Impact of Language Barriers on Healthcare Access and Quality among Limited English Proficient Patients in Obanliku and Obudu LGAs of Cross River State

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ABSTRACT

Obanliku and Obudu Local Governments are multilingual/multiethnic in nature with quite a number of its inhabitants cannot fluently speak English. Therefore, accessing and delivering qualitative healthcare seems difficult. This study examined the Impact of language barriers on accessing qualitative healthcare among limited English proficient patience in the aforementioned areas. A qualitative research approach and non-probability purposive sampling technique were used to generate data. Interviews were conducted, recorded and transcribed verbatim. The results indicated the existence of language barriers due to limited English proficiency among healthcare seekers, which affects access and delivery of healthcare services, creating an ineffective therapeutic relationship resulting in inappropriate prescriptions and clinical explanations, patients' difficulties in finding their way in healthcare facilities leading to overstaying and delay in locating vital places, greater amount of patients' dissatisfaction and resentment towards providers' attitude regarding their health situations, highlighting the need for the provision of trained interpreters. Also from the results are difficulties in understanding patients' health situations, making proper diagnoses and providing appropriate treatment. From the results obtained, the study recommends that in addition to English language, Pidgin English and the language(s) of the immediate environments should be adopted as working language(s) of public healthcare centres and hospitals. Nigerian Government should employ professionally trained interpreters, and the inclusion of major languages of the immediate environment into the curriculum programmes of healthcare trainees.

Keywords: Language barriers, Limited English proficiency, Healthcare access, Healthcare delivery

INTRODUCTION

Communication is essential in creating enabling environment for interpersonal interaction for effective cross fertilization of information, ideas, and emotion [35,56] at personal and professional settings. Effective communication is the key that unlock the gate of purposeful and meaningful symbiotic relationships. In accessing and delivering health services effective communication guarantees effective relationships, and brings about maximum satisfaction to both patients and providers in all aspects of health and welfare, from disease prevention, health promotion to quality of life [53,58]. As rightly stated by Kamila Barbara that by using communication, information is transferred, negotiation concluded, clients' needs met, and it enables cooperation and activities [36]. Communication can contribute to health impact, as communication can alter levels of knowledge, influence attitudes and increase knowledge. It plays an important role in building greater confidence in partners [62].

Quality healthcare delivery and access to good healthcare are largely depends on healthcare providers' cordial relationships with patients, and that can only be archived when there is clarity, active listening, empathy and feedback in communication. Effective communication plays a crucial role in fostering healthy and productive

relationship [56] when providers use appropriate language in offering appropriate prescriptions and patients make appropriate following of medications, instructions, visits as regularly as appointed. However, this cordiality resulting from effective. communication can be affected by language barriers. Healthcare sector as other vital sectors in human life, needs enabling environments where providers and patients are cordially coexisting, they are like a two-sided coin bounded by a language. So, if there is a barrier in language, obviously, there will be no understanding with severe implications on health care delivery and patients' treatments [10,47,51].

Provision of healthcare in Nigeria is a non-judicial constitutional human right hinged on ratification of world health organization (WHO) declaration on human right that the highest attainable standard of health is a fundamental human right without distinction on race, religion, political believes, economic or social condition [63]. Equally, article 16 of African charter on human and people rights notes that every individual shall have the right to enjoy the best attainable state of physical and mental health [60]. In the words of Michael O.D et al in Nigeria the 2016 national health policy (NHP) represents a tangible progress towards the recognition of the right to health. Building upon the foundation laid by the 1988 and 2004 policies, the 2016 NHP aims to strengthen the national health system, particularly the primary healthcare subsystem to deliver quality, effective, equitable, accessible, affordable, acceptable and comprehensive health care services to all Nigerian. Anchored in the provision of the national health act of 2014, the policy aligns with global health commitments, including the sustainable development goals (SDGs) and emphasizes the principles of universality, equity, and accountability in the healthcare delivery [45]. In spite of all these, it is believing that language barrier is a serious impediment to accessing quality healthcare, more especially in the areas like Obanliku and Obudu local government.

Obudu and Obanliku local government areas are multilingual like the other local governments in Nigeria. Even though, they have Bette and Obanliku as the dominant language each, there are numerous minorities languages such as Utugwan, ukpe, Obang, Igbo, Hausa in Obudu and Bendi Becheve, Bebi, Bisu, Busi, Bishiri, Bebi, Belinge, Efic, Fulani ect in Obanliku. These two local governments are bounded with Benue state; whose major language is Tiv. Being multilingual, the local governments abide by the national and constitutional policy of using English as official language across all government sectors, including health sector. But there is no official concession to local/ native languages in the provision and access of health care apart from the constitution political statement, stating that in addition to English language one, two or three local languages should be used in deliberating legislative matters in the state and local assemblies, courts, broadcasting radio stations, etc. [20]. This provision has not been adequately planned and executed by the states and local governments. Hence effective healthcare access and delivery is an uphill or herculean task in these multilingual settings. This violates patients bills of right initiated by the Federal Ministry of health in Nigeria which guarantees that every patient has right to relevant information in a language that they understand. This includes clear communication regarding diagnosis, tests, treatment, side effective and the potential costs of medical care [21,22,46]

Even though, there are adequate literatures ascertaining the global recognitions and acceptance of the presence of impact of language barriers in accessing quality healthcare services in other parts of the world [1,13,37,38,43,47,51], little or no literatures indicating that such researches were conducted to ascertain the difficulties faced by the low proficient English speakers, who constitute larger percentage of the population in accessing quality healthcare in the areas of study. Available relevant researches identified by the study include: Iron bar VE et al who studied the impact of primary health care delivery on the wellbeing of the rural communities in Obudu local government area, Cross river, state. The study revealed that Obudu as many rural areas in Nigeria experiences suboptimal health service delivery. And that effective primary healthcare delivery stigmatically enhances community health outcomes, reduces morbidity and mortality rates, and promotes overall wellbeing [30]. Oseremen, Dic-Ijiwere E., et al., carried a research on "demographic and serum alanine aminotransferase level of primary health care workers positive for hepatitis B surface antigen and hepatitis C virus in Cross river state [48]. Jonathan, Iwunze, carried out public enlightenment on promoting menstrual hygiene and health in communities of Obanliku women. [32]. Osim, et al researched on capacity development: a tool for promoting efficient primary health care delivery in Obudu local government

area of Cross river state [49]. Ugal David Betelwhobel, et al studied utilization and maternal health outcome among urban dwellers of Obudu and Ogoja local government areas of Cross river state [59].

From the available literatures reviewed, it is clear that scholars are consistently trying to contribute to the growth and development of skills/knowledge in the field of healthcare in the area under study. However, there is a wide gap in the area of communication between healthcare providers and patients, as evidence from the presented and available literatures non investigated on language barriers and language related issues in healthcare access and delivery. Equally, Obanliku local government is not given attention by researchers as revealed by the scope of the above preliminary reviews. These among other things will negatively affect health care access and delivery, and it will not bring about optimum performance and satisfaction from both providers and patients. Therefore, it is these gaps in the fields of health care access and delivery that stimulated the need to study impact of language barriers on healthcare access and quality among limited English proficient patients in Obudu and Obanliku local government areas of Cross river state, with the aim of contributing to effective health care access and delivery.

METHODS

This study was carried out in three public health care centers situated in two local governments, namely Obanliku and Obudu local government areas of Cross river state, respectively. The selection of the area and the study was informed by Federal Government of Nigeria policy on health care reaching every Nigerian irrespectively of their area, status, tribe, religion, and background [60, 63] aligning to United Nation's world health programme and African Union charter on one hand. On the other hand, the selection and study was made because of the facilities proximity and affordable to local communities who constitute highest percentage of the population and are vulnerable to health challenges. Based on qualitative research where inductive-deductive coding approach to data analysis was used. The study was conducted from April 2025 to April 2026 to find out the impact of language barriers on health care delivery, access and quality among limited English proficiency patients in Obanliku and Obudu local government areas of Cross river state. It was approved by the center for research, documentation and academic publications, Federal college of education Obudu and commissioner Cross river state, Ministry of education in collaboration with Cross river state Ministry of health, health research ethics committee.

The study was developed out of the researchers' consideration and believed that the areas as any other places in Nigeria are multilingual/ multiethnic, where there is likelihood health seeker may experience language barriers in accessing healthcare therein. Approach to the study is adaptation of approaches used by Olani B.A et. al [47] and Pandey M. et el [51].

Sampling strategy

A non-probability, purposive sampling technique was used to recruit participants for the generation of information relevant to issues concerning process/event under investigation. Explicitly, sampling procedure was considered in selecting limited English proficient patients who are above eighteen years, and have history of been received healthcare services within the period of, at least, of this study. For considerable personal and direct impressions, consideration was given to linguistic/ethnic backgrounds, age and educational levels. The sample of fifteen (15) patients and twelve (12) healthcare providers were recruited. Although, the sample may seem too small, however, it can be justified by the fact that the recruitment was guided by data saturation and effective theme generation and qualitative research is determined by depth and richness of the data, but not by statistical power. Beside it is quite appropriate for interview based qualitative research of this type, because it take control of considerable large portion of opinions across different languages, age groups and genders.

In recording hidden, minor or detail distinction of limited English proficient patients, the researchers in collaboration with healthcare facilities, bilingual research assistant and bilingual staff recruited patient participants. Bilingual research assistant took care of the recruitment contact, where he elaborated the safety and clarity of their roles in the patient's language. All participants were given consent forms, however, due to limited English proficiency, bilingual research assistant explain the content and scope of the consent form to

patient participants in their preferred language. All the participants used were entertained during the processes and were incentivized after the processes.

Section 1

Participants/ Clients

All participant used were health seekers/patients who are natives/inhabitants of the area, where the health facilities are situated, that is, at Obanliku, Obudu and Utugwan respectively, age 18 years old and above. Fifteen (15) individuals (fifteen (15) females) from three different health facilities in two local governments and are hereafter referred to as patients/ clients/health seekers (see demographic information of patients/ clients/ health seekers in table 1).

Table 1. sociodemographic information from participants.

Category	**Female**	**Male**
Number of participants	15	0
Age group		
18–24	9 (60%)	- -
25–34	1 (6.7%)	- - -
25–44	2 (13.3%)	- -
45–54	3 (20%)	- -
>54	----	----
Educational level attended		
Elementary	2 (13.3%)	---
Secondary	7 (46.6%)	---
Tertiary	5 (33.3%)	
Vocational training institute	1 (6.7%)	---

Data Collection

The study used a semi structured interview guide to generate data concerning participants experience of language barrier resulting from limited English language proficiency and its implication on healthcare access and quality focused on: a) preferred language of communication at health center, b) patients'/ health providers' relationship resulting from language used; c) limited English proficiency and health care access/delivery, d) healthcare providers' attitudes towards patients/clients linguistic/ethnic background; etc. Patients/clients were interviewed in their own preferred language(s) at a secured and conducive environment within the health centers and lasted for 15-20 minutes with each respondent. The respondents were coordinated and interviewed by the researcher(s) and the bilingual research assistant, and were thereafter entertained. Responses from respondents were recorded and documented. The bilingual research assistant periodically assist participants with explanations and interpretations where necessary in order to guide the respondents.

Section 2.

Participants

In section (2), healthcare providers' perspectives on effects of language barriers on quality and delivery of healthcare were studied in order to effectively present the phenomenon. Twelve healthcare providers agreed by signing the consent form: a medical director (BCH), four nurses, three lab technicians, three community health officers and a midwife participated in the interview. They are all government of Cross river state employees, working with the health care centers used for this study (see socio-demographic information captured in table 2)

Sociographic information from providers

Category	Females	Males
Number of participants	7 (58.3%)	5 (41.7%)
Age group		
18–24 years	------	------
25–34 years	2 (16.6%)	2 (16.6%)
35–44 years	2 (16.6%)	2 (16.6%)
45–54 years	3 (25%)	1 (8.3%)
>54		
Educational level(s)		
Primary/elementary	---	---
Secondary school	---	---
School of nurse science		8 (66.7%)
University		4 (33.3%)
Vocational	---	---
Cadre		
M. doctor	---	---
B C H		1 (8.3%)
Nurse		4 (33.3%)
Community health		3 (25%)
Midwifery		1 (8.3%)
Lab technology		3 (25%)

Data Collection

Healthcare providers working with studied health centers participated in two hours thirty minutes (2:30) thorough interviews, with average of 15-20 minutes per person centering on: a) language of communication during cross examination; b) availability and use of interpreters; c) effects of language (English) on healthcare delivery; d) workload effects on healthcare delivery; e) language management/ administrative effects on healthcare delivery; f) ethical knowledge on healthcare delivery. Researchers and bilingual research assistant guided the conduct and recording of the interview. The interviews were conducted in English and the respondents were allowed to use both English and pidgin English in expressing their experiences.

Analysis

The recorded health seekers' and health providers interview were transcribed verbating for analysis. The transcripts of the interview texts were carefully done to ensure true wording and phrases of the respondent through painstakers comparison with the audio-recorded voices. Although, the study is concerned with limited English proficiency to access and delivery of healthcare, language barrier appears to be the clarifying phenomenon highlighting different aspects of healthcare access and delivery impacts during the analysis. This informed the decision to concentrate on the effect of limited English proficient on access and delivery of healthcare in this research (study).

To effectively captured the analytical effectiveness and its symbioses relationship with the research, this study adopted inductive-deductive coding approach to data analyses, based on the processes involving repetitions of code generation and development processes. All information gathered were transformed into a qualitative analyses status for appropriate multiple coding process. First, initial open coding was individually performed by the researchers to develop initial codes from the data for tagging segments of the text with descriptive labels, to reveal participant's responses, given attention to respondents' information regarding language barrier to healthcare. Therefore, the researchers arranged the codes into specific appropriate functional categories to guaranteed these labels into book that stores the mapping between plaintext words or phrases and there equivalent in a code to ensure compatibility across the dataset. Based on this platform, themes development was made by identifying and assigning categories into broad conceptual themes. The coding and developed

themes were reviewed by the researchers to pilfer the best items from the collections. This marked a shift from description to interpretation of causal relationship between communication gaps and reduced healthcare access and quality. Also in this process was the application of negative case analysis to test validity of emerging themes outside participants' narratives. In preserving the reflexivity, all analytical decisions were documented and preserved by the researchers. And throughout our period of investigation, we become informed how language barriers drastically affected healthcare access and quality seriously influence our position as researchers. We discovered that our positionality as researchers shape our perception and interpretation of patients and providers advocacies, Adequate attention was given during analyses to ensure all data collected or recorded during interviews were used. In presenting direct quotation in the analyses, informants privacy was maintained using techniques of associating respondents with hospital or health center where they work. Thereby anonymizing respondents as HPL1, PHC1,2,3 etc.

RESULTS

Section A: Ability to access and deliver healthcare.

Healthcare is an issue that concern patients and health providers, that is doctors, nurses. For it to be delivered and accessed effectively, there must be giver, taker and medium through which the process accomplished. In this context, language proficiency is required for optimum access and delivery right from the start. This means general public, to whom health services are made for, should adequately have information and knowledge on healthcare services. Through their language(s) or language they understand. In Nigeria delivering and managing healthcare services is through the medium of English language, the Nation's lingua franca. But this language could not satisfy the healthcare needs of the public, since those who can speak English fluently and communicate with health providers appropriately are less than those who cannot. It is therefore, quite obvious that people may have challenges of not being aware of what healthcare services means to them, as such, accessing healthcare attitudes to them will be low. This bring about public apathy towards accessing health care services in their localities when they are sick or even when they are completely down health wise. Because they are not aware of healthcare importance and could not understand its benefits as commented by patient from PHC1: *"I am 25 years old but this is my first time visiting a clinic/ healthcare service center. This is due to experience from my relatives and friends"*

Language barrier affects patients' comprehension of discharge instructions, and patients with limited English proficiencies are likely make wrong interpretation of this information, which may/will lead to error of understanding with devastating negative consequences on application or execution. This is clearly manifested on follow-up and medication information, as commented by a patient from PHC2, thus:

"some time they will say we come on Monday for checkup, like today (I don't know how to talk it) we come to check our infections. Now again maybe in next two (2) weeks again we will come back, we will still come back for checkup because it was on Monday that we came for checkup in the next two (2) weeks we still come back then you will now give them your complaint, anything that is disturbing you, you talk to them, then they will know the medicine they will give you".

This patient doesn't know that he/she can come for periodical checkups which is different from treatment follow-up.

Ensuring the delivery of basic health services to the people of Nigeria and prioritizing other health services that may be proved with available resources is within the ambit of the government. Public should be appropriately informed. Where there is public inadequate knowledge, due lap/ b resulting from the medium used, it will affect delivery and accessing of health services as reported by interviewed patient from HPL1, thus: *"I do go to chemist when am sick, and like in my village when I go to chemist where the treatment did not cure me, I go to healthcare facility in utugwan".*

There are many cultural and personal issues that negatively influence patients' attitude toward accessing healthcare. First cultural perception on certain ailment are associated with evil. Therefore, should not be pronounced or mention for the fear of unknown. Secondly, fear of disclosure of person issues to third party

which are detrimental to relationship or person implications, sexual activity and native substances use. This mythical perception resulting to barrier in accessing health care is expressed by interviewed patient from PHC1, thus: *"yes due to privacy, I preferred or not wanting anybody to know my case, I prefer to talk/ relate with my doctors or nurses directly"* in the same connection another patient from PHC & HPL1 commented*: "yes, sometimes I prefer to talk to doctors or nurses directly because of privacy and not wanting anybody to know my health conditions".* The far, reaching consequences of this mythical perceptive on healthcare is not only culturally orientated but also linguistical. Because besides fear of unknown surrounding talking about the ailment, there is also limited vocabularies associates to patients' explanation of the nature and effect of the sickness to health providers. This affects the treatment and access to healthcare as reported by interviewed patient from PHC1 thus: *"yes I prefer to seek treatment from a native doctor in my village than clinics or hospitals".*

In delivering services to people, institutions are to make appropriate selection and use of language for effective delivery. In the healthcare facilities under study, the selection and use of the language was made in line with the government recognition and approval of English as medium in public sectors, meaning it is the language of official and national services. However, its effectiveness lies on how the institution or organization manages it. In managing a language for effective and more inclusive services, there must be monitoring on how it works or how it functions. English operating in a multilingual society where majority of the people are not formally educated, bound to face challenges of effective delivery if not effectively managed. In this connection a provider, from PHC1 who participated in the interview commented thus: *"yes the management is aware of the dangers patients with language deficiency faces in healthcare delivery".* while from PHC1, a provider comment: "*no; the management is not aware of the dangers posing by clients limited English proficiency, it is not a problem at all, we can manage it".* The provider further said: *"…… I don't periodically report to the management problems of language barrier faced in health care delivery by the clinic".* From HPL1 all health providers interviewed commented that*, "yes, the management of this hospitals are aware of dangers poses by clients' limited English proficiency in healthcare delivery*". They further commented: *"yes, we do periodically report to management about it*". And when asked about management reaction to their report of dangers pose by patients limited English proficiency in healthcare delivery, they commented thus: *"huuhh, for now, we have not actually spoken about problems of clients limited English proficiency as a challenge in the hospital because it's quite limited, is just some few patients that will come and give you that kind of problem not every patient that comes".* From PHC2, health providers commented *"no we don't use to report issue of problem barrier (limited English proficiency) faced in healthcare delivery to management authority in this clinic".* In respect to periodical clinical meetings, PHC2 comment*: "yes, we do talk about language barrier in our clinical meetings as a problem of healthcare delivery, but we don't take heavy action".*

In delivering healthcare services to people, it is widely believed that patient language or knowledge of the language use is appropriate for effective delivery. Because in communication, the speaker and the listener should be on the same page/level in terms of language used. therefore, in a situation of delivering healthcare to a multiethnic and multilingual communities, right should be given to patients or sector's language, more especially, when the patient cannot speak English language. In this regard, health provider should have a fair linguistic knowledge of the patient. And where the provider cannot speak patient's. language, there should be interpreter's to bridge the gap. Such a patient cannot be denied, healthcare service because he or she cannot\ speak English as affirmed, health providers interviewed from PHC 1,2 and HPL1 thus: *''yes, I know health care delivery in patients'/clients' language is a right not a privilege''.* And in terms of awareness which educate people about their health, there is a little or no programmes, and where it exists not much consideration is given to linguistic knowledge of the communities as one interviewed provider from HPL1 commented *''sometimes we do have educative programs in our facility, mostly when we have our clinical inspections in section, every Wednesday we do give lectures and sometimes when there is an outbreak, people will go out to create awareness campaign''* in this saturation the exercise are carried out in English as commented by a provider from HPL1, thus: *''yes, health care delivery is only effective through English language".*

Section B: Ability to establish a therapeutic affinity with healthcare providers.

English language proficiency influenced patient's – provider's relationship in healthcare facilities. Where English is the only officially recognized language of communication, patients with limited English proficiency face uphill task locating where to start administrative and clinical procedures. This was expressed by one interviewed patient from PHC1: *"Yes, definitely, I spend time trying to know what to do and where to go in searching for medication in the clinic or hospital"* This patient's way finding difficulties or deals experienced while seeking is in the form of reading and comprehending information's and directions on walls and boards that are written in English. And equally when have access to providers they are not able to effectively communicate their health challenges to health providers as expressed by a patient from PHC2, thus*: ''yes, language barrier (not being fluent in English) used to affect my confidence in expressing my health problem/needs''*.

Equally providers face challenges in delivering health services to patients with language barriers. Challenges faced recorded include: prescription, clinical examination, treatment, seeker-provider relationship, treatment progress reports. In respect to clinical examination, health provider from HPL1 commented*: ''yes, I have difficulties understanding my patient's/clients cases som*etimes'' in terms of prescription, health provider from PHC1 stated: *''yes, language barriers (English deficiency) affect patients most, in terms of prescription if they don't understand what is prescribed, this can affect the patient's treatment"*. In this connection also, health provider from HPL1 stated*: ''sometime they follow many instructions as prescribed, not all follow my instructions, some delayed taking their drugs, sometimes some of them take overdose …''* in terms of noticed effect of language barrier on patient's treatment, health provider from PHC1 stated: *"yes, language barrier (English deficiency) prolong treatment period and patients over stayed in the clinic''*. On the same issue, health provider from HPL1, stated*: ''yes, language barrier prolongs treatment period, overstayed in the hospital because, sometimes you encountered a patient, if there is no interpreter, could not understand what you are saying, especially, seeing the patient in the ward multiple times to understand the case can prolong treatment and staying in hospitals"*. Besides prolonging treatment period and over-stayed in hospital, it has also been reported that language barrier delayed treatment progress, as one health provider from HPL1 reported*: "uhhh, language barrier, how it affects them? It is possible going to slow the progress of work (treatment) because if you see patients having language barrier, it will take more time to explain, to understand, but if the patient is knowledgeable it will not take time on the patient to respond to treatment quickly".*

On effective relationship between patient and provider, which is essential in health care delivery, Providers, who are trained in English, employed and posted to a multilingual community where English is the officially recognized medium of communication, will likely experience or record difficult relationship emaciating from existing language expressing this scenario, providers from PHC1 and 2 reported*: "yes, language barrier (English deficiency) affect my relationship with my patients".*

Establishing therapeutic relationship between providers and seekers through effective exchange of ideas is essential to healthcare access and delivery. For seekers to engage and participate meaningfully in matter of cross examination he/she needs to be recognized and welcomed by providers through appropriate use of language. Providers outstanding linguistic repertoire of patients and facial friendliness during clinical discussions. This will create conducive atmosphere and environmental effectiveness in accessing and delivery of healthcare. But where the provider failed to express linguistic and facial friendly expression, the seeker may not be able to express himself or herself effectively due to insufficient, meaningful and effective vocabularies, phrases or sentences. This will affect cross-examination and eventually leads patients/seekers to frustration, as reported by a health seeker at PHC1: *"yes, I am not considered important, and experienced problem of not being attended because of my language or ethnicity by health provider"*. Similarly, speakers with limited English proficiency expressed their dissatisfaction to providers' attitudes towards their linguistic situation as patient/client from PHC1 commented: *"No, I am not satisfied being attended or treated using English as a medium of communication"*. And the other patient/client stated*: "yes, I cannot be effectively treated by doctor or nurse who does not speak my language"*. In similar experienced, patient from HPL1 elaborated thus*:*

"yes, I am not comfortable being attended by doctor or nurse who cannot speak my language, because those that speak my language at times help in explaining to me what I cannot understand in my language. If I cannot understand I will ask the nurse to assist me".

Besides being frustrated with disdainful manners and ways providers attend to them (patients/clients) due to language barriers, because there is also patients' lack of confidence exhibited by patients/seekers in providers' language, and manner in which the language was used during cross-examination, as said by one patient from PHC1*: "yeah, sometimes, I am satisfied being attended to by the nurse in the clinic. But sometimes I cannot satisfactorily being attended to. This is depending on the way people speak"*.

Section C: Availability and use of Interpreters.

For effective communication to exist there must be presenter, receiver and medium. Clinically use take or regard a presenter to be either health provider or patients, which could be also same to receiver, and the medium is the language use to bridge their gaps. Language is essential and necessary in this regard, as it can bring about satisfaction or act as a barrier in communication in most cases when information is being not communicated as desired, we inferred that there is language barrier. This could be in any environment or setting where people of different linguistic and ethnic backgrounds gathered to discharge their person or corporate responsibilities. When this situation exists, it can be. In healthcare delivery, this situation exists and can be ameliorated through inculcation of language translator program and provision of official interpreters by the requested authority. Where any of these two does not exist, surely, there will be ineffective information delivery resulting from linguistic barrier with devastating effect on the desired success in communication. Particularly on healthcare access and delivery, which is the focus of this study. The concern of this study include the availability and use of interpreters in hospitals and clinics as related to access and delivery. Interviews made with patients (health seekers) across the health institution used, showed inadequate and effective use of interpreters, as reported by patient(s)*: "no, I don't use interpreter(s) while being attended by either nurse or doctors"*. These patients/clients/seekers responses indicate dearly the there was no availability and use of interpreter(s) in the healthcare facilities for patients with limited English proficiency while seeking or accessing healthcare.

Unlike patients/clients, the providers affirmed the use of interpreters, as provider fromPHC1 comment*: "yes, we use interpreters because we have some persons from different tribes"*. Similarly, a provider from HPL1 comment*: "not always I used interpreters"*. When providers were asked during interview*, "why do you use interpreters?"*. A provider interviewed from PHC1 responded thus*: "whose language is too low, like the one in my office. People we have here (this health center) are Bette speakers, most of my colleagues are Bette. like when our English is too high for the patients understanding, we use interpreters where necessary"*. Similarly, another provider from PHC1 state*: "sometimes we use interpreters to attend to local patients like Hausas, when they come, there are some nurses who can do interpretation"*. The providers were further asked, *"where do you get the interpreters?"*. A provider from HCP1 answered: *"our colleagues here are serving as interpreters"*.

Furthermore, during interview, providers were asked in an event where there are no interpreters "*what will you do?*". A provider from PHC1 replied: *"where we do not have interpreters we use Bette or low status English (pidgin English). The way your client can understand"*. While a provider from HPL1 replied: *"when there are no interpreters, what do I do? Sometimes we stimulate the patients, to tell them where does it pain. Sign language and sometimes we married them with clinical examinations. Examine the patients just like you are examining an unconscious patient to be able to elicit what you examined"*. And when further asked, are you satisfied with the service of interpreter, a provider from HPL1 commented*: "sometimes, if they (interpreters) interpret what I said clearly, I am satisfied"* while a provider from PHC2 stated: *"on satisfaction with interpreters? Nhhh! not too well because sometimes I am not too satisfied"*.

With regard to attending patient with disability, that is, eyes, ear and language disability, the provider replied*: "no, we don't treat person with disability. The time we use to have patients with disability, they use to come with their interpreters"*. Similarly, a provider from HPL1 further stated that:

"the patient with language disability just as I said like deaf and dumb, explain using sign to them, whatever you are doing you try and do it the way the patients will understand or if the interpreters, the relation that come with the patient can understand very well, if you know that they are not getting what you say, you use the relative to explain to them".

While provider from PHC2 commented: *"like some persons we are having (deaf and dumb) I use to handle them to lab to run their test and the result we got from lab we use it. yes, I use sign language for dumb"*. Still on patients with language disability provider from PHC2 further stated: *"on how to attend patients with language disability…. nhuu! That is where the problem use to come from, we talk and still use non-verbal signs to communicate with them and there a lot of them in this community"*.

These revealed lack effective interpreters and ineffective use of interpreters by health providers in the health facilities under study, and the situation is dangerous to health care access and delivery.

Section D: Impact on Healthcare Outcomes

Nigerians have the attitude of managing their health challenges, including dangerous killer diseases like hypertension, HIV, hepatitis, diabetics, etc. on their own or through unqualified health care practitioners, fetish and native healers, and chemist or chemist shop. Self-medications managements not bad but should have guidance, directives and prescriptions of qualified trained medical personals. With adequate and effective preventive care in place dangers of misuse and misapplication of preventive medicines or medications by vulnerable population- the children under the age of five, vulnerable and low income population, pregnant women, and rural and underserved communities – will be managed. In almost all countries of the world, preventive care is being regarded as a means of solving healthcare needs and challenges of people through enlightenment and education, that is preventive care. This is partially executed in the area under study as reported by interviewed patient from PHC1, thus*: "No, we are not given preventive care program(s). however, sometimes during pregnancy, we are given but not regularly".* In addition to that, that is, limited preventive care to pregnant women, a patient from PHC2 commented, thus: *"yes, I was taught about preventive healthcare, only to pregnant women"*. This shows that there are preventive care challenges, because out-of-pregnant women, men and children are liable to health challenges that may lead to death. For effectiveness, preventive care program should be executed through outreach programs. But in the areas under study it is executed on patients who registered and are receiving treatment in the health centers, and also during periodical immunizations when there are outbreaks. This is experienced by a provider from PHC1 who commented on the existing preventive care program in their facility, thus: *"Yes we have effective programs that enlightens people about healthcare. Especially, when we are doing immunization, we normally do announce round the town to come to health center for immunization, you understand"*. In addition to the existence of periodical and circumstantial preventive care programs in the facilities under study, a provider from HPL1 commented thus*:*

"sometimes, we do have educative programs in our facilities, mostly, when we have our clinical inspection in session every Wednesday, we give lectures and sometimes when there is out break, people will go out to create awareness campaign".

. This existing preventive healthcare package obtainable in the health centers in the areas under study is not fully understood by public because of the language gap. The concept of health screening is not known by people as commented by a patient from PHC II that:

"sometimes, they will say we come on Monday for checkup, like today (I don't know how to talk it) we come to check our injections. now again, maybe in the next two weeks again we still come back, we still come back for checkup in the next two weeks, we still come back then you will give them your complain, anything that is disturbing you, you talk to them. Then, they will know the medicine they will give you".

From the above it can be concluded without been told that there is serious problem in accessing healthcare through the medium of English language. Secondly, the sold aim of preventive care program, which is education is completely missing as lamented by the patient. All these are as a result of limited English

proficiencies. English language being the formal, official language recognised and approved for communication in all formal sectors in Nigeria including health is not appropriately reaching wider population considering the fact that the number of those who speak and understand the English are less than those who cannot. The greater implication of this is on effective communication. This situation is further compounded with the issues of technical registers which require clinical linguistic knowledge that most patients in areas under study does not have. These make accessing healthcare very difficult as commented by a patient at PHC1*: "I prefer to use native language with doctors and nurses than English, because I will understand native language better"*. In addition to that another interviewed patient from PHC1 commented*: "I am not communicating effectively with doctors and nurses"*. As sensitive to life as issues on health, it has been observed that even patients who are formally educated, and can speak English language appears very careful in communicating to health providers during clinical cross-examinations. They always try to avoid miscommunication by given preference of the use of through effective language. This is reported by a patient interviewed from HPL1*: "I used both English and native language, but I prefer English, that is when the person examining me cannot speak my native language"*. This can be understood as, even though, the patient can speak English language but for effectiveness she or he prefers his native language when being cross-examined by provider(s). we can largely associate the patients view with his or her misaviodance or misinterpretation of information. Similarly, provider from PHC2 further commented*: "as you so when you came in…… I was telling her (a patient) I want your left leg, keep this leg. She was fumbling, she doesn't understand……".*

Language barriers resulting to miscommunication often leads to misunderstandings and reduce confidence and collaboration as in the case of a patient with limited English proficiency from HPL1 who commented, thus*: "Yes, I do believe that I cannot be treated by a doctor or nurse who cannot speak my native language"*. In what look like affirmation to that comment, a patient from PHC1 commented*: "No, I am not satisfied being attended or treated using English as a medium of communication"*. A client/patient from PHC2 further complained: *"sometimes, I do have difficulties understanding Doctors and Nurses' prescriptions"*. Healthcare providers being concern with the wellbeing of the patient, do always go to extra length to manage the situations, no matter how the level of their patients' language proficiency, as commented by a provider from HPL1, thus*: "I will try, yes I try to make communication effective".*

Language barrier can significantly interfere with patients' ability in locating units in healthcare facilities. Healthcare facilities are designed and constructed with intuition that it will cater for all patients needs without difficulties. However, patients finding way around healthcare facilities that should not have been a problem became more complex and challenging, especially to limited English proficiency patients. The facility is full of unfamiliar hallways and complex layouts, confusing signage and directions because that are difficult to patients. Whose level of literacy skill is low, since all information about there are written in English. The struggle to locate the right department or office, wards or rooms, and units seem waste of time and frustrating. This is contained in patients' response from HPL1 who responded, thus*: "Yes, I do spend time in knowing what to do and where to go for my treatments in clinics or hospitals".*

Effective and efficient healthcare delivery in a multilingual setting, where English is the second and official language, needs interpreter(s) whose function bridge language gaps between patient and provider. Present of interpreters control medication error and bring satisfaction to both patient and provider. Health facilities in the area understudy do not give serious attention or recognition to interpreter(s). it is exclusively providers' decision to use or not to use interpreters as commented by a provider from PHC2, thus*: "No I don't use interpreters"*. While a provider from PHC1 commented*, "Yes, we use interpreters"*. When ask how patients with limited English proficiency being taken care in the absence of interpreter, a provider from HPL1 responded, thus: *"……. Where there is no interpreter, I use pidgin English……".* And on where do they get their interpreters(s), provider from HPL1 responded: *"I get interpreters by using parents' relatives".*

Solving language barrier require administrative/managerial mechanism. This could be in form of periodical report from center weekly clinical briefings to the higher authority, where issues including clinical language management associated to communication barriers or poor technology standardization threating provider-patient are discussed. But observation showed that healthcare policy regarding planning and control of the

effect of language barrier is not in practice, as provider from PHC1 reported: *"No, I do not periodically report to the management problem of language barrier faces in the facilities healthcare delivery"*. In the same manner a provider from HPL1 commented that*: "We have not been discussing language barrier as problems of healthcare delivery in our meetings"*. And also a provider from PHC2 reported*: "No, the management have not attempted solving problems of language barrier"*.

In further adopting strategies to address language barrier, providers advocated for the place of patients' native language right in accessing and delivering of healthcare, as provider from PHC1 commented: *"Yes, healthcare delivery in patients' language is a right not a privilege, because if there is no communication there will be no effective healthcare delivery"*. And in support of the inclusion of patient native language in healthcare delivery in order to alleviate difficulties faced by patients with limited English proficiency, a provider from HPL1 commented*: "I don't so think that healthcare delivery can be only effective through English language, because other languages could be applicable"*. And in complementary statement to that, a provider from HPL1 added*: "What of patients who does not hear English at all?"*.

Appropriate language should be used for effective communication in accessing and delivering healthcare, since English language that is formally approved could not meet both people and policy expectation appropriately. In this regard a provider from PHC1 commented*: "In this locality, I will suggest, the best language for treatment should be English and local (native) language, because of the nature of the people"*. But to a provider from HLP1: *"If I will suggest, pidgin English should be appropriate language for healthcare delivery in this facility"*. While in similar situation a provider from HPC2 commented, thus*: "If I may suggest the appropriate language for health care delivery in this locality is simple English (pidgin English) and community (local) dialect"*.

DISCUSSION

This study concerns with limited English proficiency people of Obanliku and Obudu local government areas of cross river state of Nigeria. In line with similar studies on language barriers and access as well as delivery of healthcare, both patients and provider considerably agreed that limited English proficiency have greater negative implications on the delivery and access to effective health care [1, 4, 37, 43, 47, 51]. From the study, it has been observed that the cosmopolitan nature of Nigeria and its delineated local governments where English is a celebrated working language of healthcare facilities, and where people of different linguistic and ethnic backgrounds, without prejudice to their education and English efficiency, are constitutionally entitled to live [20], accessing quality healthcare will be hampered by limited English proficiency which may largely be considered an act of structural violence [47]. A preventable destruction or damage to individuals and communities resulting from operations of social facilities and its negative effects includes: inability to provide minimum resources necessary for long-term physical well-being and life opportunities [42, 47]. This adherence to use of English as a medium of communication between the provider and patients denied majority of healthcare seekers access to healthcare in their languages, in their own places, and in the facilities that are made for them. And it is absolutely a violation of patient bills of right initiated by Nigeria Federal Ministry of Health which guarantees that every patient has the right to relevant information in language they understand. This includes clear communication regarding diagnoses, tests, treatments, side effects and the potential costs of medical care [21].

Among problems of language barriers emanating from limited English proficiency identified in healthcare facilities in Obanliku and Obudu local government areas of cross river state, Nigeria, includes patient attitudes toward use of English as medium of communication in healthcare delivery. Patients participated in this study expressed desire or preference to the use of their native languages with medical providers during clinical examinations. This will bring about effectiveness in expressing their health situations. Patients expression of preference to use of their native languages in accessing healthcare. This is a sort reminder of what is neglected in the application of Nigeria policy regarding healthcare delivery, which expressed that the healthcare provider concerned shall, where possible, inform the user (patient) in a language that the user understands and in a manner which takes into account the user level of literacy [21]. This section of the healthcare act is not applied in its entirety as patients echoed their preference to the use of native language or pidgin English over English

language. The use of local or native language in communication for healthcare access and delivery in the environment where the facility is located has been rated to occupy a core part of healthcare but not as an adjunct [1, 41]. Adetola further upheld Arthur's view that local language in healthcare has been described and modifies as medicines most essential and principal tool for the delivery of quality health care [6]. Researchers found that the use of patients' language for communication have effects on outcome measures, such as patients' satisfaction, compliance with medical instruction and health improvement [39]. Not to establishing communication frame work using patients' local languages may place minority groups and indigenes of localities globally at risk of having worse health profiles compared to the populations with a large majority if they are unable to effectively communicate their concerns at health facilities [3].

This study also identified that the assumed English used during clinical examination is not standard English but rather a pidgin English. Using this variety of English whose lexical vocabularies are insufficient and inadequate to express healthcare situations and phenomenon will seriously lead patients to language barrier with greater negative implications to healthcare access, delivery and quality. This is because pidgin English is uncodified with small vocabulary without regard to English morphology which was developed to serve a very narrow range of function [31]. Therefore, it cannot accommodate medical terminologies that are technical in nature, and not suitable to express concept and phenomenon in healthcare situations. These make communications between patients and providers ineffective with negative implications on access and delivery of quality healthcare.

In this study it has been reported by both patients and providers that language barriers created ineffective therapeutic relationships where no symbiotic information sharing and enabling environment for understanding between patients and providers, which affects healthcare access and delivery, [2, 3, 13, 25, 26, 34]. Patients interviewed reported lack of information regarding side effects of the drugs given to them by providers, inappropriate clinical explanations, and no follow-up information. These can possibly interfere with cases treatment [9, 27, 51, 61]. In concordance to Wong and Lee as observed by Mba Atche, good doctor-patient communications are important and has multiple impacts on various aspects of health outcomes. Some of these various aspects are: better health outcomes, higher compliance to therapeutic regiments in patients, higher patients and clinicians' satisfaction, and a decrease in malpractice risk [43]. Similarly, Kate N et al [37], affirmed that same tongue in communicating with healthcare professionals gave better understanding of medications prescribed, side-effect of medications with overall effect of compliance to prescriptions.

The study further recorded that patients spend time and encounter difficulties locating where to start and where to go for treatments in healthcare facilities in the areas under study. This is associated with patients' poor expressive skills, in the sense that most of them cannot read inscriptions written on board, walls, and tags in the healthcare facilities. These inscriptions are information for directions made to guide patients and visitors as stated and demanded by Federal government of Nigeria through Federal ministry of health, that Federal ministry, every State ministry of health, every Local government health authority and every Private healthcare provider shall insure that appropriate, adequate and comprehensive information is disseminated and displayed at facility level on the health services for which they are responsible, which include: (a) the types of health services available, (b) the organization of health services, (c) operating schedules and time table of visits, (d) procedures for laying complains, and (e) the right and other duties of users and healthcare providers [21]. Although this act as explicitly stated is to some extent been carried out. But bearing in mind that health facilities are made to provide for persons living in Nigeria the best possible health services within the limits of available resources. Protect, promote and fulfil the rights of the people of Nigeria to have to have access to health care services [21], health providers failed to put into cognisance patients bills of right enacted by the federal commission (FCCPC) which guarantees patients the right to receive all relevant medical information in a language they understand [19, 21] into consideration for the benefits of patients. This is frustrating and delaying them whenever they intend to access health care services.

Language barrier creates negative mindset and dissatisfactions in the minds of patients as they hold resentment on providers that they are not being considered important, and are neglected while seeking health care services. In this regard, Roter and Hall [54] demonstrate that besides language there are other factors which help strengthen the doctor-patient relationship. These factors include: laughter, jokes making, personal remarks,

giving the patients compliments, friendliness, honesty, a desire to help, devotion, a non-judgmental attitude and a social orientation. Though provides may have been compelled to behave negatively to patients as a result of frustration resulting from language barrier, they ought to be professional enough in dealing with patients with limited English proficiencies as Silverman and Kinnersby [55] contented that verbal communication in medical considerations is well recognized as being important to the delivery of medical care and is usually easy to interpret and analyze. One should not be surprised, therefore, that non-verbal communication plays a significant role throughout the medical interview and is an important variable in doctor-patient interactions, concern and emotions, and helps reinforce or contradict our verbal comments. Furthermore, it has been stressed that good clinicians-patient communication makes a difference not only in patient satisfactions but in patient outcomes including resolution of chronic headaches, changes in emotional states, lower blood sugar values in diabetics, improved blood pressure readings in hypertensive but to name a few [17].

The study also recorded the use of healthcare providers, patients' relatives as interpreters and sometimes providers do rely on their intuitions in cross-examining patients. Use of provider as interpreter will amount to additional responsibility which will affect his/her primary responsibility. Use of patient relatives as interpreter will not bring about effective cross examination, particularly from the angle of patients' social desirability. Because there are cases or diseases or health condition which a patient does not want to be known to their relatives. This will not have allowed the patient to give authentic information concerning their health situation. And providers relying on their intuitions can also not going to give optimum satisfaction because of provider's likely errors in generalization. Above all, they all not professionally trained interpreters, their services in this capacity will not bring about patient-providers maximum satisfaction accessing and delivering of quality healthcare services. Hssence, there is a need for the provision of trained interpreters for limited English proficient patients. Responses from both providers and patients affirmed that the health care facilities used for this study have no trained interpreters for patients with special needs, such as deaf and dumb, and patients with limited English proficiencies. This contradicts and violates the health care ethics in Nigeria, where the right to a language or sign language interpreters is fundamental constitutional guarantee, specifically stated in section 36 (6) (e) the right to fair hearing. It ensures that non English speakers and the hearing-impaired can fully understand and engage in legal and public proceedings [20]. This is implicitly and explicitly reaffirmed by prohibition act 2018 which has legally guarantees the right of persons with disabilities to free medical and health services in public institutions, expressly indicating in section 24 (2) that patients *"shall be provided with a sign language interpreter"* where necessary [24]. This is so to United nation convention on the right of persons with disabilities (UNCRPD) which Nigeria is a signatory. Furthermore, federal government of Nigeria establishes non judiciable legal framework for the regulations and management of the Nigerian health system where it emphasis the patient right to participate in their treatment plan and obligates health care provider to ensure that patients are fully informed in a language they understand [21]. Other social desirability barriers affecting access and delivery of health care recorded include, ethnicity, cultural bias and stigmatization which force patients to seek for privacy with providers, rejecting the use of interpreters and at times do away with healthcare services. These negatively affect access and delivery of healthcare. To achieve desired objective for healthcare for all, therefore, good and appropriate language should be used because it is a form of embodiment of human civilization and culture [40].

Language barrier creates problems to providers as they encounter difficulties understanding their patients' health situations during clinical examinations. This compelled them to navigate from English language to patients' native language and pidgin English at times with the hope of getting accurate and effective information from patients. This shows that health world is a foreign country to many [people] and providers should pay closer attention to understanding the language patients use and how they draw meaning from what they hear [52]. And some time they became frustrated when they have patients who are old and can neither speak English language nor pidgin English. This situation truncate expectations and satisfactions among providers and patients, thereby affects the quality of health care delivered or received which results to adverse events [3]. Providers in their suggestion to the problem of language barrier, opted for the adoption of pidgin English as language of healthcare delivery in the areas under study. This mean a review of National health care act to include and recognize pidgin English in healthcare delivery, a call similar to constitutional provision of the use of other local languages apart from English language in deliberation of legislative matters as well as in national radio and television stations is required.

Limitation of the Study.

Two (2) local governments out of eighteen (18) local governments in cross river state and small number of patients will not be effective representation and the results might not reflect the experience of the entire people of the state and the local governments. Female patients constituted the largest proportion of the sample population used than male patients indicate that the views are more of female patients with limited English proficiency barriers. This exclusive participation of female patients, the used of few healthcare facilities and the absence of private healthcare facilities and its providers in this study are among major visible acknowledged limitations, therefore, future researches are required to include more diverse participants and healthcare facilities,

Implications

The results of this study are very important for all the states and local governments in Nigeria. With introduction of pidgin English and local language(s) into training programmes of the health care trainees and official recognition of the aforementioned language(s) as working language(s) in health centres/hospitals, there will be considerable satisfactions from both patients and providers. Government as a matter urgency should consider the training and employment of skilled interpreters to facilitate effective healthcare delivery. Furthermore, since information regarding units, wards, section, warnings, guidance, and instructions in the hospitals/clinics are provided only in English in Nigeria, the impacts these might be having on patients who cannot speak/read English is devastating, and therefore, needs attention in further studies [47].

CONCLUSION

Result of the study revealed both providers and patients are hit with devastating effect of language barriers emanating from limited English proficiency which resulted to patients calling for the use of their native language(s) in accessing healthcare, ineffective therapeutic relationships, spending time and experiencing difficulties in locating where to go for medications in healthcare facilities, patients' dissatisfaction with the manner in which they were attended by healthcare providers, and no recognition of patients social desirability as well as lack of interpreters. These no doubt affect the delivery and access of quality healthcare. The study recommends that government should as a matter of policy add to the training programs of healthcare providers general studies in Nigeria language(s), a program similar to English program in all undergraduate programs in Nigeria universities.

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Authors Contribution

Hisham Aliyu.B. Mohammed conceptualised the idea, developed the plan, prepared and apply for ethics approval. He supervised, collected and analysed data, and prepare the draft of this research. The author read and approved the final manuscript.

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Availability of Data and Materials.

The recorded interviewed clips and transcript used for this study are available from the author or upon forwarded appropriate request.

Declaration

Ethics approval and consent to participate.

This study was attested by the director center for research documentation, Federal college of education, Obudu, Cross River State, Nigeria. Dr. Francis A. Adida and forwarded to Cross River state ministry for health, health research ethics committee who after review forwarded to ministry for education. Thereafter, Cross River state commissioner for education, Associate Professor Stephen odey on behalf of government of Cross River state granted the approval. All participants were given informed consent form and accepted before engaging in the research activity.

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