MERIT RESEARCH JOURNALS
www.meritresearchjournals.org

Merit Research Journal of Art, Social Science and Humanities (ISSN: 2350-2258) Vol. 11(2) pp. 008-016, July 2026
Available online https://www.meritresearchjournals.org/journal/mrjassh

doi: 10.5281/zenodo.21763977

Original Research Article

Multilingual Medical Consultations: Linguistic Obstacles and Interactional Strategies in Mamfe, Cameroon

Ngasu Betek Etengeneng

Faculty of Letters and Social Sciences, Department of English and Foreign Languages, University of Douala

Email: etengs2019@gmail.com

Abstract

The effectiveness of a prescription depends on the patient's comprehension, which cannot be presumed in multilingual communities. This article investigates language barriers and communication strategies in medical consultations in Mamfe, Manyu Division, South West Region of Cameroon. Mamfe's linguistic landscape encompasses Kenyang, Ejagham, Cameroon Pidgin English, English, French, Igbo, and other local languages, with increasing diversity due to the Anglophone crisis and resulting displacement. The study was conducted across four health facilities (Mamfe Urban Integrated Health Centre, Mamfe District Hospital, Presbyterian Health Centre Besongabang, and Full Gospel Mission Health Centre), using a qualitative-dominant mixed methods design. Data were collected over three months from 70 participants (50 patients and 20 healthcare workers, including 3 doctors, 12 nurses, 3 laboratory staff, and 2 pharmacy staff) through questionnaires, interviews, and observation. Language barriers were most prominent during symptom description, diagnosis explanation, and prescription comprehension. Both patients and healthcare workers addressed these challenges by negotiating meaning through code-switching, use of Cameroon Pidgin English, simplified explanations, repetition, gestures, demonstrations, and informal interpretation by relatives or bilingual staff. While these strategies facilitate communication, they remain improvised rather than institutionalized, posing risks to accuracy and confidentiality. The article contends that multilingualism in Mamfe's health facilities serves as both a barrier and a resource. It concludes that effective and equitable healthcare in linguistically diverse settings requires interpreter support, simplified multilingual prescription guidance, communication training for healthcare workers, and institutional recognition of local languages as integral to quality care.

Keywords: Cameroon Pidgin English, Doctor-patient communication, Health communication, Language barriers, Mamfe, Multilingual healthcare, Negotiation of meaning

INTRODUCTION

Consultations may fail even when all participants act appropriately. For example, a healthcare worker may ask a question in English, and the patient may respond with apparent agreement that is actually a gesture of politeness, resulting in the patient leaving with a prescription they can read but not fully comprehend. Communication in healthcare constitutes an essential component of treatment: language enables patients to describe symptoms and seek clarification, while healthcare workers use it to obtain medical histories, explain diagnoses, and ensure that prescriptions are understood and followed after the consultation.

In multilingual communities, effective communication becomes significantly more challenging because participants may not share a common language or may only share a limited functional language. For instance, a patient may be fluent in Kenyang but only partially proficient in English or French, while a nurse may be

comfortable with English and Cameroon Pidgin English but lack proficiency in Ejagham or Igbo. Consequently, the success of the consultation depends not only on clinical expertise but also on the ability of both parties to negotiate meaning through repetition, simplification, translation, gestures, code-switching, or assistance from others until mutual understanding is achieved, even if imperfectly.

Cameroon is an unusually rich site for studying this kind of negotiation. English and French serve as official languages over a variety of indigenous languages that people actually think and feel in, while Cameroon Pidgin English works as an everyday lingua franca across the North West and South West Regions. Chie and Chenwi (2021) document this pattern in Cameroonian hospitals, showing that communication difficulties arise wherever healthcare workers and patients come from different language backgrounds, with measurable consequences for diagnosis and patient outcomes. Mamfe, the headquarters of Manyu Division, sharpens this picture further: the town draws patients from its own neighbourhoods, surrounding villages, and, increasingly since the onset of the Anglophone crisis, displaced communities who have left conflict-affected areas in search of safety, widening the range of languages a healthcare worker may need to work across on any given day.

This article examines how healthcare workers and patients navigate linguistic diversity across four health facilities in Mamfe, focusing on the language barriers encountered during consultations and the strategies employed to address them. The central argument is that language barriers do not merely impede communication; rather, they prompt adaptive and resourceful communicative practices. However, these practices should not be viewed as substitutes for institutional support, but rather as indicators of its insufficiency.

Background to the Study

Healthcare communication in Mamfe unfolds inside a linguistic environment that is genuinely plural rather than bilingual in any simple sense. Patients arrive speaking Kenyang, Ejagham, Cameroon Pidgin English, English, French, Igbo, and other languages, moving between these codes with varying ease. Healthcare workers, trained professionally in English or French, frequently lean on Pidgin as a practical bridge. Communication in this context is something actively worked out, encounter by encounter, and the stakes are not abstract: a patient who misunderstands a dosage instruction may take too much medication or stop early, one who cannot describe pain clearly may receive a delayed diagnosis, and one who relies entirely on a relative to interpret may lose privacy over information they would rather have kept to themselves.

Cameroon's situation is not unprecedented in the wider literature. International research on language barriers in healthcare has repeatedly connected communication difficulties to reduced patient understanding, lower satisfaction, and a higher risk of clinical error. Flores (2005, 2006) frames language barriers as a matter of access, safety, and quality of care, while Karliner et al. (2007) show that professional interpretation measurably improves clinical care for patients with limited proficiency in the dominant language, reframing language barriers as a health equity issue rather than a peripheral inconvenience. What is distinctive about Mamfe is the layering of official bilingualism over indigenous multilingualism and a widely shared Pidgin: a patient who uses English in an administrative office may reach for Kenyang the moment they need to describe pain, and healthcare workers make a mirrored adjustment, recording a diagnosis in English while explaining treatment in Pidgin because that is the language most likely to land.

The Anglophone crisis compounds this picture. Displaced persons arriving in Mamfe bring their personal linguistic backgrounds along with disrupted schooling, limited means, trauma, and unfamiliarity with formal hospital procedure, so communication difficulties are woven inside broader social and emotional strain as opposed to purely linguistic ones. This study treats healthcare communication in Mamfe as a situated multilingual practice, shaped as much by conflict, movement, and poverty as by the number of languages spoken in the room.

Statement of the Problem

Effective communication underpins safe, patient-centred healthcare, yet in multilingual settings it is repeatedly undermined by mismatches in language proficiency, unfamiliar medical vocabulary, variable literacy, and differing cultural understandings of illness. In Mamfe's health facilities, these mismatches surface in three recurring places. Patients regularly struggle to put symptoms into words the healthcare worker will recognise, reaching for local expressions that do not map neatly onto biomedical categories. Healthcare workers frequently explain diagnoses in English or French even when a patient understands considerably better in Pidgin or an indigenous language. And, perhaps most consequential, patients regularly leave a consultation without a firm grasp of their prescription: dosage, timing, duration, and possible side effects.

The strategies people reach for in response- code-switching, gesture, informal interpretation, simplified explanation- keep consultations moving but are not reliable in any strict sense. An untrained, improvising interpreter may drop information, misread medical terms, or compromise confidentiality without meaning to, and

repetition helps only if the language repeated is one the patient actually understands. Existing research has shown that language barriers exist in Cameroonian healthcare settings. Still, little of it has looked closely at how healthcare workers and patients in a specific town like Mamfe negotiate meaning in real time. Even less has considered how displacement linked to the Anglophone crisis has intensified the language variety local facilities now manage. This study tackles that gap directly.

Objectives and Research Questions

The study's general objective is to investigate language barriers and communication methods in medical consultations across selected health facilities in Mamfe. Its specific objectives are to identify the principal language barriers encountered during consultations, examine the strategies used to negotiate meaning, determine how these barriers affect patients' understanding of prescriptions, explore how displacement-driven language variation has altered healthcare communication, and propose practical recommendations to improve communication in multilingual healthcare settings.

Five research questions guide the study: What language barriers occur during medical consultations in selected Mamfe health facilities? What strategies do healthcare workers and patients use to negotiate meaning across those barriers? How do language barriers affect patients' understanding of prescriptions and treatment instructions? How has displacement-linked language variation shaped healthcare communication in Mamfe? And what measures might realistically improve communication in this and comparable settings?

Literature Review

Communication as the Core of Clinical Care

Healthcare communication is not incidental to clinical practice; it is one of its central mechanisms: how healthcare workers gather information, explain conditions, issue instructions, and support decision-making, and how patients participate meaningfully in their own care. Epstein and Street (2007) describe patient-centred communication as the joint construction of mutual understanding, constructed together turn by turn rather than transferred as a fixed message. Street et al. (2009) trace pathways through which communication shapes health outcomes, including trust, self-management, access, and comprehension, so that a patient less able to disclose symptoms accurately becomes less likely to follow through on treatment. Communication is also never symmetrical: healthcare workers carry institutional authority and specialised knowledge, and a language barrier deepens that asymmetry rather than dissolving it.

Multilingualism as both Barrier and Resource

Multilingualism in healthcare is often treated purely as a problem, but this framing is only half accurate. It generates friction, certainly, but also supplies the resources through which that friction gets managed: a nurse who moves comfortably between English, Pidgin, and Kenyang reaches more patients meaningfully than a monolingual colleague could, and a patient who can shift between Ejagham and Pidgin has more room to negotiate understanding than one confined to a single language. In Cameroon, this asset is everywhere. English and French anchor formal life, but everyday communication leans heavily on Cameroon Pidgin English, which Chie and Chenwi (2021) describe as a long-standing vehicle for cross-linguistic communication in bilingual Cameroon, a role visible in Mamfe well beyond the hospital gate. Healthcare, however, asks more of a shared language than casual interaction does: a link language sufficient for greeting or bargaining may not be precise enough for medicine, where a small misunderstanding about dosage, timing, allergy, or pregnancy status can carry serious consequences.

Language Barriers in Clinical Encounters

Language barriers arise wherever patients and health workers lack enough common language ground to communicate accurately, a gap that can involve vocabulary, pronunciation, grammar, literacy, medical terminology, or simply different cultural models for describing illness. A patient may handle everyday English comfortably and still have no purchase on expressions like hypertension, infection, dosage, or contraindication. The literature draws a consistent line from language barriers to weaker medical access and lower quality of care: Flores (2005, 2006) links these barriers directly to patient safety, satisfaction, and quality outcomes, while Karlineret al.(2007) show that professional interpretation clearly improves clinical care where patients have limited proficiency in the dominant language of the facility, rendering language barriers a matter of equity rather than convenience. In Mamfe the barriers cluster at three points: symptom description, where patients struggle to convey pain or a reproductive health concern in the consultation language; diagnosis explanation, in which healthcare workers often default to English or French while a patient understands considerably better in Pidgin or a local language; and prescription understanding, arguably the most consequential because patients continue treatment unsupervised at home, where misunderstood instructions do not announce themselves the way a confused expression does in the consultation room.

Negotiating Meaning in the Consultation

Negotiation of meaning describes the joint work speakers do to move from misunderstanding toward common understanding: repeating a question, rephrasing an instruction, asking a patient to demonstrate what they understood, switching languages mid-sentence, or bringing in a third person to interpret. In Mamfe, this is a routine, almost invisible part of clinical survival. A nurse may open in English, drop into Pidgin when a patient's face signals confusion, and ask a colleague to render a key instruction in Kenyang; a pharmacy assistant may explain dosage by anchoring it to morning, afternoon, and night rather than clock time, units that require no translation at all. The wider literature names much of what happens in Mamfe: code switching, simplification, repetition, clarification, gesture, demonstration, and informal interpretation, the last especially common wherever professional interpreters are unavailable. Code switching carries particular weight here, a pattern Communication Accommodation Theory describes as convergence, speakers adjusting their style to meet the other person halfway. Simplification does similar work in plainer form, replacing "take one tablet twice daily" with "take one in the morning and one in the evening," sacrificing exact accuracy for comprehension in a trade that tends to pay off. None of this comes without cost: family interpretation can jeopardise privacy, a relative may soften or withhold information out of shame, and an untrained interpreter may get something wrong.

Displacement and the Widening of Language Variation

The Anglophone crisis has altered daily life across the North West and South West Regions, and Mamfe, as an administrative and commercial hub, has absorbed a share of the resulting displacement. People arriving from surrounding villages bring their own languages and dialectal variation, adding to a landscape already plural before the crisis began. Displacement is treated here not as the origin of Mamfe's multilingualism but as a factor that has intensified an already complex situation, bringing more patients, a wider spread of languages within the same facilities, and more pressure on already over-worked healthcare workers. The literature confirms that language barriers affect medical service provision and that communication techniques can offset them. Still, little of it explores how conflict-driven displacement interacts with pre-existing multilingualism in a single town's health facilities, a gap this study is positioned to close.

Theoretical and Conceptual Framework

Four complementary perspectives inform the analysis, chosen because the study treats language not simply as a system to be described but as social action unfolding inside a clinical encounter. Interactional Sociolinguistics, associated with Gumperz (1982), explains how meaning is built from contextual indicators like tone, pause, gesture, code-switching, and shared background knowledge, rather than words alone: a patient's hesitation or a healthcare worker's switch into Pidgin carries interpretable weight alongside anything actually said. Communication Accommodation Theory (Giles, Coupland, & Coupland, 1991) accounts for how speakers modify their speech to close or preserve social distance. Healthcare workers in Mamfe accommodate patients by switching into Pidgin, simplifying English, or slowing down; patients accommodate in turn by reaching for English or Pidgin even where those are not their strongest languages. This mutual adjustment sits at the centre of what this article calls negotiation of meaning.

The Transactional Model of Communication (Barnlund, 1970) frames communication as continuous and reciprocal rather than one-way transmission: a healthcare worker asks, a patient answers, both adjust, and understanding accumulates through feedback, or fails to if that loop is never closed.

The Cultural Competence Framework (Betancourt, Green, Carrillo, and Ananeh-Firempong, 2003; Brach & Fraser, 2000; Tervalon and Murray-García, 1998) insists that respect for patients' cultural and language backgrounds is part of clinical care itself: patients describe illness through locally meaningful categories, may trust a relative's interpretation more than a stranger's, and need information in a language that feels like theirs.

Together, these frameworks resist a purely technical reading of language barriers as vocabulary gaps to be closed, locating the problem instead within identity, trust, power, and access.

The conceptual framework linking these ideas runs in a fairly direct line: Mamfe's multilingual environment produces communication barriers; those barriers require communication techniques; those strategies, deployed well, produce negotiation of meaning; and fruitful negotiation shapes medical outcomes such as diagnosis precision, prescription understanding, medication adherence, and patient confidence. Language variation generates the raw material for barriers, including language mismatch, uneven proficiency, unfamiliar terminology, limited literacy, and differing cultural accounts of illness. Healthcare workers and patients respond with an available repertoire of strategies, including code-switching, Pidgin, translation, repetition, gesture, simplified explanation, informal interpretation, and demonstration, feeding an active process of negotiation whose success or failure feeds directly into clinical outcomes.

This framing refuses to cast patients as passive victims of language difference or healthcare workers as

Table 1. Participants in the Study

Patients	50
Doctors	3
Nurses	12
Laboratory staff	3
Pharmacy staff	2
Total	70

simply failing at their jobs. Both groups are shown working, often skillfully, with whatever linguistic resources are available to them, capturing something true about Mamfe specifically: official language support is thin on the ground, but everyday multilingual practice is rich and constantly improvised into something workable.

METHODOLOGY

Research Design

The study employed a qualitative-dominant mixed-methods design to observe patterns of language barriers across a substantial participant group while also capturing the lived experiences and strategies used to address these barriers. Questionnaires provided the primary descriptive data, while interviews and observations offered contextual depth, recognising that critical aspects of language barriers, such as patient hesitation or a nurse's mid-sentence switch into Pidgin, are not easily quantifiable. For qualitative analysis, interview and observation data were transcribed and subject to thematic analysis. The coding process involved carefully reading through all transcripts to identify recurring themes related to language barriers, negotiation strategies, and their effects. Codes were developed both inductively from the data and deductively from existing literature. To enhance rigour, an independent second coder reviewed a subset of the transcripts and compared identified themes. Discrepancies in coding were discussed and resolved to establish consistency in interpretation; this process aimed to ensure reliability and credibility of the qualitative findings.

Study Area

The study was conducted in Mamfe, Manyu Division, South West Region of Cameroon, a multilingual town that also functions as an administrative and healthcare centre for the surrounding area, serving residents of the municipality, nearby villages, displaced populations, and travelers passing through. Four health facilities were selected: Mamfe Urban Integrated Health Centre, Mamfe District Hospital, Presbyterian Health Centre Besongabang, and Full Gospel Mission Health Centre, chosen because together they draw patients from varied linguistic, social, and geographical backgrounds.

Population and Sample

The study involved 70 participants in total: 50 patients and 20 healthcare workers, comprising 3 doctors, 12 nurses, 3 laboratory staff, and 2 pharmacy staff.

The inclusion of both patients and medical workers enhanced the study by enabling direct comparison of perspectives from both sides of the consultation. Participants were selected through purposive sampling based on their direct experience with healthcare communication: patients were chosen for their willingness to participate and recent consultation experience. In contrast, healthcare workers were selected due to their direct patient contact in the course of their duties.

Research Instruments

Three instruments were used, chosen to triangulate what participants said against what could actually be observed. A questionnaire gathered structured information on languages spoken, communication difficulties, and understanding of prescriptions. Semi-structured interviews let participants describe their experiences in their own words, and non-participant observation let the researcher watch communication techniques unfold in real consultations.

Data Collection Procedure

Data were collected over three months, following administrative authorisation and ethical clearance obtained before fieldwork began. Participants were informed of the study's purpose, and their consent was sought voluntarily, with the option to withdraw at any time. Recognising that many participants were displaced persons or belonged to marginalised groups, particular care was taken to safeguard participant vulnerability and address power dynamics. The researcher explained confidentiality and the non-evaluative nature of

Table 2. Major Languages Encountered in Consultations

Kenyang	Mother tongue for many local patients
Ejagham	Used by patients from Ejagham-speaking communities
Cameroon Pidgin English	Main bridge language
English	Formal consultation and documentation
French	Used with Francophone staff or patients
Igbo	Used by some migrant patients
Other local languages	Used by displaced or migrant patients

participation in clear, accessible language, and made deliberate efforts to ensure that no participant felt coerced or at risk of negative consequences for declining or responding bluntly. For those with limited literacy or who appeared hesitant, the study procedures were explained orally and in their preferred language, and additional time was given for questions. During the administration of questionnaires, interviews, and observations, the researcher ensured privacy where possible and avoided sensitive topics unless the participant initiated them. Observations took place discreetly so as not to disturb care or expose participants' identities. These safeguards aimed to respect participant autonomy, protect the dignity of vulnerable groups, and reinforce ethical rigour throughout the data collection process.

Data Analysis

Quantitative responses were analysed using simple frequencies and percentages, sufficient given the study's descriptive rather than inferential aims. Thematic analysis of qualitative data followed several steps designed to ensure both depth and rigour. First, all interview and observation transcripts were read multiple times to achieve familiarity with the content. Next, open coding was employed to identify units of meaning related to communication barriers, negotiation strategies, and their effects. Codes were developed both inductively from the data and deductively from categories in the existing literature. Similar codes were then grouped into broader themes, such as language barriers, symptom description, prescription understanding, use of Pidgin, code switching, informal interpretation, non-verbal communication, and displacement-related language variation. To validate the themes and improve reliability, an independent second coder reviewed a subset of the coded transcripts, and any discrepancies were discussed and resolved by consensus. This process helped to ensure that findings were trustworthy and could be replicated by other researchers following the same procedure.

Ethical Issues

Ethical approval and administrative authorisation were secured before data collection began. Participants were informed of the study's purpose, their right to withdraw, and the privacy of their responses; no real names appear anywhere in this article.

RESULTS

Patients reported speaking Kenyang, Ejagham, Cameroon Pidgin English, English, French, Igbo, and other local languages, with Pidgin emerging as the most widely shared link language. Even so, many said they still preferred their mother tongue for anything serious or emotionally impactful. No single language served everyone: English and French mattered for formal records but did not dependably meet patients' communicative requirements, Pidgin was broadly useful but not sufficient alone, and indigenous languages remained the languages of choice for emotional clarity plus detailed symptom description.

Language barriers surfaced most frequently around symptom description, diagnosis explanation, prescription comprehension, and follow-up instructions, with older patients and those with limited formal education disproportionately likely to struggle with explanations in English or French. These breakdowns were rarely total; partial understanding was more common, such as a patient grasping that medicine needed to be taken without grasping how often.

Many patients said symptoms were easier to describe in their mother tongue than in English or French; some couched in local expressions with no clean biomedical equivalent, causing a fallback on gesture. Healthcare workers described symptom histories as sometimes thin when patients lacked vocabulary in the consultation language, prompting follow-up questions, a relative pulled in to clarify, or a switch to Pidgin, evidence that diagnosis accuracy is bound up with language access. Some

Table 3. Common Communication Barriers and Their Effects

Difficulty explaining symptoms	Incomplete patient history
Limited understanding of English/French	Weak comprehension of diagnosis
Medical terminology	Confusion and anxiety
Prescription misunderstanding	Wrong dosage or poor adherence
Lack of shared language	Dependence on interpreters
Cultural illness expressions	Possible misinterpretation

Table 4. Communication Strategies Used

Code-switching	Moving between English, Pidgin, and local languages
Cameroon Pidgin English	Used as a common bridge language
Simplification	Replacing medical terms with everyday words
Repetition	Repeating dosage instructions
Clarification	Asking patients directly if they understand
Gestures	Pointing to body parts or demonstrating medicine use
Informal interpretation	Relatives or bilingual staff interpreting
Demonstration	Showing how to take medication

patients reported being told the name of their illness without completely understanding what it meant, an indication that naming a disease is not the same as explaining it.

The single strongest finding concerned prescriptions. Patients could often identify the medicine but struggled to state dosage, timing, or duration with confidence. Pharmacy staff and nurses stepped into this gap, translating instructions into the pace of daily life, morning, afternoon, evening, after food, rather than clinical time units. Because treatment continues unsupervised once the patient leaves the building, this breakdown is arguably the most consequential of all. Table 4

Cameroon Pidgin English proved the single most useful bridge, though it was not a complete solution: some elderly patients still preferred Kenyang or Ejagham, and some medical terms had no ready Pidgin equivalent. Relatives, friends, and bilingual staff filled in as interpreters wherever no healthcare worker spoke a patient's language, keeping consultations moving but prompting worries about accuracy and confidentiality. Healthcare workers consistently reported a more linguistically varied patient population as displacement from surrounding villages has continued.

DISCUSSION

The data confirm that language barriers are a genuine, recurring challenge in Mamfe's health facilities. Still, they also show that patients plus healthcare workers are not passive in the face of that challenge. They negotiate meaning actively, through a repertoire of multilingual and non-verbal strategies, supporting this article's central claim: multilingualism generates communication difficulty while simultaneously supplying the resources through which that difficulty gets managed.

The prominence of Cameroon Pidgin English is among the study's clearest findings. In Mamfe, Pidgin functions as the bridge between formal medical language and patients' everyday speech, consistent with the wider understanding of Pidgin as a communicative resource across Anglophone Cameroon and illustrating Chie and Chenwi's (2021) observation that it enhances communication in bilingual Cameroon. But Pidgin's limits are equally clear: it cannot fully substitute for mother tongue explanation, particularly for elderly patients or sensitive medical matters, where the emotional power of a first language does what a shared second language cannot. Healthcare workers who simplified their language, switched codes, repeated instructions, and used gestures were more successful at reaching genuine patient understanding, a pattern that lines up with Communication Accommodation Theory and should be read as more than social politeness; in a clinical setting, accommodation of this kind is a component of patient safety, not an optional courtesy.

Prescription understanding is regarded as the single most consequential concern in the data, precisely because the success of treatment depends on what a patient does after the consultation has ended, when no one is left to correct a misunderstanding. This sits alongside the international literature connecting language barriers to medication error; Flores et al.(2012), for instance, document the concrete clinical conse-quences that follow from errors of medical interpretation, and the pattern in Mamfe looks similar in kind, if not in scale.

The dependence on informal interpreters indicates both local solidarity and a gap in institutional provision. Relatives and bilingual staff genuinely solve an immediate communication problem, but they are not trained medical interpreters, and that gap creates real risk of omission, distortion, and lost confidentiality. A full professional interpreter service may not be financially realistic for smaller facilities in the near term. Still, language banks, targeted training for already bilingual staff, and simple multilingual prescription guides are achievable steps short of that.

The Anglophone crisis matters here too, not as the origin of Mamfe's multilingualism but as an influence that has intensified it, confirming that healthcare communication cannot be understood in isolation from the social realities surrounding it. Conflict, displacement, poverty, and language converge in the same consultation room, and treating language barriers as a self-contained technical problem misses most of what is actually happening.

Patient understanding also cannot be inferred from silence or nodding. In many Cameroonian social contexts, silence usually signals respect for authority rather than genuine comprehension, so healthcare workers need active confirmation strategies, such as asking a patient to repeat instructions in their own words. Language barriers, finally, touch dignity as much as clinical accuracy: patients addressed in a language they understand tend to feel respected, while those who cannot express themselves may feel ashamed or diminished. What this study points toward is the need for systems that support communication as a matter of course, rather than systems that hope individual goodwill will cover the gap.

CONCLUSION

This article has examined language barriers and communication techniques in medical consultations across four health facilities in Mamfe, Cameroon, drawing on data from 50 patients and 20 healthcare workers. The findings show that language barriers affect symptom description, diagnosis, prescription understanding, treatment compliance, and patient confidence, and that healthcare workers and patients respond by actively negotiating meaning through code-switching, Cameroon Pidgin English, simplification, repetition, gestures, demonstrations, and informal interpretation. Multilingualism in this setting is equally a challenge and a resource, capable of producing genuine misunderstanding but also supplying the flexible communicative tools through which that misunderstanding gets resolved, at least partially, day after day. What these informal strategies cannot do is stand in permanently for institutional support; safe and fair healthcare in a multilingual setting like Mamfe ultimately depends on deliberate, language-sensitive policy rather than the accumulated improvisation of individual healthcare workers, however skilled. Healthcare communication in Mamfe is a multilingual practice shaped jointly by local languages, Pidgin English, displacement, professional training, and patient experience.

RECOMMENDATIONS

Several useful steps follow from the results. Health facilities in Mamfe should build language profiles of their patient population so that management can plan communication support with actual data rather than assumptions. Hospitals should train already bilingual staff in basic medical interpretation, confidentiality, and translation accuracy, since Kenyang, Ejagham, Pidgin, French, and Igbo-speaking staff already exist within these facilities and need structured support to interpret more safely. Prescription instructions should be simplified and, where possible, supported with multilingual explanation, stating timing, dosage, and duration clearly. Healthcare workers would benefit from training in patient-centred communication, including repetition, active confirmation of understanding, and culturally sensitive explanation, rather than treating communication skills as an unstructured personal trait.

Facilities should also reduce reliance on relatives as interpreters for sensitive consultations, and where relatives are used, healthcare workers should still verify understanding directly. At a policy level, government and health authorities should recognise language access as part of quality healthcare delivery, and public health campaigns in Mamfe should be delivered in multiple languages, Pidgin included, so that displaced and less educated populations are not excluded from information that matters to them. Future research would benefit from close analysis of actual consultation recordings, where ethically feasible, to examine turn-taking, code-switching, and repair strategies in finer detail.

REFERENCES

Barnlund DC (1970). A transactional model of communication. In K. K. Sereno & C. D. Mortensen (Eds.), *Foundations of communication theory* (pp.83–102). Harper & Row.

Betancourt JR, Green AR, Carrillo JE, Ananeh-Firempong O (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports, 118*(4), 293–302.

Brach C, Fraser I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review, 57*(Suppl. 1), 181–217.

Chie EP, Chenwi AJ (2021). Challenges of language barriers in health services in multilingual Cameroon: The case of the North West Region. *The Int. J. Afri. Lang. Media Studies, 5*, 5–16.

Epstein RM, Street RL (2007). *Patient-centred communication in cancer care: Promoting healing and reducing suffering*. National

Cancer Institute.
Flores G (2005). The impact of medical interpreter services on the quality of health care: A systematic review. *Medical Care Research and Review, 62*(3), 255–299.
Flores G (2006). Language barriers to health care in the United States. *The New Eng. J. Med. 355*(3), 229–231.
Flores G, Abreu M, Barone CP, Bachur R, Lin H (2012). Errors of medical interpretation and their potential clinical consequences. *Annals of Emergency Medicine, 60*(5), 545–553.
Giles H, Coupland N, Coupland J (1991). *Contexts of accommodation: Developments in applied sociolinguistics*. Cambridge University Press.
Gumperz JJ (1982). *Discourse strategies*. Cambridge University Press.
Karliner LS, Jacobs EA, Chen AH, Mutha S (2007). Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review. *Health Services Research, 42*(2), 727–754.
Street RL, Makoul G, Arora NK, Epstein RM (2009). How does communication heal? Pathways linking clinician-patient communication to health outcomes. *Patient Education and Counselling, 74*(3), 295–301.
Tervalon M, Murray-García J. (1998). Cultural humility versus cultural competence. *J. Health Care for the Poor and Underserved, 9*(2), 117–125.