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From Mechanisms to Manifestations: A Scoping Review Exploring Cancer-Related Discrimination

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ABSTRACT

Objective: This scoping review examines the available qualitative evidence from systematic and scoping reviews, and mixed-methods or qualitative studies on cancer-related discrimination.

Methods: Cancer-related discrimination was defined as direct and recurring experiences of enacted stigma, behaviours, or unfair treatment based on an individual's cancer history, current cancer diagnosis, perceived cancer risk, or cancer caregiving role. A systematic search of ProQuest databases, Cochrane CENTRAL, Scopus, APA PsycINFO, MEDLINE, and Web of Science identified peer-reviewed research published before December 13, 2025. Two independent reviewers screened studies, and data were narratively synthesised using the Health Stigma and Discrimination Framework (i.e., drivers and system-level facilitators; discrimination experiences; impacts).

Results: In total, 116 studies met inclusion criteria, comprising 83 qualitative studies, 23 mixed-method, nine systematic reviews, and one scoping review. Cancer-related discrimination was reported across four contexts: (1) familial and social; (2) hiring and workplace; (3) insurance and welfare; and (4) healthcare. Discrimination drivers included misconceptions that cancer is contagious, employer concerns about productivity and costs, rigid welfare regulations, and reduced public empathy for cancers perceived as 'self-inflicted'. Reported experiences ranged from social exclusion and bullying, to workplace dismissals, job rejections, and barriers to insurance or financial support. In healthcare contexts, provider blame, judgement, and strained patient-clinician interactions were reported. Impacts of discrimination included self-isolation, concealment of diagnosis, internalised stigma, psychological distress, financial burden, and delayed treatment-seeking.

Conclusions: Cancer-related discrimination arises from cultural, institutional, and structural mechanisms, with significant impacts on quality of life and health. Coordinated policy, legal, institutional, and public education responses are required to address these challenges.

Catherine Paterson and Raymond J. Chan are co-senior authors.

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1 | Background

Cancer represents a major global public health challenge, with an estimated 20 million new cases diagnosed worldwide each year, and approximately one in five people expected to develop cancer during their lifetime [1]. The multifaceted challenges faced by cancer survivors (i.e., anyone with a history of cancer) and their caregivers are complex and widespread, encompassing financial, employment, healthcare, and advocacy-related issues [2, 3]. For people affected by cancer, perceptions of unfair treatment, or perceived discrimination, have been reported to contribute to and worsen their existing challenges [4–6]. People affected by cancer may grapple with daily problems due to a lack of fairness within existing healthcare, social, legal, and policy landscapes [7–9]. Several reports [10–14] have documented the negative attitudes, stereotypes, and discriminating behaviours directed towards people affected by cancer across many different populations, with reported prevalence rates of enacted cancer stigma reaching approximately 80% [14]. Informal caregivers and family members may also experience stigma as a result of their loved one's cancer [15]. According to a qualitative study conducted in the United Kingdom (UK), caregivers reported difficulty accessing social welfare support and employment benefits and often did not receive their full statutory benefit entitlements without support from welfare rights advocacy services [16]. Growing evidence [4, 8–11] has underscored that cancer-related discrimination directly contributes to substantial psychological distress, resulting in maladaptive behavioural coping strategies, reduced quality of life, and worse health outcomes.

Although published literature reviews [17–20] have investigated disease-related stigma and discrimination in chronic health conditions such as AIDS, and mental illness, little evidence mapping work has been published in the context of cancer. Further, reviews exploring cancer stigma, have focused primarily on internalised stigma [13, 21] (e.g., struggling with self-identity, feelings of shame). Research synthesis on enacted stigma or discrimination associated with cancer remains very limited, stressing the importance of systematically mapping the mechanisms underlying its manifestations. Understanding how cancer-related discrimination impacts people affected by cancer is crucial for implementing effective interventions. The aim of this scoping review was to clearly identify and systematically map research on cancer-related discrimination to pinpoint its driving factors, manifestations, and potential mitigation strategies. These findings will inform the development of future targeted interventions, identify potential law and policy reform measures, mobilise support systems, and revise public health approaches to alleviate the many discriminatory burdens associated with cancer.

2 | Defining Enacted Stigma and Cancer-Related Discrimination

Stigma has been defined in several different ways in the literature [22, 23]. In general, stigma refers to an individual's awareness of how others may act, think, or feel toward a person with a specific trait or identity [18], and can generally be categorised into three domains. *Anticipated stigma* refers to expectations of stigma experiences happening in the future [18],

such as thinking, “I believe I might be judged harshly because of my cancer”. *Internalised or felt stigma* is the process in which a person becomes aware of, accepts, and applies stigma to themselves [18], for instance, feeling “I am less worthy because of my cancer”. Finally, *experienced or enacted stigma* refers to overt discriminatory actions or behaviours [18], such as, “My co-workers avoid or isolate me because of my cancer diagnosis”. This review focuses on enacted stigma. Cancer-related discrimination is defined as perceived direct and recurring experiences of enacted stigmatisation, behaviours, or unfair conduct based on an individual's history of cancer, current cancer diagnosis, or perceived risk of developing cancer in the future. This definition was informed by the Health Stigma and Discrimination Framework [24]. Cancer-related discrimination also includes perceived unfair conduct experienced by informal caregivers when providing care to someone with cancer. Due to these definitions the terms enacted stigma and discrimination are used interchangeably in this evidence synthesis review. Notably, discrimination can be difficult to measure because it is often implicit, indirect, and subtle, rather than overt or clearly defined and measured. Given its subjective nature and the challenges in objectively measuring this phenomenon, this review focuses on participants' perceived experiences of discrimination, which are central to understanding how such experiences shape their decisions around their care and affect their health outcomes.

2.1 | Theoretical Framework

The Health Stigma and Discrimination Framework [24] was used to inform the definition of the phenomena of interest, interpret and discuss data, synthesise findings, present results, and formulate practical recommendations as it has been previously applied in cancer populations [24]. This comprehensive framework captures the multiple dimensions of disease-related stigma and discrimination to understand its drivers, facilitators, manifestations, and impacts (see Figure 1 and Table 1).

3 | Methods

3.1 | Study Design and Eligibility

A scoping review methodology of peer-reviewed studies was chosen to better understand the drivers, experiences and effects of cancer-related discrimination, and to identify areas for future research. This scoping review followed the Joanna Briggs Institute methodology [25] and was reported according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews (PRISMA-ScR) reporting guideline (see Checklist Supporting Information S1) [26]. The population-concept-context strategy [25], a widely used tool for defining study eligibility in scoping reviews, was used to guide the research question and inclusion criteria (see Table 2). The populations of interest for this review were people affected by cancer or individuals with pre-disposing cancer variants (e.g., presence of genetic mutations). The review included peer-reviewed, English-language articles published within the past 20 years, encompassing qualitative findings from qualitative and mixed-methods research, as well as systematic and scoping reviews. This review focused on qualitative evidence; a separate review synthesises the quantitative findings. The significant changes in cancer treatments, public awareness,

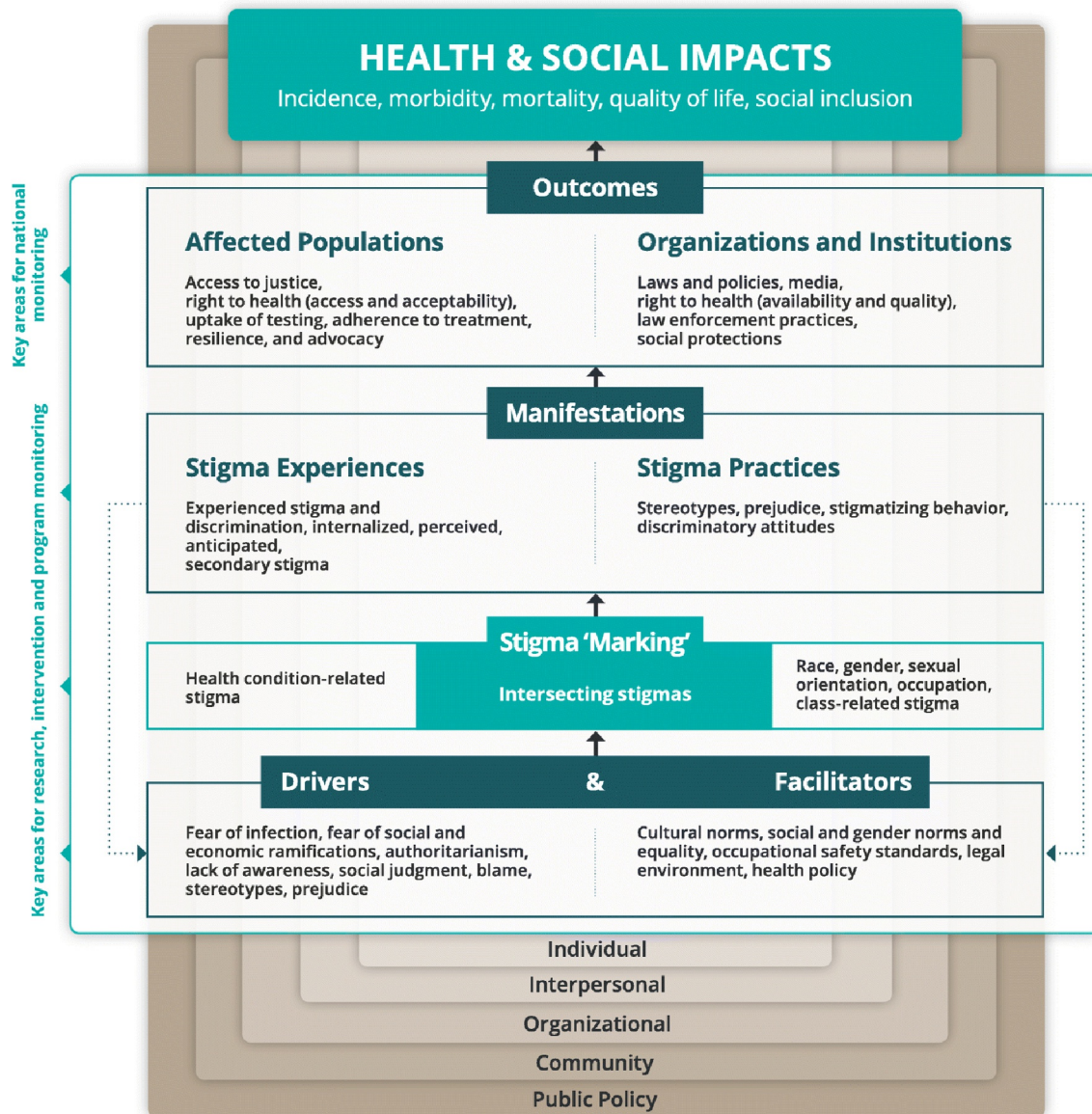


FIGURE 1 | The health stigma and discrimination framework. Reproduced with permission from stangl and colleagues.

TABLE 1 | Key definitions according to the health stigma and discrimination framework.

Category	Definition	Examples
Drivers	Underlying factors that initiate or fuel stigma from individuals.	Fear of infection, blame, concerns about productivity, authoritarianism
Facilitators	Contextual and institutional factors that can either increase or decrease stigma (influence how stigma develops); may be positive or negative (e.g., presence or absence of safety standards and/or legal protections).	Protective supplies in clinics (positive); lack of occupational safety (negative)
Manifestations (stigma experiences)	Lived realities of those affected by stigma. Represent how stigma is experienced personally or socially.	Verbal abuse, internalised shame, refusal of services, fear of being judged
Manifestations (stigma practices)	Beliefs, attitudes, and behaviours that express or reinforce stigma. How experiences of stigma influence an individual's beliefs, attitudes, and behaviours.	Stereotyping, gossip, social exclusion, discriminatory beliefs

and anti-discrimination regulation and policies [27–29] over the past 20 years, provides a landscape to understanding the evolution of factors influencing discrimination and their current

impact in the health and policy landscape. The detailed inclusion and exclusion criteria for the review are presented in Table 2.

TABLE 2 | Inclusion and exclusion criteria—Population, concept, context, study design.

Inclusion criteria	Exclusion criteria
Population Individuals with pre-disposing cancer variants—no age limit. People affected by cancer—no age limit (cancer patients, cancer survivors, family/caregivers of people with cancer). Studies that included other participants (e.g., the public, health professionals, employers, hiring managers) were also eligible, provided they included people affected by cancer among their participants.	Study populations not involving people affected by cancer or those with a genetic predisposition for cancer.
Concept Cancer-related discrimination: Direct and recurring experiences of stigmatisation, behaviours or unfair conduct based on an individual's history of cancer, current cancer diagnosis, perceived risk of developing cancer in the future or caregiving responsibilities for someone with cancer. Experiences (e.g., views, attitudes, feelings) of cancer-related discrimination. Descriptions of individual, family, social, and health outcomes.	Studies exploring discrimination experienced during cancer care that is not directly a result of a cancer diagnosis or predisposition to cancer.
Context Publications limited to peer-reviewed journal articles in the English language, published between January 2004 and December 2025 (after updated search).	Duplicate articles retrieved from different databases and literature with unavailable full texts (e.g., abstracts only, conference proceedings, news reports).
Study design Mixed-methods, systematic and scoping reviews, qualitative research, interview, focus groups, case studies, etc.	Conference abstracts, commentaries, and editorials

3.2 | Search Strategy

The search strategy was developed in consultation with a research librarian and informed by existing transdisciplinary reviews on discrimination and health, the Health and Discrimination Framework, and other relevant terms. Literature searches were conducted in ProQuest databases, Cochrane CENTRAL, Scopus, APA PsycINFO, MEDLINE, and Web of Science, from January 2004 to December 2025. A systematic search strategy initially designed for MEDLINE (via Ovid) was followed and was adapted for each database (see Supporting Information S2). Free text terms and relevant specific subjective headings (i.e., MESH, Emtree) for concepts related to ‘cancer’ (e.g., cancer survivors, cancer patients, cancer caregivers), ‘discrimination’ (e.g., stigma, prejudice, unfair) and other related terms were used. The reference lists of included articles were also searched for relevant papers that met the review inclusion criteria.

3.3 | Study Selection

The review management software Covidence [30] was used to store, organise, and manage all references identified in the literature search. After removal of duplicates, a two-stage screening process was conducted whereby titles/abstracts and full-text articles were independently screened by two blinded reviewers (OAA, JWP). In stage 1, titles and abstracts were checked for relevance to the review research question (population, concept, context, study design). Articles with unclear eligibility were retained for further assessment. In stage 2, the full-text of each article included from stage 1 were retrieved and

independently assessed for inclusion by the same two blinded reviewers. Disagreements were resolved through consensus among the two reviewers, with a third reviewer (FCW) as arbiter if required. Formal critical appraisal was not conducted, consistent with scoping review methodology [26], as the aim of this review was to systematically map the experiences of cancer-related discrimination rather than determine effectiveness or causal inferences. A minimum quality threshold was established by restricting inclusion to peer-reviewed research.

3.4 | Data Synthesis and Extraction

Data synthesis was consistent with Best Fit Framework Synthesis (BFFS) [31] approach involving (i) selection of an a priori framework derived from existing theory, (ii) deductive coding of extracted qualitative data against this framework, (iii) inductive content analysis of data not accommodated within the framework, and (iv) iterative refinement and integration of emergent themes to produce a revised framework. Following a review of relevant theoretical models and frameworks, the Health Stigma and Discrimination Framework was selected as the a priori framework to provide an initial analytical structure, comprising the drivers, facilitators, stigma experiences/practices, and impacts of discrimination.

For the analysis first a deductive coding approach was applied, whereby extracted qualitative data (including verbatim participant quotations and author-reported findings) were coded into a structured matrix based on the predefined domains of the Health Stigma and Discrimination Framework. These domains functioned as initial coding categories, enabling systematic and

transparent organisation of the data. Coding was conducted independently by two reviewers (OAA, JWP) to ensure reliability, with discrepancies resolved through discussion and consultation with a third reviewer (FCW). Second, data that could not be accommodated within the a priori framework were subjected to inductive thematic coding. This involved iterative reading, constant comparison across studies, and the generation of new codes and themes grounded in the data. Each reviewer initially developed candidate themes, which were then refined and agreed through team discussion. Through constant comparison across studies, additional themes were identified, particularly relating to the social and structural contexts in which cancer-related discrimination occurred. These themes were integrated with the original framework to produce a revised analytical framework. Contextual domains encompassing familial/social relationships, hiring and workplace settings, insurance and welfare systems, and healthcare settings emerged as cross-cutting categories through which stigma drivers,

manifestations, and impacts were experienced. All data were subsequently re-charted within the revised framework, enabling comparison both within stigma-related domains and across contextual settings. The final synthesis therefore reflected an integrated deductive–inductive analytical process consistent with Best Fit Framework Synthesis methodology [31].

4 | Results

4.1 | Study Characteristics

The literature search identified 3135 articles from databases and registers, with a further 26 articles identified through reference-list searching, resulting in 3161 records overall (see PRISMA Flow diagram in Figure 2). Following removal of 1485 duplicates, 1676 articles were screened. After title and abstract screening, 417 full text articles were assessed for eligibility, of which 116 met the criteria for inclusion in the review. The

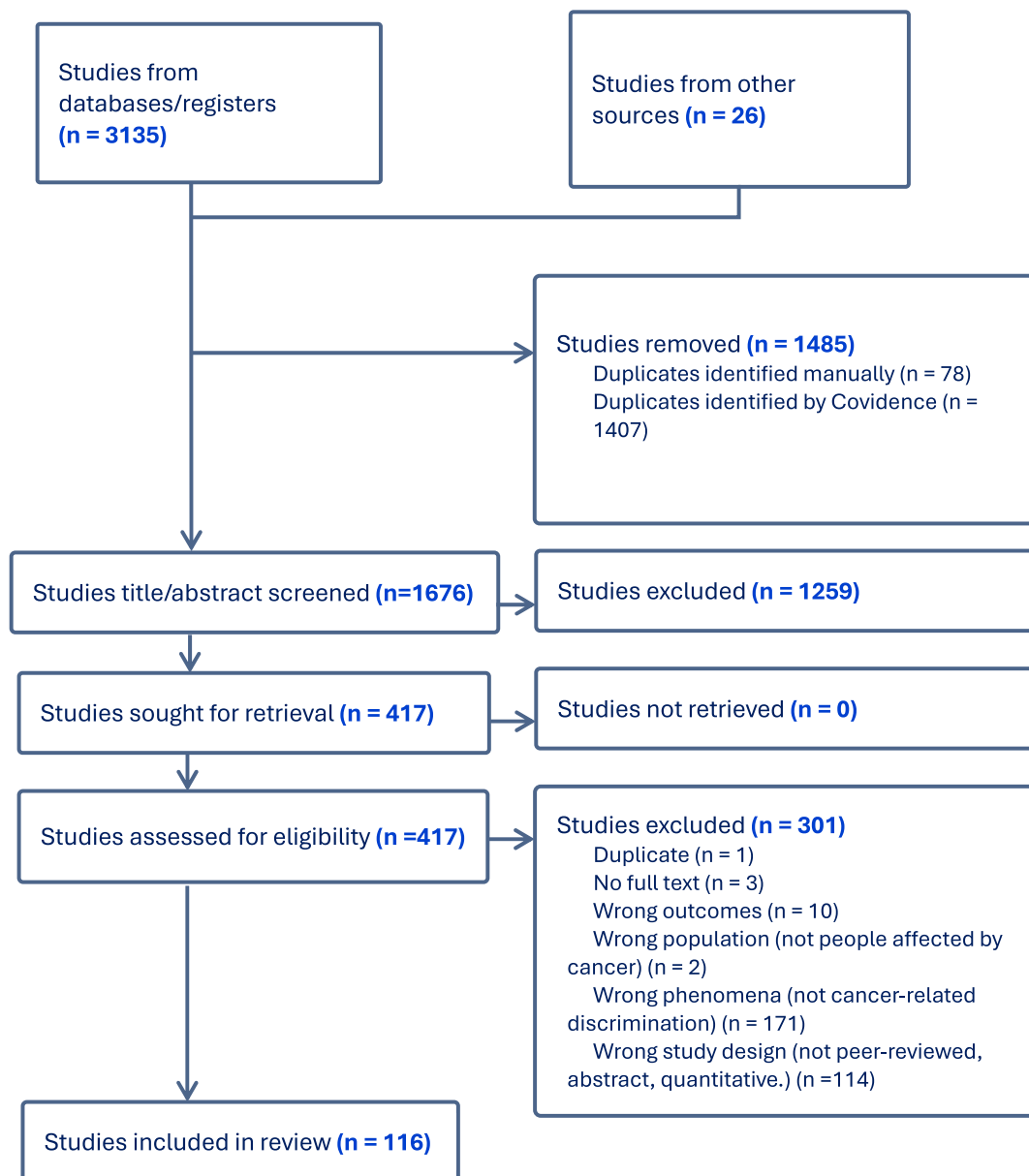


FIGURE 2 | PRISMA flow diagram.

included studies comprised 83 qualitative studies, 23 mixed-methods studies, nine systematic reviews, one scoping review. Geographically, most studies were conducted in Asia ($n = 54$), followed by Africa ($n = 21$), North America ($n = 19$), Europe ($n = 11$), and Oceania ($n = 11$).

4.2 | Types of Cancer-Related Discrimination

Reported experiences of cancer-related discrimination were characterised into four contexts: (1) familial and social; (2) hiring and workplace; (3) insurance and welfare; and (4) healthcare. The drivers, experiences, practices, impacts, and recommendations across these four contextual domains are summarised in Table 3. Figure 3 shows the number of studies reporting cancer-related discrimination within a specific context, differentiated by geographical region (3a) and by cancer group (3b), noting that individual studies could report on more than one discrimination context. Across geographical regions, studies from Asia and Africa most often described cancer-related discrimination in familial and social contexts, while those from North America more frequently reported workplace and insurance-related discrimination. Notably cancer-related discrimination in healthcare contexts was most often reported in studies with lung cancer survivors.

4.3 | Cancer-Related Discrimination Drivers and Facilitators

Cancer-related discrimination within familial and social settings was reported across multiple studies to be largely driven by misconceptions and misinformation, particularly the belief that cancer is contagious [33, 35, 37, 40, 41, 44, 46, 47, 49–55, 57–60, 63, 65, 66, 69, 73, 79, 82, 83]. This misconception often fostered fear of infection and resulted in avoidance and exclusion [33, 35, 37, 40, 41, 44, 46, 47, 49–55, 57–60, 63, 65, 66, 69, 73, 79, 82, 83]. Cultural and moralised narratives [32, 33, 53, 55, 56, 66, 69, 74, 75, 78, 79, 85–87, 93, 95] also positioned cancer as a form of divine punishment, karma, or the consequence of lifestyle choices such as smoking. Discrimination was also strongly tied to blame-based narratives suggesting that cancer was self-inflicted or the result of unhealthy behaviours, particularly in cases of lung [42, 49, 84, 89, 92], prostate [88], head and neck [83, 94], and gynaecological cancers [34]. Visible signs of illness (e.g., alopecia, disfigurement after surgery, drastic weight loss, voice changes) were also reported to act as discrimination drivers, reinforcing perceptions of abnormality, leading to bullying and social exclusion [39, 43, 44, 47, 48, 61, 62, 68, 71, 75–77, 80, 81, 90, 91, 93, 94]. Gender norms further intensified these dynamics whereby women with cancer were judged in relation to femininity, fertility, and marriageability, while men with prostate and breast cancer described threats to masculinity and perceived productivity in the workplace [33, 39, 61, 70, 75, 76, 80, 81, 91, 95]. System-level facilitators of discrimination included lack of public education, silence around illness, and harmful media portrayals that reinforced blame [33, 34, 37, 41, 42, 52, 55, 56, 64, 65, 67, 73, 78, 79, 86, 94, 96, 140].

In workplace contexts, discrimination was driven by stereotypes about survivors' productivity, health, and reliability. Employers and colleagues often assumed cancer survivors would need

excessive time off or were at high risk of recurrence, rendering them less dependable [116, 120, 122]. Discriminatory practices were also facilitated by vague or risk-averse employment policies that allowed subjective interpretation of an employee's "fitness" for work [120–122, 125]. Conversely, structured and flexible policies were reported as protective, enabling smoother reintegration into the workplace [120].

In welfare and insurance contexts, cancer-related discrimination was often thought to be facilitated by bureaucratic opacity, rigid and restrictive eligibility criteria, and limited regulatory oversight over use of genetic and other health information [8, 33, 39, 61, 70, 75, 76, 80, 81, 91, 95, 137, 138]. For example, opaque underwriting processes, the use of genetic information without adequate safeguards, and inconsistent definitions of 'pre-existing conditions' created structural disadvantages for cancer survivors and at-risk individuals [50, 125, 133].

Within the healthcare context, blame-based narratives [49, 84, 89, 92] largely drove discriminatory actions. Patients were frequently assumed to have caused their own illness through smoking or other behaviours, reducing healthcare provider empathy. System-level facilitators included public health campaigns focusing heavily on smoking risks. This unintentionally reinforced stigma practices concerning individuals diagnosed with lung cancer, including people whose cancers were non-smoking related [49, 84, 89, 92].

4.4 | Reported Cancer-Related Discrimination Experiences

In familial and social contexts, included studies described ostracism, bullying, and abandonment by family members or partners as a result of disclosing their cancer diagnosis [32–115]. Examples included spousal veto of treatment decisions such as refusal of permission for mastectomy [64], and threats of remarriage or abandonment if treatment was pursued [32, 37, 61, 70, 93]. Survivors with visible treatment effects (e.g., mastectomy, tracheostomy, alopecia) frequently experienced overt bullying, name-calling and social exclusion [39, 40, 43, 44, 48, 57, 62, 77, 83, 91, 94].

In the workplace context, studies reported that individuals experienced discrimination during both hiring processes and ongoing employment [36–38, 47, 53, 55, 57, 59, 68, 72, 76, 83, 116–133]. Cancer survivors and caregivers reported explicit exclusion from jobs during the hiring process after disclosure of a cancer history [55, 76, 116, 119, 121, 122, 126, 132], barriers to career advancement [13, 137] demotion, pressure to resign, workplace bullying [76, 133], and in some cases, revocation of employer-provided insurance benefits [57, 72, 132]. Caregivers of childhood cancer survivors in Lemmen and colleagues' study [57] described being criticised and bullied by colleagues who questioned their absences from work.

In the insurance and welfare context, studies described denial of insurance coverage; exclusion after genetic testing; and difficulties accessing superannuation, welfare or disability entitlements [122, 123, 131, 135]. Consumers reported that rigid welfare/insurance eligibility criteria and application processes

TABLE 3 | Overview of cancer-related discrimination across social/familial, workplace, insurance, and healthcare contexts.

Cancer-related discrimination domain	Study count (N)	Drivers & facilitators	Experiences	Practices	Impacts	Institutional recommendations
Familial & social	N = 87 [32–115]	Drivers: Beliefs about contagion (fear of infection); cancer patients are unhealthy, moral/religious framing (karma, punishment, divine retribution); visible signs (alopecia, mastectomy, tracheostomy, weight loss) as cues of ‘abnormality’; reproductive/sexual cancers associated with inferred sexual impropriety & shame; lung/head & neck cancers linked to ‘self-inflicted’ lifestyle blame; gender norms (masculinity, femininity). Facilitators: Widespread misinformation; secrecy norms around illness; patriarchal expectations (permission for treatment, fertility tied to worth); harmful media framing of cancer as preventable/self-caused; weak or non-existent legal protections; schools/workplaces lacking awareness.	Ostracism from peers/community/family; bullying and name-calling; partner withdrawal or abandonment; emotional detachment or remarriage threats; veto of treatment decisions (esp. mastectomy); reduced marriage prospects; gossip and reputational damage; separated spouse/family using partner’s illness to secure custody of minor children	Concealment from family, employers, schools; instructing children not to disclose; withdrawal from community/religious events; use of alternative medicine for privacy; delayed help-seeking; refusal of genetic testing/preventive care; overcompensation (rapid return to work, overexertion); self-blame and guilt.	Anxiety, depression, hopelessness; feelings of worthlessness/shame; self-isolation; difficulty reintegrating into work/school/community; strained family relationships; diminished marriageability and marital strain; delayed or abandoned treatment → advanced disease and worse prognosis; disrupted caregiving roles; financial hardship (job loss, treatment costs); caregiver burnout.	Individual/community: Survivor-led peer groups; gender- and age-sensitive counselling; public education to counter contagion myths, hereditary blame, and reproductive stigma. Org/institutional: School and workplace anti-stigma training; media guidelines to avoid blame framing; integration of psychosocial care. Policy: Anti-discrimination protections; transport/financial support schemes; funding for public campaigns; insurance and employment law reform.
Hiring & workplace	N = 33 [36–38, 47, 53, 55, 57, 59, 68, 72, 76, 83, 115–133]	Drivers: Misconceptions about productivity, reliability, and recurrence risk; stereotypes of incapacity or frailty; fear of costs (accommodations, redundancy, or pressure to	Job applicants overlooked post-disclosure; requests for recovery certificates; rescinded offers; bullying and gossip; demotion, redundancy, or pressure to	Concealment of diagnosis; wearing masks/wigs to hide visible effects; avoiding disclosure of treatment history; job changes/downshifting to	Job loss, debt, and economic insecurity; stress, anxiety, helplessness; relationship strain/divorce; career disruption; social	Individual/community: Peer and supervisor networks; disclosure support programs. Org/institutional: Standardised RTW

(Continues)

TABLE 3 | (Continued)

Cancer-related discrimination domain	Study count (N)	Drivers & facilitators	Experiences	Practices	Impacts	Institutional recommendations
		absenteeism); visible impairment leading to stigma; social norms equating illness with weakness. Facilitators: Ambiguous fitness-to-work policies; limited or poorly coordinated sick leave and RTW (return-to-work) supports; discretionary enforcement of sick leave or medical clearance requirements; informal managerial decision-making; loss of employer-based insurance; gendered expectations that women prioritise caregiving; vague protections against discriminatory hiring; inconsistent compliance with existing legal protections.	resign; reassignment to lower-benefit roles; rescission of health/insurance coverage; caregivers bullied for absences; exclusion from promotion, training, or leadership opportunities justified through ‘future health risk’ rather than current capacity.	less scrutinised roles; forgoing entitlements or benefits; reliance on rare supportive employers offering flexible duties.	isolation; withdrawal from workforce; diminished trust in employers; in supportive contexts, smoother reintegration and greater wellbeing.	pathways; flexible duties, hybrid work, and modified schedules; empathetic management; job retention policies; continued benefits. Policy: Paid sick leave; enforcement against discriminatory hiring/termination; workplace accommodations mandated by law.
Insurance/Welfare/Genetic	N = 16 [8, 45, 47, 50, 55, 122, 123, 125, 131–138]	Drivers: Cancer framed as ‘economic burden’ or pre-existing condition; actuarial bias against genetic predisposition; welfare systems designed around static criteria that don’t fit fluctuating illness”. Facilitators: Bureaucratic hurdles; fragmented communication between insurers and welfare	Coverage denials; rejection for life/disability insurance despite remission; strict welfare eligibility (must prove imminent death or disability); discouraged from applying; rejection after genetic testing; difficulty accessing superannuation or sick leave; frustration with bureaucratic processes.	Avoiding welfare/insurance applications due to fear of rejection; concealing diagnosis or family history; refusal of genetic testing to preserve insurability/employment; incurring debt or using savings; accepting lower-paid insecure jobs; avoidance of formal financial systems and opting out of welfare	Financial hardship (debt, depleted savings, housing insecurity); emotional distress, frustration, feelings of rejection or worthlessness; reduced access to treatment; worsened symptom burden due to care delays; intergenerational anxiety about hereditary risk.	Individual/community: Patient navigation services; survivorship education; peer/advocacy groups to demystify welfare and insurance; privacy safeguards for genetic data. Org/institutional: Streamlined insurer/welfare processes; transparent underwriting criteria; workplace

(Continues)

TABLE 3 | (Continued)

Cancer-related discrimination domain	Study count (N)	Drivers & facilitators	Experiences	Practices	Impacts	Institutional recommendations
Healthcare	N = 6 [49, 84, 89, 92, 107, 139]	agencies; opaque underwriting; weak and self-regulation of insurers and genetic privacy.	Provider blame/judgement ('you brought this on yourself'); strained doctor-patient communication; concealment of smoking history; those with non-smoker history wrongly accused of smoking; patients feeling less deserving of care; caregiver distress; refused biopsies or treatments; stigmatising attitudes that inferred sexual impropriety	Concealment of diagnosis/smoking history; disengagement from healthcare; avoidance of open conversations; assertion of 'non-smoker identity'; identity shifts with shame/guilt; searching for validation or alternative care.	Psychological distress (shame, guilt, regret, depression); diminished quality of life; lower treatment adherence; social isolation; caregiver burden; delayed diagnosis and worsened outcomes; erosion of trust in healthcare.	support for accessing entitlements. Policy: Stricter insurance and genetic non-discrimination laws that involves independent regulation; catastrophic cost protections; tax relief for cancer care; systemic monitoring of credit/debt risk.
		Drivers: Cancers associated with perceived 'behavioural fault' (e.g. lung, cervical/HPV-related, obesity-linked, unscreened cancers) framed as self-inflicted, morally suspect, or socially undeserving; people with smoking history seen as culpable; those without smoking history wrongly assumed to have a smoking history; contagion myths; diminished empathy for 'lifestyle' cancers. Facilitators: Stigmatising prevention campaigns (e.g. graphic anti-smoking ads); public blame narratives; media stereotypes; rushed, dehumanised clinical care limiting empathy.				Individual/community: Counselling, peer-led support groups, stigma-awareness education. Org/institutional: Provider training in empathic communication; integration of psychosocial screening and routine stigma-sensitive care; normalisation of sensitive discussions (HPV, fertility, smoking, body image). Policy: Reduce access barriers; embed stigma reduction in prevention campaigns; strengthen privacy protections for health, medical, and genetic data.

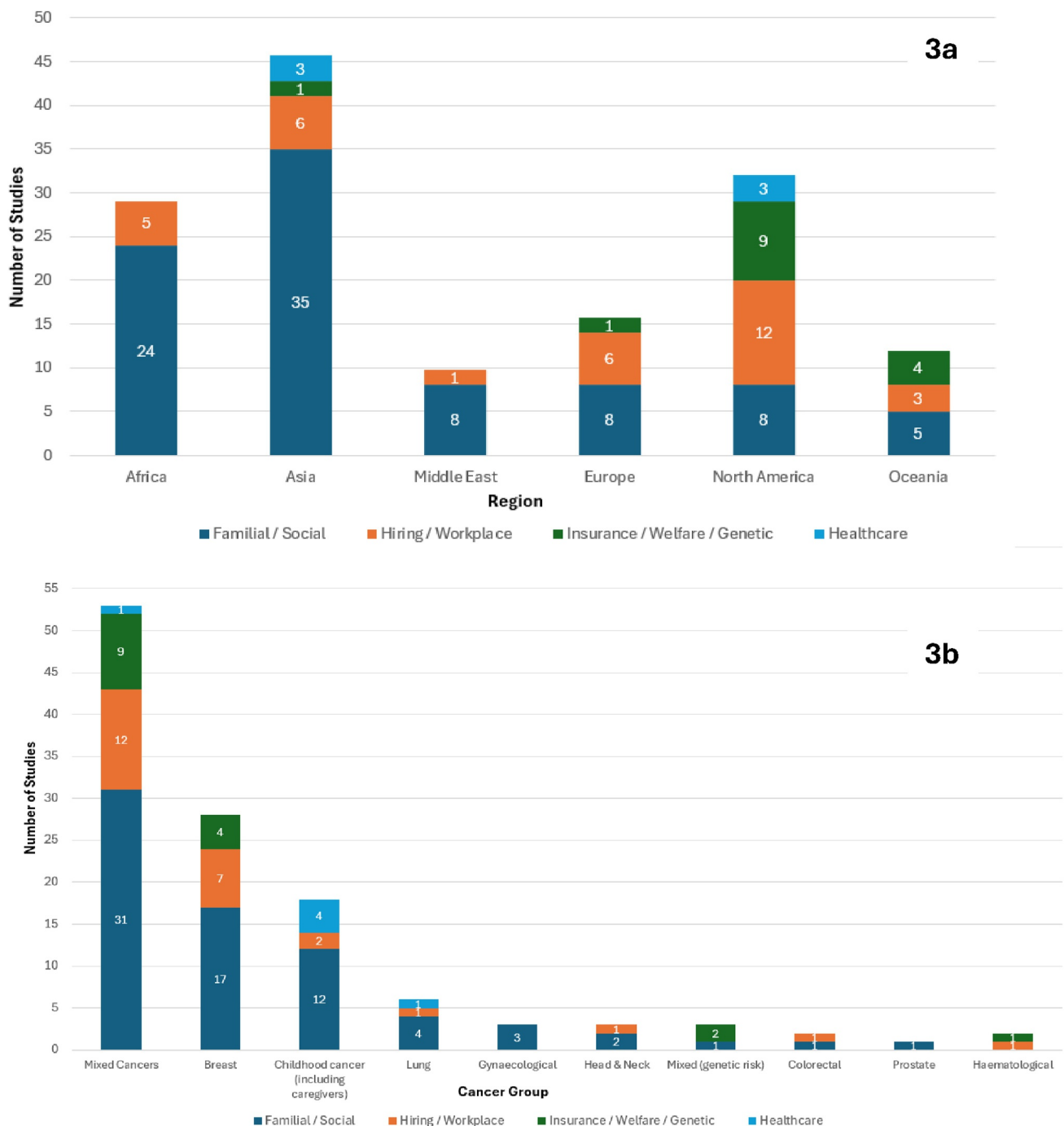


FIGURE 3 | Reported contexts of cancer-related discrimination by geographical region (3a) and cancer group (3b). Studies may be represented in more than one discrimination context category as some studies examined multiple forms of cancer-related discrimination. Consequently, the totals shown across categories exceed the total number of included studies ($n = 116$).

often failed to capture the fluctuating realities of survivorship [122, 135]. Employers sometimes discouraged employees from applying for life insurance [136], while others were denied coverage altogether following genetic testing [50, 125, 133]. In Stepanikova and colleagues' study [102], participants reported they were unable to obtain life insurance policies through their employers, as they were perceived to be an economic risk to the company, despite being cancer-free for more than 10 years. Fragmented communication with welfare agencies added further stress, with self-employed individuals particularly

disadvantaged [123, 138]. Bindley and colleagues [138] documented how bereaved Australian caregivers experienced welfare systems as implicitly punitive and distrust-oriented, characterised by having medical letters and certificates repeatedly questioned or rejected, ongoing requirements to prove job-seeking or re-validate pre-existing health conditions, and penalties linked to disrupted employment trajectories. This contributed to perceptions that welfare processes were inequitable and poorly aligned with the realities of caregiving and bereavement.

Cancer-related discrimination in the healthcare context was most often reported in relation to individuals with lung cancer [49, 84, 89, 92], where participants described being judged or blamed by healthcare providers, with patients frequently assumed to have had a smoking history whether this was true or not. These interactions led to feelings of injustice, mistrust, and alienation within the healthcare system.

4.5 | Practices (Responses and Coping Strategies)

Studies report that people affected by cancer often responded to discrimination in social and familial contexts through concealment; including hiding their diagnosis to avoid gossip, pity, or exclusion [32, 37, 41, 46, 52, 53, 55, 57, 59, 60, 63, 65, 68, 69, 74, 78–80, 83, 85, 93, 140]. Many studies reported participants withdrawing from community life [35, 39, 48, 62, 65, 75, 93], while fear of visible treatment effects (e.g., hair loss, mastectomy) also contributed to avoidance of treatment, and traditional or alternative remedies were preferred as they were perceived as more discreet [53, 61, 64, 65, 68, 70, 73, 78, 79, 86].

In the hiring and employment context, studies reported that employees often masked symptoms [53, 124, 126], accepted lower-paid roles or jobs to reduce scrutiny [119, 122, 132], or quit work entirely [129, 130]. Some chose jobs that did not require medical certificates for absences [37], while others coped by overexerting themselves to remain in favour with employers [77], returning to work immediately after treatment or striving to match colleagues' productivity [59, 77].

In the insurance and welfare context, studies reported that participants engaged in strategic avoidance behaviours to protect themselves from future exclusion and institutional penalties. Practices included withholding family history or genetic risk information, refusing genetic testing, and concealing diagnosis status to avoid insurers using genetic or other health information against them [8, 50, 55, 125, 132, 133]. Participants also reported they deliberately avoided applying for welfare benefits or insurance products altogether (despite eligibility) due to anticipated rejection or excessive administrative burden [8, 123, 134, 136, 138]. This behaviour was also driven by fears of penalties, payment suspensions, or being pursued by authorities. Other practices included taking on personal debt, relying on credit cards, paying out of pocket for services (despite potential insurance coverage), or foregoing recommended genetic testing or treatment to avoid creating documentation that might later jeopardise insurance eligibility [8, 122, 131].

Studies reporting on cancer-related discrimination in healthcare contexts often reported participant's social withdrawal, reduced engagement with services, and shifts in self-identity [49, 84, 89, 92]. Stigma experiences shaped behaviour in both society and healthcare, and was frequently linked to guilt, self-blame, and perceptions of being a burden or risk to family members [84]. To avoid judgement, some participants limited disclosure of smoking history, concealed their lung cancer diagnosis, or disengaged from healthcare entirely [49]. Others actively asserted their non-smoking status to distinguish themselves from those with smoking-related lung cancer [92].

4.6 | Impacts of Cancer-Related Discrimination

Across all contexts, cancer-related discrimination was consistently linked to poor quality of life, psychological distress including anxiety, depression, guilt, and reduced self-worth.

Cancer-related discrimination in the social context resulted in reported breakdown of family relationships, including partner withdrawal, marital instability, abandonment by spouses, and relationship dissolution [32, 36, 37, 39, 46, 48, 52, 57, 61, 64, 68, 70, 72, 79, 94]. Cancer survivors and caregivers frequently experienced loss of friendships and erosion of long-standing social connections [35, 39, 40, 43, 44, 49, 58, 60, 63, 66, 71, 77, 83, 91]. Enacted stigma also contributed to diminished marriage prospects, particularly for women, with eligibility for marriage, desirability, and future family formation reported as negatively impacted [34, 48, 57, 70, 73, 75, 140]. These experiences were reinforced by pervasive social isolation, both imposed by others and self-initiated by survivors as a protective strategy [32–96]. In studies reporting on childhood cancer survivors, patient- and caregiver-bullying was frequently cited as a barrier to school and educational re-entry [43, 57, 77, 81]. Financial toxicity and socioeconomic strain (e.g., housing instability) were also consistently reported impacts of enacted stigma and discrimination across several studies [38, 45, 57, 67, 72, 84, 95].

Employment-related discrimination carried profound economic consequences including job loss, reduced employability, demotion, and ongoing financial strain [25, 38, 43]. Survivors often incurred significant out-of-pocket costs [38, 72, 118, 119, 122, 123, 131], debt [38, 119, 129, 130], and housing insecurity [38], disrupting life plans. Unemployment and career derailment further compounded welfare insecurity [132], and balancing treatment with employment demands amplified ongoing financial distress [123]. Cancer survivors and caregivers reported that job loss significantly reduced autonomy, restricted opportunities for career development, and constrained long-term goal setting [127, 130]. These effects also extended to cancer survivors' support networks, where savings were depleted to cover treatment costs, parents altered their own career trajectories, and siblings' educational opportunities were negatively affected [57, 72, 129].

Discriminatory barriers to insurance and welfare access contributed to financial vulnerability, with studies reporting that individuals had difficulty securing benefits and income protection [134, 138], accumulating debt to compensate for coverage gaps [45], and being excluded from policies altogether [123, 133]. These exclusions intensified financial instability through persistent debt cycles [122, 138] and worsening credit security due to medical costs [45]. Studies reported on participants' distrust of insurers [125] and scepticism regarding insurance regulations [136]. These financial exclusions also produced broader psychosocial impacts, including emotional distress and hopelessness [47], anxiety about future financial security [45, 138], and fears that genetic discrimination would jeopardise future insurance access for family members, particularly children [8, 125, 136].

Cancer-related discrimination in healthcare contexts negatively affected psychological wellbeing in several studies, with

participants reporting depression, guilt, shame, frustration, and fear of judgement from providers [49, 84]. Experiences of stigma were reported to reduce quality of life and social connection, contributing to loneliness, strained family relationships, and reduced engagement with services [49, 84]. Some concealed their diagnosis or avoided discussing smoking to prevent negative reactions from clinicians [89, 92]. Stigma also disrupted treatment adherence by limiting open communication with clinicians [49, 84].

4.7 | Recommended Solutions

Across all contexts, a central recommendation reported in included studies was the implementation of comprehensive public education campaigns to address persistent misconceptions about cancer and reduce stigma. Education was viewed as critical to dispelling myths of contagion, challenging blame-based narratives, and reducing discrimination in familial, workplace, insurance, and healthcare contexts.

4.7.1 | Familial and Social Context

Reported recommendations included implementing culturally-tailored public education initiatives to correct contagion myths and reduce stigma [34, 48, 57, 70, 73, 75, 140], alongside the development of community-level peer support groups to facilitate psychosocial support [41, 46, 48, 55, 76, 78, 80, 84, 88, 92]. Additional recommendations included targeted school reintegration supports for children and adolescents, and the expansion of survivorship rehabilitation and reintegration programs to facilitate social and functional return after cancer treatment [55, 76, 77, 95].

4.7.2 | Hiring and Workplace Context

Studies emphasised the importance of supportive institutional cultures facilitated by clear return-to-work policies, paid sick leave, flexible scheduling, and empathetic communication from management to foster more inclusive environments and support reintegration [47, 118–121, 123, 132, 133]. Survivorship programs enabling reintegration through career counselling and retraining were also recommended [132]. Broader advocacy efforts from patients, clinicians, and researchers were suggested to drive policy reform and influence workplace standards that better reflect survivor needs [122], alongside the need for stronger legal protections, mandated workplace accommodations, and effective mechanisms to ensure compliance with these legal protections.

4.7.3 | Insurance and Welfare Context

Suggested reforms reported in the included studies consisted of the implementation of streamlined and transparent insurance claims processes to improve navigation and reduce administrative burden [123, 134]; the simplification of application requirements [123, 138]; independent regulation and stricter safeguards on the use of genetic data and legal protections to prevent discriminatory underwriting by insurance companies [8, 50, 136]; and welfare system changes aimed at reducing catastrophic financial impacts through improved financial assistance, greater cost transparency, and tax relief mechanisms [45, 55, 122, 131, 135]. Such welfare changes includes a review

of certain payment features including expectations of compliance with job-seeking and requirements in early bereavement for caregivers [138].

4.7.4 | Healthcare Context

Recommendations emphasised the need to strengthen clinician communication training to support empathetic, non-blaming and non-judgemental dialogue with people affected by cancer [49, 84, 89, 92]. Public health strategies to correct smoking-related misconceptions and educate patients on tobacco industry influence were also proposed, alongside increasing survivor participation in peer support as a mechanism to counter internalised blame and stigma [92].

5 | Discussion

This review is the first to synthesise qualitative evidence on cancer-related discrimination and to map the mechanisms by which it manifests. Notably, our synthesis highlights that public misconceptions, and moralising narratives (e.g., that cancer is contagious or self-inflicted) are persistent drivers of cancer-related discrimination, with all studies recommending some form of public education to combat stigma experiences (see Figure 4). Moreover, findings from this review align with previous research examining attitudes and perceptions about cancer among the general population [140–143]. People with cancer are frequently viewed by the general public as responsible for their cancer diagnosis, weak, unable or unlikely to contribute to work, and as people whom others would actively avoid [140–143]. In Cho and colleagues' [143] survey of 1011 Korean adults without a cancer history, 71.8% of participants believed that cancer survivors would never be able to contribute to society.

Such attributional attitudes are not limited to the general public [144]. Studies among health professionals [144, 145] have found systematic differences in how clinicians care for cancer survivors depending on perceived personal responsibility of their cancer. For instance, clinicians have frequently perceived lung cancer patients with a smoking history as less concerned about their illness, less knowledgeable, less adherent, and less pleasant to interact with compared to lung cancer patients without a smoking history [145]. Similar attributional patterns are well-documented in other cancers such as head and neck cancer [94] and health conditions such as mental health [146, 147] and HIV [148], where misinformation, misconceptions, and blame-based narratives fuel stigma. This review reinforces that cancer-related discrimination sits within a broader class of health-related stigma in which misinformation and attributions of personal blame amplify discrimination. This is supported by Link & Phelan's conceptual model [149], whereby stigma becomes discrimination when processes of labelling, stereotyping, separating, status loss, and enacted power converge, eventually leading to unequal outcomes.

Our findings highlight that cancer-related discrimination is not limited to interpersonal prejudice but also institutionalised in multiple contexts through structural conditions. Poor organisational and policy environments (e.g., rigid insurance and welfare eligibility criteria) can reproduce and reinforce

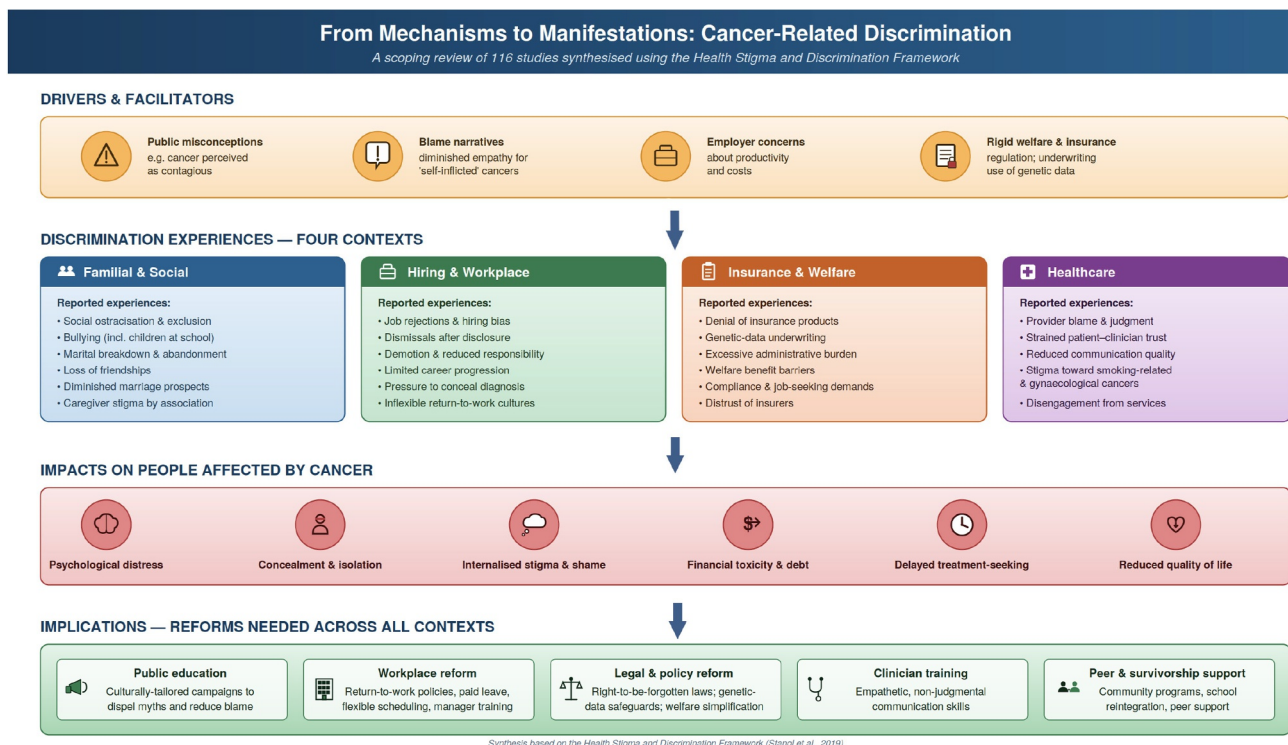


FIGURE 4 | Graphical summary.

discriminatory outcomes. For example, current income support and social security systems are often not fit-for-purpose in the context of increasingly complex and prolonged cancer treatments, such as immunotherapy or participation in clinical trials, which increase survival but may complicate eligibility for welfare benefits [138]. This deficiency in income and welfare support has carry-on effects, with our findings highlighting that people may discontinue or opt out of treatment due to financial or employment insecurity. Evidently, at a system-level, there needs to be a better understanding that cancer frequently requires recurrent episodes of care, along with recurrent episodes of employment restriction and need for income support. These findings parallel evidence from other disease-related stigma domains [24, 150], where systemic barriers amplify individual prejudice, into exclusion.

In this review, studies that examined social and familial forms of cancer-related discrimination were more frequently conducted or published in lower-middle-income countries (LMICs). By contrast, studies examining discrimination related to insurance and welfare systems; and employment and hiring practices, were more commonly undertaken in high-income countries (HICs), where formal labour markets, social security systems, and insurance frameworks render such discrimination more visible. As Heley and colleagues [151] emphasise, global cancer stigma research is unevenly distributed, and apparent regional differences could be more plausibly explained by variation in research priorities, measurement practices, and sociopolitical contexts than by cultural or socioeconomic differences in stigma itself. Thus, while geographical and cultural contexts may shape how cancer-related discrimination is constructed, expressed and recognised, the prominence of particular forms of discrimination in

HIC- or LMIC-based studies should also be understood as reflecting differences in investigation, visibility, and reporting, rather than an underlying prevalence alone.

5.1 | Intersectional Dimensions of Cancer-Related Discrimination

Strong interlinkages between cancer stigma and other stigmatised identities, such as gender and gender identity have been identified in literature [150, 152]. In this review, women reported post-diagnosis experiences of abandonment linked to perceptions of being ‘incomplete’, with reduced femininity and usefulness, particularly in relation to fertility. Socioeconomic disadvantage [153, 154] and rurality [155] have also been shown to compound stigma experiences; for example, Ernst and colleagues [154] reported that low socioeconomic status was a significant risk factor for cancer stigmatisation. Such findings reinforce the intersectionality of stigma in health [156], indicating that cancer-related discrimination cannot be fully addressed without also tackling wider systems of structural inequality.

5.2 | Future Implications

The Health Stigma and Discrimination Framework [24] emphasises that to address disease-related discrimination we must intervene ‘upstream’ by targeting stigma drivers and facilitators, while also mitigating enacted stigma once present. The Framework also highlights that stigma-reduction strategies work best when they target multiple groups and operate across different levels of society. Thus, a comprehensive approach could combine individual and community level strategies (e.g., peer support, survivor advocacy, and culturally grounded

education to dismantle contagion myths and reduce internalised shame) [150]. It could also include organisational reforms (e.g., empathetic provider training, flexible return-to-work practices, and transparent insurance processes supported by local leaders promoting positive norms), policy-level action (e.g., stigma-aware public health messaging that avoids blame narratives), and law reform (e.g., enforceable anti-discrimination and related privacy protections, such as safeguarding genetic data and the 'right to be forgotten') [150]. Legal interventions for cancer stigma are most effective when they operate to reshape the structural conditions that enable exclusion, across insurance, financial services, employment, and data governance; rather than relying primarily on individual, complaints-based enforcement [27, 151]. Recent work to embed a legally enforceable 'right to be forgotten' within supranational and national legislation in Europe illustrates both the potential and the limitations of law reform [28]. Similarly, in Australia, the Treasury Laws Amendment (Genetic Testing Protections in Life Insurance and Other Measures) Act 2025 (Cth) prohibits insurers from using adverse genetic testing results in underwriting, marking a shift from individualised disclosure toward the systemic prevention of financial discrimination. However, as this review highlights, while such measures can mitigate institutionalised financial discrimination against cancer survivors, their impact depends on careful integration with broader regulatory frameworks, and safeguards against uneven or exclusionary implementation [28]. Law reform must be embedded within a comprehensive approach that integrates legal protections with policy reform, public education, and institutional accountability.

Finally, it is integral for any cancer discrimination intervention to be sensitive to intersectional vulnerabilities. Analyses of policy and legislative responses, including right-to-be-forgotten legislation, caution that reforms grounded in normative assumptions about factors like recovery or employability risk leaving structurally marginalised groups under-protected unless intersectional disadvantage is explicitly addressed in policy, legislative design and implementation [27–29]. Without such attention, well-intentioned legal reforms and policies may formalise differential protections and entrench existing inequities.

5.3 | Strengths and Limitations

While enacted stigma has been reported across disparate studies, this review provides the first systematic synthesis focused specifically on elucidating its drivers, manifestations, and impacts, thereby moving beyond isolated accounts to identify potential points for intervention. This review presents a holistic perspective of cancer-related discrimination by capturing experiences across multiple regions and contexts: healthcare, workplace, social, familial, insurance and welfare. Additionally, it identifies recommendations, such as public education initiatives, to address stigma and reduce discrimination. By mapping the mechanisms in which discrimination manifests, the review identifies the key need for a comprehensive and intersectional approach to cancer-related discrimination as best practice for reform. This approach would encompass the integration of policy, legal, public health, and public education measures.

This scoping review was limited to peer-reviewed studies published in English, which may have introduced language and publication bias and excluded relevant evidence in non-indexed journals, and grey literature. Additionally, synthesised data was descriptive, leaving the prevalence and causal impacts of cancer-related discrimination unexplored. A further limitation is that the review included both primary studies and evidence syntheses (systematic and scoping reviews). Consequently, some primary studies may have been represented more than once across the included literature, potentially resulting in overlap of the underlying evidence base. While this may have increased the prominence of certain findings, the review's objective was to provide a comprehensive narrative synthesis of experiences of cancer-related discrimination rather than a quantitative estimate of effect, thereby reducing the potential impact of such overlap on the overall conclusions.

5.4 | Directions for Future Research

Future research should prioritise longitudinal studies to estimate the health, economic, and psychosocial effects of cancer-related discrimination, alongside evaluations of intervention effectiveness. Greater exploration of structural and intersectional dynamics of cancer-related discrimination will also be essential for maximising the effectiveness of law reform measures and designing policies that reduce inequities rather than exacerbate them.

6 | Conclusion

This review demonstrates that cancer-related discrimination is not only interpersonal, but is structurally embedded and intersectional. Cancer-related discrimination often arises from misinformation and institutional practices, producing profound consequences for people affected by cancer, caregivers, as well as those with a genetic risk for cancer. Addressing cancer-related discrimination requires coordinated interventions across individual, community, organisational, and policy levels. Crucially, these interventions must be attentive to intersectionality, as one-size-fits-all approaches risk failing to address, or even deepening, inequities experienced by the most vulnerable groups.

Author Contributions

Oluwaseyifunmi Andi Agbejule: conceptualisation, methodology, writing original draft, writing – review and editing. **Fiona Crawford-Williams:** conceptualisation, methodology, writing original draft, writing – review and editing. **Ria Joseph:** methodology, writing – review and editing. **Kim Hobbs:** methodology, writing – review and editing. **Carla Thamm:** methodology, writing – review and editing. **Sue Woodall:** methodology, writing – review and editing. **Ashleigh R. Sharman:** methodology, writing – review and editing. **Joe Wing Pun:** methodology, writing – review and editing. **Monique Bareham:** methodology, writing – review and editing. **Jenny Richards:** methodology, writing – review and editing. **James Scheibner:** conceptualisation, methodology, writing original draft, writing – review and editing. **Catherine Paterson:** conceptualisation, methodology, writing original draft, writing – review and editing. **Raymond J. Chan:** conceptualisation, methodology, writing original draft, writing – review and editing.

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Data sharing not applicable to this article as no datasets were generated or analysed during the current study.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.

Supporting Information S1: pon70614-sup-0001-suppl-data.docx.

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