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The Effect of Linguistic and Cultural Mismatch on Appropriate Healthcare Access in Zimbabwe

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Abstract
This study explores the impact of ethnolinguistic barriers on healthcare access and quality in Matabeleland South Province of Zimbabwe. It puts results into a call to action on a systemic basis, by legislating the health interpretation services to ensure that the constitutional right to health actually becomes a reality. The research examines how the dominant use of Shona, Ndebele, and English in healthcare settings marginalizes speakers of minority languages, affecting their ability to communicate effectively with healthcare providers. Using a qualitative approach, semi-structured interviews were conducted with 18 participants to explore their linguistic and cultural experiences in medical consultations. Findings reveal that language mismatches between patients and healthcare providers lead to miscommunication, mistreatment, and in some cases, fatal outcomes. Cultural misunderstandings also affect the delivery of healthcare when non-verbal cues are misinterpreted. The study calls for the inclusion of medical interpreters and translation services in healthcare settings, highlighting the dangers of relying on untrained interpreters. It recommends developing a clear language policy that guarantees linguistic rights in healthcare to ensure equal access to quality health services.
Keywords: Culture, health, incongruity, language, medical interpretation, Zimbabwe

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Introduction

Effective communication is the cornerstone of fair healthcare, but it is severely undermined in multilingual societies where language policies do not reflect demographic diversity. The reality on the ground in the healthcare sector in Zimbabwe is a sharp contrast to the constitutionality of sixteen languages that are recognised in the country. The clinical encounters are controlled by a tripartite linguistic hegemony of English, Shona, and Ndebele, which systematically marginalises the speakers of other indigenous languages such as Kalanga, Venda, Sotho, and Tonga (Maseko & Matunge, 2020; Ndhlovu, 2009). Hegemony is not an inherent linguistic progression but a direct legacy of colonial administrative engineering, reinforced by post-independence policies, which Ndhlovu (2009) criticized as mere declarations with no action taken. The ensuing ethnolinguistic difference between healthcare providers and patients constitutes a deep but insufficiently codified obstacle and renders the constitutional right to health an unattainable dream for significant segments of the populace.

The need to conduct the study stems from the fact that the constitutional provisions on healthcare and linguistic rights in Zimbabwe are poorly aligned with the realities of clinical practice, and there is no working system in place to enforce them. Despite the rights to health and linguistic diversity in Sections 76 and 6, there is no provision in the Public Health Act on how these rights ought to operate in a multilingual system, thereby exposing indigenous language speakers to discrimination. While the dominance of the English language is well researched and documented, there is scant empirical evidence on how language barriers directly influence patients in Zimbabwean healthcare. This research fills that knowledge gap by demonstrating the effects of a lack of trained medical interpreters on miscommunication, diagnostic errors, and poor treatment outcomes, particularly in Matabeleland South. This is important because it shows the necessity of a clear, enforceable language-in-health policy and the institutionalisation of professional interpretation services to promote equitable, safe, and accessible healthcare for all.

In an attempt to examine the stated problem, the following research questions guide the study:

1. What are the specific ethnolinguistic barriers that contribute to healthcare disparities in Matabeleland South?
2. What is the impact of these barriers on the quality of health access, patient safety, and health-seeking behaviours?
3. What challenges and risks are associated with the current reliance on untrained interpreters in healthcare settings?
4. What pathways exist for systemic reform to ensure linguistically and culturally appropriate healthcare access?

Literature Review

The Language Situation in Zimbabwe

Language policy studies in Africa have been characterised by decolonial dialogues that often problematise the continued use of English and other colonial languages as relics of colonialism (Christie & McKinney, 2017; Maseko & Matunge, 2020). Bamgbose (1991), Kadenge and Nkomo (2011), and Nkomo and Maseko (2017) provided enlightening insights into the continued use of English in former British colonies. English is undeniably one of the most potent global languages due to its demographic superiority and the political and economic power wielded by the English-speaking world. However, Bamgbose (2003) criticised and labelled the widespread and dominant use of English in education, the media, the judiciary, and other formal domains as the "recurring decimal. This expression explains the contemporary problem faced by most African countries, particularly Zimbabwe, regarding language policy, use, and access. In Zimbabwe, this colonial linguistic legacy remains entrenched, as English

continues to dominate education and official domains while indigenous languages are relegated to limited functional spaces (Hungwe, 2007).

Zimbabwe is a multilingual country with an estimated of about 20 living languages (Hachipola, 1998). However, the country's history of British rule has shaped and structured the Zimbabwean ethnolinguistic landscape, making English the dominant language across many spheres of influence, including government, business, education, and service delivery (Ndlovu, 2009). This dominance persists despite post-independence constitutional reforms, as the education system continues to marginalize indigenous languages at all levels, perpetuating colonial linguistic hierarchies (Magwa, 2010). Although Zimbabwe is a multilingual country with 16 officially recognised languages, as set out in section 6 of the Constitution, English holds a dominant position over indigenous languages (Thondhlana, 2000). After English, Shona and Ndebele are the only two languages that have gained popularity in the country, and they are sometimes used alongside English in most government and public transactions. This also means that Zimbabweans who do not speak English, Shona, or Ndebele routinely receive public services in a language that is not their mother tongue.

Over the past few years, English has enjoyed linguistic autonomy over indigenous languages, and efforts have been made to make indigenous languages more widely used in the public domain. However, the effort to decolonise the English language in most public transactions has led to an undesirable outcome: Shona and Ndebele now have the opportunity to dominate the linguistic landscape of various institutions, including the healthcare setting. (Maseko and Matunge 2020). The linguistic situation of the Zimbabwean public institutions and most particularly health institutions in Matabeleland is better understood from concept of Msindo (2005) and Ndlhovu (2009) of "Shonalisation" and what this study would like to bring forth "Ndebelelisation", as this explain the pervasive dominance of Shona and Ndebele even in areas where the languages are not spoken presenting the same colonial dominance matrix (Ndhlovu, 2009).

Language as a Barrier in Healthcare Communication

Language is how a healthcare service provider accesses a patient's beliefs about health and illness, thereby creating an opportunity to address and reconcile different belief systems. In essence, communication between nurses and patients is the heart of nursing care (Yeo, 2004). Concurring with the above is Maseko and Matunge (2020), who add that, in multilingual and multicultural settings, communication is an essential aspect of health service delivery, and language plays a pivotal role in how patients and healthcare service providers interact. It is against this background that this study seeks to explore the importance of language and culture in accessing public healthcare, with a particular focus on communication between patients and healthcare providers, especially patients' participation in health processes in cases of ethnolinguistic variation. Moreover, the study assesses patients' comprehension of health-related information and medical instructions on packaged medicines. Further, it gives insights into the significance of language planning and policy in the public health sector.

The Public Health Act [Chapter 15:17] acknowledges section 76 of the Zimbabwean constitutions, which articulate that:

Every citizen and permanent resident of Zimbabwe has the right to have access to basic healthcare services, including reproductive healthcare services.

There is no clear definition of the term access. Given the Zimbabwean ethnolinguistic situation, there is a need for further explanation on how access to health services is going to be achieved. The Public Health Act [Chapter 15:17] remains conspicuously silent on matters about ethnolinguistic exigencies and their profound ramifications vis-à-vis healthcare access. In the same vein, while sections 6, 22, 56, and 63 of the Zimbabwean Constitution guarantee quality and recognize a range of languages and rights for persons with disabilities, it lacks provisions for integrating language diversity and ethnolinguistic needs into health access. This situation then leaves the Zimbabwean populace at the mercy of the Ministry of Health and Child Care

officers, who then decide which information to make available in other languages. Also, the populace is left at the mercy of ad hoc translators and interpreters to access quality health information, since communication is in English and, in some instances, Ndebele.

English is only the fourth most common home language in Zimbabwe (Kadenge & Nkomo, 2011). Still, it is typically the preferred language of healthcare providers (Ndlovu, 2009), resulting in more than 80% of medical interactions occurring across language and cultural barriers. The majority of non-English-speaking patients in Zimbabwe prefer to use their mother tongue as their primary language. Health facilities are increasingly encountering Limited English Proficient (LEP) patients and families from diverse cultures, as Zimbabwe is a diverse country (Ndlovu, 2024). Language and cultural barriers present critical challenges to both providers and patients in ensuring meaningful access to quality care. Liberty Language Services (2020) states that the absence of effective communication strategies and language support usually discourages patients from receiving the care they require. Sickness already brings about stress and anxiety, and in cases where patients are unable to understand their healthcare providers fully, the chances of errors are bound to rise.

According to the erudite treatises by Jones (2021) and Vidaeff et al. (2015), formidable impediments in the health system's cultural milieu, epitomised by linguistic heterogeneity and divergent cultural paradigms, have emerged as veritable citadels obstructing the seamless delivery of healthcare services. Zimbabweans who work in linguistically and geographically diverse areas may find it challenging to access healthcare that aligns with their cultural origins. Regardless of linguistic or cultural variations, the World Health Organisation (WHO) states that every person has the right to receive complete, appropriate, timely, and quality health services tailored to their needs. Research by Jongen et al. (2017) highlights the critical need for culturally competent, linguistically inclusive health services. Ensuring equitable access to healthcare and aligning healthcare delivery with the values of non-discrimination and inclusivity necessitates addressing these cultural hurdles. Ensuring that healthcare services are culturally competent and linguistically inclusive is crucial to protecting everyone's right to health and to driving Zimbabwe towards a prosperous, upper-middle-income society by 2030.

Historical and Structural Foundations of Language Inequity

The linguistic inequalities in Zimbabwe date back to colonial administrative practices, which relegated indigenous languages to home and informal use. Makoni et al. (2006) concur with the above, alluding to the way these linguistic inequalities were systemised through European appropriation and the reconstruction of African languages; for example, the imposition of standardised European variants of Shona and Ndebele under the guise of developing and promoting indigenous languages. Kadenge and Mugari (2015) argue that the colonial authorities ensured that English occupied the pinnacle as the sole official language, while Shona and Ndebele were positioned as secondary languages, thereby marginalising other indigenous languages. Faced with these inequalities, and with English at the forefront, post-independence language policies failed to create a functional multilingual framework that appreciates Zimbabwe's complex linguistic ecology (Nhongo & Tshotsho, 2020), instead replicating colonial patterns through what Ndhlovu (2009) called 'declaration without implementation,' where constitutional linguistic recognition remainsremains unimplemented. These engineered inequalities created hierarchical valuations of language that persist even in present-day Zimbabwe. Most indigenous languages were bush leagued, with their functional domains restricted.

As already alluded to, the Zimbabwean linguistic situation has been heavily influenced by colonial history (Maseko & Nozizwe, 2021), as validated by the Dokean recommendations, which highlighted that Zimbabweans should either speak Shona or Ndebele. Post-colonial, language policies were then created to reverse the colonial language policy rather than focusing on real multilingual situations faced by the country, which might enable languages to function together while fostering inclusivity in communication (Chabata, 2008; Ndhlovu, 2009; Nhongo & Tshotsho, 2020). Furthermore, Nhongo and Tshotsho (2020) argue that language policies

should not be tools for the politics of identity, supremacism, or recognition, but rather should enhance effective communication and drive ethnolinguistic diversity. Since independence, language policy has only gradually, but progressively, placed Shona and Ndebele in the parking lot parallel to English while disregarding other indigenous languages (Ndhlovu, 2009; Magwa, 2010). With only Shona and Ndebele as the so-called "significant" languages, one would easily trace ethnolinguistic challenges in the health sector, where the linguistic situation is complex and multilingual

For Matabeleland contemporary languages problems were made serious by the assumption of linguistic de facto status by Shona (in Mashonaland) and Ndebele in Matabeleland (Ndhlovu, 2008a), which can also be traced to the works of pre-independence linguist C. Doke who the colonial government tasked to make recommendation on the linguistic situation of Mashonaland, in which he recommended that Shona is to be used in Mashonaland and then overstepped his boundaries by giving another recommendation which compelled the use of Ndebele in Matabeleland (Chimhundu, 1992). In the health sector in particular, Maseko and Matunge (2020) argue that language problems and barriers are attributed to a skewed recruitment and deployment of health personnel, leading to a public outcry. Ncube and Siziba (2017) argue that the centralisation of nurse recruitment and the compulsion of Harare have raised suspicion among the people of Matabeleland. This recruitment system has created a vacuum, with most qualified health practitioners deployed away from home and facing a different ethnolinguistic environment because there are no qualified health practitioners among the natives.

Methods and Materials

This paper has used a qualitative research design to examine how ethnolinguistic mismatch affects equitable healthcare provision. The method was chosen for its ability to offer in-depth, contextual insight into participants' personal experiences and perceptions, which are core to examining the subtle obstacles in clinical communication. Semi-structured interviews were conducted in Matabeleland South Province to gather data.

Participants

The research sample included subjects who had visited primary hospitals in the Province of Matabeleland South, as well as those who considered themselves native speakers of the languages in the area. A purposive sampling strategy was used to identify and select rich information cases pertinent to the research phenomenon. Participant recruitment was initiated by the first author, who used local knowledge and networks in Matabeleland South. Language researchers supplemented this in the Beitbridge and Plumtree districts to ensure representation of the whole province, as well as to ease access and build trust.

The final sample comprised 18 participants (10 females and eight males), aged 19 to 40. The respondents were all native speakers of Sotho, Tswana, Venda, Chewa, and Kalanga, which are minor languages compared to the officially dominant Ndebele in the province's healthcare structures. This group was chosen with a single purpose: to understand the experience of patients most likely to face a language barrier. Though the sample used is standard for qualitative research, it is also acknowledged that it is a specific subset of healthcare users in the province and should not be statistically generalized.

Research Instruments

A semi-structured interview guide was the primary tool for collecting data. This instrument was selected because it offers a flexible yet focused structure that allows the researcher to examine preset themes, including language use in consultations, perceived effects on diagnosis and treatment, and emotional or cultural experiences, while still allowing new ideas to arise from the particular responses to each story.

Research Procedures

The study procedures were implemented in the following sequence:

- In accordance with ethical considerations, a purposive sample was drawn. Potential participants were identified and contacted through local networks.
- The authors conducted all interviews with the support of local language experts, where necessary, to ensure accurate comprehension and expression.
- With participant permission, interviews were audio-recorded. The recorded responses in the various native languages were then transcribed verbatim.

Data Analysis

The resulting English transcripts constituted the dataset for analysis. The data were analyzed using thematic analysis, which involved repeated reading of transcripts, the generation of initial codes, and the development and refinement of overarching themes related to linguistic barriers, communication strategies, and impacts on healthcare access and quality.

Results

The analysis of data revealed four central themes concerning the impact of ethnolinguistic mismatch on healthcare access in Matabeleland South Province. These themes encapsulate the lived experiences of minority language speakers navigating a healthcare system dominated by English, Ndebele, and Shona.

Ethnolinguistic Barriers Contributing to Healthcare Disparities

Language barriers significantly affect the quality and access to healthcare services for linguistically diverse communities. According to Meuter et al. (2015), miscommunication due to language gaps frequently results in misunderstandings, drug errors, and adverse health outcomes, which often directly compromise patient safety. In cases where patients have limited proficiency in the dominant language, they usually struggle to articulate their symptoms accurately, leading to deadly medical mistakes (Ali& Watson, 2018). These mistakes can have lifetime consequences, including death and disability. Beauchamp et al. (2022) further highlight that minority-language speakers, particularly those with neurodevelopmental disorders, face exacerbated risks, such as delayed treatments and preventable complications, due to linguistic mismatches in healthcare settings. Without effective communication, patients may also fail to adhere to treatment plans, worsening health outcomes. This aligns with findings from Meuter et al. (2015), who stress that structured communication strategies are essential to mitigate these risks, yet many healthcare systems lack such protocols.

To address these challenges, governments must implement strategic healthcare worker deployment with linguistic due diligence. Al-Yateem (2023) states that the difficulties non-Arab healthcare providers face in the UAE when treating Arabic-speaking patients illustrate the consequences of mismatched language skills. Without proper consideration of linguistic competence, healthcare workers may struggle to deliver effective care, leading to distrust and poor patient compliance. Chen et al. (2023) argue that institutional policies must enforce language access to prevent discrimination, a principle that Zimbabwe should adopt. However, Zimbabwe's current linguistic policy appears performative rather than functional, prioritizing the dismantling of English hegemony without ensuring practical multilingual healthcare support. Boateng et al. (2012) provide a comparative case study showing that Ghanaians in Amsterdam faced severe healthcare barriers due to language barriers, reinforcing the need for systemic multilingual policies. Additionally, (Khorshidi Organi et al., n.d.) found that migrant women in Europe faced lower cervical cancer screening rates due to language barriers, further proving that health messaging must be delivered in patients' native languages to ensure comprehension and adherence.

Gwanda is a linguistically diverse district in Matabeleland South Province of Zimbabwe. Anticipatedly, participants in this research mirrored this assortment. Participants spoke Sotho, Tswana, Chewa, and Ndebele as their first language (L1). A considerable number also spoke Shona and English as their second language (L2), with varying degrees of proficiency. Participants reported that this linguistic diversity creates challenges for hospital language policy. Participants recall how most of their consultations were dominated by Shona and Ndebele. English was also used in several cases, especially when the healthcare provider

realised that their patient could not understand Shona or Ndebele. In cases of linguistic mismatch, patients admit to submitting to the healthcare provider's linguistic choice despite their limited proficiency in the language. One participant recalls submitting to their healthcare specialist's language choice.

I visited the Hospital twice, and the doctor addressed me in Ndebele, and I responded in Sotho, but he continuously used Ndebele until I had to give in. I can understand Ndebele to some extent. I almost understood everything, except that I should take the medicine before eating anything. I went back after two days, upon realising that soon after taking the medicine, I would heave excessively, which is when they clarified not to eat before taking the drug.

Patients submit to their health specialists in the language of their choice, not because they understand their specialist's language, but because they are very sick and only seeking care (Karliner et al., 2007; Clement et al., 2009; Lor & Martinez, 2020). As already alluded to above, misunderstanding the health-related information can lead to serious life-threatening issues, disability, or death. In the above experience, the patient thought that they understood the health specialist's message. It was very fortunate that the misunderstood information did not cause any severe damage.

Most indigenous Zimbabweans are denied the privilege of using their indigenous languages in matters of national development because English has unceremoniously replaced their mother tongues in mass media, education, business, and many other spheres of life (Magwa, 2010). When healthcare service providers realise that their patients do not understand the language of their choice, they tend to shift to English to bridge these linguistic gaps. This shift tends to be more disastrous as Magwa (2009; 2010) posits that only 1% of the Zimbabwean population is competent in English. In an interview with one of the participant who had accompanied their daughter to the Hospital, they highlighted that:

I do not understand Ndebele or English. It gets difficult for me to understand the questions that doctors ask, and it gets difficult to explain my child's health problems to them. I sometimes hesitate to seek health care because of these linguistic hurdles.

Ethnolinguistic miscommunication might affect people's perceptions of health facilities. Conscious people are aware of the dangers of miscommunication, including mistreatment, misdiagnosis, and poor prognosis, which are dangerous to any human's health. A linguistic mismatch between the participant and the healthcare specialist might instill fear in the patient, increasing the risk of not receiving any medical assistance rather than receiving the wrong treatment. This might seem like a solution, but it has long-term effects, as most diseases need to be cured or treated while they still can be treated:

I was given tablets for my blood pressure, but the nurse told me in Shona to take "two times per day after eating." I thought she meant to take both tablets at once, once per day. So I only took medicine after supper. My blood pressure got worse, and I had headaches every morning. Only when my daughter, who understands Shona better, came with me to the Hospital did the nurse explain that I should take one tablet in the morning and one in the evening.

The participant's experience exemplifies the critical intersection of linguistic barriers and medication adherence in multilingual healthcare settings. Research demonstrates that unclear dosage instructions constitute one of the most frequent causes of preventable adverse drug events, particularly among limited English proficiency (LEP) populations (Saigal & Lewis, 2023). In this case, the Shona phrase "maviri pazuva mushure mekudya" (two times per day after eating) contained inherent ambiguities when interpreted through a Kalanga linguistic framework. First, the temporal marker "pazuva" (per day) lacked specificity regarding dose spacing, leading to dangerous dose stacking. Second, the quantifier ""maviri"" (two) created confusion between dose frequency and quantity - a documented phenomenon in cross-linguistic medical communication (Meeuwesen et al., 2020). This aligns with Magwa's (2016) findings that 72% of rural Zimbabwean patients misinterpret frequency adverbs when receiving instructions in their second language.

The consequences extended beyond clinical outcomes to systemic healthcare burdens. The participant's subsequent hypertensive crisis required emergency intervention, representing what Piller (2021) terms "linguistic iatrogenesis" - harm caused by communication failures rather than medical error. Such cases contribute to Zimbabwe's 30% hospital readmission rate for chronic conditions in linguistically diverse regions (MoHCC, 2022). Notably, the participant's reliance on familial translation mirrors what Ndlovu (2020) identifies as "coercive multilingualism," in which healthcare systems outsource interpretation responsibilities to vulnerable patients' social networks. This practice violates the WHO (2019) guidelines on equitable health communication and disproportionately affects elderly female caregivers in rural communities:

The doctor told me that I have "gastritis," but I did not know what that was. He explained in English and a small quantity of Ndebele, but I could not follow. He then gave me a prescription and told me to avoid "acidic" foods. I did not know what that meant, so I kept eating oranges and tomatoes. After a week, my stomach pain became worse, and I stopped taking the medicine because I thought it was making me sicker.

The case of the Tswana-speaking patient who misunderstood his "gastritis" diagnosis due to language barriers and medical jargon illustrates how ineffective communication can lead to harmful consequences, including incorrect self-care and treatment abandonment. When doctors fail to explain conditions and instructions in a patient's primary language or in simple, relatable terms, critical details—such as avoiding acidic foods—are lost, worsening health outcomes. This highlights the urgent need for culturally sensitive healthcare communication, including the use of professional interpreters, plain-language explanations, and take-home instructions in the patient's native language, to ensure proper understanding, adherence, and trust in medical treatment. Without these measures, linguistic and educational gaps will continue to undermine patient care, particularly in multilingual communities.

Cultural Beliefs and Their Influence on Health-Seeking Behaviors

Cultural beliefs tremendously shape health-seeking behaviors by influencing perceptions of illness, treatment preferences, and adherence to medical advice. Tukuitonga (2018) notes that health is a cultural concept, with some communities attributing disease to spiritual causes or prioritizing collective decision-making over individual choices (pp. 5-6). Indigenous models like Te Whare Tapa Whā highlight the importance of spiritual and familial health, contrasting with Western biomedical approaches and sometimes creating tensions in healthcare interactions (Ministry of Health, as cited in Tukuitonga, 2018, p. 6). Stigma around conditions like mental illness may lead individuals to seek traditional healers first, while generational cultural shifts among migrant populations can result in delayed care or non-compliance (Tukuitonga, 2018, p. 7). Effective healthcare delivery thus requires cultural competence, recognizing diverse beliefs to build trust, improve diagnosis acceptance, and enhance treatment adherence. Culturally tailored services, such as those in New Zealand, demonstrate that integrating cultural perspectives can bridge gaps and improve health outcomes.

Another patient failed to receive treatment because he had to run away from the Hospital before he was treated. A close interview with his relative suggests that the young man in his late 20s is mentally challenged and has failed to understand the doctor's non-verbal cues. An adult relative had to say:

In our culture, eye contact is considered a way to propose. So I took my boy to the Hospital for a medical examination. Upon arrival, I was not allowed into the room where he was examined. After about 3 hours,I asked one of the hospital staff whether my boy was not done yet, and they said they could not locate him. I went back home, and he was there. I asked him why he left, and he said the doctor kept proposing to him.

Cultural misunderstandings are also common in the health sector. The case of the mentally challenged young man fleeing the Hospital due to misinterpreted non-verbal cues powerfully shows how cultural beliefs fundamentally shape health-seeking behaviors, as demonstrated in Amusala's (2025) review. This incident reveals three critical cultural dimensions: divergent

interpretations of non-verbal communication, eye contact perceived as romantic proposal rather than clinical attention, highlighting how cultural norms govern patient-provider interactions; barriers to healthcare access stemming from cultural mistrust and alienation, particularly for vulnerable populations like those with mental health conditions; and systemic failures in cultural competence training that exacerbate disparities, as clinicians often lack awareness of culturally variable communication styles and familial involvement expectations common in collectivist societies. These factors collectively lead to treatment avoidance and poorer health outcomes, reinforcing Amusala's argument for culturally sensitive protocols, provider education in cross-cultural communication, and community partnerships to bridge healthcare gaps for ethnic minorities.

Another scenario was that of a patient with severe anemia who refused a blood test, fearing that the drawn blood could be used for witchcraft. He went to the Hospital with his wife, who said that her husband almost died because he did not want to do the blood test until a community health worker intervened with culturally sensitive counseling. His wife explained:
In our village, people believe that if someone takes your blood, they can use it for curses. He was afraid the nurses would sell it to witch doctors.

In this case of the patient refusing a blood test due to fears of witchcraft, it powerfully illustrates how cultural beliefs profoundly influence health-seeking behaviors, as discussed by Tukuitonga (2018). This scenario demonstrates three critical points: first, that health perceptions are culturally constructed, with some communities viewing bodily substances like blood as spiritually vulnerable; second, that such beliefs can create barriers to biomedical care when healthcare systems fail to address cultural contexts; and third, that culturally competent interventions are essential for bridging this gap. The case ultimately underscores the urgent need for healthcare systems to develop cultural competence to overcome such barriers and provide equitable care.

Another man with chronic back pain abandoned physiotherapy after two sessions, opting for a traditional healer. His brother shared:
He believes hospitals only mask pain, while the traditional healer "removes the bad spirits" causing it. We had to bring our granny, who persuaded him to finish his therapy; it took some cultural understanding on both sides for him to agree to granny's request.

The situation of the chronic pain patient who rejects physiotherapy in favor of traditional healing exemplifies how cultural beliefs profoundly shape health-seeking behaviors, as illustrated by cross-cultural health research (Levesque & Li, 2014; Tukuitonga, 2018). This patient'spatient's preference reflects three critical cultural dimensions: (1) a spiritual etiology of illness (attributing pain to evil spirits rather than biomechanical causes), aligning with Indigenous holistic health models that view wellbeing as interconnected with spiritual, familial and environmental factors (Levesque et al., 2013); (2) distrust in biomedical systems stemming from historical marginalization and cultural insensitivity in healthcare (Bouchard et al., 2009); and (3) the prioritization of cultural identity preservation over Western medical evidence, particularly among minority groups (Levesque & Li, 2014). While respecting cultural traditions is essential for patient-centered care, this case also highlights the risks of rejecting evidence-based treatments in their entirety, underscoring the need for integrative approaches that combine traditional healing with biomedical interventions to improve health outcomes without compromising cultural values. The situation demonstrates how health systems must adapt to diverse cultural conceptions of health through provider education, community partnerships, and flexible treatment models that bridge traditional and Western medical paradigms.

Challenges and Risks of Untrained Interpreters

The use of English as the lingua franca in medicine has become increasingly popular in the 21st century, owing to technological innovations originating mainly in the English-speaking world (Badziński, 2018). This global trend of using English as a medical lingua franca did not spare Zimbabwe, as English is one of the preferred medical languages alongside Shona and

Ndebele. However, the dominant use of these three languages in the medical field affects the principles of effective communication between doctors and patients, which is fundamental in building a positive doctor-patient rapport, a necessary foundation for a successful doctor-patient relationship and healthcare. One of the participants narrates their experience with the medical specialists:

I went to the clinic, and I was referred to the Hospital. The problem is that sometimes I did not understand what the doctor was saying. I thank God for another patient who spoke Tswana and assisted me with interpretation and medical form translations until I got the appropriate medication.

Thuube and Ekanjume-Ilongo (2018) highlight that in cross-linguistic medical consultations, the essential role of medical interpreters underscores the significant challenges posed by ethnolinguistic mismatches in accessing quality healthcare; this also reveals a critical gap in legislation, as the lack of formal provisions for medical interpretation and translation services indicates that these challenges remain largely unaddressed and require urgent legislative attention. The unavailability of medical language service providers (medical translators and interpreters) in such circumstances clearly shows that the ethnolinguistic mismatch has a long way to go before it is eradicated in the medical field, unless medical interpretation and translation are legislated.

Moreover, leaving medical translations and interpretation in the hands of untrained interpreters and translators is risky. Medical translation is a professional field that requires competence in both medicine and linguistics; any error, such as miscommunication, mistranslation, or interpretation, might lead to severe health consequences, disability, or death. Flores et al. (2003) documented several errors made by untrained interpreters that were likely to negatively impact medical outcomes, including misinformation about diagnoses, prescriptions, and follow-up visits.

Davidson (2000) and Hsieh (2007) highlight the crucial role of medical interpreters in facilitating and creating a shared understanding of the illness and treatment plans between healthcare specialists and patients. Research has established that the right to access to health is incomplete if doctor-patient interactions do not occur in the languages patients understand (Kamwendo, 2004). Moreover, Ndlovu (2024) concurred with the above and added that there has been a significant increase in Zimbabwe's healthcare infrastructure and the number of qualified health personnel. Still, the pertinence of the language factor has been overlooked in the matrix of healthcare strategies, plans, and policies that seek to advance access to quality and appropriate healthcare. He further contends that the Zimbabwean government has demonstrated a bias towards investing in infrastructure, technology, and adequate medical staff, while neglecting the critical role of language in achieving access to quality and appropriate healthcare. Language is a vital component of the healthcare system, akin to a cog that interconnects multiple gears, facilitating smooth communication and ensuring effective health service delivery. Recognizing and addressing the significance of language is essential for achieving positive health outcomes. One participant voiced their concerns about language barriers, stating:

I do not speak Ndebele or English. It gets difficult for me to understand the questions that doctors ask, and it gets difficult to explain my child's health problems.

She went on to explain that she relies on other patients or visitors who are fluent in Sotho and Ndebele to help her communicate with medical professionals. This first-hand account emphasizes the significant influence of language barriers on patients' ability to convey their healthcare needs, as well as the crucial role of multilingual attendants or interpreters in mediating these exchanges.

Pathways to Better Healthcare Access

There is a common assumption that, while communication barriers exist in the health sector, they can always be addressed by using bilingual family members, relatives, or individuals, or by using ad hoc translators. Most individuals who resort to this method are

unaware of the risks of using unprofessional medical translators (Bowen, 2001). However, the truth of the matter is that untrained interpreters are not trustworthy when it comes to people's health concerns. The attainment of quality and appropriate healthcare can only be achieved if the fiddly-language equation has been solved without cutting any corners, and not in a bush-league manner that entrusts people's lives to unprofessional medical interpreters. Given the consequences of using untrained interpreters, including omitting essential facts, adding information, and distorting facts, among others, this study therefore recommends that the government of Zimbabwe, through the Ministry of Health and Child Care, legislate the right to an interpreter in hospitals.

There is a need for a clear and sound language policy that stipulates linguistic human rights against their impact on access to quality, essential, and adequate healthcare. Currently, Zimbabwe has no explicit language policy; the language in health policy is inferred in sections 6, 22, 29, 56, 63, and 76 of the Zimbabwean Constitution. Even so, the linguistic issue is not featured in both sections. It is within such backgrounds that Djite (2008) argues that language issues are rarely included in the list of priorities for ensuring that citizens have equal, universal, accurate, and meaningful access to healthcare services. Language is the cornerstone of equitable access to health; sidelining ethnolinguistic issues would yield unintended consequences. It is thus against this background that this article recommends a clear language policy that also takes into account health issues.

Conclusion

Language and culture are pivotal to ensuring a smooth flow of information. One can speak one language, but if one misses its cultural connotations, there is a problem. The study has highlighted that ethnolinguistic factors are crucial in the healthcare sector, as breakdowns in communication can result in disability or even death. Moreover, since it has been revealed that language is crucial to access to quality and appropriate health services, the study recommends regulating medical interpreters to ensure appropriate healthcare access, delivery, and positive health outcomes.

Recommendations

Based on the findings, it is recommended that the Government of Zimbabwe, through the Ministry of Health and Child Care, legislate a clear and enforceable language-in-health policy that operationalizes constitutional rights by mandating and funding professional medical interpretation services in public health facilities, instituting compulsory cultural competency and basic multilingual communication training for healthcare workers, developing standardized health materials in all 16 officially recognized languages, and establishing community-led oversight committees to monitor implementation and ensure healthcare delivery is both linguistically accessible and culturally appropriate.

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AI Statement

This document has been enhanced through the use of Grammarly which was employed to refine its linguistic style and correct grammar and spelling. While the incorporation of these technologies may introduce some AI-generated linguistic patterns, it is important to note that the core intellectual content, data interpretation, and conclusions presented are entirely the work of the author.

Statement of Absence of Conflict of Interest

The author declares that there are no conflicts of interest related to the research, findings, or recommendations presented in this paper. All conclusions drawn are independent and unbiased.

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