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Enhancing Healthcare Accessibility and Patient Satisfaction through Effective Communication Strategies: A Case Study in Bangladesh

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ABSTRACT

Effective communication is critical in improving healthcare accessibility and patient satisfaction, especially in diverse and resource-constrained settings like Bangladesh. This study investigates the impact of communication strategies on healthcare delivery using a qualitative case study approach. Focusing on a public healthcare facility that serves both rural and urban populations, the research explores how various communication practices, ranging from face-to-face interaction to digital tools like telemedicine, shape patient experiences and access to care. Semi-structured interviews with patients and healthcare providers revealed that communication strategies significantly influence how patients navigate the healthcare system. Thematic findings show that empathetic provider-patient interaction, language-appropriate communication, and accessible digital technologies enhance both satisfaction and service reach. However, challenges such as low health literacy, infrastructural limitations, and socio-economic disparities continue to hinder effective communication. These barriers highlight the need for context-specific interventions. The study emphasizes that improving healthcare outcomes requires a multifaceted approach to communication, one that combines interpersonal sensitivity, cultural awareness, and technological adaptation. The findings offer practical insights for healthcare practitioners and policymakers, suggesting that the integration of human-centered communication strategies and inclusive digital tools can play a vital role in achieving equitable and patient-centered care in Bangladesh.

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Introduction

Effective communication within healthcare systems plays a pivotal role in enhancing access to services and fostering patient satisfaction. In low-resource settings such as Bangladesh, where disparities in infrastructure, literacy, and provider availability are prominent, the quality and clarity of communication can determine whether a patient seeks care, understands their condition, or adheres to medical advice. This study investigates how different communication strategies influence healthcare accessibility and patient satisfaction in Bangladesh, using a case study approach grounded in social cognitive theory.

Bangladesh presents a compelling context for such inquiry. The healthcare system faces significant challenges due to high population density, socio-economic inequality, and an uneven distribution of services between urban and rural areas (Karim & Islam, 2015). These conditions create barriers to accessing timely and appropriate care, particularly for marginalized communities. In this environment, effective communication is not only a means of information transfer but a crucial factor that can empower patients, reduce confusion, and improve trust in healthcare providers (Islam et al., 2018).

For this study, "effective communication strategies" refer to both formal and informal practices that enhance the clarity, responsiveness, and accessibility of health-related interactions between providers and patients. These include interpersonal communication techniques (e.g., empathetic listening, use of plain language), digital interventions (e.g., telemedicine and SMS reminders), and community outreach programs (e.g., health education through local workers or media). The study does not assume the existence of a nationally coordinated communication policy; rather, it explores how these strategies emerge or operate within the practice of healthcare delivery at the institutional level.

While the title of the study does not explicitly mention telemedicine, its inclusion in the analysis is justified by the

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growing role of digital health tools in improving healthcare reach in Bangladesh. Particularly in remote areas, telemedicine has helped bridge geographic gaps, making specialist advice more accessible without physical travel. Therefore, telemedicine is analyzed as a component of the broader communication landscape within the healthcare system.

The terminology used in the study also reflects the Bangladeshi healthcare context. In this research, the term "healthcare providers" encompasses doctors, nurses, midwives, community health workers, and family planning officers. This broad definition is necessary because patients in Bangladesh often interact with a range of provider types across both formal and informal care settings. Unlike in Western contexts, where the distinction between clinical roles is more rigid, the Bangladeshi system often involves blended or overlapping responsibilities.

Patient satisfaction, often used as an indicator of healthcare quality, is heavily influenced by the nature of communication between patients and healthcare providers. Empirical studies have shown that empathetic communication, shared decision-making, and attention to cultural norms significantly enhance patient trust and treatment compliance (Street et al., 2009; Trzeciak & Gaughan, 2012). In Bangladesh, where health literacy varies widely and social hierarchies influence doctor-patient relationships, communication plays a vital role in shaping perceptions of care (Ahmed et al., 2016).

The rapid expansion of digital health tools, including mobile health (mHealth) applications and teleconsultation platforms, has introduced new dimensions to healthcare communication in Bangladesh. These technologies offer promising avenues to overcome traditional access barriers, yet they also introduce challenges, such as inconsistent connectivity and digital literacy gaps (Ferdous, 2023). This dual reality reinforces the importance of investigating how communication is practiced and experienced across diverse healthcare environments.

Given these complexities, this study aims to provide a context-sensitive analysis of how communication strategies influence healthcare accessibility and patient satisfaction. Using a qualitative case study design, the research focuses on a public healthcare facility serving a socio-economically diverse population. The study is guided by the following research questions:

RQ 1: How do different communication strategies employed in healthcare facilities affect the accessibility of healthcare services in Bangladesh?

RQ 2: What role does effective communication play in enhancing patient satisfaction with healthcare services in Bangladesh?

RQ 3: How do socio-economic factors influence the effectiveness of communication strategies in improving healthcare accessibility and patient satisfaction in Bangladesh?

By investigating these questions, the study seeks to generate insights that can inform policy and practice, particularly in settings where resources are limited, and the stakes of communication are high.

Literature Review

Effective communication strategies within healthcare systems are increasingly recognized for their role in improving both healthcare accessibility and patient satisfaction. In resource-constrained settings like Bangladesh, where socio-economic disparities and infrastructure gaps persist, the ability of communication to bridge these gaps has been the subject of growing scholarly attention.

Healthcare communication is not merely the exchange of information but a multidimensional process that influences patients' understanding, treatment adherence, trust in providers, and overall satisfaction (Cline & Bjorck, 2016). The World Health Organization (2017) emphasizes that communication is a key component of people-centered healthcare, contributing to patient safety and quality of care. This emphasis is particularly important in low- and middle-income countries where systemic inefficiencies hinder equitable healthcare delivery.

In Bangladesh, communication becomes both a facilitator and a barrier, depending on how it is implemented. Structural challenges such as population density, rural-urban divides, and limited resources make it difficult for healthcare providers to ensure consistent communication across diverse populations (Karim & Islam, 2015). These factors often create informational gaps between patients and healthcare workers, especially where health literacy is low or where services are understaffed (Islam et al., 2018).

Empirical studies highlight the importance of culturally sensitive and linguistically appropriate communication in improving healthcare outcomes (Street et al., 2009). In the Bangladeshi context, where patients often differ widely in literacy levels, gender norms, and access to care, effective communication must be tailored to social and cultural realities (Ahmed, 2016). Patients are more likely to trust and follow medical advice when it is delivered in familiar terms and by providers who demonstrate empathy and respect.

One significant challenge is that doctor-patient relationships in Bangladesh are often hierarchical, making two-way communication difficult. Patients may hesitate to ask questions or clarify instructions, which can result in poor adherence to medical regimens. This has been observed in studies where provider dominance in clinical encounters led to patient disengagement and reduced satisfaction (Choudhury, 2020).

The integration of digital communication tools such as mobile health (mHealth) and telemedicine is emerging as a potential solution to address geographical and logistical barriers in Bangladesh. Telemedicine initiatives have been deployed to extend services to remote communities, enabling virtual consultations and digital health education (Labrique et al., 2017). Studies have found that such tools improve the timeliness of care and reduce travel costs, particularly for rural populations (Ferdous, 2023).

However, digital technologies introduce a new layer of inequality, particularly for patients lacking access to smartphones, stable internet, or technical literacy. While

promising, these tools are most effective when combined with human support and face-to-face care options, especially in populations with limited digital experience.

Patient satisfaction is another critical focus in the literature, reflecting not only the quality of care but also the perceived respect, clarity, and responsiveness of communication (Trzeciak & Gaughan, 2012). Studies have found that patients consistently report higher satisfaction when providers offer clear explanations, show empathy, and involve them in decision-making processes (Street & Haidet, 2011). In Bangladesh, where cultural expectations shape healthcare-seeking behavior, these interpersonal dynamics are particularly salient (Sharma & Romas, 2018).

Despite these advancements, language barriers and low health literacy continue to undermine the potential benefits of improved communication. Many patients are unable to fully understand prescriptions, discharge instructions, or the rationale behind treatment plans, especially when healthcare providers use technical or English-language terms (Schwartzberg et al., 2007).

The COVID-19 pandemic further highlighted the centrality of communication in health systems. Studies have documented how communication tools like mHealth apps were used to convey preventive measures, symptom tracking, and emotional support during lockdowns, especially in low-resource settings (Liu et al., 2020). These experiences underline the importance of resilience in communication systems, not only for daily care but also for public health emergencies.

Literature strongly supports the notion that effective healthcare communication is foundational to improving both access and satisfaction. For Bangladesh, the evidence suggests that multifaceted approaches, including culturally appropriate provider-patient dialogue, digital tools like telemedicine, and targeted health education, are essential to overcoming current barriers. Future communication interventions should be context-sensitive and inclusive, addressing not only the content of messages but also how, when, and by whom they are delivered.

Theoretical Framework

Social Cognitive Theory (SCT), originally proposed by Albert Bandura, provides a compelling framework for analyzing the complex interactions between individual behavior, cognitive processes, and environmental influences (Bandura, 1986). In healthcare settings, where patient outcomes depend not only on medical interventions but also on how individuals perceive and engage with communication, SCT offers valuable tools to examine the behavioral underpinnings of health decision-making. This framework is particularly relevant for understanding how communication strategies, such as telemedicine, interpersonal interaction, and community outreach, can shape healthcare accessibility and satisfaction in a resource-constrained context like Bangladesh.

Core Concepts of Social Cognitive Theory

SCT rests on several key constructs that help explain how people acquire and enact behaviors: self-efficacy, outcome expectations, observational learning, reciprocal determinism, and behavioral reinforcement. Each of these components offers unique insight into the psychological and social mechanisms that underpin communication within the healthcare environment.

Self-efficacy, or the belief in one's ability to perform specific behaviors, is a central tenet of SCT. Within healthcare communication, self-efficacy determines whether a patient feels capable of asking questions, seeking clarification, or using a telemedicine platform. Patients with higher self-efficacy are more likely to engage with healthcare providers, adhere to treatment plans, and navigate healthcare systems independently (Bandura, 1994). In the Bangladeshi context, where literacy and access gaps are widespread, the presence or absence of self-efficacy plays a crucial role in determining how patients respond to health communication.

Outcome expectations refer to an individual's anticipation of the results of a particular behavior. When patients believe that asking questions will lead to better care, or that using telehealth will reduce travel costs and time, they are more inclined to adopt these behaviors. In this sense, the quality of communication from providers can shape both the patient's belief in treatment effectiveness and their motivation to participate.

Observational learning, another pillar of SCT, involves acquiring knowledge and behavioral models by watching others. In rural or community settings, patients often form expectations about healthcare by observing peers who successfully accessed services or received positive interactions from providers. These peer models help normalize help-seeking behavior and reduce fear or resistance toward medical systems.

Reciprocal determinism, the idea that behavior, personal factors, and the environment all interact dynamically, further enhances SCT's explanatory power. For instance, when a patient has a supportive provider (environment), believes they can understand the health information (personal factor), and follows medical instructions (behavior), all three elements reinforce each other in a positive cycle. In contrast, if one of these factors is missing, such as an unsupportive environment or a disempowered patient, the cycle breaks down, reducing the likelihood of positive health outcomes.

Behavioral reinforcement is also relevant. When patients receive positive feedback, such as respect from providers or successful treatment outcomes, they are more likely to repeat those health-seeking behaviors. Conversely, if they are dismissed or confused by medical instructions, they may disengage altogether.

Applying SCT to Healthcare Communication in Bangladesh

In this study, SCT serves as an interpretive framework for analyzing how patients and healthcare providers in Bangladesh navigate the communication process. Given the country's socio-economic diversity, infrastructural challenges, and regional disparities, understanding how patients learn, adapt, and make choices is critical.

Patients who felt confident using telemedicine, asking questions, or seeking clarification during medical consultations exhibited high levels of self-efficacy, often shaped by positive prior experiences or community support. In contrast, those who felt intimidated by doctors, misunderstood medical terms, or lacked access to digital

tools were often hesitant to engage, reflecting diminished self-efficacy and limited outcome expectations.

Observational learning also played a strong role in patients' decision-making processes. For example, community members often reported using health services or calling providers only after seeing others in their neighborhood do so successfully. In some cases, patients mentioned specific people, neighbors, relatives, or local leaders, whose health journeys encouraged them to seek similar services. These examples highlight the importance of social modeling in driving behavioral change.

Environmental factors also varied significantly. In urban settings, patients often had more exposure to formal communication campaigns and digital tools, whereas in rural areas, face-to-face interaction with community health workers was the main channel of communication. SCT's emphasis on environmental context allows us to account for how these differences shape patient behaviors across populations.

Moreover, the reciprocal nature of SCT was visible in how improved communication practices from healthcare provider's boosted patient confidence, which in turn improved adherence and satisfaction. Participants who were treated with empathy and spoken to in their own language felt empowered to participate in healthcare decisions, illustrating the feedback loop central to SCT.

Limitations of SCT in This Context

While SCT offers a strong foundation for understanding communication behaviors, it is not without limitations. Its focus on individual agency and cognition may underplay the structural and institutional barriers that shape patient behavior in low-resource settings like Bangladesh. For instance, SCT cannot fully explain why patients lack access to trained providers, why gender norms restrict open communication in clinics, or how infrastructural issues prevent stable telemedicine implementation. These are systemic challenges that operate beyond the cognitive or behavioral level. As such, SCT may need to be supplemented with structural or critical frameworks to fully capture the institutional forces at play. Furthermore, SCT does not address power dynamics explicitly, which is a significant gap when analyzing hierarchical healthcare settings. In Bangladesh, where doctors are often perceived as unquestionable authority figures, patient agency is not always encouraged. A theory that does not explicitly engage with power relations may overlook critical barriers to equitable communication.

Alternative Theoretical Models (Why SCT Was Preferred)

Although this study uses SCT as the guiding framework, it is important to acknowledge other relevant models that could inform healthcare communication research. The Health Belief Model (HBM), for example, focuses on individuals' perceptions of threat and their evaluation of benefits and barriers to taking action. While HBM can explain why people do or do not seek care, it does not account for environmental learning or social modeling, making it less comprehensive for studying provider-patient communication. The Transactional Model of Communication, which conceptualizes communication as a two-way, dynamic process, is also relevant. It could be especially useful for examining the flow of feedback between patients and providers. However, it does not include behavioral or psychological factors such as self-efficacy or reinforcement, which are central to this study's aims. SCT was ultimately selected because it provides a more integrated understanding of how personal, behavioral, and environmental factors interact. This multidimensional lens allows for a richer interpretation of communication strategies and their impact on healthcare outcomes.

Methodology

This study employed a qualitative case study approach to investigate the impact of communication strategies on healthcare accessibility and patient satisfaction in Bangladesh. The case study design was selected to enable an in-depth exploration of participants' lived experiences, allowing for rich contextual interpretation of communication practices in a specific healthcare setting. The healthcare facility selected for this study is a mid-sized public hospital located in a semi-urban region of Bangladesh. This facility was purposively chosen due to its unique positioning: it serves both rural and urban patients, offers telemedicine services, and operates a range of outpatient and community outreach programs. The site also maintains a relatively high patient turnover and diverse staff composition, making it ideal for exploring a broad range of communication dynamics.

Demographic diversity, availability of digital communication infrastructure (e.g., basic telemedicine), and accessibility for the research team were all considered during site selection. This hospital reflects common constraints faced by many healthcare centers in Bangladesh, resource limitations, patient overload, and a mix of traditional and digital communication systems, which make it an appropriate context for studying communication practices in a low-resource environment.

A qualitative case study method was deemed appropriate because it allows for the nuanced examination of complex social phenomena, such as provider-patient communication, in natural settings. This methodology is particularly suitable for understanding how individuals perceive and engage with health communication in a specific institutional and cultural context.

Purposive sampling was used to select participants who had direct and recent experience with healthcare communication at the facility. Participants included both healthcare providers (doctors, nurses, community health workers) and patients (or caregivers of patients) who had visited the facility in the previous three months. The sample consisted of 18 participants in total: 10 patients and 8 healthcare providers. Patients were selected across age groups, gender identities, and socio-economic backgrounds to capture diverse perspectives. Providers were selected based on their involvement in direct communication with patients during outpatient consultations or community outreach activities.

The inclusion criteria for patients required that they had received care involving verbal or telemedicine-based communication during their visit. For providers, participation required a minimum of six months of active service at the hospital. Exclusion criteria included administrative staff and patients who were critically ill at the time of recruitment. The final sample size of 18 was

determined through iterative data collection and concurrent analysis. Interviews continued until data saturation was achieved, that is, the point at which no new themes or variations were emerging from the data. After the 15th interview, repeated patterns began to appear, and the final three interviews confirmed the consistency of core themes. This approach follows standard qualitative practices for ensuring depth and completeness in thematic analysis.

Semi-structured interviews were used to collect data, as this method allows for both guided questioning and open-ended responses. An interview guide was developed based on themes from the literature, the research questions, and the theoretical framework (Social Cognitive Theory). The guide included prompts related to patients' experiences with verbal and digital communication, satisfaction with provider interaction, barriers to understanding medical advice, and perceived accessibility of services.

Interviews were conducted in Bangla to ensure clarity and comfort for participants. Each session lasted between 30 to 45 minutes and was audio-recorded with informed consent. Interviews took place in private rooms within the hospital premises or, in the case of community health workers, at local outreach centers. Telemedicine users were also interviewed separately to capture their experiences with remote communication. These interviews were either in-person or conducted by phone, based on participant preference.

All interviews were transcribed verbatim and translated into English by bilingual researchers familiar with local healthcare terminology. Thematic analysis was employed to examine the data. The process involved repeated reading of transcripts, open coding, categorization of codes, and theme development. NVivo 12 software was used for coding and organizing data. Two researchers independently coded the transcripts and later cross-validated the themes to enhance reliability. Themes were derived both inductively from the participants' narratives and deductively through alignment with the constructs of Social Cognitive Theory (e.g., self-efficacy, outcome expectations, observational learning). This hybrid approach allowed for both theory-driven insights and the emergence of grounded, context-specific findings.

Ethical approval for this study was obtained from the Institutional Review Board (IRB) of the healthcare facility prior to data collection. All procedures adhered to standard ethical guidelines for human subjects research. Special attention was given to the informed consent process, particularly for participants with limited literacy. Consent forms were read aloud by the researcher, and participants were asked to verbally confirm their understanding before signing (or thumb-printing) the form in the presence of a witness. Participants were informed of their right to withdraw at any time without penalty. Confidentiality was carefully maintained throughout the study. All data were anonymized by replacing names and identifiers with codes. Interview recordings and transcripts were stored on password-protected devices accessible only to the research team. For participants who used telemedicine services, additional precautions were taken to ensure privacy. These included using encrypted communication platforms and conducting interviews in spaces where conversations could not be overheard. Participants were also asked whether their household members were aware of their teleconsultations to ensure that no unintended disclosures occurred during remote interviews.

Given the qualitative nature of this study, researcher reflexivity was essential. Field notes were maintained after each interview to reflect on researcher assumptions, participant interactions, and contextual factors that might influence data interpretation. To reduce the risk of researcher bias, the following measures were implemented. Triangulation across patient and provider accounts, independent coding by two researchers. member checking with five participants to validate the accuracy of transcript interpretations. Researchers avoided leading questions during interviews and ensured that participant responses guided the depth and direction of conversation. This approach upheld the integrity and authenticity of the data collected.

Results

This section presents the thematic findings derived from qualitative interviews with patients and healthcare providers. Through in-depth narrative accounts, several themes emerged regarding communication strategies, patient-provider interaction, and healthcare accessibility in Bangladesh. The results are presented without interpretation, which is reserved for the discussion section.

Effectiveness of Communication Channels

Participants underscored the critical role of effective communication channels in enhancing both access to healthcare services and patient satisfaction. A central theme was the transformative impact of communication technology, especially in geographically remote regions where traditional access to healthcare services remains limited. One participant stated, *"Telemedicine has made it easier for us in remote areas to consult doctors without traveling long distances."* This reflects how access to remote consultations through telehealth platforms helped eliminate the burden of long-distance travel, particularly for elderly and financially constrained patients.

Participants also highlighted the increasing reliance on mobile phones for health communication, including direct calls to healthcare providers, appointment scheduling, and follow-ups. One female respondent mentioned that receiving SMS reminders for immunization schedules significantly improved her ability to manage her child's care. This reflects an adaptation of digital tools to local healthcare practices. Some participants noted that while video calls were useful, they preferred voice calls due to bandwidth issues or discomfort with camera usage. Others relied on informal community health networks to disseminate key health messages via loudspeakers or local community radio broadcasts.

Another vital finding was the emphasis on language and cultural sensitivity in communication. Several participants reported that receiving medical information in their native language improved understanding and reduced anxiety during consultations. One respondent shared, *"Healthcare providers who speak our language and understand our culture make us feel more comfortable and cared for."* Some participants also mentioned that they appreciated when providers avoided complex medical

jargon. One said, "*Doctors who explain things in simple Bangla help us feel less afraid.*" In regions with ethnic minorities, participants explained that community health workers often acted as cultural and linguistic intermediaries between patients and doctors.

Patient–Provider Interaction

The quality of patient-provider interactions emerged as a foundational factor in shaping healthcare experiences. Participants across socio-economic backgrounds identified empathy, respect, and attentiveness as defining elements of effective communication during medical encounters. One participant explained, *"When doctors listen to our concerns and treat us with respect, it makes a big difference in how we feel about our care."* Such relational elements appeared to influence not just the perception of care but also trust and confidence in the provider.

In addition, clear and comprehensive sharing of information played a vital role. Participants consistently valued healthcare providers who explained diagnoses, treatment plans, and medication instructions in an understandable and patient-friendly manner. As another respondent said, *"When doctors explain things clearly and involve us in decision-making, we feel more confident in following their advice."*

Several participants mentioned that consultations often felt rushed in public hospitals. However, when doctors took even a few extra minutes to listen and respond to questions, it dramatically improved their sense of being cared for. Many respondents emphasized non-verbal cues such as eye contact, a calm tone, and open body language as indicators of a provider's attentiveness. One woman said, *"When the nurse held my hand and smiled before giving the injection, it calmed me down."* In private healthcare facilities, patients perceived interactions as generally more polite and detailed, but cost was often a barrier. Public facilities, in contrast, had overcrowded settings that made such communication less personal.

Barriers to Effective Communication

Several significant barriers to effective communication were identified, particularly among rural and underserved populations. One of the most frequently cited issues was the language barrier, especially when healthcare providers used English medical terminology. A participant stated, *"Sometimes I don't understand what the doctor is saying when they use difficult words."* This lack of clarity created confusion and reduced adherence to treatment advice. Additionally, low health literacy among patients was commonly reported. Participants described feeling hesitant to ask clarifying questions, particularly when providers appeared rushed or authoritative. One participant said, *"We are afraid to ask too many questions, so sometimes we just nod even when we don't understand."*

A recurring theme was the lack of patient-friendly written materials in local languages. Several elderly participants mentioned difficulty reading prescriptions or instructions. Some relied on family members to interpret or accompany them to appointments. Infrastructural limitations also posed a substantial challenge. Unreliable internet connectivity, poor mobile networks, and electricity outages disrupted telemedicine appointments. A participant noted, *"We sometimes struggle with poor internet connections during telehealth appointments, making it hard to communicate effectively with our healthcare providers."* In some rural clinics, participants mentioned that power cuts during video consultations caused providers to abruptly switch to phone calls, which affected the continuity and clarity of care. Others cited logistical barriers such as overcrowded waiting areas, lack of seating, and short consultation windows, which created stress and limited the time available for communication.

Impact on Healthcare Accessibility

The findings suggest that communication strategies are instrumental in improving access to healthcare, particularly in under-resourced and geographically isolated communities. The introduction of telemedicine was seen as a major advancement. A participant stated, *"Telemedicine has brought specialists closer to us. We can now get expert advice without traveling far, which has made a significant difference in accessing timely healthcare."* Participants who previously delayed or avoided seeking care due to travel costs reported now using virtual consultations as a first step in care-seeking. In some cases, family members were able to show reports or scans via WhatsApp and receive recommendations from providers, reducing delays and associated expenses.

Community outreach efforts were also noted to enhance healthcare accessibility. Health camps, door-to-door visits by community health workers, and informational events helped raise awareness of available services. One participant commented, *"Health camps and awareness sessions in our community have made healthcare services more accessible and understandable for everyone."* Participants in low-income urban areas also mentioned the usefulness of loudspeaker announcements and mosque-based health awareness talks to reach non-literate audiences.

Influence on Patient Satisfaction

Empathetic communication and provider behavior emerged as major contributors to patient satisfaction. Participants repeatedly emphasized that when providers treated them kindly, took time to listen, and acknowledged their concerns, their overall healthcare experience improved significantly. One respondent stated, *"When doctors treat us nicely, we feel like we matter."*

Others described feeling respected when providers remembered their names or followed up on previous issues. One said, "When the nurse asked how I was feeling today based on last week's visit, it made me feel cared for." Several women participants shared that female health workers were easier to speak with, especially when discussing reproductive or personal issues. Gender-sensitive communication was considered highly important in those contexts. Clear communication was also cited as a key factor. When patients fully understood their diagnosis and treatment plan, they felt more empowered and in control. One participant said, *"I followed the doctor's advice because I understood everything she said. That made me feel confident."*

Socio-Economic Factors and Communication Effectiveness

Socio-economic status significantly influenced the effectiveness of communication strategies. Participants from lower-income households often lacked access to smartphones, computers, or consistent internet, which limited their ability to participate in telemedicine. A respondent noted, *"I don't have a smartphone, so I have to rely on neighbors or go to the hospital directly."* Additionally, poor families often could not afford private clinics where doctor-patient communication was perceived to be better.

Low literacy levels were another challenge, particularly for older adults. Participants described difficulties in reading prescriptions or appointment slips. One said, *"I ask my son to explain the doctor's note because I can't read it properly."* Several participants said they would like doctors or nurses to use pictures or diagrams to help explain health problems and treatments. Despite these challenges, many noted that community health workers played a vital role in bridging gaps. They often translated complex information, reminded patients of follow-ups, and helped navigate hospital bureaucracy. One participant remarked, *"The community health worker is like a family member. She explains everything and even comes with us to the hospital sometimes."*

Discussion

The findings of this study provide valuable insights into how communication strategies shape healthcare accessibility and patient satisfaction in Bangladesh. By applying Social Cognitive Theory (SCT), the study highlights how behavior, cognition, and environmental factors interact within the healthcare communication process (Bandura, 1986). This discussion is structured to interpret key findings, relate them to the theoretical framework, and connect them with the existing literature. It also identifies contextual implications, limitations, and future directions.

Effective communication strategies, particularly through telemedicine and mobile health (mHealth) platforms, have been shown to reduce geographical and logistical barriers in healthcare access. Participants described these technologies as enabling consultations without travel, which supports prior research showing how digital tools improve access in low-resource contexts (Labrique et al., 2017). Under SCT, the use of technology reflects an environmental factor that influences patient behavior. Patients who observed others using telemedicine, or who had positive expectations about its benefits, were more likely to adopt these platforms. This reflects observational learning and outcome expectation components of SCT (Bandura, 1994). The role of local health camps and community outreach, often using culturally appropriate messaging, also aligns with SCT's emphasis on environmental reinforcement. These interventions not only increased awareness but also helped build patient self-efficacy to seek care, especially for marginalized populations. The findings suggest that communication technologies alone are not enough. They must be paired with culturally sensitive, linguistically appropriate, and trust-building communication methods to make healthcare genuinely accessible.

The study reinforces the idea that empathy, respectful treatment, and clear communication are critical determinants of patient satisfaction. This aligns with existing research showing that positive interpersonal communication fosters trust and improves health outcomes (Street et al., 2009; Trzeciak & Gaughan, 2012). From an SCT perspective, such interactions enhance patient self-efficacy, the belief in one's capacity to manage health. Patients who received clear explanations and felt respected were more likely to understand medical instructions, follow treatment plans, and return for follow-ups. This interpretation is particularly important in the Bangladeshi context, where hierarchical doctor-patient dynamics often limit dialogue. When providers broke down that hierarchy through respectful communication, patients felt empowered. The presence of gender-sensitive communication also emerged as a contextually significant factor. Female patients, especially in reproductive health scenarios, expressed greater comfort when interacting with female healthcare workers, a dynamic that can shape both adherence and satisfaction. These findings suggest that communication training for healthcare professionals must go beyond technical clarity and incorporate emotional intelligence, cultural sensitivity, and non-verbal communication.

Despite progress, several structural and behavioral barriers continue to hinder communication. Language barriers, health illiteracy, and infrastructural limitations were common. Participants often felt unable to ask questions or clarify confusion during consultations, which reflects low levels of perceived self-efficacy, a central SCT construct. The literature confirms that such barriers reduce the effectiveness of communication and may compromise patient adherence (Choudhury, 2020; Schwartzberg et al., 2007). Moreover, technological solutions such as telemedicine are limited by inconsistent infrastructure and digital access, particularly among socio-economically disadvantaged groups. These findings emphasize that any communication strategy must be grounded in equity and inclusivity. Interventions that overlook literacy levels, language needs, or gender-specific concerns are unlikely to be effective across diverse populations. While SCT remains a useful lens, this section also acknowledges a limitation of the theory. SCT focuses heavily on individual agency and may underemphasize structural barriers like poverty, gender norms, or policy deficits.

The application of Social Cognitive Theory in this study allows for a nuanced understanding of how communication influences behavior within real-world health systems. Its focus on self-efficacy, outcome expectations, and observational learning is highly relevant to analyzing communication-based interventions. However, SCT's limitations must be acknowledged, especially in the Bangladeshi context. The theory may underrepresent systemic inequalities or structural determinants of communication (e.g., inadequate digital infrastructure or centralized medical hierarchies). These gaps could be addressed by supplementing SCT with context-specific insights.

Alternative models like the Health Belief Model (HBM), which focuses on perceived barriers and cues to action, and the Transactional Model of Communication, which emphasizes two-way feedback, could also offer

relevant conceptual tools in future research. However, SCT was retained in this study for its broader applicability in behavior-focused interventions and its explanatory power regarding patient empowerment and technology adoption (Bandura, 1997). The study builds on and extends prior research on healthcare communication in low- and middle-income countries. Consistent with findings by Islam et al. (2018), participants in this study emphasized the importance of clear communication in navigating complex healthcare systems. Similar to Ferdous (2023), who examined mHealth use during COVID-19, participants in this study saw telemedicine as a practical, though unevenly accessible, solution to care delays. At the same time, challenges described by participants echoed concerns raised by Schwartzberg et al. (2007) about literacy and language acting as invisible barriers in health communication.

What this study adds is a grounded, qualitative exploration of how patients themselves perceive and navigate these barriers, and how small but meaningful changes in communication style can reshape the healthcare experience.

Conclusion

This study explored how communication strategies influence healthcare accessibility and patient satisfaction in Bangladesh through a qualitative case study grounded in Social Cognitive Theory. The findings underscore that effective communication is not simply a support function but a central determinant of patient experience and service access. From digital tools like telemedicine to face-to-face interactions shaped by empathy and cultural sensitivity, communication consistently emerged as a powerful force in shaping patient outcomes. A key takeaway is that technological advancement alone cannot solve healthcare access disparities. While telemedicine helped patients in rural areas overcome geographic barriers, its success depended on supportive human factors such as language clarity, provider attitude, and culturally responsive engagement.

Similarly, patient satisfaction was deeply tied to interpersonal elements. Empathy, respect, and clear explanations not only enhanced trust but also empowered patients to take an active role in their care. These insights confirm and expand upon existing literature on the relationship between communication quality and healthcare outcomes in low-resource settings (Street et al., 2009; Trzeciak & Gaughan, 2012). However, barriers such as language gaps, low health literacy, and infrastructural challenges continue to prevent many patients—particularly those from disadvantaged socio-economic groups, from fully benefiting from communication initiatives. These findings call for urgent, multi-level interventions that are sensitive to both technological and human dimensions.

In response to the findings, the following policy actions are recommended: develop and implement training programs for healthcare providers focused on culturally competent communication, emphasizing empathy, clarity, and non-verbal engagement. Expand government-funded telemedicine services to underserved areas, with subsidies for internet access and mobile devices for low-income families. Create and distribute multilingual health education materials, using plain language and visual aids, especially in areas with low literacy. Institutionalize communication standards in healthcare through a national framework, possibly under a new or existing public body responsible for healthcare quality assurance. Support community health workers as key intermediaries by offering them enhanced communication training and formal recognition in the national health strategy.

While this study contributes to understanding the intersection of communication and healthcare in Bangladesh, several avenues remain for future investigation, mixed-methods studies can enhance generalizability by combining qualitative findings with patient satisfaction surveys or service usage data. Longitudinal research could assess whether improvements in communication practices lead to sustained changes in patient outcomes. Exploration of emerging tools, such as AI-based chatbots, voice-assistive technologies, and mobile applications, could provide insight into scalable communication innovations. Finally, comparative studies across urban and rural facilities, or public and private sectors, may help identify structural and cultural variations in communication effectiveness.

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Competing Interest

The author reports that there are no competing interests to declare.

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