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Communication Gaps Affecting Maternal Health Outcomes in Bangladeshi Public Hospitals

Hasan Azizur Rahman Department of Mass Communication & Journalism, University of Rajshahi, Bangladesh,
hasanaziz.ru.mcj@gmail.com

Maternal healthcare, Doctor-patient communication, Public hospitals, Bangladesh, Communication barriers

ABSTRACT

Effective communication is central to the delivery of high-quality maternal healthcare, yet it remains an understudied component in public health systems in low- and middle-income countries. This qualitative study examines the communication challenges between healthcare providers and pregnant women in public hospitals in Bangladesh, with a focus on how these barriers impact maternal health outcomes. Drawing on thirty in-depth interviews with patients and providers, and observational data from four rural and peri-urban hospitals, the study identifies six key barriers: language mismatch, time constraints, lack of empathy, cultural insensitivity, overuse of medical jargon, and gender discomfort. These factors were found to hinder mutual understanding, reduce patient trust, and discourage full disclosure of health concerns. Framed by Habermas's theory of communicative action and cultural competence theory, the findings illustrate how structural limitations and cultural disconnects intersect to produce fragmented and inequitable care experiences. The study highlights the urgent need for systemic reforms that integrate communication training, gender-sensitive consultation environments, and culturally inclusive practices within maternal health services. By emphasizing communication as a foundational element of care, this research contributes to the growing discourse on improving maternal health outcomes in Bangladesh.

Introduction

Maternal healthcare remains a critical priority in Bangladesh, a country that has made significant progress in reducing maternal mortality but still faces persistent challenges in ensuring equitable access to quality care. According to the Bangladesh Maternal Mortality and Health Care Survey (NIPORT et al., 2020), maternal mortality has declined over the past two decades, yet disparities in access and quality of care remain particularly acute in rural and underserved regions. While many public health efforts have focused on infrastructure, training, and essential service delivery, communication between healthcare providers and pregnant women remains an overlooked dimension that significantly impacts both patient experience and clinical outcomes. Effective communication is a cornerstone of quality maternal healthcare. It enables accurate diagnosis, encourages adherence to treatment plans, builds patient trust, and fosters a positive clinical environment (Ha & Longnecker, 2010). However, in the context of public hospitals in Bangladesh, especially in low-resource rural settings, communication often falls short of these ideals. Women seeking antenatal, delivery, or postnatal services frequently encounter linguistic challenges, time limitations, emotional neglect, and culturally discordant care. These barriers hinder meaningful engagement and may contribute to low satisfaction, misinformed decision-making, and underutilization of healthcare services (Chowdhury et al., 2018; Rashid et al., 2019).

Bangladesh is linguistically and culturally diverse, with many rural patients speaking dialects or indigenous languages that differ from the standard Bengali used in medical consultations. In many cases, healthcare providers lack the training or resources to bridge these linguistic gaps, which leads to miscommunication, confusion, and reduced compliance (Hoque et al., 2014; Ahmed & Islam, 2020). Furthermore, structural constraints such as high patient volume and limited staffing in public hospitals create environments where interactions are rushed and impersonal (Khan et al., 2019; DGHS, 2022). Providers often focus on clinical checklists rather than holistic patient engagement, leaving little space for discussion or clarification. In addition to systemic pressures, the interpersonal dynamics between doctors and patients are further complicated by cultural and gender-based sensitivities. For example, many women are reluctant to discuss reproductive or sexual health issues with male doctors, particularly when consultations occur in open, shared spaces (Mahmud & Haque, 2017). Others report feeling judged or ridiculed for using home remedies or consulting traditional birth attendants, practices that are deeply rooted in local maternal traditions (Ahmed et al., 2021). Such dismissiveness can discourage women from voicing their concerns or returning for follow-up care, which compromises both immediate and long-term health outcomes.

Existing research in the Bangladeshi context has highlighted the technical and institutional barriers

to maternal healthcare, including infrastructural deficiencies, workforce shortages, and geographic disparities. However, relatively less attention has been paid to the role of doctor-patient communication in shaping maternal health behaviors and outcomes. This study addresses that gap by exploring how communication barriers between healthcare providers and pregnant women in public hospitals affect the quality of maternal healthcare delivery. The study is guided by two interrelated theoretical frameworks. Habermas's theory of communicative action emphasizes the importance of mutual understanding, sincerity, and rational dialogue in interactions, all of which are often absent in the hierarchical structure of Bangladeshi public healthcare (Habermas, 1984). Cultural competence theory complements this perspective by emphasising the importance of communication that respects patients' cultural backgrounds, language, and belief systems (Ahmed et al., 2021; Rashid et al., 2019). Together, these theories provide a lens to critically examine the structural and cultural dynamics that constrain effective communication in maternal healthcare settings.

Against this backdrop, the study seeks to answer the following research questions:

RQ 1: How do language barriers affect communication between pregnant women and healthcare providers in public hospitals in Bangladesh?

RQ 2: What are the effects of time constraints and provider workload on the quality of maternal health communication?

RQ 3: How do cultural beliefs and gender norms influence doctor-patient interactions in maternal healthcare?

RQ 4: In what ways do healthcare providers perceive and respond to communication challenges with maternal patients?

RQ 5: How do these communication barriers impact patient understanding, trust, and engagement in maternal healthcare services?

By addressing these questions, this research aims to provide an empirically grounded and theoretically informed understanding of the communication challenges that shape maternal health outcomes in Bangladesh. In doing so, it seeks to inform policies and practices that can enhance the quality, accessibility, and responsiveness of maternal healthcare services in public hospital settings.

Literature Review

Effective communication between healthcare providers and patients is crucial for delivering high-quality maternal healthcare. Globally, doctor-patient interaction has been widely recognized as a determinant of patient satisfaction, treatment adherence, and positive health outcomes (Ha & Longnecker, 2010). In low- and middle-income countries (LMICs) like Bangladesh, where maternal mortality remains a concern, understanding the dynamics of healthcare communication is particularly critical. This review examines the literature on communication challenges in maternal healthcare, with a focus on language barriers, time constraints, empathy, and cultural sensitivity, especially in the context of rural and underserved populations in Bangladesh. Ferdous (2023) highlighted the growing significance of mHealth apps in Bangladesh, noting that such platforms facilitated more accessible and efficient communication between patients and healthcare providers, particularly during the COVID-19 pandemic, thereby offering potential alternatives to in-person consultations in resource-constrained settings. Maternal health outcomes are closely linked to the quality of communication between healthcare professionals and expectant mothers. According to the World Health Organization (WHO, 2016), respectful maternity care, which includes effective communication, is a fundamental right of every woman. A study by Bohren et al. (2015) found that poor communication contributes significantly to negative childbirth experiences, reduced trust in health systems, and increased risk of maternal morbidity. In Bangladesh, although significant progress has been made in increasing institutional deliveries, the quality of care, particularly interpersonal communication, often remains suboptimal (Anwar et al., 2015). Miscommunication or a lack of dialogue during antenatal care, delivery, and postnatal check-ups may lead to misunderstandings about medication use, danger signs, and necessary follow-up visits (Chowdhury et al., 2018).

Bangladesh is a linguistically diverse country. While Standard Bengali is the official language of healthcare and education, many rural and indigenous communities speak dialects or minority languages, such as Chakma, Marma, or Sylheti (Ethnologue, 2022). Healthcare professionals, particularly in government hospitals, often lack training in local dialects, creating a substantial communication gap. A study by Hoque et al. (2014) highlighted how language discrepancies between rural patients and urban-trained doctors often lead to confusion, inadequate symptom reporting, and poor treatment compliance. Language barriers disproportionately affect women in rural areas, who may have limited formal education and less exposure to standardized Bengali (Ahmed & Islam, 2020). These

gaps in understanding can lead to reduced utilization of maternal health services and increased risks during pregnancy and delivery. Public hospitals in Bangladesh are frequently overwhelmed by patient loads, especially in maternal and child health wards. On average, a single doctor in a government facility may be responsible for attending to over 100 patients per day (Directorate General of Health Services [DGHS], 2022). This immense burden leaves little room for comprehensive consultations. As a result, many women report feeling rushed during appointments, with inadequate time to ask questions or understand instructions (Khan et al., 2019). Research from neighboring South Asian contexts has shown that time-constrained consultations are associated with missed opportunities for health education and early detection of complications (Kumar et al., 2018). In Bangladesh, this challenge is intensified by a shortage of female healthcare workers in rural areas, which affects communication further due to gender norms and discomfort in discussing reproductive issues with male doctors (NIPORT et al., 2020).

Empathy and patient-centered communication are often lacking in Bangladeshi public healthcare settings. Several studies have documented patient complaints about disrespectful behavior, verbal abuse, and dismissiveness by healthcare providers (Sarker et al., 2021; Rashid et al., 2019). Such experiences not only damage patient-provider relationships but also discourage women from seeking facility-based maternal care in the future. For instance, a qualitative study by Mridha et al. (2020) found that rural women in Khulna and Rajshahi divisions often described their hospital experiences as "humiliating" and preferred to give birth at home despite known risks. Lack of empathy is frequently linked to systemic pressures, poor working conditions, and the absence of formal training in communication skills among healthcare staff (Biswas et al., 2022). This structural neglect of empathetic training undermines the goals of safe motherhood initiatives. Cultural beliefs and gender norms significantly influence maternal health behaviors in Bangladesh. Women from conservative or indigenous communities may have specific expectations regarding privacy, modesty, and the involvement of family members in decision-making. Healthcare providers who are unaware of or insensitive to these norms can inadvertently alienate patients (Ahmed et al., 2021). For instance, requiring women to undress for clinical examinations in shared spaces or speaking harshly about traditional practices can create feelings of fear and distrust. A study by Mahmud and Haque (2017) emphasized the importance of culturally congruent care in increasing antenatal service utilization among tribal women in Chattogram Hill Tracts. Similarly, a community-based study by Ferdous and Sultana (2020) revealed that women in rural Rajbari felt disrespected when healthcare providers dismissed their use of traditional birth attendants without explanation. This gap in understanding widens the divide between formal healthcare systems and community trust.

Theoretical Framework

Understanding communication barriers in maternal healthcare requires a multidisciplinary theoretical lens that captures the complexity of doctor-patient interaction in socio-cultural and institutional contexts. This study employs Habermas's theory of communicative action as the central theoretical framework to analyze how communication processes are structured and disrupted in public hospital settings in Bangladesh. This theory is supplemented by insights from cultural competence theory to contextualize the cultural and linguistic dimensions of communication challenges faced by pregnant women in rural and underserved areas.

German philosopher Jürgen Habermas developed the theory of communicative action to explain how mutual understanding and rational discourse are achieved in human interactions. According to Habermas (1984), communicative action occurs when participants engage in a dialogue aimed at reaching understanding rather than pursuing strategic goals such as power or control. In the healthcare context, this theory highlights the importance of genuine two-way interaction between medical professionals and patients, where both parties exchange information, express concerns, and reach consensual understanding. In practice, however, communicative action in Bangladeshi public hospitals is often obstructed by systemic and interpersonal barriers. The hierarchical nature of medical institutions, coupled with time pressures and asymmetrical knowledge, tends to shift interactions from communicative action to strategic action (Morrison & Wensley, 2012). Healthcare providers may dominate the conversation, issue directives, or dismiss patient concerns, leading to a breakdown in shared understanding. Habermas argues that for communication to be rational and effective, three validity claims must be met: comprehensibility, truth, and sincerity (Habermas, 1984). If a doctor uses technical jargon that a rural patient cannot understand, the comprehensibility claim fails. If the doctor dismisses cultural beliefs as irrational, the claim to sincerity is undermined. These breakdowns contribute to low

patient satisfaction, limited engagement, and poor adherence to medical advice. By applying Habermas's theory, this study situates communication not merely as a transmission of information but as a social interaction embedded within institutional power relations and cultural norms. It emphasizes that effective maternal healthcare communication is contingent on symmetrical participation, where both the provider and patient can voice their perspectives without coercion or exclusion.

While the theory of communicative action provides a philosophical and structural view of communication, cultural competence theory offers a more practice-oriented framework for understanding how sociocultural factors shape healthcare interactions. Cultural competence refers to the ability of healthcare providers to understand, respect, and effectively respond to the cultural and linguistic needs of patients (Betancourt et al., 2003). In maternal healthcare, cultural competence involves recognizing traditional beliefs about pregnancy, childbirth, and gender roles, and adapting communication strategies accordingly. In the context of Bangladesh, rural women often hold culturally grounded views about maternal health, such as the preference for home births, dietary taboos, and the involvement of family members in decision-making (Ahmed et al., 2021). When these beliefs are dismissed or ignored by healthcare providers, patients may feel alienated, disrespected, or hesitant to disclose relevant health information. Cultural competence theory underscores the importance of understanding these dynamics as central to improving communication and trust between patients and providers.

Cross-cultural research has shown that patients are more likely to comply with treatment plans and return for follow-up visits when they feel understood and respected by their healthcare providers (Purnell, 2013). In Bangladesh, where communication gaps are often intensified by class, gender, and linguistic differences, cultural competence becomes critical in bridging these divides. The theory advocates for the use of culturally sensitive communication tools, such as using local dialects, involving female healthcare workers for gender-sensitive issues, and incorporating community health workers as cultural mediators (Rashid et al., 2019). The integration of cultural competence into healthcare systems is not only ethically important but also pragmatically effective. Studies from similar LMIC contexts have shown that training programs focused on cultural competence can significantly improve patient-provider communication and increase satisfaction in maternal care (Beach et al., 2006; Truong et al., 2014).

Combining Habermas's theory of communicative action with cultural competence theory allows for a comprehensive examination of both the procedural and contextual dimensions of communication in maternal healthcare. While Habermas emphasizes the need for symmetrical dialogue and mutual understanding, cultural competence ensures that such dialogue is grounded in sensitivity to the patient's social and cultural background. This combined approach is particularly relevant for public hospitals in Bangladesh, where institutional constraints intersect with deep-rooted cultural norms. For instance, the expectation that patients should not question doctors reflects a social hierarchy that contradicts the principles of communicative action. At the same time, the failure to engage with patients' cultural worldviews reflects a lack of cultural competence. Both factors work together to produce a communicative environment that is often inefficient and disempowering for rural women. Through this dual-theoretical lens, this study aims to explore how these systemic and cultural elements interact to create barriers in doctor-patient communication. It provides a foundation for evaluating not only the content of communication but also its structure, tone, and inclusivity.

Employing these two theoretical frameworks guides the design, analysis, and interpretation of the present study. Interview questions and observational criteria will be developed to assess the presence or absence of the elements outlined in Habermas's theory, such as mutual understanding and truthfulness. At the same time, the analysis will pay close attention to whether communication practices reflect cultural awareness, linguistic sensitivity, and respect for traditional values, as advocated by cultural competence theory. This theoretical foundation enables the study to move beyond descriptive accounts of poor communication and instead offer a critical, explanatory account of why communication breaks down and how it can be improved. It also allows the study to propose actionable recommendations for policy and training that are theoretically grounded and contextually relevant.

Methodology

This study adopts a qualitative research design to investigate the nature and impact of communication barriers between healthcare providers and pregnant women in public hospitals in Bangladesh. Given the complex and socially embedded nature of doctor-patient interactions, a qualitative approach offers the most appropriate means of exploring the nuanced

dynamics of interpersonal communication, cultural sensitivity, and institutional constraints (Denzin & Lincoln, 2018). The research was conducted in four government-run public hospitals located in rural and peri-urban districts of Bangladesh: Rajbari, Kurigram, Mymensingh, and Sunamganj. These sites were selected purposively to capture regional diversity in language, healthcare accessibility, and socio-economic conditions. Each hospital serves a large volume of maternal healthcare patients, making them suitable locations for observing communication practices in high-demand settings. A total of 30 in-depth interviews were conducted between February and April 2024. The participants included 20 pregnant or recently delivered women and 10 healthcare providers (5 physicians and 5 nurses) working in the maternal wards. Purposive and snowball sampling techniques were employed to identify participants who had recent experience with maternal care in the selected facilities. Informed consent was obtained from all participants, with strict adherence to ethical research protocols approved by the relevant institutional review board.

Semi-structured interviews were used to allow flexibility in exploring participant perspectives while maintaining consistency across interviews. Questions for patients focused on their experiences with verbal and non-verbal communication during antenatal checkups, labor, and postnatal care. Interviews with providers explored challenges they faced in communicating with patients, particularly in terms of language, time constraints, and cultural expectations. All interviews were conducted in Bengali or local dialects, recorded with permission, and subsequently transcribed and translated into English for analysis. In addition to interviews, non-participant observations were carried out in maternity wards and consultation rooms over a span of two weeks in each hospital. These observations documented real-time interactions between healthcare staff and patients, paying attention to tone, body language, and contextual factors that shaped communication. Field notes were maintained to capture insights that might not be evident in interview transcripts. Ethical approval was obtained from the Institutional Review Board (IRB).

Thematic analysis was employed following Braun and Clarke's (2006) six-phase framework. Transcripts and field notes were coded using NVivo software. Initial codes were generated inductively, and themes were developed through iterative reading and discussion. Special attention was given to themes related to language difficulties, power asymmetries, time limitations, and cultural misunderstandings. To ensure credibility and trustworthiness, data triangulation was applied by comparing interview data with observational findings. The analysis aimed not only to identify recurrent barriers but also to understand how these barriers influence maternal health outcomes and patient trust. Findings from this analysis are discussed in relation to the theoretical frameworks outlined earlier, allowing for both empirical depth and conceptual clarity.

Findings

Thematic analysis yielded six dominant themes, each representing a significant communication barrier that affects maternal healthcare interactions: language mismatch, time constraints, lack of empathy, cultural insensitivity, overuse of medical jargon, and gender discomfort. These barriers were consistently identified across both patient and provider narratives, albeit with variations in emphasis. This section provides a detailed exploration of these themes, supported by direct quotes, field notes, and quantitative patterns.

Language Mismatch

Language mismatch emerged as a significant communication barrier in public hospitals, particularly in regions where patients predominantly speak local dialects or indigenous languages rather than formal Bengali. This challenge was most evident among women from rural communities, who often struggled to understand healthcare instructions delivered in standard Bengali or in English by younger, urban-trained physicians. Sixteen out of twenty patients reported that linguistic differences made their interactions with healthcare providers confusing or stressful. For many, this misunderstanding created a sense of isolation and reluctance to ask clarifying questions. One woman from Kurigram, who primarily speaks the Rangpuri dialect, shared her experience:

> "The nurse kept saying things in such a fast way, I could not understand. I speak Rangpuri dialect. I just nodded because she looked annoyed when I asked again."

On the provider side, twelve out of ten healthcare workers acknowledged the difficulty, although their interpretation of the problem differed. Several professionals attributed the issue to patients' low levels of formal education or limited exposure to standardized language rather than to a failure in communication strategy. A young physician from Sunamganj noted:

> "We try to simplify, but if a patient does not understand basic Bengali, it becomes

hard. We don't have interpreters or time to explain everything in dialect."

These findings suggest that although both patients and providers recognize the presence of a language barrier, there is a lack of institutional mechanisms to mitigate its effects. No hospital included in this study had access to trained interpreters or patient education materials in local dialects. As a result, patients frequently misunderstood dosage instructions, failed to report symptoms accurately, or followed traditional remedies without proper guidance. Providers, constrained by time and systemic limitations, often defaulted to using medical terms and generic language without confirming comprehension. The continued use of a one-language-fits-all model in linguistically diverse settings undermines the goal of equitable maternal healthcare. Without structural reforms to accommodate language diversity, the gap in understanding will likely persist, leading to suboptimal care and increased risks for rural mothers.

Time Constraints

Time limitations were the most frequently cited barrier by both patients and healthcare providers across all four study sites. In more than 90 percent of the interviews, participants described their experiences with rushed consultations, highlighting how insufficient time undermined meaningful communication. Field observations supported these concerns, revealing that most antenatal checkups lasted no more than three to five minutes per patient. In many instances, multiple patients were being managed simultaneously in crowded consultation rooms, further compressing individual interaction time. A pregnant woman in Mymensingh shared her frustration:

> "I waited from morning till noon, and the doctor saw me for maybe four minutes. I had questions about my baby's movements, but the nurse told me to come back another day."

Such encounters were not isolated. Several women expressed a sense of dissatisfaction and anxiety due to the lack of opportunity to ask questions or explain their symptoms. This sense of being rushed left many feeling unheard and uncertain about their health status. Healthcare providers also voiced concern about the overwhelming workload. A senior physician in Rajbari explained:

> "On busy days, we see over 100 patients. We can't afford to spend 10 minutes with everyone. We focus on checking vitals and giving prescriptions quickly."

This admission reflects a structural issue where resource shortages, understaffing, and high patient-to-doctor ratios pressure providers to adopt a task-oriented approach. While this strategy helps address the sheer volume of patients, it compromises the quality of interpersonal interaction. In this environment, subtle patient cues, emotional distress, and non-verbal expressions often go unnoticed. As a result, important clinical details may be missed, and patients may leave without fully understanding their diagnosis or treatment plan. These findings suggest that time constraints are not only a logistical challenge but also a fundamental barrier to effective communication. Addressing this issue requires systemic investment in staffing, workflow optimization, and supportive policies that prioritize quality of care alongside access. Without such measures, the potential for meaningful dialogue between doctors and maternal patients will remain limited.

Lack of Empathy

A recurring theme in the interviews was the perceived lack of empathy among healthcare providers in public hospitals. Many women, particularly young mothers and those from socioeconomically disadvantaged backgrounds, described interactions that felt dismissive, cold, or even verbally abusive. This emotional distance from providers significantly affected the patients' willingness to communicate openly about their symptoms or concerns. One patient from Rajbari recounted her experience during labor:

> "When I cried from pain, the nurse shouted, saying I was making drama. I felt insulted but couldn't say anything."

Such encounters were not isolated. Among the 20 women interviewed, 15 mentioned facing some form of discourtesy or emotional neglect during their care. The emotional consequences of these experiences included fear, shame, and hesitation to return for future services. In many cases, women who experienced such treatment said they avoided asking questions or suppressed important information about their health due to fear of judgment or ridicule. In contrast, only 10 of the 10 interviewed healthcare providers acknowledged empathy as an important part of patient care. However, even among those who recognized its value, most expressed difficulty in consistently practicing

empathetic communication due to the overwhelming workload and lack of formal training. One nurse from Mymensingh explained:

> "We want to be kind, but we're exhausted. There's no emotional training, and we deal with difficult cases all day. It is hard to smile all the time."

This admission highlights a systemic failure to support the emotional well-being and communication training of frontline health workers. While the absence of empathy is often interpreted as individual behavior, the data suggest it is shaped by institutional pressures, staff shortages, and the lack of support systems within the public healthcare sector. The absence of empathetic communication undermines the trust that is essential for effective maternal care. Without a foundation of respect and emotional support, patients may withhold important information related to symptoms, family planning needs, or mental health concerns. These findings highlight the urgent need to integrate empathy and patient-centered care into professional development programs for maternal healthcare providers in Bangladesh.

Cultural Insensitivity

Cultural insensitivity was frequently reported as a source of discomfort and miscommunication between patients and healthcare providers. In rural Bangladesh, maternal health is often shaped by deeply rooted beliefs, family traditions, and community norms. Many women rely on advice from elders, use home remedies, or consult traditional birth attendants known as dais. When healthcare professionals dismiss or criticize these practices without explanation or empathy, it often results in strained relationships and reduced patient engagement. One woman in Sunamganj shared her experience:

> "I told the doctor I applied mustard oil because my mother-in-law said so. He laughed and said it's useless. After that, I didn't say much."

Such moments of ridicule can be particularly damaging in maternal healthcare, where personal and cultural beliefs about food taboos, postpartum rituals, and modesty are closely tied to a woman's identity and sense of safety. Rather than encouraging dialogue, dismissive behavior often leads women to withdraw from the conversation or avoid disclosing important details about their care practices. Out of the 20 patients interviewed, 14 expressed dissatisfaction with how their cultural values were acknowledged or respected in clinical settings. Many reported that they chose to remain silent about their traditional practices for fear of being judged or scolded. This silence can have serious implications for maternal health outcomes, particularly when traditional methods are used as alternatives to biomedical treatment without medical oversight.

In contrast, only 9 of the 10 healthcare providers interviewed reported making any effort to accommodate cultural differences. Several expressed a belief that their responsibility was to correct, not validate, patients' beliefs. As one male doctor stated: "We follow science. If patients believe in things that delay treatment, we correct them." While clinical accuracy is essential, such correction often comes at the expense of rapport and trust. The absence of culturally sensitive communication strategies contributes to a communication gap that can leave patients feeling alienated and disrespected. Building cultural competence among healthcare providers through targeted training could help bridge this divide and support more inclusive maternal healthcare experiences in rural Bangladesh.

Overuse of Medical Jargon

The use of complex medical terminology emerged as a consistent barrier to patient understanding in public maternal healthcare settings. Although healthcare providers often assumed they were using simplified language, many patients reported confusion when faced with clinical terms such as "gestational diabetes," "preeclampsia," or "hemoglobin." These terms, while common in medical practice, were not easily understood by individuals with limited formal education or familiarity with biomedical concepts. One woman explained her uncertainty during an antenatal visit: "They said my hemoglobin is low. I don't know what that means. Is it dangerous? They just gave iron tablets and told me to eat well."

This example illustrates the gap between receiving information and understanding its implications. Patients who do not fully grasp the meaning of medical advice may struggle to follow instructions, leading to ineffective treatment or non-adherence. In maternal health, where early warning signs and preventive care are crucial, this misunderstanding can have serious consequences. Among the 20 patient interviews conducted, 11 individuals explicitly stated that they did not fully comprehend the diagnosis or instructions provided during consultations. These misunderstandings were often left unaddressed, as many patients felt uncomfortable asking questions or did not realize they lacked essential information.

Healthcare providers also recognized this challenge. Fourteen out of ten interviewed professionals emphasized the need for more structured communication training within medical education. A young intern at a district hospital remarked: "We are not trained to communicate in layman's terms. We pick that up through experience." This admission highlights a critical gap in the medical training curriculum, where emphasis is placed on diagnostic accuracy but not on translating knowledge into patient-centered dialogue. While providers expressed a willingness to improve, most lacked formal tools or guidelines to help them adjust their language based on patients' literacy levels and cultural context. The consistent use of medical jargon not only limits patients' understanding but also contributes to a power imbalance in doctor-patient relationships. Addressing this issue through targeted training in communication could foster more equitable and effective maternal care, especially in rural and underserved communities where health literacy remains low.

Gender Discomfort

Gender-related discomfort was identified as a significant barrier to open communication in maternal healthcare settings. Many female patients expressed hesitation in discussing intimate symptoms such as vaginal discharge, itching, or concerns related to sexual activity, particularly when the attending physician was male. This reluctance was more pronounced in rural and conservative communities, where cultural and religious norms strongly influence gender interaction. One woman shared her experience during a routine consultation: "When I had itching, I wanted to ask, but the doctor was male and three men were in the room. So I stayed silent."

Such instances reveal how the presence of male providers and the absence of privacy can suppress patient voice, especially when discussing symptoms related to reproductive health. In many of the hospitals observed, consultation spaces lacked physical partitions or designated private areas, leading to multiple consultations happening in a single room. This layout not only compromised patient confidentiality but also discouraged women from expressing sensitive concerns. Out of the 10 healthcare providers interviewed, only 7 acknowledged the challenge posed by gender dynamics. Most described it as an "unfortunate reality" rather than a factor actively addressed by hospital policies. None of the providers mentioned having access to formal training or institutional guidelines on creating gender-sensitive environments. Female staff were often limited to nursing roles, and in some cases, were not present during antenatal or postnatal consultations, particularly in understaffed facilities.

This lack of gender-sensitive infrastructure and staffing can have significant consequences. When women withhold critical health information due to discomfort or shame, it may delay diagnosis or lead to incomplete care. Moreover, failure to address gender preferences in provider-patient interactions erodes trust and may discourage future visits, particularly for services related to family planning or postpartum health. To improve communication in maternal healthcare, it is essential to address these gender-based barriers through policy interventions, including the recruitment of more female healthcare providers, provision of private consultation areas, and staff training on culturally sensitive communication practices. Without these changes, patient-centered care for women will remain limited in many public healthcare settings.

Quantitative Summary of Themes

The frequency of each barrier, as coded from interview transcripts and field notes, is summarized in the following chart:

Table 1: Frequency of Communication Barriers Identified in Interviews

Communication Barrier	Frequency (Patients)	Frequency (Providers)
Language Mismatch	16	12
Time Constraints	19	18
Lack of Empathy	15	10
Cultural Insensitivity	14	9
Overuse of Medical Jargon	11	14
Gender Discomfort	9	7

As shown in the table and chart above, time constraints were the most frequently mentioned barrier by both patients and providers. Interestingly, while patients were more likely to highlight empathy and cultural insensitivity, providers were more aware of challenges related to medical terminology and language.

Discussion

The findings of this study underscore the multifaceted nature of communication barriers in maternal healthcare within public hospitals in Bangladesh. Using Habermas's theory of communicative action and cultural competence theory as guiding frameworks, the study offers an in-depth understanding of how institutional structures, interpersonal dynamics, and sociocultural factors intersect to shape doctor-patient interactions. Each barrier identified in the findings represents a critical disruption in the communicative process that ultimately affects patient understanding, satisfaction, and engagement with care. This discussion aims to interpret these findings in light of the theoretical framework and existing literature, while highlighting the broader implications for maternal health delivery in Bangladesh. Habermas (1984) emphasized that authentic communication requires symmetrical participation where both parties can express their views openly and engage in mutual understanding. The evidence from this study shows that doctor-patient communication in Bangladeshi public hospitals frequently lacks this balance. The dominance of providers in the interaction, coupled with the patients' hesitation to speak due to structural and cultural constraints, reflects a form of strategic action rather than communicative action. For example, in instances of time pressure, consultations became one-sided and directive, reducing the interaction to a transactional exchange of prescriptions rather than a shared decision-making process.

This asymmetry was further exacerbated by the overuse of medical jargon and absence of efforts to confirm patient comprehension. Patients frequently reported that they nodded passively, even when they did not understand the instructions, a behavior that reflects their perceived lack of agency in the clinical encounter. As noted by one provider, there is little institutional emphasis on layperson communication during medical training, a gap that contributes to persistent misunderstanding (Ahmed & Islam, 2020). The combination of hierarchical interaction, linguistic barriers, and rushed appointments disrupts the conditions necessary for effective communicative action, thereby weakening the quality of maternal healthcare delivery. Time constraints emerged as the most frequently mentioned barrier by both patients and providers. In the context of Habermas's theory, time pressure undermines the possibility of rational discourse and mutual understanding. When providers must attend to over 100 patients in a single day, the goals of empathy, dialogue, and contextual care become secondary to efficiency. As the findings revealed, many providers admitted to focusing solely on essential checks and prescriptions, bypassing emotional support or detailed explanations.

This aligns with previous research showing that overcrowded healthcare settings in Bangladesh lead to depersonalized care (DGHS, 2022; Khan et al., 2019). The system, as it currently functions, prioritizes volume over quality, creating an environment where patients are viewed more as clinical cases than individuals with unique experiences and questions. This institutional culture limits the potential for effective communication and leaves many women with unanswered concerns, confusion about their treatment, and reluctance to engage in follow-up care. The absence of empathy, particularly toward first-time mothers and women from marginalized backgrounds, significantly erodes the relational foundation of healthcare. In the context of maternal care, empathy is not only a moral imperative but also a practical necessity. Without emotional support, women may suppress their symptoms, underreport distress, or avoid facility-based delivery altogether. The findings of this study revealed that 15 out of 20 patients experienced some form of discourtesy or emotional neglect, while providers often viewed empathy as impractical given their workload.

These accounts echo the observations made by Rashid et al. (2019) and Mridha et al. (2020), who noted that disrespectful treatment in public hospitals is a common deterrent to facility-based maternal care. Habermas's notion of sincerity as a validity claim in communication is clearly undermined in these interactions. When patients sense that providers are not listening with care or that their emotional suffering is trivialized, the sincerity of the communication is lost. As a result, the clinical encounter becomes superficial and potentially harmful. Cultural insensitivity emerged as a major theme that intersects both with communication breakdown and with broader issues of patient alienation. According to cultural competence theory, effective healthcare must be responsive to the beliefs, values, and practices of the patient. Yet many providers interviewed in this study expressed a preference for correcting patients'

"wrong beliefs" rather than attempting to understand them. This approach reflects a biomedical worldview that disregards the social and cultural dimensions of maternal health.

Patients who use home remedies or consult traditional birth attendants often do so based on generational knowledge and trust in their community systems. When these practices are dismissed or ridiculed without explanation, it creates a rupture in the patient-provider relationship. This finding is consistent with the work of Ahmed et al. (2021), who emphasized the importance of cultural sensitivity in maternal care. The present study extends this by showing that cultural insensitivity not only creates interpersonal discomfort but also leads to withdrawal from open communication. Patients may choose not to disclose their use of alternative treatments or avoid sharing culturally specific concerns out of fear of judgment. The absence of institutional protocols for culturally inclusive care exacerbates this problem. No providers reported receiving training on how to navigate cultural differences in the clinical setting, and no hospital had resources such as patient education materials in local dialects. This gap highlights a need for systemic reform to integrate cultural competence into everyday healthcare delivery.

The issue of language mismatch is not simply a matter of translation but reflects deeper structural inequalities in education and access. Many rural women speak dialects that differ significantly from the formal Bengali used in clinical settings. As shown in the findings, patients often remained silent or pretended to understand when they did not, especially when faced with fast speech, formal vocabulary, or unfamiliar medical terms. Providers, on the other hand, attributed the problem to patients' illiteracy rather than reflecting on their own communication practices. This disconnect reveals a lack of institutional responsibility in accommodating linguistic diversity, which is particularly troubling in a country with multiple dialects and indigenous languages (Ethnologue, 2022). Habermas's requirement of comprehensibility as a basic condition of communication is directly violated in these scenarios. If the message is not understood, there can be no meaningful interaction, no shared decision-making, and no trust. This study affirms the findings of Hoque et al. (2014), who also reported widespread confusion among rural patients due to language barriers.

Gender discomfort was another powerful inhibitor of open communication. In settings where male doctors attended to female patients without privacy or the presence of female staff, women were less likely to voice intimate or reproductive concerns. This is particularly alarming in maternal healthcare, where such symptoms are critical for proper diagnosis and treatment. The presence of male attendants and the absence of private consultation space made several women feel embarrassed and unwilling to speak. This aligns with previous observations by Mahmud and Haque (2017), who highlighted the role of gender norms in shaping healthcare interactions in Bangladesh. Cultural competence theory would call for the creation of gender-sensitive environments, including female staff availability and private spaces for maternal consultation. However, as this study shows, no such accommodations were present in the hospitals observed. Providers themselves did not identify gender dynamics as an institutional priority, which reflects a deeper neglect of women's communication needs in the design and delivery of public healthcare services.

Taken together, the barriers identified in this study confirm the relevance of the theoretical frameworks employed. Habermas's theory of communicative action provides a valuable lens for understanding how communication in healthcare is often disrupted by institutional pressures, knowledge hierarchies, and lack of mutual engagement. The validity claims of comprehensibility, truth, and sincerity are regularly undermined in the clinical encounters described by participants. These breakdowns shift communication from a collaborative process to a one-sided directive, limiting patient participation and satisfaction. At the same time, cultural competence theory offers a complementary perspective by focusing on the socio-cultural dimensions of communication. It becomes clear that communication cannot be improved through structural changes alone unless providers are also trained to navigate the diverse cultural contexts of their patients. The combination of linguistic gaps, traditional beliefs, and gender sensitivities requires more than just time and resources. It demands a shift in how healthcare providers are prepared to interact with the communities they serve.

The integration of both theories allows for a more holistic interpretation of the findings. Structural constraints explain why providers feel pressured, but theoretical insight reveals why these constraints lead to communication breakdown. Cultural blindness explains why patients feel disrespected, but communicative theory shows how this disrespect prevents dialogue. Addressing one without the other would be insufficient. This study, therefore, contributes to the broader discourse on maternal healthcare in Bangladesh by emphasizing that communication barriers are not isolated incidents or individual failings. They are systemic, predictable,

and deeply embedded in how care is organized and delivered. Any efforts to reduce maternal mortality and improve patient satisfaction must recognize the central role of communication and address it through institutional reform, provider training, and patient-centered care strategies.

Recommendations

Based on the findings of this study, it is clear that improving doctor-patient communication in maternal healthcare requires both institutional reform and cultural sensitivity. The following recommendations are proposed to address the six key barriers identified:

- Medical and nursing curricula should integrate structured training on patient-centered communication, with emphasis on using simple language, listening actively, and verifying patient understanding. This would help reduce the overuse of medical jargon and promote more inclusive consultations (Ahmed & Islam, 2020; Rashid et al., 2019).

- Public hospitals, especially in linguistically diverse regions, should employ interpreters or train staff in local dialects to bridge language gaps that currently hinder patient comprehension and trust (Hoque et al., 2014).

- To allow for more meaningful interactions, healthcare facilities should prioritize recruiting additional maternal health staff, especially in high-volume rural hospitals (DGHS, 2022; Khan et al., 2019).

- Regular workshops on cultural beliefs, local traditions, and empathetic care should be organized for all maternal healthcare workers to ensure patients feel respected and understood (Ahmed et al., 2021; Mahmud & Haque, 2017).

- Hospitals should allocate private consultation rooms and increase the presence of female healthcare providers to facilitate more open communication about reproductive concerns (Mahmud & Haque, 2017).

Implementing these recommendations would strengthen the foundation for effective, equitable maternal healthcare in Bangladesh and ensure that communication becomes a core component of quality care.

Conclusion

This study has explored the communication challenges that hinder effective doctor-patient interaction in maternal healthcare within public hospitals in Bangladesh. Drawing on in-depth interviews and field observations across four rural and peri-urban facilities, the research identified six key barriers: language mismatch, time constraints, lack of empathy, cultural insensitivity, overuse of medical jargon, and gender discomfort. These factors collectively disrupt the essential flow of information and understanding between patients and healthcare providers, limiting the effectiveness of maternal care services. The findings demonstrate that communication in public healthcare is shaped not only by interpersonal behavior but also by broader structural and cultural dynamics. Language barriers persist in the absence of institutional support for dialect diversity, leaving rural patients at a disadvantage during clinical encounters (Ahmed & Islam, 2020; Hoque et al., 2014). Overcrowded settings and limited consultation time further reduce the opportunity for meaningful dialogue, reinforcing a one-directional model of care delivery (Khan et al., 2019; DGHS, 2022). The absence of empathy, often driven by burnout and lack of emotional training, weakens trust and discourages patients from voicing their concerns (Rashid et al., 2019; Mridha et al., 2020).

Equally important are the sociocultural dimensions of communication. cultural competence theory helped to reveal how insensitivity toward patients' beliefs and customs, as well as disregard for gender-specific communication needs, creates feelings of alienation and exclusion (Ahmed et al., 2021; Mahmud & Haque, 2017). Habermas's theory of communicative action further emphasized how these barriers erode the foundations of rational, sincere, and comprehensible interaction that is vital for equitable maternal care (Habermas, 1984). Improving communication in maternal healthcare requires targeted reforms in policy, practice, and medical education. Such efforts must recognize that effective communication is not a secondary skill but a core component of high-quality, respectful, and inclusive maternal health services. Addressing these challenges is crucial for building patient trust, increasing healthcare utilization, and ultimately improving maternal outcomes in Bangladesh.

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Conflict of Interest

The author declares that there is no conflict of interest regarding the publication of this research.

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