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Research Article

Linguistic Challenges Experienced in the Healthcare Communication Process by Healthcare Providers and Patients in Multilingual Windhoek, Namibia

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Abstract

The study investigated the communicative experiences and cultural/linguistic challenges experienced in the Namibian healthcare context. The main objective of this study was to examine the linguistic challenges experienced in the healthcare communication process by healthcare providers and patients in multilingual Windhoek, Namibia. This qualitative study employed an exploratory and descriptive study design to generate qualitative data. Data were collected through open-ended questionnaires and follow-up interviews. Data were analysed through thematic content analysis. The purposefully selected sample of 30 healthcare providers working in private and public hospitals and healthcare facilities around Windhoek was identified. Thirty-five (35) patients participated in the study through voluntary self-selection sampling. The Communication Accommodation Theory (CAT) was employed since, when applied to healthcare communication, it allows the prediction and explanation of non-verbal and verbal behavioural modifications healthcare providers and patients make to their behaviour to create, maintain, or decrease the social distance in interaction. This is relevant since the study's main aim was to investigate the communication experiences of healthcare providers and patients. Verbal and non-verbal communication behaviours can dictate how effective healthcare communication is modified during healthcare consultations, deliberations, and administration. Therefore, CAT was useful in clarifying issues such as the causes of communication breakdown as well as those that enable positive communication experiences and outcomes. The study identifies that beyond linguistic discordance in healthcare communication, additional barriers arise from divergent cultural backgrounds, religious values, disparities in cross-cultural exposure, and variations in lived experiences. Ultimately, the findings demonstrate that effective healthcare communication is compromised not merely by linguistic misunderstandings between healthcare providers and patients but equally by insufficient intercultural competence, entrenched belief systems, and subtle sociocultural dynamics that transcend purely linguistic differences. These findings underscore the multidimensional nature of healthcare communication barriers, which stem from both explicit cultural contrasts and nuanced elements of identity formation among diverse populations such as Windhoek Namibia.

Keywords

Healthcare, Healthcare Communication, Multilingualism, Culture, Beliefs, Verbal and Non-verbal Communication

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1. Introduction

Effective communication between healthcare providers and their clients is a critical part of healthcare [1], with recent studies emphasising its role in reducing medical errors and improving patient outcomes [2]. Burns [3] elaborates that good communication between patients and doctors is important because poor communication results in difficulties in service provision and reception [4, 5]. This is particularly prominent in multilingual settings, where language discordance can exacerbate misunderstandings and compromise care quality [6].

This sociolinguistic investigation examined interprofessional communication dynamics between healthcare practitioners and patients within clinical settings in Windhoek, Khomas Region, Namibia. The research encompassed physicians, physiotherapists, pharmacists, and nurses across selected public and private healthcare institutions, with particular emphasis on practitioners' self-reported communicative practices and barriers encountered in multilingual healthcare environments. The study contributes to global health scholarship by analysing linguistic diversity as a critical variable in therapeutic interactions, a phenomenon receiving growing empirical attention in cross-cultural medical communication research.[7]. The study focused on the patients' communication challenges encountered during their visits to healthcare facilities because of language discordance, a barrier shown to disproportionately affect health equity in sub-Saharan Africa [8].

The multilingual, multi-ethnic, and multicultural characteristics of Namibia, therefore, cannot be distanced from its healthcare context. Like the country in general and Windhoek city specifically, the healthcare context, in terms of communication, is faced with challenges from both the healthcare providers' and the patients' sides. After all, communication is intended for both giving and receiving information [9]. Both parties (HCPs and patients) are challenged with these linguistic and cultural challenges daily during healthcare interactions [10, 11]. This situation obliges and challenges multilingual healthcare institutes to put in place measures, such as trained interpreter services or digital translation tools, to enable communication between healthcare providers and patients [12].

2. Materials and Methods

This study adopted a qualitative research model, employing exploratory and descriptive study designs to produce qualitative data. Exploratory studies are undertaken when the phenomenon under study is not well known or less explored [13, 14], an approach validated by recent methodological frameworks for under-researched healthcare contexts [15]. This study focused on healthcare communication in Namibia, and the researcher, through a review of related literature, found that it needed to be explored. The exploratory nature of this study is necessitated by the fact that the communication gaps, needs, and challenges experienced in the healthcare system in Namibia (Windhoek specifically) cannot be understood singly as they are. The researcher understood that a close study of this nature needs to be done on the causes and find reasons and possible solutions to the communication challenges experienced by healthcare providers and patients. The descriptive design is utilised to describe the communication experiences of healthcare providers and patients [16, 13], aligning with contemporary qualitative health research practices [17]. Describing the communication experiences of the healthcare providers and the healthcare recipients provides insights, reveals, and clarifies the challenges experienced when health matters are discussed.

The sample for this study was generated from the two categories of respondents, namely, healthcare providers and patients (healthcare recipients). Qualitative studies are generally based on non-probability and purposive sampling [18, 19], a strategy increasingly recommended for focused phenomenological inquiry [20]. For this study, in the case of healthcare providers, as part of purposeful sampling, snowball sampling was employed. This is because the researcher had an idea about the type of respondents who would have the necessary information and, therefore, identified and requested them to participate. This sample (HCPs), therefore, was purposefully selected to ensure that participants who met the inclusion criteria were part of the study [21]. The researchers identified possible participants (healthcare providers) through the snowball/network or chain referral sampling technique [22] a method validated for hard-to-reach professional populations in low-resource settings [23]. Healthcare providers who were eligible to take part in this study should have been practicing in either private or public healthcare facilities in Windhoek, Namibia. They should have worked in the Namibian healthcare sector for five years or more. Both expatriate and Namibian healthcare providers were welcome to participate and had equal opportunities to participate in the study. They were selected using the same selection criteria. This is because the researchers' focus was on the challenges experienced in healthcare communication by and with healthcare providers in Windhoek. If any Namibian or expatriate healthcare provider met the inclusion criteria, they were eligible to participate.

Though the researcher knew that she needed patient respondents, she did not know who they would be as individual participants, but she knew where and how to access them. The sampling for the patient participants was thus done differently from the way healthcare providers were sampled. The researcher employed self-selection or voluntary sampling techniques to recruit patient participants to participate in the study, a method critiqued but widely used for its efficiency in clinical settings [24]. Healthcare recipients who were eligible to take part in this study were those who had visited a hospital

or healthcare provider within 30 days of data collection. These patients were expected to respond to the questionnaire questions at the research point and leave it there. The researcher collected questionnaires to avoid the questionnaires going missing. Critical to note is that the self-sampling method used to recruit patients for this study does not allow the researcher to contact the participants. These respondents should be able to at least understand and read basic English, and they should have visited a hospital or healthcare provider in Windhoek during the days during which data were collected.

Data was collected, firstly, through a questionnaire with closed-ended questions (demographic information section only), and the rest were open-ended questions. This was followed by in-depth interviews (only with healthcare provider respondents who did not provide comprehensive answers in their questionnaire responses), a hybrid approach gaining traction in health communication research [25].

3. Results

The study's main finding is that in addition to linguistic discordance experienced in healthcare communication, other causes of discordance emanate from the differences in cultural backgrounds, cultural and religious beliefs, exposure to different cultures and lifestyles, as well as experiences. Lack of professional interpretation services also contributes to the lack of mutual intelligibility between healthcare providers and patients. The study's major conclusions are that healthcare providers in hospitals and healthcare facilities in Windhoek are both locals and expatriates, and understanding a language does not mean understanding the cultural practices, beliefs, and social norms of the people. In some cultures, some diseases and situations cannot be mentioned by name, and this variety needs to be comprehended by the two parties. There is, therefore, a need for regulated interpretation services for professional healthcare interpreters in and around healthcare centres.

4. Discussion

In the current study, the researcher paid special attention to healthcare communication and the challenges healthcare providers and healthcare recipients experience in the process of providing and receiving healthcare services. Multilingualism is found in the current study, as both an enabler and a disabler in the healthcare communication process. Challenges that healthcare providers and patients experience because of functioning in a multilingual healthcare setting include delays in service provision and reception because of discordance. In most cases, an interpreter must be called in to help the two parties understand each other. The biggest challenge with the interpretation services revealed by the current study's findings is that there are no readily available trained interpreters in and around healthcare centres and hospitals. Ad hoc translators are used, and these can range from healthcare providers, patients' family members, any available person who can understand the patient's language and English, including institutional workers such as cleaners. This jeopardises the patients' right to privacy since even if it is not their wish that a third party knows about their medical conditions, the interpreter will do so.

Other challenges include the fact that in different cultures, people relate to and discuss diseases and ailments differently. Empirical data for this study indicated that language is not the only means through which healthcare provision, reception should be deliberated, and its effectiveness measured. Data showed that in some cultures, for instance, it is a taboo to mention certain body parts and some diseases directly or by name. Therefore, if a healthcare provider, for instance, does not know this about the culture of the people he/he is rendering services to, the likelihood is that there might be a misunderstanding, which may lead to misdiagnosis and wrong treatment. The opposite is also true: that if the healthcare provider, for instance, refers to a certain body part or disease directly in the presence of patients from cultures where such diseases or body parts are not mentioned directly, it will be regarded as rude, disrespectful, or viewed in a negative light altogether. The patients might receive a shock and might be reluctant to freely discuss their situations or provide detailed information necessary for their effective treatment or therapy.

5. Conclusions

This study aimed to examine the linguistic challenges encountered in healthcare communication between healthcare providers and patients within Namibia's multilingual context. Findings revealed that multilingualism functions as both a facilitative and obstructive factor in clinical interactions. Key challenges identified include systemic delays in service delivery due to linguistic discordance, necessitating frequent reliance on third-party interpreters. A critical issue highlighted by this investigation is the absence of professionally trained interpreters in healthcare facilities in multilingual Windhoek, resulting in the ad hoc use of untrained personnel, ranging from healthcare staff and patients' family members to institutional workers such as cleaners. This practice compromises patient confidentiality, as sensitive medical information is unavoidably disclosed to unauthorised individuals.

Further challenges stem from culturally mediated communication norms. Empirical data demonstrated that language alone does not suffice to ensure effective healthcare delivery; cultural taboos significantly influence discourse. For instance, direct references to specific diseases or body parts are prohibited in certain cultural contexts, potentially leading to misdiagnosis or therapeutic resistance if providers lack cross-cultural competence. Reciprocally, patients may experience distress or withhold critical information when providers disregard these cultural norms, undermining diagnostic accuracy and treatment efficacy.

Conversely, the current study identified substantive benefits of multilingualism in healthcare settings. Providers proficient in multiple languages reported enhanced capacity to communicate directly with patients, eliminating reliance on interpreters and fostering more accurate clinical assessments. Multilingual patients similarly experienced fewer barriers in articulating symptoms, enabling timely and precise care. Beyond clinical utility, multilingualism facilitates broader social integration, as linguistic congruence promotes trust and cooperation across diverse cultural groups. Respondents emphasized additional advantages, including reduced misunderstandings, streamlined service delivery, and strengthened confidentiality through direct provider-patient communication without third-party intervention.

These findings underscore the duality of multilingualism in healthcare: while it introduces complexities tied to interpreter dependency and cultural sensitivity, it simultaneously serves as a vital resource for optimising care quality, patient autonomy, and cross-cultural therapeutic alliances. The study overall advocates for systemic reforms, including interpreter training programs and cultural competence education in Healthcare training institutions and among citizens, to mitigate risks while leveraging Namibia's linguistic diversity as an asset.

Abbreviations

CAT	Communication Accommodation Theory
HCPs	Health Care Providers

Author Contributions

Theresia Mushaandja is the sole author. The author read and approved the final manuscript.

Data Availability Statement

Additional data is available from the corresponding author upon reasonable request.

Conflicts of Interest

The author declares no conflicts of interest.

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