

CANCER STIGMA AMONG ADULTS RESIDING IN KAGESHWORI MANOHARA MUNICIPALITY, KATHMANDU, NEPAL

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ABSTRACT

Cancer being the fifth leading cause of death in Nepal. A number of cancer cases are growing everyday which contributes morbidity, financial hardship and mortality. Cancer stigma across the care continuum, hinders preventive health-seeking, screening uptake and treatment adherence, and care engagement. A cross-sectional research design was used to assess the cancer stigma among adults in Aalapot, Kageshwori Municipality, Kathmandu. Total 294 adult was interviewed by using cancer stigma scale (CASS). Systematic random sampling technique was used for data collection. Data was analyzed by using SPSS-22. Descriptive and Inferential statistics was used for data analysis. The results of the study founds low stigma 164 (55.8%) level among the respondents. However, 130 (44.2%) respondents had higher stigma whereas highest stigma present in the severity domain which suggests persistent negative perceptions while low stigma in the policy opposition domain reflects greater acceptance of policies supporting people with cancer. *Brahmin/Chhettri* felt low cancer stigma than others. Married respondents had higher cancer stigma than unmarried. There was a statistical association between the selected socio-demographic variables such as ethnicity, marital status and occupation with level of stigma. The findings indicate that overall cancer stigma was low but varied across different domains. These findings highlights the need for educational interventions to reduce misconceptions and further decrease cancer related stigma. Improving health literacy reduces sociocultural fears that delay the diagnosis.

KEYWORDS

Adult, cancer, stigma, Kageshwori, Kathmandu

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DOI: <https://doi.org/10.3126/nmcj.v28i3.101216>

Received on: April 05, 2026

Accepted for publication: August 03, 2026

Cite this paper as: Saud M, Shrestha S, Maharjan S, Piya N. Cancer stigma among adults residing in Kageshwori Manohara Municipality, Kathmandu, Nepal. *Nepal Med Coll J* 2026; 28: 181-9.

INTRODUCTION

Cancer is the rapid growth of abnormal cells beyond their normal limits, which can invade nearby body parts and spread to other organs; the latter process is referred as metastasis. The widespread metastases are the cause of death from cancer. It is a leading cause of death worldwide, accounting for nearly 10 million deaths and 19.3 million new cancer cases in 2020.¹ The incidence of cancer was two to three fold higher for both sexes whereas mortality varied less than two fold for men and little for women.² The majority of deaths from cancer occur in low and middle income countries, partly due to poor public awareness of the signs and symptoms of cancer.³ In India, the cancer incidence was estimated to be 100.4/100,000 in 2022.⁴

According to GLOBOCAN 2022 statistics, the number of new cases is 22008 and cancer related deaths are 14,704 for Nepal. The age standardized incidence rate is 81.6 in both sexes and the Lung, stomach and cervix uteri are the top three leading cancers among both sexes.⁵ The leading cause of death by noncommunicable disease (NCD) is cardiovascular disease, which leads at 22.0% of total deaths, followed by other NCDs (14.0%), chronic respiratory diseases (13.0%), cancers (8.0%) and diabetes (3.0%).⁶

Cancer is the fifth leading cause of death in Nepal which requires comprehensive strategy for screening, early detection and treatment to control future burden.⁷ The increasing incidence of cancer stigma acts as a barrier to both care and support. Cancer stigma may lead to delayed diagnosis and treatment, especially in low- and middle-income countries.⁸

Cancer is a stigmatized disease in many countries that impacts the quality of life and mental health of people affected by cancer.⁹ Various studies suggest that cancer is one of the serious disease and cancer stigma is prevalent in many societies.¹⁰ Cancer stigma influences the perception and behavior of people which hinders cancer screening, prevention and control. Therefore, reducing cancer stigma is critical to reduce the cancer burden and promote health. Thus, the researcher aimed to assess cancer stigma among adults of Kageshwori Manohara Municipality in Kathmandu.

MATERIALS AND METHODS

A descriptive cross-sectional study design was used to assess the level of cancer stigma of adults residing at Aalapot, Ward-2 of Kageshwori Manohara Municipality. The

study period was from December 2024 to June 2025. Total 294 (with adding 10.0% non-response rate) adults of 18 completed years to 65 years was included in the study.¹¹ Adults who were available during the data collection period and who could understand and speak Nepali language and those who were willing to participate on a voluntary basis was included in the study. Adults people with cancer, mentally ill and bed ridden was excluded in this study. Systematic random sampling technique was used to select the samples. The total household of Allapot was 752 according to Kageshwori Manohara Municipality office and number was given to each house considering ward office centre. Considering the sample size of 294, the sampling interval was 3. To find the starting point randomly one household was selected and adults was selected from selected household, then adults was selected from every 3rd household. If the adult population was not available at systematically selected household then next consecutive household was used and if more than one adult were available in the house, then simple lottery method was used to select one adult from the house.

A validated cancer stigma scale (CASS) was used to assess cancer stigma among apparently healthy adults.¹² Permission was taken from the researcher to use this tool. This tool assess cancer stigma among adults which included cancer stigma scale consisting 25 items. Each item was measured by six point likert scale with possible cancer stigma as severity, personal responsibility, awkwardness, avoidance, policy opposition and financial discrimination. Score ranged from 1 to 6 with higher score indicating more stigmas. There were positive as well as negative statements. The positive statements was marked as 6, 5, 4, 3, 2, and 1 for strongly agree, moderately agree, slightly agree, slightly disagree, moderately disagree, and strongly disagree, respectively. Similarly, reverse markings was done for negative statements. The possible score range for CASS is from 6 to 150. Higher scores (more than and equal to mean score) denotes higher stigma and lower the mean score (less than mean score) indicates low stigma.

Pretesting of instrument was done in 10% of estimated sample size which was 29. Pretesting was done in ward number 1 of Kageshwori Manohara Municipality. A CASS tool was already validated in Nepal to assess cancer stigma among general population in Nepal. The Cronbach's alpha of Nepali CASS tool was 0.88.

Data collection was conducted only after obtaining the formal approval from research

committee of Nepal Medical College, (Ref No: 31-081/082) Institutional Review Committee. Formal written permission was obtained from Ward-2 Aalapoti of Kageshwori Manohara Municipality for data collection by submitting the request letter from Nepal Medical College. Informed and written consent was obtained from each respondent and objectives of the study was explained before data collection. A face to face structured interview schedule was used to collect data. During data collection privacy was maintained by taking interview separately at home setting. Each day 6 to 8 respondents was interviewed for 10-15 minutes each working day by using CASS questionnaire.

The data coding, entering and analysis were performed by SPSS-16. Collected data was entered into SPSS-16 and analyzed using both descriptive and inferential statistics. Descriptive statistics such as frequency, percentage, mean, standard deviation and inferential statistics was used to assess the association between the variables chi-square was used at 95% confidence interval level ($P < 0.05$).

RESULTS

As shown in table-1, a total of 294 respondents were recruited in the study of which 132 (44.9%) were between the age group 40-59 years where 34 (11.0%) respondents were senior citizens and the mean age was 41.8 ± 12.5 years. More than two thirds 192 (65.3%) were female and 102 (34.7%) were male. *Brahmin/Chhettri* was the predominant ethnicity 206 (70.1%). Majority of them 251 (85.1%) were married and 32 (10.9%) were unmarried. About one fourth of the respondents 73 (24.8%) had attained higher secondary education level and 35 (11.9%) of them had no formal schooling. Elaborating on the educational status, more than one third 34 (11.6%) are literate and one fifth 59 (20.1%) had attained primary education and 28 (9.5%) of them had attained doctoral degree. More than one third 110 (37.4%) were engaged in agriculture followed by 69 (23.9%) were homemakers, 50 (17.0%) were service holders, 42 (14.3%) had business and 23 (7.8%) were students respectively. Average of total family income per month was 39,642. Majority of respondents 261 (88.8%) had no cancer in family and one fourth 74 (25.2%) had no cancer in Surroundings (Table-2).

Table-3 presents the responses of respondents to questions related to their believe towards the cancer stigma. While, measuring awkwardness one third (59.5%) of the respondents strongly

agree with the statement that they feel ease around someone with cancer and only small proportion (8.2%) expressed strong

Table 1: Socio-demographic characteristics of respondents (n=294)

Variables	n	%
Age (years)		
≤39	128	43.5
40-59	132	44.9
≥60	34	11.6
mean±SD=41.8±12.5 (Min=19, Max=65)		
Gender		
Male	102	34.7
Female	192	65.3
Ethnicity		
<i>Brahmin/Chhettri</i>	206	70.1
<i>Adhibasi Janajati</i>	82	27.9
<i>Dalit</i>	4	1.4
<i>Madhesi</i>	2	0.7
Marital status		
Married	251	85.4
Unmarried	32	10.9
Widow/widower	11	3.7
Educational status		
Illiterate	35	11.9
Literate	34	11.6
Primary	59	20.1
Secondary	65	22.1
Higher secondary	73	24.8
University	28	9.5
Occupation		
Service	50	17.0
Agriculture	110	37.4
Business	42	14.3
Homemaker	69	23.5
Student	23	7.8
Family Income		
Average income ≤39642	188	63.9
Average income >39642	106	36.1

Table 2: History of cancer (n=294)

Cancer in Family	n	%
No	261	88.8
Yes	33	11.2
Cancer among neighbours		
No	220	74.8
Yes	74	25.2

Table 3: Item-wise analysis of CASS responses among study participants (n=294)

Items	DS n (%)	DM n (%)	DS n (%)	AS n (%)	AM n (%)	AS n (%)
Awkwardness						
I would feel at ease around someone with cancer ®	24 (8.2)	15 (5.1)	11 (3.7)	18 (6.1)	51 (17.3)	175 (59.5)
I would feel comfortable around someone with cancer ®	31 (10.5)	11 (3.7)	8 (2.7)	19 (6.5)	58 (19.7)	167 (56.8)
I would find it difficult being around someone with cancer	185 (62.9)	43 (14.6)	10 (3.4)	11 (3.7)	16 (5.4)	29 (9.9)
I would find it hard to talk with someone with cancer	194 (66)	43 (14.6)	10 (3.4)	13 (4.4)	11 (3.7)	23 (7.8)
I would feel embarrassed discussing cancer someone who had it	147 (50)	39 (13.3)	13 (4.4)	26 (8.8)	30 (10.2)	39 (13.3)
Severity						
Once you've had cancer you can never be 'normal' again	78 (26.5)	32 (10.9)	22 (7.5)	37 (12.6)	66 (22.4)	59 (20.1)
Having cancer usually ruins a person's career	58 (19.7)	29 (9.9)	19 (6.5)	32 (10.9)	61 (20.1)	95 (32.3)
Getting cancer means having to mentally prepare oneself for death	84 (28.6)	23 (7.8)	14 (4.8)	30 (10.2)	60 (20.4)	83 (28.2)
Having cancer ruins close personal relationships	143 (48.6)	29 (9.9)	15 (5.1)	32 (10.9)	26 (8.8)	49 (16.7)
Cancer devastates the lives of those it touches	160 (54.4)	28 (9.5)	11 (3.7)	23 (7.8)	29 (9.9)	43 (14.6)
Avoidance						
I would try to avoid a person with cancer	230 (78.2)	27 (9.2)	8 (2.7)	5 (1.7)	7 (2.4)	17 (5.8)
I would distance myself physically from someone with cancer	228 (77.6)	22 (7.5)	11 (3.7)	5 (1.7)	10 (3.4)	18 (6.1)
I would feel irritated by someone with cancer	242 (82.3)	26 (8.8)	12 (4.1)	3 (1)	4 (1.4)	7 (2.4)
I would feel angered by someone with cancer	239 (81.3)	29 (9.9)	11 (3.7)	3 (1)	5 (1.7)	7 (2.4)
If a colleague had cancer, I would try to avoid them	207 (70.4)	33 (11.2)	5 (1.7)	9 (3.1)	17 (5.8)	23 (7.8)
Policy opposition						
More government funding should be spent on the care and treatment of those with cancer	7 (2.4)	8 (2.7)	7 (2.4)	10 (3.4)	35 (11.9)	227 (77.2)
The needs of people with cancer should be given top priority	7 (2.4)	4 (1.4)	1 (0.3)	6 (2)	22 (7.5)	254 (86.4)
We have a responsibility to provide the best possible care for people with cancer	18 (6.1)	2 (0.7)	10 (3.4)	12 (4.1)	37 (12.6)	215 (73.1)
Personal responsibility						
A person with cancer is accountable for their condition	92 (31.3)	21 (7.1)	15 (5.1)	44 (15)	57 (19.4)	65 (22.1)
A person with cancer is liable for their condition	87 (29.6)	27 (9.2)	16 (5.4)	40 (13.6)	64 (21.8)	60 (20.4)
If a person has cancer, it's probably their fault	117 (39.8)	34 (11.6)	17 (5.8)	43 (14.6)	49 (16.7)	34 (11.6)
A person with cancer is to blame for their condition	135 (45.9)	32 (10.9)	16 (5.4)	35 (11.9)	42 (14.3)	34 (11.6)
Financial discrimination						
Bank should be allowed to refuse loans for cancer related reasons	187 (63.6)	25 (8.5)	17 (5.8)	24 (8.2)	15 (5.1)	26 (8.8)
Bank should be allowed to refuse mortgages applications	160 (54.4)	31 (10.5)	9 (3.1)	28 (9.5)	18 (6.1)	48 (16.3)
It is acceptable for insurance companies to reconsider a policy if someone has cancer	59 (20.1)	13 (4.4)	6 (2)	24 (8.2)	64 (21.8)	128 (43.5)

Note: DS: disagree strongly (1), DM: disagree moderately (2), DS: disagree slightly (3), AS: agree slightly (4), AM: agree moderately (5), AS: agree strongly(6)

disagreement. More than half 167 (56.8%) strongly agree to being comfortable around someone with cancer. 185 (62.9%) respondents strongly disagree with difficulties being around someone with cancer. 194 (66.0%) respondents believed that it is hard to talk with someone

Table 4: Level of cancer stigma (n=294)

Level of cancer stigma	n	%
Low stigma (<61 mean score)	164	55.8
High stigma (≥61 mean score)	130	44.2

Table 5: Mean score and standard deviation of domains of CASS (n=294)

Domains of cancer stigma	Mean score	Std. deviation
Awkwardness	10.5	6.03
Severity	16.4	7.06
Avoidance	7.8	4.5
Policy opposition	4.4	2.78
responsibility	12.6	6.4
Financial discrimination	8.9	4.1

with cancer. 147 (50.0%) respondents were strongly disagree with the statement of feeling embarrassed in discussing cancer someone who had it. Regarding severity, more than half 55.2% were agreed with the statement when once cancer had never normal again. One third respondents 95 (32.3%) believed that having cancer usually ruins career. About two third respondents felt that having cancer is to mentally prepare oneself for death. 143 (48.6%) respondents strongly disagree that cancer ruins close personal relationships. More than half respondents disagree strongly with the statement that cancer devastates the lives of those it touches. In regard to avoidance, majority of respondents disagreed strongly in regards to avoiding a person with cancer. Majority of respondents disagreed strongly with distancing themselves physically from persons with cancer (77.6%), feeling irritated (82.3%), angered (81.3%) and avoid colleague who had cancer (70.4%) respectively. Regarding policy opposition majority (77.2%) respondents strongly perceived that the government should spend funds on care and

Table 6: Association between Socio-demographic variables and cancer Stigma (n=294)

Variables	Level of stigma		P Value
	Low stigma	High stigma	
Age			
≤30	40 (24.4%)	30 (23.1%)	0.793
>30	124 (75.6%)	100 (76.9%)	
Gender			
Male	58 (35.4%)	44 (33.8%)	0.786
Female	106 (64.6%)	86 (66.2%)	
Ethnicity			
Brahmin/Chhetri	123 (75.0%)	83 (63.8%)	0.038
Others	41 (25%)	47 (36.2%)	
Marital status			
Married	133 (81.1%)	118 (90.8%)	0.020
Single	31 (18.9%)	12 (9.2%)	
Educational status			
Illiterate	17 (10.4%)	18 (13.8%)	0.360
literate	147 (89.6%)	112 (86.2%)	
Occupation			
Non-homemaker	133 (81.1%)	92 (70.8%)	0.038
Homemaker	31 (18.9%)	38 (29.2%)	
Cancer in family			
No	141 (86.0%)	120 (92.3%)	0.088
Yes	23 (14%)	10 (7.7%)	
Cancer among neighbours			
No	116 (70.7%)	104 (80.0%)	0.148
Yes	48 (29.3%)	26 (20.0%)	

Note: Chi square test, P value is statistically significant if <0.05.

treatment, 86.4% respondents felt strongly that the needs of persons with cancer should be given top priority and 73.1% felt that persons with cancer should receive the best of care. One third respondents 92 (31.3%) strongly disagreed that a person suffering from cancer was accountable for their condition. 39.8% respondents strongly disagreed that a person with cancer was to blame for their condition. While assessing the financial discrimination respondents disagreed strongly that it was acceptable for banks to refuse loan or that bank should be allowed to refuse mortgages applications (63.6% and 54.4%) respectively. Less than half (43.5%) respondents strongly agreed that it was acceptable for insurance companies to reconsider a policy.

Table-4 represents about the level of cancer stigma in which the result of the study founds low stigma 164 (55.8%) level among the respondents. However, 130 (44.2%) respondents perceived high level of cancer stigma. The overall mean score was 61.

Table-5 revealed the findings related to mean score and standard deviation of different domains of cancer stigma. Domain wise mean score and standard deviation was calculated. The highest stigma was prevalent in Severity domains among all the domains where the mean score is 16.4 ± 7.06 . Regarding awkwardness the mean score is 10.5 and standard deviation is 6.03, which means cancer stigma persists among the respondents. Likewise, related to responsibility cancer stigma (mean score 12.6 ± 6.4) was present in a varying level. The lowest cancer stigma is in the policy opposition, avoidance and financial discrimination where mean score is 4.4 ± 2.78 , 7.8 ± 4.5 , 8.9 ± 4.1 , respectively.

Table-4 shows the association between selected socio-demographic variables and level of stigma where the age, gender, educational status, cancer history in family and surroundings were not significantly associated with the level of stigma. However, ethnicity, marital status and occupation exhibited statistical association with the level of stigma. Regarding ethnicity, *Brahmin/Chhetri* respondents 123 (75.0%) had a lower level of stigma ($P=0.038$) towards cancer than others. There Married respondents 118 (90.8%) had higher cancer stigma than unmarried ($P=0.020$). Regarding occupation 133 (81.1%) non homemakers were found to have a low level of cancer stigma. Statistically significant association was seen between occupation with level of stigma ($P < 0.038$).

Correlation with domains of cancer stigma:

Severity was significantly positively correlated with avoidance ($r=0.268$, $P < 0.01$), responsibility ($r=0.273$, $p < 0.001$) and financial discrimination ($r=0.149$, $P < 0.01$) and was significantly associated with all the domains except policy opposition. Awkwardness was significantly correlated with financial discrimination and policy opposition. However, responsibility did not show significant correlations with most variables.

DISCUSSION

The study findings reflect a low stigma level among the respondents but it was still present with varying level among the respondents. The finding is consistent with the study conducted in various countries.^{11,13-16} This finding contrasts with study in China, which found higher cancer stigma among respondents.¹⁷ The highest stigma level is present in the 'Severity' domain. This finding is consistent with the studies conducted in various countries.^{11,14,15} In contrast with this a study conducted in Dhulikhel, Nepal concluded the highest stigma level pertained to personal responsibility.¹³

Our study results showed that the highest stigma was prevalent in 'severity' domain followed by personal responsibility, awkwardness, financial discrimination and avoidance respectively. Likewise, lowest stigma seen in policy opposition, financial discrimination and avoidance. These findings are supported by another study conducted in Nepal.^{11,13} However, the results were contradictory to a study done in Saudi that reported lowest stigma was present in personal responsibility and avoidance.¹⁴

The current study observed low stigma in policy opposition recommending government support and priority care for cancer patients. Similar to our findings, a study conducted in different parts of Nepal reported low stigma in policy opposition.^{11,13}

In this study, more than half respondents agreed that they would never be normal again after having cancer. This finding is in contrast with the study conducted in Nepal and India which revealed that more than two third of respondents disagreed.^{11,18} Only few respondents believed that cancer can ruins close relationships. This finding was supported by the study conducted in Nepal and India.^{11,14} However, it contrasted with the findings of study conducted in Africa that revealed a persistent view related to straining of family relations.¹⁹ Regarding the statements about 'mentally

preparing oneself for death'; the study finding was supported by the both studies conducted in India where they believed that life is finished and nothing is there after getting cancer.^{16,20}

This study reported more than half respondents disagreed strongly that cancer devastates the lives of those it touches. About two third respondents felt ease around someone with cancer. More than half respondents reported that they had felt ease around and were comfortable with persons with cancer in our study. These findings was consistent with the study conducted in Nepal and India.^{11,14,16}

In our study, it was seen that one third respondents agreed that a person with cancer is blame for their condition. Similar finding was observed in India, where they belief cancer is due to the bad deed occurred in their current or past life.¹⁶ In contrast, a study conducted in England found that only a few respondents agreed personal responsibility statements, such as that a person with cancer is to blame for their condition.¹⁵ In avoidance domains, we found that few respondents avoided a person with cancer. Majority of the respondents disagreed with avoiding a person, feeling angered, irritated, maintaining physical distance and avoid them if colleague had cancer. Similarly, our study finding was supported by the study conducted in England where, few adults anticipated avoiding someone with cancer.¹⁵ Likewise, another study conducted in Nepal reported the similar results.¹¹ In contrast, to this a study conducted in India revealed that the people avoid the person who is had cancer due to the fear of transmission.¹⁶

In policy opposition domain, majority of respondents agreed with the statements that the people with cancer should be given top priority, government should spend more funding on their care and responsibility of all to provide best care for people with cancer. A study done among general population in Nepal showed similar results regarding policy opposition. Regarding the financial discrimination, majority of respondents disagreed that it was acceptable for bank to refuse loans, mortgage applications to people with cancer. However, they agreed that it is acceptable for insurance companies to reconsider an insurance policy. This results was supported by the study conducted in Nepal and England.^{11,15}

The association between selected socio-demographic variable and level of stigma where the age, gender, educational status, cancer history in family and surroundings was not statistically significance with the level of

stigma. These findings were not consistent with the results of studies in Nepal and England.^{11,15} However, in Saudi no significant association was seen between cancer stigma in terms of education and history of cancer.¹⁴ Our study found, higher stigma observed with the increasing age. This finding was similar with study conducted in Saudi Arabia and Nepal.^{14,21} In contrasts to the study of China, which found higher cancer stigma among respondents of younger age.²²

In the present study, both the male and female respondents felt cancer stigma. However, more than two third female respondents had higher stigma than male. Similarly, in the Pakistan, it was found that female respondents had higher cancer stigma.²³ However, this is in contrast with the study conducted in Saudi where male exhibited higher stigmatization.¹⁴ As we found the significant association between ethnicity, marital status and occupation with level of stigma, These findings were not consistent with the results of previous studies in Nepal.²¹ Those respondents who worked outside home had lower cancer related stigma than economically inactive individuals. This finding is similar with a study in Kenya, which found lower cervical cancer stigma among those who worked outside the home.²⁴

The current study showed that 'severity' was significantly and positively correlated with avoidance ($r=0.268$, $P < 0.01$), responsibility ($r=0.273$, $p < 0.001$) and financial discrimination ($r=0.149$, $P < 0.01$) and was significantly associated with all domains except policy opposition. Awkwardness was significantly correlated with financial discrimination and policy opposition. However, responsibility did not show significant correlations with most variables. A study conducted in UK exhibit that the severity and policy opposition are not correlated.¹² This finding is contradictory with the study conducted in Saudi revealed positive correlation with severity, awkwardness, financial discrimination, policy opposition, personal responsibility and avoidance.¹⁴

In conclusion, this study concluded low stigma level among more than half of the respondents but still present cancer stigma in various domains. The highest stigma persist in severity domains and the lowest stigma was prevalent in policy opposition domains. *Brahmin/Chhettri* felt low cancer stigma than others. Married respondents had higher cancer stigma than unmarried. Non homemaker believed low level of cancer stigma. However, further research is required to carryout to find other driving factors.

This study was conducted in a single community which cannot be generalized to all the populations of the country. This study does not provide underlying reasons behind the outcomes. This study does not generate the changes over the time about the cancer stigma. The results of the study depend on the truthfulness and accuracy of respondent's response. Social desirability bias may have influenced the responses.

ACKNOWLEDGEMENT

The authors would like to express sincere gratitude to all those who provide direct and indirect support to complete this work and thank to all the participants for their valuable time and support to carry out this study.

Conflict of Interest: None

Source of research fund: This research is funded by University Grant Commission (UGC). The grant number is SRDIG-81/82- HS-09.

REFERENCES

1. WHO. Cancer 2020. Available from: <https://www.who.int/news-room/fact-sheets/detail/cancer>. (Accessed on: Nov 2024)
2. Sung H, Ferlay J, Siegel RL *et al*. Global Cancer Statistics 2021: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. *CA Cancer J Clin* 2021; 71: 209-49
3. Al-Azri M, Al-Hamed I, Al-Awisi H, Al-Hinai M, Davidson R. Public awareness of warning signs and symptoms of cancer in Oman: A community-based survey of adults. *Asian Pac J Cancer Prev* 2015; 16: 2731-7. DOI: 10.7314/APJCP.2015.16.7.2731
4. Sathishkumar K, Chaturvedi M, Das P, Stephen S, Mathur P. Cancer incidence estimates for 2022 & projection for 2025: result from national cancer registry programme, India. *Indian J Med Res* 2022; 156: 598-7. DOI: https://doi.org/10.4103/ijmr.ijmr_1821_22.
5. WHO Nepal. International Agency for research on cancer. Global cancer observatory. Cancer Today. GLOBOCAN 2022 statistics. Available from: <https://gco.iarc.who.int/media/globocan/factsheets/populations/524-nepal-fact-sheet.pdf>. (Accessed on: Nov 2024)
6. WHO. Noncommunicable diseases (NCD) country profiles: Nepal. 2014. Available from: https://apps.who.int/iris/bitstream/handle/10665/128038/9789241507509_eng_sequence=1 (Accessed on: Nov 2024)
7. Dhimal M, Dahal U, Khadka K *et al*. Cancer incidence and mortality in selected districts of Nepal in 2019. *J Nepal Health Res Counc* 2022. Available from: <https://nhrc.gov.np/wp-content/uploads/2022/08/Population-Based-Cancer-Registry-Report-2019-1.pdf>. (Accessed on: Nov 2024)
8. Squiers L, Siddiqui M, Kataria I *et al*. Perceived, experienced, and internalized cancer stigma: perspectives of cancer patients and caregivers in India. Research Triangle Park RTI Press; 2021. DOI: <https://doi.org/10.3768/rtipress.2021.rr.0044.2104>.
9. Johnson SE and Samson M. Cancer stigma: the need for policy and programmatic action. *J Nat'l Cancer Inst* 2024; 2024: 45-50.
10. Fujisawa D and Hagiwara N. Cancer stigma and its health consequences. Exit Disclaimer. *Curr Breast Cancer Rep* 2015; 7: 143-50
11. Shrestha R, Shrestha G, Paneru P. Cancer stigma in non-patient population visiting B&B Hospital, Lalitpur, Nepal: a descriptive cross-sectional study. *Asian Pac J Cancer Care* 2023; 8: 275-9. DOI: 10.31557/APJCC.2023.8.2.275-279
12. Marlow LA and Wardle J. Development of a scale to assess cancer stigma in the non-patient population. *BMC cancer* 2014; 14: 1-2.
13. Paneru B, Karmacharya A, Bharati A *et al*. Association between cancer stigma and cervical cancer screening uptake among women of Dhulikhel and Banepa, Nepal. *PLoS One* 2023; 18: e0285771. DOI: 10.1371/journal.pone.0285771.
14. Albenayyan HA, AlSubaie R, Alarfaj MO *et al*. Cancer stigma among 800 Saudi citizens: a cross-sectional study and literature review. *Cureus* 2023; 15. DOI: 10.7759/cureus.49088.
15. Vrinten C, Gallagher A, Waller J, Marlow LAV. Cancer stigma and cancer screening attendance: a population based survey in England. *BMC Cancer* 2019; 19: 566. DOI: 10.1186/s12885-019-5787-x.
16. Nyblade L, Stockton M, Travasso S, Krishnan S. A qualitative exploration of cervical and breast cancer stigma in Karnataka, India. *BMC Womens Health* 2017; 17: 1-5. DOI: 10.1186/s12905-017-0407-x.
17. Jin R, Xie T, Zhang L, Gong N, Zhang J. Stigma and its influencing factors among breast cancer survivors in China: a cross-sectional study. *Eur J Oncol Nurs* 2021; 52: 101972. DOI: 10.1016/j.ejon.2021.101972.
18. Mohana Priya S and Annie Elizabeth T. Cancer stigma among the caregivers of cancer patients, a cross-sectional study from a secondary care hospital in Andhra Pradesh, South India. *Int J Sci Res Arch* 2024; 12: 2097-102. DOI: <https://doi.org/10.30574/ijrsra.2024.12.1.0995>
19. Mandizadza E and Moyo S. A phenomenological study on experiences of cancer stigma amongst selected people living with cancer in rural and urban Zimbabwe. *AAS Open Res* 2021; 4: 48. DOI: <https://doi.org/10.12688/aasopenres.13282.1>

20. Bhattacharyya GS, Malhotra H, Babu G, Vora A, Bhattacharyya S. Cancer stigma related to beliefs of patients and care providers. *Ann Oncol* 2018; 29: 55. DOI: 10.1093/annonc/mdy296.006
21. Shrestha A, Stangl AL, Paneru B *et al.* Validation of the cancer stigma scale in Nepalese Women. *Asian Pac J Cancer Prev* 2023; 24: 204–14. DOI: 10.31557/APJCP.2023.24.1.207.
22. Ye X, Liu HY, Lu SR *et al.* Translation and validation of the Chinese version of the Cancer Stigma Scale. *J Oncol Pharm Pract* 2019; 25: 1622–30. DOI: 10.1177/1078155218802627.
23. Sarfraz M, Waqas H, Ahmed S, Rurush-Asencio R, Mushtaque I. Cancer-related stigmatization, quality of life, and fear of death among newly diagnosed cancer patients. *OMEGA-J Death Dying* 2025; 91: 659-74. DOI: <https://doi.org/10.1177/00302228221140650>
24. Rosser JI, Njoroge B, Huchko MJ. Cervical cancer stigma in rural Kenya: what does HIV have to do with it?. *J Cancer Educ* 2016; 31: 413–8. DOI: 10.1007/s13187-015-0843-y.