

***FORM 2.1 Annual Social Impact Report by
Social Enterprise***

*(In terms of Regulation 91E (1) of SEBI (Listing Obligations and Disclosure Requirements)
Regulations, 2015)*

*[This Impact Report is to be prepared Annually by Social Enterprise for Social Projects/Programs
Funded by Security Listed on SSE of BSE/NSE]*

Assessment for the Financial Year (the year reported upon) 1st April 2025 to 31st March 2026

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INSTRUCTIONS:

*All Social Enterprises with currently Listed Securities on the SSE, will prepare an **Annual Social Impact Report in Form 2.1** for each project funded through a listed security on any SSE, with reference to the details provided in the Final Fund Raising Document (FFRD) at the time of listing and the Solution Implementation Plan (SIP) prepared thereafter to implement the project. This requires one Impact Report per currently listed security to be made annually by a Social Enterprise till the security is listed on the SSE. The Social Impact Assessment will be prepared by the Social Enterprise and it will get it assessed by an external Social Impact Assessor who is empaneled with an SRO specified by SEBI.*

Form 2.1 has four Sections

***Section A:** deals with general information, information of project timeline for needful third party evaluation (if any), identifying the presence of KPIs in the solution implementation plan and knowing in very brief about the baseline situation. This needs to be filled by a Social Enterprise project.*

***Section B:** deals with annual progress report to be filled by Social Enterprise prior to the conduct of Social Impact Assessment. It is important to note that Social Enterprises will make entry of the **annual progress that are contextually relevant** for the KPIs set for that particular year as per the Solution Implementation Plan.*

***Section C:** deals with the statement of primary assessment by Assessors based on the entries made by Social Enterprise in the progress report in **Section B**. Social Impact Assessors will provide specific comments on aspects placed in **Section C** of this form in their Social Impact Assessment Report.*

***Section D:** deals with Confirmation by Social Enterprise*

***Section E:** deals will all the supplementary information to be provided in the form of Annexes*

Social Enterprise is required to submit the Annual Social Impact Assessment Report in Form 3.1 to the respective SSE.

SECTION -A: To be filled by Social Enterprise

1. General Information

	Item	Social Enterprise Response
1.	Listing ID	Not Applicable [Yet to be listed]
2.	Name of the organization	Grace Cancer Foundation
3.	Name of program	1.NCD Cancer Screenings and Cancer Awareness Programs 2. HPV Vaccination Programmes
4.	Duration	FY 2025-26
5.	Program mode: (one time/ongoing)	Ongoing
6.	Program area - States with Districts [mention aspirational blocks, if any, as covered as per NITI Aayog]	Program Area - States: Andhra Pradesh, Telangana, Karnataka, and Chhattisgarh.
7.	Beneficiary group(s)/segment(s)*	1. NCD Cancer Screening and Cancer Awareness Programmes Beneficiary Group(s)/Segment(s): ● Female: 19,071 ● Male: 15,633 ● Total Beneficiaries: 34,704 2. HPV Vaccination Programmes A total of 1,745 HPV vaccine doses were administered across the following states: ● Andhra Pradesh: 40 doses ● Telangana: 855 doses ● Karnataka: 850 doses ● Total: 1,745 doses .
8.	Thematic Areas as per SSE	1. NCD Cancer Screening and Cancer Awareness Programme

		Thematic Area: Healthcare Sub-Thematic Area: Cancer Screening, Prevention & Awareness Target Segment: Underserved and Less-Privileged Communities Geographical Coverage: Andhra Pradesh, Telangana, Karnataka & Chhattisgarh SSE Alignment: Promoting healthcare, including preventive healthcare, prevention and treatment of non-communicable diseases (NCDs), including cancer, and improving access to healthcare services for underserved and less-privileged communities. ● 2. HPV Vaccination Programme ● Thematic Area: Healthcare - Preventive Healthcare, HPV Vaccination & Cervical Cancer Prevention Program Focus: Prevention of HPV infection and HPV-related cancers, particularly cervical cancer, through vaccination, awareness and community outreach. Target Beneficiaries: Eligible adolescent girls and other recommended target groups, particularly those from underserved and less-privileged communities. Geographical Coverage: Andhra Pradesh, Telangana & Karnataka SSE Alignment: Promoting healthcare, including preventive healthcare, with a focus on improving access to preventive healthcare services for underserved and less-privileged communities and supporting the prevention of HPV-related cancers, including cervical cancer.
9.	SDG Goals Aligned	For NCD Cancer Screenings and Cancer Awareness Programs, the most relevant UN Sustainable Development Goals (SDGs) are:

		1. <i>SDG 3 - Good Health and Well-being (Primary)</i> ○ <i>Promote health and well-being for all.</i> ○ <i>Supports cancer screening, early detection, prevention, treatment, and health awareness.</i> 2. <i>SDG 5 - Gender Equality</i> ○ <i>Particularly relevant to women's' cancer screening and awareness, including breast and cervical cancer.</i> 3. <i>SDG 10 - Reduced Inequalities</i> ○ <i>Relevant because the programs focus on improving access to healthcare for underserved and less-privileged communities.</i> <i>Recommended entry for your SSE document:</i> <table> <tr> <th><i>SDG</i></th> <th><i>Goals</i></th> <th><i>Aligned:</i></th> </tr> <tr> <td><i>SDG 3 - Good Health and Well-being;</i></td> <td></td> <td><i>SDG 5 - Gender Equality;</i></td> </tr> <tr> <td><i>SDG 10 - Reduced Inequalities.</i></td> <td></td> <td></td> </tr> </table> <i>Primary SDG: SDG 3 - Good Health and Well-being.</i> HPV Vaccination Programmes <i>HPV Vaccination Programmes aim to prevent Human Papillomavirus (HPV) infection and reduce the long-term risk of HPV-related cancers, particularly cervical cancer. The programme focuses on increasing awareness, facilitating access to HPV vaccination, and encouraging timely vaccination among eligible beneficiaries, especially adolescent girls and other recommended target groups. The initiative also promotes cancer prevention through community awareness, education and appropriate healthcare referrals.</i>	<i>SDG</i>	<i>Goals</i>	<i>Aligned:</i>	<i>SDG 3 - Good Health and Well-being;</i>		<i>SDG 5 - Gender Equality;</i>	<i>SDG 10 - Reduced Inequalities.</i>		
<i>SDG</i>	<i>Goals</i>	<i>Aligned:</i>									
<i>SDG 3 - Good Health and Well-being;</i>		<i>SDG 5 - Gender Equality;</i>									
<i>SDG 10 - Reduced Inequalities.</i>											
10.	<i>Alignment with National and State Schemes & priorities</i>	<i>Alignment with National and State Schemes & Priorities</i> National Level:									

		The program aligns with the Government of India's National Programme for Prevention and Control of Non-Communicable Diseases (NP-NCD), particularly its focus on population-based cancer screening, early detection, health promotion, awareness, and referral services. The national programme covers screening for common cancers including oral, breast and cervical cancer. StateLevel: The program supports the NCD and public-health priorities of Andhra Pradesh, Telangana, Karnataka and Chhattisgarh, by extending cancer screening, early detection and awareness services to underserved communities. Andhra Pradesh implements NCD activities under the National Health Mission, including the national NCD programme. Telangana's current health priorities specifically include universal NCD screening and outreach for common cancers, including oral, breast and cervical cancer. The program aligns with the Government of India's National Programme for Prevention and Control of Non-Communicable Diseases (NP-NCD) and National Health Mission priorities, with a focus on cancer prevention, population-based screening, early detection, health awareness and referral. At the state level, the program supports the NCD and public-health priorities of Andhra Pradesh, Telangana, Karnataka and Chhattisgarh by improving access to cancer screening and awareness services, particularly for underserved and vulnerable communities
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** For Environmental and Cultural Programs/Projects- please state the segment(s)*

2. Designated timeline for Mid-term and End-term (if any) *

Phase	Financial Year (From)	Financial Year (To)	Possible month of Review
Pre Project implementation	-		NA

<i>Phase I: Project Start to mid-term</i>	2025	2026	
<i>Phase II: Midterm to End term</i>	2025	2026	

**Depending on the length of the project period, the projects/ programs of 3 year or more duration need mid-term evaluation. The mid-term evaluation of 3/5-year project will be co-terminus with of 2ndyear / 3rd year annual evaluation cycle. The end-term evaluation is co-terminus with the annual end year project evaluation cycle, unless found necessary to conduct special evaluation exercise beyond the end year project evaluation cycle*

We understand that projects/programs with a duration of three years or more require a mid-term evaluation. For a 3-year project, the mid-term evaluation will be conducted during the 2ndyear annual evaluation cycle, while for a 5-year project, it will be conducted during the 3rdyear annual evaluation cycle.

The end-term evaluation will be conducted during the final year as part of the annual project evaluation cycle, unless a separate/special evaluation is considered necessary.

We will accordingly follow the evaluation requirements based on the project duration.

3. Solution implementation plan and KPIs:

<i>Sl no.</i>	<i>Parameters</i>	<i>Yes/No/ partially yes</i>	<i>If yes, give the reference page in SIP</i>
<i>i.</i>	<i>Has the Solution implementation plan (SIP) considered the Guiding framework on Logic Model* for plan preparation?</i>	Yes	
<i>ii.</i>	<i>Has timeline based KPIs for outcome, output and activities been delineated in clear qualitative and quantitative terms in the SIP?</i>	Yes	
<i>iii.</i>	<i>Have the parameters** of reach, depth and inclusion integrated appropriately in the KPIs in SIP?</i>	Yes	
<i>iv.</i>	<i>Are each of the KPIs verifiable?</i>	Yes	
<i>v.</i>	<i>Have the means of verification worked out in clear terms for each KPIs?</i>	Yes	
<i>vi.</i>	<i>Have the stakeholders been mapped out</i>	Yes	

	<i>clearly for consultation and feedback across the timeline of the project?</i>		
<i>*Annex-1 of Guiding Framework on Logic Model {Section III (I)} of USIAF</i> <i>** Annex-2 of Guiding Framework on Logic Model {Section III (I)} of USIAF</i>			

3. Baseline and situation analysis

What is the baseline status at the start of the activity, intervention, program or project?

At the start of the program, access to regular cancer screening and early-detection services was limited among underserved communities in the identified project areas. Awareness regarding cancer prevention, early warning signs, and the importance of timely screening was also inadequate. There was a need to strengthen community-level outreach, screening coverage, early identification of suspected cases, and referral linkages to appropriate healthcare facilities. The program was therefore designed to address these gaps through cancer screening camps and cancer awareness activities across Andhra Pradesh, Telangana, Karnataka, and Chhattisgarh. Detailed baseline findings and the situation analysis are provided in the relevant sections/pages of the Solution Implementation Plan (SIP).

SECTION -B: To be filled by Social Enterprise

4. Report on Performance and Outcome

4.1 Stated overall outcome and overall outcome KPIs (to be filled by Social Enterprise)

Stated overall outcome: Improved access to cancer screening, early detection and cancer awareness services among underserved communities, leading to increased awareness, timely identification of suspected cancer cases, and improved linkage to appropriate healthcare services.

Stated overall KPIs:

1. Number of beneficiaries reached through cancer screening and awareness programs.
2. Number of individuals screened for cancer.
3. Number of suspected/abnormal cases identified and referred for further diagnosis/treatment.
4. Percentage of beneficiaries demonstrating improved awareness of cancer prevention, early warning signs and screening.
5. Number of underserved communities/locations covered across Andhra Pradesh, Telangana, Karnataka and Chhattisgarh

4.2 Annual Progress in Outcome KPIs vis-à-vis Overall outcome KPIs for the year reported upon (previous year)

<i>Stated Intermediate Outcome/s of the project and their KPIs</i>	<i>KPIs Applicable** at different Outcome levels (1,2 and 3) for the year reported upon</i>	<i>What has been accomplished in KPIs mentioned at Col. 2 ?</i>	<i>What could not be accomplished mentioned in Col. 2 ?***</i>	<i>Why it could not be accomplished? Any challenges? ***</i>	<i>Unintended negative outcome, if any</i>
1	2	3	4	5	6
Outcome 1: Improved access to cancer screening services among underserved communities in the	1. Number of beneficiaries reached through cancer screening and awareness programmes. 2. Number of individuals screened for	The NDC Cancer Screening and Cancer Awareness Programmes reached 34,704 beneficiaries, comprising 19,071 female and 15,633 male beneficiaries. Screening and awareness activities	N.A	N.A	N.A

identified project areas.	cancer.	were conducted to improve access to preventive healthcare and early detection services among underserved communities.			
Outcome 2: Increased awareness among beneficiaries regarding cancer prevention, early warning signs and the importance of timely screening.	Percentage of beneficiaries demonstrating improved awareness of cancer prevention, early warning signs and screening.	Cancer awareness and community outreach activities were undertaken among the target communities. 34,704 beneficiaries were reached through the NDC cancer screening and awareness programme, supporting awareness regarding cancer prevention, early warning signs and the importance of timely screening.	N.A	N.A	N.A
Outcome 3: Improved early identification of suspected cancer cases and linkage of identified beneficiaries to appropriate healthcare services for further diagnosis and treatment.	Number of suspected/abnormal cases identified and referred for further diagnosis/treatment.	Among the total screenings done by Grace Cancer Foundation in the FY 2025-26 around 600 suspected/Abnormal cases were identified.	N.A	N.A	N.A
Outcome 4: Increased access to HPV vaccination for eligible beneficiaries, particularly target groups from	Number of HPV vaccine doses administered.	A total of 1,745 HPV vaccine doses were administered during the reporting period: 40 doses in Andhra Pradesh, 855 doses in Telangana and 850 doses in Karnataka.	N.A	N.A	N.A

underserved communities, supporting prevention of HPV infection and HPV-related cancers.					
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**Stated intermediate outcome/s and external KPIs meant for Third party evaluation needs to be mentioned from the fundraising document*

***Only timeline based KPI metrics applicable for third party evaluation for the year reported upon needs to be mentioned*

****Stated Assumptions and Risks in the fundraising document also need to be taken into consideration in answering what and why*

4.3 Annual Progress of Activities and Inputs vis-à-vis stated Output KPIs in the year reported upon (previous year)

State overall output KPIs* at each level of outcome Unit**	units	Overall activity target of the project (unit)	Activity target of the year reported upon		Achievement during the year reported upon		Deviation (if any) for the year reported upon		Reasons for deviation
			Physical (unit**)	Financial (Rs.)	Physical (unit**)	Financial (Rs.)	Physical (unit**)	Financial	
1		2	3	4	5	6	7 (Col 5-3)	8 (Col 6-4)	9
Statement of Outcome 1: Improved access to cancer screening and cancer awareness services among underserved communities.									
Output 1.1 KPI - Number of beneficiaries reached through cancer screening and awareness programs	Beneficiaries	To reach 34,704 beneficiaries through cancer screening and cancer awareness programmes, with an estimated indirect outreach of 1,00,000 beneficiaries across the programme areas.	34,704 Indirect Beneficiaries: 1,00,000	4,75,00,000	34,704	4,75,00,000	N.A	N.A	N.A
Output 1.2 KPI - Number of individuals screened for cancer	Individuals screened	Screening of 15,663 male and 19,071 female beneficiaries:	34,704 Male: 15,663 Female: 19,071	N.A	34,704 Male: 15,663 Female: 19,071	4,75,00,000	N.A	N.A	N.A

		ries,	19,071						
Output 1.3 KPI- Number of underserved communities/locations covered across Andhra Pradesh, Telangana, Karnataka and Chhattisgarh	States/locations	4 states	4 States	N.A	4 States - Andhra Pradesh, Telangana, Karnataka and Chhattisgarh	N.A	N.A	N.A	N.A
Statement of Outcome 2: HPV Vaccination, Improved identification of suspected/abnormal cases and linkage to									
Output 2.1 KPI - Percentage of beneficiaries demonstrating improved awareness of cancer prevention, early warning signs and screening	Beneficiaries	To administer HPV vaccination to 1,745 beneficiaries and promote awareness of HPV infection, cervical cancer prevention, and the importance of timely vaccination, with an	1745 Indirect Beneficiaries: 5500	31,41,000	1745	1745 Indirect Beneficiaries: 5500	?	N.A	?

		estimated indirect outreach of 5,500 beneficiaries.							
Output 2.2 KPI - Cancer awareness and community outreach activities	Individuals screened	To undertake cancer awareness and community outreach activities for 1,745 beneficiaries through HPV vaccination and related awareness initiatives, with a focus on underserved communities.	1745	?	?	1745	?	N.A	?
Output 2.3 KPI	States/locations	To implement the HPV Vaccination Program across three States, namely Andhra	3 States Andhra Pradesh Telangana Karnataka	N.A	3 States Andhra Pradesh Telangana Karnataka	N.A	N.A	N.A	N.A

		Pradesh, Telangana and Karnataka, with a focus on improving access to preventive healthcare among underserved communities.							
Statement of Outcome 3: Improved identification of suspected/abnormal cases and linkage to appropriate healthcare services.									
Output 3.1 KPI- Number of suspected / abnormal cases identified	Cases	?	?	?	?	?	?	N.A	?

NOTE: Column no 3,4,5 and 6 should consider only the target and achievement of the year reported upon (previous year)

***Intermediate outcome wise output/outputs KPI targeted.**

***The number of outcomes and outputs will differ from project to project based on the fundraising document**

****Unit to be set as per the physical activity**

4.4 Cumulative deviation in output KPIs under each outcome KPI of the previous years before the year reported upon

Outputs at each level of outcome*	Cumulative KPI target and finance provided in previous years before the year reported upon		Cumulative KPI achievement and finance utilized in the previous years before the year reported upon		Cumulative Deviation, if any, in the previous years*		Reasons for deviation , if any
	KPI (unit*)	Financial (Rs.)	KPI (unit**)	Financial (Rs.)	KPI (unit**)	Financial (Rs.)	KPI and /or Finance

1	2	3	4	5	6	7	8
Outcome 1 KPI	N.A	N.A	N.A	N.A	N.A	N.A	N.A
	N.A	N.A	N.A	N.A	N.A	N.A	N.A
Outcome 2 KPI	N.A	N.A	N.A	N.A	N.A	N.A	N.A
	N.A	N.A	N.A	N.A	N.A	N.A	N.A

**For details see year on year physical and financial progress of the organization*

***Unit to be set as per the physical activity*

4.5 Convergence and contribution of the year reported upon (previous year)

Intermediate outcome wise KPIs at each level	Convergence from the outside the project			Contributions rendered voluntarily by target beneficiaries/ community/ entity, if any	
	Convergence items* Unit****	Agencies***	Estimated money value***** of convergence (Optional)	Contribution items** Units****	Estimated money value of***** contribution (Optional)
1	2	3	4	5	6
Outcome 1 KPIs:Improved access to cancer screening and awareness services	Coordination and support for cancer screening, awareness and community outreach activities Unit: Activities / Programmes	Healthcare professionals, hospitals, local stakeholders and community representatives	N.A	Beneficiary and community participation in screening and awareness activities Unit: Participants	N.A
Outcome 2 KPIs:Increased awareness regarding	Community outreach and awareness support Unit:	Healthcare professionals, hospitals, local stakeholders and community	N.A	Community participation in awareness and outreach activities	N.A

cancer prevention, early warning signs and timely screening	Awareness activities	representatives		Unit: Participants	
Outcome 3 KPIs: Improved identification of suspected/abnormal cases and linkage to appropriate healthcare services	Referral and healthcare coordination for suspected/abnormal cases Unit: Referral / Healthcare support	Healthcare professionals and hospitals	N.A	Beneficiary participation and cooperation in referral/follow-up process Unit: Beneficiaries	N.A

@the applicability of this format will depend from project to project. Wherever applicable is important to assess through this format. Please refer to Annex-1 **Point 8** (Handling convergence, contribution and sustainability by SE) of Guiding Framework on Logic Model for needful guidance.

* Convergence Items consists of assets/ expertise/capacities or any other support mobilized through partnerships, networks and influence from the stakeholders within and outside the project.

** Any agreed upon voluntary contribution time, money, materials, or labour to the project (social/ environmental/ cultural) activities by the target community/entity, or stake undertaken by the target community/entity to sustain the project with considerations for reach, depth, inclusion.

*** Agencies could be any government or any non-government partner institutions and individuals who has a stake in the project or whose stake need to be developed in the interest of the Project.

****Unit to be set as per the convergence/ contribution item.

*****Giving this information is optional, but this will be very useful in creating narrative on stakeholders' participation/contribution in tangible terms. This should be provided only if the organization has a reasonable basis of calculation to provide this information.

4.6 Past performance trend

What has been the past performance trend? What are the organization's learnings on what went well and what did not work well?

Grace Cancer Foundation (GCF) has shown steady growth in its outreach and cancer-screening activities, expanding its work across underserved communities through mobile screening, awareness programmes and partnerships. The organization has increasingly focused on early detection, prevention and accessible healthcare services.

Between 2023 and 2025, Grace Cancer Foundation screened 74,150 people through 429 camps and identified 6,074 non-communicable disease cases, including 1,267 cancer cases. The programme experience indicates the importance of community mobilisation, accessible screening, timely referral and follow-up in achieving meaningful outcomes.

What has worked well is GCF's community-based approach, mobile screening model, strong partnerships and use of technology to reach larger populations.

Key challenges have included ensuring consistent follow-up after screening, maintaining quality while expanding, and tracking long-term patient outcomes.

Key Learnings

GCF has learned that early detection is most effective when supported by strong community outreach and accessible screening services. Building partnerships with healthcare providers, government agencies and other stakeholders helps expand reach and strengthen service delivery. The organization has also recognized the importance of timely referrals, follow-up and outcome tracking to ensure that screening leads to meaningful health outcomes. Going forward, GCF will focus on scaling proven models, strengthening systems and using technology to improve efficiency and impact.

5. Report on risks and unintended negative outcome

6.1 *In the previous year, what have you seen as the biggest risks* to the achievement of the desired impact? How are these being mitigated?*

GCF: The key risks include limited participation among underserved communities, geographical and logistical constraints in reaching remote areas, availability of trained healthcare personnel, and delays in referral or follow-up after screening. These risks are mitigated through community mobilisation, coordination with local stakeholders and healthcare professionals, planned deployment of medical teams and screening resources, and referral and follow-up support for beneficiaries requiring further evaluation.

6.2	<i>Describe any potential unintended negative outcome of this project seen in the year reported upon (previous year). How are these being addressed?</i> <i>GCF: A potential unintended outcome of cancer screening is anxiety or distress among beneficiaries receiving abnormal or suspected screening results. This is addressed through appropriate communication, counselling and referral for further medical evaluation.</i>
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7. Report on stakeholder consultation

Has the organization taken into consideration relevant stakeholders' feedback in the year reported upon? What has been the stakeholder wise feedback? and how they have been used by the organisation? *relevant stakeholders mean those mapped out in the SIP for taking feedback during the period reported upon.*

GCF:

Relevant stakeholders include beneficiaries, healthcare professionals, volunteers, hospitals, local stakeholders and community representatives. Feedback and field-level observations are considered in beneficiary mobilisation, planning of screening activities, awareness activities and delivery of services.

8. Report on sustainability of the interventions made as envisaged in the Fund Raising Document

Has the project recommended a sustainability plan in FRD and SIP?

If yes, any measures implemented from SIP for sustainability of activity/intervention/programs or project outcomes during the year reported upon? When the organization will start preparing/ prepared a withdrawal plan for exit?*

** Organisation may state what is being done in stakeholder consultations, convergence initiatives, community contribution and stake development; and in the collaboration & advocacy front for effective handing over and sustainability of the project. Any other needful measures adopted beyond above points may also be mentioned.*

GCF: The programme is supported through continued community outreach, engagement with healthcare professionals and local stakeholders, established screening mechanisms and referral linkages.

9. Plan for using Social Impact Assessment for Knowledge Management

How the knowledge on Social Impact Assessment has been used by the organization to create a sharper narrative about the Sector works and how such knowledges are being disseminated to the stakeholders for cross learning to the Sector's advantage?

**It could involve publishing the executive summary of the Social Impact Assessment on the Organization's website or discussing on the uniqueness of the organization's impact assessment experience to uncover certain issue-based realms that could be spread for cross-learning to the Sector's advantage.*

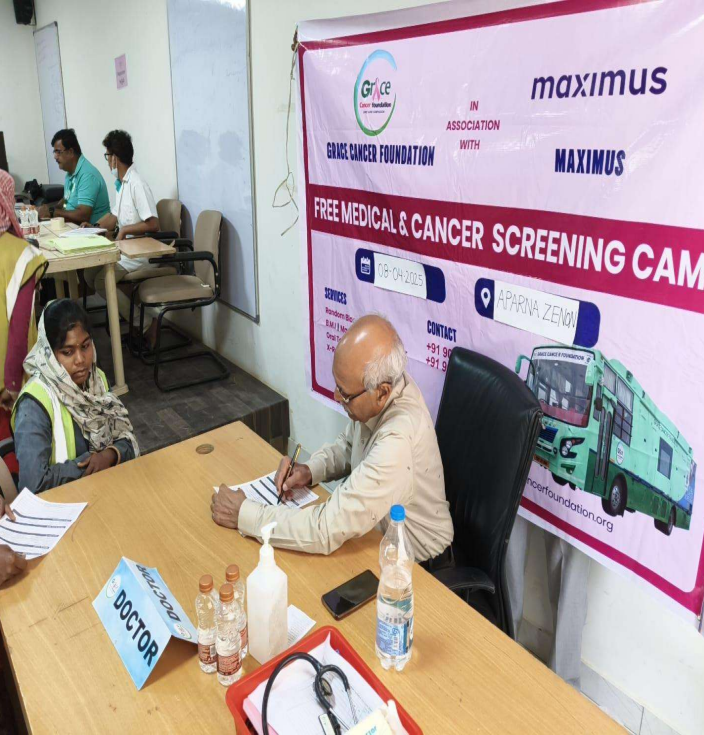
GCF: The Social Impact Assessment findings will be used to strengthen programme planning, KPI monitoring, documentation and outcome tracking, with relevant learnings shared with programme teams and stakeholders for improving future cancer screening and awareness initiatives.

**to be filled by the Social Enterprise after receiving the comments on Annual Impact Report from Assessors at Section C and before the final draft*

10. Plans for the next Social Impact Assessment Cycle*

11. Photographs conveying before and after impact of the Programme









12. Annexures

Item	NA	If applicable	
		Yes	No
1) Blank copy of any questionnaire or survey forms used	NA	Yes	No
2) Summary analysis of surveys undertaken		Yes	
3) Copies of other consultation details (such as focus group write-ups, workshop notes, etc.)			
4) Copies of evidence summarized or quoted in the social impact report		Yes	No
5) Notes of the previous social impact assessment meetings (when applicable)			
6) Past Social Impact Assessment Statements for the projects funded by the Listed Security (when applicable)			
7) Completion certificate of SEBI approved mandatory capacity building workshops			
8) Case Studies/ Stakeholder Testimonials		Yes	
9) All stand-alone reports and that have contributed to the organisation's impact reporting for this period		Yes	

SECTION – C: To be filled by Assessors for facilitating assessment with respect to the entry made by Social Enterprise at Section A and B

13. Analysis of Solution Implementation Plan (SIP)@ and Key Performance Indicators@

@This is applicable only for first year Social Impact Assessments

13.1 Solution Implementation Plan

Comment on the alignment of SIP with the Guiding Framework on Logic Model and alignment of plan preparation with the format placed therein? Do the included KPI metrics address reach, depth and inclusion parameters** in objectively verifiable terms? If not objectively verifiable, please suggest modification.*

**Annex-1 of Guiding framework on logic model (Section III(I)) of USIAF*

***Annex-2 of Guiding framework on logic model (Section III(I)) of USIAF*

13.2 Key performance indicator for reporting

Comment on the appropriateness of Key Performance Indicators (KPI) on outcome, output, activities and input placed in SIP in achieving impact? Is there any modification required to make these indicators more objectively verifiable? Are the means of verification of KPIs clear and sufficient?

14. Previous Social Impact Assessments, if any@

@ Not applicable in first year Social Impact Assessment of the project

14.1	<i>Include a short outline on how the issues raised and recommendations for action in the previous Social Impact Assessment have been followed through. *</i>
14.2	<i>Has the target segment changed in the previous year? If so, why?</i>

15. Report on Performance

15.1 Performance on outcome

15.1.1	<i>A narrative report on the degree to which the program/ project is living up to its stated objectives</i>
15.1.2	<i>Analysis and interpretation of the outputs</i>
15.1.3	<i>Analysis and interpretation of the outcomes</i>
15.1.4	<i>Interpreting and explaining the impact</i>
15.1.5	<i>Gaps and challenges identified</i>
<i>*This should be with reference to the baseline and KPI narratives kept in FFRD and SIP, and the information provided in Section B in relation to the identified KPIs</i> <i>* This will include any appropriate calculations and interpretations. The report on project objectives should consider the social, environmental, cultural and economic dimensions of performance and impact as appropriate.</i> <i>*Refer Unified Social Impact Assessment Framework for this exercise</i>	

15.2 Stakeholder feedback

How has the Social Enterprise taken into consideration stakeholder feedback in this reporting period?

**The report shall include the details of stakeholders consulted and how the organization has used their feedback in program implementation.*

15.2.1 Contribution

Comment on the trend in the mobilization of voluntary community support/contribution or the stake developed by the community/ entity that have contributed to, or will contribute in the future to the accomplishment of these goals and sustainability of the project. How can this be improved further?

**Refer to the details provided under at point 5.5 of Section-B for answering these points.*

15.2.2 Knowledge management and advocacy

Comment on how best the organization is doing to create a sharper narrative through Social Impact Assessment to the Sector's advantage.

**Refer to the details provided under at point 9 of Section-B for answering these points.*

15.2.3 Write key measures taken for sustainability of the project. Comment on the adequateness of these measures. Cite further needful measures, if any?

**Reference may be drawn from the comments given at point 8 and sub-points under 14*

**Towards the end year of the project, take reference of withdrawal plan prepared by the project for making exit.*

16. Issues for Achievements

16.1 The Social Impact Assessment will have revealed several issues that have to be tackled as well as achievements to celebrate. Write the key achievements of the program. Also comment on identified risks and mitigation measures adopted/ to be adopted to address this and any unintended negative outcome reported and measures adopted/ to be adopted to address this.

** Internal risks are organizational and HR capacity issues and external risks are conditions such as unfavorable changes in market and/or policy framework conditions.*

GCF: During FY 2025-26, Grace Cancer Foundation continued its cancer screening and awareness activities across underserved communities. The programme reached 34,704 beneficiaries and covered Andhra Pradesh, Telangana, Karnataka and Chhattisgarh, with 34,704 cancer screenings reported. Key risks included limited participation, geographical and logistical constraints, availability of healthcare personnel, and delays in referral and follow-up. These risks were addressed through community mobilisation, coordination with healthcare professionals and local stakeholders, deployment of screening resources and referral support. A potential unintended outcome is anxiety or

distress arising from abnormal screening results, which is addressed through appropriate communication, counselling and referral for further medical evaluation

16.2 Has there been any material (significant) change in the organization's implementation model in the last one year? Suggest material changes required in future, if any.

**Material changes means any pertinent change including organizational changes that significantly affect the decision of the stakeholders and also affect the way of carrying out of the project/ program.*

GCF: No material change was made to the implementation model during FY 2025-26. The programme continued through community mobilization, cancer awareness activities, screening camps, healthcare professionals, local stakeholder engagement and referral support. No material change is proposed at this stage

16.3 Outline the steps and actions required to effectively implement the program, It includes Revised Action Plan; Resources; Stakeholder engagement; Timeline; Training and Capacity building; Monitoring and Evaluation

GCF: Identification of target communities and beneficiaries; selection of programme locations; community needs assessment; coordination with healthcare professionals and local stakeholders; planning of cancer screening and awareness activities; arrangement of medical equipment, resources and manpower; beneficiary mobilization; development of awareness and communication materials; scheduling and logistical planning for screening camps; and establishment of referral mechanisms for suspected cases.

SECTION – D Confirmation by Social Enterprise

I, Dr. Chinnababu Sunkavalli on behalf of Grace Cancer Foundation, confirm that the social impact assessment process was carried out as per the terms of reference of the engagement and the draft report was shared with us and our responses heard. The minutes of the Social Impact Assessment Meetings capture our responses and the points for action. These minutes are maintained in our records. Feedback as appropriate will be incorporated for review in the next social impact assessment cycle.

Remarks, (if any):

Authorised Representative of Grace Cancer Foundation

Name: Dr. Chinnababu Sunkavalli

Sunkavalli

Chinna Babu

Digitally signed by
Sunkavalli Chinna Babu
Date: 2026.09.05
17:02:32 +05'30'

Signed:

Date: 05-09-2026

Place: Hyderabad



Seal of the Social Enterprise

Grace Cancer Foundation

FY 2025-26 Summary & Analysis | Based on SEBI SSE Form 1B Annual Self-Disclosures
Reporting period: 1 April 2025 - 31 March 2026 | NSE SSE Registration: NSESENPO00165

Rs 6.13 Cr Total Spending FY25-26	36,000+ Beneficiaries Reached	176 Villages Covered	34,578 Cancer Screenings	4 States Geographic Spread	31 Total Employees
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Overview

Grace Cancer Foundation (GCF) operated a portfolio of five programmes in FY 2025-26, all under the Non-Communicable Disease (NCD) / cancer screening and awareness theme, aligned with SDG 3 (Good Health and Well-being, Target 3.4) and India's National Programme for Prevention and Control of Non-Communicable Diseases (NP-NCD). Annual spending grew sharply from Rs 3.69 Cr (FY 2024-25) to Rs 6.13 Cr (FY 2025-26), an increase of roughly 66%, driven primarily by expansion of the Telangana NCD screening programme. The organisation's flagship NCD Cancer Screening and Cancer Awareness Programme alone accounted for 77.6% of total programme spending in the year, comfortably meeting the SSE requirement to cover at least 67% of spending in the Annual Impact Report.

Financial Trend (3-Year Spending)

Financial Year	Annual Spending (INR)	Year-on-Year Change
FY 2023-24	4,11,40,195	-
FY 2024-25	3,68,84,393	down ~10.3%
FY 2025-26	6,12,58,481	up ~66.1%

Programme-wise Performance (FY 2025-26)

Programme	Geography	Spend (INR)	Reach	Direct Beneficiaries
Telangana NCD Screening & Awareness	Telangana	2,09,95,080	100 villages	19,669
HPV Vaccination Programme	TG / KA / AP	27,92,000	-	1,481
Andhra Pradesh NCD Screening & Awareness	Andhra Pradesh	9,65,900	27 villages	13,701
Chhattisgarh NCD Screening & Awareness	Chhattisgarh	5,22,000	8 villages	348
Karnataka NCD Screening & Awareness	Karnataka	4,42,600	7 villages	1,616

Telangana is the dominant geography, accounting for roughly 79% of total programme expenditure and the largest share of villages covered and beneficiaries reached. The HPV Vaccination Programme is the second largest line item, reflecting a preventive-care push alongside the core screening work.

Top Donors / Funding Partners

Annexure

Donor	Geography	Contribution (INR)
Cigna Health Solutions / Evernorth Health Services India	Telangana	1,04,28,580
Quambiant Design Build Pvt Ltd	AP, Telangana	50,00,000
Maximus GCC Technology & Business Services (India)	TG, AP, KA	29,75,000
Ryan India Tax Services Pvt Ltd	Telangana	25,00,000
Smart Gen Infra Pvt Ltd	Telangana	15,00,000

Corporate CSR partners fund the majority of top-line programme costs; the five largest donors together committed over Rs 2.24 Cr, concentrated in Telangana.

Organisational Scale

Category	Count
Permanent Employees	22
Temporary Employees	3
Employees on Contract	6
Total Employees	31
Volunteers Engaged	4,000+

Impact Highlights - Flagship NCD Programme

Under the NCD Cancer Screening and Cancer Awareness Programme (77.6% of FY spend), GCF conducted 34,578 cancer screenings across 159 villages in Telangana, Andhra Pradesh, Karnataka and Chhattisgarh, split roughly between 18,945 female and 15,633 male beneficiaries. Activities combined community mobilisation, awareness camps, clinical screening, and referral support for suspected cases requiring further evaluation. No material change was made to the implementation model during the year, indicating a maturing, repeatable delivery approach rather than a pivot.

Governance & Compliance Status

Requirement	Status
Statement of Compliance (Form 1B.4)	Filed - signed by Founder Trustee
Related-Party Transaction Disclosure	Reported per Income Tax Act s.13(3)
Audited Financial Statements & IT Returns	Confirmed available (Yes)
FCRA / Registrar Annual Returns	Confirmed available (Yes)
Impact Report spend coverage (min. 67%)	77.6% - requirement met

Key Observations

- Spending nearly doubled year-on-year after a dip in FY 2024-25, signalling a significant scale-up phase in FY 2025-26.
- Programme concentration is high: one thematic area (NCD/cancer) and one state (Telangana) drive the large majority of spend and reach.

Annexure

- Donor base is corporate-CSR heavy and concentrated among five entities; broadening the donor base could reduce funding-concentration risk.
- All mandatory SSE disclosure and compliance items for Form 1B are marked complete, with no flagged gaps in the self-reported filing.

This summary is derived from Grace Cancer Foundation's self-reported SEBI SSE Form 1B (FY 2025-26 filing). It is a condensed analytical overview, not a substitute for the full disclosure document or audited financials.

A 10-Year Review of Health Care Screening Conducted by the Grace Cancer Foundation, a Non-Profit Organization in Telangana

Chinnababu Sunkavalli, Prameela Sunkavalli, Anthony Vipin Das, Kanakaveti Sai Sri Krishnaja

Affiliations

Grace Cancer Foundation, Hyderabad, Telangana, India

Corresponding Author

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Conflict of Interest: None

Funding: Grace Cancer Foundation (GCF)

Keywords: Public Health, Screening, Cancer, LMIC, India

Introduction

Cancer screening involves detecting cancers before symptoms appear, giving participants the best chance of a successful outcome. Cancer survival rates are worse, treatment-related complications are more common, and healthcare expenses are higher when cancer care is delayed or unavailable.

Breast cancer, the most common cancer in women, can be detected through mammography, which can reveal tumors too small to feel. Cervical cancer is commonly screened using the Papanicolaou (Pap) test, which examines cervical cells for abnormal changes. Oral cancer, one of the leading cancers worldwide in both sexes, can be identified earlier through systematic visual inspection and palpation of the oral cavity under bright light.

Screening is proven to reduce cancer incidence and mortality, yet patients in low- and middle-income countries typically have poorer prognoses than those in high-income countries due to lack of knowledge, late diagnosis, and inequitable access to affordable treatment. Breast, cervical, and lip/oral cavity cancers together account for 34% of the 1.15 million cancer cases diagnosed annually in India, with significant regional variation.

According to the NFHS-5 report (2019–2021), only 1.9%, 0.9%, and 0.9% of women in India had ever undergone cervical, breast, and oral cavity screening respectively, and about 1.2% of men had undergone oral cavity screening. In 2020, Telangana recorded 7,491 cases of breast cancer and a cervical cancer incidence of 9.71 per 100,000 — against screening rates of just 0.3% (breast) and 3.3% (cervical) in the state.

The Grace Cancer Foundation (GCF) is an Indian non-profit established a decade ago to combat cancer through four strategic pillars: education & awareness, early detection, treatment & rehabilitation, and cutting-edge research — offering CURE, CARE, and COMPASSION through early intervention. GCF identified districts in Telangana with low screening rates per NFHS-5 and launched cancer screening camps in these underserved areas.

Methodology

With support from the government, local authorities, and sponsors, the GCF team selects underserved areas and conducts a site recce, assessing local facilities and mobile screening bus accessibility. After discussion with

sponsors, the team prepares a plan of action and scope of work for each staff member, then packs all equipment and medicines before dispersal to the camp site.

The camp follows a standardized patient-screening protocol, known internally as “The GCF Way”:

- Registration — Volunteers help participants complete registration forms; each patient receives a unique identification number for tracking.
- Triage — Trained personnel conduct initial assessments to prioritize needs by urgency, expediting acute or urgent cases.
- Medical Examinations — Qualified professionals conduct clinical assessments, including medical history review, vital signs, and physical examination (palpation, auscultation, inspection).
- Diagnostic Tests — Designated areas host PAP smear, X-ray, and mammography testing, run by trained technicians under strict safety protocols.
- Counseling — Qualified counselors provide participants with results, preventive guidance, lifestyle advice, and emotional support.

Standardized protocols, regular staff training, comprehensive documentation, and strict patient confidentiality measures are maintained across all camps for quality and continuity of care.

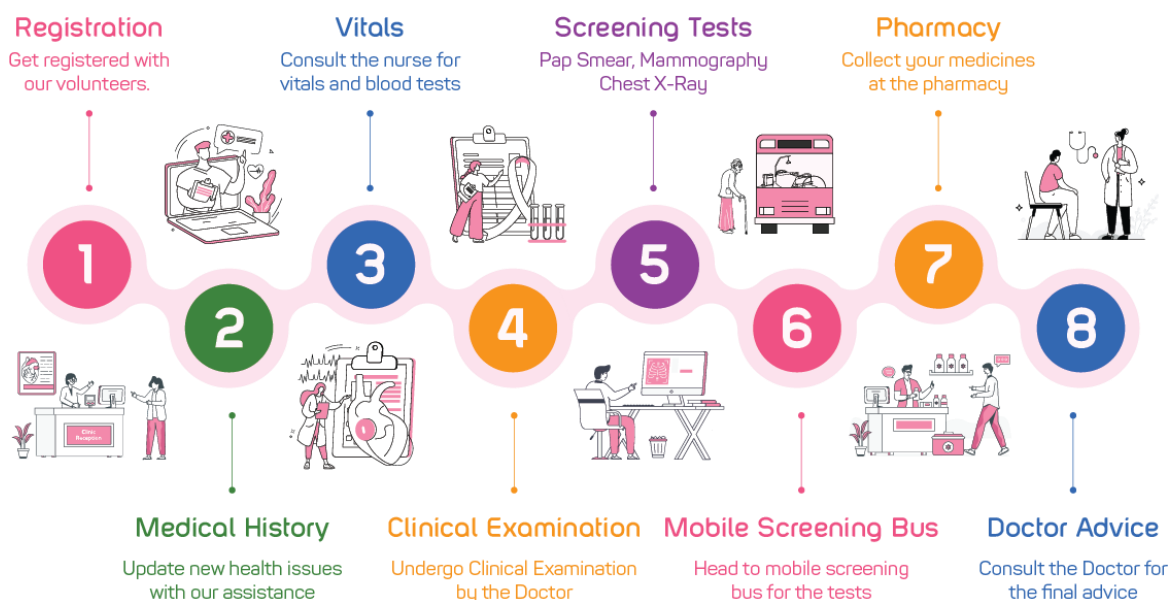


Fig. 1: The GCF Way — Protocol of Screening Patients

GCF has also implemented electronic medical record systems for streamlined data management, mobile diagnostic units to improve outreach in remote areas, community engagement strategies (awareness campaigns and local partnerships), and feedback mechanisms for continuous quality improvement.

Results

Of 122 camps conducted, 57 were dedicated to awareness (98,730 participants), while 65 camps combined awareness and screening services (30,953 participants).

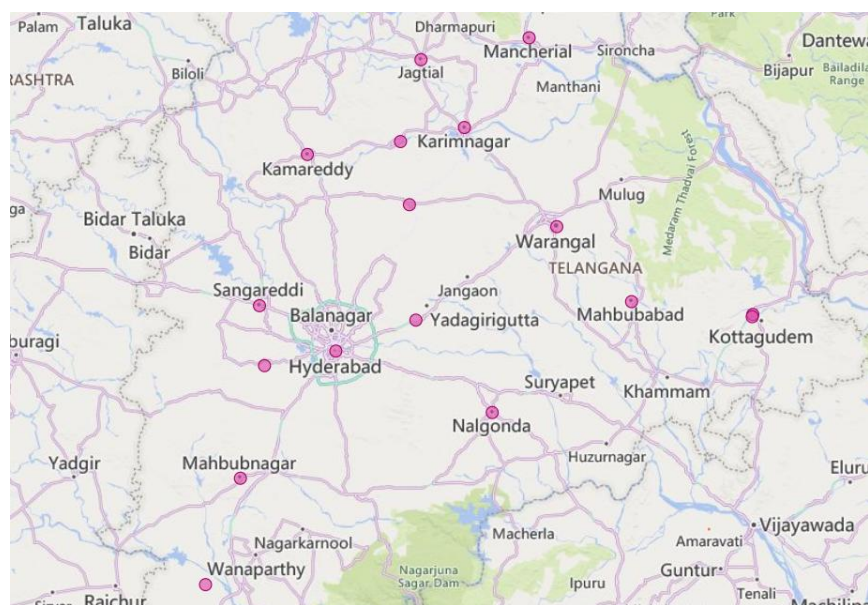


Fig. 2: Geospatial Mapping of Screening Locations in Telangana

Table 1: Segregation of camp types and participation

Type of Camps	No. of Camps	People Participated
Total	122	1,29,683
Awareness camps	57	98,730
Both awareness and screening camps	65	30,953

Table 2: Segregation of screening camps and participation

Type of Camps	No. of Camps	People Participated
Total	660	87,050
Screening camps	258	48,914
Surgery, Screening camps	402	38,136 (incl. 2,352 surgeries, 64 chemos)

Overall, 660 camps recorded 87,050 participants: 258 screening camps (48,914 participants) and 402 surgery-and-screening camps (38,136 participants), including 2,352 surgeries and 64 chemotherapy sessions.

Awareness Topics

Awareness topics covered (with participation) included: Symptoms of COVID-19 and Management (100, lowest); Importance of breast cancer screening and risk factors; Impact of EMF on cancer; Health and hygiene; EMF and Cancer; Cancer prevention through lifestyle modification (1,300); and Importance of cancer screening and prevention, which drew the highest participation at 93,975.

Site- and Year-wise Highlights

- Khammam Surgery camps: number of surgeries done ranged from a low of 3 to a high of 14.
- Indur Cancer Hospital, Nizamabad: 2,299 surgeries performed; 33,695 people participated in screenings.
- A smaller hospital site recorded 2 surgeries against 50 screening participants.
- Hyderabad locations: Gachibowli recorded 1,800 participants in screening and awareness sessions.
- Telangana-wide screening and awareness split: 58% of participants came from Jadcherla.

- Nizamabad: majority of participants (3,650) were from Indur Cancer Hospital, followed by Kandakurthy village.
- Rangareddy: majority of participants (2,652) were from Ayodhya Nagar, followed by 2,000 from Shamshabad.
- Year-wise (Telangana): highest participation (6,108) was in Rangareddy in 2016, followed by 5,000 in Karimnagar in 2015.
- Screening-only sessions in Telangana: highest participation (500) was in Bodhan.
- Screening sessions in Hyderabad: Lakshmipuram led with 405 participants, followed by Koti with 285.
- Year-wise screening (2013–2018): highest participation (7,684) was in Rangareddy district in 2018.
- Year-wise screening (2019–2020): highest participation (3,115) was in Khammam district in 2019.
- Year-wise screening (2021–2022): highest participation (5,290) was in Nizamabad district in 2021.
- Year-wise screening (2023): highest participation (6,355) was in Khammam district in 2023.

Discussion

Camps showed a diverse distribution based on primary focus: among 660 total camps, 57 focused solely on awareness, 65 combined awareness and screening, 258 focused on screening, and 402 offered surgery and screening. Awareness-only camps drew substantial participation (98,730), serving as platforms to educate communities on issues ranging from COVID-19 management to cancer prevention through lifestyle change.

Camps combining awareness and screening recorded 30,953 participants, underscoring the value of integrating the two to maximize impact. Camps offering surgery and screening together reached 38,136 participants, reflecting a comprehensive approach to addressing health concerns identified during screening. Screening practice remains far lower than awareness and attitude toward screening — for instance, an Indian study found cervical Pap-smear screening uptake of only 2.4% among rural women.

The “Importance of cancer screening and prevention” topic drew the highest participation of any awareness theme, reflecting strong community interest in prevention. Lack of information, misconceptions, financial limitations, and illiteracy are commonly linked to delays in seeking care. Roughly 70% of cancers in India stem from preventable factors, underscoring the value of targeted interventions, and cancer prevention, screening, and early diagnosis are cost-effective ways to improve survival and reduce economic burden.

Mobile Screening Units (MSUs) help remove access barriers, saving cost and time — particularly valuable for women who cannot afford to forgo daily income to travel long distances to clinics. GCF has identified mobile cancer screening as key to overcoming hesitancy among underserved rural populations, who often avoid early detection due to social stigma around non-communicable diseases. By 2023, GCF had reached 12 million people across 130 countries, promoting awareness of early cancer detection, screening, and active lifestyles to prevent chronic disease.

Conclusion

This study underscores the value of health awareness camps as effective platforms for promoting preventive healthcare. The findings carry significant implications for public health initiatives, particularly in designing targeted strategies to boost community engagement with preventive care. By building on the success of awareness camps and integrating screening and surgical services where needed, policymakers can optimize resource allocation and maximize the impact of health campaigns — ultimately improving health outcomes and community well-being.

Myths and misconceptions on Breast cancer among women in Hyderabad, India

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Abstract:

Background:

Misconceptions and myths are part of the rising incidence of breast cancer. False information about the clinical presentation, diagnosis, and treatment of breast cancer makes it more difficult to diagnose the disease early and deteriorates the doctor-patient bond. This study was designed to find the common myths and false beliefs are regarding breast cancer

Methodology:

A cross-sectional study was conducted in Hyderabad, Telangana in June 2024. A total of 122 women participated in the study. Women under 20-70 years old with or without a history of breast cancer were included in the study. Participants were interviewed using a pre-piloted questionnaire designed to assess the prevalent myths and misconceptions about breast cancer. The data was analyzed by SPSS version 23.

Results:

The mean age of the participants was 44.7 ± 13.1 years. The majority of the participants were employed (56.6%), most of the women were married (88.5%) and were postgraduates (54.1%). The most common myth was feeling stressed (85.2%), followed by exposure to electromagnetic radiation (84.4%) and wearing a tight bra (76.2%). A significant number of participants did not believe breast cancer to be a result of God's curse (86.9%) or evil eye (90.2%). The association

between the education level and misbeliefs related to breast cancer was found to be statistically significant with a p-value of 0.012

Conclusion:

The misinformation on Breast Cancer can be highly persuasive and contributes to diagnostic delays. It is essential to design comprehensive breast cancer education campaigns and awareness programs addressing the myths and misconceptions related to breast cancer to decrease the burden of delayed presentation among women in Hyderabad

Keywords:

Introduction:

Breast cancer (BC) is a leading health concern among women due to its high mortality and morbidity rate the five-year survival rate in metastatic breast cancer is less than 30%. Studies using epidemiological methods linked various factors to the onset and progression of breast cancer risk.

Risk factors that are closely linked to the development of disease include menopause, marriage at a later age, and first childbirth. Breast tumors typically begin as ductal hyperproliferation and, after being continuously stimulated by different carcinogenic factors, progress into benign tumors or even metastatic carcinomas.¹⁻³

Recently, the GLOBOCAN 2020 data by the IARC (International Agency for Research on Cancer) reported the worst breast cancer incidence and prevalence in 185 countries. Breast cancer is the leading most commonly diagnosed cancer with a total of 2.3 million new cases of breast cancer.

The prevalence of breast cancer is the highest in Asian countries like India and Pakistan.⁴ . Breast cancer remains the fast-growing cancer in India after cervical cancer. The National Cancer Registry Program in 2018 estimated approximately 1,62,468 new breast cancer cases and 87,090 deaths due to breast cancer in India.⁵

Misconceptions and myths are part of the rising incidence of breast cancer. False information about the clinical presentation, diagnosis, and treatment of breast cancer makes it more difficult to diagnose the disease early and deteriorates the doctor-patient bond. Thus, falsehoods, myths, and misinformation have been classified as worldwide risks. The prevalence of myths in society

is also influenced by cultural beliefs. Patients use harmful interventions in the hopes of finding a cure thanks to the misinformation.^{6,7}

This study was conducted to understand the common myths and false beliefs regarding breast cancer. The study was conducted in an urban setting. Determining the prevalent myths can aid in the creation of awareness campaigns and updated protocols which are aimed at reducing the amount of false information causing delays in diagnosis and treatment.

Objectives:

To assess the level of awareness of BC causation myths and misbeliefs among the women residents in Hyderabad

To analyze factors associated with having good awareness level of BC mythical causes.

Methodology:

Study design: Cross sectional study

Study population: Women residents of Hyderabad

Sample size: Based on the observations from the previous study (94.3 %) women believed in at least one of the mentioned myths using $n = z^2 * pq / d^2$ where $z = 1.96$, p = proportion of women who believed myths on breast cancer was found to be 94.3% ⁽⁸⁾, $q = 100 - p$, d = absolute precision of 5%, the sample size attained was 83 considering 15% non-responsive rate, it will be rounded off to 100.

Sampling technique: Random sampling

Study duration: 1 month

Data collection:

The researchers created google forms and shared with the participants through social media platforms, written consent was taken from all participants. The purpose of the research and the procedure of data collection was explained to the participants. The participants were asked to fill out a proforma designed after a thorough literature search and review. Information was obtained regarding the myths, misconceptions and cultural beliefs about breast cancer, and their approach

toward diagnosis and treatment was recorded. The self-designed 18- questionnaire was translated into Telugu. The inclusion criteria were all females aged 20-80 years with or without a history of breast cancer. All participants denying consent were excluded from the study.

Data analysis:

The data fed in SPSS version 23 and analyzed using descriptive statistics. All questions for myths and misconceptions were scored (one point for a correct response and zero for an incorrect or not sure response). The determinant of the correct responses were based on the review of current guidelines and literature. The categorical variables were evaluated as frequencies and means. The level of correlation between education status and the prevalence of misconceptions were determined using the chi-square test. A p-value of 0.05 were considered significant for all tests.

5-point Likert scale questions (1="strongly disagree" to 5="strongly agree"). This was done to reduce the potential of participants answering questions at random. Responses with 'disagree' or 'strongly disagree' were considered correct; all others were considered incorrect. The participant were given one point for each recognized myth to be incorrect.

Results:

Socio-demographic characteristics:

Tab 1: Age of the participants

Age	Frequency	Percentage
18-30 years	13	10.6
31-50 years	78	63.9
51-70 years	24	19.6
Above 70 years	7	5.7

The table no.1 shows age of the participants the mean age of the participants was found to be 44.7 ± 13.1 years, majority of them are of 31-50 years $n=78$ (63.9%) followed by 51-70 years $n=24$ (19.6%).

Tab 2: Educational status

Educational status	Frequency	Percentage
Higher education	8	6.6
Graduate	48	39.3
Post Graduate	66	54.1

The table no.2 shows among the people who participated majority of them n=66 (54.1%) had done their post-graduation followed by Graduates n=48 (39.3%).

Tab No.3: Occupational status

Occupation	Frequency	Percentage
Unemployed/housewife	50	41
Employed	69	56.6
Student	3	2.5

The table no.3 shows among the people who participated majority of them n=69 (56.6%) are employed followed by unemployed/ housewife n=50 (41%).

Tab no. 4: Marital status

Marital status	Frequency	Percentage
Married	108	88.5
Unmarried	10	8.2
Divorced/Widowed	4	3.3

The table no. 4 shows among the people who participated majority of them n=108 (88.5%) are married followed by unmarried n=10 (8.2%).

Tab no.5: Causes perceived among the participants on breast cancer causation due to Myths

Myths		Frequency	Percentage
Eating Burnt Food	Agree	66	54.1

	Disagree	56	45.9
Eating food containing artificial sweeteners	Agree	84	68.9
	Disagree	38	31.1
Using microwave ovens	Agree	82	67.2
	Disagree	40	32.8
Having physical trauma	Agree	53	43.4
	Disagree	69	56.6
Using cleaning products	Agree	88	72.1
	Disagree	34	27.9
Feeling stressed	Agree	104	85.2
	Disagree	18	14.8
Exposure to electromagnetic frequencies	Agree	103	84.4
	Disagree	19	15.6
Wearing a tight bra	Agree	93	76.2
	Disagree	29	23.8

The table no.5 shows the majority of the people have myths related to feeling stressed n=104 (85.2%), exposure to electromagnetic radiation n=103 (84.4%) and wearing tight bra n=93 (76.2%) [9]

Tab no.6: Misbeliefs on breast cancer among women

Misbeliefs	Type of question	Frequency	Percentage
Do you think every lump is cancer?	Yes	11	9
	No	111	91
Are only painful lumps associated with cancer	Yes	44	36.1
	No	78	63.9
does breast cancer always run in families	Yes	59	48.4
	No	63	51.6
Is breast cancer God's curse	Yes	16	13.1
	No	106	86.9
does evil eye cause breast cancer	Yes	12	9.8
	No	110	90.2
Does breastfeeding offer immunity to cancer completely	Yes	60	49.2
	No	62	50.8
Does everyone with breast cancer die	Yes	8	6.6
	No	114	93.4
Can alternative medicine and faith healers cure Breast cancer	Yes	77	63.1
	No	45	36.9

Is breast cancer contagious	Yes	7	5.7
	No	115	94.3
Can radiation from a mammogram cause breast cancer	Yes	58	47.5
	No	64	52.5

The table no.6 shows that the majority of the people considered that every lump is not cancer n=111 (91%), Breast cancer is not God's curse n=106 (86.9%), Breast cancer is not caused by evil eye n=110 (90.2%), everyone with breast cancer will not die n=114 (93.4%), breast cancer is not contagious n=115 (94.3%)

Tab no.7: Awareness levels on myths related to BC causation

Awareness levels	Frequency	Percent
Average	26	21.3
Good	89	73.0
Poor	7	5.7

The table no. 7 shows that majority of the people participated in the study have good knowledge n=89 (73%) of cause of myths related to breast cancer

Tab No.8: Awareness levels on misbeliefs related to BC

Awareness levels	Frequency	Percent
Average	32	26.2
Good	84	68.9
Poor	6	4.9

The table no.8 shows that the majority of the people who participated in the study have good knowledge n=84 (68.9%) of misbeliefs related to breast cancer

Tab No.9: Association of Socio-demographic characteristics and myths and misconceptions

Socio-demographic characteristics	Categories	Average	Poor	Good	Chi-square test	p-value
Education	Higher education	3 (37.5)	5 (62.5%)	0	4.963	0.291
	Graduate	12 (25%)	35 (72.9%)	1 (2.1%)		
	Post Graduate	11 (16.7%)	74.2%)	6 (9.1%)		
Occupation	Unemployed/housewife	13 (26%)	35 (70%)	2 (4%)	2.057	0.725
	Employed	12 (17.4%)	52 (75.4%)	5 (7.2%)		

	Student	1 (33.3%)	2 (66.7%)	0		
Marital status	Married	23 (21.3%)	78 (72.2%)	7 (6.5%)	2.535	0.638
	Unmarried	3 (30%)	7 (70%)	0		
	Divorced/Widowed	0	4 (100%)	0		

The results show that there is no statistically significant association between the socio-demographic characteristics (education, occupation, and marital status) and the average, poor, and good categories of causes attributed to myths related to breast cancer

Tab No.10: Association of Socio-demographic characteristics and myths and misconceptions

Socio-demographic characteristics	Categories	Average	Good	Poor	Chi-square test	p-value
Occupation	Unemployed/housewife	17 (34%)	29 (58%)	4 (8%)	5.314	0.257
	Employed	14 (20.3%)	53 (76.8%)	5 (2.9%)		
	Student	1 (33.3%)	2 (66.7%)	0		
Marital status	Married	29 (26.9%)	74 (68.5%)	5 (4.6%)	2.539	0.638
	Unmarried	3 (30%)	6 (60%)	1 (10%)		
	Divorced/Widowed	0	4 (100%)	0		
Education	Higher education	4 (50%)	4 (50%)	0	12.884	0.012
	Graduate	13 (27.1%)	29 (60.4%)	6 (12.5%)		
	Post Graduate	15 (22.7%)	51 (77.3%)	0		

The results show a statistically significant association between the education level and the average, good, and poor categories, of misbeliefs related to breast cancer as indicated by the p-value of 0.012, which is less than the significance level of 0.05. However, no statistically significant association exists between occupation and marital status in the average, good, and poor categories of misbeliefs of breast cancer.

Discussion:

The findings of this study highlight several critical issues regarding breast cancer awareness and misconceptions among women in Hyderabad. The fair level of adequate knowledge (21.3%) underscores a substantial gap in understanding crucial aspects of breast cancer, such as its

symptoms and treatment options. This gap is particularly concerning given that early detection through awareness can significantly improve outcomes for breast cancer patients.

According to our study, the awareness levels of myths related to Breast cancer causation was good (73%) and when compared with all the causes attributed to myths related to breast cancer between the 2 studies there is no similarity to the study conducted by Mohamedraed Elshami et al on Palestinian women where the awareness level was found to 5.1% which is comparatively very low with our study this might be due to cultural geographical and educational levels between the two countries [9].

According to the study by Sulhera Khan et al on myths and misconceptions related to breast cancer in the Pakistani population, it was found that faith healers and alternative medicine can cure breast cancer (47.5%). Where in our study it was found to be 62%. A significant number of participants believed breast cancer to be a result of God's curse (31.4%) or evil eye (38.7%). Where in our study it was found that BC is a result of God's curse (13.1%) and evil eye (9.8%) is quite less. [7]

In our study, the majority of the women mentioned the most common myths are feeling stressed (85.2%), exposure to electromagnetic radiation (84.4%), and wearing a tight bra (76.2%) which is similar to the study conducted by Ruth Abraham on knowledge and myths related to breast cancer where the Most common was the use of deodorants or perfumes (71.4%) and tight bras (64.3%), increased the risk of breast cancer. Ryan and colleagues surveyed 748 Irish participants and found a lower proportion (29%) believing of wearing a tight bra as a BC risk factor

Alternatively, results from a study carried out in Mumbai by Prusty et al. showed that about half of the participants believed that breast cancer required the removal of one or both breasts. These variations in breast cancer myths underscore regional disparities in views and underscore the necessity of focused education and awareness campaigns adapted to particular geographic settings.

[8, 11]. According to our study, 5.7% of participants believed that breast cancer could be transmitted like a contagious disease. This misconception doesn't align with findings from a study by Elobaid et al. (2016), which indicated that such beliefs contribute to fear surrounding breast cancer screening and concerns about social isolation. [10] Low cancer awareness was linked to poor cancer survival, as found by Niksic and colleagues. [12]

Our study identified significant associations between knowledge levels and socio-demographic factors. Participants with a family history of breast cancer and those from urban areas tended to

have fewer misconceptions. Importantly, education level showed a statistically significant correlation with the prevalence of myths, underscoring the role of education in promoting an accurate understanding of breast cancer.

The significant association between higher education levels and reduced prevalence of myths underscores the effectiveness of education in correcting misconceptions. This highlights the importance of integrating accurate information about breast cancer into educational curricula and community health programs, especially in rural and less educated populations where myths may be more prevalent.

Conclusion:

Healthcare professionals should be aware of the myths and misconceptions prevalent in society. This misinformation on Breast Cancer can be highly persuasive and contributes to diagnostic delays. It is essential to design comprehensive breast cancer education campaigns and awareness programs addressing the myths and misconceptions related to breast cancer to decrease the burden of delayed presentation among women in Hyderabad. This leads to improvement in early detection rates and increased chance of curative treatment and survival.

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MEGA MEDICAL AND CANCER SCREENING CAMP

PARTICIPANT DETAILS

Reg. Number :		Name :	
Age :	Gender : ☐ Male ☐ Female	Mobile :	
Address :			

MEDICAL HISTORY

☐ Smoking : If Yes Number of times per day :	☐ Alcohol	☐ Tobacco Chewing
☐ Diabetes : If Yes Duration :	☐ Hypertension : If Yes Duration :	
☐ Tuberculosis	☐ Jaundice	☐ Lump/Swelling
☐ Bleeding PV or PR	☐ Whitedischarge per Vagina	☐ Weight Loss
☐ Hoarseness of voice	☐ Nagging Cough	☐ Indigestion
☐ Skin Changes	☐ Backache	☐ Family history of cancer

Chief Complaints (S) :

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VITALS & BLOOD TESTS

TEMP :	PULSE : / min	Blood Pressure : /	Height :
Weight :	BMI :	SPO2 :	GRBS : mg/dl
☐ HEPATITIS B	☐ HEPATITIS C		

CLINICAL EXAMINATION

☐ Pallor	☐ Lymphadenopathy	☐ Icterus	☐ Edema
Oral cavity :			
Neck :			
Breast (Right) :			
Breast (Left) :			
Per Abdomen :			

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MEGA MEDICAL AND CANCER SCREENING CAMP

P / A			
P / R Exam			
P / V Exam			
Diagnosis :			
Rx :			
Referral :			
PARTICIPANT DETAILS			
☐ PAP SMEAR : Ladies > 21years & without hysterectomy		☐ MAMMOGRAPHY : Ladies > 40years	
☐ CHEST X RAY			
RECOMMENDED TESTS			
Pain Clinic		SP02<90%	
		BMI	<25 25 29 >29
Diabetes	Diagnosed first time	Known	Hypertension
	Diagnosed first time	Known	
Malignancy : If yes Type			
Benign Tumors : If yes Type			
Any Other Diagnosis :			
LIFE STYLE MODIFICATION			
Obesity		Physical Activity	

నేను..... గ్రేస్ కేన్సర్ ఫౌండేషన్ మరియు దాని వైద్యులు, సిబ్బంది మరియు / లేదా ఏజెంట్లకు దీన్ని అంగీకరిస్తున్నాను. నా గురించి వెల్లడించిన సమాచారం రోగ నిర్ధారణలు / షరతులు, ఔషధ లేదా మధ్యపాన వినియోగం, నివేదికలు, అంచనాలు మరియు రోగనిర్ధారణలు, అలాగే చరిత్ర మరియు భౌతిక ఫలితాలు, సంప్రదింపులు మరియు చికిత్స సిఫార్సులు, పైన వ్రాసినట్లుగా నా సమాచారం బహిర్గతం చేసేందుకు గ్రేస్ కేన్సర్ ఫౌండేషన్ అధికారం కలిగి ఉంది.

GRACE CANCER FOUNDATION

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