery system. To induce a state of healing and to regain health, the government allows people to put their lives in the hands of traditional healers, doctors, and nurses. There is a fusing of traditional and western practices. Agents can choose to utilize a variety of treatment options exclusively, successively, or simultaneously.

6.10. Challenges Posed by the Coexistence of the Practices of Traditional Caring Culture and Western Caring

It is important to bear in mind that the coexistence of the practices of traditional caring culture and the western nursing is a challenge. Nurses and doctors use to accuse traditional healers for not dealing appropriately with hygiene in the practices of care. Meanwhile, doctors and nurses argue that traditional medicine is fraught with problems of imprecise dosage, charlatanism, exaggerated claims of abilities, and inadequate knowledge of anatomy, hygiene, poor diagnosis, and disease transmission, all of which put patients' health and lives at risk. Many complications from the treatment provided by traditional healers have been reported by nurses. For example, three of the respondent stated that traditional healers use barks of trees, herbs, and roots to treat all kind of leg fractures, and as a result, there are sometimes infections, hazards associated with these treatments. Many patients lose their legs when they

come to the hospital because of inadequate treatment (infections) they have received from the treatment of traditional healers. Nurses and doctors say that the practices of traditional caring culture are associated with the arbitrary dosage of traditional medicine and that the treatment can take a long time.

However, there have been situations in which traditional healers believe that western medicine practitioners seek merely to steal their secrets or to condemn their art. In reality, in regard to hygiene, these two systems both have problems with infections and complications, given that the country does not have an infection reporting system in either traditional or modern medicine. Cleaning and hand hygiene are irregular and below standard in some areas. There is a lack of water, soap, sanitation, and other facilities.

In summary, the principles and primary features present in the practices of traditional caring culture have important links to the practices of western nursing, and incorporating or integrating these traditional characteristics of care will most likely help current nursing care to improve, most notably in the way it caters to the needs of modern-day patients. People are happy to have the availability of both the traditional caring culture and western nurse care practices because it offers them the opportunity to make a free choice between the types of care they want and can afford.

7. CHAPTER VII: CONCLUSION

Many aspects of the practices of traditional caring culture can be linked to the practices of western nursing. Both the traditional caring cultures and western nursing cares world views have strengths that need to be integrated into the caring process. There is a strong national healthcare system that integrates both traditional medicine and modern medicine in the delivery of healthcare. The two systems coexist and have a relationship to each other despite several differences. The government has affected the cooperation between traditional and modern medical practitioners by means of a system of mutual referrals, an imperative that requires both types of healers to take part in some basic training pertaining to the “alternative” type of care. Both systems refer patients to the alternative when appropriate. Practitioners incorporate some of the ideas and practices employed by their counterparts, thus improving their own practice. Cooperation through a system of mutual referrals helps to improve the accessibility and appropriateness of healthcare, as well as the quality of care for the patients. People appreciate the opportunity to choose between the practices of the traditional caring culture and the practices of western nursing culture.

The practices in western nursing are similar to that of traditional caring culture in many ways. There are differences in communication style and some caring practices. Traditional healers have more time for communication. There are some differences also in the interactions between healers, traditional practitioners, and western nursing care in relation to the medical conditions of the patients. The practices of traditional caring culture are governed by secrecy. These two systems have different views regarding illness etiology and treatment methods. Physical care, nursing skill, attention, regular checkups, confidentiality, and good behavior are aspects of both the traditional caring culture and western nursing practices.

This research describes the practices that allow for the identification of the underlying concepts in traditional caring culture in Cameroon: compassion in caring, caring through comforting, caring through respecting the patient’s beliefs and culture, and the authenticity and genuineness of caring. The perception of showing compassion in caring supports the understanding and importance of compassion to the nursing practice. It requires nurses to go deeper and to go beyond their hands-on skills and techniques and to focus on alleviating suffering and pain through empathetic concern. The practices of caring with compassion is a

major facet in the traditional caring culture; it requires nurses and healers to be more attentive and to wholeheartedly care for people who are going through certain things.

Traditional caring culture was perceived to encompass respect for all religious faiths and practices. The participants also noted that the traditional caring culture involves the authentic and genuine practice of caring toward their patients. All these principles of traditional caring culture have been said to have positive results or consequences for various elements, such as the quality and effectiveness of nursing care, the overall well-being of the patients, and the personal and professional development of the nurses and other nursing care providers.

As presented in this thesis, Bourdieu's perspectives have contributed to possibilities for interpretation and ways of understanding and explaining the treating of illness and the caring experience, structures, and caring and treatment practices. Bourdieu's perspectives enabled me to extend the traditional views of resources and poverty to reconsider the different types of positions and resources or disposition such as (economic capital, cultural capital, and social capital) that work as tools for caring and promoting health and creates the different positions that is meaning, attitudes in word and action towards treatment of illness and sickness and related to caring practices. Bourdieu's concepts, based on the interplay of habitus, capital, and field, and the broader societal structures, helped my understanding of the ways that the experience of culture is shaped by broader societal and institutional practices. Using Bourdieu's perspectives also offered the possibility of viewing the influences of structure and their underlying "logic" and helped to illustrate how these serve as forces of conservation or transformation. These perspectives offered insight into discourses on culture and health and culture and caring. By referring to habitus, capital, and the fields that people navigate within, and the emic-etic perspectives, I explored the ways in which culture and practices of caring are conceptualized as embodied, enduring, and shifting.

Recognizing habitus and capital helps with our understanding of the complexities that accompany being a caring agent. Considering the social field allows us to understand how practices are contextualized within the society. Doctors, nurses and traditional healers, and patients' relatives are constantly exposed to the traditional caring culture and modern medicine creating challenges in the caring functions they provide to their patients. These systems are integrated in the society of Cameroon and they work, live and exist side by side.

Both have a longer or shorter history that by understanding them both as symbols of the society also help us in respecting both system as value contributing to people health and as the way agents care for each other due to their history, tradition, culture and possibilities for the benefit of people.

The research aim was to describe, understand and explain the practices of treatment and especially caring in Cameroon, particularly, the relationship between the practices of the traditional caring culture and western nursing care in order to contribute to elaborate on a theory of caring practices in Cameroon.

References

- Abdulai, A. M., & Shamshiry, E. (2014). Natural Resource Endowments and Development Trend in the Muslim World. In *Linking Sustainable Livelihoods to Natural Resources and Governance* (pp. 77-130). Springer Singapore.
- Agbor, A. M., & Naidoo, S. (2011). Knowledge and practice of traditional healers in oral health in the Bui Division, Cameroon. *J Ethnobiol Ethnomed*, 7(6).
- Amin, A. A., & Awung, W. J. (2008). Economic analysis of private returns to investment in education in Cameroon. *Developing a Sustainable Economy in Cameroon*, 219.
- Ardener, E. (1962). The political history of Cameroon. *The world today*, 341-350.
- Arnold, G. (2014). *The resources of the Third World*. Routledge.
- Atkinson, P., & Hammersley, M. (1994). Ethnography and participant observation. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 248-261). Sage Publications.
- Awasom, N. F. (2000). *The reunification question in Cameroon history: was the bride an enthusiastic or a reluctant one?*. *Africa Today*, 47(2), 90-119.
- Bah, T. M.. 1993. "Le facteur peul et les relations interethniques dans l'Adamaoua au XIXe siècle." In *Peuples et cultures de l'Adamaoua (Cameroun)*, ed. Jean Boutrais, 61-86. Paris: ORSTOM/Ngaoundéré-Anthropos.
- Belcher, A. E., Dettmore, D., & Holzemer, S. P. (1989). Spirituality and sense of well-being in persons with AIDS. *Holistic Nursing Practice*, 3(4), 16-25.
- Berge Akselberg, A. K. (2012). *Hva gjør helsepersonell når de utfører helsearbeid i hjemmesykepleien – og hvordan formes deres handlinger?* Bergen: Universitetet i Bergen.
- Bourdieu, P. (1977). *Outline of a theory of practice*. Cambridge: Cambridge University Press.
- Bourdieu, P. (1983). *The field of cultural production, or: the economic world reversed*. *Petics*, 12, 311-356
- Bourdieu, P. (1984). *Distinction: A social Critique of the Judgment of Taste*. London: Routledge and Kegan Paul.
- Bourdieu, P. (1986). Habitus, code et codification. *Actes de la recherche en sciences sociales*, 64(1), 40-44.

- Bourdieu, P. (1989). Social Space and Symbolic Power. *Sociological Theory*, 7(1), 14-25.
- Bourdieu, P. (1989). *La noblesse d'État: grandes écoles et esprit de corps*. Les Editions de minuit.
- Bourdieu, Pierre (1989a). "Social Space and Symbolic Power." *Sociological Theory* 7-1 (June): 18-26 (reprinted in *In Other Words*, 1994 rev. ed.).
- Bourdieu, Pierre. (1990a). *The Logic of Practice*. California: Stanford University Press.
- Bourdieu P. 1990b. *In other words: Essays towards a reflexive sociology*. Oxford: Polity Press.
- Bourdieu, P. (1990). *In other words: Essays towards a reflexive sociology*. Stanford University Press.
- Bourdieu, P., & Passeron, J. C. (1990). *Reproduction in education, society and culture* (Vol. 4). Sage.
- Bourdieu, P. (1991). *Language and symbolic power*. Harvard University Press.
- Bourdieu, P. (1991). *The craft of sociology: Epistemological preliminaries*. Walter de Gruyter.
- Bourdieu, P. (1992). *The Logic of Practice*. Cambridge: Polity Press.
- Bourdieu, P., & Wacquant, L. J. (1992). *An invitation to reflexive sociology*. Cambridge: Polity Press.
- Bourdieu, Pierre and Loic J. D. Wacquant (1992). *An Invitation to Reflexive Sociology*, Chicago: The University of Chicago Press
- Bourdieu, P. (1993). *Sociology in question* (Vol. 18). Sage.
- Bourdieu, P. (1996). *The rules of art: Genesis and structure of the literary field*. Stanford University Press.
- Bourdieu P. (1998). *Practical reason: On the theory of action*. Stanford, Calif: Stanford University Press.
- Bourdieu, Pierre. (1998a). *Practical Reason; on the Theory of Action*. Cambridge: Polity Press.
- Bourdieu, P. (1999). Understanding. In *The weight of the world. Social suffering in the contemporary society*. Polity Press.

- Bourdieu, P., (1999). *The Weight of the World : social suffering in contemporary society*. Cambridge: Polity Press.
- Bourdieu, (2000). *The Politics of Protest'' (interview) socialist review*, 18-20, 19.
- Bourdieu, P. (2000). *Pascalian meditations*. Stanford University Press.
- Bourdieu, P. (2005). *The social structures of the economy*. Polity.
- Bourdieu, P. (2006). The forms of capital.(1986).
- Bourdieu, P. (2008). The Forms of Capital. *Readings in economic sociology*, 4, 280.
- Boyle, P. M. (1996). Parents, private schools, and the politics of an emerging civil society in Cameroon. *Journal of Modern African Studies*, 34, 609-622.
- Bradshaw, A. (1999). The virtue of nursing: The covenant of care. *Journal of Medical Ethics*, 26, 477–481.
- Calhoun, Craig (1993). Habitus, field and capital: the question of historical specificity
In: Calhoun, Craig and LiPuma, Edward and Postone, Moishe, (eds.)
Bourdieu: Critical Perspectives. *University of Chicago Press, Chicago, IL, USA*, 61-88. ISBN 9780226090924
- Calhoun, Craig (2006). Habitus, field and capital In: Beilharz, Peter, (ed.) *Postwar American Critical Thought. SAGE hallmarks in postwar critical thought*. SAGE Publications, New York, USA. ISBN 9780761944157
- Callewaert, S. (1992). Kultur, pædagogik og videnskab; om habitusbegrepet og praktikteorien hos Bourdieu. Viborg (2002): Akademisk Forlag A/S. 2.utg., 3. oplag.
- Cameroon, Y. (1987). A West African perspective. *The Father's Role: Cross Cultural Perspectives*, 273.
- CIA. (2013). *The World Factbook: Cameroon*. Retrieved from CIA:
<https://www.cia.gov/library/publications/the-world-factbook/geos/cm.html>
- CIA. (2013). The World Factbook. *Central Intelligence Agency*. Retrieved from <https://www.cia.gov/library/publications/the-world-factbook/fields/2177.html>
- Chichom Mefire, A., Etoundi Mballa, G. A., Azabji Kenfack, M., Juillard, C., & Stevens, K. (2013). Hospital-based injury data from level III institution in Cameroon: Retrospective analysis of the present registration system. *Injury*, 44(1), 139-143.
- Chul-Young, R. (2008). Health care utilization by rural patients: What influences hospital choice? *Social Work in Public Health*, 23(1), 75–94.

- Classbase, (2013). Education- System.
<http://www.classbase.com/Countries/Cameroon/Education-System> Retrieved 2013-10-15
- Connell, B. (2009). Language diversity and language choice: a view from a Cameroon market. *Anthropological Linguistics*, 51(2), 130-150.
- Crossman, A. (2013). *Convenience Sample*. Retrieved from
<http://sociology.about.com/od/Types-of-Samples/a/Convenience-Sample.htm>
- Earley, A. (2010). Sustainability not all that matters: lessons from Cameroon. *Archives of disease in childhood*, archdischild187260.
- Darshan, S., & Bestus, H. (2000). Vitality, health and cultural diversity. *Compas Newsletter for Endogenous Development*, 3, 4–7.
- DeLancey, MD, Mbuh, RN, og DeLancey, M. (2010). *Historisk ordbok av Republikken Kamerun*. Lanham, Md: Scarecrow Press.
- Delmar, C. (2012). The excesses of care: A matter of understanding the asymmetry of power. *Nursing Philosophy*, 13, 236–246.
- Dent, M. (2006). Patient choice and medicine in health care. *Public Management Review*, 8(3), 449–462.
- De Smet, P. (1999). African herbs and healers. *Compass Newsletter for Endogenous Developments*, No.3 July 200, P.26.
- Broady, D. (1984). Skeptron. Anteckningar om en mycket gammal stav. *i Skeptron*, (1), 8-26.
- Broady, D, Lundgren UP. (1984) Skeptron 1. Tema: Rätten att tala. Stockholm: Symposium Bokförlag;.
- Broady, D. (1998), Kapitalbegreppet som utbildningssociologiskt verktyg, 1998
- Drønen, T. S. (2005). The role of religion in social change: the arrival of Christianity among the Dii people in Adamawa, Northern Cameroon (1934-1960).
- Drønen, T. S. (2007). A Missionary Discourse on Conversion. *Mission Studies*, 24, 99-126.
- Dumais, S. A. (2002). Cultural capital, gender, and school success: The role of habitus. *Sociology of education*, 44-68.
- Echu, G. (2004). The language question in Cameroon. *Linguistik online*, 18(1), 19-33.
- Foucault, M. (2012). *The birth of the clinic*. Routledge.

- Fleischer, A. (2007). Family, obligations, and migration: the role of kinship in Cameroon. *Demographic research*, 16(13), 413-440.
- Fokunang, C. N., Ndikum, V., Tabi, O. Y., Jiofack, R. B., Ngameni, B., Guedje, N. M., & Lohoue, J. (2011). Traditional medicine: past, present and future research and development prospects and integration in the National Health System of Cameroon. *African Journal of Traditional, Complementary and Alternative Medicines*, 8(3).
- Fonlon, B. (1969). The language problem in Cameroon (an historical perspective). *Comparative Education*, 5(1), 25-49.
- Fonlon, B. (1969). The language problem in Cameroon (an historical perspective). *Comparative Education*, 5(1), 25-49.
- Fonjong, L. (2002). Research Note: Micro Financial Institutions as Agents of Improvement of Women's Economic Position in North Western Cameroon. *Atlantis: Critical Studies in Gender, Culture & Social Justice*, 26(2), 120-130.
- Fonjong, L. (2005). Nongovernmental Organisations And The Struggle For A New Status For Rural Women In North Western Cameroon. *Advances in Sociology Research*, 2, 1.
- Fongwa, M. N. (2002). International Health Care Perspectives: The Cameroon Example. *Journal of Transcultural Nursing*, 13 (4), 325-330.
- Frobenius, L. 1987. *Peuples et sociétés traditionnelles du Nord-Cameroun*. Vol. 83 Studien zur kulturkunde. Stuttgart: Franz Steiner Verlag Wiesbaden GMBH.
- Gadinga, A. D. (2013). Impact of China's Aid on Economic Development in Africa: The Case of Cameroon.
- Gam, R., & Gam, R. (2009, Jan/Feb). Cameroon. *New Moon Girls*, 16 (3), pp. 14-17.
- Gaventa, J. (2003). *Power after Lukes: a review of the literature*, Brighton: Institute of Development Studies.
- Gill, P., Stewart, K., Treasure, E., & Chadwick, B. (2008). Methods of data collection in qualitative research: Interviews and focus groups. *British Dental Journal*, 204 (6), 291 - 295.
- Gondje, M. (2011). SCHOOL OF MISSION AND THEOLOGY STAVANGER.
- Grenfell, M. (Ed.). (2011). *Bourdieu, language and linguistics*. Bloomsbury Publishing.
- Greenberg, J. H. (1948). The Classification of African Languages. *American Anthropologist*, 50(1), 24-30.

- Grenfell, M. J. (2007). *Pierre Bourdieu: education and training*. Continuum.
- Grenfell, M. (Ed.). (2011). *Bourdieu, language and linguistics*. Bloomsbury Publishing.
- Gros, J. G. (1995). The hard lessons of Cameroon. *Journal of Democracy*, 6(3), 112-127.
- Hammersley, M. (1992). *What's wrong with ethnography?: Methodological explorations*. Psychology Press.
- Hardy, A. (2008). The Integration of Traditional and Western Medicine In Ngaoundéré, Cameroon. *ISP Collection*, 574.
- Harris, M. (1990). Emics and etics revisited. *Emics and etics: The insider/outsider debate*, 48-61.
- Hillenbrand, E. (2006). Improving traditional-conventional medicine collaboration: Perspectives from Cameroonian traditional practitioners. *Nordic Journal of African Studies*, 15, 1–15.
- Houston, S. (2002). Reflecting on Habitus, Field and Capital Towards a Culturally Sensitive Social Work. *Journal of Social Work*, 2(2), 149-167.
- Illich, I. (1976). Medical nemesis.
- Jenkins, R. (1992). *Pierre Bourdieu*. London: Routledge Press.
- Jenkins, R. (2013). *Pierre bourdieu*. Routledge.
- Johnstone, M. J., & Kanitsaki, O. (2007). Clinical risk management and patient safety education for nurses: a critique. *Nurse education today*, 27(3), 185-191.
- Julius, N. V. (1990). Le Cameroun 1884-1985. Cent ans d'histoire.
- Karakayali, Nedim (2009). "Social Distance and Affective Orientations". *Sociological Forum* 24 (3): 538
- Kleinman AM (1975): Explanatory models in health care relationships, in Health of the Family (National Council for International Health Symposium) Washington, D.C., NCIH, pp. 159-172
- Kleinman, A., Eisenberg, L., & Good, B. (1978). Culture, illness, and care clinical lessons from anthropologic and cross-cultural research. *Annals of internal Medicine*, 88(2), 251-258.
- Koffman, J., Morgan, M., Edmonds, P., Speck, P., & Higginson, I. J. (2008). "I know he controls cancer": The meanings of religion among Black Caribbean and

- White British patients with advanced cancer. *Social science & medicine*, 67(5), 780-789.
- Kolcaba, K. Y. (1994). A theory of holistic comfort for nursing. *Journal of Advanced Nursing*, 19(6), 1178-1184.
- Kolcaba, K. (2003). *Comfort theory and practice: a vision for holistic health care and research*. Springer Publishing Company.
- Kong-Ming, P. (1977). Traditional and modern health care: An appraisal of complementarity. *International Social Science Journal*, 29(3), 483–495.
- Kottak, Conrad (2006). *Mirror for Humanity*, p. 47. McGraw-Hill, New York. ISBN 978-0-07-803490-9
- Kouega, J. P. (2007). *A dictionary of Cameroon English usage* (Vol. 10). Peter Lang.
- Kouega, J. P. (2007). The language situation in Cameroon. *Current issues in language planning*, 8(1), 3-93.
- KPMG International. (2012). *Cameroon: Country Profile*. Africa: KPMG Services Proprietary Limited.
- Kwintessential L. S. (2014), Cameroon - Language, Culture, Customs and Etiquette. Retried 17.08.2014 from <http://www.kwintessential.co.uk/contact-us>
- Labhardt, N. D., Aboa, S. M., Manga, E., Bensing, J. M., & Langewitz, W. (2010). Bridging the gap: how traditional healers interact with their patients. A comparative study in Cameroon. *Tropical Medicine & International Health*, 15(9), 1099-1108.
- Lantum, D.N. (1978). *The Pros and Cons of Traditional Medicine in Cameroon*, Yaounde: UCHS/University Yaounde.
- Larsson, I. E., Sahlsten, M. J., Segesten, K., & Plos, K. A. (2011). Patients' perceptions of nurses' behaviour that influence patient participation in nursing care: A critical incident study. *Nursing Research and Practice*.
- LeCompte, M. D., & Schensul, J. J. (1999). Choosing and Designing an ethnographic research project. In M. D. LeCompte & J. J. Schensul (Eds.), *Designing and Conducting Ethnographic Research* (pp. 97-126). AltaMira Press.
- LeCompte, M. D., & Schensul, J. J. (2010). *Designing and Conducting Ethnographic Research*. (J. J. Schensul & Margaret D LeCompte, Eds.) *Ethnographers Toolkit* (Vol. 1, p. 220). AltaMira Press.

- Le Vine, V. T. (1964). *The Cameroons, from Mandate to Independence*. Univ of California Press.
- Lipson J. (1991) The use of self in ethnographic research: In: Morse JM. (Ed.). *Critical issues in qualitative research methods*. Sage: London: 73-90.
- L'Oeuvre de Santé de Eglise Evangélique Luthérienne au Cameroun (OSEELC). December 3, 2008. Retrieved January 6, 2009.
- Lode K. 1990. *Appelés à la liberté, histoire de L'Eglise Evangélique Luthérienne au Cameroun*. IMPROCEP EDITION
- Malinowski, A., & Stamler, L. L. (2002). Comfort: exploration of the concept in nursing. *Journal of advanced nursing*, 39(6), 599-606.
- Martinsen, K., & Boge, J. (2004). Kunnskapshierarkiet i evidensbasert sykepleie.
- Martin, C. (2014). *A Critical Introduction to the Study of Religion*. Routledge.
- Mbaku, J. M. (2005). *Culture and customs of Cameroon*. Greenwood Publishing Group.
- Mbanya, D. N., Zebaze, R., Kengne, A. P., Minkoulou, E. M., & Awah, P. (2001). Knowledge, attitudes and practices of nursing staff in a rural hospital of Cameroon: how much does the health care provider know about the human immunodeficiency virus/acquired immune deficiency syndrome?. *International Nursing Review*, 48(4), 241-249.
- Mbuagbaw, T. E., Eyongetah, T., & Brain, R. (1974). *A History of the Cameroon*. Addison-Wesley Longman Ltd.
- Morse, J. M., Havens, G. A., & Wilson, S. (1996). The comforting interaction: developing a model of nurse-patient relationship. *Scholarly Inquiry for Nursing Practice*, 11(4), 321-43.
- Muller, J. C. (1996). Ideology and dynamics in Dii chiefdoms. A study of territorial movement and population fluctuation (Adamawa Province, Cameroon). *Ideology and the Formation of Early States, Studies in Human Society*, 11, 99-115.
- Muller, J. C. (2000). "Comment "dépaganiser" sans christianiser ni islamiser. Un dilemme dea Dii de l'Adamaoua (Nord-Cameroun)." *Gradhiva*, no. 27:39-51.
- Muller, J. C. (2001). Inside, outside, and inside out: Masks, Rulers, and Gender among the Dii and Their Neighbors. *African Arts*, 58-96.
- Muller, J.C. 2002. Les rites initiatiques des *Dii de l'Adamaoua (Cameroun)*. Vol. 16 Sociétés Africaines. Nanterre: Société d'ethnologie.

- Myking, M. (2013). Palliasjon på sykehjem: Hva gjør helsepersonell i møte med alvorlig syke og døende pasienter-og hvordan formes deres handlinger?
- Nash, R. (1999). Bourdieu, 'Habitus', and Educational Research: is it all worth the candle?. *British journal of sociology of education*, 20(2), 175-187.
- Nationmaster, (2014),
<http://www.nationmaster.com/compare/Cameroon/Norway/Health>
- Ndenecho, E. N. (2008). Indigenous knowledge of medicinal plants and challenges in developing ethnoharmacology in Africa: example of Oku, Cameroon. *International Journal of Environment and Sustainable Development*, 7(4),418-429.
- Neba, E. N. (2011). Traditional health care system and challenges in developing ethnoharmacology in Africa: example of Oku, Cameroon. *Studies on Ethno-medicine*, 5(2), 133-139.
- Ngambouk Vitalis, P. (2013). The Social Epidemiology of Malaria among the Bali Nyonga, Northwest Cameroon. *Health, Culture and Society*, 4(1).
- Ngoh, V. J. (1990). *Cameroun 1884-1985: cent ans d'histoire*. CEPER.
- Ngongo, L. (1982). *Histoire des forces religieuses au Cameroun: de la Première Guerre mondiale à l'Indépendance (1916-1955)* (Vol. 1). KARTHALA Editions.
- Ntangsi, J. (1998). "An analysis of Health sector expenditure in Cameroon using National Health Account Framework". World Bank.
- Ntangsi, J. (2013). *An analysis of health sector expenditures in Cameroon using a national health Accounts Framework*. Retrieved from Harvard University Website: <http://www.hsph.harvard.edu/takemi/files/2012/10/rp141.pdf>
- O'Guinn, T. C., Faber, R. J., & Imperia, G. (1986). Subcultural influences on family decisionmaking. *Psychology & Marketing*, 3(4), 305-317.
- Öztürk, Ş. (2011). Pierre Bourdieu's Theory of Social Action. *SOSYAL BİLİMLER ENSİTÜSÜ DERGİSİ*, 1(15).
- Petersen, K. A. (1993). At konstruere en teori om sygepleje. I *Overveielser og metoder i sundhedsforskningen*. Akademisk Forlag.
- Petersen. Karin Anna (1995). *Praktikteori i sundhedsvidenskab*. Akademisk Forlag.
- Petersen KA. (1995b). Ligheder og forskelle i nyere teorier om praktikernes erkendelsesgrundlag. I: Petersen KA, red. *Praktikteori i sundhedsvidenskab*. København: Akademisk forlag, 81–100.

- Petersen, Karin Anna (1996): "Hvorfor Bourdieu?"; In: Fokus på sygeplejen, Munksgaard, København, pp.123-143, 20 p
- Petersen, Karin Anna (2008): "En teori om praksis og en teori om viden", In: *Pierre Bourdieu. Centrale tekster inden for sociologi og kulturteori*, Frydenlund, København, pp. 70-71, 2.p.
- Petersen, K. A. (2010). Klinisk betyder empirisk. In: Gjallerhorn, tema: Om bioøkonomi og uddannelse til sundhed, pp. 30-41
- Petersen, K. A., & Callewaert, S. (2014). *Praxeologisk sygeplejevidenskab-hvad er det?: En diskussion med det subjektivistiske og det objektivistiske alternativ*. BoD–Books on Demand.
- Prasad, P. (2005). *Crafting qualitative research: Working in the postpositivist traditions*. ME Sharpe.
- Pretorius, E. (1991). Traditional and modern medicine working in tandem. *Curationis*, 14(4), 10-13.
- Pondi, J. E. (1997). Cameroon and the Commonwealth of Nations. *The Round Table*, 86(344), 563-570.
- Poverty and Health Care*. (2013). Retrieved from Our Africa Website: <http://www.our-africa.org/cameroon/poverty-healthcare>
- Reay, D. (2004). 'It's all becoming a habitus': beyond the habitual use of habitus in educational research. *British journal of sociology of education*, 25(4), 431-444.
- Reed-Danahay, D. (2002). Remembering Pierre Bourdieu 1930-2002. *Anthropological Quarterly*, 75(2), 375-380.
- Republic of Cameroon, 1995: Presidential decree no. 95-040 .
- Rhynas, S. J. (2005). Bourdieu's theory of practice and its potential in nursing research. *Journal of Advanced Nursing*, 50(2), 179–186.
- Ritzer, G. F. (Ed.). (2004). *Encyclopedia of social theory*. Sage publications.
- Robbins, D. (2002). Sociology and philosophy in the work of Pierre Bourdieu, 1965-75. *Journal of Classical Sociology*, 2(3), 299-328.
- Robson, C. (2002). *Real world research*. Oxford: Blackwell Publishers.
- Rosier, P. K. (2005). Comfort Theory and Practice: A Vision for Holistic Health Care and Research. *Clinical Nurse Specialist*, 19(1), 49.

- Rutz, H., & Balkan, E. M. (2013). *Reproducing class: Education, neoliberalism, and the rise of the new middle class in Istanbul*. Berghahn Books.
- Sackett, D.L., Straus, S., Richardson, S., et al., (2000). Evidence-based medicine: How to practice and teach EBM (2nd ed.). London: Churchill Livingstone.
- Sales, A. (Ed.). (2012). *Sociology Today: Social Transformations in a Globalizing World*. Sage.
- Santoro, M. (2011). From Bourdieu to cultural sociology. *Cultural Sociology*, 5(1), 3-23.
- Schensul, S. L., Schensul, J. J., & LeCompte, M. D. (1999). *Essential ethnographic methods: Observations, interviews, and questionnaires* (Vol. 2). Rowman Altamira.
- Shields, L. (2003). The difference between quantitative and qualitative research. *Pediatric Nursing*, 15(9), 24.
- Siegel, K., Anderman, S. J., & Schrimshaw, E. W. (2001). Religion and coping with health-related stress. *Psychology and Health*, 16(6), 631-653.
- Simmel, G. (1976). *The Stranger*. The Sociology of Georg Simmel' New York: Free Press.
- Smith, W. (2014). Using Bourdieu's Reflexive Sociology to uncover physical education teacher education (PETE) practices. *Waikato Journal of Education*, 19(1).
- Spradley, J. P. (1979). The Ethnographic Interview. *The Ethnographic Interview* (pp. 1-106).
- Stevens, K.R. (2009). *Essential evidence-based practice competencies in nursing*. (2nd Ed.) San Antonio, TX: Academic Center for Evidence-Based Practice (ACE) of University of Texas Health Science Center San Antonio.
- Stewart, P. J., & Strathern, A. (2004). *Witchcraft, sorcery, rumors and gossip* (Vol. 1). Cambridge University Press.
- Swartz, D. L. (2005). In memoriam: Pierre Bourdieu 1930–2002. In *After Bourdieu* (pp. 17-23). Springer Netherlands.
- Swidler, A. (1986). Culture in action: Symbols and strategies. *American sociological review*, 273-286.
- Tembon, A. C. (1996). Health care provider choice: The North West province of Cameroon. *International Journal of Health Planning and Management*, 11, 53–67.
- Time, V. M. (2014). Women, law, and human rights in Cameroon: Progress or status quo?. *Journal of Law and Conflict Resolution*, 6(1), 1-6.

- Tourangeau, A. E., Giovannetti, P., Tu, J. V., & Wood, M. (2002). Nursing-related determinants of 30-day mortality for hospitalized patients. *Canadian Journal of Nursing Research*, 33 (4), 71–88.
- Trevino, M. B. (2011). Cameroon. In G. A. Barnett, *Encyclopedia of Social Networks* (pp. 103-104). Thousand Oaks, CA: Sage.
- Turner, V. (1969). Liminality and communitas. *The ritual process: Structure and anti-structure*, 94-130.
- Tutton, E., & Seers, K. (2003). An exploration of the concept of comfort. *Journal of clinical nursing*, 12(5), 689-696.
- Tzortzis, A. (2003, June 30). *African healers join the AIDS fight*. Retrieved from The Christian Science Monitor: <http://www.csmonitor.com/2003/0630/p07s02-woaf.html>
- UNDESA, (2011). Data in the tables are those available to the Human Development Report Office as of 15 October 2012, unless otherwise specified. <http://hdrstats.undp.org/en/indicators/69206.html>
- Van der Geest, S. (1982). The efficiency of inefficiency: medicine distribution in South Cameroon. *Social science & medicine*, 16(24), 2145-2153.
- Wacquant, L. J. D. (1989). Towards a Reflexive Sociology : A Workshop with Pierre Bourdieu. *Sociological Theory*, 7(1), 26-63.
- Webb, J., Schirato, T., & Danaher, G. (2002). *Understanding Bourdieu*. Sage.
- Weick, K. E. (2007). The generative properties of richness. *Academy of Management Journal*, 50, 14-19.
- West, B. (2011). *Cameroon*. Bradt Travel Guides.
- West, B. (2008). *Cameroon: The Bradt Travel Guide*. Bradt Travel Guides.
- Whitehead, T. L. (2005). Basic classical ethnographic research methods. ... *community and Cultural Assessment Research ...*, 1-28.
Retrieved from <http://www.cusag.umd.edu/documents/workingpapers/classicalethnomethods.pdf>
- Widin, J. (2010). *Illegitimate practices: Global English language education* (Vol. 8). Multilingual Matters.
- WHO (2002). WHO Traditional Medicine Strategy 2002–2005. (available at: http://libdoc.who.int/hq/2002/WHO_EDM_TRM_2002.1.pdf)
- WHO (2003). Traditional Medicine. WHO Fact Sheet 134. (Accessed April 5, 2014 at <http://www.who.int/mediacentre/factsheets/2003/fs134/en/>)

Yoder-Wise, P. (1999). *Leading and managing in nursing* (2nd ed.). St. Louis, MO: Mosby.

Yovsi, R. D. (2014). Parenting Among the Nso of the Northwest Province of Cameroon. In *Parenting Across Cultures* (pp. 253-266). Springer Netherlands.

Appendix A: Definition of key terms

The following are definitions of the most important terms related to this study:

Capital

Capital is according to Bourdieu (1986) an accumulated labor that is acquired in the present while providing the capacity for people to act in the future. Capital can assure three forms (Bourdieu, 2011): economic, social and cultural. Cultural Capital is the culturally valued ways of being, knowing, and acting. They include knowledge, skills, taste, lifestyle and qualification. Social capital are considered to be the powers and the resources that stem from networks of relationships. Economic capital are money, material wealth, commodities, and physical resources.

Field

Field is the broader social context in which agents interact. It is both a physical and social spaces, networks of social relations (Everett, 2002), structured systems of social positions within which struggles or maneuvers take place over resources, stakes and access. Field is both the setting in which social action takes place and relational spaces. Field is space in which dominant and subordinate groups struggle for control over resources (Dumais, 2002; Wacquant, & Deyanov, 2002). The focus is on power, domination, and class.

Habitus

Habitus is a set of dispositions, reflexes and forms of behaviour people acquire through acting in society. It reflects the different positions people have in society, for example, whether they are brought up in a middle class environment or in a working class suburb. It's part of how society reproduces itself...(Bourdieu, 2000). It's an accumulation of persistent beliefs or attitudes, behaviors, norms, and tastes of

particular set of people, call as class (Bourdieu and Wacquand, 1992). The habitus is according to Bourdieu (1998a, p.81), also, a socialised body, a structured body, a body which has incorporated the immanent structures of a world or of a particular sector of that world-a field- and which structures the perception of that world as well as action in that world. Further Habitus can be defined as “a system of lasting and transposable dispositions which, integrating past experiences, functions at every moment as a matrix of perceptions, appreciations and actions and makes possible the achievements of infinitely diversified tasks” (Bourdieu, 1977, p. 95).

Praxeology

Praxeology means logic of practice it's a way of creating new knowledge of practices through both a subjective and an objective way of construction knowledge from both a historical perspective, the context, and a subjectived lived experience but also the knowledge about the structure that creates and have an impact of the practices.

In *Outline of a Theory of Practice* (Bourdieu, 1977), Bourdieu stated that the social world may be the object of three modes of theoretical knowledge, each of which implies a set of (usually tacit) anthropological theses. Although these modes of knowledge are strictly speaking in no way exclusive, and may be described as moments in a dialectical advance towards adequate knowledge, they have only one thing in common, the fact that they are opposed to practical knowledge. We have a knowledge called phenomenological or ethnomethodological, this sets out to make explicit the truth of the primary experience of the social world. This phenomenological or ethnomethodological knowledge which reads, interprets, makes explicit the primary and ordinary experience of everyday life in the social world.

We have also a knowledge termed objectivist which breaking from the primary knowledge, constructs the objective relations (e.g. economic or linguistic) which structure practice and representations of practice i.e., in particular, primary knowledge, practical and tacit, of the familiarworld." breaking with objectivist knowledge, a questioning of its conditions of possibility and thus its limits.

Finally, According to Pierre Bourdieu (1977), it is only by means of a second break, which is needed in order to grasp the limits of objectivist knowledge, an inevitable moment in scientific knowledge, and to bring to light the theory of theory and the theory of practice inscribed in its practical state, in this mode of knowledge, that we can integrate the gains from it into an adequate science of practices. Praxeology is the study and the description of daily practice- in this case, the study of daily practice. It's also a study of things as they are, rather than in theory.

References

- Bourdieu, P. (1977). *Outline of a theory of practice*. Cambridge: Cambridge University Press.
- Bourdieu, P. (1986). *The three forms of capital*. In *Handbook of theory and research for sociology of education*, ed. JG Richardson, 241-58. New York: Greenwood Press.
- Bourdieu, P. (2000). "The Politics of Protest" (interview) *socialist review*, 18-20, 19.
- Bourdieu, P. (2011). The forms of capital.(1986). *Cultural theory: An anthology*, 81-93.
- Bourdieu, P. and Wacquant,L. (1992). *An Invitation to Seflexive sociology*. Cambrige Polity Press
- Dumais, S. A. (2002). Cultural capital, gender, and school success: The role of habitus. *Sociology of education*, 44-68.
- Everett, J. (2002). Organizational research and the praxeology of Pierre Bourdieu. *Organizational Research Methods*, 5(1), 56-80.
- Wacquant, L., & Deyanov, I. (2002). Taking Bourdieu into the field. *Berkeley Journal of Sociology*, 180-186.

APPENDIX B: INTERVIEW PROTOCOL

Interview with patients

Good day, what is your name?

Where are you from? City/village?

Where do you live today?

What did you parents do?

Where were your parents born? Mother and father?

What did you grandparents do? And where were your grand parents born?

Please tell me, do you have an education? Where did you get your education? How come that you got interested in education?

Do you have any relatives?

Do you have a bicycle, or a house?

Can you describe a typical day when you're sick? Describe your personal experience as patient.

Describe how is it to be sick at home or in hospital. What does your family do when your are sick?

Describe anything new, spontaneous, or unexpected that has happened during your time in hospital?

Describe what you have liked and disliked during your staying in the hospital.

Describe the verbal tone in which the nurses speak to you with.

How do nurses treat you? Can you describe the manner in which the nurses treat you?

Describe your experience of being treated by a healer.

Are you satisfy with the nursing /healers care care ?

Interview with nurses

Good day! Please tell me your name.

Where are you from? City/village?

Where do you live today?

What did you parents do?

Where were your parents born? Mother and father?

What did you grandparents do? And where were your grand parents born?

Where did you get your education? How come that you got interested in education?

What was the main issue regarding the subject of nursing

Please tell me about your specific responsibilities.

Are you married? Do you have children?

What activities do you do when in your office?

What activities do you do when out of your office?

What do you do when you visit your patients?

Do you have a salary, or a house?

Describe your educational background.

Describe a typical day with a patient.

Describe the tone in which you speak with your patients.

Describe the manner in which you treat your patients.

Describe how you communicate with your patients.

Describe how your personal knowledge, skills, and attitude can contribute to a patient's wellbeing.

Tell me about your experiences with relatives in the hospital. What do you consider to be the role of the relative in patient care?

Please tell me about your experiences caring for patients?

Are you satisfy with your work ?

Interview with relatives

Good day! Please tell me your name and age.

Where are you from?

Where are you from? City/village?

Where do you live today?

What did you parents do?

Where were your parents born? Mother and father?

What did you grandparents do? And where were your grand parents born?

Please tell me, do you have an education?

Please describe your role as father, mother, son, or sibling in the family?

Describe what it is like to have a sick family member at home. What do you do when someone gets sick at home?

Please tell me what you do when someone in your family gets sick.

Describes how you treat illness, if you do not go to the hospital.

Describe what you do when someone is get sick home?

Describe your role as a relative in a hospital.

Describe how you cope when you can't bring your patients to hospital.

Do you have your own produce/field, poultry, horse, or cows?

Do you have a bicycle, or a house?

Describe the tone in which the nurses speak with you.

If you have use a healer, please describe a typical experience with them.

Are you satisfy with the nursing /traditional healers care ?

Interview with local health authorities and healthcare administrators
--

Good day! Please tell me your name and age.

Describe your educational background.

Where are you from? City/village?

Where do you live today?

What did you parents do?

Where were your parents born? Mother and father?

What did you grandparents do? And where were your grand parents born?

Please tell me about your specific responsibilities in your professional role.

What do you do when you are in your office?

What do you do when you are out of your office?

What do you do when you visit with patients?

Do you have salary, or a house?

Describe the manner in which you deal with nurses.

Could you please tell me the positive and negative impacts your work has had on your life.

How much do you earn in a month?

Could you please describe to me one of your typical working days?

What are your feelings about your work?

Interview with Traditional Healer
--

Good day! Please tell me your name, age, and describe how you became a Healer.

Where are you from? City/village?

Where do you live today?

What did you parents do?

Where were your parents born? Mother and father?

What did you grandparents do? And where were your grand parents born?

Tell me about your specific responsibilities in that role.

Describe what you do when a patient visits you.

Describe a day with a patient.

Describe what you do when you deal with patients.

Are you satisfy with your work ?

APPENDIX C



INFORMATION SHEET FOR PARTICIPANTS

PROJECT TITLE:

Relationship between traditional caring culture and western nursing care in Cameroon

INVITATION

My name is Emmanuel Aoudi Chance, and I am a student at the University of Bergen. You are invited to participate in a research study exploring the relationship between traditional caring culture and nursing care at the Protestant Hospital of Ngaoundéré in Cameroon. Through this proposed study, I intend to address the current lack of research evidence on this relationship. This study has been designed to discover your perspective and experiences with regard to traditional caring culture and western nursing care in Cameroon. These notions will determine the impact of traditional caring culture on the nursing care provided by health professionals. Therefore, it is very important to understand your perspective on this issue, as this will provide valuable information that can help sustain and improve patient care.

Should you agree to take part, I will ask you to answer some questions. There are no right or wrong answers—I just want to know your opinion. This study will involve an audiotaped interview. The discussion should take about 30 minutes at most. The interview will be conducted at a time and place nominated by you. Please note that some of the questions will relate to your personal history and experiences at the Protestant Hospital of Ngaoundéré .

Participation is voluntary. If you do not want to take part, you do not have to give a reason and there will be no pressure to change your mind. You can also withdraw from the discussion at any time. Please note, if you choose not to participate or

withdraw during the discussion, this will not affect your relationship with the Protestant Hospital of Ngaoundéré.

RISKS AND BENEFITS

This study may not pose any benefits or risks for you. Its findings will only provide important information to nurses, relatives, local health authorities, and healthcare administrators on how to improve patient care. If you feel distressed during the interview, I will stop the process and refrain from further queries, proceeding only if you wish to do so.

CONFIDENTIALITY

All the information you provide will be confidential and will be used for the purposes of this study only. To ensure anonymity, once the study is complete, all collected data will be securely destroyed. During the project also, the information will be used such that participants cannot be individually identified. No one will be able to link any information you provide back to you. Thus, your anonymity will be safeguarded at all times.

WITHDRAWING FROM THE STUDY

You may decide to withdraw from the study at any time without explanation. You have the right to omit or to refuse to respond to questions asked of you. You are free to withdraw consent. You are free to discontinue participation at any time.

CONTACT

If you have any queries or concerns with any aspect of this study, please contact me by phone on 00 47 476 30 433 or by email at chaemao@yahoo.no.

You may also contact my professor:

Karin Anna Petersen
Universitetet i Bergen, Postboks 7800, 5020 BERGEN
Karin.Petersen@igs.uib.no

THANK YOU VERY MUCH FOR YOUR HELP!



INFORMED CONSENT FORM

PARTICIPANT

PROJECT TITLE

Relationship between traditional caring culture and western nursing care in Cameroon

By signing below, you agree that: (a) you have read and understood the Participant Information Sheet; (b) any questions you have about your participation in this study have been answered satisfactorily; (c) you are aware of the potential risks (if any); and (d) you are taking part in this research study voluntarily and without coercion.

Participant's signature

Date

INTERVIEWER

I have fully explained to the respondent _____
the nature, aim, and procedure of this study, as presented above. All respondents will have a copy of the Information Sheet.

Signature of Interviewer

Date

Print Name

Position

**APPENDIX D: THE REGIONAL COMMITTEE FOR MEDICAL AND
HEALTH RESEARCH ETHICS**

Region: REC West	Officer: Trine Anikken Larsen	Telephone: +4755978497	Our date: 19.12.2013	Our ref: 2013/2014/REK vest
			Your date: 05.11.2013	Your ref:

Karin Anna Petersen

2013/2014 The Relationship between Traditional Caring Culture and Nursing Care in Cameroon

Body responsible for the research: University of Bergen

Project leader: Karin Anna Petersen

With reference to your application dated 2013-11-05. The Regional Committee for Medical and Health Research Ethics, Western Norway (REC West) reviewed the application in the meeting, 2013-11-28, pursuant to The Health Research Act § 10.

Description of the project

The study will explore the relationship between traditional caring culture and nursing care in Cameroon. The study delves into an in-depth assessment of the perceptions and experiences of patients, relatives, nurses, local health authorities and health care administrators with regard to the traditional caring culture and nursing care. This research will determine the impact of a traditional caring culture on the nursing care of health professionals and examine how traditional caring culture influences the current state of nursing care among nursing professionals. The researcher will interview 25 persons in Cameroon.

Evaluation

The purpose of the study is to examine the perceptions and experiences of patients, relatives, nurses, local health authorities and healthcare administrators with regard to traditional caring culture and nursing care in Cameroon. The researcher will interview 25 persons in Cameroon to determine the possible impact of a traditional caring culture on the nursing care of health professionals in general, and to improve the quality care.

The committee finds that the study in question does not require an approval from the Regional Committee for Medical and Health Research Ethics in Norway.

We hereby confirm that the project «The Relationship between Traditional Caring Culture and Nursing Care in Cameroon» by project leader Karin Anna Petersen, Professor, at the Department of Global Public Health and Primary Care, University of Bergen, is exempted from review by the Regional Committee for Medical and Health Research, Western Norway.

Decision

The project is exempted from review by the Regional Committee for Medical and Health Research Ethics.

Appeal

The project leader may appeal the committee's decision, see the Administration Act § 28. The appeal must be sent to the REC Western Norway within three weeks of receiving this letter. If the decision is upheld by

REC Western Norway, the appeal will be forwarded to the National Research Ethics Committee for Medical and Health Research for a final assessment.

Sincerely,

Ansgar Berg
Prof. Dr.med
Committee chairman

Trine Anikken Larsen
Executive officer

Kopi til: postmottak@uib.no

APPENDIX E: THE DATA PROTECTION OFFICIAL FOR RESEARCH

Karin Anna Petersen
Institutt for global helse og samfunnsmedisin Universitetet i Bergen
Postboks 6165
5892 BERGEN

Vår dato: 28.10.2013

Vår ref: 36015 / 2 / KH

Deres dato:

Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 23.10.2013. Meldingen gjelder prosjektet:

<i>36015</i>	<i>Relationship between traditional caring culture and nursing care in Cameroon</i>
<i>Behandlingsansvarlig</i>	<i>Universitetet i Bergen, ved institusjonens øverste leder</i>
<i>Daglig ansvarlig</i>	<i>Karin Anna Petersen</i>
<i>Student</i>	<i>Emmanuel Aoudi Chance</i>

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, <http://www.nsd.uib.no/personvern/meldeplikt/skjema.html>. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, <http://pvo.nsd.no/prosjekt>.

Personvernombudet vil ved prosjektets avslutning, 01.06.2014, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Vigdis Namtvedt Kvalheim

Kjersti Haugstvedt

Kontaktperson: Kjersti Haugstvedt tlf: 55 58 29 53

Vedlegg: Prosjektvurdering

Kopi: Emmanuel Aoudi Chance Monrad mjeldes vei 35 5161 LAKSEVÅG

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.

Avdelingskontorer / District Offices:

OSLO: NSD, Universitetet i Oslo, Postboks 1055 Blindern, 0316 Oslo. Tel: +47-22 85 52 11. nsd@uio.no

TRONDHEIM: NSD, Norges teknisk-naturvitenskapelige universitet, 7491 Trondheim. Tel: +47-73 59 19 07. kyrre.svarva@svt.ntnu.no

TROMSØ: NSD, SVF, Universitetet i Tromsø, 9037 Tromsø. Tel: +47-77 64 43 36. nsdmaa@sv.uit.no



Prosjektvurdering - Kommentar

Prosjektnr: 36015

The Data Protection Official for Research finds the letter of information satisfactory according to the Personal Data Act.

When the project is completed, by 01.06.2014, the data material will be made anonymous by deleting directly and indirectly identifying variables and audio-recordings will be deleted. In order for the data to be fully anonymised, all directly identifying data, such as names/reference numbers must be deleted, and indirectly identifying data in the remaining material must be deleted or changed.