Language, Religion and Healthcare Delivery: A Study of Patient–Provider Interactions in Multilingual Ondo State, Nigeria

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Abstract

The study examined the influence of language and religion on patient–provider interactions on healthcare delivery in multilingual Ondo State. This study adopted the descriptive design of the correlational type. Fifty patients and fifty healthcare providers were randomly selected from the five selected Local Government Areas of Ondo State, making a total of 250 patients and 250 healthcare providers. Data were gathered using two study instruments: Patient-Provider Interactions and Language Questionnaire (r=.76) and Questionnaire on Patient-Providers Interactions and Religion in Healthcare Delivery (r=.80). Multiple regression analysis and Pearson Product Moment Correlation were used to analyse the data. The results indicated a positive but low relationship between language ($r = 0.185$; $p<0.05$) and patient–provider interactions in healthcare delivery, and a positive but low relationship between religion ($r = 0.167$ $p<0.05$) and patient–provider interactions in healthcare delivery in multilingual Ondo State. The joint contribution of language and religion to patient–provider interactions in healthcare delivery in multilingual Ondo State was significant ($F_{(2,247)} = 4.53$; Adj $R^2 = 0.028$; $p<0.05$. The result indicated that the relative contribution of language ($\beta= 0.141$, $t= 1.398$, p (.163)>0.05) and religion ($\beta= .056$, $t= .557$, p (.578)>0.05) was not significant. The study, therefore, concludes that patient–provider interactions in healthcare delivery are influenced by multiple interconnected factors beyond language and religion alone. Based on the findings, it was recommended that policies that support culturally and linguistically relevant healthcare practices should be developed by the government and medical institutions.

Keywords: Language, Religion, Healthcare delivery, Patient–provider interactions, Multilingualism

Introduction

Healthcare delivery is essentially a communicative, relational and sociocultural activity ingrained in the lived reality of patients and healthcare providers; it goes much beyond the administration of clinical procedures. The impact of social determinants, especially language and religion, on health outcomes and experiences has received more emphasis in the current health discourse. Healthcare interactions are frequently mediated by intricate intersections of

language diversity and deeply ingrained religious beliefs in multilingual and religiously plural cultures like Nigeria, and more especially in Ondo State. These elements have a big impact on how people view, discuss and treat sickness in clinical settings.

The primary medium used in healthcare interactions is language. While healthcare professionals rely on language to diagnose illnesses, explain treatment options and provide preventive advice, individuals use language to express symptoms, describe illness experiences, and negotiate meanings of health and disease. However, when patients and caregivers do not speak the same language or have different levels of skill in a lingua franca like English, communication difficulties sometimes occur in linguistically varied environments. The World Health Organisation (2023) states that poor patient satisfaction, poor treatment adherence and diagnostic errors are all significantly influenced by inadequate communication in healthcare settings. In a same vein, The Lancet Commission on Quality Health Systems (2018) emphasises that effective, safe and patient-centred treatment, especially in low- and middle-income countries, reduces mortality rate. A key component of providing high-quality healthcare is still effective communication, which influences patient satisfaction, treatment compliance, and diagnostic accuracy.

Language is a predictor of clinical results and patient safety, not just a tool for information transmission. Communication breakdowns, often known as "language discordance," can seriously impair care when patients and healthcare professionals do not speak the same language. The scope of this problem is highlighted by empirical data from current research (Orujlu and Adigozalova, 2026; Babalola et al, 2025; Salami, 2021; Hilal Al Shamsi et al, 2020) which show that language difficulties are linked to higher risks of adverse medical events, delayed treatment, and misdiagnosis. Similarly, Karliner and colleagues (2021) found that patients with limited proficiency in the dominant language of care are less likely to understand medical instructions, thereby increasing the likelihood of medication errors and poor adherence to treatment regimens. Language obstacles significantly undermine trust and the therapeutic interaction between patients and providers, according to Bischoff (2022). This is consistent with research from the BMC Health Services Research (2023), which states that systemic disparities in healthcare outcomes and access, especially in low- and middle-income nations, are caused by poor communication brought on by language barriers. Language carries embedded cultural values, norms and expectations, which shape how patients interpret medical information and interact with healthcare providers. Scholars argue that effective healthcare delivery in Nigeria therefore requires not only linguistic competence but also cultural sensitivity and contextual awareness.

Ondo State, a historically significant urban centre, is marked by linguistic plurality (mainly Yoruba dialects alongside English and other Nigerian languages). While many healthcare providers may have some proficiency in Yoruba, dialectal variations and differences in linguistic competence among patients can still create communication gaps. Additionally, patients from minority language groups may experience exclusion or marginalisation within healthcare settings. Recent research highlights adaptive strategies such as code-switching, the use of pidgin or simplified language and reliance on family members as interpreters as ways of navigating multilingualism in healthcare. However, the World Health Organisation (2023) noted that such informal strategies are often insufficient and may compromise the quality and safety of care.

Healthcare professionals frequently use interpreters in multilingual contexts, whether they are formal or informal (friends, family, or untrained staff). Interpretation creates new issues with accuracy, confidentiality, and ethical behavior even if it may help close communication gaps. According to Flores (2019), unskilled interpreters often leave out, misrepresent, or misinterpret important medical information, which raises clinical risks. According to Schwei et al.(2022), using unofficial interpreters may jeopardise patient autonomy and privacy, especially in delicate health situations like mental or reproductive health. Thus, research advocates language support systems, such as training healthcare providers in culturally competent communication, hiring qualified medical interpreters and the integration of indigenous languages into healthcare communication

Beyond language barriers, Ondo State is marked by religious diversity (including Christianity, Islam and indigenous belief systems). Religion is a sociocultural force that influences people's health-related attitudes, actions and decision-making. Patients frequently interpret sickness through spiritual frameworks in Nigeria, where religion dominates almost every area of social life, assigning reasons to supernatural powers, divine will, or moral failings. Religion offers explanatory frameworks that help people understand how diseases arise, frequently attributing sickness to spiritual, moral, or supernatural causes (Shipurut, 2024). Religious convictions can affect attitudes toward biomedical therapies, adherence to recommended treatments, and preferences for conventional or faith-based therapeutic methods. Patients' "explanatory models" of sickness, which are frequently influenced by religious views, can diverge greatly from biological viewpoints. These variations may have an impact on patients' acceptance or rejection of medical advice. For instance, some religious communities may place a higher priority on faith-based healing techniques like anointing, prayer, or prophetic intervention, occasionally postponing or replacing medical care. The ongoing significance of religion in healthcare behaviour is supported by recent empirical research. Studies by Adebayo (2022) and the Pew Research Centre (2023), showed that religious devotion has a substantial impact on health-seeking behaviour in sub-Saharan Africa, frequently dictating whether people seek hospital care, spiritual assistance, or a combination of both.

In a similar vein, Koenig (2022) shows that religious convictions can have both beneficial and detrimental effects on health outcomes, encouraging resilience and coping on the one hand while possibly preventing the use of specific medical interventions on the other. Medical decisions may be directly impacted by certain religious ideas. For example, certain Islamic and traditional beliefs may influence views toward reproductive health services, vaccinations, or end-of-life care, while other Christian denominations, like Jehovah's Witnesses, oppose blood transfusions based on doctrinal interpretations. Moreover, religious practices such as fasting, dietary restrictions, and ritual observances can influence medication adherence and treatment schedules.

Patients frequently blend biological and spiritual approaches to healthcare, engaging in what is referred to as "medical pluralism" (Adebayo, 2021). This integrative approach may improve psychological well-being, but it can also lead to conflict when medical advice and religious beliefs diverge. Therefore, academics support healthcare approaches that are attentive to cultural and religious differences. According to Levin (2020), acknowledging and honouring patients' religious convictions can foster better communication, increase trust and improve

treatment compliance. As a result, as part of larger frameworks for cultural competency in healthcare delivery, healthcare providers are urged to acquire religious competence.

In healthcare settings, the relationship between language and religion can either help or impede the provision of efficient services. Patient trust, satisfaction and treatment adherence tend to increase when healthcare personnel exhibit cultural and linguistic competency, which is defined as the capacity to comprehend, respect and correctly respond to patients' cultural and language demands. On the other hand, a lack of such expertise could lead to incorrect symptom interpretation, insufficient patient education and even moral quandaries, especially when religious convictions clash with medical advice. Betancourt (2021) contends that removing linguistic and cultural barriers is crucial for lowering health disparities and raising the standard of healthcare and this has contributed to the extensive discussion of the idea of cultural competency in health communication studies.

The subtle ways that language and religion influence routine clinical interactions at the local level have received little attention, despite continuous efforts to enhance Nigeria's healthcare infrastructure. There is a lack in context-specific assessments that reflect the lived experiences of patients and healthcare professionals within particular areas because existing research frequently concentrate largely on national or regional patterns. Therefore, this study looked into how language and religion influence patient-provider interactions in healthcare delivery in Ondo State. It looks into how communication, trust, diagnosis and treatment outcomes are affected in healthcare settings by linguistic and religious diversity. The study intended to add to current scholarly discussions on patient-centerd care, health equity and culturally responsive healthcare delivery by using a socio-cultural and communication perspective. In the end, it is anticipated that the results would influence policy, improve professional development and encourage more inclusive healthcare practices not only in Ondo State but also in other multilingual and multicultural Nigerian contexts and elsewhere.

Statement of the Problem

English is the dominant language of medical communication in linguistically varied Nigeria but a significant segment of the population, especially in Ondo State, speaks the language poorly. This poor proficiency poses serious obstacles to efficient communication in healthcare delivery. The consequences of this are highlighted in academic evaluations of the Nigerian healthcare system. Recent studies have indicated that language barriers in the Nigerian healthcare settings contribute to miscommunication, reduced patient engagement and lower quality of care. In spite of the increasing recognition of communication and cultural competence in healthcare, significant challenges persist in addressing how language and religion shape patient–provider interactions in healthcare delivery in Ondo State and across Nigeria.

Many healthcare encounters are affected by language discordance as a considerable number of patients have limited proficiency in English, the dominant language of medical communication. This often results in misinterpretation of symptoms, diagnostic errors and poor adherence to treatment. At the same time, religion strongly influences health-seeking behaviour and treatment decisions. Research has also shown that some patients often rely on spiritual interpretations of illness or prioritise faith-based healing, sometimes leading to delayed care or resistance to medical interventions. Evidence shows that religiosity

significantly shapes healthcare utilisation in sub-Saharan Africa. More importantly, the combined effect of language and religion remains insufficiently explored, particularly at the local level. Healthcare providers often lack the training and institutional support needed to address these intersecting factors effectively, leading to communication gaps, reduced trust and inequitable healthcare outcomes. Failure to integrate cultural and linguistic competence into healthcare systems perpetuates disparities in care.

Therefore, the problem this study addresses is the limited understanding of how language and religion jointly influence patient–provider interactions in healthcare delivery in Ondo State, and the absence of context-specific strategies to improve culturally and linguistically responsive healthcare delivery.

Research Objectives

The study determined the following: To

1. investigate the relationship among the independent variables (language and religion) and patient–provider interactions in healthcare delivery in multilingual Ondo State.
2. examine the joint contribution of language, religion and patient–provider interactions in healthcare delivery in multilingual Ondo State.
3. assess the relative contribution of the independent variables (language and religion) and patient–provider interactions in in healthcare delivery in multilingual Ondo State.

Research Questions

The following research questions guided the study:

1. What relationship exists among the independent variables (language and religion) and patient–provider interactions in healthcare delivery in multilingual Ondo State?
2. What is the joint contribution of language, religion and patient–provider interactions in healthcare delivery in multilingual Ondo State?
3. What is the relative contribution of the independent variables (language and religion) and patient–provider interactions in in healthcare delivery in multilingual Ondo State.

Methodology

This study adopted the descriptive design of the correlational type. Five Local Government Areas were randomly selected from the 18 Local Government Areas in Ondo State. Fifty patients and fifty healthcare providers were randomly selected from the five selected Local Government Areas, making total of 250 patients and 250 healthcare providers. Data were gathered using three study instruments: Patient-Provider Interactions and Language Questionnaire (r=.76) and Questionnaire on Patient-Providers Interactions and Religion in Healthcare Delivery (r=.80). Multiple regression analysis and Pearson Product Moment Correlation were used to analyse the data.

Results

Research Question 1: What relationship exists between the independent variables (language and religion) and patient–provider interactions in healthcare delivery in multilingual Ondo State?

Table 1: Correlation Matrix Showing the Relationship between Independent Variables and Patient–Provider Interactions in Healthcare Delivery in Multilingual Ondo State

Variables	Language	Religion	Patient–provider interactions
Language	1		
Religion	0.185** 0.003	1	0.785** 0.000
Patient–provider interactions	0.167** 0.08	0.785** 0.000	1
Mean	53.7	52.9	52.1
STD.D	19.38	13.42	12.65

* denotes significant at p<0.05

Table 1 shows that there is a positive, low relationship between language (r = 0.185; p<0.05) and patient–provider interactions in healthcare delivery in multilingual Ondo State. This means that language is related to patient–provider interactions in healthcare delivery in multilingual Ondo State. Also, there is a positive, low relationship between religion (r = 0.167 p<0.05) and patient–provider interactions in healthcare delivery in multilingual Ondo State. This means that religion is related to patient–provider interactions in healthcare delivery in multilingual Ondo State.

Research Question 2: What is the joint contribution of language, religion and patient–provider interactions in healthcare delivery in multilingual Ondo State?

Table 2 Summary of Multiple Regression Analysis on Composite Contribution of Independent Variables to Patient–Provider Interactions in Healthcare Delivery

Sources of Variance	Sum of Squares	Df	Mean Square	F	Significant
Regression	3315.234	2	1657.617	4.534	.012*
Residual	90299.166	247	365.584		
Total	93614.400	249			
R = 0.188 R Square = 0.035 Adjusted R Square = 0.028 Std. Error of the Estimate = 19.120					

Table 2 indicates that the joint contribution of the independent variables (language and religion) to the prediction of patient–provider interactions in healthcare delivery in multilingual Ondo State ($F_{(2,247)} = 4.53$; Adj $R^2 = 0.028$; p<0.05). This implies that language and religion variable when taken together, jointly contributed to patient–provider interactions in healthcare delivery in multilingual Ondo State. Table 2 reveals a multiple regression coefficient (R = 0.188), which means that language and religion have a joint positive relationship with patient–provider interactions in healthcare delivery in multilingual Ondo State. This implies that language and religion are positively and significantly related to patient–provider interactions in healthcare delivery in multilingual Ondo State. Table 2 further reveals a multiple regression adjusted ($R^2 = 0.028$). This implies that 2.8% difference in patient–provider interactions in healthcare delivery in multilingual Ondo State is as the result

of the joint contribution of language and religion, while the remaining 97.2.0% may be due to other factors and residuals not under investigation in this model.

Research Question 3: What is the relative contribution of the independent variables (language, religion, and healthcare delivery) and patient–provider interactions in multilingual Ondo State?

Table 3: Summary of Multiple Regression Showing Relative Contribution of Independent Variables on Patient–Provider Interactions in Healthcare Delivery

Model	Unstandardized Coefficients		Standardized Coefficient		T	Sig.
	Beta	Std. Error	Beta (β)	Rank		
(Constant)	38.433	5.318			7.228	0.000
Language	0.204	0.146	0.141	2nd	1.398	0.163
Religion	0.086	0.154	0.056	1st	0.557	0.578

Table 3 shows that the relative contribution of language (β = 0.141; t = 1.398; p>0.05) to patient–provider interactions in healthcare delivery in multilingual Ondo State is not significant. This indicates that language does not predict patient–provider interactions in healthcare delivery in multilingual Ondo State. The relative contribution of religion (β = 0.056; t = 0.557; p>0.05) to patient–provider interactions in healthcare delivery in multilingual Ondo State is not significant. This indicates that religion does not predict patient–provider interactions in healthcare delivery in multilingual Ondo State.

Discussion of Findings

Table 1 revealed that language is significantly related to patient–provider interactions in healthcare delivery in multilingual Ondo State. The findings also showed a positive but low relationship between religion and patient–provider interactions in healthcare delivery. This finding agrees with the studies of Hilal Al Shamsi et al. (2020), Orujlu and Adigozalova, (2026) and Babalola et al, (2025) who reported that language discordance increases the risk of misunderstanding, misdiagnosis and reduced quality of care. Similarly, Karliner (2021) found that limited shared language between patients and providers reduces comprehension and engagement, thereby weakening interaction quality. The finding is consistent with the Communication Accommodation Theory, which posits that effective communication depends on individuals' ability to adjust their speech and communicative behaviour to align with those of their interlocutors. In multilingual healthcare settings, limited linguistic convergence between patients and providers may result in miscommunication, reduced empathy, and weaker interpersonal relationships. The finding also supports the Cultural Competence Model, which identifies language as an important component of culturally responsive healthcare delivery. Betancourt (2003) argued that sociocultural and linguistic barriers in healthcare occur at organisational, structural, and clinical levels, thereby affecting the quality of patient care and communication.

However, the weak magnitude of the relationship suggests that language alone may not be the strongest determinant of patient–provider interaction. This position is supported by studies which argue that effective healthcare communication is influenced by multiple factors

such as institutional support, interpreter services, communication skills, and health literacy. Hudelson and Vilpert (2009) noted that the availability of trained interpreters and adaptive communication practices can reduce the negative effects of language barriers in healthcare settings. This may explain why the relationship found in this study was statistically significant but relatively weak, as patients and providers in Ondo State may rely on adaptive strategies such as code-switching, informal interpreters and the use of dominant local languages.

Table 2 revealed that language and religion jointly have a positive and significant relationship with patient–provider interactions in healthcare delivery in multilingual Ondo State. This finding supports the position of the World Health Organization (2023), which emphasises that quality healthcare delivery must integrate effective communication alongside healthcare infrastructure and service provision. Similarly, studies on multicultural healthcare communication have shown that language barriers and cultural differences can threaten patient safety and reduce the quality of care where effective communication systems are absent. Religion did not contribute statistically significantly, but its negative direction points to a potential indirect impact on patient-provider interactions. This is consistent with the findings of Koenig (2022), who contended that even when such impacts are not immediately quantifiable in quantitative studies, religious beliefs and values may influence patients' attitudes about healthcare, treatment preferences, and communication styles. On the other hand, some academics contend that in situations where provider behavior is already governed by common cultural norms, institutional policies, and professional ethics, religion may not have a major impact on healthcare communication. This implies that the impact of religion may differ among communities and healthcare settings.

Table 3 revealed that language did not significantly predict patient–provider interactions in healthcare delivery in multilingual Ondo State. Similarly, religion did not significantly predict patient–provider interactions in healthcare delivery. Importantly, the joint contribution of the independent variables was not statistically significant, accounting for only 0.7% of the variance in patient–provider interactions. This implies that other unexamined variables, such as healthcare providers' communication skills, institutional policies, socio-economic status, interpreter availability and patients' health literacy, may play more substantial roles in determining interaction quality. This finding corroborates the position of Betancourt (2021), who maintained that healthcare communication outcomes are shaped by multiple interacting factors beyond language alone, including cultural competence and broader healthcare system dynamics. In contrast to studies that emphasise the strong effect of language barriers on healthcare delivery, the present study suggests that language and religion may only have limited predictive power within the context of multilingual Ondo State. This may indicate that healthcare workers and patients in the study area have developed coping mechanisms that reduce the severity of linguistic and religious barriers during healthcare interactions.

Conclusion

The study showed that although language and religion are important variables for comprehending patient-provider interactions in healthcare delivery in multilingual Ondo State, their direct impact is small and statistically insignificant. The negative correlations shown imply that, when improperly managed, linguistic diversity and contextual complexity may impede rather than improve successful communication. The results showed that structural and language factors alone are not enough to improve healthcare delivery. Effective

patient–provider interaction depends on a broader integration of communication competence, cultural sensitivity, and system-level support. As a result, in multilingual environments, language continues to be a significant but insufficient predictor of healthcare interaction outcomes.

Recommendations

Based on the findings, the study recommends the following:

1. To enhance the quality of interactions, healthcare facilities should organize training in patient-centred communication and language proficiency and also, employ qualified interpreters.
2. To improve comprehension and patient involvement, clinical settings should promote the use of regional languages like Yoruba.
3. Policies that support culturally and linguistically relevant healthcare practices should be developed by the government and medical institutions.

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