

Social and Cultural Acceptability of the Brahams Protocol, a Lifestyle-Integrated, Partner-Supported Breast Cancer Awareness, Screening and Breast Health Vigilance Ecosystem: A Cross-Sectional Survey among Healthcare Workers

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ABSTRACT

Background: Delayed diagnosis remains a major contributor to breast cancer mortality, particularly in low- and middle-income countries. The Brahams Protocol (BP) is a lifestyle-integrated, partner-supported breast cancer awareness, screening, and breast health vigilance ecosystem designed to complement existing evidence-based screening strategies. Its successful implementation depends on social and cultural acceptability.

Objective: To evaluate the social and cultural acceptability of the Brahams Protocol among healthcare workers.

Methods: A cross-sectional survey was conducted among healthcare professionals following structured educational sessions on the Brahams Protocol. Of 300 participants, 273 completed the survey (response rate: 91.0%). A 20-item questionnaire assessed the protocol's social and cultural acceptability. Descriptive statistics and gender-based comparative analyses using Chi-square or Fisher's exact tests were performed.

Results: Acceptance of the Brahams Protocol was consistently high, with affirmative responses exceeding 88% across all 20 survey items. Nearly all participants agreed that the protocol could positively change traditional attitudes towards women's health (99.6%), strengthen emotional bonding and facilitate acceptance (99.3%), reflect mutual care and shared responsibility within marriage (98.9%), promote socially responsible women's health (98.5%), and become a socially accepted norm (98.5%). Female participants expressed significantly more favorable perceptions than males for 7 of the 20 survey items ($P = 0.002$ – 0.033).

Conclusions: Healthcare professionals demonstrated high social and cultural acceptability of the Brahams Protocol. These findings provide the first implementation evidence supporting prospective evaluation of this partner-supported breast health vigilance ecosystem and justify future longitudinal studies to assess behavioral adherence, timely healthcare escalation, and breast cancer outcomes.

Keywords : Brahams Protocol; Breast cancer awareness; Breast cancer screening; Breast health vigilance; Early detection; Social acceptability; Cultural acceptability; Implementation science; Partner-supported screening; Behavioral intervention; Public health.

INTRODUCTION

Early Detection: The Persistent Unmet Need in Breast Cancer Control

Over the past two decades, breast cancer management has undergone a remarkable transformation, driven by advances in molecular diagnostics, precision oncology, targeted systemic therapies, antibody–drug conjugates, immunotherapy, surgical techniques, radiotherapy, and multidisciplinary cancer care. These innovations have substantially improved survival and quality of life for many patients. Nevertheless, the overall effectiveness of these therapeutic advances continues to depend fundamentally on the stage at which the disease is diagnosed. Early-stage detection remains the single most important predictor of prognosis, offering the greatest opportunity for curative treatment while reducing treatment-related morbidity, healthcare expenditure, and long-term disease burden. Breast cancer continues to be the most frequently diagnosed malignancy and the leading cause of cancer-related mortality among women worldwide. The World Health Organization (WHO) Global Breast Cancer Initiative has therefore identified early detection, timely diagnosis, and comprehensive treatment as the three strategic pillars for reducing breast cancer mortality and improving health equity worldwide. [1,2]

Despite sustained global efforts, delayed presentation remains a major challenge, particularly in low- and middle-income countries, where patient-related, sociocultural, behavioral, economic, and health-system barriers continue to delay recognition of breast abnormalities and timely healthcare seeking. Consequently, a substantial proportion of women continue to present with locally advanced or metastatic disease, limiting the full benefit of contemporary therapeutic advances. These observations reinforce that improving the proportion of women diagnosed with Stage I and Stage II disease remains one of the greatest unmet priorities in global breast cancer control. [1,2]

Periodic Screening Alone Cannot Ensure Continuous Breast Health Vigilance

Population-based breast cancer screening programs, particularly mammography, have substantially reduced breast cancer mortality and remain the cornerstone of evidence-based early detection. However, all organized screening programs are inherently episodic, being performed at predetermined intervals, whereas breast cancer is a biologically dynamic disease that evolves continuously. New lesions may develop, occult tumors may progress, and subtle clinical changes may become detectable during the interval between scheduled screening examinations. Furthermore, screening performance may be influenced by factors including age, breast density, adherence to screening recommendations, accessibility of healthcare services, and resource availability, both financial and infrastructural. Consequently, although periodic screening remains indispensable, it cannot by itself provide continuous breast health vigilance throughout a woman's lifetime. [3–5] Over and above this, the human factors, social norms, customs and traditions further impose a limitation to the extent to which screening methods can be effective for early cancer detection.

These biological and practical realities suggest that complementary approaches capable of promoting sustained breast health awareness, facilitating earlier recognition of breast cancer abnormalities, and encouraging timely healthcare escalation between routine screening encounters may further strengthen existing evidence-based screening strategies without replacing them. [3–5]

Social and Cultural Acceptability: The Foundation of Successful Implementation

The effectiveness of any public-health intervention depends not only on its scientific validity and clinical efficacy but also on its successful adoption within the communities it is intended to serve. Increasingly, implementation science recognizes that interventions must be socially acceptable, culturally compatible, behaviorally feasible, and capable of sustained integration into everyday life before meaningful population-level impact can be achieved. Even interventions supported by robust scientific evidence may experience poor uptake when they conflict with prevailing cultural beliefs, social norms, perceptions of privacy, gender roles, or family dynamics. Consequently, evaluation of social and cultural acceptability has become a fundamental prerequisite for successful translation of innovative healthcare interventions into routine practice. [6–8]

This consideration assumes particular importance for behavioral interventions involving breast health, where cultural sensitivities, interpersonal relationships, modesty, and communication within families may substantially influence willingness to participate, adherence over time, and long-term sustainability. Understanding these implementation determinants is therefore essential before considering wider community adoption of any novel breast health intervention. [6–8]

The Brahams Protocol: A Lifestyle-Integrated, Partner-Supported Breast Health Vigilance Ecosystem

The Brahams Protocol (BP) has previously been proposed as a lifestyle-integrated, partner-supported, structured breast cancer awareness, screening, and breast health vigilance ecosystem designed to complement existing evidence-based screening recommendations. Rather than replacing mammography, clinical breast examination, or other established screening modalities, the protocol seeks to promote continuous breast health vigilance through shared health responsibility between partners, facilitate earlier recognition of breast abnormalities, and encourage timely healthcare escalation whenever concerning changes are identified. The conceptual framework and scientific rationale underpinning the Brahams Protocol have been described previously, providing the theoretical basis for its potential role as a complementary behavioral strategy within comprehensive breast cancer control. [9,10]

Bridging the Evidence Gap: Evaluating Social and Cultural Acceptability of the Brahams Protocol

Although the conceptual framework of the Brahams Protocol has been established, its successful translation into clinical practice and broader public-health implementation depends upon evidence demonstrating that it is socially acceptable, culturally compatible, behaviorally feasible, and perceived as practical by its intended users. To date, no empirical study has systematically evaluated these implementation determinants among healthcare professionals. Healthcare workers represent an appropriate population for such evaluation because of their medical knowledge, familiarity with breast cancer screening practices, and potential role as future advocates for evidence-based public-health interventions. Accordingly, the present study was undertaken to evaluate the social and cultural acceptability of the Brahams Protocol among healthcare workers as an essential first step towards assessing its implementation potential and informing future clinical, community-based, and public-health adoption. [6–10]

MATERIALS AND METHODS

Study Design and Participants

The survey was undertaken during eight structured educational seminars conducted at Sarvodaya Hospital, Faridabad, and Sarvodaya Hospital, Noida, between April and June 2026. The survey is reported in accordance with the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) guidelines.

A total of 300 nursing personnel attended the seminars. Of these, 273 participants voluntarily completed the survey questionnaire, yielding an overall response rate of 91.0%. Overall, 212 participants were female and 61 were male, with an age range of 24–41 years.

Survey Instrument

A structured, self-administered questionnaire developed by the investigators was used for data collection. The questionnaire comprised a demographic profile and multiple predefined domains evaluating different dimensions of the Brahams Protocol. The present manuscript reports findings from the Social and Cultural Acceptability domain, one of the many domains included in the survey, which was assessed using 20 dichotomous (Yes/No) questions.

Data Collection

The questionnaire was administered immediately after completion of each educational seminar. Participation was voluntary and anonymous. Participants were informed about the purpose of the survey, and only fully

completed questionnaires were included in the final analysis.

Ethical Considerations

The study was conducted in accordance with the ethical principles of the Declaration of Helsinki. The survey was an anonymous, voluntary, non-interventional knowledge assessment that collected no clinical, identifiable, or personal health information and preceded any educational or protocol-related intervention; as such, it did not require formal institutional ethics committee approval. Participation was voluntary and anonymous, and completion of the questionnaire was taken to imply informed consent.

Statistical Analysis

Data were entered into Microsoft Excel and analyzed using IBM SPSS Statistics (Version XX.X; IBM Corp., Armonk, NY, USA). Descriptive statistics were used to summarize participant characteristics and survey responses. Categorical variables were expressed as frequencies and percentages. Comparisons between male and female participants were performed using the Chi-square test or Fisher's exact test, as appropriate. Odds ratios (ORs) with 95% confidence intervals (CIs) were calculated for statistically significant associations. A two-tailed P value of <0.05 was considered statistically significant.

RESULTS

Participant Characteristics

A total of 300 nursing personnel attended the educational seminars, of whom 273 voluntarily completed the survey, yielding an overall response rate of 91.0%. The respondents comprised 212 females (77.7%) and 61 males (22.3%), with an age range of 24–41 years.

Table 1. Demographic Characteristics of Survey Participants (N = 273)

Characteristic	Number (%)
Total participants	273 (100.0)
Female	212 (77.7)
Male	61 (22.3)
Age range (years)	24–41
Survey period	April–June 2026
Survey sites	Sarvodaya Hospital & Research Centre, Faridabad and Noida
Response rate	91.0%

Social and Cultural Acceptability of the Brahams Protocol

Responses to the 20-item Social and Cultural Acceptability domain demonstrated a high level of acceptance of the Brahams Protocol among both female and male participants. Across all questionnaire items, affirmative ("Yes") responses exceeded 88% overall, with several statements receiving agreement from more than 98% of respondents. The highest levels of agreement were observed for statements relating to mutual care and shared responsibility within marriage, promotion of preventive healthcare, cultural acceptability, and the potential of the Brahams Protocol to positively influence societal attitudes towards women's health.

Table 2. Responses to the Social and Cultural Acceptability Domain

Q	Survey Question	Female Yes n (%)	Male Yes n (%)	Overall Yes n (%)
1	Socially acceptable today	193 (91.0)	49 (80.3)	242 (88.6)

2	Community will view BP positively	201 (94.8)	50 (82.0)	251 (91.9)
3	Couples practicing BP appreciated	199 (93.9)	51 (83.6)	250 (91.6)
4	Promotes socially responsible women's health	210 (99.1)	59 (96.7)	269 (98.5)
5	Reflects mutual care/shared responsibility	212 (100)	58 (95.1)	270 (98.9)
6	Compatible with cultural values	194 (91.5)	50 (82.0)	244 (89.4)
7	Without compromising modesty	208 (98.1)	54 (88.5)	262 (96.0)
8	Acceptable in urban/rural communities	191 (90.1)	51 (83.6)	242 (88.6)
9	Culture should not prevent awareness	209 (98.6)	58 (95.1)	267 (97.8)
10	Overall culturally acceptable	209 (98.6)	59 (96.7)	268 (98.2)
11	Can change traditional attitudes	212 (100)	60 (98.4)	272 (99.6)
12	Encourages discussion within marriage	210 (99.1)	59 (96.7)	269 (98.5)
13	Promotes shared preventive healthcare	210 (99.1)	59 (96.7)	269 (98.5)
14	Emotional bond facilitates acceptance	211 (99.5)	60 (98.4)	271 (99.3)
15	Education > culture	198 (93.4)	53 (86.9)	251 (91.9)
16	Can change societal attitudes	210 (99.1)	55 (90.2)	265 (97.1)
17	Younger couples accept more	211 (99.5)	59 (96.7)	270 (98.9)
18	Can reduce stigma	210 (99.1)	58 (95.1)	268 (98.2)
19	Different cultures will accept	196 (92.5)	55 (90.2)	251 (91.9)
20	Could become socially accepted norm	210 (99.1)	59 (96.7)	269 (98.5)

Percentages are calculated within gender groups (Female n = 212; Male n = 61). Overall percentages are based on all respondents (N = 273).

Gender-wise Comparison

Comparison of responses between female and male participants demonstrated broadly similar perceptions across most survey items. However, statistically significant gender differences were observed for seven of the twenty questions (Questions 1, 2, 3, 5, 6, 7, and 16). Female participants were significantly more likely than male participants to express favourable responses regarding the social acceptability of the Brahams Protocol, positive community perception, appreciation of couples practising the protocol, its reflection of mutual care and shared responsibility within marriage, compatibility with cultural values, preservation of modesty and dignity, and its potential to contribute to positive societal attitudes towards women's preventive health.

Table 3. Gender-wise Comparison of Responses

Question	Statistical Test	P value	Significant
Q1	Chi-square	0.020	Yes
Q2	Fisher's Exact	0.003	Yes
Q3	Chi-square	0.011	Yes
Q4	Chi-square	NS	No
Q5	Fisher's Exact	0.011	Yes
Q6	Chi-square	0.033	Yes

Q7	Fisher's Exact	0.003	Yes
Q8	Chi-square	NS	No
Q9	Fisher's Exact	NS	No
Q10	Fisher's Exact	NS	No
Q11	Fisher's Exact	NS	No
Q12	Fisher's Exact	NS	No
Q13	Fisher's Exact	NS	No
Q14	Fisher's Exact	NS	No
Q15	Chi-square	NS	No
Q16	Fisher's Exact	0.002	Yes
Q17	Fisher's Exact	NS	No
Q18	Fisher's Exact	NS	No
Q19	Fisher's Exact	NS	No
Q20	Fisher's Exact	NS	No

NS = Not statistically significant ($P \geq 0.05$).

Table 4. Odds Ratios for Statistically Significant Gender Differences

Question	Odds Ratio	95% CI	P value
Q1	2.49	1.13–5.47	0.020
Q2	4.02	1.65–9.80	0.003
Q3	3.00	1.25–7.24	0.011
Q5*	25.43	1.29–499.28	0.011
Q6	2.37	1.05–5.34	0.033
Q7	6.74	1.90–23.87	0.003
Q16	11.45	2.25–58.32	0.002

*Odds ratio estimated using the Haldane–Anscombe correction because one cell contained a zero count.

DISCUSSION

1. Social Acceptability: The Foundation of Successful Implementation

Social acceptability is a fundamental determinant of the successful implementation of any population-based health intervention. While the clinical effectiveness of breast cancer screening has been extensively investigated, its real-world impact ultimately depends on public willingness to adopt and sustain the recommended behavior. Implementation science recognizes acceptability as a core implementation outcome that influences intervention uptake, feasibility, adherence, and long-term sustainability. Consequently, interventions that fail to align with prevailing social values, cultural norms and interpersonal dynamics often experience poor participation despite strong scientific evidence (6–8).

Breast cancer screening is particularly influenced by behavioral and interpersonal factors because decisions regarding breast health are frequently shaped by modesty, cultural beliefs, family dynamics and partner support rather than medical knowledge alone. Systematic reviews have consistently identified social and

cultural acceptability as a major determinant of screening participation across diverse populations (11–16). The present survey therefore evaluated whether a structured, partner-supported breast health vigilance model is perceived as socially and culturally acceptable among healthcare professionals. The high level of acceptance observed provides a strong foundation for future implementation studies rather than evidence of clinical effectiveness.

2. Persistent Social and Cultural Barriers Continue to Limit Breast Cancer Screening

Despite advances in breast cancer awareness and screening programs, participation remains strongly influenced by social and cultural factors. Systematic reviews consistently identify embarrassment, modesty, fear of diagnosis, stigma, misconceptions about personal risk and limited health literacy as persistent barriers to screening across diverse populations (11–14,16).

Interpersonal influences including family attitudes, social norms and partner support further determine whether women undergo screening or delay evaluation (11–14).

Collectively, these findings indicate that improving awareness alone is insufficient to achieve sustained behavioral change (11,12,15).

Social and cultural acceptability should therefore be regarded as a prerequisite for successful implementation rather than merely a determinant of screening uptake (6–8,18).

Table 5. Landmark studies on social and cultural determinants of breast cancer screening and the implementation gap addressed by the Brahams Protocol

Author (Year)	Country / Region	Study design	Study population / Sample	Principal findings	Limitation of existing evidence	Contribution of the present study (BP)
Srinath et al. (2023) [12]	LMICs	Systematic review (67 studies)	Women from low- and middle-income countries	Acceptability, embarrassment, modesty, fear, lack of spousal/family support and cultural beliefs were major barriers to screening.	Identified barriers but proposed no behavioral intervention to address them.	Evaluates the social and cultural acceptability of a behavioral model designed to address these recognized barriers.
Tavakoli et al. (2024) [13]	Global	Systematic review	34 studies (36,043 women)	Screening behavior was influenced by cultural beliefs, social support, motivation, self-efficacy and cues to action.	Did not evaluate structured partner-supported behavioral interventions.	Demonstrates acceptability of a structured partner-supported breast health vigilance model.
Sawhney et al. (2023) [14]	India	Comparative observational study	544 women	Socio-cultural factors remained major determinants of participation	Focused on barriers without evaluating behavioral	Suggests the feasibility of a culturally compatible behavioral

				despite reduction of financial and geographic barriers.	solutions.	strategy.
Bolarinwa & Holt (2023) [15]	United Kingdom	Mixed-methods systematic review	Ethnic minority women	Religion, embarrassment, language, cultural beliefs and family support significantly influenced screening uptake.	Examined determinants of non-participation rather than intervention acceptability.	Evaluates acceptability of an intervention addressing relational and cultural determinants.
Ferrari et al. (2025) [16]	International	Systematic review & meta-analysis	44 RCTs (161,141 participants)	Educational interventions, reminders, navigation and culturally tailored programs improved mammography uptake.	Primarily targeted attendance rather than behavioral restructuring.	Positions BP as a complementary behavioral strategy beyond attendance promotion.
Ebrahimoghli et al. (2025) [17]	LMICs	Systematic review & meta-analysis	174 studies (>78 million women)	Screening uptake remained strongly associated with education, income, rural residence and social determinants.	Quantified determinants without evaluating intervention acceptability.	Provides acceptability evidence before implementation of a behavioral intervention.
Hoedemakers et al. (2025) [18]	International	Systematic review & meta-analysis	63 studies (healthcare professionals and general public)	Acceptability was a key determinant of successful implementation of new screening strategies.	Focused on personalized risk-based screening rather than behavioral models.	Extends acceptability research to a structured partner-supported behavioral intervention.
Shi et al. (2024) [19]	International	Systematic review	Women at increased familial risk	Behavioral interventions improved screening participation among high-	Restricted to high-risk populations and did not involve partner-	Broadens behavioral intervention research to a population-level

				risk women.	supported models.	preventive approach.
Present study	India	Cross-sectional survey	273 healthcare professionals	Demonstrated high social and cultural acceptability of a structured, partner-supported breast health vigilance ecosystem.	Initial acceptability only; implementation outcomes not assessed.	Provides the first acceptability data supporting future implementation studies of the Brahams Protocol.

3. The Brahams Protocol Addresses an Unmet Behavioral Gap

Current breast cancer screening strategies primarily seek to improve awareness, access and participation in periodic screening. In contrast, the Brahams Protocol adopts a partner-supported, lifestyle-integrated model of continuous breast health vigilance. Rather than viewing breast health as an individual responsibility, it encourages shared responsibility within an existing and trusted marital relationship (9,10,11).

Importantly, the Brahams Protocol is not intended to replace established screening recommendations; instead, it is conceived as a complementary behavioral strategy designed to address recognized social and cultural barriers while reinforcing breast awareness and timely healthcare-seeking (3–5,12–16).

Whether this model translates into improved clinical outcomes requires prospective longitudinal evaluation.

Table 6. Comparison of Existing Behavioral Strategies for Breast Cancer Screening with the Brahams Protocol

Behavioral strategy	Primary objective	Typical intervention	Major limitation	How the Brahams Protocol differs
Mammography awareness programs	Increase mammography attendance	Public education campaigns	Episodic and dependent on healthcare access	Promotes continuous lifestyle-integrated breast health vigilance between formal screening visits.
Clinical Breast Examination (CBE)	Encourage professional breast examination	Examination by trained healthcare professionals	Requires healthcare visits and trained personnel	Encourages regular breast awareness within the home while complementing clinical evaluation.
Breast awareness programs	Improve breast health knowledge	Health education and awareness sessions	Knowledge does not always translate into sustained behavior	Emphasizes repeated behavioral reinforcement through shared responsibility.
Breast Self-Examination (BSE) education	Teach self-examination techniques	Individual self-examination training	Relies solely on individual compliance and confidence	Introduces partner-supported breast health vigilance within an established relationship.
Reminder systems	Improve screening compliance	SMS, telephone calls, mailed reminders	Time-limited and programmer-dependent	Encourages habit formation through routine partner engagement rather than

				external reminders.
Patient navigation programs	Improve access to screening	Navigation by healthcare workers	Health-system dependent and resource intensive	Behaviorally driven, requiring minimal healthcare infrastructure after education.
Community health worker interventions	Increase participation in screening	Community outreach and counselling	Resource intensive and dependent on program sustainability	Household-centered approach integrating breast health into daily life.
Mobile health (mHealth) interventions	Reinforce awareness and screening attendance	Mobile applications, text messaging	Technology dependent with variable long-term adherence	Relies on interpersonal interaction rather than digital engagement.
Culturally adapted educational interventions	Improve cultural acceptability	Tailored educational programs	Primarily educational without modifying sustained behavior	Integrates breast health within existing marital and family relationships.
Couple- or family-supported health interventions	Improve preventive health behaviors	Family engagement and counselling	Limited evidence specifically for breast health vigilance	Operationalizes partner involvement through a structured, lifestyle-integrated behavioral model.
Behavior change interventions	Promote preventive practices	Counselling, motivational strategies	Often disease- or program-specific	Integrates behavioral reinforcement into routine daily life.
Brahams Protocol	Promote continuous breast health vigilance	Structured, partner-supported, lifestyle-integrated behavioral model	Requires prospective implementation and outcome validation	Addresses recognized socio-cultural barriers while complementing existing evidence-based breast cancer screening strategies.

4. Interpretation of the Present Findings

The present survey extends existing evidence by demonstrating a high level of social and cultural acceptability of a structured, partner-supported breast health vigilance model among healthcare professionals. Participants perceived the Brahams Protocol as compatible with prevailing social values and cultural norms rather than as an intrusion into personal privacy or family relationships.

From an implementation perspective, these findings are important because acceptability precedes adoption. Interventions perceived as acceptable by their intended users are more likely to be adopted, implemented and sustained in routine practice (6–8,18).

Although behavioral adherence and clinical outcomes were not evaluated, the findings provide a strong rationale for prospective implementation studies.

5. Public Health Implications

The effectiveness of any population-based health intervention depends not only on scientific validity but also on public acceptance (6–8,18).

The high level of social and cultural acceptability observed in the present survey suggests that the Brahams Protocol may represent a feasible behavioral strategy to complement existing breast health initiatives.

If validated through prospective implementation studies, this approach may strengthen breast awareness,

promote continuous breast health vigilance and encourage timely healthcare-seeking, particularly in settings where social and cultural barriers continue to limit participation in conventional screening programs (11–16).

6. Strengths and Limitations

The principal strength of this study is that it is among the first to evaluate the social and cultural acceptability of a structured, partner-supported breast health vigilance model. The high response rate and inclusion of healthcare professionals from two tertiary care centres provide a robust assessment of initial acceptability. Limitations include the cross-sectional design, assessment of perceptions rather than behavior, inclusion of healthcare professionals only, and the absence of longitudinal outcome data.

7. Future Directions

Future studies should evaluate the acceptability and adoption of the Brahams Protocol among couples from diverse cultural and socioeconomic backgrounds. Prospective longitudinal implementation studies are required to determine whether the observed high acceptability translates into sustained behavioral engagement, earlier recognition of breast abnormalities, timely healthcare-seeking and successful community-level implementation.

CONCLUSION

The present cross-sectional survey demonstrates a high level of social and cultural acceptability of the Brahams Protocol among healthcare professionals. Participants largely perceived the protocol as compatible with prevailing social values, cultural norms, and interpersonal relationships, suggesting that a structured, partner-supported approach to breast health vigilance may be acceptable within this population.

These findings address an important implementation question by establishing the acceptability of the Brahams Protocol before evaluating its behavioural or clinical effectiveness. As a lifestyle-integrated, partner-supported breast health vigilance ecosystem, the Brahams Protocol is intended to complement, rather than replace, existing evidence-based breast cancer awareness and screening strategies.

While the study was limited to healthcare professionals and assessed perceptions rather than behavioural outcomes, the high level of acceptability provides a strong rationale for prospective implementation studies in broader community settings. Future longitudinal research should evaluate adoption, adherence, behavioural impact, early recognition of breast abnormalities, healthcare-seeking behaviour, and public health adaptability across diverse populations.

If validated through such studies, the Brahams Protocol has the potential to emerge as a culturally acceptable, scalable, and sustainable behavioural approach to strengthening breast health awareness and vigilance alongside established breast cancer screening programmes.

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