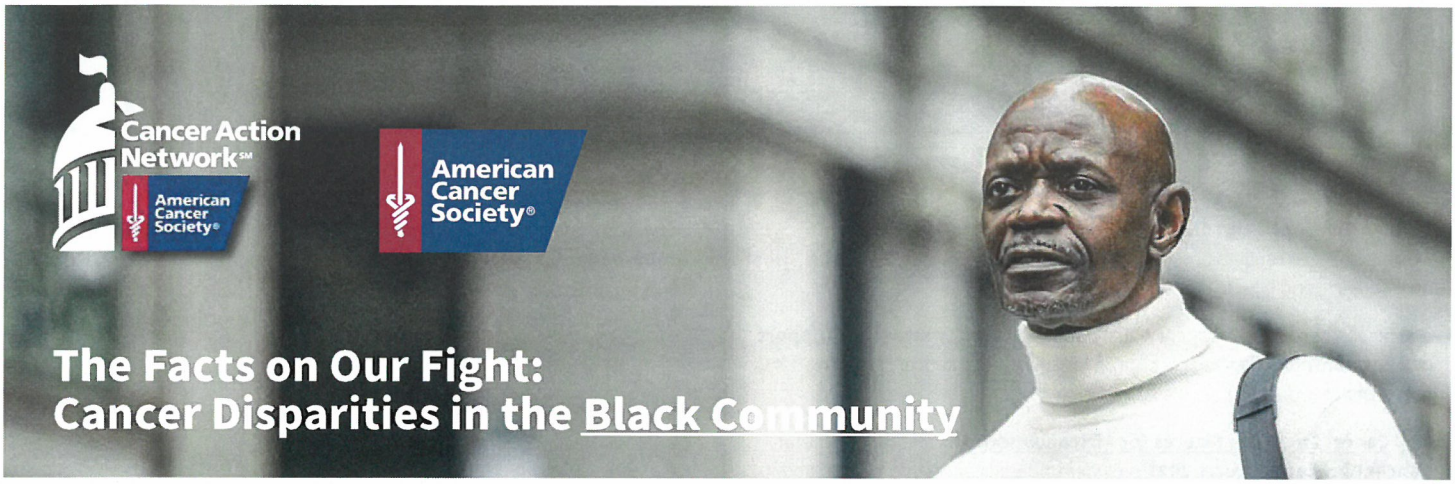

Cancer affects everyone, but it doesn't affect everyone equally.

Black people are disproportionately burdened by cancer and experience greater obstacles to cancer prevention, screening, treatment, and survival because of systemic factors that are complex and go beyond the obvious connection to cancer. These obstacles include structural racism, poverty, jobs with inadequate pay, low quality education and housing, and limited access to the healthcare system and insurance coverage.

Reducing cancer disparities across the cancer continuum and advancing health equity is an overarching goal of the American Cancer Society (ACS) and our non-profit, non-partisan affiliate, the American Cancer Society Cancer Action Network (ACS CAN). Health equity means everyone has a fair and just opportunity to prevent, find, treat, and survive cancer.

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April 2021

In the U.S., research has shown that:

- Black people have the highest death rate and shortest survival of any racial/ethnic group for most cancers.[1]
- Black men have a 7% higher overall cancer incidence rate, but a 14% higher mortality compared to non-Hispanic White men.[1]
- Prostate cancer death rates in Black men are double those of every other racial/ethnic group.[2]
- Despite lower incidence rates in Black women compared with White women for uterine corpus and breast cancers, death rates for these cancers in Black women are about 98% and 40% higher, respectively.[8]
- Black people have higher incidence and mortality for colorectal cancer than any other racial/ethnic group except for Alaska Native people, with death rates that are 36% higher than in White people.[8]
- According to a recent Agency for Healthcare Research and Quality report, Black people receive worse medical care than White people on 76 of 190 measures, including effective treatment for breast and colorectal cancers.[3]
- Black people living in segregated communities are more likely than those who don't live in segregated communities to be diagnosed with breast and lung cancer after it has spread and to die from these cancers.[4]

What also contributes to these disparities?

- **Racial bias and discrimination in health care and every other aspect of society as well as differences in insurance coverage** contribute to poor health for many racial and ethnic groups, including Black people.[5]
- **Disparities in access to paid sick and vacation days among Black workers disproportionately limit access** to life-saving cancer screening and other preventive medical care, not to mention risk of job loss and financial hardship. More than one-third (36%) of Black workers report having no paid time off of any kind, away from their jobs.[7]
- In a review of the scientific literature, **racial residential segregation contributed to poor cancer outcomes** in 70% of the studies. Living in segregated areas was also associated with increased chances of later-stage diagnosis of breast cancer and higher breast cancer mortality.[4]
- **Black individuals make up less than 3% percent of participants in pharmaceutical clinical trials** while making up 13% of the current US population.

Here are some ways ACS and ACS CAN are working to address cancer disparities and to advance health equity with the Black community.

RESEARCH

ACS is funding **61 health disparities research grants**, reflecting $49 million in research to better understand what cancer disparities exist, what causes them, and how to decrease them.

ACS researchers publish papers which have been used to **inform or support public health policies**, cancer control initiatives, and cancer screening guidelines to reduce cancer disparities.

ACS' **Cancer Facts and Figures for African Americans** and more general **Cancer Facts and Figures 2021** provides updated cancer information about African Americans and Black people, including **statistics on cancer occurrence and risk factors, as well as information about prevention, early detection, and treatment**.

PROGRAMS, SERVICES, AND EDUCATION

With funding from the **Robert Wood Johnson Foundation**, ACS is pilot-testing community projects across the U.S. that **explore, identify, and implement community-driven solutions** to advance health equity and address social determinants of health contributing to cancer disparities.

The **24/7 Cancer Helpline** provides support for people dealing with cancer and connects them with **trained cancer information specialists** who can answer questions and provide guidance and a compassionate ear.

ADVOCACY

ACS CAN is advocating for public policies to **reduce disparities and improve health outcomes at all levels of government**, including the following:

- ✓ Supporting the Centers for Disease Control and Prevention (CDC)'s **National Breast and Cervical Cancer Early Detection Program (NBCCEDP)**, which provides community-based breast and cervical cancer screenings.
- ✓ **Improving access to health insurance and protecting provisions of the Affordable Care Act (ACA) that specifically aid people of color**, who are more likely to be diagnosed at advanced stages of disease and less likely to receive or complete treatment.
- ✓ Supporting policies that **ensure people of color with cancer are enrolled in clinical trials**. Representation in clinical trials is important because the studies help ensure that medicines and treatments are safe and effective for people of all racial and ethnic backgrounds.
- ✓ Advocating for **ending the sale of all flavored tobacco products**, including menthol cigarettes, which prevents the tobacco industry from targeting communities of color, and **addressing systemic racism in the enforcement of tobacco control laws** by advocating it be entrusted to public health officials or other non-police officers.
- ✓ Advocating for **smoking cessation treatment that is barrier-free, comprehensive, and widely promoted** for people enrolled in Medicaid.

PARTNERSHIPS

ACS has partnered with **The Links, Inc.** to develop the **Health Equity Ambassador Links (HEAL) program**. ACS has trained more than 250 Links members as health equity ambassadors. These trained health equity ambassadors have delivered health equity information in communities. With help from an **Anthem Foundation** grant, in 2021, The Links, Inc. has committed to having another 500 ambassadors trained, which is expected to reach over 100,000 individuals in the next two years.

With funding from the **National Football League (NFL)** , ACS is supporting Federally Qualified Health Centers (FQHCs) and safety-net hospitals in 32 cities as they **help women of color and women with no insurance or who are underinsured get access to cancer screening, timely follow-up, and timely access to care, regardless of their insurance status or ability to pay** through the CHANGE (Community Health Advocates implementing Nationwide Grants for Empowerment and Equity) Program.

ACS is partnering with **Pfizer Global Medical Grants** to reduce the breast cancer mortality disparity between Black and White women, reduce disparities impacting Black men facing prostate cancer, and **address disparities in the delivery of cancer care** impacting outcomes for Black people facing cancer.

The **National Black Justice Coalition** collaborates with ACS and ACS CAN to **reach Black LGBTQ+ communities and other constituents** with important messages relating to cancer prevention and early detection.

ACS is **contributing to ongoing dialogue and collaborating around health equity issues with additional Black-led social, civic, and faith organizations** such as the African Methodist Episcopal Church, Alpha Kappa Alpha (AKA) Sorority, Inc., Delta Sigma Theta Sorority, Inc., Phi Beta Sigma Fraternity, Inc., and Zeta Phi Beta Sorority, Inc. These partnerships are critical in **leveraging our mutual commitments to saving lives and reducing cancer disparities among African Americans and Black people** through health education on cancer prevention and early detection, access to resources for people who have cancer and their caregivers, fundraising, and supporting ACS CAN's public policy work. Contact **inclusion@cancer.org** for more information.

Black South Carolinians are much more likely to be diagnosed with more advanced stages of colorectal cancers (CRC) than White South Carolinians. Significant disparities in screening rates, incidence and mortality exist between urban and rural South Carolinians. With funding from the Centers for Disease Control and Prevention, ACS launched the **South Carolina Communities Unite to Increase CRC Screening Learning Collaborative in partnership with the University of South Carolina** to address these disparities. Five health system partners, ranging from South Carolina's largest FQHC to rural hospital owned primary care practices, participate in intense quality improvement training and are currently identifying the root causes for cancer screening disparities within their patient populations.

To ACS and ACS CAN, health equity is essential to our mission. It's what we believe in, and it's a moral imperative if we are to achieve our vision of a world without cancer and meet our 2035 goal of reducing cancer mortality by 40%. Most importantly, **if we are to reduce cancer disparities, we need to listen to the experiences and perspectives of Black people with cancer, their caregivers, and their communities, and engage them in the fight against cancer every step of the way.** It will take all of us working together to do this.

For more information, please visit: fightcancer.org/healthdisparities and cancer.org/healthequity

April 2021

Cancer screening saves lives.

Screening Recommendations

These recommendations are for people at average risk for certain cancers. Talk to a doctor about which tests you might need and the screening schedule that's right for you. It's a good idea to also talk about risk factors, such as lifestyle behaviors and family history that may put you or your loved one at higher risk.

Age 25-39

- **Cervical cancer screening** recommended for people with a cervix beginning at age 25.

Age 40-49

- **Breast cancer screening** recommended beginning at age 45, with the option to begin at age 40.
- **Cervical cancer screening** recommended for people with a cervix.
- **Colorectal cancer screening** recommended for everyone beginning at age 45.
- At age 45, African-Americans should discuss **prostate cancer screening** with a doctor.

Age 50+

- **Breast cancer screening** recommended.
- **Cervical cancer screening** recommended.
- **Colorectal cancer screening** recommended.
- People who currently smoke or formerly smoked should discuss **lung cancer screening** with a doctor.
- Discussing **prostate cancer screening** with a doctor recommended.

Questions to Ask a Doctor

- What cancer screening tests are recommended for someone my age?
- How often should I get the screening tests?
- Where can I go to get screened?
- How do I schedule my screening tests?
- Will my screening tests (or other costs) be covered by my health insurance?
- What will the screening tests cost if they are not covered by insurance?

Cancer Screening Conversation Starters

- I care about you and your health. Are you getting regular cancer screening tests?
- Did you know there are tests that can catch changes in your body before they become cancer?
- My breast/colorectal/cervical cancer screening is coming up. Have you scheduled yours yet?
- Regular cancer screening is important. Is there anything I can do to help you get screened, like get information, schedule an appointment, or help with childcare or transportation?

Questions about Screening?

Visit **cancer.org/get-screened** for cancer screening FAQs, including information about how to schedule a screening test, how to afford screening with or without insurance, and more.

African American/Black
Community Brief

African American/Black 10 Key Cancer Facts

- **The lifetime probability of being diagnosed with cancer among black men and black women is 41% and 34%,** respectively, compared with 42% and 39%, respectively, among whites.
- **The overall cancer death rate in males was 47% higher in blacks than in whites in 1990, but reduced to 24% higher in 2012.** Among females, the disparity decreased from 19% higher in 1991 to 14% in 2012.
- **Lung cancer accounts for the largest number of cancer deaths among both men (27%) and women (22%),** followed by prostate cancer in men (12%), and breast cancer in women (19%). For both men and women, colorectal cancer is expected to be the third leading cause of cancer death.
- **During 2008 through 2012, the overall breast cancer incidence rate in black women was 124.3 cases per 100,000 women,** which was 3% lower than that in white women (128.1 per 100,000 women). However, rates were higher in black women than in white women in 7 states (Alabama, Kentucky, Louisiana, Mississippi, Missouri, Oklahoma, and Tennessee) and were not significantly different in 24 states.
- **Breast cancer incidence rates are also higher among blacks than whites for women under age 45.** The median age of diagnosis is 58 years for black women, compared with 62 years for white women.
- **From 2003 to 2012, colorectal cancer death rates declined faster in black women than in white women** (3.3% vs 2.9% per year), but declines were slower in black men than in white men (2.5% vs 3.0%). As a result, the racial gap is shrinking in women, whereas rates in men have remained about 50% higher in blacks than in whites since 2005.
- **The 5-year relative survival rate is lower in blacks than in whites for every stage of diagnosis for most cancer sites.** Much of the difference in survival is due to barriers that limit access to timely, appropriate, and high-quality medical care, which also results in later stage at diagnosis, when treatment choices are more limited and often less effective.
- **In black men, incidence rates from 2003 to 2012 decreased by 2.0% per year for all cancers combined** as well as for the top three cancer sites (prostate, lung, and colorectal).
- **In black women, overall cancer incidence rates during this time remained unchanged,** reflecting increasing trends in breast cancer, countered by decreasing trends in lung and colorectal cancer rates.
- **Obesity increases cancer risk, and black women have the highest body mass index (BMI) of any sex-racial/ethnic group.** During 2013-2014, nearly 6 in 10 black women were obese (BMI≥30) compared to nearly 4 in 10 white women. The prevalence of obesity is similar in black and white men (38% and 35%, respectively).
- **Blacks are also less likely than whites to participate in leisure time physical activity** and to meet recommendations for aerobic activity.

African American/Black Community Statistics

- 41.2 million African Americans in the US
- 2.4 million affluent African American households with an income of $75,000 or more
- $1.1 trillion in buying power, $1.3 trillion by the year 2017
- African Americans/Blacks make up approximately 13% of the US population.

African American/Black Community Behavior

- Credibility of marketers is linked to meaningful and consistent involvement in the African-American community.
- African Americans donate 25% more of their discretionary income than do whites.
- Approximately 15% of African American philanthropic dollars fund educational causes.
- 38% of African Americans select products or services when they feel the marketing tactics are created with them in mind as well as show them visually using or benefiting from it.
- About 189,910 new cancer cases and 69,410 cancer deaths were expected to be diagnosed among blacks in 2016, including 93,990 cases in men and 95,920 cases in women.
- Prostate cancer is expected to be the most commonly diagnosed cancer in black men, and breast cancer is expected to be the most commonly diagnosed cancer in black women.
- The value of religion, reading religious materials, prayer, and other forms of non-organized religious participation are part of the fabric in the life and culture of many African Americans/Blacks.
- Compared with other racial or ethnic groups, African Americans/Blacks are more likely to report a formal religious affiliation, with 87% describing themselves as belonging to one religious group or another.

Community Briefs provide an overview of the community of focus. These documents are meant to be used as refreshers after training.

American Cancer Society®

Patient Version

American Cancer Society®

Prostate Cancer Fact Sheet

Prostate cancer can start in any area of the prostate. The prostate is a gland found only in males. In the US, prostate cancer is the most common type of cancer in men (other than skin cancer) and the second-leading cause of cancer death (after lung cancer).

Risk Factors

- **Age** Men of any age can get prostate cancer, but the risk of having it is higher after age 50.
- **Race/Ethnicity** The risk of getting prostate cancer is higher in African American men and in Caribbean men of African ancestry than in men of other races.
- **Family history** Men who have a close relative (father or brother) who has had prostate cancer are at a higher risk of developing this disease. The risk is higher for men who have a brother with the disease than for those who have a father with it. Having more than one close relative who has had the disease increases the risk even more, especially if their relatives were young when the cancer was found.
- **Inheriting gene changes** Certain gene changes (most commonly *BRCA1* and *BRCA2* genes) or having Lynch syndrome can increase a man's risk of getting prostate cancer.
- **Diet** Men who eat a lot of red meat or high-fat foods may have a higher risk of getting prostate cancer.

Prevention

There is no sure way to prevent prostate cancer, and some risk factors can't be changed such as age, race, and family history of the disease. But there are some things that might help lower the risk. Regular physical activity, staying at a healthy weight, and eating a diet high in vegetables and low in fat might help lower the risk of prostate cancer.

Screening and Early Detection

Screening is testing for cancer in people who have no symptoms. At this time, it's not clear if the benefits of prostate cancer screening outweigh the risks for most men. The American Cancer Society recommends that men have a chance to make an informed decision with their health care provider about whether to be screened for prostate cancer. The decision should be made after getting information about the risks and potential benefits of prostate cancer screening. **Men should not be screened unless they have received this information.** The discussion about screening should take place at:

- **Age 50 for men who are at average risk** and are expected to live at least 10 more years
- **Age 45 for men at high risk**, including African American men, Caribbean men of African ancestry, and men who have a first-degree relative (father or brother) diagnosed with prostate cancer at an early age (younger than 65)
- Age 40 for men at even higher risk, including those with more than one first-degree relative who had prostate cancer at an early age

After this discussion, men who decide to get screened should be tested with the prostate-specific antigen (PSA) blood test. Some doctors might do a digital rectal exam (DRE) as part of screening. How often a man is tested will depend on their PSA level, general health, preferences, and values.

Signs and Symptoms

Early-stage prostate cancer usually has no symptoms. More advanced prostate cancer (cancer that may have spread outside the prostate) may cause symptoms, such as:

- Problems urinating, such as pain or burning during urination or the need to urinate more often, especially at night
- Blood in the urine or semen
- Trouble getting an erection
- Weakness or numbness in the legs or feet, or not being able to control the bladder or bowel, caused by cancer pressing on the spinal cord
- Pain in the hips, spine, ribs, or other areas, caused by cancer that has spread to the bones

Treatment

Treatment for prostate cancer depends on the type and stage of the cancer, results from special testing that might be done on the tumor, as well as the person's age, other health problems, and personal choices. Men who are diagnosed with prostate cancer should discuss all treatment options and make informed treatment decisions together with their doctors.

Living With Prostate Cancer

From the time a person is diagnosed with prostate cancer, their quality of life is affected in some way. Different physical, social, psychological, spiritual, and financial issues can come up at any time during the cancer experience and after treatment is over.

Some types of prostate cancer can be serious. Palliative care is focused on helping to improve the quality of life and dealing with issues that people living with a serious illness might have. People with advanced prostate cancer may benefit from having palliative care at any time from the point of diagnosis, throughout treatment, and beyond.

Good communication between a person with cancer and their health care team is important and involves:

- Asking and answering questions
- Working together to set care goals
- Making shared decisions
- Managing side effects and other issues
- Making sure to schedule follow-up tests and care

To learn more, visit **cancer.org/prostatecancer**.