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Afghan Refugee Women's Experiences of Communication Apprehension and Fear of Physician in the Iranian Health Care System, during COVID-19 Pandemic, Rafsanjan, Iran (2020)

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Abstract

Background: Information about the refugees' experiences in the health care system is needed to improve the quality of health care delivered. This study aimed to investigate the experiences of Communication Apprehension (CA) and Fear of Physician (FoP) in the Afghan refugee women referred to the Iranian health care clinics during the COVID-19 pandemic in the year 2020 in Rafsanjan, Iran.

Materials and Methods: In this descriptive cross-sectional study, conducted between March-July 2020, two hundred forty Afghan women in Rafsanjan, Iran, were selected using convenience sampling. Data collection included the demographic, Personal Report of Communication Apprehension (PRCA-24: score range of 24-120), and Fear of Physician (FoP: score range of 5-20) questionnaires. Data were analyzed using an Independent t-test, as well as ANOVA, Chi-square, and Fisher exact tests. The significance level was $p<0.05$.

Results: The mean age of the participants was 28.81 ± 7.21 years old, and their ages ranged from 16 to 60; further, 97.9% of them were married. Based on the results, the overall mean score of PRCA was 67.07±15.68. Moderate to severe communication apprehension was revealed in 199 participants (82.9%), while 235 participants (97.9%) had moderate to severe fear of physician.

Conclusion: Although many factors could contribute to CA and FoP, as the COVID pandemic had just spread and fear of this unknown virus was at its very peak during this study, the researchers assume that the high rate of CA and FoP level could be related to the COVID pandemic. It is suggested that educational workshops should be held for medical care providers to prevent further communication problems.

Keywords: Communication, Anxiety, Fear, Women, Refugees, COVID- 19.

Introduction

The COVID-19 outbreak has had a significant impact on many aspects of individual and social life. The consequences of the COVID-19 crisis have led to the disruption of normal communication among health care providers and patients. Effective communication during a crisis plays an essential role in reducing uncertainties, thereby reducing the psychological impacts

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experienced by people [1]. As many researchers had predicted, the COVID-19 pandemic would likely continue to spread widely across the globe throughout 2020-2021 [2, 3]. Social distancing and visitor restrictions in health care facilities have been widely implemented to diminish the devastating impact of the disease. Although very effective in controlling the disease, these policies and practices have complicated communication among healthcare workers and patients [4].

Communication as a key factor for improving patient health is vital for the refugees [5]. Also, the life-saving care for non-communicable and chronic infectious diseases, including diabetes and HIV/AIDS, is another critical issue for refugees [6]. Communication barriers, specifically communication apprehension (CA), are factors that cause stress and put a high demand on both refugees and health care professionals. CA is an individual fear and anxiety associated with either real or anticipated communication with another person or persons [7, 8].

A study carried out in the European health care system indicates insufficient language knowledge as the main cause of communication barriers [11]. Refugees experience anxiety that is intensified as they are, in most cases, unable to return to the country of their origin, and this fact contributes to their mental distress [12]. Another factor that may act as a barrier to the refugees' communication with the healthcare team is the fear that care will be denied [13]. Based on the world health organization reports, refugee women are at higher risk of mental and physical health problems due to such factors as lack of social support, discrimination, and poverty [14, 15]. It has been reported that over half of the refugee population are women [16], most often with young children. Yet, they often remain underrepresented and marginalized in both care settings and at home, receiving insufficient consideration and support due to socio-cultural and language barriers [17]. Without the aid and support of their immediate families as wives and/or mothers, these women have to bear more burden in the process of immigration in order to support their family members and adjust to a new way of living [18].

Long before the outbreak of COVID-19, studies of communication problems had gained attention, and Richmond et al., among others, recommended that "future research should investigate the impact of physicians' engagement in positive communication behaviors on the patients' apprehension and medical outcomes" [19]. Another obstacle that has not received considerable attention and prevents adequate medical care is Fear of Physician (FoP) [20]. Richmond et al. found out that CA and FoP were positively related [19].

FoP is a common phenomenon and affects all people, no matter old or young. Usually, people who suffer from this difficulty ask fewer questions regarding their health care, thus losing their autonomy in their health care issues. Ahmed and Bates point out that this fear is sometimes so severe that patients avoid licensed physicians and refer to "informed sources of healthcare" [21]. Differences in communication skills, education, ethnicity, gender, language, and socioeconomic status, are the major causes of this fear [22]. FoP is also associated with a variety of negative relationships and clinical outcomes.

Refugees, especially minority women, have been studied regarding their level of CA; however, few studies have been conducted in the clinical setting and face-to-face contact with physicians and health care workers. The current study adds to this body of literature by exploring CA among the refugee women living in the South East of Iran, who are also of a low socioeconomic status (SES) due to political, social, and economic reasons. To the best of our knowledge, no earlier study has been conducted in the same scope in Iran. Thus, this study aims to investigate the experiences of Communication Apprehension (CA) and Fear of Physician (FoP) in the Afghan refugee women referred to the Iranian health care clinics during the COVID-19 pandemic in the year 2020 in Rafsanjan, Iran.

Materials and Methods

This was a descriptive cross-sectional study. The research population consisted of 237 Afghan women referred to two Family Health Centers (FHC) in the city of Rafsanjan, Iran, which are run under the supervision of the United Nations High Commission for Refugees (UNHCR) and Rafsanjan University of Medical Sciences. We calculated the study sample size by

$$n_1 = \frac{(Z_{1-\frac{\alpha}{2}})^2 \times (\sigma_1^2)}{\Delta^2},$$

formula with the effect size of 1, confidence interval of 95%, and standard deviation of 6.46 based on an earlier study [23]. We determined a sample size of 160. Considering the possibility of sample loss, 240 participants were estimated. They were selected by the convenience method in March–July 2020. Being alert and aware of the time and place, being able to speak Persian,

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having no psychiatric diseases, taking no neuropsychiatric drugs, being able to participate in research and collaboration, and signing the informed consent form were the inclusion criteria for this study. The unwillingness to participate in the research and incomplete questionnaires were the exclusion criteria. Finally, 237 persons completed the questionnaires.

Data collection tools included a demographic (including age, husband's age, religion, birthplace, number of family members, number of children, educational level, marital status, history of illness, and accommodation status), Personal Report of Communication Apprehension (PRCA-24), and FoP questionnaires. PRCA-24 is a scale designed to measure one's fear associated with either real or anticipated communication in four different dimensions (public speaking, group discussion, meeting, and interpersonal), devised by McCroskey in 1972 and underwent several revisions in 1978 and 1982. The interpersonal dimension is the level of fear or anxiety associated with either real or anticipated communication with another individual in face-to-face interaction. Meeting and group discussion dimensions are related to the level of fear or anxiety emerging during the meetings or small group gatherings. The public speaking dimension is the type of CA that most people deal with when the situation arises. The scores range of this questionnaire is between 24 –120 overall and between 6-30 for each subdomain. Scores between 83 -120 indicate a high level of communication apprehension, scores between 55-83 show a moderate level of communication apprehension, and scores between 24-55 indicate a low level of communication apprehension. Beatty et al. point out that these four contexts are highly related to one another [24]. PRCA-24 has high predictive validity and reliability (Cronbach's alpha, >0.90). In Iran, the validity and reliability of this questionnaire were confirmed by Hashemi et al. [23]. The scale uses 24 five-point Likert items, ranging from 1 ("Strongly disagree") to 5 ("Strongly agree"), and it may be overall scored by adding up the rating of the 24 items, or it can be computed separately for each dimension. The participants also filled out a 5-item state anxiety measure developed by Spielberger (1966). Many people are fearful and/or anxious about communicating with their physicians. It is believed that this fear/anxiety is, in some part, a function of the way the physician communicates with the patient. This FoP instrument was developed to measure this feeling (score range between 5-20). Alpha Cronbach reliability estimates for these instruments should be expected to be near 0.90 (19). Data were collected by Afghan health care workers in the two FHC using face-to-face interview methods; if the participants were literate, they filled out the questionnaires by themselves. The protocol of the study was approved by the ethics committee of Rafsanjan University of Medical Sciences (IR.RUMS.REC.1398. 152) in terms of bioethics considerations. Therefore, permission was obtained from the ethics committee of Rafsanjan University of Medical Sciences to have the COVID 19 in the title and the manuscript. All the data by chance were gathered during the COVID outbreak and might have affected the results. The study objectives were explained to the participants, with their names and information kept confidential.

The data were analyzed using descriptive and analytical statistics (Independent t-test, as well as ANOVA, Chi-square, and Fisher exact tests) using SPSS software version 20.0 (SPSS Inc., Chicago, IL). The significance level was less than 0.05.

Results

A total of 237 women participated in this study. The mean age of the participants was 28.81 ± 7.21 years, and their ages ranged from 16 to 60 years old. The mean age of the participants' husbands was 31.31 ± 10.02 years, and their ages ranged from 20 to 73 years old. The majority of participants (97.9%) were married. The birthplace of the majority (63.3%) was Iran. Further, the majority of the women were Sunni Muslims (142 persons: 59.9%). Frequencies of other demographic characteristics are presented in Table 1.

Based on the results, the overall mean score of PRCA was 67/07 ± 15.68 /15/59 ± 5.31, 15/96 ± 4.78, 16/91 ± 4.79, and 18/60 ± 5.43 for subdomains of group discussion, meeting, interpersonal, and public speaking, respectively. The overall mean score of FoP was 14.29±2.83. Moderate to severe anxiety (CA) was revealed in 199 participants (84%), while 235 participants (99.2%) had moderate to severe FoB (Table 2). Regarding FoP, 57.8% of the participants (137 persons) reported an extreme degree of FoP while visiting the clinics.

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Table 1. Participants' demographic characteristics

Characteristics		No (%)
Age	<30 years	154 (65)
	31-50 years	81(34.2)
	>50 years	2 (0.8)
Husband's age	<30 years	118 (49.8)
	31-50 years	115 (48.5)
	>50 years	4 (1.7)
Birthplace	Iran	150 (63.3)
	Afghanistan	87 (36.7)
Religion	Shia Muslims	95 (40.1)
	Sunni Muslims	142 (59.9)
Number of family members	1-3	15 (6.3)
	4-6	50 (21.1)
	>6	172 (72.6)
Number of children	0	5 (2.1)
	1-3	136 (57.4)
	4-6	67 (28.3)
	>6	29 (12.2)
Educational level	Illiterate	80 (33.8)
	Elementary	69 (29.1)
	Secondary	25 (10.5)
	Diploma	47 (19.8)
	Higher than diploma	16 (6.8)
Marital status	Single	5 (2.1)
	Married	232 (97.9)
Husband's job	worker	218 (93.9)
	Etc	14 (6.1)
History of illness	Yes	57 (24.1)
	No	180 (75.9)
Accommodation	Camp	95 (40.1)
	Outside of camp	142 (59.9)

The normality of the data was examined using the Kolmogorov-Smirnov test, and parametric tests were used due to the normal distribution of the data (P>0.05). According to the results, there was no significant difference between the overall score of PRCA based on the demographic characteristics; however, the mean score of FoP in participants born in Afghanistan (with a history of illness) was higher than others (Table 3).

Table 2. Frequency of anxiety according to PRCA, subdomains, and Fear of Physician among participants

Characteristics	Anxiety	No (%)
Group discussion	Mild	36 (15.2)
	Moderate	151 (63.7)
	Severe	50 (21.1)
Meetings	Mild	61 (25.7)
	Moderate	135 (57.0)
	Severe	41 (17.3)
Interpersonal	Mild	20 (8.4)
	Moderate	135 (57.0)
	Severe	82 (34.6)
Public speaking	Mild	47 (19.8)
	Moderate	154 (65.0)
	Severe	36 (15.2)
Total PRCA	Mild	38 (16.0)
	Moderate	154 (65.0)
	Severe	45 (19.0)
Fear of physician	Mild	2 (0.8)
	Moderate	98 (41.4)
	Severe	137 (57.8)

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Table 3. Comparison of the mean and standard deviation of Personal Report of Communication Apprehension and Fear of Physician based on the demographic characteristics

Characteristics		PRCA Mean± SD	P	FoP Mean ±SD	P
Age	<30 years	67.70 ± 15.57	*0.61	14.23 ± 2.77	*0.51
	31-50 years	66.06 ± 16.09		14.35 ± 2.95	
	>50 years	60.01 ± 15.68		16.50± 0.71	
Husband's age	<30 years	66.88 ± 15.68	*0.95	14.21 ± 2.67	*0.81
	31-50 years	67.33 ± 16.01		14.35 ± 3.02	
	>50 years	65.25 ± 5.56		15.01 ± 1.82	
Birthplace	Iran	66.74 ± 16.35	**0.66	14.01 ± 2.67	**0.03
	Afghanistan	67.65 ± 14.54		14.81 ± 3.02	
Religion	Shia muslims	67.87± 16.61	**0.52	14.02 ± 2.83	**0.22
	Sunni muslims	66.54 ± 15.07		14.47± 2.82	
Number of family members	1-3	69.07 ± 17.02	*0.71	14.69 ± 2.05	*0.06
	4-6	68.96 ± 14.96		13.34 ± 2.54	
	>6	66.43 ± 15.81		14.54 ± 2.91	
Number of children	1-3	68.35 ± 16.50	*0.26	14.18 ± 2.63	*0.61
	4-6	66.79 ± 14.53		14.43± 3.07	
	>6	62.93 ± 14.55		14.64 ± 3.21	
Educational level	Illiterate	66.86 ± 15.36	*0.98	14.68 ± 2.50	*0.23
	Elementary	68.17 ± 14.56		14.08 ± 3.08	
	Secondary	67.56 ± 17.17		14.52 ± 2.87	
	Diploma	65.72 ± 17.17		14.29 ± 2.88	
	Higher than diploma	66.62 ± 17.14		12.81 ± 2.83	
Husband's job	worker	67.72 ± 15.84	**0.07	14.35 ± 2.91	**0.01
	Etc	59.61 ± 13.09		13.38 ± 1.12	
History of illness	Yes	68.14 ± 16.27	**0.56	14.98 ± 3.29	**0.03
	No	66.74 ± 15.59		14.07 ± 2.66	
Accommodation	Camp	67.41 ± 16.22	**0.78	13.92 ± 2.76	**0.10
	Outside of camp	66.85 ± 15.37		14.54 ± 2.85	

***** ANOVA, **Independent t-Test, The level of significance was set at $p < 0.05$.

Discussion

According to the results, most Afghan refugee women who participated in this study reported a moderate level of CA and a severe degree of FoP when referred to the FHC. Health care is considered a key factor for an immigrant's integration into society. Back et al. named three core principles for effective communication skills: dealing with emotions rather than giving a lot of information, delivering information “in simple and understandable sentences”, respecting the patient values as the core of medical treatment plans [2]. Based on the existing literature, language and miscommunication between refugees and their health care providers are perceived to be the most limiting barriers to health care access [25]. While previous studies of resettled refugee health issues have largely focused on health upon arrival in a host country, we investigate communication problems and fear of physicians in the women refugees living in Iran permanently [26].

One major factor in the high level of FoP could be related to the fact that, unlike the interviewers who were from Afghan backgrounds and thus very familiar with the cultural background of the participants, the physicians were all Iranians. Another issue could be the COVID-19 pandemic and the associated fear. The virus in question is highly transmissible, with the average infected person spreading the disease to up to 3 other people [27]. It is important to point out that cultural understanding eases the patient-physician relationship, and because medical examinations require physical examination and touch, the female patients do not feel at ease being examined by even female physicians. Physicians, therefore, should accommodate and adjust to the patient's expectations in reducing their fear. Also, fear of Corona infection may have led to being jittery and nervous during the medical examinations, thus causing higher CA and FoP. In a study done in Khorassan province of Iran on Afghan refugees' health status, many participants had mentioned feelings of anxiety, nervousness, and even discrimination while receiving health care [26].

Since the refugee camps host people from different backgrounds and cultures, physicians usually serve culturally diverse populations. According to Ahmed and Bates, this diversity affects how patients and physicians communicate [21], possibly leading to lesser medical care received. Over 57% of the participants in this study reported having severe fear of physicians; considering the fact that a large number of these

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mothers were illiterate, this FoP not only hinders the delivery of health care but also leads to higher CA. Although the results relating to literacy level were not statistically significant, it is an important factor in communication aspects, and further studies in this matter seem necessary.

One factor for this high level of fear may be the disease stigmatization. Refugee women might fear abandonment by the husband or the society if diagnosed with a disease. Many factors may lead female refugees to seek help or have effective communication with their physicians, among which fear of isolation, racism, discrimination, and marginalization with all its social and economic ramifications can be mentioned [28]. It seems that being neglected and misunderstood by health workers is the common experience of immigrants, indicated by the present study, which is in agreement with other studies (Jain et al., 1985; Cave et al., 1995; Ferran et al., 1999). Some studies (e.g., one conducted by Vydelingum) found that some patients could not communicate with nurses and felt lonely and isolated. The real problem in their care was that some nurses did not have a positive attitude towards them [29]. Haydari et al. conducted a similar study in Iran on Afghan refugees' health service delivery and concluded that the refugees felt being discriminated against and also ignored by both the health care system and the personnel delivering the care [26].

One factor that could be related to the low or medium level of CA among the participants is that the nurses, caretakers, and clerks conducting and distributing the questionnaires at these clinics were also of Afghan origins; therefore, these women felt safer and in their own community, while the physicians were primarily Iranians. Thus, FoP was reported to be higher. In a Canadian study with similar scope, most refugee women felt that they could not discuss their feelings of depression with their doctors because either they were too rushed or did not ask them any questions in this regard [30]. In another study, some participants indicated insufficient or impersonal communication between themselves and their health care providers [31]. However, the participants in this study did not share this feeling, and we could conclude that the presence of Afghan health workers and similar linguistic backgrounds and even accents had decreased their anxiety levels. In the study mentioned above, the lack of communication during health examinations had led to their inadequacy. In a study carried out in Sweden, 30% of the refugee health care seekers did not understand what they were being told [32]. World Health Organization (WHO) points out that one of the most important and effective interventions in public health response to any occasion is "to proactively communicate what is known, what is unknown, and what is being done to get more information, with the objectives of saving lives and minimizing adverse consequences" [33].

This study had several limitations. First, sampling was performed in a single community in southeast Iran. Therefore, the results cannot be extrapolated necessarily to other populations of this region or elsewhere in Iran. Second, this study was done during the pandemic of COVID-19, and some of the interviews were conducted at the peak; therefore, it is likely that both the interviewers and the participants had anxiety both during the interviews and while they were filling out the questionnaires. It should be considered that female refugees have been forced out of their homes and undergone incredible hardships prior to resettlement within a host country, which has created specific health needs. In order to better allocate resources and serve this population more effectively, we recommend population-specific research and evaluation of the existing programs, which will most likely contribute to the improvement of the care provided.

Conclusion

Based on the results of this study, Afghan refugee women have a moderate to severe level of CA and a high degree of FoP. The results could be helpful to the health care system and, specifically, caregivers in the refugee camps, provide adequate health care services, and prevent these vulnerable groups from falling into the cracks of the health care system. The health care providers are also suggested to be sensitive to the communication problems in refugee women and adapt measures to help people communicate with their physicians and healthcare workers without feelings of fear or apprehension.

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