

Gender, Geography and Cancer Care: A Sociological Study of Breast and Cervical Cancer Hospitalisation in Manipur

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Abstract:

Cancer among women represents a growing public health concern in India's northeastern region, where complex socio-cultural and structural factors shape access to healthcare. This study examines the patterns of hospitalisations for breast and cervical cancer among women in Manipur, with a focus on socio-demographic and geographical inequalities. A retrospective descriptive study was conducted using inpatient records from the Female Oncology Ward at the Regional Institute of Medical Sciences (RIMS), Imphal. The study includes 147 female patients diagnosed with breast (n=88) and cervical cancer (n=59) between January and December 2024. Data were analysed using descriptive statistics to examine age distribution, district of origin, religion, and monthly admission patterns.

The findings indicate that breast cancer constituted a higher proportion of hospital admissions (59.9%) compared to cervical cancer (40.1%). Breast cancer patients were relatively younger (mean age 51.3 years), whereas cervical cancer patients were older (mean age 57.5 years). A pronounced geographical disparity was observed, with 82.3% of patients originating from valley districts and only 17.7% from hill districts. Monthly admission patterns showed uneven distribution, with over half of admissions concentrated in four months of the year. The study highlights that hospitalisation patterns are shaped not only by disease profiles but also by structural inequalities in access to healthcare. These findings underscore the need for decentralised screening, improved accessibility to tertiary care, and context-specific health interventions to address disparities in cancer care among women in Manipur.

Keywords: Cancer Hospitalisation, Breast Cancer, Cervical Cancer, Manipur.

Introduction

Cancer is a major global public health concern with consequences extending beyond the biological pathology into the social and cultural dimensions of patients' lives. The burden of cancer incidence and mortality is rapidly growing worldwide, posing significant challenges for public health systems, particularly in low and middle-income countries (Mohanty et al., 2023).

According to recent statistics, in 2022, there were 20 million new cancer cases and 9.7 million deaths worldwide, highlighting the critical need to study the unique challenges and disparities associated with cancer care (WHO, 2024). Among the various forms of cancer, those that affect women, breast and cervical cancers are most prevalent worldwide. In the Northeastern region of India, including Manipur, surveillance data from the National Cancer Registry Programme indicate a worrying rise in cancer cases. Recent figures show that

Manipur's rate of increase 6.48% increase considerably exceeds the national average of 2.4% recorded in 2022 (Belchin, 2023).

Women in the Indian state of Manipur face unique challenges due to the intricate interplay of gender, culture, and resource availability in government healthcare institutions. Socio-economic constraints, limited healthcare infrastructure, and cultural perceptions regarding health and illness further exacerbate these challenges. As Susan Sontag (1978) argued in *Illness as Metaphor*, cancer is not merely a biological disease but is embedded in cultural meanings that shape how illness is perceived and experienced.

According to a report on the "Monitoring Survey of Cancer Risk Factors and Health System Response in North East Region", people in Manipur face a high burden of cancer risk factors and poor healthcare-seeking behaviour (Imphal Free Press Bureau, 2022). However, these biological explanations often eclipse critical sociological analysis of how women navigate cancer detection and treatment within specific cultural and structural constraints. Complementing this structural perspective, Minocha (1996) conceptualises this process as medical socialisation through which patients must navigate unfamiliar institutional environments, often in ways that advantage those with greater social and cultural capital. As she documented, the moment a patient enters the hospital gate, she encounters unfamiliar spaces, signboards in languages she may not read, and a hierarchy of personnel whose roles she must decipher. This process of incorporation is not neutral; it systematically advances patients with greater literacy, prior hospital exposure, and linguistic familiarity.

The Regional Institute of Medical Sciences (RIMS), Imphal, serves as a premier tertiary care referral centre for Manipur and neighbouring states, making it a critical site for examining patterns of cancer hospitalisation. However, limited research has systematically analysed inpatient data from a sociological perspective.

This study addresses this gap by analysing inpatient admissions of breast and cervical cancer patients in the Female Oncology Ward at RIMS during 2024. Specifically, it examines:

1. Socio-demographic characteristics of hospitalised women,
2. Differences between breast and cervical cancer patients, and
3. Structural and cultural factors shaping hospitalisation patterns.

By situating hospitalisation within a sociological framework, the study moves beyond clinical metrics to highlight how inequalities in geography, gender and access shape cancer care in Manipur.

Research Methodology:

Study Design

This study adopts a retrospective descriptive research design based on hospital inpatient records. The design is appropriate for examining patterns of hospitalisation and socio-demographic characteristics of patients within a defined institutional setting.

Study site

The study was conducted at the Regional Institute of Medical Sciences (RIMS), Imphal, Manipur, a tertiary care referral hospital serving Manipur and neighbouring northeastern states of India. The institute functions as a major centre for cancer diagnosis, treatment, and inpatient care in the region.

Study period and sample

The study covers the period from 1 January to 31 December 2024. The sample consists of all female patients admitted to the Female Oncology Ward with a primary diagnosis of breast cancer (n=88) and cervical cancer (n=59) during this period.

Records with incomplete or missing core variables (age, diagnosis, or district of origin) were excluded from the analysis. The final analytical sample comprised 147 patient admission records.

Data variables and collection

Data were extracted manually from the ward admission and discharge registers using a structured data extraction sheet designed for the study. The extraction process focused on ensuring consistency and completeness of entries across all selected cases. The following variables were recorded:

1. Socio-demographic Variables: Age (in years, later categorised), District of Origin (Imphal West, Imphal East, Thoubal, Bishnupur, Senapati, Kakching, Ukhrul, Chandel, Churachandpur, Others), and Religion (Hindu, Christian, Muslim)
2. Clinical Variable: Type of cancer (Breast or Cervical).
3. Temporal Variable: Month of Admission.

Data Analysis and Sociological Framework

Data were entered and analysed using Microsoft Excel. Descriptive statistical techniques, including frequencies, percentages, mean, and ranges, were used to summarise the data. Comparative analysis was undertaken to examine differences between breast and cervical cancer patients across demographic and geographical variables. The analysis remains descriptive in nature and does not involve inferential statistical testing.

Conceptual Perspective on Cancer Hospitalisation:

This study does not apply a formal theory-driven model but adopts a sociological perspective to interpret patterns of cancer hospitalisation among women in Manipur. Given the descriptive nature of the data, the analysis is guided by selected conceptual insights rather than tested theoretical constructs. Central to the interpretation is the notion of structural inequality, which helps to explain disparities in access to healthcare across geographical and social groups. Differences in hospitalisation patterns between the valley and hill districts, as well as variations across age groups, are understood in relation to the unequal distribution of healthcare infrastructure, economic resources, and physical accessibility to tertiary care institutions.

In addition, sociological perspectives on the cultural meaning of illness provide a contextual understanding of how cancer may be perceived within specific social settings. Cultural beliefs, stigma, and fear associated with cancer may influence when and how women seek medical care, particularly in resource-constrained environments. The concept of biographical disruption is used in a limited interpretive sense to understand the implications of diagnosis among women in different age groups. For younger women, illness may intersect with key life stages such as employment, marriage, and caregiving responsibilities, thereby shaping their engagement with healthcare systems.

These perspectives are used cautiously and interpretively to contextualise observed patterns rather than to establish causal relationships. The aim is to situate hospitalisation data with broader social and structural contexts, without extending beyond what the data can empirically support.

Ethical Considerations

The study is based on secondary data obtained from hospital records. Patient confidentiality and anonymity were strictly maintained throughout the research process. No personally identifiable information was recorded or used in the analysis.

Results

1. Trends in Oncology OPD Registrations (2022- 2024)

To contextualise the inpatient admissions analysed in this study, longitudinal data on the Oncology Outpatient Department (OPD) registration at RIMS were examined for the period 2022-2024. The OPD serves as the primary entry point for cancer diagnosis, treatment initiation, and follow-up care, thereby reflecting broader trends in cancer burden and healthcare utilisation.

Table 1: Year-Wise Oncology OPD Registrations (2022-2024)

Year	Female Patients	Male Patients	Total Patients
2022	6912	4277	11189
2023	6265	3916	10181
2024	6386	3353	9739
Total	19563	11546	31109

The longitudinal OPD data reveal a small decrease in cancer-related consultations over the three years. The female patients constitute a higher proportion of OPD registrations across the years, reflecting a higher burden of gender-specific cancers.

2. Overall OPD Patient Distribution

Table 2: Overall Oncology OPD Registrations (2024)

Patient Category	Number of Patients	Percentage
Female Patients	6386	65.60%
Male Patients	3353	34.42%
Total OPD Patients	9739	100%

The OPD records show a total of 9,739 patients registered in 2024. Of these, 6,386 (65.60%) were female patients, while 3,353 (34.42%) were male patients. Female patients constituted nearly two-thirds of the total OPD registrations.

3. Female Ward Inpatient Distribution

Among women hospitalised in the Female Oncology Ward with primary diagnosis of breast or cervical cancer in 2024, the following distribution was observed.

Table 3: Inpatient distribution

Total Patients (Breast & Cervical)	147 patients
Breast Cancer Patients	88 patients (59.9%)
Cervical Cancer Patients	59 patients (40.1%)

The table indicates that 88 patients (59.9%) were diagnosed with breast cancer, and presents a larger proportion than 59 patients (40.1) with cervical cancer. Breast cancer cases constituted the majority of inpatient admissions within the study sample.

4. Demographic Profile Analysis

Table 4: Age Distribution by Cancer Type

Age Group	Breast Cancer	Cervical Cancer
<30 years	4 (4.5%)	0 (0%)
30-49 years	34 (38.6%)	15 (25.4%)
50-69 years	43 (48.9%)	36 (61.0%)
≥70 years	7 (8.0%)	8 (13.6%)
Mean age	51.3 years	57.5 years

The age distribution of patients shows distinct patterns across two cancer types.

Among breast cancer patients, the mean age was 51.3 years, with cases ranging from 18 to 70 years. The largest proportion of patients (48.9%, n=43) fell within the 50-69 years age group, followed closely by those aged 30-49 years (38.6%, n=34). Patients aged below 30 years accounted for 4.5% (n=4), while those aged 70 years and above constituted 8.0% (n=7). Cervical cancer patients had a higher mean age of 57.5 years, with an age range of 31-80 years. The majority of cases (61.0%, n=36) were concentrated in the 50-69 years age group. Patients aged 30-49 years comprised 25.4% (n=15), and those aged 70 years and above accounted for 13.6% (n=8). No cases were recorded in the below 30 years category for cervical cancer.

Religious Distribution:

Table 5: Religion Distribution

Religion	Breast cancer	Cervical Cancer	Total	Percentage (%)
Hindu	72 (81.8%)	48 (81.4%)	120	81.6%
Christian	14 (15.9%)	10 (16.9%)	24	16.3%
Muslim	2 (2.3%)	1 (1.7%)	3	2.0%

The distribution of patients by religion indicates that the majority belonged to the Hindu community. Out of the total 147 patients, 120 (81.6%) were Hindu, 24 (16.3%) were Christian, and 3 (2.0%) were Muslim.

A similar pattern was observed across both cancer types. Among breast cancer patients, 81.8% (n=72) were Hindu, 15.9% (n=14) were Christian, and 2.3% (n=2) were Muslim. Among cervical cancer patients, 81.4% (n=48) were Hindu, 16.9% (n=10) were Christian, and 1.7% (n=1) were Muslim.

5. Geographical Analysis- The Core of Structural Inequality

Table 6: District Distribution by Cancer Type

District	Breast Cancer	Cervical Cancer	Total	% of Total
Imphal West	25	15	40	27.2%
Thoubal	19	20	39	26.5%
Imphal East	13	8	21	14.2%

Bishnupur	16	5	21	14.2%
Senapati	11	1	12	8.1%
Kakching	2	2	4	2.7%
Ukhrul	0	4	4	2.7%
Chandel	0	3	3	2.0%
Churachandpur	2	0	2	1.4%
Others (Noney, Kangpokpi)	0	1	1	0.6%

The geographical origin of patients revealed a pronounced concentration in the valley districts surrounding Imphal. The four major valley districts-Imphal-West, Thoubal, Imphal-East, and Bishnupur- together accounted for 121 patients (82.3%) of the total 147 admissions. In contrast, all hill districts combined contributed only 26 patients (17.7%).

Imphal West emerged as the single largest contributor with 40 patients (27.2%), comprising 25 breast cancer and 15 cervical cancer cases. Thoubal followed closely with 39 patients (26.5%), demonstrating a nearly equal distribution with 19 breast cancer and 20 cervical cancer cases. Notably, Thoubal recorded the highest absolute number of cervical cancer cases (n=20) among all districts. Imphal East and Bishnupur districts each contributed 21 patients (14.2% each). However, their cancer profiles were marked differently. Imphal East had a breast-to-cervical ratio of 13:8, while Bishnupur had a ratio of 16:5. Senapati was the leading hill district, contributing 12 patients (8.1%), with a striking 11 breast cancer cases and 1 cervical cancer case. Kakching and Ukhrul each contributed 4 patients,

though with opposite cancer patterns, where Kakching had an equal number of both cancer cases (2 each), while Ukhrul's cases were exclusively cervical. Chandel contributed 3 patients (2.0%), all with cervical cancer. Churachandpur contributed 2 patients (1.4%), both with breast cancer. Other hill districts (Noney and Kanpokpi) combined contributed 1 patient (0.6%), a cervical cancer case.

Table 7: Monthly Admission Patterns

Month	Breast Cancer (n=88)	Cervical Cancer (n=59)	Total (n=147)
January	14	6	20
February	5	5	10
March	4	4	8
April	6	4	10
May	2	2	4
June	5	4	9
July	4	1	5
August	9	3	12
September	6	8	14
October	11	7	18
November	10	8	18
December	12	7	19

Admissions throughout 2024 were not evenly distributed. The data reveals distinct peaks in some months, which shows a seasonal pattern. The highest peak months were January($n=20$) and December($n=19$), followed closely by October and November ($n=18$ each). Together, the four-month period accounted for 75 admissions (51.0% of the total annual). The lowest admission months were seen in May ($n=4$), June($n=9$), and July($n=5$). The three-month period recorded only 18 admissions (12.2% of the annual total)-less than a single peak month.

Discussion:

Research indicates that developing Asian countries, including India, have a higher proportion of younger women diagnosed with breast cancer compared to their counterparts in developed Asian and Western countries, a trend associated with poorer prognosis. India, as a representative developing country, faces distinct socio-economic, cultural, and healthcare challenges that influence disease presentation. Studies show that locally advanced cancers account for approximately 50% of the total (Gaurav A et al., 2007). Furthermore, regional disparities exist in India, with north-eastern states reporting a lower burden of breast cancer; Meghalaya, in particular, has the lowest recorded burden (Vaitheeswaran K et al., 2024).

According to data published by the Indian Council of Medical Research – National Centre for Disease Informatics and Research (2021), Manipur has a total population of 2855794, with a sex ratio of 985 based on the 2011 census, and the Age-Adjusted Incidence rate (AAR) is higher in females (71.1 per 100,000 females) than in males (62.8 per 100,000 males). Furthermore, the data from the 2022 NCDIR report on the monitoring survey of cancer risk factors and health system response in the northeast region reveal that the leading cancer site in females is breast cancer (15.4%), followed by cervical cancer (9.5%).

The observed trends in Oncology OPD registrations between 2022 to 2024 reveal a noticeable decline in patient attendance over time. While this pattern might superficially suggest a reduction in disease burden, it is more plausibly indicative of constraints in healthcare access and utilisation. In contexts such as Manipur, where healthcare infrastructure remains unevenly distributed, a decline in OPD visits may reflect barriers including financial constraints, transportation challenges, and reduced access to tertiary care facilities. Rather than representing improved population health, this trend may point to delays in initial consultation, with patients seeking care only when symptoms become severe enough to necessitate hospitalisation.

The findings of this hospital-based study offer a more critical profile of breast and cervical cancer patients in Manipur. The predominance of breast cancer (59.9%) over cervical cancer (40.1%) among hospitalised women in Manipur reflects global epidemiological trends where breast cancer has become the most common female malignancy. According to Sung et al. (2021), breast cancer has become the most commonly diagnosed cancer worldwide. In 2020, it accounted for 7% of 9.9 million cancer deaths annually and was the second leading cause of oncological deaths (Sung et al., 2021). According to the WHO (2024), cervical cancer is said to be preventable and curable, as long as it is detected early and managed effectively. However, the substantial cervical cancer (40.1%) indicates persistent gaps in screening coverage, health awareness, and access to preventive services, particularly among older and rural women.

The distinct age profiles of breast and cervical cancer patients reveal important generational and gendered dynamics. With a mean age of 51.3 years and 38.6% of patients under 50, breast cancer in Manipur disproportionately affects women in their peak productive and reproductive years, leading to profound social implications. A breast cancer diagnosis at this life stage constitutes what Sociologists call “biographical

disruption” (Bury, 1982)- an event that fractures taken-for-granted assumptions about life trajectory¹. Sontag (1978) would add that this disruption is intensified by the metaphors surrounding cancer itself. Unlike other chronic illnesses, cancer is often framed as a “death sentence”, an “invasion,” or a “battle to be fought” - military metaphors that position the patient as a warrior whose survival depends on relentless combat against the disease. For a young woman in Manipur, internalising such metaphors can transform a medical diagnosis into an existential crisis, amplifying feelings of isolation, failure and social abandonment. The presence of four patients under 30, including an 18-year-old, is particularly alarming, for these young women face not only the clinical realities of cancer but also carry the symbolic weight of the disease. Cancer derails education, delays or prevents marriage, and fundamentally alters the life possibilities of these young women patients.

In contrast, cervical cancer patients were significantly older, with a mean age of 57.5 years, with 74.6% aged 50 or above. This pattern reflects a generational failure of preventive healthcare. These women reached adulthood and entered their reproductive years during decades when cervical screening was either unavailable in Manipur or inaccessible to rural and marginalised populations. Their advanced age at diagnosis represents a lifetime of missed opportunities for early detection.

Demographic profiling indicated a predominant Hindu representation of 81.6%, Christians and Muslim cohorts accounting for 16.3% and 2.0% respectively. This heterogeneity highlights the influence of regional demographics and socio-cultural frameworks on healthcare accessibility within the Manipuri context. In Manipur, societal taboos and cultural norms can restrict women’s capacity to seek healthcare information and services. According to the World Health Organisation (2024), structural inequalities and socio-cultural barriers significantly shape women’s access to timely cancer diagnosis and treatment, particularly in low-resource settings. Sontag (1978) also observed that cancer has historically been “a disease of the guilty” (p. 40)- a contribution attributed to moral and psychological judgements about the ill. The metaphorical burden that cancer as a moral failing may explain part of the underrepresentation of the minority communities in hospital data, as women from these communities may turn to faith-based institutions rather than the tertiary healthcare system, RIMS, or may hide their diagnosis altogether to avoid congregational judgment.

The most striking finding of this study is the extreme geographical disparity in hospitalisations. 85% of the patients originated from the valley districts, where hill districts contributed a mere 15% of the caseload. This is not a measure of disease burden; it is a measure of differential burden to care- a manifestation of what medical anthropologist Paul Farmer (2004) termed “structural violence”, where social structures systematically harm individuals by preventing them from meeting their basic needs². Also, the Thoubal district’s profile demands focused attention. With 20 cervical cancer cases, the highest of any district, and a near-equal breast: cervical (19:20) cancer ratio. The geographical disparity in hospitalisations reflects not only the physical distance hill women must travel but also the social distance they encounter upon arrival. Minocha (1996) documented how patients in Indian hospitals undergo a phased process of “medical socialisation” – from navigating signboards in English and Hindi to understanding the hierarchy of doctors, nurses and ancillary staff. Critically, she observed that patients sought help from “the lower paramedical ayahs and

¹ The term “biographical disruption”, introduced by Michael Bury (1982), refers to the way chronic illness can interrupt an individual’s expected life trajectory, affecting social roles, identities and future plans. In this study the concept is used in a limited interpretive sense to contextualise the potential social implications of cancer diagnosis among women, rather than an empirically tested framework.

² The concept of “structural inequality” denotes systemic disparities in access to resources and opportunities arising from social, economic, and institutional arrangements. Relatedly, Farmer (2004) conceptualises “structural violence” as how such inequalities constrain individuals’ ability to access healthcare and other basic needs.

sweepers, who appeared to be most akin to them in dress, appearance and language, and therefore, in their reckoning, more approachable” (p. 43). For hill district women in Manipur, many of whom speak languages other than Manipuri or English, this social navigation is compounded by linguistic alienation. The absence of staff who share their language, the unfamiliarity of hospital protocols, and the reliance on informal intermediaries create additional layers of exclusion that may deter hospitalisation altogether or delay it until the disease advances. The near-complete absence of patients from remote hill districts like Tamenlong, Pherzwal, Kamjong, and Tengnoupal raises a disturbing possibility. Women from these areas may be dying of cancer without ever entering the tertiary healthcare system. Their absence from hospital records renders them statistically invisible. Sontag (1978) wrote extensively about the silence and secrecy that historically surrounded cancer- a disease that was “not spoken of” and whose very name was “whispered” (p.5).

The observed monthly distribution of admissions indicates clustering in specific periods of the year, particularly between October and January. However, the study relies on secondary data; it does not capture the motivations underlying healthcare-seeking behaviour. Therefore, the observed pattern should be interpreted cautiously. Economic cycles, seasonal mobility, or agricultural schedules may influence when patients are able to access hospital care. These interpretations remain indicative and require further investigation through primary data.

Cultural meanings attached to cancer also influence how patients perceive and respond to illness. As Susan Sontag (1978) argued, cancer is often accompanied by metaphorical interpretations that frame it as a moral or existential condition. Such meanings can affect disclosure, delay health-seeking, and shape interactions with healthcare providers. In contexts where stigma or fear surrounds cancer, these symbolic dimensions may further complicate timely access to care. Yet the seasonal pattern observed in Manipur reveals a different rationality. Women and families make calculated decisions about when to seek care based on household financial reserves, and other factors such as the opportunity cost of time and travel feasibility. This tendency can be further understood through the work of Howard Waitzkin (2009), who argues that in many cultural contexts, psychological and social distress is not openly articulated but instead manifests through physical symptoms. Such culturally mediated expressions of distress may obscure early warning signs and complicate timely diagnosis, thereby reinforcing patterns of delayed healthcare utilisation.

Taken together, the findings demonstrate that cancer hospitalisation patterns in Manipur cannot be understood solely through epidemiological indicators. Rather, they reflect the intersection of structural inequalities, cultural meanings, and institutional barriers that shape women’s pathways to care. This underscores the importance of integrating sociological perspectives into cancer research and health policy, particularly in contexts marked by social and geographical disparities.

Conclusion:

This study offers a sociologically grounded analysis of breast and cervical cancer hospitalisations among women in Manipur, highlighting how patterns of care are shaped by structural, demographic, and institutional factors. By focusing on inpatient admissions at a tertiary care centre, RIMS, the study brings attention to a critical subset of patients whose conditions have progressed to stages requiring hospital-based intervention. The observed variations in OPD utilisation and hospitalisation patterns suggest that barriers such as limited accessibility, economic constraints, and uneven infrastructure continue to shape women’s pathways to diagnosis and treatment.

The findings demonstrate that hospitalisation patterns are not evenly distributed across the population but are influenced by age, geography, and access to healthcare systems. The concentration of patients from the valley

districts, alongside the limited representation from hill regions, underscores persistent spatial inequities in access to tertiary care. Similarly, variations in the age distribution and admission patterns point to broader gaps in early detection, preventive services, and timely utilisation of healthcare. The predominance of breast cancer over cervical cancer among hospitalised women reflects both global epidemiological shifts and the specific dynamics of healthcare-seeking and prevention in the region. Analysis of age profiles reveals that breast cancer disproportionately affects women in their economically and socially productive years. In contrast, cervical cancer is concentrated among older women—a pattern that underscores generational gaps in screening and prevention efforts.

The largely Hindu religious composition of the hospitalised cohort broadly reflects regional demographics but also points to possible disparities in healthcare access among minority groups. The stark geographical disparity with valley districts contributing an overwhelming majority of admissions—evidences the ongoing impact of infrastructural and social inequities on women's capacity to access tertiary care, consistent with the conceptual framework of structural violence (Farmer, 2004).

Observed seasonality in admission patterns further suggests that broader socio-economic and seasonal factors mediate healthcare utilisation. However, given the reliance on secondary data, such patterns should be interpreted as indicative rather than explanatory. Ultimately, the data illustrate that disparities in cancer outcomes in Manipur are socially constructed and structurally embedded in the region's historical, economic, and cultural landscape. Addressing these inequities demands a holistic approach, one that integrates sociological insights with biomedical strategies, prioritises district-level and community-specific interventions, and is responsive to the lived realities of women across social strata. Policymakers and health system actors should treat the evidence generated by this study as an impetus to design contextually grounded, equity-oriented interventions capable of reducing preventable suffering and improving cancer outcomes for all women in Manipur.

By situating hospital-based data within a sociological perspective, this study contributes to a more nuanced understanding of cancer care inequalities and underscores the need for integrated approaches that bridge biomedical and social dimensions of health.

Limitations:

This study has several limitations. As a single-centre study conducted at a tertiary care hospital, RIMS, Imphal, the findings reflect the experiences of women who were able to access hospital-based services; they cannot be generalised to the wider population of women with cancer in Manipur. The analysis is limited to hospitalised cases and does not capture patients receiving outpatient care or those who remain outside the formal healthcare system. The dataset covers a single year (2024), which restricts the capacity to assess longitudinal trends. In addition, the use of secondary quantitative data limits the scope for understanding the lived experiences, decision-making processes, cultural beliefs, and barriers. These dimensions require qualitative approaches, such as interviews, ethnography, and focus groups, to fully illuminate the social pathways underlying the patterns. Future research integrating quantitative and qualitative approaches would provide a more comprehensive understanding of cancer care pathways in the region.

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