Georgian Scientists
ქართველი მეცნიერები
Vol. 8 Issue 3, 2026
https://doi.org/10.52340/gs.2026.08.03.05

Women, Power, and Cancer: A Public Health Review

Tamriko Bulia[1]

[1]School of Health Sciences, The University of Georgia

ABSTRACT

Cancer affects women not only as a biological disease but also through social, economic, cultural, and political pathways. Women interact with cancer as individuals at risk, patients, survivors, family caregivers, health professionals, researchers, advocates, and policy-makers. However, gender inequality and unequal power relations continue to shape women's exposure to cancer risk factors, access to prevention and screening, timeliness of diagnosis, treatment adherence, survivorship outcomes, palliative care experiences, unpaid caregiving responsibilities, and professional opportunities within oncology systems. This review examines gender inequities across the cancer continuum, moving beyond a narrow focus on "women's cancers" to consider cancer as a broader women's health and public health priority. Drawing on global evidence and the conceptual framework advanced by the Lancet Commission on women, power, and cancer, the article highlights how asymmetries in decision-making, knowledge, economics, and leadership influence cancer outcomes. Particular attention is given to unpaid caregiving, financial vulnerability, oncology workforce inequities, and the need for gender-responsive cancer control policies. A gender-responsive approach to oncology requires sex-disaggregated data, equitable access to prevention and treatment, caregiver support, financial protection, integration of palliative care, and stronger representation of women in cancer leadership. Recognizing the relationship between women, power, and cancer is essential for more equitable, humane, and sustainable cancer care.

Keywords: women and cancer; gender equity; cancer control; public health; palliative care

INTRODUCTION

Cancer is often framed primarily as a biomedical problem, defined by tumor biology, stage, treatment modality, and survival outcomes. While these dimensions are essential, they do not fully explain how cancer is experienced by women across different societies and health systems. For women, cancer is also shaped by gender norms, economic dependence, caregiving

expectations, social stigma, access to information, decision-making power, and the organization of health services. These factors influence whether women can avoid preventable risks, participate in screening, seek timely diagnosis, afford treatment, complete care, return to work, receive palliative support, or participate in cancer leadership and policy-making.

The global cancer burden among women is substantial. GLOBOCAN 2022 estimates show that cancer remains a leading cause of morbidity and mortality worldwide, with female breast cancer representing one of the most common cancers globally and the most commonly diagnosed cancer among women (Bray et al., 2024). However, the burden of cancer in women extends far beyond breast, cervical, ovarian, and endometrial cancers. Women are also affected by lung, colorectal, gastric, liver, hematologic, and other malignancies, and they experience the consequences of cancer as patients, survivors, caregivers, health workers, researchers, and advocates. The Lancet Commission on women, power, and cancer emphasized that women interact with cancer in complex and multiple roles, including as healthy individuals participating in prevention, as people living with and beyond cancer, as unpaid caregivers, and as members of the cancer workforce and policy community (Ginsburg et al., 2023).

Despite this complexity, cancer has often been insufficiently integrated into the women's health agenda, which has historically focused more strongly on reproductive and maternal health. This narrow framing risks under-recognizing cancer as a major women's health issue and obscures the gendered social determinants that influence cancer outcomes. The Lancet Commission argues that cancer policies and guidelines should explicitly include sex and gender to respond to the needs and aspirations of women in all their roles across the cancer continuum (Ginsburg et al., 2023).

This review examines women, power, and cancer as a public health issue. It explores how gender inequality affects cancer prevention, screening, diagnosis, treatment, survivorship, palliative care, caregiving, and leadership. It also considers implications for Georgia and similar health systems, where financial constraints, regional service concentration, family-based caregiving, and limited integration of supportive and palliative care may intensify gender-related inequities. The central argument is that cancer care cannot be truly patient-centered or equitable unless it recognizes how gender and power shape women's risks, access to care, caregiving roles, professional opportunities, and health outcomes.

WOMEN AND CANCER BEYOND "WOMEN'S CANCERS"

Discussions of women and cancer often focus on cancers of the breast, cervix, ovary, uterus, and other reproductive organs. These cancers are undeniably important. Breast cancer remains the most commonly diagnosed cancer among women globally, with approximately 2.3 million new cases in 2022, and cervical cancer remains a preventable yet persistent cause of premature mortality in many countries (Bray et al., 2024; World Health Organization [WHO], 2020). The WHO global strategy to eliminate cervical cancer as a public health problem is built on

vaccination, screening, and treatment, reflecting the possibility of preventing many deaths through coordinated public health action (WHO, 2020).

However, reducing women and cancer to "women's cancers" is conceptually and politically limiting. Women are affected by all major cancer types, and their experiences are shaped not only by biological sex but also by gendered social realities. For example, women with lung cancer may face delayed recognition if symptoms are not associated with traditional risk profiles, especially among never-smokers. Women with colorectal or gastric cancer may experience diagnostic delays due to competing family responsibilities, limited access to screening, or normalization of symptoms. Women with advanced cancers may face complex decisions about treatment, caregiving, fertility, sexuality, body image, employment, and end-of-life care.

A broader framework recognizes that cancer is a women's health issue, not because it affects only female-specific organs, but because women's risks, access, experiences, and outcomes are shaped by gendered structures. These structures include unequal access to education and health information, limited financial autonomy, lower decision-making power within households, occupational exposures, gender-based stigma, and disproportionate responsibility for unpaid care. Therefore, a gender-responsive cancer agenda must include both sex-specific cancers and all cancers affecting women across the life course.

This broader perspective also prevents the marginalization of women as caregivers, clinicians, nurses, social workers, researchers, and policy-makers. Cancer systems often depend heavily on women's paid and unpaid labor, yet women may remain underrepresented in leadership and decision-making positions. A public health review of women and cancer must therefore examine not only disease burden but also the distribution of power within cancer systems.

GENDER INEQUITIES ACROSS THE CANCER CONTINUUM

Prevention

Cancer prevention is shaped by the social conditions in which women live. Exposure to risk factors such as tobacco, alcohol, unhealthy diet, physical inactivity, occupational hazards, air pollution, and infectious agents is not distributed equally. Gender norms may influence whether women can access health information, negotiate safer environments, seek vaccination, or participate in preventive care. In some settings, women may have limited autonomy over health decisions, transportation, finances, or time, all of which affect preventive behavior.

HPV vaccination is a clear example of the intersection between cancer prevention, gender, policy, and public trust. Cervical cancer is largely preventable through HPV vaccination, screening, and treatment of precancerous lesions. The WHO's cervical cancer elimination strategy sets ambitious 90–70–90 targets: 90% of girls fully vaccinated with the HPV vaccine by age 15, 70% of women screened with a high-performance test by ages 35 and 45, and 90% of women with cervical disease receiving appropriate treatment (WHO, 2020).

However, the success of such strategies depends on more than vaccine availability. It requires public awareness, trust, school-based or community-based delivery systems, affordability,

parental acceptance, and gender-sensitive communication. In contexts where misinformation, stigma, or limited access to adolescent health services exist, girls may remain unprotected despite the availability of effective prevention tools. Therefore, prevention must be understood as a matter of health systems, education, gender norms, and policy implementation.

Screening and Early Detection

Screening and early detection are central to reducing cancer mortality, but women's access to these services is often shaped by social and structural barriers. Breast and cervical cancer screening programs may exist formally, yet participation can remain unequal due to cost, distance, fear, embarrassment, lack of information, low health literacy, distrust of institutions, or competing family responsibilities. Women living in rural or underserved regions may face additional barriers, including transportation costs, limited availability of specialists, and fragmented referral pathways.

Gender norms can also affect screening behavior. In some communities, women may prioritize family needs over their own health, delay care because of caregiving duties, or avoid gynecological examinations due to stigma, modesty concerns, or fear of diagnosis. These barriers are not simply individual choices; they reflect social expectations and power relations. A woman who lacks financial independence or decision-making authority may be less able to attend screening even when she understands its importance.

Early detection strategies must therefore be designed with women's lived realities in mind. Mobile screening, community outreach, HPV self-sampling where appropriate, patient navigation, culturally sensitive education, and integration with primary care can help reduce barriers. Screening programs should also monitor participation by age, region, socioeconomic status, and other equity indicators to identify groups that are being left behind.

Diagnosis

Timely diagnosis depends on symptom recognition, health-seeking behavior, primary care access, referral systems, diagnostic capacity, and affordability. Women may experience diagnostic delay when symptoms are normalized, minimized, or attributed to stress, menopause, reproductive conditions, or caregiving fatigue. Delays may also occur when women postpone care because of household responsibilities, fear of financial consequences, or limited ability to travel.

Diagnostic inequities are particularly important in cancers where early symptoms are vague or non-specific, such as ovarian, gastric, colorectal, lung, and pancreatic cancers. In these cases, health literacy, clinician awareness, and referral pathways are critical. Gender bias may also influence communication: women's symptoms may be under-investigated or insufficiently validated in some clinical encounters. Although this varies by context, it highlights the importance of respectful, patient-centered diagnostic care.

From a public health perspective, diagnostic delay is not only a clinical problem but also a systems problem. Weak primary care pathways, limited access to imaging and pathology, high out-of-

pocket costs, and concentration of diagnostic services in urban centers can all contribute to late-stage diagnosis. Gender-responsive cancer control must therefore strengthen diagnostic systems while addressing the social barriers that prevent women from seeking and completing evaluation.

Treatment

Cancer treatment involves complex decisions about surgery, radiotherapy, systemic therapy, supportive care, fertility preservation, rehabilitation, and palliative care. Gender inequality can influence treatment access and adherence through financial dependence, caregiving responsibilities, employment insecurity, transportation barriers, and communication gaps. Women may delay or interrupt treatment if they cannot afford indirect costs, arrange childcare, take time off work, or travel repeatedly to oncology centers.

Financial toxicity is especially relevant for women. The Lancet Commission and related discussions emphasize that women may be more vulnerable to financial catastrophe related to cancer because of lower income, less secure employment, unpaid caregiving responsibilities, and reduced decision-making power over household resources (Ginsburg et al., 2023). Financial hardship may influence whether women initiate treatment, complete therapy, purchase supportive medications, attend follow-up visits, or access rehabilitation and psychosocial support.

Treatment communication must also be gender-sensitive. Women may need information about fertility, sexuality, body image, menopause, family roles, return to work, caregiving responsibilities, and long-term treatment effects. These issues are often under-discussed in routine oncology practice, especially in busy or resource-limited settings. A patient-centered model should create space for these concerns and integrate multidisciplinary support, including nursing, psychology, social work, rehabilitation, fertility counseling, and palliative care.

Survivorship

As cancer survival improves, survivorship has become a major public health issue. Women living beyond cancer may experience fatigue, pain, lymphedema, neuropathy, anxiety, depression, sexual dysfunction, infertility, premature menopause, cognitive changes, fear of recurrence, employment disruption, and financial hardship. Survivorship is not simply the period after treatment; it is a long-term phase requiring coordinated medical, psychosocial, and social support.

Gender roles strongly shape survivorship. Women may be expected to resume family and caregiving responsibilities quickly, even while experiencing persistent symptoms. They may face body image concerns after breast, gynecological, colorectal, or other cancer treatments. Younger women may confront fertility loss, relationship strain, or career disruption. Older women may face isolation, fixed incomes, comorbidities, and dependence on family caregivers.

Survivorship care plans should therefore include not only surveillance for recurrence but also rehabilitation, psychosocial care, sexual health, fertility support, financial counseling, return-to-work guidance, and management of chronic treatment effects. A gender-responsive survivorship

model recognizes that recovery is not only biological; it is social, economic, relational, and psychological.

Palliative Care

Palliative care is a crucial component of comprehensive cancer care, yet access remains uneven across many health systems. Women may need palliative care as patients with advanced cancer, but they also frequently provide palliative and end-of-life care as family caregivers. This dual role makes palliative care central to the women, power, and cancer agenda.

For women with advanced cancer, timely palliative care can improve symptom control, communication, psychosocial support, quality of life, and care planning. However, palliative care is often introduced late, especially when it is misunderstood as synonymous with imminent death. Gendered expectations may also affect how women express suffering, request help, or prioritize their own comfort. Women may minimize symptoms to avoid burdening family members or may continue caregiving duties despite advanced illness.

For women as caregivers, palliative care systems often rely on unpaid labor. Family caregivers manage medications, hygiene, feeding, transportation, emotional support, communication with clinicians, and end-of-life care at home. In many societies, this work is disproportionately performed by women. Yet caregiver burden is frequently invisible in health policy, poorly measured in clinical practice, and insufficiently supported by social protection systems.

Gender-responsive palliative care should therefore include caregiver assessment, respite support, bereavement care, financial counseling, home-based services, and recognition of unpaid caregiving as a public health issue. Integrating palliative care earlier in oncology care is not only clinically beneficial; it is also a strategy to reduce hidden suffering among patients and families.

UNPAID CAREGIVING AND THE INVISIBLE ECONOMY OF CANCER

One of the most powerful dimensions of women, power, and cancer is unpaid caregiving. Cancer care does not occur only in hospitals and clinics. Much of it occurs at home, where family members provide daily practical, emotional, and logistical support. Across many contexts, this work is disproportionately carried out by women: mothers, wives, daughters, sisters, daughters-in-law, and grandmothers.

Unpaid caregivers may coordinate appointments, accompany patients to treatment, manage medications, monitor symptoms, provide nutrition and hygiene, communicate with health professionals, arrange finances, and offer emotional support. In advanced cancer, they may also provide complex home-based care, including pain management, mobility assistance, wound care, and end-of-life support. This labor is essential to the functioning of cancer systems, yet it is often absent from cost calculations, workforce planning, and policy design.

The invisible economy of cancer refers to the unpaid time, emotional energy, and financial sacrifice that families—especially women—contribute to cancer care. Cancer systems often depend on women's unpaid labor while failing to recognize, protect, or compensate it. This creates a paradox: women sustain the cancer care system, but the system may not sustain them.

Caregiving can affect women's employment, income, physical health, mental health, social participation, and long-term financial security. Women may reduce working hours, leave employment, decline career opportunities, or experience burnout. They may also experience anxiety, depression, sleep disturbance, social isolation, and anticipatory grief. When caregiving is combined with poverty, rural residence, limited services, or lack of home care, the burden becomes even greater.

Public health policy must recognize caregivers as a population with legitimate health and social needs. Practical strategies include caregiver screening, respite services, home-based palliative care, caregiver education, psychological support, paid leave, employment protection, transportation assistance, and social benefits. Without such measures, cancer care remains dependent on an inequitable and unsustainable model of unpaid female labor.

WOMEN IN THE ONCOLOGY WORKFORCE AND LEADERSHIP

Women are central to the oncology workforce. They work as physicians, nurses, psychologists, social workers, pharmacists, researchers, public health professionals, patient navigators, administrators, and advocates. However, representation in the workforce does not automatically translate into power. In many settings, women remain underrepresented in senior leadership, academic promotion, guideline committees, research funding, conference visibility, editorial boards, and policy-making positions.

This leadership gap matters because decision-making structures shape cancer priorities. If women are underrepresented in leadership, issues such as caregiving burden, gender-sensitive communication, fertility, sexual health, financial vulnerability, workplace discrimination, and palliative care integration may receive less attention. Leadership diversity is therefore not only a matter of fairness; it is a matter of better cancer policy.

Gender inequities in oncology careers may be driven by multiple factors: unequal domestic responsibilities, maternity-related career interruptions, implicit bias, limited mentorship, pay gaps, harassment, exclusion from professional networks, and fewer opportunities for high-visibility roles. Women may be concentrated in clinical service delivery while men are more represented in senior academic, administrative, or policy positions. These patterns can reproduce power imbalances within cancer systems.

Addressing workforce inequity requires institutional and policy-level action. Strategies include transparent promotion criteria, mentorship and sponsorship programs, parental leave policies, flexible career pathways, anti-harassment protections, pay equity monitoring, leadership training, and gender-balanced representation in committees, conferences, research teams, and

editorial structures. Cancer systems that aim to be equitable for patients must also be equitable for the professionals who deliver care.

INTERSECTIONALITY: NOT ALL WOMEN EXPERIENCE CANCER EQUALLY

A gender-responsive cancer agenda must avoid treating women as a homogeneous group. Women's cancer experiences differ by age, income, education, geography, employment, disability, migration status, ethnicity, social support, cancer type, disease stage, and health-system context. Intersectionality helps explain how multiple forms of disadvantage combine to shape cancer risk, access, and outcomes.

Low-income women may face greater barriers to prevention, screening, diagnosis, and treatment because of out-of-pocket costs, transportation expenses, informal employment, and limited savings. Rural women may experience geographic barriers, fewer specialists, longer travel times, and delayed referral. Older women may face ageism, comorbidities, fixed income, and social isolation. Younger women may face fertility concerns, childcare responsibilities, career disruption, and financial instability. Women with disabilities may encounter inaccessible facilities, communication barriers, and inadequate adaptation of screening services.

Intersectionality is particularly important for palliative care and survivorship. A woman with advanced cancer who lives in a rural area, has low income, and lacks family support may experience a very different care trajectory from an urban, financially secure patient with access to multidisciplinary services. Similarly, a woman caregiver who is also employed, raising children, and caring for an older relative may face a compounded burden.

Equity-oriented cancer control requires data systems that can identify these differences. Sex-disaggregated data are necessary but not sufficient. Cancer registries, screening programs, treatment databases, and survivorship studies should also capture relevant social determinants where feasible, including geography, socioeconomic status, insurance coverage, and access barriers. Without such data, inequities remain hidden, and policy responses remain generic.

POLICY IMPLICATIONS FOR GENDER-RESPONSIVE CANCER CONTROL

Gender-responsive cancer control requires moving from recognition to implementation. First, sex and gender should be explicitly incorporated into national cancer control plans, clinical guidelines, screening strategies, survivorship programs, and palliative care policies. This does not mean creating separate systems for women; it means ensuring that cancer systems understand and respond to gendered barriers and needs.

Second, prevention and screening programs should be designed for equitable access. HPV vaccination, cervical cancer screening, breast cancer screening, tobacco control, and public awareness campaigns should consider regional disparities, health literacy, stigma, affordability,

and women's time constraints. Community outreach, primary care integration, mobile services, and patient navigation can help reduce barriers.

Third, financial protection must be strengthened. Cancer policies should reduce out-of-pocket payments for essential diagnostics, treatment, supportive medications, rehabilitation, and follow-up. Financial toxicity should be recognized as a quality-of-care issue, particularly for women with low income, unstable employment, or caregiving responsibilities. Financial navigation and social work should be integrated into oncology care.

Fourth, caregiver support should become a formal part of cancer policy. Health systems should assess caregiver burden, provide education and psychosocial support, develop respite services, and connect caregivers to social protection mechanisms. Paid leave and employment protection for cancer patients and caregivers are important public health interventions, not merely labor policy issues.

Fifth, palliative care should be integrated early and equitably. Gender-responsive palliative care should address symptom control, psychosocial distress, family communication, caregiver burden, financial hardship, and end-of-life preferences. It should be available not only in specialized centers but also through regional, community, and home-based models.

Sixth, women's leadership in oncology should be strengthened. Gender-balanced representation should be promoted in cancer policy committees, professional societies, academic leadership, research collaborations, clinical trial leadership, editorial boards, and conference programs. Women's participation in decision-making is essential for transforming cancer systems from within.

RELEVANCE FOR GEORGIA AND SIMILAR HEALTH SYSTEMS

The women, power, and cancer framework is highly relevant for Georgia and similar transitional health systems. In such contexts, cancer care may be affected by regional service concentration, fragmented referral pathways, out-of-pocket costs, limited supportive care infrastructure, and strong reliance on family caregiving. These system-level characteristics can intensify gender-related inequities.

Women in Georgia may interact with cancer in multiple roles: as patients seeking screening, diagnosis, and treatment; as family caregivers supporting relatives with advanced disease; as physicians, nurses, and health professionals delivering oncology and palliative care; and as researchers and educators contributing to cancer knowledge. Yet the structural conditions surrounding these roles may not be equally supportive. Regional disparities, financial vulnerability, limited access to psychosocial services, and late integration of palliative care may place an additional burden on women and families.

A gender-responsive cancer agenda for Georgia and similar systems could include several priorities. These include strengthening breast and cervical cancer screening participation, improving HPV vaccination awareness, expanding regional access to diagnostic and oncology

services, integrating palliative care earlier, developing caregiver support mechanisms, monitoring financial toxicity, and ensuring women's representation in cancer policy and leadership.

Importantly, gender-responsive cancer control should not be viewed as a narrow women's issue. It is a health system quality issue. When women cannot access timely diagnosis, when family caregivers are unsupported, when financial hardship interrupts treatment, or when women professionals are excluded from leadership, the entire cancer system becomes less effective and less equitable.

CONCLUSION

Women, power, and cancer are a critical public health issue. Cancer affects women not only through biological disease but also through gendered pathways of risk, access, care, labor, economics, and leadership. Women experience cancer as patients, survivors, caregivers, health workers, researchers, advocates, and policy-makers, yet unequal power relations continue to shape their opportunities and outcomes across the cancer continuum.

A strong cancer control strategy must move beyond a narrow focus on women's cancers and recognize the broader ways in which gender influences prevention, screening, diagnosis, treatment, survivorship, palliative care, caregiving, and professional advancement. Gender inequality can delay diagnosis, limit access to treatment, increase financial vulnerability, intensify the unpaid caregiving burden, and exclude women from decision-making structures that shape cancer policy.

Addressing these inequities requires coordinated action. Health systems should collect sex-disaggregated and equity-oriented data, expand access to prevention and screening, reduce financial barriers, integrate palliative care, support caregivers, and promote women's leadership in oncology. Cancer centers should incorporate financial navigation, psychosocial care, survivorship support, and caregiver assessment into routine practice. Policymakers should recognize affordability, caregiving, and gender-responsive service design as core components of cancer control.

As cancer care advances, equity must advance with it. Effective treatment is not enough if women cannot access it, complete it, afford it, or participate in shaping the systems that deliver it. Recognizing women, power, and cancer as a central public health priority is essential for building cancer systems that are more just, humane, patient-centered, and sustainable.

REFERENCES

Bray, F., Laversanne, M., Sung, H., Ferlay, J., Siegel, R. L., Soerjomataram, I., & Jemal, A. (2024). Global cancer statistics 2022: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. *CA: A Cancer Journal for Clinicians, 74*(3), 229–263. https://doi.org/10.3322/caac.21834

Ginsburg, O., Vanderpuye, V. D., Beddoe, A. M., Bhoo-Pathy, N., Bray, F., Caduff, C., El Saghir, N. S., Fadhil, I., Jedy-Agba, E., Lopes, G., Ly, M., Ngan, H. Y. S., Rabeneck, L., Soerjomataram, I., & others. (2023). Women, power, and cancer: A Lancet Commission. *The Lancet, 402*(10417), 2113–2166. https://doi.org/10.1016/S0140-6736(23)01701-4

King's College London. (2023). *Focus on women, power and gender to transform cancer care: Lancet report*. https://www.kcl.ac.uk/news/women-power-and-gender-to-transform-cancer-care-lancet-report

National Cancer Institute. (2023). *Women, Power, and Cancer: A Lancet Commission*. https://www.cancer.gov/about-nci/organization/cgh/news-announcements/2023/lancet-commission-report-women-power-cancer

Union for International Cancer Control. (2023). *How gender inequities and power dynamics shape the global cancer landscape*. https://www.uicc.org/news-and-updates/news/how-gender-inequities-and-power-dynamics-shape-global-cancer-landscape

Union for International Cancer Control. (2026). *Women, power, and cancer: Implementing the Lancet Commission's recommendations*. https://www.uicc.org/online-course-women/power/and-cancer-implementing-lancet-commissions-recommendations

World Health Organization. (2020). *Global strategy to accelerate the elimination of cervical cancer as a public health problem*. World Health Organization. https://www.who.int/publications/i/item/9789240014107

World Health Organization. (2020). *World Health Assembly adopts global strategy to accelerate cervical cancer elimination*. https://www.who.int/news/item/19-08-2020-world-health-assembly-adopts-global-strategy-to-accelerate-cervical-cancer-elimination

World Health Organization. (n.d.). *Cervical Cancer Elimination Initiative*. https://www.who.int/initiatives/cervical-cancer-elimination-initiative