



DR. SMITA SHARMA FOUNDATION  
CANCER AWARENESS EDITION • AUGUST 29, 2026



A SPECIAL PUBLIC-HEALTH REPORT

# CANCER IN WOMEN

*A Growing Global Concern — and India's Urgent Health Challenge*

*What the latest global evidence, Tata Memorial Centre and India's National Cancer Registry Programme reveal about women's cancer, early detection and survival.*

## THE BIG PICTURE

20.6 million new cancer cases worldwide in 2024

## BREAST CANCER

2.4 million women diagnosed globally

## INDIA

What the National Cancer Registry Programme reveals

## TATA MEMORIAL

Why early diagnosis matters

## CERVICAL CANCER

The preventable cancer

## EARLY DETECTION

Know the signs. Act early.

# Why This Conversation Matters

Cancer among women is no longer a concern that belongs only inside oncology departments. It has become a major public-health issue that touches families, workplaces and entire communities. The most urgent question is not simply how many women develop cancer each year — it is why some women are diagnosed early and go on to recover, while others reach a hospital only after their disease has advanced.

The latest global evidence, drawn from the 2026 *Global Cancer Statistics* analysis based on GLOBOCAN 2024, is unambiguous. Breast cancer is now the most commonly diagnosed cancer among women in the world, and it was the leading cancer by incidence among women in 164 of 186 countries studied (Sung et al., 2026).

For India, the picture is especially significant. Breast cancer has become the leading cancer among women in most urban cancer registries, even as cervical cancer continues to cause substantial illness and death in many parts of the country. Meanwhile, population-based studies reveal considerable differences in breast-cancer survival between different regions of India (Chaturvedi et al., 2022; Sathishkumar et al., 2024).

***Cancer outcomes depend not only on whether cancer develops, but also on how early it is detected and how quickly effective treatment becomes available.***

## GLOBAL EVIDENCE

GLOBOCAN 2024 and WHO data on incidence, mortality and survival.

## INDIA'S REGISTRIES

NCRP population data spanning 11 registries and 17,331 women.

## CLINICAL EVIDENCE

Tata Memorial Centre's cohort of young women with breast cancer.

### THE GLOBAL SNAPSHOT • 2024

20.6M

estimated new cancer cases worldwide

2.4M

estimated female breast-cancer cases globally

9.8M

cancer deaths worldwide in 2024

Source: Sung et al., 2026; GLOBOCAN 2024

This publication brings together global evidence, India's National Cancer Registry Programme, and clinical data from Tata Memorial Centre — one lens at a time — to explain what is known, what remains uncertain, and what women and families can do with that knowledge.

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ABOUT THIS EDITION

Published as a public-health awareness resource by Dr. Smita Sharma Foundation, this edition draws on GLOBOCAN 2024, the WHO, India's National Cancer Registry Programme and peer-reviewed clinical research. Full references appear on page 21.

A NOTE ON THIS PUBLICATION

This is a cancer-awareness and public-health education resource. It does not provide individual medical advice, diagnosis or treatment. See the full disclaimer on page 22.



Throughout this edition, look for the small source tags — **GLOBOCAN** **NCRP** **TATA** **NFHS-5** — marking exactly which evidence base each figure comes from.



# 01

SECTION ONE

## THE GLOBAL PICTURE

*How many women are affected by cancer worldwide, and why the burden is expected to keep growing over the coming decades.*

# The Global Cancer Burden Is Growing

Cancer affects women at every stage of life, although the risk of most cancers rises substantially with age. The latest GLOBOCAN 2024 estimates indicate that cancer caused approximately 9.8 million deaths worldwide in 2024, alongside 20.6 million new cases across both sexes (Sung et al., 2026).

Looking ahead, the global cancer burden is projected to rise to approximately 34.4 million new cases annually by 2050 — a 67% increase from 2024 — if current demographic trends continue.

That does not mean cancer is becoming biologically more aggressive. Much of the projected increase reflects population growth, population ageing, longer life expectancy, urbanisation, changing lifestyles, obesity and metabolic risk, tobacco and alcohol exposure, persistent infections, reproductive and demographic change, and unequal access to prevention and treatment.

Cancer is therefore both a medical problem and a health-system problem — and the projected increase is expected to weigh most heavily on countries with lower levels of human development, where health systems are least prepared to absorb it.

NEW CANCER CASES WORLDWIDE, PER YEAR

20.6M

2024 (estimated)

34.4M

2050 (projected)

+67%

CANCER DEATHS WORLDWIDE, 2024

9.8M

estimated deaths across all cancer types, both sexes

Roughly 1 in 2 people diagnosed with cancer worldwide will die of the disease

Source: Sung et al., 2026; GLOBOCAN 2024.

***The projected rise is not inevitable biology — it is a call to expand prevention, early diagnosis and treatment alongside a growing disease burden.***

# Breast Cancer: The Leading Cancer Among Women

Breast cancer is now the most frequently diagnosed cancer among women globally. The 2026 GLOBOCAN analysis estimated approximately 2.4 million new breast-cancer cases in 2024, accounting for roughly 11.8% of all cancer cases worldwide, and approximately 694,000 breast-cancer deaths. Breast cancer was the leading cancer among women in 164 of 186 countries studied (Sung et al., 2026). The World Health Organization reports similar figures.

The scale of this disease means breast cancer is no longer an issue confined to specialist cancer care — it is a major women's-health issue that concerns every community, every workplace and every family.

***The future burden could be larger still.***

A major international analysis published in *Nature Medicine* examined breast-cancer incidence and mortality across 185 countries. Kim et al. (2025) found substantial geographical differences and projected that, if current trends continue, annual incidence could rise to approximately 3.2 million cases by 2050, with approximately 1.1 million deaths a year. The study also estimated that approximately one in 20 women worldwide could develop breast cancer during their lifetime.

These projections are not inevitable — they describe what could happen if current demographic and epidemiological trends continue, and they underline why prevention, early diagnosis and effective treatment need to expand alongside the growing disease burden (Kim et al., 2025).

GLOBOCAN 2024

2.43M

estimated female breast-cancer cases globally, 2024

694,000

estimated breast-cancer deaths, 2024

164 / 186

countries where breast cancer is the leading cancer among women

LOOKING TOWARD 2050

3.2M

projected annual cases by 2050, with ~1.1 million deaths a year, if current trends continue

Source: Kim et al., 2025, *Nature Medicine*

1 in 20

women worldwide may develop breast cancer in her lifetime

11.8%

of all cancer cases worldwide, both sexes combined

# A Woman's Chance of Survival Is Not the Same Everywhere

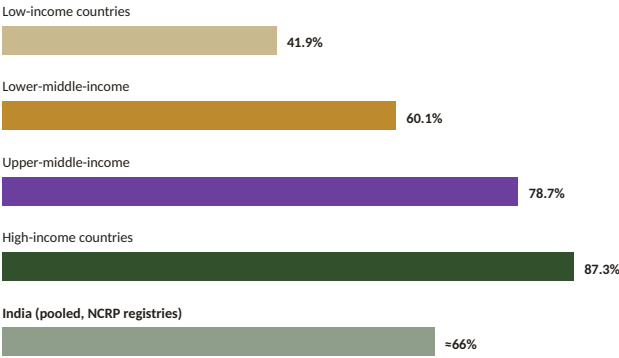
Perhaps the most important issue in the global cancer story is not incidence, but survival inequality. WHO's breast-cancer data show substantial differences between countries according to their level of human development.

In countries with very high Human Development Index (HDI) levels, roughly 1 in 12 women may develop breast cancer during her lifetime, but only about 1 in 71 die from it. In low-HDI countries, roughly 1 in 27 women may develop breast cancer — fewer than in high-HDI settings — yet about 1 in 48 die from it. In other words, **lower incidence does not mean lower mortality risk**.

A major reason is unequal access to early diagnosis, pathology, surgery, radiotherapy, chemotherapy, hormonal and targeted therapy, follow-up, rehabilitation and palliative care. WHO emphasises that early diagnosis linked to comprehensive treatment is essential to reducing breast-cancer mortality.

*The difference is not simply biological. It reflects differences in early detection, diagnosis, treatment capacity and access to care.*

FIVE-YEAR BREAST-CANCER SURVIVAL, BY SETTING



Source: World Health Organization, 2026; Sathishkumar et al., 2024 (India pooled estimate).  
Bars are scaled proportionally to the reported percentage. India's figure comes from a different methodology (11 population-based registries) and is shown for context, not direct pooling.

**Early diagnosis linked to comprehensive treatment — not geography alone — is what changes survival.**



# 02

SECTION TWO

## INDIA'S CANCER STORY

*A country in epidemiological transition — where breast cancer is rising in cities even as cervical cancer remains a major rural burden.*



# India: A Changing Cancer Landscape

India is experiencing a significant change in its women's-cancer profile. The National Cancer Registry Programme (NCRP) provides some of the most important evidence available on this transition. Chaturvedi et al. (2022) analysed 102,287 women's-cancer cases using data from 28 population-based cancer registries and 58 hospital-based cancer registries covering 2012–2016.

The study found substantial geographical variation. Breast cancer was the leading cancer among women in most urban registry populations, while cervical cancer remained the leading cancer in some rural registry areas, including Barshi and Osmanabad & Beed (Chaturvedi et al., 2022).

*India cannot be viewed as having one uniform cancer pattern.*

Different states, cities and communities experience different combinations of cancer risk — which is precisely why national averages can conceal as much as they reveal, and why registry-level detail matters for planning services.

POPULATION-BASED VS. HOSPITAL-BASED REGISTRIES

Population-Based Cancer Registries (PBCRs)

Record all cancer cases within a defined geographic population, giving true incidence and survival for that area.

Hospital-Based Cancer Registries (HBCRs)

Record cases treated at a specific hospital — valuable for clinical detail, but shaped by referral patterns rather than the whole population.

The 2012–2016 NCRP analysis combined **28 population-based** and **58 hospital-based** registries — 102,287 women's-cancer cases in all.

THE URBAN-RURAL SPLIT

| SETTING                          | LEADING WOMEN'S CANCER |
|----------------------------------|------------------------|
| Most urban registries            | Breast cancer          |
| Barshi, Osmanabad & Beed (rural) | Cervical cancer        |

Source: Chaturvedi et al., 2022, NCRP.

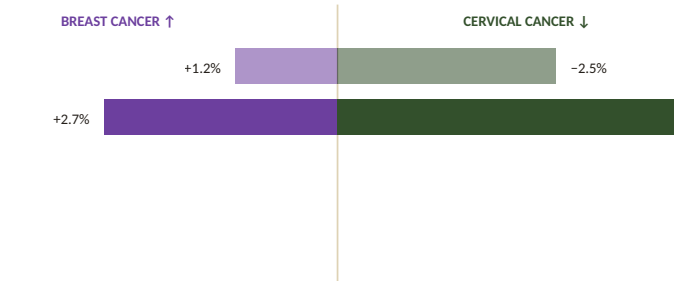
# Breast Cancer Is Rising While Cervical Cancer Has Declined

Sathishkumar et al. (2021) examined breast- and cervical-cancer trends using population-based registry data from five Indian cancer registries. They found a significant increase in breast-cancer incidence across the registries, with estimated annual increases ranging from approximately 1.2% to 2.7%.

Cervical-cancer incidence, by contrast, showed significant declines — ranging from approximately 2.5% to 4.6% annually, depending on the registry. The researchers' age-period-cohort analysis suggested that changes across generations may have contributed to these trends (Sathishkumar et al., 2021).

This decline should not be read as meaning cervical cancer has ceased to be a concern — far from it. It remains a major, and largely preventable, cause of illness and death among Indian women, as the next section explains.

ESTIMATED ANNUAL CHANGE IN INCIDENCE (5 REGISTRIES)



Ranges reflect variation across the five registries studied; not every registry moved at the same rate. An age-period-cohort model suggests generational change is a factor.  
Source: Sathishkumar et al., 2021.

**TWO TRENDS, ONE TRANSITION**

Breast cancer is becoming increasingly prominent across Indian registries. Cervical cancer remains a major problem in many areas, but has declined in several registry populations — evidence, most likely, of the combined effects of screening, changing risk exposure and generational change.



# 03

SECTION THREE

## INSIDE INDIA'S CANCER CENTRES

*What Tata Memorial Centre's clinical evidence tells us about young women with breast cancer — and what population registries add to that picture.*

# What Tata Memorial's Clinical Evidence Shows About Young Women

TERTIARY-CARE CLINICAL COHORT — NOT A NATIONAL ESTIMATE

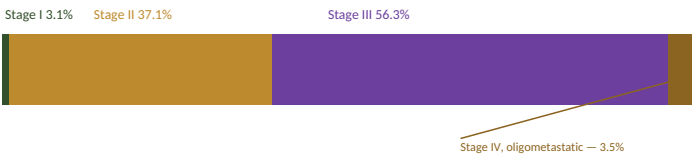
Tata Memorial Centre in Mumbai is one of India's leading tertiary cancer institutions. Bajpai et al. (2021) studied 1,228 women aged 40 or younger treated with curative intent there. The results were striking: only 3.1% had Stage I disease, while 56.3% already had Stage III disease at presentation, and 75.5% were lymph-node positive.

The cohort also included 34.4% with triple-negative breast cancer and 27% HER2-positive disease — both biologically more aggressive subtypes.

*These figures do not mean 56.3% of all young Indian women with breast cancer have Stage III disease.*

This was a tertiary-care cohort, and referral patterns influence who is seen at such centres — women with more advanced or complex disease are more likely to be referred onward. Even so, the findings offer a powerful clinical warning: a major Indian cancer centre was treating substantial numbers of young women whose disease had already reached an advanced stage by the time of diagnosis.

STAGE AT PRESENTATION — 1,228 WOMEN AGED ≤40



Source: Bajpai et al., 2021, Tata Memorial Centre.

75.5%

were lymph-node positive at diagnosis

36 yrs

median age of women in the cohort

| STAGE AT DIAGNOSIS         | 5-YEAR OVERALL SURVIVAL |
|----------------------------|-------------------------|
| Stage I                    | 100%                    |
| Stage II                   | 86.7%                   |
| Stage III                  | 77.3%                   |
| Stage IV (oligometastatic) | 69.7%                   |

*A major Indian cancer centre was treating substantial numbers of young women whose disease had already reached an advanced stage by the time of diagnosis.*

# From Hospital to Population: What India's Registries Reveal

A single hospital's experience, a city's registry, and a national programme each answer a different question. Reading them together — without merging them into one dataset — is what makes the evidence trustworthy.

## TERTIARY CENTRE

### Tata Memorial Centre

Clinical depth. Detailed stage, biology and outcome data for patients actually treated at the centre — shaped by referral patterns, not population-representative.

## POPULATION REGISTRY

### AIIMS Delhi Cancer Registry

Population incidence and survival for a defined catchment area — surveillance data, distinct from Tata Memorial's clinical cohort and from national NCRP publications.

## NATIONAL PROGRAMME

### National Cancer Registry Programme

Geographic and national cancer patterns, pooling population-based registries across India — coverage and methodology vary by state and registry.

*Behind every statistic is a woman — but behind every statistic is also a method, and the two should never be confused with one another.*

## WHY THIS DISTINCTION MATTERS

A finding from a tertiary cancer centre describes the patients treated there, not all women in the country. A population-based registry describes a defined geographic population, but registry coverage and completeness vary. A national programme pools many registries, but should not be read as implying identical coverage everywhere in India. Throughout this publication, each figure is labelled with its source so that clinical evidence, population evidence and national evidence are never mistaken for one another.

1

Read the clinical cohort for depth, not for national prevalence.

2

Read the registry for a defined population's incidence and survival.

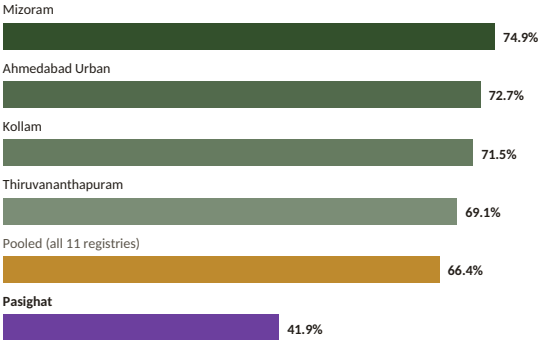
3

Read the national programme for geographic patterns, not uniformity.

# Where a Woman Lives Can Matter

NCRP — 11 POPULATION-BASED REGISTRIES, 17,331 WOMEN, DIAGNOSED 2012–2015

5-YEAR RELATIVE SURVIVAL BY REGISTRY



Source: Sathishkumar et al., 2024, NCRP.

Sathishkumar et al. (2024) studied 17,331 women with breast cancer diagnosed between 2012 and 2015 across 11 Indian population-based cancer registries. The pooled five-year age-standardised relative survival — a measure that allows cancer outcomes to be compared between populations with different age structures — was 66.4%.

But the difference between the highest and lowest reported registry estimates was approximately 33 percentage points, from 74.9% in Mizoram to just 41.9% in Pasighat.

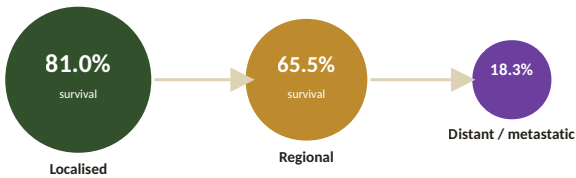
*The variation does not prove that geography itself causes poorer survival. It reflects the combined effects of stage at diagnosis, access to healthcare, treatment availability, socioeconomic factors, referral patterns and other determinants.*

This demonstrates that the experience of breast cancer is not uniform across India — and that closing this gap is a health-system priority, not only a clinical one.

## WHAT NARROWS THE GAP

- Earlier stage at diagnosis
- Access to specialist treatment
- Shorter referral pathways
- Reduced financial barriers to care

# Early Diagnosis Changes the Odds



Five-year population-level observed survival, NCRP analysis.  
Source: Sathishkumar et al., 2024.

The same NCRP study reported five-year observed survival of approximately 81.0% for localised disease, 65.5% for regional disease, and only 18.3% for distant metastatic disease (Sathishkumar et al., 2024).

This does not mean every patient with metastatic breast cancer shares the same prognosis, nor that survival is determined by stage alone. Tumour subtype, molecular characteristics, treatment, age, general health and response to therapy all matter.

**Nevertheless, the population-level relationship between stage and survival is clear: earlier diagnosis creates a greater opportunity for effective treatment.**

This is why early diagnosis — recognising symptoms and investigating them promptly — is one of the most important components of cancer awareness for women and families alike.

## THE TAKEAWAY

**81.0%**

survival when disease is caught while still localised

**65.5%**

survival once disease has spread regionally

**18.3%**

survival once disease has spread to distant sites

Population-level figures, not individual predictions — but a clear, consistent signal that the earlier a cancer is found, the more treatment options remain open.



# 04

SECTION FOUR

## THE CANCER WE CAN PREVENT

*Cervical cancer, HPV, screening and the early-detection gap that still leaves too many Indian women unreached.*



# Cervical Cancer: The Cancer We Can Prevent

Cervical cancer is fundamentally different from breast cancer. Almost all cases are associated with persistent infection by high-risk human papillomavirus (HPV) — which is what makes this cancer so unusually preventable.

The disease can, in principle, be interrupted at several points: HPV vaccination, cervical screening, identification of precancerous change, and treatment of that precancer before it ever becomes invasive cancer.

The WHO's global cervical-cancer elimination strategy is built around three measurable targets, known as **90–70–90**:

- 90% of girls fully vaccinated against HPV by age 15
- 70% of women screened with a high-performance test by ages 35 and 45
- 90% of women with cervical disease receiving appropriate treatment

*Cervical cancer represents one of the clearest examples in medicine where prevention can interrupt cancer before it ever becomes invasive.*

## FROM INFECTION TO PREVENTION



## WHO'S 90–70–90 CERVICAL-CANCER ELIMINATION TARGETS



of girls fully vaccinated against HPV by age 15



of women screened with a high-performance test by ages 35 & 45



of women with cervical disease receiving appropriate treatment

# Screening Matters — But Follow-Up Matters Too

"Screening" and "early diagnosis" are often used interchangeably, but they are not the same. **Screening** tests people without symptoms to find cancer or precancer earlier. **Early diagnosis** means recognising symptoms and investigating them promptly. A woman can notice a change quickly and still face a long delay before a definitive diagnosis — which is why both strategies are needed, and why the right one depends on cancer type, age and individual risk.

Evidence from India's National Family Health Survey-5 (NFHS-5) highlights how far organised prevention still has to reach. Subramanian et al. (2024) found reported screening participation of only approximately **0.9% for breast cancer** and **1.9% for cervical cancer** among women aged 30–49 studied, along with clear socioeconomic inequalities in who was screened.

*These figures reflect the specific NFHS-5 methodology and age group studied, and should not be treated as a universal measure of every form of cancer screening in India.*

Even so, they point to a real public-health challenge: many women who could benefit from organised prevention and early-detection services are simply not being reached.

## SCREENING

Testing women who have no symptoms, in order to find cancer or precancerous change earlier — the strategy behind HPV vaccination and cervical screening programmes.

NFHS-5 • WOMEN AGED 30–49

0.9%

reported breast-cancer screening

1.9%

reported cervical-cancer screening

Source: Subramanian et al., 2024, NFHS-5 analysis.

## WHY WOMEN REACH CARE LATE

Barriers rarely act alone — they reinforce each other: limited awareness, fear and stigma, assuming a painless lump is harmless, financial constraints, family responsibilities, distance from specialist care, referral delays, and fear of treatment itself. A woman may notice a lump but delay seeking care because she fears the diagnosis; further delays can follow before imaging, biopsy and treatment begin — leaving a disease that is biologically unchanged but clinically far harder to treat.

## EARLY DIAGNOSIS

Recognising a symptom, seeking medical advice quickly, and moving promptly through evaluation, diagnosis and referral to treatment.



# 05

## SECTION FIVE

# KNOW THE SIGNS

*Don't ignore persistent changes. Most symptoms are not cancer — but every persistent, unusual change deserves medical evaluation.*

# Know the Signs. Don't Ignore Persistent Changes.



## BREAST

- A new lump or thickening
- Change in breast size or shape
- Dimpling or skin changes
- Persistent redness or skin change
- Nipple inversion or unusual nipple changes
- Abnormal or bloody nipple discharge
- Persistent breast or underarm swelling

A cancerous lump can be entirely painless. WHO advises that an abnormal lump should be medically evaluated **even when it does not hurt** — most breast lumps are not cancer, but a suspicious lump still needs assessment.



## CERVICAL / REPRODUCTIVE HEALTH

- Abnormal vaginal bleeding
- Bleeding after sexual intercourse
- Bleeding after menopause
- Unusual, persistent discharge
- Persistent pelvic discomfort

Endometrial cancer is strongly linked to obesity and prolonged oestrogen exposure. Abnormal uterine bleeding — especially after menopause — should never be dismissed as simply part of ageing.

***These symptoms do not automatically mean cancer. They should be medically evaluated when persistent, unusual or concerning.***

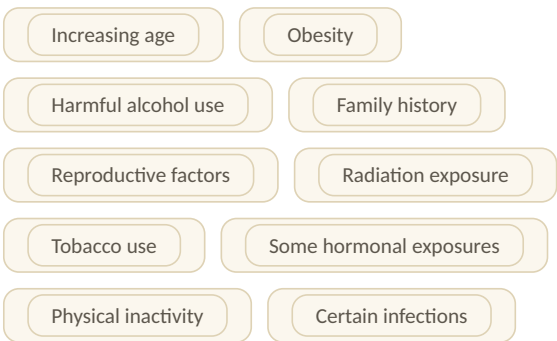
### OVARIAN CANCER — OFTEN VAGUE, EASY TO MISS

Ovarian cancer can be difficult to detect early because symptoms may be vague: persistent abdominal or pelvic discomfort, persistent bloating, early satiety, or changes in urinary or bowel habits. When these are persistent or unusual, they warrant medical evaluation.

# Risk Factors — and the Myth of the "Lifestyle Disease"

There is a growing tendency to attribute rising breast-cancer incidence entirely to modern lifestyles. That explanation is too simple. WHO notes that approximately **80% of breast cancers occur in women without specific risk factors** other than sex and age.

Known risk factors can include:



Inherited mutations such as **BRCA1**, **BRCA2** and **PALB2** can substantially increase risk in some women. However, most women diagnosed with breast cancer do not have a known family history.

***Not having a family history does not mean a woman cannot develop breast cancer.***

## MYTH VS. FACT

### MYTH

*"Only women with a family history get breast cancer."*

### FACT

Most women diagnosed with breast cancer do not have a known family history.

### MYTH

*"A painless lump is harmless."*

### FACT

Pain is not a reliable way to distinguish benign from malignant breast conditions.

## RISK REDUCTION, NOT A GUARANTEE

The 2026 GLOBOCAN analysis emphasises primary prevention — tobacco control, infection prevention, reducing alcohol consumption and excess body weight, and increasing physical activity — as central to global cancer control (Sung et al., 2026). Modifying risk factors can reduce the likelihood of cancer; it cannot eliminate it entirely.

# Too Young for Breast Cancer?

Breast cancer is strongly associated with increasing age, but younger women can also develop the disease. The Tata Memorial cohort discussed earlier in this publication included women aged 40 or younger, with a median age of just 36 — and more than half already had Stage III disease at presentation (Bajpai et al., 2021).

*"I am too young to have breast cancer" can be a dangerous assumption.*

Age affects risk — it does not provide immunity. A persistent or suspicious breast change should be medically evaluated rather than dismissed solely because of age. This publication does not suggest that young women require the same screening intensity as older women; rather, it emphasises that any suspicious or persistent change deserves timely medical attention, regardless of age.

FAMILY HISTORY — TWO-WAY  
AWARENESS

**If you have a strong family history**

Discuss your risk with an appropriately qualified healthcare professional.

**If you have no family history**

Do not assume you are protected — most breast cancers occur without a known hereditary link.

36

median age in the Tata Memorial  
young-women cohort

≤40

age range studied — women 40 or  
younger

56.3%

already had Stage III disease at  
diagnosis

***Age affects risk — it does not provide immunity. A persistent change deserves attention at any age.***

# Behind Every Statistic Is a Woman

Cancer does not end when treatment begins. Women may experience fatigue, pain, treatment-related menopause, fertility concerns, changes in body image, lymphoedema, anxiety, depression, fear of recurrence, employment disruption, financial stress, and changes in family relationships.

The Tata Memorial study among younger women found that fertility and menopausal concerns were clinically significant — a reminder that survival alone does not fully describe the impact of cancer on a woman's life (Bajpai et al., 2021).

Families face treatment costs, transportation, accommodation, lost income, caregiving expenses and long-term financial pressure — costs that can be especially severe when specialist treatment is concentrated in major cities. Late diagnosis, more complex treatment, and greater financial burden can become a reinforcing cycle. Early diagnosis has the potential to interrupt that cycle.

*Behind the global figure of 2.4 million breast-cancer diagnoses are mothers, daughters, sisters, wives, grandmothers, professionals, caregivers and students — women who are often supporting others while quietly managing their own illness.*



*A person — not only a patient outcome*

***A woman should not be viewed merely as a tumour or a treatment outcome. She is a person whose health, family life and future may all be affected.***

# Myths & Facts

## *A painless breast lump is harmless.*

Pain is not a reliable way to distinguish benign from malignant breast conditions.

## *If there's no family history, I can't get breast cancer.*

Most women diagnosed with breast cancer do not have a known family history.

## *Cancer always means death.*

Many cancers can be successfully treated, particularly when diagnosed early and managed appropriately.

## *Cervical cancer isn't really preventable.*

HPV vaccination combined with regular screening can prevent most cervical cancers before they ever become invasive.

## *Only older women get breast cancer.*

Risk increases with age, but younger women can also develop breast cancer.

## *Screening alone is enough.*

Screening must be followed by appropriate diagnosis and treatment when an abnormality is found.

## *Breast cancer is only caused by modern lifestyle.*

About 80% of breast cancers occur in women with no specific risk factor besides sex and age.

## *Without a family history, ovarian or endometrial cancer isn't a concern.*

Most cases occur without a known hereditary link — persistent symptoms deserve evaluation regardless of family history.

### EARLY DIAGNOSIS DOES NOT GUARANTEE A CURE

Cancer is biologically complex. Some aggressive cancers can progress despite early detection, while some advanced cancers respond remarkably well to modern treatment. Nevertheless, population-level evidence consistently shows that cancer diagnosed before extensive spread offers a greater opportunity for effective treatment — the Indian breast-cancer data make this clear, with 81.0% five-year survival for localised disease compared with 18.3% for distant metastatic disease.

***WHO reports breast-cancer mortality in high-income countries has fallen by approximately 40% since the 1980s — proof that progress is possible.***



# What Can Reduce Cancer Risk?

Avoid tobacco

Limit harmful alcohol

Maintain a healthy body  
weight

Regular physical activity

HPV vaccination

Appropriate screening

Know your family history

Timely medical evaluation

*Risk reduction, not a guarantee — not every cancer can be prevented, but several important risk factors can be modified.*

## Don't Diagnose Yourself. Don't Ignore Yourself.

Persistent or concerning symptoms should be assessed by a qualified healthcare professional. This publication does not recommend self-diagnosis, specific medicines, or personalised medical advice of any kind — its purpose is awareness, so that a woman recognises when to seek that professional evaluation.

### CANCER AWARENESS SHOULD NOT CREATE FEAR

Effective awareness produces knowledge and appropriate action — not panic. A cancer diagnosis does not automatically mean death. Outcomes have improved substantially because of earlier diagnosis, better surgery, radiotherapy, endocrine treatment, chemotherapy, targeted therapies, improved pathology and multidisciplinary care. The challenge now is ensuring those benefits reach women everywhere.

### THE MOST IMPORTANT MESSAGE

***Early awareness, timely medical evaluation, appropriate prevention, accurate diagnosis and effective treatment can change the course of cancer.***

For women and families, knowledge can mean recognising a warning sign sooner. For communities, awareness can reduce fear and stigma. For healthcare systems, early diagnosis can mean better outcomes. And for society, improving women's cancer outcomes means protecting not only individual lives, but families, livelihoods and future generations.

# The Evidence Behind This Publication

This publication draws on global cancer statistics, India's national registries, and peer-reviewed clinical research. Each figure in this edition is labelled with its source so that global estimates, national registry data and single-centre clinical evidence are never mistaken for one another.

## GLOBOCAN

Sung et al., 2026 — Global Cancer Statistics 2024

## JOURNAL

Kim et al., 2025 — *Nature Medicine*, breast-cancer trends across 185 countries

## NCRP

Chaturvedi et al., 2022 — Women's cancers in the National Cancer Registry Programme

## NCRP

Sathishkumar et al., 2021 — Breast & cervical cancer trends in India

## NCRP

Sathishkumar et al., 2024 — Breast-cancer survival across 11 Indian registries

## TATA MEMORIAL

Bajpai et al., 2021 — Young women with breast cancer, tertiary-care cohort

## NFHS-5

Subramanian et al., 2024 — Female cancer screening in India

## WHO / ICMR-NCDIR

World Health Organization; ICMR-National Centre for Disease Informatics and Research; AIIMS Delhi Cancer Registry

***Where figures come from different methodologies — a GLOBOCAN estimate, an NCRP population-based registry, a Tata Memorial tertiary-care cohort, or an NFHS-5 survey analysis — they are presented separately, never combined into a single number.***

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#### MEDICAL DISCLAIMER

This publication is intended for cancer awareness and public-health education. It does not constitute medical advice, diagnosis or treatment. Most symptoms described in this publication can have causes other than cancer. Anyone experiencing a persistent, unusual or concerning symptom should seek assessment from a qualified healthcare professional. Screening recommendations may vary according to age, individual risk and national guidelines.



## DR. SMITA SHARMA FOUNDATION

*A Life Spent Lighting the Way. A Foundation to Keep It Burning.*

Dr. Smita Sharma Foundation stands beside every life that feels forgotten, abandoned or alone — reaching out with open arms to cancer patients facing difficult journeys, elders who have no one, children seeking warmth and hope, persons with disabilities needing care, and cows left helpless on the streets. Every step is guided by compassion; every life touched becomes family.

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