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COVID-19 and multidimensional deprivation in rural women with cancer in Iran

According to World Health Organization (WHO), palliative care is recognized as a human right and approach for improving patients' and caregivers' health and quality of life by providing adequate and sustainable healthcare systems [1]. Although the population of patients with cancer is higher in under-resourced contexts than in others, the availability and access to palliative care are fewer, especially in rural and remote areas [2]. The occurrence of COVID-19 has increased disparities and challenges owing to limited access to health services and delayed diagnosis and treatment of cancer in resource and remote contexts [3].

The pandemic will be more problematic for rural women as their illness will induce the loss of workforce in housekeeping, agriculture, and animal husbandry. Also, the rising costs of chemotherapy, economic recession, and financial burden during the pandemic have created severe difficulties for patients and their families [4]. Economic hardships would induce more mental distress in rural women due to a lack of financial autonomy and family support dependency. Besides, low health literacy increases anxiety and depression of the patient and her family and a misconception about the disease, advantages, and risks of treatment options. Such a situation may deter them from communicating appropriately with care providers, less satisfaction with healthcare services, and unsuitable adherence to treatment regimens and mitigate side effects [5].

The rural population may adhere less to health protocols to prevent infection, such as wearing masks and disinfectants due to financial or cultural barriers [3, 6]. Keeping physical distance and social isolation has been identified as a critical strategy to prevent COVID-19. However, living in crowded houses and lack of access to a separate room, toilet, and bath or suitable air fresh can increase infection transmission risk between family members [3, 7]. Rural women mostly have lower literacy or limited access to social media to get updated information and medical consultations [8] and obtain support from family and relatives. Therefore, they must commute long distances to reach specialized centres to obtain radiotherapy or chemotherapy and may experience a long waiting time in clinics or delayed surgery [3]. These complex journeys would have many adversities, such as psychosomatic exhaustion and food insecurity. Furthermore, most social classes do not have cars and

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use public vehicles for transportation which can raise the risk of infection.

When admitted to the hospital, they would endure more psychological harm and feel lonely due to strict rules and social restrictions during the pandemic since they are accustomed to having close social networks. Feeling loneliness and social isolation may negatively affect their health by increasing stress and inflammation or decreasing immunity [9, 10]. Meanwhile, such women may experience social or self-stigma due to religious or cultural beliefs related to illness.

In summary, it seems that social disparities during the Coronavirus outbreak have increased disparities in rural women's health or well-being with cancer. It is urgent to make policies and regulations to empower rural residents and informal caregivers to improve the quality of life of women with cancer and their families. For example, they are raising media literacy, the desire to use and availability of technology for access to health information, changing the public attitudes toward palliative care, and removing stereotypes in the villages.

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