A STUDY ON THE STIGMAS AMONG THE TRIBAL COMMUNITY ASSOCIATED WITH CANCER, SPECIAL REFERENCE TO DISAMA VILLAGE KARBI ANGLONG ASSAM.

A Dissertation Submitted to the Department of Social work for the fulfilment of the requirement for the award of the degree of Master of Social Work (MSW)

Submitted to:

Department of Social Work
MSSV, Guwahati Unit

Submitted by:

Sarmon Timung
MSW, 4th Semester
Roll no. MSW-22/23
Registration No. MSSV-0023-008-001607
Session: 2023-25

MAHAPURUSHA SRIMANTA SANKARADEVA VISWAVIDYALAYA
GUWAHATI, UNIT
RUPNAGAR-781032

A STUDY ON THE STIGMAS AMONG THE TRIBAL COMMUNITY ASSOCIATED WITH CANCER, SPECIAL REFERENCE TO DISAMA VILLAGE KARBI ANGLONG ASSAM.

A Dissertation Submitted to the Department of Social work for the fulfilment of the requirement for the award of the degree of Master of Social Work (MSW)

Submitted to:

Department of Social Work
MSSV, Guwahati Unit

Submitted by:

Sarmon Timung
MSW, 4th Semester
Roll no. MSW-22/23
Registration No. MSSV-0023-008-001607
Session: 2023-25

MAHAPURUSHA SRIMANTA SANKARADEVA VISWAVIDYALAYA
GUWAHATI UNIT
RUPNAGAR-781032

মহাপুৰুষ শ্ৰীমন্ত শঙ্কৰদেৱ বিশ্ববিদ্যালয়
MAHAPURUSHA SRIMANTA SANKARADEVA VISWAVIDYALAYA
[RecognizedUnderSection2 (f) ofUGCAct, 1956] GUWAHATI
CONSTITUENT UNIT
Sankari Sanskriti Kendra, Rupnagar, Bhangagarh, Guwahati-781032, Assam

Department of Social Work

CERTIFICATE

I have the pleasure to certify that **Mr. Sarmon Timung,** MSW 4th semester student bearing Roll No. **MSW-22/23** with Registration No. **MSSV-0023-008-001607** of **2023** has successfully completed the dissertation entitled "A **study on the Stigma among the tribal community associated with Cancer, with Special reference to Disama village, Karbi Anglong, Assam"**. He has made a successful completion of this research by his own.

I wish him a bright future.

(Dr.DeepshikhaCarpenter)
HOD (i/c)
Department of Social Work
Guwahati Unit, MSSV,
Nagaon

Head (I/C)
Dept. of Social Work
MSSV

Dr. Deepshikha Carpenter, HOD (i/c)
Mobile No: 7637887130
Email-deepshahacarpenter@mssv.ac.in

Website:www.mssv.ac.in ■ E-mail:registrarmssv@gmail.com ■ PhoneNo.:95310-89104

মহাপুৰুষ শ্ৰীমন্ত শঙ্কৰদেৱ বিশ্ববিদ্যালয়
MAHAPURUSHA SRIMANTA SANKARADEVA VISWAVIDYALAYA
[RecognizedUnderSection2 (f) of UGC Act, 1956]
GUWAHATI CONSTITUENT UNIT
Sankari Sanskriti Kendra, Rupnagar, Bhangagarh, Guwahati-781032, Assam

Department of Social Work

CERTIFICATE OF SUPERVISOR

This is to certify that **Mr. Sarmon Timung** student of MSW 4th semester bearing Roll No. **MSW-22/23** with Registration No. **MSSV-0023-008-001607** of **2023**, MSSV, Guwahati unit has successfully carried out his dissertation entitled **"A study on the Stigma among the tribal community associated with Cancer, with Special reference to Disama village, Karbi Anglong, Assam"** as a student researcher under my supervision and guidance for the partial fulfillment of the requirement for the award of the degree of MASTER **OF SOCIAL WORK (MSW).**

The work reported in this research has not been submitted elsewhere and the facts presented here are true to the best of my knowledge.

I wish him all the very best for his future Endeavour.

Bikha.
11/06/2025

Dipshikha Boruah
Teaching Associate
Department of Social Work
Guwahati Unit, MSSV, Nagaon

Research Supervisor
Dept. of Social Work
MSSV

Place: MSSV, Guwahati Unit
Date: ...11/06/25...

MAHAPURUSHA SRIMANTA SANKARADEVA VISWAVIDYALAYA

GUWAHATI UNIT

Department of Social Work

Date: 03.06.2025

Plagiarism verification Certificate

Title of the Research Project: A study on the Stigma among the tribal community associated with Cancer, with Special reference to Disama village, Karbi Anglong, Assam

Total Page: 67

Researcher: Sarmon Timung

Supervisor: Dipshikha Boruah

Department: Social Work

This is to certify that the above Research Project (Dissertation) was scanned for similarity detection in Duplichecker software tool. The softcopy of the Research Project on which the Plagiarism Check has been carried out is the identical softcopy of the hardcopy, which is being submitted for evaluation. The Process and outcome of the Plagiarism Check is given below:

Analyzed document: SARMONMSW2223
Submitted on: 03-06-2025
Time: 2:37 PM
Submitted by: Ms. Dipshikha Boruah
Submitter email: dipshikhaboruah541@gmail.com
Total Word Count: 17350
Similarity Index: 3.56%
Analysis address: dipshikhaboruah541@gmail.com

The complete thesis/dissertation submitted by the student researcher, the Analysis Report and the Exported report from Original Profile have been shared with the Library in-charge for review through e-mail.

DSikha
11/06/2025

Analyzed by- Dipshikha Boruah
Date: 03-06-2025
Place: Guwahati

(Signature of supervisor)
Department of Social Work
MSSV, Guwahati Unit

DECLARATION OF ORIGINALITY

I, **Sarmon Timung**, student of 4th semester, Department of Social Work (Roll No. MSW-22/23 and Registration No. **MSSV-0023-008-001607**, Guwahati Unit, Mahapurusha Srimanta Sankaradeva Viswavidyalaya (MSSV), Nagaon do hereby declare that this dissertation, entitled **"A study on the Stigma among the tribal community associated with Cancer, with Special reference to Disama village, Karbi Anglong, Assam"** Is an original work of mine and is the result of my own intellectual efforts, under the guidance of **Dipshikha Boruah**, Teaching Associate, Department of Social Work, MSSV, Guwahati Unit. I acknowledge and cite the entire original source (i.e., key documents and authors names) that helped me in writing this research project. I am not violating any author's copyright. I do hereby also declare that the contents of this dissertation have never been submitted to this or any other university (either in part or fully) for award of any degree.

Sarmon Timung
11/06/25.
Sarmon Timung

MSS-22/23

MSSV-0023-008-001607

Place: Guwahati, Assam

ACKNOWLEDGEMENT

Words often fall short when it comes to expressing heartfelt gratitude, for true appreciation comes from deep within. With immense sincerity, I take this opportunity to express my gratitude to all those who contributed to the successful completion of this study.

First and foremost, I extend my deepest gratitude to my Research Guide, Dipsikha Boruah Assistant Professor, Department of Social Work, Mahapurusha Srimanta Sankaradeva Viswavidyalaya (MSSV), whose unwavering support, insightful guidance, and constant encouragement were instrumental throughout this research journey. Her mentorship has been a cornerstone of this study.

A heartfelt thank you goes to all the respondents who willingly shared their experiences and perspectives. This study would not have been possible without their active participation and honest contributions.

I am equally thankful to my friends and well-wishers, whose moral support and encouragement have helped me stay motivated during challenging times. I am also grateful to the MSSV, Guwahati Unit, for offering me the platform and necessary resources to carry out this study effectively.

My deepest appreciation is reserved for my parents. Their unwavering emotional and financial support, along with their constant encouragement, has been my greatest source of strength throughout this academic journey.

Sarmon Timung

Roll No. MSW-22/23

Registration No. MSSV-0023-008-001607

Place: MSSV Guwahati Unit.

ABSTRACT

Cancer is a major global health concern, affecting millions of lives across diverse communities. It is a complex disease characterized by the uncontrolled growth of abnormal cells, which can spread to different parts of the body. Despite advancements in medical science and treatment, cancer remains associated with significant social stigma, particularly in marginalized communities, including tribal populations. This research explores the multifaceted nature of stigma related to cancer within the tribal community of Disama village, East Karbi Anglong, Assam. Despite growing medical advancements, cancer continues to carry a significant social burden, especially in culturally rooted and resource-limited settings. Using a qualitative, descriptive design and purposive sampling, data were collected primarily from 15 adult respondents through unstructured interviews, observation, and active listening and secondary data using articles and journals. The study identifies how cultural beliefs such as cancer with karma, black magic, or divine punishment fuel fear, secrecy, and discrimination. The stigma leads to emotional distress, social exclusion, and delays in diagnosis and treatment. Women face additional burdens of being labeled impure or unmarriageable, while caregivers and youth especially girls are affected through interrupted education and increased responsibilities. Findings align with the literatures, which shows stigma as a barrier to healthcare-seeking and emotional well-being. The impact is made up of misinformation, lack of awareness, poverty, and inaccessible healthcare infrastructure. Literature reviewed further confirms that stigma negatively influences screening participation and treatment outcomes. The study explores the need for culturally sensitive interventions, community engagement, and education campaigns to dismantle misconceptions and promote early detection and inclusive care. Addressing stigma through community based strategies, integrating traditional and modern healthcare, and improving health system responsiveness are crucial for reducing cancer disparities in tribal and underserved populations. This research underscores the urgent need for holistic, empathetic approaches to reduce cancer stigma and improve outcomes across social, psychological, and structural dimensions.

Keywords- Cancer, Stigma, Karma, Black magic, Cultural beliefs, Emotional burden

TABLE OF CONTENTS

Chapter I

Introduction

INTRODUCTION

Cancer is a major global health concern, affecting millions of lives across diverse communities. It is a complex disease which is characterized by the uncontrolled growth of body cells, which later on spread to different parts of the body harming it to various extend. Even with the advancements in medical science and treatment, cancer remains associated with numerous social stigmas, particularly in marginalized communities, including tribal populations. Cancer is a life-changing diagnosis, but understanding what to expect can help you feel more in control of your health and well-being. This overview provides insight into the entire journey from diagnosis through recovery. Cancer basically occurs when abnormal cells grow uncontrollably, which a person may suffer due to genetic mutations or environmental factors. A healthcare provider uses certain treatments such as surgery, chemotherapy, radiation, and immunotherapy, depending on the type and stage of cancer. Taking care of one’s physically and emotionally is essential, whether you’re undergoing treatment or navigating life after recovery. By understanding your condition and engaging in your care, you can play an active role in your healing journey and face the challenges ahead with greater resilience.

Symptoms of cancer vary from person to person. General cancer symptoms may include:

- Fatigue.
- Night fever
- Loss of appetite.
- Night sweats.
- Persistent pain.
- Skin colour changes,
- Unexplained weight loss.
- Changes in Bowel or Bladder Habits

- New lumps or bumps.
- Persistent Cough or Hoarseness

Some other symptoms may include:

- Blood in your pee or in your stool.
- Changes in the shape, size of a skin mole.
- Coughing up blood.

Cancer is a complex disease recognised by the uncontrolled growth of abnormal cells, which can invade and destroy the surrounding tissues and shows various kinds of symptoms and may spread to distant parts of the body. The main cause of cancer includes a wide range of genetic, environmental, and lifestyle factors. Exposure to carcinogens, such as tobacco, certain infections (like HPV or Hepatitis B), environmental pollutants, unhealthy diets, and genetic mutations are among the common risk factors. Depending on the type and stage of the disease, treatment is done. Early diagnosis and timely intervention are critical in improving survival rates and quality of life.

Cancer is a life changing diagnosis that affects not only the physical health but also their psychological and emotional well-being in patients as well as the family members. The emotional toll can be immense, involving feelings of fear, anxiety, helplessness, and depression. Managing the disease effectively requires a holistic approach that includes not only medical treatment but also emotional support, lifestyle adjustments, and community engagement. Being informed about the nature of cancer, the trajectory of the disease, and the available treatment options can empower individuals to make educated choices about their health. Maintaining a strong support system and staying actively engaged in one's care are essential components of the recovery journey.

In India, cancer stigma is a uproaring issue that cuts across caste, class, and community lines. However, its impact is particularly acute among vulnerable populations such as women, the poor, and indigenous (tribal) communities. In these contexts, stigma is often intensified by intersecting factors such as illiteracy, poverty, patriarchal norms, and deep-rooted traditional beliefs. These beliefs are reinforced by a lack of access to credible information and healthcare resources, leading to fear, denial, and social withdrawal among those affected.

Tribal communities in India, comprising over 8% of the country's population, are among the most socioeconomically disadvantaged groups. Spread across different states and linguistic groups, tribal populations such as the Gonds, Santhals, Bhils, Nagas, Karbis, and Dimasas maintain distinct cultural practices and worldviews. However, they often share commonalities in terms of limited access to education, healthcare, and employment opportunities. Health infrastructure in tribal areas is frequently underdeveloped, with poorly equipped primary health centers, lack of trained medical personnel, and long distances to tertiary care hospitals. These systemic barriers create significant delays in the diagnosis and treatment of chronic diseases like cancer.

In many tribal societies, cancer is poorly understood, and there is a tendency to explain the illness through supernatural or spiritual frameworks. It is not uncommon for cancer to be attributed to past sins, ancestral curses, black magic or divine retribution. These interpretations reflect the cultural logic of the communities and serve to make sense of an otherwise incomprehensible illness. However, such beliefs can lead to fatalism, where individuals see the disease as unavoidable or untreatable. Consequently, they may avoid seeking biomedical care and turn instead to traditional healers or spiritual practitioners, thereby delaying effective medical intervention.

The stigma associated with cancer in tribal areas is also exacerbated by fear and misinformation. Individuals with visible symptoms, such as disfigurement due to surgery or weight loss from chemotherapy, may be subject to gossip, social distancing, or even exclusion from communal events. Women, in particular, may face heightened stigma, especially in cases of breast or cervical cancer, which are often linked with notions of impurity or loss of femininity. In patriarchal tribal settings, this can result in domestic violence, abandonment, or difficulty in securing marriage prospects for younger women who are survivors or relatives of patients. These social consequences further entrench the cycle of silence and stigma.

The consequences of cancer stigma are profound. At the individual level, it can lead to psychological distress, decreased self-esteem, and loss of identity. Socially, it results in isolation, strained relationships, and reduced community participation. At the systemic level, stigma hampers public health efforts, as it deters people from participating in screening programs, attending awareness campaigns, or seeking timely medical care. Studies have shown that fear of social judgment and discrimination is a significant reason why individuals do not disclose symptoms or visit hospitals until the disease has progressed significantly.

Cancer stigma, a global issue, involves negative attitudes, stereotypes, and discriminatory practices towards individuals with cancer, impacting their health, well-being, and social lives. It can lead to social isolation, delayed treatment, and poorer health outcomes. Cancer stigma is one of such trending barrier which is increasingly recognized as an important factor in influencing health awareness and promotion leading to disease prevention and control.

In many tribal societies, cancer is often misunderstood due to a lack of awareness, leading to myths, fear, and discrimination against patients. Limited access to healthcare, traditional beliefs, and social taboos further contribute to the stigma, preventing early diagnosis and treatment. Tribal communities may attribute cancer to supernatural causes, karma, or lifestyle choices, which can result in isolation and neglect of those affected.

Addressing cancer stigma in tribal communities requires culturally sensitive interventions, improved healthcare accessibility, and awareness campaigns to dispel myths. Encouraging community-based support and integrating modern medicine with traditional beliefs can help in bridging the gap, ensuring better outcomes for cancer patients while reducing societal discrimination.

Cancer continues to be a formidable health challenge worldwide, with stigma remaining a critical barrier to effective care, especially in tribal communities. In these settings, the interplay of cultural beliefs, social discrimination, and healthcare inaccessibility creates a complex web that hinders early detection, treatment, and recovery. Addressing cancer stigma in tribal populations requires a nuanced understanding of local contexts and a commitment to culturally responsive, inclusive, and empathetic healthcare delivery. Only by engaging communities, respecting their worldviews, and ensuring equitable access to information and services can we hope to reduce stigma and improve cancer outcomes for all.

1.1 **Operational definitions**

Cancer: Cancer is a medical condition marked by the uncontrolled growth and spread of abnormal cells in the body. It can affect various organs and systems, often leading to serious health complications or death if not diagnosed and treated early using appropriate medical interventions. According to the World Health Organization (WHO), cancer is a large group of diseases characterized by abnormal cells growing uncontrollably, potentially invading nearby tissues and spreading to other parts of the body.

Stigma: Stigma is a set of negative and unfair beliefs that a society or group of people have about something. It is a social phenomenon involving negative labelling, stereotyping, and discrimination against individuals based on certain characteristics or conditions. In health contexts, stigma can lead to social exclusion, shame, and delayed care, particularly for diseases like cancer that are misunderstood or feared.

Tribal: Tribal refers to indigenous communities with distinct cultural, linguistic, and social practices, often living in geographically isolated or rural areas. In India, tribal populations are officially recognized as Scheduled Tribes and typically face socio-economic disadvantages, limited access to education, and inadequate healthcare infrastructure.

1.2 Statement of the problem

Cancer stigma in rural communities, particularly among tribal populations, remains a significant barrier to early detection, treatment, and overall patient well-being. Limited awareness, cultural beliefs, and misinformation often lead to fear, discrimination, and social exclusion of individuals diagnosed with cancer. Many rural communities perceive cancer as a curse, punishment, or untreatable condition, resulting in delays in seeking medical help and poor adherence to treatment plans.

The Disama village of Karbi Anglong district which is a very remotely area lacks in terms of development in all sectors like education, infrastructure, medical facilities etc. which sets them back compared to the other village. Due to such lack of awareness and education, stigmas related to cancers are prominent in the area, which creates problem in early diagnosis of the cancer. In Any kind of sickness, they prefer their own cultural practices and if anyone is somehow diagnosed, they follow the prevalent stigmas existing in the village, resulting in various social problems and difficulties for both the patients as well as the family. When individuals in Disama exhibit symptoms suggestive of cancer, they are more likely to seek help from local healers or perform cultural rituals rather than consulting a healthcare professional. This delay in seeking proper medical care significantly hampers early diagnosis and timely intervention. Moreover, those who are eventually diagnosed with cancer often face social exclusion, discrimination, and even blame from the community. This stigmatization extends to their families, affecting their social standing and interactions. As a result, cancer patients and their families often suffer in silence, unable to access emotional or medical support, further worsening their psychological, social, and physical well-being.

1.3 Significance of the study

This study on cancer stigma in tribal areas is crucial as it highlights the socio-cultural barriers that prevent timely diagnosis and treatment, ultimately affecting survival rates and quality of life. Tribal communities often face unique challenges, including deep-rooted myths, lack of awareness, and poor healthcare access, which contribute to the stigma surrounding cancer. By understanding these challenges, this study can help policymakers, healthcare professionals, and social workers develop culturally sensitive awareness programs to educate tribal populations about cancer causes, prevention, and treatment.

This study on cancer stigma in Disama village, Karbi Anglong, is important because it highlights the real challenges people face in a remote, underdeveloped area. With poor access to healthcare, education, and basic infrastructure, many villagers have little understanding of cancer, leading to fear, shame, and isolation for those affected. This stigma often delays diagnosis and treatment, making the illness even harder to fight. By understanding how the community views cancer, the study hopes to uncover the barriers people face and find ways to support them better. The goal is to raise awareness, reduce stigma, and help create more accessible and compassionate healthcare solutions. This research could guide future efforts by health workers, policymakers, and NGOs to bring meaningful change and support to the people of Disama. Stigma surrounding cancer in Disama village gives rise to strong attitudinal barriers, where fear, blame, and misconceptions prevent individuals from seeking timely medical help. People often hide their illness due to shame, leading to social withdrawal and treatment delays. These negative attitudes significantly hinder effective healthcare access and recovery.

1.4 Objectives of the study

1. To explore the stigmas prevalent among the community
2. To explore the challenges associated with the stigmas in early cancer detection.
3. To study the impact of Stigma associated with cancer diagnosis and treatment.

1.5 Research questions

1. What are the common beliefs and perceptions about cancer in tribal communities?
2. What role do cultural and traditional beliefs play in shaping attitudes toward cancer in tribal societies?
3. How does cancer-related stigma impact the mental health and social relationships of patients in tribal areas?
4. What barriers do cancer patients in tribal areas face in accessing healthcare services?

Chapter II

Literature Review

Literature Review

Mishra S. I et al. (2023) in the article "*A culturally informed model to enhance breast, cervical, and colorectal cancer screenings*." explores the development at increasing breast, cervical, and colorectal cancer screenings among American Indian adults in rural New Mexico. The authors gathered perspectives from both American Indian adults and healthcare providers to identify barriers and facilitators to cancer screening in this population. The findings highlight the importance of incorporating cultural values and beliefs into health interventions to enhance participation in screening programs. Key barriers identified include historical mistrust of healthcare systems, limited access to healthcare facilities, and cultural differences in understanding cancer and preventive care. The study emphasizes the role of community engagement and culturally tailored education in overcoming these challenges. The authors propose a model that incorporates cultural sensitivity, community-based approaches, and collaborations between healthcare providers and local leaders to increase screening rates and improve cancer prevention outcomes. This research underscores the need for culturally relevant interventions to address health disparities in underserved populations.

Redvers, N. et al (2022) in the article "*Colorectal cancer community engagement: A qualitative exploration of American Indian voices from North Dakota*." conducted a qualitative study to explore American Indian perspectives on colorectal cancer (CRC) in North Dakota. The study aims to identify barriers to CRC screening and prevention within this population, which experiences higher rates of cancer incidence and poorer outcomes compared to non-Indigenous populations. Through interviews and focus groups, participants shared their experiences and concerns regarding CRC, including cultural and logistical challenges that affect screening uptake. Key themes included mistrust of the healthcare system, lack of culturally relevant health education, and barriers to access, such as transportation and financial constraints. Participants emphasized the importance of culturally appropriate communication and community-based approaches to increase CRC awareness and screening rates. The findings suggest that building trust between healthcare providers and American Indian communities, alongside improving accessibility and culturally relevant educational materials, is essential to overcoming these barriers and reducing CRC disparities in Indigenous populations. It explores the critical role of community engagement in addressing cancer health inequities.

Nadeau et al. (2022) in the article **"***Identification of cancer-related risk and protective factors for American Indian youth: A mixed studies review*," exploring a mixed-methods review to identify cancer-related risk and protective factors among American Indian youth. This review synthesizes quantitative and qualitative studies to highlight key factors that contribute to cancer risk and prevention in this demographic. The authors found that risk factors for cancer among American Indian youth include poor dietary habits, low physical activity levels, tobacco use, and exposure to environmental toxins. Conversely, protective factors identified include strong cultural connections, community involvement, and family support systems. The study emphasizes the complex interplay of individual, familial, and community factors that influence cancer risk in American Indian youth, alongside the need for culturally relevant interventions. The authors suggest that public health strategies focused on enhancing protective factors, such as strengthening cultural resilience and community-based education, may help reduce cancer risk and promote healthier behaviors in this population. The review underscores the importance of culturally tailored prevention programs to address the unique health challenges faced by American Indian youth and reduce cancer disparities in Indigenous communities.

Nadeau et al. (2022) in the article **"***Understanding stigma as a barrier to accessing cancer treatment in South Africa: Implications for public health campaigns*." explores stigma as a significant barrier to accessing cancer treatment in South Africa, highlighting its impact on both the social and healthcare experiences of cancer patients. The study reveals that cancer stigma in South Africa is multifaceted, influenced by cultural perceptions, fear, and misconceptions surrounding the disease. Many individuals diagnosed with cancer avoid seeking treatment due to concerns about social rejection and the association of cancer with death and incurability. The research also emphasizes that the stigma faced by cancer patients is often compounded by socioeconomic factors and limited access to healthcare services. The authors argue that stigma not only affects the emotional well-being of patients but also leads to delays in diagnosis and treatment initiation, ultimately worsening cancer outcomes. The study calls for the development of targeted public health campaigns aimed at reducing cancer-related stigma, promoting early detection, and improving access to treatment. It stresses the importance of culturally appropriate interventions to challenge harmful beliefs and support individuals in overcoming stigma when accessing care.

Ginjupalli R. et al. (2022) in the article **“***Developing a framework to describe stigma related to cervical cancer and HPV in western Kenya*.” develops a framework to understand stigma related to cervical cancer and Human Papillomavirus (HPV) in western Kenya, a region with a high burden of cervical cancer. The authors explore how stigma surrounding these conditions affects health-seeking behaviors and treatment outcomes. Key factors contributing to stigma include cultural perceptions of cancer as a fatal disease, the association of HPV with sexual activity, and social shame related to both the disease and its transmission. These stigmas are compounded by gender dynamics, where women are often blamed for HPV-related cervical cancer. The study proposes a multi-dimensional framework that incorporates individual, interpersonal, and community-level factors to explain how stigma operates and influences care-seeking patterns. It also emphasizes the importance of culturally appropriate health interventions that address these stigmas, reduce misinformation, and promote education about cervical cancer and HPV. The authors argue for integrating community leaders and local health providers in the development of stigma-reducing strategies to improve screening and treatment adherence in the region.

Oshiro M. et al (2022) "*Factors related to help-seeking for cancer medical care among people living in rural areas*." explores the factors influencing the help seeker cancer medical care among individuals living in rural areas. The authors synthesize existing literature to identify barriers and facilitators that affect timely cancer diagnosis and treatment in rural settings. Key barriers include geographic isolation, limited access to healthcare facilities and specialists, financial constraints, and cultural beliefs that delay seeking medical care. Additionally, patients in rural areas often face logistical challenges such as transportation issues and a lack of local support systems. The review also highlights the role of social networks, community stigma, and healthcare provider attitudes in shaping help-seeking behavior. The authors suggest that targeted interventions, such as improving healthcare infrastructure, increasing public awareness, and promoting culturally sensitive healthcare, are essential to overcoming these challenges. They advocate for further research to develop comprehensive strategies to enhance access to cancer care in rural communities and reduce health disparities.

Anisah J Husman and Elizabeth O Akin-Odanye (2021) conducted a study *on "Impact of stigma and stigma focused intervention on screening and treatment outcome in cancer patients"* exploring systematically reviews cancer-related stigma across various populations, highlighting its negative impact on psychosocial well-being and treatment outcomes. Stigma was prevalent not only among the general public but also among elites and healthcare providers, with higher rates reported in developing countries. The experience of stigma varied by cancer type, and cancer was widely associated with imminent death, leading many patients to conceal their diagnosis and delay seeking medical care. While stigma often resulted in negative psychological effects, some patients reported posttraumatic growth. However, research on effective stigma-reduction interventions remains limited. The study underscores the urgent need for targeted strategies to address cancer stigma in both clinical and public domains. Public awareness campaigns should be designed carefully to educate communities without reinforcing negative perceptions. Increasing understanding and acceptance of cancer patients can improve early diagnosis, treatment adherence, and overall quality of life for those affected.

Linda M Pak et al. (2021) conducted a study *on "Cancer awareness and stigma in rural assam India: baseline survey of the detect early and save desh program"* it explore the crucial knowledge gaps between the people and sociocultural barriers affecting cancer screening in rural Assam, India. Awareness of the carcinogenic effects of betel nut was low (47%), and only one-third recognized key oral cancer symptoms. Misconceptions about cancer causes were present in 10% of respondents, while 42-57% expressed negative stigma regarding its impact on personal and professional life. These findings underscore the need for targeted education initiatives to correct misconceptions, reduce stigma, and promote screening participation. Addressing these barriers is essential for the effective implementation of early detection programs, ultimately improving cancer outcomes in India. The study provides critical insights for healthcare policymakers to develop culturally sensitive interventions that enhance cancer awareness and acceptance of screening services. Develop culturally sensitive interventions that enhance cancer awareness and acceptance of screening services.

Safi S et al. (2021) in the article "*Assessing knowledge and perceptions about cancer among American Indians of the Zuni Pueblo*." explores cancer knowledge and perceptions among the Zuni Pueblo, a Native American community in New Mexico. The research highlights the lower cancer screening rates and later-stage cancer diagnoses in American Indians, which are compounded by a cultural stigma surrounding cancer. The stigma, often linked to death, inhibits open discussions about the disease, contributing to limited knowledge about its causes, diagnosis, and treatment. Using focus groups, the researchers uncovered community members' general lack of cancer awareness and their emotional challenges when faced with the disease. Participants identified lifestyle choices, environmental exposures, and heredity as primary risk factors for cancer but viewed the disease as largely unpredictable. The study calls for culturally relevant educational materials and interventions to address knowledge gaps and reduce stigma. These findings emphasize the need for culturally tailored approaches to improve cancer screening rates and reduce health disparities in American Indian communities.

.**Squiers et al. (2021)** in the article *"Perceived, experienced, and internalized cancer stigma: Perspectives of cancer patients and caregivers in India*." explored cancer stigma in India by examining the perceptions, experiences, and internalized stigma of cancer patients and their caregivers. Using qualitative interviews, the study uncovered various dimensions of stigma, including how individuals with cancer and their families feel socially isolated, discriminated against, and often avoid disclosing their diagnosis due to fear of judgment. The research identified that cancer stigma was not only perceived but also internalized by patients and caregivers, leading to feelings of shame and guilt. Factors contributing to this stigma included cultural beliefs, misconceptions about cancer, and the association of cancer with death. Participants also discussed the psychological toll of stigma, which affected their emotional well-being and ability to seek timely treatment. The study calls for the development of anti-stigma campaigns and supportive interventions to reduce the social and emotional burden of cancer stigma in India. It emphasizes the need for culturally sensitive approaches to enhance cancer awareness and reduce the negative impacts of stigma on patient care and support.

Grigolon L., & Lasio L. (2020) in the article *"Stigma as a Barrier to Treatment and Adoption of Innovation*." explored the role of stigma as a barrier to both treatment and the adoption of innovative healthcare practices, particularly in the context of marginalized populations. The study examines how stigma can negatively influence individuals' willingness to seek treatment and embrace new medical technologies or interventions. The authors argue that stigma, often linked to social, cultural, or psychological factors, exacerbates healthcare disparities by fostering feelings of shame, fear, and rejection. This stigma can lead to delayed treatment, non-adherence to prescribed care, and resistance to adopting innovations in medical practices or technologies. The study further discusses the implications of stigma for healthcare providers and public health campaigns, suggesting that addressing stigma through education, community engagement, and the development of supportive healthcare environments is essential to improving health outcomes and promoting the acceptance of innovative treatments. Grigolon and Lasio emphasize the need for strategies that reduce stigma and create inclusive, stigma-free spaces that foster trust and encourage individuals to seek timely care and adopt new healthcare solutions.

Gifford et al. (2019) in the article **"***Providing culturally safe cancer survivorship care with Indigenous communities"* explores a study protocol aimed at developing culturally safe cancer survivorship care for Indigenous communities. The study uses an integrated knowledge translation approach to collaborate with Indigenous communities to ensure the development and delivery of survivorship care that is culturally relevant and respectful. Recognizing the unique needs and challenges faced by Indigenous cancer survivors, the researchers emphasize the importance of addressing both the medical and cultural aspects of care. The protocol outlines a process of co-design with community partners to ensure that the care model incorporates Indigenous perspectives, values, and traditional practices alongside conventional healthcare strategies. The study also seeks to engage healthcare providers in cultural safety training to enhance their ability to deliver effective care to Indigenous patients. The authors argue that providing culturally safe survivorship care is essential to improving health outcomes and promoting well-being among Indigenous cancer survivors. This study protocol provides a framework for creating a more inclusive and responsive healthcare system that can better meet the needs of Indigenous communities.

Vrinten, C et al (2019) in the article *"Cancer stigma and cancer screening attendance: a population based survey in England"* explores the relationship between cancer stigma and screening attendance in England's general population. Conducted through home-based interviews with 1,916 adults aged 18–70, the research utilized the validated Cancer Stigma Scale (CASS) to assess six dimensions of stigma: Severity, Personal Responsibility, Awkwardness, Avoidance, Policy Opposition, and Financial Discrimination. Findings revealed that while overall stigma levels were low, certain aspects particularly perceptions of cancer's severity were more pronounced. Notably, higher stigma scores correlated with lower participation in recommended screenings for cervical, breast, and colorectal cancers. Demographically, men and individuals from ethnic minority backgrounds exhibited higher stigma levels. The study underscores the importance of addressing specific stigma components to enhance screening uptake, suggesting that targeted interventions could mitigate barriers and promote early cancer detection.

Oystacher T et al. (2018) article "*Understanding stigma as a barrier to accessing cancer treatment in South Africa."* explores the significant burden of cancer in Africa, noting that approximately 700,000 new cases are diagnosed annually, with South Africa facing specific challenges due to stigma and limited awareness, which lead to delayed diagnoses and treatment. The authors explore how cultural beliefs contribute to cancer stigma, with views that cancer is a fatal disease or a punishment for immoral behavior, noting that stigma around cancer is less studied compared to diseases like HIV/AIDS. Applying Link and Phelan's Modified Labeling Theory, the authors examine how stigma manifests through visible symptoms, diagnosis by traditional healers, and formal diagnosis by physicians. Anticipated discrimination resulting from these labels often leads to secrecy and avoidance of treatment. The role of traditional healers is emphasized as crucial, with partnerships between traditional and biomedical practitioners suggested to improve access and reduce stigma. The study also highlights how previous health campaigns on

HIV/AIDS have shaped public perceptions of cancer, complicating stigma reduction efforts. The paper calls for culturally sensitive interventions to address these issues.

Kabalimu T. K. et al (2018) in the article "*Social and cultural factors affecting treatment seeking behavior of patients with cancer of the cervix at Ocean Road Cancer Institute in Dar es Salaam, Tanzania."* explores the social and cultural factors influencing treatment-seeking behaviors among patients with cervical cancer at the Ocean Road Cancer Institute in Dar es Salaam, Tanzania. The authors identify several key factors that delay or prevent individuals from seeking timely cancer treatment, including cultural beliefs, stigma, and traditional healing practices. Cultural perceptions of cancer as a fatal or taboo disease contribute to fear and denial, leading many patients to delay seeking medical care. Additionally, gender roles and social norms may discourage women from accessing healthcare or disclosing their symptoms. The study also highlights the role of family members, community influences, and financial constraints in shaping treatment decisions. Traditional healers are often the first point of contact, with some patients opting for traditional remedies instead of medical treatment. The authors recommend culturally sensitive interventions that address these social and cultural barriers, raise awareness about cervical cancer, and encourage early detection and treatment. Engaging community leaders and integrating traditional healing practices with formal healthcare could improve treatment-seeking behaviors in the region.

Nyblade L. et al (2017) in the article "A *qualitative exploration of cervical and breast cancer stigma in Karnataka, India*." explores the stigma related to cervical and breast cancer mainly based in Karnataka, India, and its impact on healthcare-seeking behaviors. The authors explore how cultural beliefs, social norms, and misconceptions contribute to the stigma associated with these cancers. The findings reveal that cancer is often viewed as a fatal and shameful disease, leading individuals to avoid diagnosis and treatment due to fear of discrimination and social isolation. Gender roles, particularly the perception of women as caregivers rather than patients, also influence attitudes toward cancer and its treatment. The study highlights the ways in which this stigma is compounded by the association of cervical and breast cancers with sexual activity and body image, leading to feelings of guilt and embarrassment among patients. The authors advocate for the development of culturally sensitive health communication strategies that address these stigmas, increase awareness about early detection, and encourage women to seek medical care without fear of judgment. Community engagement and support systems are also identified as critical components in reducing stigma and improving access to cancer care.

Page B. (2015) in the article **"***Lung cancer in rural and remote Aboriginal and Torres Strait Islander communities in Queensland: Awareness and identifying health needs in a cultural context*." Explores about the lung cancer awareness and the health needs for the indegenous and Torres Strait Islander communities in rural and remote areas of Queensland, Australia. The author investigates how cultural factors, healthcare access, and community awareness influence the diagnosis, treatment, and prevention of lung cancer in these communities. Key challenges identified include limited awareness of lung cancer symptoms, cultural barriers to seeking healthcare, and a lack of culturally appropriate health education. The study also highlights the impact of social determinants such as geographic isolation, economic hardship, and the historical mistrust of the healthcare system, which further complicates access to timely medical care. The author calls for targeted public health interventions that incorporate Indigenous cultural perspectives and emphasize community engagement to improve awareness and care. The study stresses the importance of developing culturally relevant strategies for lung cancer prevention, early detection, and treatment to address disparities in health outcomes within these communities.

Fujisawa, D., & Hagiwara, N. (2015) in the article *"Cancer Stigma and its Health Consequences"* explores how stigma negatively influences cancer-related health outcomes across the care continuum. It emphasizes that stigma manifests in various forms perceived, experienced, and internalized resulting in social isolation, emotional distress, and delayed medical help-seeking. Stigmatized individuals often avoid screening, conceal their illness, and experience reduced quality of life due to shame and fear of discrimination. The literature also shows how cultural beliefs and misconceptions intensify stigma, particularly in low-resource or marginalized communities. These consequences extend beyond the patient, affecting caregivers and community attitudes as well. Importantly, the review points out that cancer stigma can exacerbate existing health disparities by creating barriers to early detection and adherence to treatment. The study advocates for integrating stigma-reduction strategies into public health and clinical interventions. Overall, it underscores the urgent need for culturally sensitive awareness efforts to mitigate stigma's harmful effects on cancer care.

Gupta A et al (2015) in the article *"Development of a Scale to Assess Cancer Stigma in the Non-Patient Population"* explores a significant advancement in understanding how stigma operates beyond patients to the general public. The researchers designed and validated a multi-dimensional scale that measures public attitudes toward individuals with cancer, focusing on dimensions such as social avoidance, personal responsibility, awkwardness, and perceived severity. Through psychometric testing, the scale demonstrated strong reliability and validity, offering a useful tool for public health researchers and educators. The findings reveal that even among those not directly affected by cancer, stigmatizing beliefs such as associating cancer with death or personal fault are prevalent. The scale can be instrumental in identifying areas for targeted awareness campaigns and stigma-reduction interventions. Overall, the study fills a methodological gap by providing a standardized measure to quantify cancer stigma in broader populations, which is critical for designing inclusive and effective health education strategies.

Itty T. L et al (2014) in the article “*Shared and unshared barriers to cancer symptom management among urban and rural American Indians*.” investigates the barriers to cancer symptom management faced by the American Indians residing in both rural and urban areas. The authors identify both shared and unique challenges experienced by these populations in managing cancer symptoms, emphasizing the differences between urban and rural settings. Shared barriers include limited access to healthcare services, cultural beliefs that influence healthcare-seeking behaviors, and financial constraints. Rural residents, however, face additional challenges such as geographic isolation, fewer healthcare facilities, and a reliance on traditional medicine, which can delay seeking formal medical care. Urban American Indians also experience difficulties, though they may have more access to healthcare services, including the challenge of navigating complex healthcare systems. The study highlights the need for tailored interventions that address both shared and unique barriers in these different settings. The authors recommend that healthcare strategies be culturally sensitive and incorporate both traditional and modern healthcare approaches to improve symptom management and overall care for American Indian cancer patients.

Marlow, L. A., & Wardle, J. (2014) in the article *"Development of a Scale to Assess Cancer Stigma in the Non-Patient Population"* explores the important advancement in understanding the way stigma operates beyond the patients to the general public. The researchers designed and validated a multi-dimensional scale that measures public attitudes toward individuals with cancer, focusing on dimensions such as social avoidance, personal responsibility, awkwardness, and perceived severity. Through psychometric testing, the scale demonstrated strong reliability and validity, offering a useful tool for public health researchers and educators. The findings reveal that even among those not directly affected by cancer, stigmatizing beliefs such as associating cancer with death or personal fault are prevalent. The scale can be instrumental in identifying areas for targeted awareness campaigns and stigma-reduction interventions.

Overall, the study fills a methodological gap by providing a standardized measure to quantify cancer stigma in broader populations, which is critical for designing inclusive and effective health education strategies.

Daley C.M. et al. (2011) in the article **"***American Indian community leader and provider views of needs and barriers to colorectal cancer screening*." explores the views of American Indian community leaders and healthcare providers or workers regarding their needs and barriers to mainly colorectal cancer screening in American Indian populations. The authors identify key barriers that hinder colorectal cancer screening, including cultural beliefs, mistrust of the healthcare system, and limited access to healthcare services, particularly in rural areas. Community leaders and providers emphasized the importance of culturally tailored interventions to increase awareness and encourage participation in screening programs. They also highlighted the need for better communication between healthcare providers and American Indian communities to address misconceptions and provide culturally relevant information. Furthermore, logistical issues such as transportation, lack of healthcare facilities, and financial constraints were also noted as significant barriers. The study suggests that overcoming these barriers requires community-based, culturally sensitive strategies, including the involvement of trusted community leaders and healthcare providers, to enhance colorectal cancer screening rates and reduce health disparities among American Indians.

Schiller. et al. (2009) conducted a study on *"Perceived stigma, self-blame, and adjustment among lung, breast, and prostate cancer patients"* examines the impact of stigma and self-blame on psychological adjustment in cancer patients using self observation and helplessness models. The study involved lung, breast, and prostate cancer patients, with a focus on how perceived stigma influences self-blame and mental well-being. Findings supported the looking-glass self model, showing that perceived stigma and self-blame were linked to poorer psychological adjustment. The study also confirmed the learned helplessness model, demonstrating that self-blame mediated the relationship between stigma and psychological distress. This mediation effect was more pronounced in lung cancer patients than in those with breast or prostate cancer. Furthermore, lung cancer patients were more likely to attribute their illness to internal causes, which correlated with worse psychological outcomes. These results highlight the need for tailored psychological interventions in cancer care, particularly for lung cancer patients, who experience higher levels of stigma and self-blame. The study suggests that addressing these psychological factors could improve emotional well-being and overall adjustment to illness. Future research should explore ways to reduce stigma in cancer care and develop support systems that minimize self-blame, fostering better psychological outcomes for patients.

Shahid et al. (2009) in the article *"Understanding, beliefs and perspectives of Aboriginal people in Western Australia about cancer and its impact on access to cancer services*." explores the beliefs and perspectives of Aboriginal people in Western Australia regarding cancer and how these perceptions affect their access to cancer services. The study highlights that cancer is often seen through a cultural lens that includes fear, mistrust, and misconceptions, which contribute to delayed diagnosis and treatment. Aboriginal participants expressed a lack of awareness about cancer and its treatment, with many linking cancer to death and considering it a taboo subject. The study identified that these cultural beliefs, combined with logistical barriers such as geographic isolation, financial constraints, and limited access to healthcare, created significant challenges in seeking timely cancer care. Furthermore, a general mistrust of the healthcare system, stemming from historical and ongoing experiences of marginalization, was found to exacerbate the reluctance to engage with cancer services. The study advocates for culturally appropriate interventions that address both the social and cultural barriers to cancer care, emphasizing the importance of community-based education, trust-building, and the inclusion of Aboriginal cultural practices in cancer care services. These efforts are crucial to improving access to and utilization of cancer services in Aboriginal communities.

Shahid S. et al (2009) in the article **"***Understanding, beliefs, and perspectives of Aboriginal people in Western Australia about cancer and its impact on access to cancer services."* It explores the understanding, beliefs, and perspectives of Aboriginal people in Western Australia regarding cancer and its impact on accessing cancer services. The authors identify significant cultural, social, and systemic barriers that influence Aboriginal people's willingness and ability to seek cancer care. These include a lack of awareness about cancer symptoms, culturally inappropriate healthcare services, and historical mistrust of the medical system. Additionally, the study reveals that cancer is often perceived through a fatalistic lens, with many Aboriginal people associating it with death and thus delaying seeking treatment. Social determinants such as geographic isolation, poverty, and limited access to healthcare services further exacerbate these barriers. The authors suggest that culturally sensitive healthcare interventions, which incorporate Aboriginal values, beliefs, and community networks, are essential for improving access to cancer services. Engaging Aboriginal leaders and community-based health workers in cancer awareness campaigns and health service delivery is recommended to reduce health disparities and promote earlier diagnosis and treatment.

Chapple. et. al (2004) in their article *"Stigma, shame, and blame experienced by patients with lung cancer"* explore the stigma experiences by patients suffering from lung cancer, particularly due to the strong association among the smoker. Regardless of their smoking history, patients often felt judged, which influenced their interactions with family, friends, and healthcare providers. Many, especially non-smokers or those who had quit years ago, felt unfairly blamed for their illness. Some attributed the real responsibility to tobacco companies, criticizing their unethical practices. The stigma led some patients to hide their condition, which had negative financial and emotional consequences. Media portrayals, particularly anti-smoking advertisements, were also seen as contributors to stigma by reinforcing fear and blame rather than support. Patients expressed concerns that this stigma might affect their diagnosis, access to treatment, and even research efforts related to lung cancer. The article concludes that while smoking cessation campaigns are essential, they should be carefully designed to avoid further stigmatizing those already suffering. Clinical and educational strategies must balance awareness with empathy to ensure that lung cancer patients receive the support and care they need without feeling blamed for their illness. The article effectively highlights the deep psychological and social impact of stigma on lung cancer patients, calling for a more compassionate public health approach.

Chapter III

Research Methodology

Research Methodology

Research methodology refers to the systematic process and techniques used by researchers to conduct a study or investigation. It serves as a roadmap for researchers, guiding them through the process of designing, conducting, and interpreting their studies in a rigorous and systematic manner. In this study, the researcher will use the qualitative method for the collection of data.

A researcher would choose a qualitative method to study cancer stigma in Disama village of Karbi Anglong because it allows for a deeper understanding of people's personal experiences, beliefs, and emotions. In a remote and underdeveloped area like Disama, where cultural values, traditions, and limited health awareness strongly influence how cancer is perceived, qualitative research can capture the voices and stories of those directly affected. Through interviews, focus group discussions, and observations, the researcher can explore how stigma develops, how it impacts individuals and families, and how the community responds to cancer cases. This method is ideal for uncovering sensitive issues, such as fear, shame, or discrimination, which may not be fully understood through numbers alone. By listening closely to the lived experiences of villagers, the researcher can gain meaningful insights that can guide culturally appropriate interventions, education programs, and support systems to reduce stigma and improve cancer care in the community.

3.1 Theoretical Framework

A theoretical framework is a foundation of ideas, concepts, and theories used to understand a research problem or phenomenon. It provides a roadmap for organizing research questions, designing methods, and interpreting findings. In essence, it helps researchers connect their work to existing knowledge and provide a structured way to approach a research area. The researcher chose Goffman’s Stigma Theory (1963) and Health Belief Model (1974) as it is the only theory that aligned with the topic of research conducted in the Disama village of East karbi Anglong.

1. Goffman’s Stigma Theory (1963) Erving Goffman's stigma theory, introduced in his 1963 book *"Stigma: Notes on the Management of Spoiled Identity,"* explores how society labels and treats individuals who deviate from accepted norms. According to Goffman, stigma is an discrediting attribute that reduces someone from a whole and a normal person to a tainted. He identifies three types of stigma: physical deformities, individual character flaws (such as addiction or mental illness), and “tribal” stigma related to race, religion, or nationality. Goffman emphasizes the impact of social interactions on identity. When people are stigmatized, they often experience shame, isolation, and discrimination, which can affect their mental and emotional well-being. In the context of illness like cancer, especially in traditional or less-informed communities, stigma may arise from fear, misconceptions, or cultural beliefs. Goffman’s theory helps explain how stigma functions socially and psychologically, and why it is important to address it through awareness and empathy.. In the context of cancer, tribal communities may view the disease as a curse, punishment, or result of past actions, leading to social exclusion and discrimination.
2. Health Belief Model (HBM) (Rosenstock, 1974) The Health Belief Model (HBM) is a psychological framework used to understand why people make certain health choices, particularly in preventing or managing illnesses like cancer. It suggests

that individuals are more likely to take health-related action if they believe they are at risk understand the seriousness of the condition believe the action will reduce the risk and feel that the barriers to taking action are manageable The model also includes cues to action like reminders, symptoms, or advice and self-efficacy, or the confidence in one's ability to take the action. This model helps explain why individuals in tribal communities might avoid cancer screening and treatment due to perceived severity, barriers and low perceived benefits of medical intervention.

3.2 Research Design

The researcher will conduct the study by using qualitative research methods. The research design will be descriptive. A researcher would use qualitative and descriptive research design in cancer stigma research to gain an in-depth understanding of the complex social, emotional, and cultural factors influencing stigma in a community like Disama village. Qualitative research **is** particularly effective for exploring sensitive issues like cancer stigma because it allows participants to express their experiences, feelings, and perceptions in their own words. Through interviews, focus groups, or observations, the researcher can uncover nuanced insights into how individuals perceive cancer, the associated fears, and the social reactions they face. This approach helps capture the underlying psychological and cultural aspects of stigma, which are often difficult to quantify.

3.3 Universe of the study

The study focuses on Disama village of East Karbi Anglong, the study will focus mainly on the adult residing in the area for interviews, as the location is far away from the town area and lacks development which made it as a favourable place for research related to cancer stigmas.

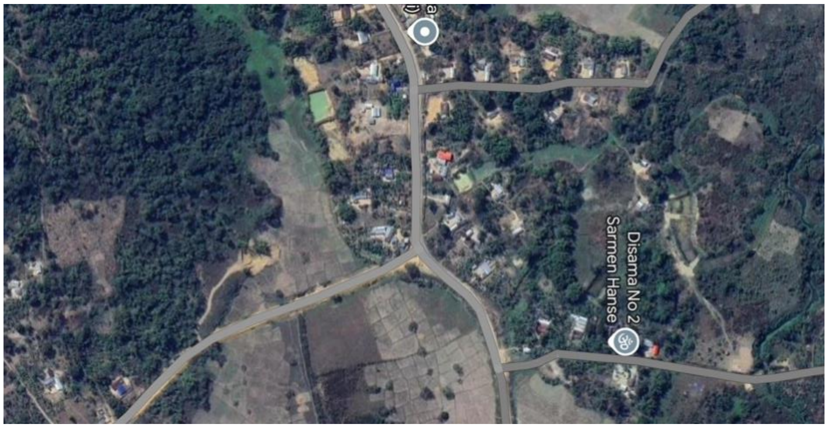

Fig: Disama Village (Source: Google map)

https://maps.app.goo.gl/wt7Q7qXtLHpw7zU58

3.4 Sampling Techniques

Non probability sampling: Non-probability sampling refers to a sampling technique where not every individuals among the population have a chance of being selected equally . This method relies on the researcher's judgment or convenience rather than random selection.

Purposive sampling: Purposive sampling is a non-probability sampling technique where the researcher selects participants based on specific characteristics or qualities that are relevant to the study. In this method, individuals are chosen deliberately because they possess particular knowledge, experiences, or viewpoints that are critical to the research focus. Purposive sampling is ideal because the researcher needs to focus on individuals who are directly affected by cancer or have significant insight into the social attitudes and stigma surrounding the disease. Due to the prevalent stigma and cultural disbelief cultural disbeliefs play a significant role in shaping how cancer is perceived among the tribal population. Many community members associate cancer with curses, divine punishment, or black magic rather than biological causes. These beliefs fuel fear, shame, and secrecy, preventing open discussion and early diagnosis. The stigma is so pervasive that families often hide the illness to avoid social exclusion and protect their reputation within the community.

3.5 Sampling size

Using Simple random sampling 15 participants will be selected from the larger population to ensure fair representation. The respondents may include both gender male and female resident to the Disama village. The researcher opted only fifteen participants due to time constraint as the research is to be done in a specific time period. Also through the sampling techniques the information required can be easily achieved for the research.

3.6 Method of data collection

The researcher will use unstructured interview as a tool for data collection and observation and active listening technique. The researcher used unstructured interviews schedule for gathering basic information **,** observation, and active listening in cancer stigma research to gain a deeper insights, and understanding of the topic. This open-ended approach helps uncover hidden aspects of stigma that might not be revealed through structured formats. Observation provides valuable context, allowing the researcher to see firsthand how stigma manifests in daily life, including non-verbal cues and social dynamics. It captures the real-world impact of stigma on behaviours such as social interactions, healthcare-seeking, or isolation. Active listening enhances the interview process by building trust and creating a supportive environment, which is crucial when discussing sensitive issues. It also helps the researcher pick up on emotional subtleties, allowing for a deeper understanding of the emotional and psychological toll of cancer stigma. Together, these methods offer rich insights into the social and emotional dimensions of stigma.

3.7 Tools for data analysis

The researcher organised and coded the interview data using QDA miner lite v3.0.5, qualitative data analysis software to make the procedure easier. The researcher use thematic analysis as it brings out the major themes that are being prominently discussed throughout the research topic, through thematic analysis method of qualitative data analysis it helps in identification and analyzing of report patterns, themes within a dataset.

3.8 Ethical consideration and consent

Informed Consent – Participants must fully understand the purpose of the study and voluntarily agree to participate.

Confidentiality – Personal information of the respondent shared should be kept private and not disclose without permission.

3.9 Limitations

Geographical Constraints – The study focuses on Disama area, limiting the generalizability of results to other areas.

Small Sample Size – With only 15 respondents, the findings may not fully represent the entire community residing in Disama village.

3.10 Inclusive and exclusive criteria

Inclusive criteria will include

1. Participants of adult age group of 18+
2. Individuals residing in Disama Village, East Karbi Anglong.
3. Both the genders and other identities
4. Willing participants who voluntarily agree to participate in the study.

Exclusive criteria will include

1. Individuals below 18years of age.
2. Non-resident of the chosen area.
3. Unwilling respondent.
4. Individuals who didn’t posses any knowledge on cancer or cancer stigma.

CHAPTER IV

Data Analysis and Interpretation

Data analysis and Interpretation

4.1 Cultural and Religious Beliefs Contributing to Stigma

4.1.1 Karma and Divine Punishment

In Disama village, cancer is often believed to be a result of past sins or divine retribution. Out of the I5 respondent all of the respondent talks about it. This belief frames cancer as morally deserved, reinforcing guilt and discouraging medical intervention. People associate illness with spiritual wrongdoing, making patients internalize stigma and avoid seeking help.In the community studied, cancer is often perceived as a result of past wrongdoings or karmic retribution. This belief holds that individuals are punished by divine forces for sins committed in their current or previous lives. Such views lead to internalized guilt and shame among patients and discourage them from seeking medical help. Instead, they may turn to spiritual rituals or traditional healers, delaying biomedical treatment. The moral framing of cancer also causes social exclusion, as people may believe the illness is deserved, reinforcing stigmatization within the family and community.

4.1.2 Black Magic and Spiritual Causality

Most of the respondent view cancer as caused by supernatural forces like black magic or evil spirits basically the older generation due to their believes from their period of time. This belief attributes the illness to spiritual imbalance or mystical attacks, leading families to seek traditional healers rather than biomedical care. The perception deepens emotional distress and delays treatment. Some respondents associate cancer with black magic or spiritual attacks from envious or malicious individuals. These beliefs suggest that the disease is caused by supernatural forces rather than biological factors. Cancer is seen as a weakening of the spirit, making patients vulnerable emotionally and physically. As a result, people often seek relief through rituals, spiritual healers, or exorcisms, rather than medical care. This reinforces stigma and fear, especially when the illness is viewed as a curse. These explanations provide a culturally familiar way to understand suffering but lead to harmful delays in diagnosis and treatment.

4.2 Social Isolation and Silence

4.2.1 Avoidance by Others

It was the most common response from the respondents, as Cancer patients often face social exclusion, as community members fear contagion or shame. This isolation leads to emotional suffering and makes recovery harder. People withdraw support, which discourages open discussion about the illness and contributes to loneliness. Patients with cancer frequently experience social distancing, as people fear catching the disease or being associated with it. The youth often sees or come across with such situation .Community members may avoid physical contact or even conversation, leaving the patient feeling abandoned. This avoidance stems from misconceptions and fear of contagion, as well as the stigma of illness being a moral or spiritual blemish. As a result, individuals may withdraw socially or become isolated, increasing their emotional and psychological burden. This lack of support severely affects their quality of life and mental health during an already vulnerable period.

4.2.2 Taboo and Family Secrecy

Families conceal cancer diagnoses to avoid social embarrassment and gossip. This secrecy stems from viewing cancer as a curse or disgrace, which prevents patients from receiving emotional or social support, and often leads to delayed treatment. Cancer is often treated as a taboo subject, discussed in soft tones or not mentioned at all. Families may hide a diagnosis out of fear of gossip, shame, or damage to their reputation. In some cases, even the patient may be kept in the dark about their own condition. This secrecy prevents open communication and timely care, and it isolates the patient emotionally. It also limits opportunities for receiving community support or accessing healthcare services. It mainly affects the younger generation of the family leaving them in state of despair due to such taboo. The silence reinforces stigma by making the illness appear shameful or unacceptable to acknowledge publicly.

4.3 Emotional and Psychological Burden

4.3.1 Depression and Hopelessness

Most of the respondents major emotional burden were seem to be the depression and hopelessness of being getting cured. The stigma and chronic nature of cancer create profound psychological distress. Patients often feel hopeless about survival, particularly when shunned by others. The illness becomes emotionally debilitating, contributing to depressive symptoms and suicidal thoughts in some cases. The stigma surrounding cancer often leads to severe emotional suffering, with many patients reporting feelings of depression and hopelessness. The belief that cancer equals a death sentence or divine punishment deepens despair. When patients are socially isolated or blamed, they internalize negativity and lose the will to fight or seek help. The absence of emotional support and the fear of being judged create a sense of worthlessness and inevitability. This psychological burden significantly affects their ability to cope with the illness, reducing treatment compliance and increasing mental health issues.

4.3.2 Guilt and Shame

Over the time the respondent portrayed the Patients internalize blame for their illness due to community perceptions and moral judgments. This self-blame intensifies emotional pain, resulting in shame and the belief that they brought the illness upon themselves, which further prevents them from seeking help. Many patients feel intense guilt, believing that their illness is a result of personal failure or wrongdoing. Cultural beliefs about karma, black magic, or lifestyle habits like tobacco use further intensify these feelings. Shame prevents patients from disclosing their condition or seeking emotional support, leaving them to suffer in silence. This self-blame is especially strong when families or communities reinforce the idea that cancer is deserved. Guilt also arises from the burden patients place on their loved ones, contributing to a deteriorating mental state and discouraging open conversations about their needs or fears. Where one of the respondent quoted "*cancer brings shame in the community even though the reason for its cause is completely different.*"

4.4 Barriers to Early Detection and Treatment

4.4.1 Fear of Judgment

Fear of being judged or stigmatized deters individuals from cancer screening or sharing symptoms. This silence leads to late diagnoses and worsens outcomes. Many prefer to keep symptoms private rather than face social scrutiny. Cancer is viewed as a shameful illness, and people worry about being labeled or blamed. This fear is especially strong in tight-knit communities where gossip spreads quickly. As a result, symptoms are ignored or hidden until the disease progresses to an advanced stage. The stigma delays not only diagnosis but also treatment, reducing survival chances and increasing the emotional burden on the patient and family.

4.4.2 Gender-Related Shame

Out of the I5 respondent 5 respondent were women where they put out how women perceived cancer, in particular, by avoid seeking medical attention for reproductive or breast issues due to modesty norms. Cultural discomfort with body-related discussions prevents early detection, reinforcing stigma and shame. Cultural norms around modesty and purity make it difficult for them to seek screening or even discuss symptoms. There is often embarrassment about being examined by male doctors, and fear of being seen as "impure" or unworthy of marriage. This shame leads to late diagnosis and limited treatment options, disproportionately affecting women's health outcomes and deepening gender-based stigma around cancer. Where few women quoted "*why we women are always being blamed or seen as impure when undergoes such kind of cancer".*

4.5 Socioeconomic and Structural Barriers

4.5.1 Poverty and Transport Difficulties

Most of the respondent out of I5 responded financial limitations as one of the barriers that prevent patients from accessing cancer treatment. The cost of travel, medication, and consultations is often unaffordable. Lack of transportation or nearby health centers worsens this barrier. Limited financial resources prevent many families from seeking timely medical care. The costs of transportation, diagnosis, and treatment are often beyond reach, especially in rural areas with poor infrastructure. Patients may miss appointments or forego care entirely due to lack of funds. These economic constraints are compounded by the need to prioritize daily survival over long-term health, especially in households with multiple dependents. As a result, poverty not only delays treatment but also magnifies feelings of helplessness and abandonment.

4.5.2 Healthcare Inaccessibility

Remote locations, inadequate infrastructure, and understaffed facilities restrict access to timely care. Delays in diagnosis and treatment due to these barriers contribute to poor survival outcomes and increase suffering. In many rural or underdeveloped areas, healthcare facilities are scarce or located far away. Even when they are accessible, long wait times, language barriers, and lack of trust in the system discourage patients from seeking help. Health workers are portrayed as being insensitive to the emotional needs of cancer patients, further discouraging follow-up care. This lack of access leads patients to rely on traditional or spiritual healers, reinforcing the cycle of delayed treatment and increased stigma.

4.6 Stigmatic Impact on Caregivers

4.6.1 Emotional and Physical Strain

Out of all the respondent I3 of them talked about the Caregivers difficulties both physically and mentally cause often family members, experience burnout, stress, and anxiety while looking after cancer patients. Emotional support is scarce, and the burden impacts their well-being and ability to provide long-term care. Caregivers, often immediate family members, face overwhelming emotional and physical demands while supporting cancer patients. The burden includes managing the patient’s needs, dealing with community stigma, and suppressing their own feelings. Many experience burnout, sleep deprivation, and psychological distress. Without adequate support, caregivers are left to shoulder intense responsibilities alone. Their role often goes unrecognized, making them feel invisible and emotionally drained. The situation worsens when they are also stigmatized for being close to the patient, which isolates them further and reduces their capacity to provide care effectively.

4.6.2 Financial Burden

Caring for a patient often leads to job loss or income disruption. Families spend significant resources on treatment, sometimes selling assets or going into debt, leading to long-term financial strain. Treating cancer often requires a significant amount of money, pushing families into debt or forcing them to sell assets. Caregivers may need to quit their jobs or reduce work hours to provide full-time care, leading to loss of income. The dual pressure of medical expenses and lost wages results in immense financial strain. This burden is compounded by additional costs such as transportation, food, and traditional remedies. The economic pressure can also lead to tension within the family, conflict over care responsibilities, or even neglect of the patient due to resource exhaustion. Most of the financial burden occurs due to the contagious stigmatic belief which leaves the caregiver or bread earner of the family with distress and unable to occupy any kind of job or works.

4.7 Stigma in the Workplace

4.7.1 Discrimination and Job Loss

I3 of the respondent responded on Patients fear in workplace due to discrimination or fear of losing their jobs if their diagnosis becomes known. This leads to secrecy and reduces access to employee benefits or medical leave, worsening their condition. Cancer patients often fear discrimination or job termination if their diagnosis becomes known at work. Some employers perceive them as unfit or unreliable, regardless of their ability to perform. In certain cases, people have reported being demoted, excluded from opportunities, or outright dismissed. This discrimination discourages people from disclosing their illness or seeking necessary medical leave. It fosters a hostile work environment where cancer is seen as a liability, not a health issue. The fear of income loss and career setbacks compounds the stress of the illness itself.

4.7.2 Concealment of Illness

To avoid professional repercussions, many hide their illness from employers and colleagues. This secrecy prevents them from accessing workplace support and may lead to treatment interruptions. Due to fear of workplace discrimination, many individuals choose to hide their cancer diagnosis. This concealment may delay treatment, as people avoid taking time off or refuse visible therapies like chemotherapy. Concealment also leads to emotional suppression, as patients cannot talk openly about their needs or struggles with colleagues. The act of hiding illness creates additional stress and isolation, weakening the support system that could otherwise be found in the workplace. This silence reinforces broader societal stigma and prevents collective awareness or advocacy for patients' rights at work.

4.8 Gendered Dimensions of Stigma

4.8.1 Seen as Impure or Unfit for Marriage

About I0 respondent among the I5 responded that Women with cancer are viewed as unclean or unmarriageable, especially if they undergo surgery like mastectomy. Families worry about daughters' prospects, reinforcing stigma and silence.In some communities, women with cancer especially breast or reproductive cancers are seen as impure or physically damaged. This perception severely affects their marriage prospects and social standing basically girls in their age of getting married. Unmarried women may be considered undesirable, while married women might face neglect or even abandonment by their spouses. The belief that a woman's body must remain "whole" and "clean" to be worthy of marriage reinforces harmful gender norms. These stigmatizing ideas marginalize women, increase their emotional suffering, and discourage them from seeking timely diagnosis and treatment.

4.8.2 Internalized Self-Blame

Women often blame themselves for their illness due to societal expectations around purity, behavior, and care giving roles. This deepens emotional suffering and deters them from seeking care. This internalized stigma is heightened by societal silence around women's health and modesty norms that prevent open discussion. Women may feel ashamed of how cancer affects their bodies, especially after surgeries like mastectomy, leading to lowered self-esteem and isolation. This self-blame can delay care-seeking, reduce participation in support networks, and increase depression. The emotional toll is particularly high when these women are also caretakers for others in the family.

4.9 Interruption of Education and Youth Burden

4.9.1 Youth as Caregivers

Among the I5 respondent 6 of the responded that the youth or the Young family members especially girls become caregivers, sacrificing their own needs. The stress affects their mental health and future opportunities. In families affected by cancer, young people especially girls often take on care giving roles due to the absence of adult support. These youth caregivers manage household tasks, provide emotional and physical care to the patient, and sometimes even assist in medical decisions. Their involvement comes at the cost of their own well-being and development. They experience emotional stress, social isolation, and academic disruption. Their childhood is shortened as they take on adult responsibilities prematurely. The care giving burden impacts their mental health and limits their future opportunities for education and personal growth. The respondent even quoted "whenever there's a cancer patient in a household the young caregiver had to go through a lot of things at a very tender age, their life seems snatched away from them."

4.9.2 School Dropouts

Many children leave school to support or care for ill relatives. This disrupts their education, perpetuates poverty, and limits their long-term prospects. Due to financial hardship or care giving responsibilities, many young individuals particularly girls are forced to leave school when a family member is diagnosed with cancer. Education is reprioritized as families focus on treatment costs and care giving. Some drop out temporarily, while others never return, leading to long-term socioeconomic disadvantages. These youth may also face stigma at school if peers or teachers view cancer as shameful or contagious. The interruption of education not only limits personal development but also perpetuates cycles of poverty and inequality, especially for female students.

4.10 Role of Superstitions and Misinformation

4.10.1 Fear of Contagion

Most of the respondent responded how False beliefs of cancer being contagious leading to social distancing and fear. This fuels isolation and stigma, preventing proper support or care. A common myth in the community is that cancer is contagious. This misconception causes others to avoid touching, visiting, or sharing food with patients. Even family members may keep their distance, isolating the patient emotionally and physically. The fear of catching cancer spreads misinformation and reinforces the idea that patients are dangerous or impure. This leads to further stigma, delays in seeking care, and emotional trauma for the patient. The belief in contagion highlights the urgent need for public education on cancer's causes and transmission.

4.10.2 Eclipse Myths and Food Taboos

People avoid certain foods or blame celestial events like eclipses for causing cancer. These myths delay treatment and promote fear rather than understanding. Some believe that cancer is caused or worsened by exposure to eclipses or eating certain foods, such as sour fruits or spicy dishes. These myths divert attention from scientific understanding and encourage avoidance of treatment. Patients may be advised by elders to follow specific food restrictions or stay indoors during celestial events, rather than consult a doctor. Such superstitions may comfort families with a cultural explanation for suffering, but they also increase fear, delay medical intervention, and contribute to misinformation that stigmatizes patients further. As one of the elderly respondent quoted " *as an old age person in my village it is believed that getting exposed during eclipse attracts evil spirit which result in causing various diseases."*

4.11 Blame and Moral Judgments

4.11.1 Lifestyle Blame (e.g., Tobacco Use)

9 of the respondent responded how Patients are blamed for behaviors like smoking, drinking, or diet, suggesting they "caused" their cancer. This prevents empathy and encourages judgment. Cancer patients, especially men, are often blamed for their illness due to behaviors like smoking, chewing tobacco, or drinking alcohol. Even when these behaviors may not be the cause, the assumption that patients brought the disease upon themselves reinforces moral judgment. This blame reduces community empathy and discourages others from seeking help out of fear of being judged. It also leads to shame and guilt in patients, which affects their mental well-being and willingness to disclose their diagnosis or pursue treatment openly.

4.11.2 Moral Failure Labeling

Cancer is linked to supposed immoral behaviors, reinforcing the idea that the patient is at fault. This view alienates patients and increases shame. Beyond lifestyle, cancer is sometimes seen as a punishment for perceived immoral behavior such as disobedience, or dishonesty further stigmatizing those diagnosed. Patients are labeled as morally weak or cursed, and this belief leads to social rejection and gossip. Even within families, such labeling can result in neglect or blame. This moral framing of illness discourages support and fosters an environment where people suffer in silence. It also deters others from acknowledging symptoms, fearing the same social condemnation.

4.12 Community Gossip and Judgment

4.12.1 Gossip and Speculation

I0 of the respondent responded about the Villagers gossip about cancer patients, which amplifies stigma and discourages openness. This fear of being talked about causes families to remain silent. When someone is diagnosed with cancer, rumors often spread throughout the community. People speculate about the causes of the illness, linking it to immoral actions, lifestyle choices, or curses. Gossip not only invades the patient's privacy but also amplifies the shame and emotional distress they experience. It leads to social withdrawal and discourages others from speaking openly about their health. Families may become cautious in their interactions, fearing damage to their social reputation. This environment of constant scrutiny makes it difficult for patients and their families to seek support or discuss their struggles publicly.

4.12.2 Damage to Family Reputation

A cancer diagnosis is seen as a social blemish, especially if the patient is a young woman. It affects marriage prospects and social standing. The stigma associated with cancer extends beyond the individual to affect the entire family. Families especially those with daughters worry that a cancer diagnosis will damage their social image and reduce marriage prospects for the children. In tightly knit communities, this reputational risk leads to concealment, silence, and restricted social interaction. Families may go to great lengths to hide the illness, even from close relatives. This fear of social judgment can delay diagnosis and treatment, ultimately harming the patient while creating long-term consequences for family unity and well-being.

4.13 Failure of Healthcare System Response

4.13.1 Lack of Empathy and Training

II of the respondent talks about how Health workers often lack cultural sensitivity and emotional training, leading patients to feel misunderstood or dismissed. Patients often report that healthcare providers show little emotional understanding or empathy during treatment. Doctors may rush consultations, dismiss patient concerns, or communicate insensitively, leaving individuals feeling unheard and dehumanized. This is especially damaging for patients already grappling with stigma and emotional distress. A lack of psychological support or proper explanation of the illness deepens confusion and fear. In some cases, healthcare workers may reflect the same cultural biases as the community, reinforcing stigma instead of addressing it. This gap in empathetic care discourages follow-up visits and reduces trust in the medical system.

4.13.2 Rushed or Judgmental Treatment

Patients report being judged or treated with indifference during hospital visits, making them reluctant to return for care. Many patients feel their healthcare experience is impersonal and judgmental. Medical professionals may scold patients for lifestyle choices or question their moral character, particularly when tobacco or alcohol use is involved. Such attitudes make patients reluctant to return for care or complete their treatment. The fast-paced nature of public hospitals often results in hurried interactions that leave no room for questions or emotional reassurance. This lack of patient-centered care, combined with a moralistic tone, contributes to distrust in the system and perpetuates feelings of shame and neglect.

4.14 Lack of Awareness and Health Education

4.14.1 No Screening Campaigns

Few outreach programs exist to inform people about cancer symptoms or screening, leading to widespread ignorance.12 respondent talks about the significant gap in cancer awareness at the community level. Many people have never encountered a cancer screening campaign or been educated about early detection. As a result, symptoms are ignored or misinterpreted until the disease reaches an advanced stage. This lack of public health outreach keeps cancer in the shadows, reinforcing stigma and fear. Without targeted awareness efforts especially in rural areas misconceptions persist, and people remain unaware of accessible treatments or preventive measures. The absence of organized education reinforces silence around cancer and delays timely care.

4.14.2 Symptom Misunderstanding

People misinterpret cancer symptoms or attribute them to minor issues, delaying timely care and worsening prognosis. Due to limited health literacy, many people do not recognize early symptoms of cancer or confuse them with minor, curable illnesses. Some may attribute weight loss, fatigue, or pain to non-serious causes or spiritual problems. Misunderstanding symptoms leads to delays in seeking medical help and reliance on home remedies or traditional healers. This confusion is worsened by the lack of accessible educational materials or trained community health workers. As a result, by the time individuals seek care, cancer is often in an advanced stage, reducing chances of recovery and reinforcing fatalistic attitudes.

4.15 Silencing Through Pity

4.15.1 Passive Sympathy

8 respondent out of I5 responded how Patients receive surface-level sympathy without meaningful action or emotional support. This passive response discourages honest conversations. Community members may say kind words or express sorrow but avoid deeper engagement or support. This type of pity reinforces the patient's status as someone to be mourned rather than helped, silencing their voice and discouraging advocacy. The focus remains on passive sadness rather than meaningful aid, such as offering time, money, or emotional reassurance. This dynamic makes patients feel invisible and unwanted, further alienating them from the community and weakening their social safety net.

4.15.2 Lack of Practical Help

Despite expressions of concern, few offer actual assistance like food, transport, or money, leaving families overwhelmed. Though many people may express concern or say they “feel bad” for the patient, few offer tangible support. Help with transportation, care giving, meals, or emotional support is often absent. This lack of practical aid leaves the patient and family overwhelmed and isolated. The emotional strain increases when the community fails to translate sympathy into action. In some cases, patients perceive such behavior protect the image of the sympathizer rather than truly help. This dynamic amplifies stigma and discourages the patient from seeking community assistance in the future.

4.16 Impact on Family Structure and Dynamics

4.16.1 Family Breakdown or Conflict

The emotional and financial strain of cancer often leads to divorce, abandonment, or family rifts. I0 respondent out of I5 responded that Cancer often places extreme stress on families, sometimes leading to marital discord, separation, or conflict between relatives. Financial burdens, emotional strain, and care giving pressures can overwhelm family members, resulting in blame and resentment. Some spouses or extended family may abandon the patient, unwilling or unable to cope with the responsibilities. This breakdown in family cohesion leaves the patient more vulnerable and isolated. It also affects children and dependents, who experience instability and emotional trauma. In cases of conflict, the patient may be blamed for causing division, compounding their psychological suffering.

4.16.2 Intra-Family Blame and Neglect

Blame within families especially toward the patient results in neglect, emotional abuse, or withdrawal of support. Blame is sometimes directed at the patient for causing misfortune or ruining future prospects such as financial security or marriage opportunities. This leads to emotional neglect or reduced care giving attention, especially when the patient is female or elderly. Caregivers may accuse patients of being a burden or express frustration openly, deepening the patient’s feelings of guilt and worthlessness. When blame dominates family dynamics, emotional support breaks down, and the home becomes another space of stigma rather than a refuge. This can push patients into silence, depression, or even self-isolation.

CHAPTER V

Findings and Discussion

Findings

This study explores the multifaceted nature of stigma associated with cancer in Dimasa village, uncovering deep-seated cultural, social, psychological, and structural factors. Through qualitative inquiry with 15 respondents, several interconnected themes emerged, revealing how stigma influences patients' lived experiences, their families, and the broader community response. The findings underscore how stigma is shaped by traditional beliefs, gender norms, misinformation, systemic neglect, and socio-economic vulnerability.

5.1.1 Demographic Overview of the Respondents

The study was conducted in Disama village, located in the remote and underdeveloped region of East Karbi Anglong, Assam**.** A total of 15 respondents participated in the research, selected through purposive sampling based on their experience, knowledge, attitudes toward the disease. The demographic profile of the participants include both male and female respondents. Participants belonged to the adult age group (18 years and above)**,** with the majority aged between 30 and 50 years. Most respondents were farmers, daily wage laborers, or homemakers**,** indicating a low-income and rural livelihood profile**.** A significant portion had limited formal education**,** with many having completed only primary or middle school, contributing to limited awareness about cancer and healthcare access. All respondents belonged to the tribal community residing in Disama village, with shared cultural beliefs, traditional health practices, and community dynamics that influenced their understanding and responses to cancer.

5.1.2 Cultural and Religious Beliefs as Catalysts for Stigma

A dominant theme across all interviews from which it was found that most of the respondent belief that cancer is a spiritual or moral consequence rather than a medical condition. Many respondents viewed cancer as a punishment for past sins, aligning with karmic ideologies and divine retribution. This belief was deeply ingrained and cut across age and gender. It led to shame, silence, and isolation, as patients were seen not just as sick but as morally flawed.

In parallel, beliefs in black magic and spiritual causality were also prevalent. Several participants reported that cancer could be caused by curses or the evil intentions of others. This supernatural framing shifted responsibility from biological causes to mystical forces, thus influencing health-seeking behaviours. Patients were often taken to spiritual healers or subjected to rituals instead of being referred for medical treatment. This reliance on non-medical interpretations delayed formal diagnosis and fuelled community fear and exclusion.

5.1.3 Social Isolation and Enforced Silence

Stigma manifested socially through avoidance, isolation, and silence. All the I5 Respondents shared experiences of being shunned by neighbours and extended family. Some reported that even basic interactions, such as sharing meals or sitting together, ceased after their diagnosis. This social distancing stemmed partly from the belief that cancer was contagious, and partly from the notion that talking about the disease would bring shame upon the family.

In many cases, cancer was treated as a taboo subject within the household. Families often kept the diagnosis secret to protect their social reputation or to preserve marriage prospects for daughters. The practice of hiding cancer resulted in emotional neglect and denied patients the opportunity for social and emotional support, further compounding their distress.

5.1.4 Emotional and Psychological Toll

Cancer patients experienced significant emotional and psychological distress, exacerbated by stigma and isolation. Depression and hopelessness were commonly reported, with many individuals expressing a sense of fatalism and emotional exhaustion. The belief that cancer was a form of punishment or a death sentence led to deep despair, especially in the absence of emotional support systems.

Feelings of guilt and shame were internalized by many patients, particularly when they were blamed for their illness due to lifestyle factors like smoking or alcohol use. Women, in particular, were more vulnerable to self-blame due to entrenched gender expectations and purity norms. These emotional burdens not only affected patients' mental health but also influenced their willingness to seek and complete treatment.

5.1.5 Barriers to Early Detection and Treatment

Fear of judgment and cultural taboos significantly hindered early diagnosis and timely treatment. I4 of the Respondents mentioned and found that they delayed going to the doctor out of fear that they would be stigmatized or blamed for their illness. In many cases, the fear of being seen entering a cancer clinic or hospital kept patients away until symptoms became unbearable.

Gender-related shame was particularly significant among women, who faced difficulty in discussing breast or reproductive health. Social norms regarding modesty and purity discouraged women from undergoing screenings or sharing symptoms. This delay in diagnosis, often until the cancer reached an advanced stage, reduced treatment efficacy and increased mortality risks.

5.1.6 Socioeconomic and Structural Challenges

Poverty and geographic inaccessibility further intensified stigma by limiting access to care. All of the I5 respondents lived in remote areas with poor transportation facilities, and the cost of travel, diagnosis, and treatment was prohibitively high. In the absence of government or NGO support, families had to choose between basic survival and healthcare. This economic burden often led to treatment abandonment, which the community interpreted as "giving up," reinforcing the stigma of helplessness or failure.

Additionally, healthcare inaccessibility contributed to delayed diagnosis and worsened health outcomes. The absence of specialized cancer services nearby led people to rely on spiritual or traditional healers, reinforcing non-medical explanations and perpetuating cycles of stigma and neglect.

5.1.7 The Caregiver's Burden

Almost I5 respondent responded and found out that Family caregivers faced immense emotional, physical, and financial strain. Without institutional support, they took on the responsibility of daily care, often at the cost of their own well-being. Caregivers reported feelings of exhaustion, helplessness, and emotional breakdown, especially when they had to provide 24/7 care.

Financially, care giving led to job losses and reduced household income. Some caregivers had to borrow money or sell property, further impoverishing the family. Additionally, caregivers were sometimes stigmatized themselves—viewed as carriers of misfortune or as having poor moral judgment for associating closely with someone who was ill. This created a ripple effect of stigma extending beyond the patient.

5.1.8 Workplace Discrimination and Concealment

Stigma also affected patients in the workplace. I3 Respondents shared that disclosure of a cancer diagnosis often led to discrimination, reduced responsibilities, demotion, or outright job loss. As a result, many chose to conceal their illness to avoid being treated differently or losing income.

This concealment came at a cost. Patients avoided medical leave or treatments that had visible side effects, such as chemotherapy, for fear of exposure. This led to interrupted or incomplete treatment, exacerbating the severity of the disease. The need to hide the illness also created emotional tension, preventing patients from seeking workplace support or accommodations.

5.1.9 Gendered Dimensions of Cancer Stigma

Gender played a significant role in shaping stigma. Women, especially those with cancers affecting the breasts or reproductive organs, were viewed as “damaged” or “impure.” This perception severely impacted their marriage prospects, sometimes leading to abandonment by spouses or rejection by in-laws. In communities where a woman's value is closely tied to her reproductive and marital roles, cancer signified the loss of femininity and social worth.

Self-blame among women was particularly pronounced. Many felt ashamed of how the disease affected their appearance or physical integrity. These internalized beliefs discouraged women from seeking support, increased isolation, and deepened their psychological suffering.

5.1.10 Impact on Education and Youth Responsibilities

The stigma related to cancer in communities like Disama village has a profound impact on education and youth responsibilities, particularly among girls. When a family member is diagnosed with cancer, young individuals often daughters are expected to take on care giving roles due to the absence of formal support systems. This results in many students missing school or dropping out entirely to manage household responsibilities and care for the patient. The emotional burden of care giving, coupled with the stigma and secrecy surrounding the illness, isolates these youths from their peers and disrupts their academic and social development. Additionally, the fear of gossip and judgment within the community discourages families from allowing their children, especially girls, to continue education. Over time, this contributes to a cycle of limited opportunities, poverty, and educational inequality. The impact on youth is not only educational but also psychological, as they are burdened prematurely with adult responsibilities and emotional strain.

5.1.11 Superstition and Misinformation

Superstitions and misinformation were major contributors to stigma. Fear of contagion, belief in curses, and food taboos were common across respondents. People avoided cancer patients due to irrational fears, believing they could contract the disease through touch or shared objects.

Other myths included the belief that exposure to eclipses or eating certain foods caused or worsened cancer. These beliefs influenced both community behaviour and patients' own decisions, leading to self-isolation, dietary restrictions, and resistance to medical advice. The pervasiveness of such misinformation highlighted the lack of effective health education and community outreach.

5.1.12 Moral Judgments and Victim-Blaming

9 responded that Cancer was often viewed through a moral lens, where the patient was held responsible for their illness. This was particularly the case for those who had used tobacco or alcohol, who were seen as having brought cancer upon themselves. Even in cases where no clear behavioural cause existed, community members speculated about hidden vices or spiritual misdeeds.

These moral judgments compounded stigma by framing illness as deserved. Patients internalized this blame, experiencing shame and reduced self-worth, while others in the community saw them as cautionary tales rather than individuals deserving support.

5.1.13 Community Gossip and Reputation Damage

Gossip played a significant role in how stigma was perpetuated. A cancer diagnosis often became public knowledge, followed by speculation and social exclusion. People feared that having a cancer patient in the family would tarnish their reputation, especially when it came to arranging marriages for daughters or sons.

This pressure led families to hide the diagnosis or avoid discussing it publicly. The fear of social exclusion discouraged open conversation, leaving patients emotionally isolated and discouraged from seeking help outside the family.

5.1.14 Healthcare System Gaps

Many patients reported a lack of empathy from healthcare providers, feeling rushed, misunderstood, or judged during treatment. Doctors were sometimes dismissive, especially if the patient’s lifestyle was deemed a contributing factor. This treatment reinforced the stigma patients already faced at home and in the community.

The absence of emotional or psychological support in medical settings made the experience traumatic, discouraging patients from continuing care or attending follow-ups. These healthcare system failures contributed to delays, incomplete treatment, and negative perceptions of medical institutions.

5.1.15 Absence of Health Education and Awareness

A lack of awareness about cancer was a consistent theme. Most of the respondents had never encountered a cancer screening campaign or did not know the early symptoms of the disease. Misunderstandings were common, with some confusing cancer with infectious diseases or believing that treatment was futile.

The absence of targeted health education efforts reinforced myths and discouraged proactive health-seeking behaviour. Without accessible information, cancer remained shrouded in fear and silence, and early detection remained rare, leading to poor outcomes.

5.1.16 Silencing Through Pity

Interestingly, pity also functioned as a silencing mechanism. While some community members expressed sympathy, this often did not translate into practical help. Surface-level pity masked a deeper discomfort and allowed the community to appear compassionate without offering real support.

This passive sympathy reinforced the patient’s isolation, as it failed to meet their emotional or material needs. In some cases, it further disempowered the patient by reinforcing their identity as someone to be mourned rather than helped.

5.1.17 Disruption of Family Dynamics

Cancer disrupted family structures and led to blame, conflict, and even abandonment. Marriages broke down, relationships frayed, and the stress of illness triggered arguments and emotional withdrawal. Intra-family blame such as accusing the patient of bringing shame or financial ruin intensified the emotional toll.

Patients often found themselves at the centre of familial breakdowns, leading to further isolation and neglect. For some, family became another source of stigma, reinforcing a cycle of silence, shame, and psychological burden.

5.2 Discussion

The findings of this study in Disama village provide a profound understanding of how cancer-related stigma manifests within tribal communities, particularly those that are socioeconomically disadvantaged and culturally insulated. The thematic analysis reveals that cancer stigma is deeply embedded in religious, social, psychological, and structural domains. These findings align closely with both the reviewed literature and the theoretical frameworks adopted in the study—**Goffman's Stigma Theory** and the **Health Belief Model (HBM)** it highlights the intersection of cultural perceptions and health behavior in tribal societies.

5.2.1. Cultural and Religious Interpretations of Cancer

One of the most prominent findings is the belief that cancer is a consequence of divine punishment or black magic. This mirrors Goffman's concept of "tribal stigma" and "moral failing"**,** where individuals are dishonored due to character flaws or spiritual corruption. According to Goffman, such attributes reduce a person from a "whole" to a “defiled” individual, which is precisely what happens in Disama. Cancer patients are often seen as deserving their illness due to karmic retribution or curses.

This cultural interpretation is echoed in several studies. For example, Shahid et al. (2009) highlighted how Aboriginal people in Australia viewed cancer as a death sentence or a spiritual curse, resulting in delay and denial of medical care. Similarly, Nadeau et al. (2022) described how stigma in African contexts was reinforced by fatalistic beliefs and spiritual attributions, which discouraged early detection. The literature thus reinforces the finding that spiritual and moral interpretations of cancer are globally prevalent in marginalized communities and serve as powerful barriers to healthcare engagement.

5.2.2. Social Isolation, Silence, and Reputation Damage

The theme of social isolation and silence emerged strongly in the analysis. Patients were reported to be avoided by community members, families often concealed diagnoses, and discussions around cancer were considered taboo. According to Goffman, the fear of “spoiled identity” leads individuals to hide stigmatized conditions, often resulting in secrecy and emotional distress. The internalization of stigma, or what Goffman calls “felt stigma,” is evident in how patients avoid disclosure and suffer in silence.

This is supported by Squiers et al. (2021), who found that patients and caregivers in India often internalized stigma, leading to psychological withdrawal and reduced access to treatment. Similarly, in Redvers et al. (2022), American Indian communities reported that social judgment and gossip made cancer patients reluctant to disclose their illness, much like the experiences reported in Disama village.

5.2.3. Emotional and Psychological Consequences

The psychological burden depression, hopelessness, guilt, and shame highlighted in the findings can be explained through both Goffman’s theory and the Health Belief Model**.**

Goffman emphasizes the emotional consequences of being labeled as deviant, while the Health Belief Model highlights how perceived severity and barriers influence health decisions.

Studies like Schiller et al. (2009) confirm that self-blame and learned helplessness are common among cancer patients, especially when stigma is internalized. In Disama, individuals often blamed themselves for their illness, a trend also seen in Chapple et al. (2004) where lung cancer patients experienced guilt regardless of smoking history. Such psychological responses reduce health-seeking behavior and erode social support networks.

5.2.4. Gender and Stigma

Gendered dimensions of stigma in Disama village were particularly striking. Women were seen as "impure" or "damaged" due to cancers affecting their breasts or reproductive systems. This aligns with findings from Nyblade et al. (2017), who observed that Indian women with cervical or breast cancer experienced intense shame and were often blamed for being sexually impure.

This perception fits within both Goffman’s framework (where bodily “abnormalities” are stigmatized) and the HBM, which explains how perceived social consequences (like losing marriage prospects) outweigh perceived benefits of treatment. The result is that women delay seeking care, hide symptoms, and endure emotional isolation highlighting the need for gender sensitive health interventions.

5.2.5. Barriers to Early Detection and Healthcare Access

Fear of judgment and cultural shame, particularly among women, was found to delay early detection. This matches the **Health Belief Model**, which suggests that perceived barriers such as fear of social rejection can prevent individuals from engaging in preventive health behaviors like screening.

Linda M. Pak et al. (2021) noted that in rural Assam, a lack of awareness and stigma about cancer significantly reduced screening rates. This is directly parallel to the findings in Disama village, where respondents delayed diagnosis due to embarrassment or fear of being labeled.

5.2.6. Superstitions and Misinformation

Misinformation such as beliefs in cancer being contagious or caused by eclipses—played a key role in reinforcing stigma. This resonates with global findings. In Safi et al. (2021), American Indian populations reported a strong association between cancer and death, fostering fatalism and avoidance. Similarly, Oshiro et al. (2022) emphasized how cultural beliefs, combined with lack of education, contribute to delayed healthcare-seeking in rural areas.

According to the HBM, such beliefs lower perceived benefits of medical treatment and increase perceived barriers. People rely on cultural logic, especially when modern medical understanding is absent or mistrusted.

5.2.7. Structural and Socioeconomic Barriers

The intersection of stigma with poverty**,** transportation difficulties**,** and healthcare inaccessibility's another critical finding. These systemic issues reinforce each other, creating a vicious cycle. Theoretical models such as Health Belief Model do not just account for individual attitudes but also suggest that external cues to action, such as health campaigns or community programs, are crucial. In the absence of these, even individuals with knowledge may not act.

Studies such as those by Gifford et al. (2019) and Mishra et al. (2023) recommend community-based and culturally informed programs to address these combined barriers confirming that both infrastructure and cultural sensitivity are key.

5.2.8. Impact on Caregivers and Family Dynamics

Caregivers in the study reported emotional exhaustion, financial strain, and social neglect. This burden led to family conflicts, neglect, and in some cases, relationship breakdowns. Goffman's theory accounts for courtesy stigma, wherein those associated with the stigmatized individual also face discrimination. This concept helps explain why caregivers in Disama feel isolated and unsupported.

In Shahid et al. (2009) and Itty et al. (2014), similar effects were seen among caregivers in Aboriginal and American Indian communities, reinforcing the idea that stigma affects entire households, not just patients. This underscores the need for family-inclusive support systems.

5.2.9. Workplace and Educational Impact

Fear of job loss, concealment of illness, and disruption of education particularly among youth caregivers reflect broader socioeconomic consequences of stigma. These findings support Grigolon & Lasio's (2020) argument that stigma is a barrier to not only treatment but also social participation and innovation adoption. When stigma forces people into secrecy or school dropout, the long-term cycle of poverty and illness continues.

Chapter VI

Suggestions

6.1 Suggestion

6.1.1 Culturally Sensitive Health Education Campaigns

Design awareness programs that respect local beliefs while correcting misinformation. Use community leaders, traditional healers, and visual storytelling to challenge myths about karma, contagion, and black magic as causes of cancer because Misinformation, cultural myths and perpetuate stigma delays treatment. Culturally relevant messages correct misconceptions and enhance perceived benefits of early detection.

6.1.2 Community-Based Anti-Stigma Interventions

Organizing a support groups and open forums where cancer survivors and families can share experiences. This reduces fear, encourages open dialogue, and normalizes cancer as a treatable condition. Because a place like disama which is located in remotely areas it requires such kinds of intervention

6.1.3 Mobile Screening and Outreach Camps

Organizing a regular mobile health camps and offering free cancer screening and consultations in remote villages. Because Structural barriers like transport and clinic access hinder early diagnosis. Bringing services to the community improves access and reduces reliance on traditional healers for first consultation.

6.1.4 Youth Education in Schools

Integrate cancer education into secondary school health curricula, especially focused on myths and care giving roles. As Youth, especially girls, drop out to become caregivers. Educating them early can help in building resilience, reduces stigma, and empowers them to seek help or support others effectively. It also interrupts the intergenerational cycle of ignorance and stigma.

6.1.5 Partnerships with Traditional Healers

Engagement and training of local spiritual healers to recognize cancer symptoms and refer patients to medical care. As Many patients first approach traditional healers due to spiritual beliefs. Rather than rejecting this practice, integrating healers creates a bridge between traditional and modern medicine, improving access and trust.

6.1.6 Anti-Stigma Media Campaigns

Use radio, wall paintings, and local media to share anti-stigma messages, survivor stories, and healthcare facts. Because Mass media influences public opinion. When used responsibly, it can counteract the negative stereotypes, reduce public stigma, and normalize seeking care, as supported by multiple studies and the Health Belief Model’s "cue to action" component.

6.1.7 Financial Support and Transport Services

Partnership with NGOs or local governments to provide free transportation and subsidies for low-income families. As Socioeconomic barriers and poverty worsen stigma and delay care. Removing cost and distance barriers improves access, reduces patient stress, and signals institutional support, fostering trust.

Conclusion

In conclusion Stigma related to cancer in Disama village, East Karbi Anglong, emerges as a multifaceted issue shaped by deep-rooted cultural beliefs, misinformation, social isolation, and systemic barriers. Cancer is often seen as a result of karma, black magic, or divine punishment, causing patients to internalize guilt and shame while discouraging them from seeking medical help. The illness is viewed as taboo, leading to secrecy within families and avoidance by the community, which further isolates patients. Women face added burdens, being labelled as impure or unfit for marriage, and many families fear social judgment and reputation loss, which delays diagnosis and treatment. Misinformation, such as beliefs in contagion and food taboos, worsens the stigma and reinforces fear. The impact extends beyond patients caregivers experience emotional burnout and financial strain, while youth, especially girls, drop out of school to provide care. In workplaces, cancer patients often conceal their condition to avoid discrimination. Healthcare inaccessibility, economic hardship, and lack of culturally sensitive education programs further perpetuate this cycle. These challenges highlight the urgent need for culturally appropriate interventions such as local awareness campaigns, integration of traditional and modern healthcare, community dialogues, and improved medical access. Breaking the silence around cancer and providing holistic support to both patients and their families are essential to reducing stigma. Ultimately, dismantling cancer stigma in tribal communities like Disama requires empathy-driven, grassroots strategies that prioritize education, inclusion, and accessible care.

The study used a qualitative and descriptive research design with purposive sampling to select 15 adult participants from the village. Through unstructured interviews, observation, and active listening, the researcher gathered in-depth insights into the lived experiences of cancer patients and their families. This method was effective in capturing emotional and cultural dimensions of stigma. However, the study is limited by its small sample size due to time constrain.. `

Reference

- Akin-Odanye, E. O., & Husman, A. J. (2021). Impact of stigma and stigma-focused interventions on screening and treatment outcomes in cancer patients. Ecancermedicalscience, 15, 1308. https://pmc.ncbi.nlm.nih.gov/articles/PMC8580722/
- Chapple, A., Ziebland, S., & McPherson, A. (2004). Stigma, shame, and blame experienced by patients with lung cancer: qualitative study. BMJ, 328(7454), 1470. https://www.bmj.com/content/328/7454/1470
- Daley, C. M., James, A. S., Filippi, M., Weir, M., Braiuca, S., Kaur, B., ... & Greiner, K. A. (2012). American Indian community leader and provider views of needs and barriers to colorectal cancer screening. Journal of Health Disparities Research and Practice, 5(2), 2. https://pmc.ncbi.nlm.nih.gov/articles/PMC3520438/
- Else-Quest, N. M., LoConte, N. K., Schiller, J. H., & Hyde, J. S. (2009). Perceived stigma, self-blame, and adjustment among lung, breast and prostate cancer patients. Psychology and Health, 24(8), 949–964. https://www.tandfonline.com/doi/abs/10.1080/08870440802074664
- Fujisawa, D., & Hagiwara, N. (2015). Cancer stigma and its health consequences. *Current Breast Cancer Reports*, *7*, 143-150. https://link.springer.com/article/10.1007/s12609-015-0185-0

- Gifford, W., Thomas, R., Barton, G., & Graham, I. D. (2019). Providing culturally safe cancer survivorship care with Indigenous communities: Study protocol for an integrated knowledge translation study. Pilot and Feasibility Studies, 5, 1–6. https://link.springer.com/article/10.1186/s40814-019-0422-9
- Ginjupalli, R., Mundaden, R., Choi, Y., Herfel, E., Oketch, S. Y., Watt, M. H., ... & Huchko, M. (2022). Developing a framework to describe stigma related to

cervical cancer and HPV in western Kenya. BMC Women's Health, 22(1), 39. https://link.springer.com/article/10.1186/s12905-022-01619-y

- Grigolon, L., Lasio, L., & Evans, W. (2021). Stigma as a barrier to treatment and adoption of innovation (No. crctr224_2021_277). University of Bonn and University of Mannheim. https://wwz.unibas.ch/fileadmin/user_upload/wwz/00_Forschungsseminar/2022_HS_PAPER_LGrigolon.pdf
- Gupta, A., Dhillon, P. K., Govil, J., Bumb, D., Dey, S., & Krishnan, S. (2015). Multiple stakeholder perspectives on cancer stigma in North India. *Asian Pacific journal of cancer prevention: APJCP*, *16*(14), 6141. https://pmc.ncbi.nlm.nih.gov/articles/PMC5572627/
- Itty, T. L., Hodge, F. S., & Martinez, F. (2014). Shared and unshared barriers to cancer symptom management among urban and rural American Indians. The Journal of Rural Health, 30(2), 206–213. https://onlinelibrary.wiley.com/doi/abs/10.1111/jrh.12045
- Kabalimu, T. K., Mushi, G. K., & Muindi, R. (2018). Social and cultural factors affecting treatment seeking behaviour of patients with cancer of the cervix, at Ocean Road Cancer Institute in Dar es Salaam, Tanzania. Huria: Journal of the Open University of Tanzania, 25(2), 54–63. https://www.ajol.info/index.php/huria/article/view/187638
- Marlow, L. A., & Wardle, J. (2014). Development of a scale to assess cancer stigma in the non-patient population. *BMC cancer*, *14*, 1-12. https://link.springer.com/article/10.1186/1471-2407-14-285
- Mishra, S. I., Adsul, P., Leekity, S., Rodman, J., Sussman, A. L., Kelly, K., ... & Shah, V. (2023). A culturally informed model to enhance breast, cervical, and colorectal cancer screenings: Perspectives of American Indian adults and healthcare providers in rural New Mexico. Cancer Causes & Control, 34(10), 855–871. https://link.springer.com/article/10.1007/s10552-023-01721-y

- Nadeau, M., Wise, K., Farfan Cuela, V., Olson, D., & Saravana, K. (2022). Identification of cancer related risk and protective factors for American Indian youth: A mixed studies review. Frontiers in Public Health, 10, 828776. https://www.frontiersin.org/articles/10.3389/fpubh.2022.828776/full
- Nyblade, L., Stockton, M., Travasso, S., & Krishnan, S. (2017). A qualitative exploration of cervical and breast cancer stigma in Karnataka, India. BMC Women's Health, 17, 1–15. https://link.springer.com/article/10.1186/s12905-017-0407-x
- Oshiro, M., Kamizato, M., & Jahana, S. (2022). Factors related to help-seeking for cancer medical care among people living in rural areas: A scoping review. BMC Health Services Research, 22(1), 836. https://link.springer.com/article/10.1186/s12913-022-08205-w
- Oystacher, T., Blasco, D., He, E., Huang, D., Schear, R., McGoldrick, D., ... & Yang, L. H. (2018). Understanding stigma as a barrier to accessing cancer treatment in South Africa: Implications for public health campaigns. Pan African Medical Journal, 29(1), 1–12. https://www.ajol.info/index.php/pamj/article/view/177083
- Page, B. (2015). Lung cancer in rural and remote Aboriginal and Torres Strait Islander communities in Queensland: Awareness and identifying health needs in a cultural context. https://core.ac.uk/download/pdf/43374308.pdf
- Pak, L. M., Purad, C. C., Nadipally, S., Rao, M. P., Mukherjee, S., Hegde, S. K., & Golshan, M. (2021). Cancer awareness and stigma in Rural Assam, India: Baseline survey of the Detect Early and Save Her/Him (DESH) program. Annals of Surgical Oncology, 28(12), 7006–7013. https://link.springer.com/article/10.1245/s10434-021-10366-7
- Redvers, N., Wilkinson, M., & Fischer, C. (2022). Colorectal cancer community engagement: A qualitative exploration of American Indian voices from North

Dakota. BMC Cancer, 22(1), 158. https://link.springer.com/article/10.1186/s12885-021-09119-2

- Safi, S., Ghahate, D., Bobelu, J., Sussman, A. L., Rodman, J., Wandinger-Ness, A., ... & Shah, V. (2022). Assessing knowledge and perceptions about cancer among American Indians of the Zuni Pueblo, NM. Journal of Cancer Education, 37(6), 1752–1759. https://link.springer.com/article/10.1007/s13187-021-02023-0
- Shahid, S., Finn, L., Bessarab, D., & Thompson, S. C. (2009). Understanding, beliefs and perspectives of Aboriginal people in Western Australia about cancer and its impact on access to cancer services. BMC Health Services Research, 9, 1–9. https://link.springer.com/article/10.1186/1472-6963-9-132
- Squiers, L., Kataria, I., Nyblade, L., Bann, C. M., Dhillon, P. K., Siddiqui, M., ... & Lynch, M. (2021). Perceived, experienced, and internalized cancer stigma: Perspectives of cancer patients and caregivers in India. https://books.google.co.in/books?id=82Z2EAAAQBAJ
- Vrinten, C., Gallagher, A., Waller, J., & Marlow, L. A. (2019). Cancer stigma and cancer screening attendance: a population based survey in England. *BMC cancer*, *19*, 1-10. https://link.springer.com/article/10.1186/s12885-019-5787-x

APPENDIX

Informed Consent

I, Sarmon Timung , a student of the Social Work Department, Mahapurusha Srimanta Sankaradeva Viswavidyalaya, Guwahati Unit, promise that this interview schedule will only be used for my dissertation titled, "*A study in the stigma among the tribal community associated with cancer, with special reference to disama village, east Karbi Anglong, Assam"* under the supervision Dipsikha Boruah, Assistant Professor, Department of Social Work, MSSV, Guwahati Unit. I assure you that your answers will be kept confidential and used solely for educational purposes. Therefore, I kindly request your valuable input in responding to the following set of questions.

Sarmon Timung

MSW 4th semester

Dept. of Social Work

Interview Schedule

Objective 1

To explore stigmas prevalent among the community.

- What are the most common stigmas in your community?
- How do people in your community typically react when someone is diagnosed with cancer?
- What are some of the common beliefs about cancer in your community?
- What role does religion or spirituality play in how people perceived cancer in your community?
- What kind of superstitious belief associated with cancer in your cancer?
- How comfortable do people feels discussing cancer openly?
- What changes do you think are necessary to reduce stigma and improve support for cancers patients and survivors?

Objective 2

To explore the challenges associated to cancer in early cancer detection and treatment.

- How does stigma affect the willingness of an individual to seek cancer screening for early detection?
- How does people in your community face when it comes to getting regular cancer screenings?
- What are the emotional challenges a cancer patients might face after cancers diagnosis?
- What are the psychological challenges a cancer patients might face after cancer diagnosis?

- What are some social challenges faced by an individual for early cancer treatment and detection?
- What are the workplace challenges faced by the individuals for early cancer treatment and detection?
- What are the difficulties faced by the caregiver while supporting the patient?
- How do economic factors impact a person’s ability to get tested for cancer at an early stage?

Objective 3

To study the impact of stigma associated with cancer diagnosis.

- How does stigma influence the way cancer patients perceived themselves?
- How does stigma plays an important role in delaying treatment?
- What impact does the cancer related stigma affects the psychosocial health of the people?
- How does the stigma surrounding cancer affect the emotional well being of individuals diagnosed with the disease?
- How does cancer stigma affect relationships between patients and their family members?
- What impact does stigma have on cancer patients in workplace or professional environment?
- How does stigma impact the level of support and care cancer patients receive from healthcare professional?