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“Time and the world do not stand still. Change is the law of life. And those who look only to the past or the present are certain to miss the future.” — John F. Kennedy

If there is one thing we at the American Cancer Society have learned in our nearly century of experience fighting cancer, it is that this disease never rests. That’s why we don’t, either – and why we are relentless in our battle to pursue victories against this enemy.

In the pages that follow, you will see that we have accomplished much in this fight. Indeed, since our organization began, we have been fortunate enough to play a vital part in the history of cancer, contributing to nearly every major game-changing advance made in the past 100 years. We celebrate our progress – and we recognize the importance of noting and measuring it each year.

Yet at the same time, we are not content to rest on our laurels. Today, we are at a defining moment in the history of the fight against cancer – and of the American Cancer Society. In 2010, cancer is projected to become the leading cause of death worldwide, followed by heart disease and stroke, and it also causes the most economic harm around the globe. Yet today, we also know more about how to prevent, detect, and treat this disease than ever before. With the right interventions and platforms in place, we can accomplish incredible things toward the goals we outline in this report.

That’s why we at the American Cancer Society are laser-focused on one end goal: saving more lives from cancer, not just across the nation, but around the world. We’re already saving 350 more birthdays each and every day, thanks to the progress we’ve been making against the disease just since the early 1990s, when cancer death rates began to decline. But we’re not satisfied with that. We’re pushing forward, working relentlessly to lead a global fight for a world with tens of thousands more birthdays per day, transforming our organization to be as innovative, effective, and efficient as possible to achieve that goal. We believe a world with more birthdays is not just possible – it’s a goal we’re morally obligated to champion and one we’ve already begun to realize today.

Together, we are confident that we can build on the progress detailed in the following pages – and that together, we can transform the world of tomorrow into one with less cancer – and many more birthdays.

George W. P. Atkins
Chair, National Board of Directors

Alan G. Thorson, MD, FACS
President

John R. Seffrin, PhD
Chief Executive Officer
The 2010 American Cancer Society Strategic Plan Progress Report is organized around and illustrates progress toward the outcome statements described in the Society’s 2010 Strategic Plan.

It presents significant achievements by the Society and by the larger cancer community, as well as areas of challenge where future improvements are critical. It clearly shows that if we do the right things, cancer is potentially the most preventable and the most curable of the chronic, life-threatening diseases facing Americans.

The National Board of Directors develops and approves a strategic plan annually. It is developed with input from volunteers and staff nationwide, and it sets forth a framework within which the American Cancer Society will both lead and act. The plan consists of several connected but discrete elements and integrates mission delivery, income development, and global cancer control. It serves not only as a reference and guide for decision-making and the development of operational plans, but also as an organizer for measuring and reporting progress.
Introduction

Mission

The American Cancer Society is the nationwide community-based voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives, and diminishing suffering from cancer, through research, education, advocacy, and service.

All elements of the strategic plan are driven by this mission statement. We deliver on that mission by working with our millions of supporters to save lives and create more birthdays by helping people stay well, helping people get well, by finding cures, and by fighting back.

2015 Goals

Our challenge goals for the nation include reducing cancer incidence and mortality and improving quality of life for people touched by cancer. These goals articulate the aspirations of the entire cancer community.

Nationwide Objectives

These specific targets for the cancer community address areas designed to impact the 2015 goals for incidence, mortality, and quality of life.

Overarching Principles

These are specific areas adopted as cross-cutting issues directly related to the achievement of all nationwide objectives.

American Cancer Society Leadership Roles, Focus Areas, Pillars, Mission Outcomes

The leadership roles identify the Society’s chosen areas of focus in support of the 2015 goals and nationwide objectives. They define our optimal role in the fight against cancer and are based on our unique capabilities. The four leadership roles, 12 focus areas, two supporting pillars, and mission outcomes direct the strategies we pursue to accelerate progress toward the 2015 goals.

Mission outcomes represent a subset of the nationwide objectives of the cancer community in which the Society intends to “lead the way.” It is these outcomes that drive the activities employed by the Society. A clear focus and investment in the pillars of advocacy and disparities support the leadership roles and focus areas. Cancer is more than a scientific and medical challenge – it is a matter of public policy. Effective advocacy at all levels of government for proven solutions in the fight against cancer is necessary. One of the overarching themes of the Society’s 2015 goals, nationwide objectives, and leadership roles is eliminating disparities in the cancer burden experienced by many in the United States. The Society works aggressively to eliminate cancer disparities through a multi-layered approach of research, collaborations, community outreach, and public policy changes.

Global Cancer Control

According to the World Health Organization estimates, cancer will become the leading cause of death globally this year, surpassing heart disease and stroke. In addition, for the first time, research shows that cancer has the most devastating economic impact of any cause of death in the world – costing the global economy nearly a trillion dollars a year. In order to have a significant and sustainable impact on the growing disease burden, cancer and tobacco control must become a political and public health priority. The Society’s global program leverages our institutional knowledge, assets, and infrastructure to increase awareness and resources to fight cancer and tobacco and to work with multi-sectoral partners to develop and implement unique evidence-based cancer and tobacco control programs throughout the world.

Income Development

Fundraising is the foundation that underpins our ability to achieve our strategic plan. The Integrated Fundraising Plan supports and intersects with our mission activities to accomplish our leadership roles and contribute to the success of the 2015 goals.
Introduction

A Brief Glimpse at What We Do
At the American Cancer Society, we’re saving lives from cancer and helping create a world with more birthdays. We’ve been at this for nearly a century, and more than 11 million American cancer survivors are proof that our hard work is paying off. But we can – and must – do more to help bring cancer under control as we continue to deliver on our vision of a world with more birthdays. As a global grassroots force of more than three million volunteers, we fight for every life threatened by every cancer in every community by helping people stay well and get well, by finding cures, and by fighting back.

Helping People Stay Well
The American Cancer Society knows that the key to a world with more birthdays is preventing cancer and finding it early, when it is easiest to treat. That’s why we’re working every day to help people stay well, whether they want to quit smoking, eat right, get active, or find out what screening tests are right for them.

Helping People Get Well
Whether it’s the middle of the day or the middle of the night, the American Cancer Society is there for people facing cancer and their loved ones. We help guide people through every step of a cancer experience, so they can focus on getting well.

Finding Cures
The Society funds research that helps us better understand, prevent, find, and treat cancer. As the nation’s largest private funder of cancer research, the Society has long been at the forefront of the scientific battle against this disease, leading the way to a tomorrow with better treatments, new early detection tests, more cures ... and more birthdays.

Fighting Back
Across the nation, the American Cancer Society provides ordinary people an extraordinary opportunity to help create a world with less cancer and more birthdays. We empower people everywhere to fight cancer in their communities and to work with lawmakers to make America a healthier place to live.

At the American Cancer Society, we don’t just focus on one type of cancer or one way to combat the disease. Our work covers the entire spectrum of the cancer fight, from prevention and early detection, to support during treatment, to end-of-life care and quality of life after a cancer experience. We’re working as a global institution to truly bring cancer under control in this century.

What to Expect in This Report
The first chapter of the progress report lists the outcome statements described in the strategic plan. This is followed by a series of chapters highlighting progress being made toward our 2015 goals, nationwide objectives, and leadership roles, as well as global cancer control and income development efforts. Progress toward these outcome statements is measured using graphs and text to highlight current trends and challenges that demand attention. Information in the progress report reflects data available as of September 2010.

The final chapter illustrates the historical change in our outcome statements from 1996 to August 2010.
Outcome Statements

2015 Goals

- 50 percent reduction in age-adjusted cancer mortality rates by 2015
- 25 percent reduction in age-adjusted cancer incidence rates by 2015
- Measurable improvement in the quality of life (physical, psychological, social, and spiritual) from the time of diagnosis and for the balance of life of all cancer survivors by 2015

Principles

Information
State-of-the-art information on issues related to incidence, mortality, risk factors, prevention, early detection, treatment, survivorship, and quality of life (physical, social, psychological, and spiritual) will be available and accessible through all appropriate channels to all people.

Measurement
Monitoring systems that track relevant incidence, mortality, risk factor and screening prevalence, and quality-of-life dimensions should be available nationwide.

Disparities
Eliminate differences in the incidence, prevalence, mortality, and burden of cancer and related adverse health conditions, beyond what would be expected under equitable circumstances that exist among specific population groups in the United States. These population groups may be characterized by gender, age, race/ethnicity, education, income, social class, disability, geographic location, or sexual orientation.

Collaboration
Efforts should be increased toward working collaboratively with other organizations and agencies to achieve our common cancer control goals and objectives.

Access to Quality Treatment
Assure that all people diagnosed with cancer have access to appropriate, quality treatment and follow up, achieving zero percent disparities in treatment outcomes.
Nationwide Objectives

**Colorectal Cancer**

**BY 2015:**
- **Incidence:** By 2015, reduce the age-adjusted incidence rate of colorectal cancer by 40%.
- **Mortality:** By 2015, reduce the age-adjusted mortality rate of colorectal cancer by 50%.
- **Early Detection:** By 2015, increase to 75% the proportion of people aged 50 and older who have colorectal screening consistent with American Cancer Society guidelines.

**BY 2010:**
- **Incidence:** By 2010, reduce the age-adjusted incidence rate of colorectal cancer by 30%.
- **Mortality:** By 2010, reduce the age-adjusted mortality rate of colorectal cancer by 40%.
- **Behavior Change:** By 2010, 60% of people aged 50 and older will have received colorectal screening consistent with American Cancer Society guidelines.

**Lung Cancer/Adult and Youth Tobacco Use**

**BY 2015:**
- **Incidence:** By 2015, reduce the age-adjusted incidence rate of lung cancer by 45%.
- **Mortality:** By 2015, reduce the age-adjusted mortality rate of lung cancer by 50%.
- **Adult Tobacco Use:** By 2015, reduce to 12% the proportion of adults aged 18 and older who are current cigarette smokers.
- **Adult Smokeless Tobacco Use:** By 2015, reduce to 0.4% the proportion of adults aged 18 and older who are current users of smokeless tobacco.
- **Youth Tobacco Use:** By 2015, reduce to 10% the proportion of high school students (younger than 18) who are current cigarette smokers.
- **Youth Smokeless Tobacco Use:** By 2015, reduce to 1% the proportion of high school students (younger than 18) who are current users of smokeless tobacco.
**Outcome Statements**

**BY 2010:**
- **Adult Tobacco Use:** By 2010, reduce to 18.5% the proportion of adults aged 18 and older who are current cigarette smokers.
- **Adult Tobacco Use:** By 2010, reduce to 22% the proportion of adults (25 and older) with less than a high school education who are current cigarette smokers.
- **Youth Tobacco Use:** By 2010, reduce to 15% the proportion of high school students (younger than 18) who are current cigarette smokers.

**Breast Cancer**

**BY 2015:**
- **Incidence:** By 2015, reduce the age-adjusted incidence rate of breast cancer by 15%.
- **Mortality:** By 2015, reduce the age-adjusted mortality rate of breast cancer by 50%.
- **Early Detection:** By 2015, increase to 90% the proportion of women aged 40 and older who have breast screening consistent with American Cancer Society guidelines.

**Prostate Cancer**

**BY 2015:**
- **Incidence:** By 2015, reduce the age-adjusted incidence rate of prostate cancer by 15%.
- **Mortality:** By 2015, reduce the age-adjusted mortality rate of prostate cancer by 50%.
- **Early Detection:** By 2015, increase to 90% the proportion of men who follow age-appropriate American Cancer Society detection guidelines for prostate cancer.

**BY 2010:**
- **Mortality:** By 2010, reduce the age-adjusted mortality rate of prostate cancer by 40%.
Outcome Statements

Nutrition and Physical Activity

BY 2015:

- **Overweight/Obesity:** By 2015, the trend of increasing prevalence of overweight and obesity among US adults and youth will have been reversed, and by 2015, the prevalence of overweight and obesity will be no higher than in 2005.

- **Behavior Change:** By 2015, increase to 70% the proportion of adults and youth who follow American Cancer Society guidelines with respect to the appropriate level of physical activity, as published in the American Cancer Society Guidelines on Nutrition and Physical Activity for Cancer Prevention.

- **Behavior Change:** By 2015, increase to 75% the proportion of persons who follow American Cancer Society guidelines with respect to consumption of fruits and vegetables, as published in the American Cancer Society Guidelines on Nutrition and Physical Activity for Cancer Prevention.

BY 2010:

- **Overweight/Obesity:** By 2010, the increasing trends in overweight and obesity for both US adults and youth will have stopped.

- **Behavior Change:** By 2010, increase to 60% the proportion of adults and youth who meet American Cancer Society guidelines for physical activity, as published in the American Cancer Society Guidelines on Nutrition and Physical Activity for Cancer Prevention.

- **Behavior Change:** By 2010, increase to 45% the proportion of adults and youth who meet American Cancer Society guidelines for fruit and vegetable consumption, as published in the American Cancer Society Guidelines on Nutrition and Physical Activity for Cancer Prevention.

Skin Cancer

BY 2015:

- **Behavior Change:** By 2015, increase to 75% the proportion of people of all ages who use at least two or more of the following protective measures, which may reduce the risk of skin cancer: avoiding the sun between 10:00 a.m. and 4:00 p.m., wearing sun-protective clothing when exposed to sunlight, properly applying sunscreen (SPF 15 or higher), and avoiding artificial sources of ultraviolet light (e.g., sun lamps, tanning booths).
Outcome Statements

Comprehensive School Health Education

BY 2015:
• **Comprehensive School Health Education**: By 2015, increase to 50% the proportion of school districts that provide a comprehensive or coordinated school health education program.

• **School Health Councils**: By 2015, 90% of school districts will have active school health councils.

• **School Health Coordinators**: By 2015, 90% of school districts will have school health coordinators.

BY 2010:
• **Comprehensive School Health Education**: By 2010, 35% of school districts will provide comprehensive or coordinated school health education.

Quality of Life

BY 2015:
• **Pain Control**: By 2015, all 50 states and the District of Columbia will have received a grade of B or higher on the Pain Policy Report Card, and at least 10 states will have received a grade of A.

• **Symptom Control**: By 2015, establish and implement a process to measure the effective control of pain, other symptoms, and side effects for those affected by cancer.

• **End-of-life Care**: By 2015, increase use of best practice end-of-life care.

Access to Care

BY 2015:
• **Health Care Coverage**: By 2015, the proportion of individuals without any type of health care coverage will decrease to 0%.

• **Out-of-pocket Costs**: By 2015, no more than 2% of individuals diagnosed with cancer will report difficulties in obtaining medical care due to high out-of-pocket costs.

• **Completion of Recommended Treatment**: By 2015, establish and implement a process for measuring the completion of recommended treatment based on established guidelines, including participation in clinical trials.
Leadership Roles, Focus Areas, Supporting Pillars, Mission Outcomes

Leadership Role – Information

Support better decisions by making available high-quality, timely, understandable information, especially to newly diagnosed cancer patients and their caregivers.

Focus Areas:
- Being a trusted provider of unbiased, general information
- Being a trusted provider of interactive, personal information and guidance

Leadership Role – Research

Leverage the Society’s scientific credibility and unique position to support innovative, high-impact research – through both direct funding and the ability to influence the amount and direction of research funding from other sources.

Focus Areas:
- Extramural funding of innovative and high-impact research
- Intramural funding to conduct, collaborate, and publish high-impact research, assisting both internal and external cancer control strategies
- Influence the amount and direction of funding and policy changes that support research.

Leadership Role – Quality of Life

Improve quality of life of cancer patients, caregivers, and survivors by assisting primarily with service referral, community mobilization, collaboration, advocacy, and, where appropriate, directly providing services.

Focus Areas:
- Refer patients and caregivers to optimal local services via multiple channels.
- Influence investment by local communities in high-impact quality-of-life services and policies through community mobilization, collaboration, and advocacy.
- Where necessary, directly provide services where the Society is uniquely able to do so.
Outcome Statements

Leadership Role – Prevention and Early Detection

Increase the prevention and early detection of cancer.

Focus Areas:
- Prevent and detect colorectal cancer as early as possible.
- Reduce tobacco use to prevent lung and other cancers.
- Prevent and detect breast cancer as early as possible.
- Improve nutrition and physical activity to decrease the incidence of overweight-/obesity-related cancers.

Supporting Pillars

- Advocacy – The leadership roles will be supported by a clear focus and investment in advocacy. Advocacy will be supported at the local, state, and national levels with dedicated staff, direct funding, and volunteer involvement.
- Disparities – The American Cancer Society recognizes the importance of disparities in each of its leadership roles and will focus its efforts on them. Disparities will be addressed through direct service delivery, advocacy efforts, and direct outreach to underserved communities.

Mission Outcomes

Prevention and Detection:
- Tobacco Focus: Decrease tobacco prevalence rates in adults and youth.
- Colorectal Focus: Increase colorectal screening among adults 50 and older.
- Breast Focus: Increase breast screening among women 40 and older.
- Nutrition/Physical Activity Focus: Decrease the prevalence of overweight and obesity.

Information and Quality of Life:
Begin to develop data collection methods to monitor the improvement of health-related quality-of-life outcomes (physical, emotional, social and spiritual well-being) relative to:
- Increasing cancer knowledge and empowering patients and caregivers to participate in decision-making, communicate with their treatment team, and cope with issues that arise throughout their cancer experience
- Increasing patient and caregiver physical and psycho-social symptom management/well-being
- Reducing barriers to receiving quality treatment
Global Cancer Control

The American Cancer Society’s Global Health Program works to:

• Establish cancer as a global health and development priority.
• Reduce the incidence of tobacco-related cancers in low- and middle-income countries, with a special emphasis on sub-Saharan Africa.

Global Tobacco Control – Mission Outcome:

• By 2015, prevent any increases in the smoking prevalence rate among both youth and adults in sub-Saharan Africa.

Income Development

BY 2015:
By 2015, increase total public revenue to $1.22 billion, annually.

By 2011:
By 2011, increase total public revenue to $975 million, annually.
Cancer – All Sites
Yet because lives are still being lost to cancer, we can – and we must – do more.

**Trends:**
- Death rates continue to decline in measurable, inspiring numbers.
- The probability that a person with cancer will survive at least five years after diagnosis has improved steadily over the past several decades.

**Challenges:**
- Eliminating disparities in the cancer burden by race, ethnicity, and socioeconomic status remains a challenge.
- There is no population-based surveillance data to adequately measure elements directly related to quality of life.

**Bottom Line:**
Between now and 2015, many new cancer cases and cancer deaths can be averted with concerted action to control tobacco and obesity, by redoubling efforts in mammography and colorectal screening, and by enacting policies to close gaps in access to cancer prevention, early detection, and treatment services.
Progress toward the Nationwide 2015 Goals at a Glance: Cancer – All Sites

<table>
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<tr>
<th>By 2015</th>
<th>Progress</th>
<th>2015 Trends</th>
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<tr>
<td><strong>Incidence:</strong> 25% reduction</td>
<td>Baseline 1992 to 2007: 7.5% reduction</td>
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<tr>
<td><strong>Mortality:</strong> 50% reduction</td>
<td>Baseline 1991 to 2007: 17.2% reduction</td>
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<tr>
<td><strong>Quality of Life:</strong> Measurable improvement for all cancer survivors</td>
<td>No population-based surveillance data sets currently exist to provide reliable baseline measurements and ongoing assessments of progress toward this goal.</td>
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likely to meet goal 🎉, possible to meet goal 🎈, unlikely to meet goal 🙁, unknown 🎉, dashboard metric 🌟
Cancer – All Sites

Launching the movement for more birthdays in 2009 was a clear sign that the Society will not be satisfied until cancer never steals another year from anyone’s life.

People across America came together through this movement, engaging with the organization in new and different ways and relentlessly pursuing continued success in this fight.

Age-adjusted Incidence Rates

2015 Goal
25% Reduction

- The latest joinpoint trend (1999-2007) shows a 0.7 annual percent decrease.
- About 1,529,560 new cases are expected to be diagnosed in 2010.
- Given the current trends in overall cancer incidence, and in consideration of trends in major cancer risk factors, it is unlikely that we will meet the 2015 goal.

- Cancer incidence rates are consistently higher in men than in women.
- In the United States, men have a slightly less than 1 in 2 lifetime risk of developing cancer; for women, the risk is a little more than 1 in 3.
- About 77 percent of all cancers are diagnosed in persons 55 years and older.
Cancer incidence rates for all sites combined are consistently higher in African American men than in white men; however, the disparity is decreasing.

Cancer incidence rates for all sites combined are generally higher in white women than in African American women.

African Americans have the highest cancer incidence rate of any racial or ethnic group. From 2003-2007, incidence rates among African Americans were approximately 4 percent higher than those in whites.

Asian Americans/Pacific Islanders have the lowest cancer incidence rates.
Age-adjusted Mortality Rates

2015 Objective

50% Reduction

- More than 1,500 people die of cancer every day.
- From 1993-2001, cancer mortality rates declined 1.1 percent annually. The latest joinpoint trend shows an acceleration of the decline to 1.6 percent per year from 2001-2007.
- Fully reaching the 2015 goal will require substantial breakthroughs in early detection and/or in cancer treatment.
- Given the current trends in overall cancer mortality, it is unlikely that we will meet the 2015 goal.

- The declines in death rates were greater in men than in women, due in large part to the substantial decrease in tobacco-related cancer deaths among men.
- Death rates decreased for 10 of the 15 most common cancers in both men and women.

The National Institutes of Health estimates overall costs for cancer in 2010 at $263.8 billion: $102.8 billion for direct medical costs; $20.9 billion for lost productivity due to illness; and $140.1 billion for lost productivity due to premature death.
Beginning January 1, 2011, Medicare will cover annual wellness visits so that doctors and patients can develop personalized prevention plans that take a comprehensive approach to improving health. Medicare beneficiaries will no longer have to pay any out-of-pocket costs for effective preventive services, including mammograms, colonoscopies, and the annual wellness visit.

- Overall, cancer death rates are higher in African American men than in white men and in African American women than in white women, despite the lower incidence rates among African American women.

- African Americans have a substantially higher cancer death rate than all other races or ethnicities.

- In 1991, the mortality rates for African Americans were 32 percent higher than for whites; in 2007, this disparity was 22 percent.

- Asian Americans/Pacific Islanders have the lowest cancer death rates, about half the rate of African Americans.
Survival Rates

Continued increases in cancer survival are expected as a result of improvements in treatment, as well as advanced methods for – and better participation in – early detection.

- The probability that a person with cancer will survive has improved considerably over time.
- This improvement largely reflects progress in diagnosing certain cancers at an earlier stage, as well as advances in treatment.

- The five-year relative survival rate for African Americans remains lower than that of whites.

- Among the four major cancer sites and melanoma, the five-year relative survival rate is highest for prostate cancer (greater than 99 percent), and lowest for lung cancer (16 percent).
- Most of the leading cancer sites have experienced significant increases in patient survival.
- Approximately 11.7 million Americans with a history of cancer were alive in January 2007, according to the NCI. Some of these individuals were cancer-free, while others still had evidence of cancer and may have been undergoing treatment.

The overall number of persons in the United States living after a cancer diagnosis is expected to increase greatly over the next decade due to the aging and growth of the population, as well as improvements in survival. Research shows that uninsured patients are more likely to be treated for cancer at late stages of disease, and they’re more likely to receive substandard care.
Leading Causes of Death and Life Years Lost

- Cancer, the second leading cause of death, was responsible for approximately 19 percent of all deaths in 1975 and 23 percent of all deaths in 2007.

- Modifiable behavioral risk factors are leading causes of mortality in the United States. Quantifying these provides insight into the effect of recent trends and the implications of missed prevention opportunities.

- The most prominent contributors to all causes of death in 2000 were tobacco (18 percent), poor diet and physical inactivity (17 percent), and alcohol use (4 percent).

As of 2010, all 50 states, nine Pacific Island jurisdictions and one US territory (Puerto Rico), seven tribes, and the District of Columbia have published comprehensive cancer control plans. This is a substantial increase from just five states and one tribal consortium with comprehensive cancer control plans in 2000. Currently, many states, territories, and tribes are developing plan implementation budgets, seeking funding, and implementing their plans at the state and local levels.
Asian Americans have the lowest cancer incidence and death rates when compared to non-Hispanic whites, African Americans, and Hispanics in the United States. However, cancer is the leading cause of death among Asian Americans, with heart disease being first among the other racial and ethnic groups.

**Leading Causes of Death and Life Years Lost**

- Mortality rates alone give an incomplete picture of the burden deaths impose on the population. Another measure, which adds a different dimension, is the years of life lost due to premature death.
- Of the major causes of death, cancer has the most significant impact on person-years of life lost.

- It is estimated that more person-years of life are lost due to lung and bronchus cancer than cancers of the breast, colorectum and prostate, and melanoma combined.

- The estimated average number of years of life lost per person for all cancers combined is more than 15 years.
The leadership roles and focus areas identify the Society’s chosen areas of interest in support of the 2015 goals and nationwide objectives. They define our optimal role in the fight against cancer and where we believe we can have the greatest degree of impact, and are based on our unique capabilities.

• Information
• Quality of Life
• Research
• Prevention and Detection
  - Colorectal Cancer
  - Lung Cancer
  - Breast Cancer
  - Nutrition and Physical Activity
The leadership roles commit the American Cancer Society to a broad-based effort to prevent and search for cures for cancer, to advocate effectively at all levels of government for policies that will help advance the fight against cancer, and to work to eliminate disparities in the cancer burden.

**Leadership Roles – Information and Quality of Life**

*Society volunteers continue to offer direct assistance to local cancer patients and their families through programs such as Road To Recovery®, Look Good…Feel Better®, and Reach To Recovery®.*

**Information and Quality of Life**

**Information Leadership Role:**

Support better decisions by making available high-quality, timely, understandable information, especially to newly diagnosed cancer patients and their caregivers.

Informed decision-making is critical to cancer prevention, early detection, treatment, and improved quality of life. The American Cancer Society, through emphasis on information as a leadership role, strives to deliver accurate, unbiased information in a timely fashion and in a form that is easily accessed and understood. This is a fundamental service of the American Cancer Society.

**Quality of Life Leadership Role:**

Improve quality of life of cancer patients, caregivers, and survivors by assisting primarily with service referral, community mobilization, collaboration, advocacy, and where appropriate, directly providing services.

The tremendous growth in the number of cancer survivors expected by 2015 underscores the need to improve quality of life for all survivors throughout the survival continuum. Attending to the lifelong needs of cancer survivors and their loved ones has been a central focus of the American Cancer Society for many years, and its designation as a leadership role ensures that it will remain so.

*Thanks to American Cancer Society volunteers, cancer patients receive thousands of free rides to treatment every year.*
The American Cancer Society Patient Navigator Program helps patients, families, and caregivers during their cancer experience by placing trained Society navigators in strategically selected cancer treatment and care facilities to provide personalized guidance, information, resource referral, and emotional support. The Society’s Patient Navigator Program is located in 130 hospitals across the country and served more than 68,000 constituents in 2009.

- Preliminary data shows that the American Cancer Society served approximately 557,300 unique constituents with patient-related information and patient programs in fiscal year 2010, a slight increase from 2009.
- The number of newly diagnosed constituents and uninsured or Medicaid constituents increased by 18,000 (up 6 percent) and 5,000 (up 7 percent), respectively.
- This reflects continued improvements in outreach and in data capture for diagnosis date and insurance status.

- All channels, except the National Cancer Information Center (NCIC), increased or remained stable from 2009 to 2010 estimates.
- The NCIC channel decreased by 2 percent; the Patient Service Center channel and the local office channel remained stable from 2009 to 2010; the in-hospital navigator channel increased by 23 percent; and the Other Channels increased by 32 percent.
- Growth in Other Channels was driven by innovations such as the Clinician Portal, fax referral service, and Volunteer Resource Centers.

The Society continues to develop and publish low-literacy documents in a variety of languages that address prevention, early detection, treatment, and survivorship issues.

- Dashboard metrics. *Includes referrals to American Cancer Society and community patient programs. †Preliminary data.
The Personal Health Manager (PHM) is designed to help newly diagnosed cancer patients and their caregivers organize diagnosis and treatment information. Available in 10 languages, the PHM can be personalized to the needs of individual patients. More than 140,000 Personal Health Managers have been provided to patients and their caregivers.

- Unique views of cancer information on cancer.org increased by approximately 1.2 million in 2009, approaching 18 million unique views.
- There were more than 1.6 million unique visitors to the Society's Cancer Survivors Network in fiscal year 2010, an increase of 346 percent over the past fiscal year. There were more than 2.6 million visits in fiscal year 2010, and there are currently 120,000 registered members from 218 countries and territories.

The Health Insurance Assistance Service expanded to 50 states and the District of Columbia in 2010, up from 42 states in 2009, 36 states in 2008, 30 states in 2007, 26 states in 2006, and 10 states in 2005, and has answered calls from more than 29,000 constituents.
The Call Back Initiative is part of the Society’s strategy to strengthen its relationship with key audiences, especially newly diagnosed patients, by monitoring the consistency and quality of service provided and to generate demand by offering additional services.

Average satisfaction scores for constituents completing each type of Call Back survey were strong and consistent across strategies.

In 2009, the Society provided transportation services to approximately 57,000 constituents who received hundreds of thousands of rides. More than 13,000 volunteer drivers provided both support and rides to treatment for constituents through our Road To Recovery program.

In 2010, the Society launched its newly redesigned cancer.org Web site. With more sophisticated and relevant search features, more user-friendly navigation, and an updated design, the new site offers an improved experience for anyone looking for information, help, or ways to fight back against cancer.

In 2009, the Society provided transportation services to approximately 57,000 constituents who received hundreds of thousands of rides. More than 13,000 volunteer drivers provided both support and rides to treatment for constituents through our Road To Recovery program.

**Leadership Roles – Information and Quality of Life**

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The Society continues to publish the most current cancer statistics and trend information in a variety of Cancer Facts & Figures publications. These publications are the most widely cited source for cancer statistics.
Since opening in January 1997, the National Cancer Information Center (NCIC) has handled approximately 13.5 million calls, about 850,000 calls a year. NCIC services are now available in 170 languages through a translation service.

- The number of constituents who could not be provided with a referral to an American Cancer Society or community patient program at the time of their initial request has remained stable over the past three years at approximately 22,000 or 4.4 percent to 4.6 percent of total requests.

- Most constituents with requests that were initially unmet were eventually served. Approximately 2.3 percent of constituents in 2009 requesting a service had needs that were never met by the Society or by referral to a community organization.

- The 2010 estimates again reflect a significant increase in original requests for service, as well as improved documentation of unmet needs.
The Patient Protection and Affordable Care Act

Forty-six million people in America are uninsured. Another 25 million are underinsured – they have insurance, but their coverage is inadequate. Insured or not, millions of people don’t have access to cancer prevention, early detection, and evidence-based treatment and care options that give them a fighting chance against this disease.

For decades, our nation’s health care system has failed to meet the needs of people with cancer, many of whom are denied coverage, offered inadequate policies that do not cover pre-existing conditions, or charged far more than they can afford for the care they need. However, in March 2010, President Obama signed health care legislation into law that includes several provisions that will meaningfully improve the health care system for cancer patients and their families.

The Patient Protection and Affordable Care Act (Affordable Care Act) meets ACS CAN’s priorities for meaningful health care reform in the following ways:

- Increases the emphasis on disease prevention, such as eliminating out-of-pocket costs for lifesaving cancer screenings
- Guarantees access to quality, affordable health care, regardless of whether a person has a pre-existing health condition
- Emphasizes a patient’s quality of life, such as by ensuring access to treatment for pain

Passage of the Affordable Care Act is only the beginning of the Society and ACS CAN’s efforts to ensure that all Americans have access to quality health care. Many provisions in the new law will not take effect until 2014, and many provisions need to be strengthened. ACS CAN and the Society will continue to work at the federal, state, and local levels to ensure that the new law provides an improved health care structure that is as strong as possible for people with cancer and their families.

Access to Care

Health Care Coverage

2015 Objective:

Proportion of individuals without any type of health insurance will decrease to zero percent.

- In 2008, the percentage of persons in the United States between the ages of 18 and 64 who reported being uninsured was 19.91 percent. This was a small increase from 19.64 percent in 2007.
- Continued and sustained declines will require coordinated efforts across the public, private, and nonprofit sectors.

Source: National Health Interview Survey – Item measuring health care coverage for citizens 18-64 years old
Out-of-pocket Costs
2015 Objective:

Proportion of individuals diagnosed with cancer who report difficulties obtaining medical care due to high out-of-pocket costs will decrease to 2 percent.

- In 2008, the percentage of persons in the United States who reported problems with out-of-pocket health care costs increased to 8.91 percent from 7.23 percent in 2007.

- A new ACS CAN poll of families affected by cancer shows that cancer patients, survivors, and their families continue to struggle to afford health care and pay for other basic needs such as food and heat in a troubled economy. The poll finds that nearly half of cancer patients and survivors under age 65 have had difficulty paying health care costs such as health insurance premiums, co-pays, and prescription drugs in the past two years. One-third of those currently in active treatment have had to delay some type of health care in the past year.

In fiscal year 2010, more than 55,000 cancer patients and their caregivers stayed 225,000 nights in the 30 American Cancer Society Hope Lodge® facilities, saving those guests more than $20 million in lodging expenses. Two new Hope Lodge facilities – in Lubbock, Texas, and Memphis, Tennessee – will open in 2010, and in Rochester, New York, a new facility replacing an existing lodge will begin serving guests, bringing the total number of Hope Lodge rooms to 930, a 10 percent increase from fiscal year 2009. In addition to guests served through Hope Lodge, 4,283 patients were provided hotel lodging, removing financial and logistical barriers and allowing patients to choose the best care available, even if it meant traveling far from home for treatment.
Completion of Recommended Treatment

2015 Objective:

*Establish and implement a process for measuring the completion of recommended treatment based on established guidelines, including participation in clinical trials.*

- At the present time, there are no national cancer surveillance systems that include both subjective outcomes collected directly from cancer survivors and verified clinical data regarding cancer diagnosis, treatment, and disease status.
- Staff is currently working on various plans for measuring completion of recommended treatment.

Quality of Life

Pain Control

2015 Objective:

*All 50 states and the District of Columbia will receive a grade of B or higher on the Pain Policy Report Card, and at least 10 states will receive an A.*

An estimated 30 percent of newly diagnosed cancer patients, 30 percent to 50 percent of patients undergoing treatment, and 70 percent to 90 percent of patients with advanced disease experience pain.

- In 2008, 33 states received a grade of B or higher on the Pain Policy Report Card, up from 32 states in 2007; only 12 states received a grade of B or higher in 2000.
- In 2008, five states (Oregon, Kansas, Michigan, Virginia, Wisconsin) received a grade of A; in 2000, no states received a score of A.
- Pain policies are becoming more balanced, even compared with 2009. Since 2007, 13 states had policy changes, and in seven of those states the change was sufficient to improve the grade. Georgia showed the largest grade improvement, increasing from a D+ to a B.
- No state's grade decreased in the past year or even since 2000, and 88 percent of states now have a grade of at least C+.
Symptom Control
2015 Objective:

*Establish and implement a process to measure the effective control of pain, other symptoms, and side effects for those affected by cancer.*

- Findings from the Society’s Studies of Cancer Survivors (SCS) and other data sources indicate that pain, fatigue, and emotional distress are among the most common symptoms and side effects reported by cancer patients and survivors. Society scientists from Behavioral Research and Surveillance and Health Policy Research are currently conducting an environmental scan of existing data sets, potential partners, and projects that could provide methods and means of monitoring symptom-related trends.

End-of-life Care
2015 Objective:

*Increase use of best practice end-of-life care.*

- Those dying of cancer may suffer unnecessarily due to lack of optimal palliative care services or futile attempts at curative treatment that do not extend life but do diminish quality of life. A number of organizations, such as the National Quality Forum, have developed and are continuing to develop indicators of quality end-of-life care (e.g., proportion of patients dying of cancer admitted to hospice, receiving acute care, or dying at home). The Society’s intramural scientists and others have implemented these indicators in a variety of datasets to describe the end-of-life care that cancer patients receive.

Nationwide Objectives Related to Leadership Roles

Quality of life is an increasingly important outcome among persons affected by cancer. However, measurement and surveillance of quality of life remain a challenging area, as a result of inadequate systems, poor consensus on measurement tools, and limited funding and national attention. Despite these challenges, the Society continues to lead the charge in exploring ways to maximize both the quantity and quality of relevant data.
Research Leadership Role:

Leverage the Society’s scientific credibility and unique position to support innovative, high-impact research – both through direct funding and the ability to influence the amount and direction of research funding from other sources.

In 2009, the Society spent $150 million on research and health professional training and has invested more than $3.5 billion in cancer research since the program began in 1946. The Society’s comprehensive research program consists of extramural grants, as well as intramural programs in epidemiology, surveillance and health policy research, behavioral research, and statistics and evaluation. Intramural programs are led by the Society’s own staff scientists.
Two additional Society-funded scientists were named Nobel laureates in 2009, bringing the organization’s total record to 44 winners of science’s top honor.

The research leadership role focuses on influencing the amount and direction of funding for cancer research, with research advocacy being one of the Society’s key strategies.

Federal funding for research increased by $639 million at the National Institutes of Health in 2009. Funding for the National Cancer Institute increased by $35 million in 2009.

Research conducted through clinical trials drives the development of innovations to improve cancer care and patient quality of life. Yet, consistently low enrollment of adults in clinical trials, particularly among racial and ethnic minority groups and low-income groups, delays our progress and contributes to ongoing disparities in health outcomes. Nearly 20 percent of adult cancer patients are eligible for participation in cancer clinical trials, but enrollment among adults consistently ranges between only 3 percent and 5 percent.

• Federal Research Budgets

<table>
<thead>
<tr>
<th>Year</th>
<th>NIH Budget</th>
<th>NCI Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>$28.93</td>
<td>$4.79</td>
</tr>
<tr>
<td>2008</td>
<td>$29.38</td>
<td>$4.83</td>
</tr>
<tr>
<td>2009</td>
<td>$30.40</td>
<td>$4.97</td>
</tr>
</tbody>
</table>

Source: American Cancer Society Cancer Action Network
The American Cancer Society continues to launch Cancer Prevention Study-3 (CPS-3), a large cohort study that will further our understanding of factors that cause or prevent cancer. The Society’s epidemiologists are recruiting volunteers for a study of lifestyle, behavioral, environmental, and genetic factors that cause or prevent cancer in partnership with American Cancer Society Relay For Life® events across the country. Approximately 70,000 volunteers have been enrolled in the study to date.

Each year, approximately 400 research applications are approved for funding; however, due to budget limitations, all of them may not get funding. The term “pay-if” refers to those applications that are funded if money becomes available. In fiscal year 2009, 46 pay-ifs were funded at $17.3 million; of those, 25 were funded with special gifts that were restricted to pay grants that would not have been funded otherwise, adding $4 million to the research operations budget, a decrease of nearly 38 percent over the previous year.

Since 1999, the Society has funded 117 studies totaling $99 million devoted to the poor and medically underserved. Thirty-five percent of this research focuses on the African American population, encompassing the cancer continuum from prevention to survivorship.
Current knowledge indicates that a majority of cancers may be prevented through widespread implementation of effective interventions. Tobacco use, physical inactivity, obesity, and poor nutrition are major preventable causes of cancer and other diseases in the United States.

Current scientific evidence indicates that the wider application of available screening and early detection techniques can significantly reduce the number of deaths from breast, cervical, and colorectal cancers. Aside from avoiding tobacco and maintaining a healthy body weight, getting recommended cancer screenings is the most important measure people can take to stay well.

- Colorectal Cancer
- Lung Cancer
- Breast Cancer
- Nutrition and Physical Activity
Colorectal cancer is the third most common cancer in both men and women and accounts for almost 9 percent of all cancer deaths.

**Trends:**
- Incidence rates continue to decline, currently at a rate of 2.6 percent annually.
- Mortality rates continue to decline, currently at a rate of 1.7 percent annually, though not statistically significant.

**Challenges:**
- Screening for colorectal cancer has increased among all populations. However, screening remains inadequate, despite its proven effectiveness.
- The disparity in mortality rates between African Americans and whites has increased substantially since the early 1980s.

**Bottom Line:**
People who follow recommended screening guidelines, maintain a healthy weight, engage in regular physical activity, and consume a healthy diet can substantially reduce their risk of developing colorectal cancer. As more people follow the Society’s prevention and early detection guidelines, colorectal cancer incidence and mortality will continue to drop.
## Progress toward the Nationwide Objectives at a Glance: Colorectal Cancer

<table>
<thead>
<tr>
<th>By 2015</th>
<th>Progress</th>
<th>2015 Trends</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Incidence:</strong> Reduce by 40%</td>
<td>Baseline 1992 to 2007: 21.9% reduction</td>
<td>🌟</td>
</tr>
<tr>
<td><strong>Mortality:</strong> Reduce by 50%</td>
<td>Baseline 1991 to 2007: 30.4% reduction</td>
<td>🎈</td>
</tr>
</tbody>
</table>
| **Early Detection:** 75% of people 50 and older have colorectal screening | 2008 Screening rate: 53.2% (NHIS: Combined FOBT or endoscopy)  
2008 Screening rate: 63.1% (BRFSS: Combined FOBT or endoscopy – Adult 50+) | 🎈 |

<table>
<thead>
<tr>
<th>By 2010</th>
<th>Progress</th>
<th>2010 Trends</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Incidence:</strong> Reduce by 30%</td>
<td>Baseline 1992 to 2007: 21.9% reduction</td>
<td>🌟</td>
</tr>
<tr>
<td><strong>Mortality:</strong> Reduce by 40%</td>
<td>Baseline 1991 to 2007: 30.4% reduction</td>
<td>🎈</td>
</tr>
</tbody>
</table>
| **Behavior Change:** 60% of people 50 and older have colorectal screening | 2008 Screening rate: 53.2% (NHIS: Combined FOBT or endoscopy)  
2008 Screening rate: 63.1% (BRFSS: Combined FOBT or endoscopy – Adult 50+) | 🌟 |

- 🌟 Likely to meet goal
- 🎈 Possible to meet goal
- 🎈 Unlikely to meet goal
- ❓ Unknown
- 🎈 Dashboard Metric
American Cancer Society researchers reported that the colorectal cancer incidence rate is increasing among young adults under the age of 50 in the United States, and this may be related to rising obesity rates as well as unfavorable dietary changes.

**Age-adjusted Incidence Rates**

**2015 Objective**

40% Reduction

**2010 Objective**

30% Reduction

- The more rapid decrease in the most recent time period (2.6 percent per year from 1998-2007) partly reflects an increase in screening, which can detect and remove colorectal polyps before they progress to cancer.

- If recent decreases continue, it is likely that we will meet our 2010 and 2015 goals.

- African Americans have a greater risk of developing colorectal cancer than any other racial or ethnic group in the United States.

- Although incidence rates are declining significantly in both African Americans and whites, rates in African Americans are 25 percent higher than those in whites.
The Society is collaborating with quality improvement organizations around the country to increase promotion and utilization of colorectal and breast cancer screening by providing resources and promising practices to address disparities in cancer prevention, screening, and treatment.

**Age-adjusted Mortality Rates**

**2015 Objective**

*50% Reduction*

**2010 Objective**

*40% Reduction*


- Recent decreases must accelerate to meet 2010 and 2015 goals.

- As with other major cancer sites, colorectal cancer mortality rates among African Americans remain consistently higher than mortality rates for other racial and ethnic groups.

- In 1991, the mortality rate for African Americans was 27 percent higher than whites; by 2007, this disparity had grown to 44 percent.
Research shows that the full range of colorectal cancer screenings can be covered for little or no additional cost to insurers, employers, or employees.

Survival Rates

- Privately insured patients diagnosed with stage II colorectal cancer are more likely to survive five years than uninsured patients diagnosed with stage I colorectal cancer.

- While survival rates for both whites and African Americans have increased in the past two decades, the disparity between these two groups has increased.

- African Americans are less likely to be diagnosed at the localized stage, and they have lower survival rates than whites at all stages of the disease.

The National Colorectal Cancer Roundtable (NCCRT), a coalition supported by the American Cancer Society and the Centers for Disease Control and Prevention, is a national coalition of public, private, and voluntary organizations, and invited individual experts dedicated to reducing the incidence of and mortality from colorectal cancer in the United States, through coordinated leadership, strategic planning, and advocacy. The roundtable works as a catalyst to stimulate key member organizations to act earlier, more effectively, and collaboratively in the area of colorectal cancer screening.

The Centers for Disease Control and Prevention (CDC) has launched the Colorectal Cancer Program (CRCCP) by providing funding to 26 states and tribes across the United States. The program supports population-based screening efforts and provides colorectal cancer screening services to low-income men and women between the ages of 50 and 64 who are underinsured or uninsured for screening, when no insurance is available. The CRCCP expands on the CDC’s Colorectal Cancer Screening Demonstration Program. The American Cancer Society is an important collaborative partner in this program.
Colorectal Cancer

People with no health insurance coverage have significant access barriers, and as a result are less likely to be up to date with colorectal cancer (CRC) screening compared to their insured counterparts. Between 2000 and 2008, there were increases in the use of CRC screening within recommended time intervals across race and ethnic groups of insured adults (aged 50 to 64 years) and modest increases in CRC screening among the uninsured; however, screening prevalence remains 50 percent to 70 percent lower among uninsured groups compared to those with health insurance. The largest increases in CRC screening utilization occurred among insured non-Hispanic African Americans.

Early Detection

2015 Objective

75% Screened

2010 Objective

60% Screened

Although utilization is improving, colorectal cancer screening prevalence continues to lag behind use of mammography and Pap testing. The following information is according to the 2008 NHIS:

Among adults 50 and older, the use of any colorectal cancer (CRC) testing within recommended time intervals (fecal occult blood test [FOBT] within the past year, a sigmoidoscopy within the past five years, or a colonoscopy within the past 10 years) increased between 2000 (38 percent) and 2008 (53.2 percent). The increase appears to be due entirely to an increase in use of endoscopy procedures for CRC testing (in 2008: 50.2%), while use of FOBT testing declined (in 2008: 10 percent).
In 2008, the prevalence of colorectal cancer screening varied by race, education, health insurance coverage, and immigration status; those without health insurance, those with less than a high school education, Hispanics, and immigrants who had been in the United States for fewer than 10 years were the least likely to have had a colorectal cancer screening test.

Providing insurance coverage of the full range of colorectal cancer screening tests has been shown to increase screening rates. Improving insurance coverage for the full range of colorectal screening tests is a high priority for the Society. This year, Hawaii passed legislation ensuring insurance coverage of colorectal cancer screening in accordance with Society guidelines. Twenty-seven states and the District of Columbia, more than half the nation, now have these coverage guarantees. In addition, a growing number of states now have programs to provide colorectal cancer screening for low-income, uninsured, and underinsured men and women.

- Based on the Behavioral Risk Factor Surveillance System (BRFSS) survey data, the state median for colorectal screening rates per the Society’s screening guidelines have increased from 53.1 percent in 2002 to 63.1 percent in 2008.
- Recent increases in colorectal cancer screening may be related to increased awareness efforts, expansions in health care coverage by states and Medicare, and the establishment of screening programs in certain states.
- There is significant need for improvement in rates among uninsured adults; this population segment is being screened at less than half the rate of the general population.
- Trend to 2010: Likely to meet objective
- Trend to 2015: Possible to meet objective

- The number of states receiving a gold, silver, or bronze rating for advocacy in support of colorectal cancer screening coverage increased from 33 in 2007 to 39 in 2009.
Lung Cancer

Leadership Role Focus Area:
Reduce tobacco use to prevent lung and other cancers.

Lung cancer is the leading cause of cancer death in both men and women, accounting for about 28 percent of all cancer deaths and 15 percent of all cancer diagnoses. Since 80 percent of lung cancer deaths are linked to tobacco use, lung cancer is one of the most preventable of all cancers.

Trends:
• Incidence and death rates continue to decline significantly in men.
• Incidence rates in women are approaching a plateau after continuously increasing for several decades, while death rates have begun to decrease.
• Advocacy efforts continue to be successful in increasing the number of smoke-free laws, increasing state excise taxes, increasing funding for prevention programs and cessation services, and fighting tobacco industry advertising and promotion efforts.

Challenges:
• Progress in reducing smoking among adults and high school students has stalled in the past few years.
• There is still a disproportionately high level of tobacco use among less educated adults.
• Average funding levels by state for comprehensive tobacco control remain at less than half the minimum levels recommended by the Centers for Disease Control and Prevention.
• Smokeless tobacco products are increasing in popularity among youth.

Bottom Line:
Stopping tobacco use, or not starting, is the single most important action people can take to reduce cancer suffering and premature death in the United States.

This year marked the one-year anniversary – or first birthday – of the Family Smoking Prevention and Tobacco Control Act. When the president signed the act into law on June 22, 2009, it granted the US Food and Drug Administration the authority to regulate the manufacturing, marketing, and sale of tobacco products. The law’s enactment was a high priority for the Society and ACS CAN, whose volunteers and staff worked for more than a decade in support of its passage.
## Progress toward the Nationwide Objectives at a Glance: Lung Cancer

<table>
<thead>
<tr>
<th>By 2015</th>
<th>Progress</th>
<th>2015 Trends</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Incidence:</strong> Reduce by 45%</td>
<td>Baseline 1992 to 2007: 12.2% reduction</td>
<td>?</td>
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<tr>
<td><strong>Mortality:</strong> Reduce by 50%</td>
<td>Baseline 1991 to 2007: 14.1% reduction</td>
<td>?</td>
</tr>
<tr>
<td>• <strong>Adult Tobacco Use:</strong> Reduce to 12%</td>
<td>2009 prevalence rate: 20.6% (NHIS)*</td>
<td>?</td>
</tr>
<tr>
<td>Adult Smokeless Tobacco Use: Reduce to 0.4%</td>
<td>2008 prevalence rate: 3.6% (SAMHSA)*</td>
<td>?</td>
</tr>
<tr>
<td>• <strong>Youth Tobacco Use:</strong> Reduce to 10%</td>
<td>2009 prevalence rate: 19.5% (YRBS)*</td>
<td>?</td>
</tr>
<tr>
<td>Youth Smokeless Tobacco Use: Reduce to 1%</td>
<td>2009 prevalence rate: 8.9% (YRBS)*</td>
<td>?</td>
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<tr>
<th>By 2010</th>
<th>Progress</th>
<th>2010 Trends</th>
</tr>
</thead>
<tbody>
<tr>
<td>• <strong>Adult Tobacco Use:</strong> Reduce to 18.5%</td>
<td>2009 prevalence rate: 20.6% (NHIS)*</td>
<td>?</td>
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<tr>
<td>• <strong>Adult Tobacco Use:</strong> Reduce to 22% for adults with less than a high school education</td>
<td>2009 prevalence rate: 28.5% (NHIS)*</td>
<td>?</td>
</tr>
<tr>
<td>• <strong>Youth Tobacco Use:</strong> Reduce to 15%</td>
<td>2009 prevalence rate: 19.5% (YRBS)*</td>
<td>?</td>
</tr>
</tbody>
</table>

 Thumbnails: 👍 Likely to meet goal; 🚫 Unlikely to meet goal; ? Unknown; ● Dashboard metric

*NHIS = National Health Interview Study. YRBS = Youth Risk Behavior Surveillance System. SAMHSA = Survey on Drug Use and Health.
In 2009, an estimated 21 percent of adults, or 46.6 million Americans, smoked cigarettes in the United States. The statistics for youth are even more troubling – 1 in 5 high school students is a smoker. Every day, an estimated 3,500 children in the United States smoke their first cigarette, and more than 1,000 children become addicted, daily smokers; as many as half of those children who continue to smoke throughout their lifetimes will eventually die prematurely from smoking-related diseases.

Smoke-free laws reduce cigarette consumption and save health care dollars. They encourage smokers to quit, increase the number of successful quit attempts, and reduce the total number of cigarettes smoked.

Age-adjusted Incidence Rates

2015 Objective
45% Reduction

- Trend to 2015: Unlikely to meet objective

In the United States, the health and productivity costs attributed to smoking are $10.28 per pack of cigarettes.
In the past 10 years, all states combined have spent just 3.2 percent of their total tobacco-generated revenue on tobacco prevention and cessation programs. From fiscal year 2000 to fiscal year 2009, the states received $203.5 billion in tobacco revenue: $79.2 billion from the tobacco settlement and $124.3 billion from tobacco taxes. During this time, the states have allocated just $6.5 billion to tobacco prevention and cessation programs.

- Among men, lung cancer incidence has been declining since the late 1980s; among women, the rates have been essentially stable since 1999 after a long period of increase. The downward trend in men is on track to meet the 45 percent reduction goal, but the trend among women is not.
- In 2007, rates were almost 1.4 times higher in men than in women.
- Lung cancer trends are largely a reflection of tobacco use trends over the preceding 20-year period.

- Incidence rates for African Americans remain consistently higher than for other racial groups; however, a steeper decline has been observed for African Americans as compared to whites in recent years, likely due to historical changes in tobacco use.
- In 2007, the lung cancer incidence rate for African Americans was approximately 15 percent higher than the rate for whites. This was down from a 36 percent difference in 1992.

Cessation services increase quit rates by 30 percent. Tobacco cessation telephone counseling can increase successful quit attempts by more than 50 percent, compared to using no cessation intervention.
Age-adjusted Mortality Rates

2015 Objective

50% Reduction

- Lung cancer is one of our biggest challenges because it represents 28 percent of all cancer deaths.
- Trend to 2015: Unlikely to meet objective

- Between 2003 and 2007, death rates for women decreased by 0.9 percent per year, after increasing for several decades.

- African Americans have a higher lung cancer death rate than any other racial or ethnic group, but the gap has narrowed.
- In 1991, the mortality rate for African American men was 41 percent higher than for white men; in 2007, the gap was 28 percent. However, in ages under 40, the black-white disparity is nearly eliminated.
We now know with certainty that consistent efforts and focused resources can make a difference in saving lives from cancer.

Grassroots advocacy efforts continue to protect millions of dollars in funds from state tobacco settlements from being diverted away from tobacco control programs.

**Survival Rates**

- Survival rates for both African Americans and whites remain low; most lung cancers are not detected at an early stage, when chances of survival are greatest.
- The five-year relative survival rate is 53 percent for cases detected in the localized stage; however, only 15 percent of lung cancers are diagnosed this early.
Tobacco Use

**Adult Prevalence Objectives**

2015 – 12% (current smokers)
2010 – 18.5% (current smokers); 22% (current smokers – low education levels)

**Youth Prevalence Objectives**

2015 – 10% (current smokers)
2010 – 15% (current smokers)

- Current cigarette use estimates represent a dramatic decline in both consumption and the prevalence of smoking in the United States since the release of the first US Surgeon General’s Report on Smoking and Health in 1964.

- According to the National Health Interview Survey (NHIS), between 1997 and 2004, the percentage of adults who smoke decreased from 27.6 percent to 18.5 percent in women. Smoking rates among all adults have remained stable at approximately 20 percent since 2004. Currently, an estimated 77.8 percent of smokers smoke cigarettes daily.

- The largest disparities in smoking prevalence are by socioeconomic status, race/ethnicity, and state of residence.

- Adults without a high school degree are almost three times as likely to be current smokers than those with a college degree.

- The prevalence of smoking among American Indian/Alaska Native adults is the highest among all racial/ethnic groups and is more than three times that of Asian American adults.
The state median for the Behavioral Risk Factor Surveillance System (BRFSS) data from 2009 shows that 18.2 percent of adults are current smokers. There remains a disproportionately high level of tobacco use among low-educated adults.

Trend to 2015: Unlikely to meet objective
Trend to 2010: Possible to meet objective

In 2009, approximately 19.5 percent of youth were current smokers, which is 45 percent lower than the peak levels in the late 1990s.

Researchers expect that smoking rates among 10th- and 12th-graders will continue to decline as the current eighth-graders, who smoke at lower rates, get older.

Trend to 2015: Unlikely to meet objective
Trend to 2010: Unlikely to meet objective

In fiscal year 2010, states will collect $25.1 billion in revenue from the tobacco settlement and tobacco taxes, but will spend just 2.3 percent of it – $567.5 million – on tobacco prevention and cessation programs. The states also receive $62 million in federal grants for tobacco prevention, for total funding of $629.5 million. In the past year, states have cut funding for tobacco prevention by $103.4 million, or 15.4 percent.

In fiscal year 2010, only North Dakota provides funding at the CDC minimum levels; only nine other states are funding at even half the recommended level; and 40 states and the District of Columbia are spending less than half the CDC’s minimum amount.

If each state maintained target funding levels for five years, there would be an estimated five million fewer smokers in the United States.
- The number of states reporting full Medicaid smoking cessation coverage increased from 12 states in 2005 to 28 states in 2009.

- In 2009, 17 states and the District of Columbia had partial coverage and six states had no coverage.

- In 2009, 23 states received a grade of "A."

- More than half of states now have an "A" or "B" grade.

- The Society and ACS CAN continue to advocate vigorously for smoke-free laws to reduce the incidence of lung cancer and other smoking-attributable diseases.

- The percentage of the population protected by smoke-free laws in bars, restaurants, or workplaces, as well as comprehensive laws covering all three areas, showed significant increases in the past several years.

- Three states passed comprehensive smoke-free laws in 2010.

- Almost half of the US population is now covered by comprehensive laws, and more than 60 percent are covered by at least one law.
Raising tobacco taxes is one of the most effective measures to stop children from starting to smoke, as well as to reduce overall tobacco consumption. A 10 percent increase in the price of a pack of cigarettes will reduce youth smoking by 7 percent and overall consumption by approximately 4 percent.

- Currently, 29 states and the District of Columbia have cigarette tax rates of $1 per pack or higher; 14 states and the District of Columbia, $2 or higher; five states, $3 or higher; and one state, New York, has a cigarette tax rate of more than $4 per pack.
- Since 2002, 47 states, the District of Columbia, and several US territories have collectively increased their cigarette tax rates more than 100 times.
- The Society and ACS CAN continue to urge Congress to substantially increase the federal tobacco tax.
Tobacco companies spend $20 to market tobacco products for every dollar states spend to fight tobacco use. In all, the companies spend $12.8 billion a year on marketing.

### Tobacco Use

#### Adult Prevalence Objectives

2015 – 0.4% (Smokeless)

- Smokeless tobacco use among adults in the United States has remained essentially flat for more than a decade.
- Trend to 2015: Unlikely to meet objective

#### Youth Prevalence Objectives

2015 – 1% (Smokeless)

- While there is progress compared to the mid-1990s, smokeless tobacco use among youth was essentially flat between 1999 and 2007, and has risen to 8.9 percent in 2009.
- Trend to 2015: Unlikely to meet objective

---

Enhancing the availability of tobacco cessation treatment by encouraging better insurance coverage, strong community-based interventions, and adequate funding for cessation programs will curb tobacco-related deaths and disease, especially among low-income populations that need it most.
Breast cancer affects more women in the United States than any other cancer except skin cancer. Of cancer deaths, only lung cancer kills more women than breast cancer.

**Trends:**
- Incidence rates have been declining since 1999, after continuously increasing for two decades.
- Mortality rates continue to decrease more than 2 percent per year.
- Mammography screening rates have been essentially flat since 2000.

**Challenges:**
- A substantial number of women are still not getting recommended mammograms.
- Overweight and obesity rates are not improving.
- Disparities in the breast cancer burden continue to exist.

**Bottom Line:**
The greatest opportunity to save lives from breast cancer continues to be timely, high-quality mammography screening for all eligible women. Breast cancer is much more successfully treated if detected early.
## Progress toward the Nationwide Objectives at a Glance: Breast Cancer

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2015 Progress</th>
<th>2015 Trends</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Incidence:</strong></td>
<td>Baseline 1992 to 2007: 4.4% reduction</td>
<td>👍</td>
</tr>
<tr>
<td><strong>Mortality:</strong></td>
<td>Baseline 1991 to 2007: 30.3% reduction</td>
<td>🚫</td>
</tr>
<tr>
<td><strong>Early Detection:</strong></td>
<td>2008 screening rate: 53.0% (NHIS: Mammography within the past year)</td>
<td>🚫</td>
</tr>
<tr>
<td></td>
<td>2008 screening rate: 62.1% (BRFSS: Mammography within the past year)</td>
<td></td>
</tr>
</tbody>
</table>

**Dashboard metric:**

- 👍 Likely to meet goal
- 🚫 Unlikely to meet goal
- 🚪 Possible to meet goal
- 🟢 Unknown
- • Dashboard metric
The American Cancer Society believes that by partnering with community-based organizations, worksites, and health care systems, Society volunteers and staff can bring accurate, innovative, and compassionate answers and support to the people we serve.

Age-adjusted Incidence Rates

2015 Objective

15% Reduction

• After continuously increasing for more than two decades, the latest jointpoint trend (1998-2007) indicates a 1.6 percent decrease per year.

• The recent decline may be due to the combined effects of decreased mammography screening rates and the sudden decline in the use of hormone therapy following the publication of results from the Women’s Health Initiative, which linked combined estrogen and progestin hormone therapy to increased risk of breast cancer.

• If the trend continues, we would exceed the 2015 goal of a 15 percent decrease.

• Although breast cancer incidence rates are lower among African Americans compared to whites, African American women have significantly higher mortality rates.
Age-adjusted Mortality Rates

2015 Objective
50% Reduction

- Breast cancer death rates decreased 30.3 percent from 1991-2007. The decline can largely be attributed to earlier detection and more effective treatment.
- The current decline is 2.2 percent per year; if this trend continues, we will nearly meet the 2015 goal.

- African American women have substantially higher death rates, compared to other racial and ethnic groups.
- In 1991, African American mortality rates were 18 percent higher than rates for whites; in 2007, they were 41 percent higher.
Survival Rates

Breast cancer is the leading cause of cancer deaths among Hispanic women and the second leading cause of death among all other groups.

The Society’s Circle Of LifeSM – an initiative aimed at providing cancer education and resources to American Indian and Alaska Native communities – launched field tests in more than 10 tribal communities in May 2010. Results from those field tests will be used to refine resources so the program can be disseminated nationwide. The initiative has led to new partnerships with the Indian Health Service Community Health Representative program and other nationwide organizations serving native communities.

- Survival rates among both African American women and white women significantly increased from 1975-2006; nonetheless there remains a substantial gap between the two groups.
- The absolute difference in the survival rate between whites and African Americans from 1975-1977 to 1999-2006 has changed very little.

The American Cancer Society’s Reach To Recovery program continues to play a pivotal role in helping women through the breast cancer journey and is just one part of the community of support offered by the Society.

![Survival Rates Chart]

*Five-year relative survival rates

In 2010, the American Cancer Society launched Choose You™ – a national movement that encourages women to put their own health first and make healthy lifestyle choices to stay well and help prevent cancer. The campaign challenges women to make healthier choices and supports them in their commitment to eat right, get active, quit smoking, and get regular cancer screening tests. As part of this program, individuals can sign up for a Choose You Commitment. This online resource provides tools and support to enable women to commit to and achieve their personal health and wellness goals.
Breast Cancer

Early Detection

2015 Objective
Screening Rates at 90%

National breast cancer screening data is available from the National Health Interview Survey (NHIS) that measures screening within the past year and past two years. The NHIS has tracked trends in mammography since 1987.

- The percentage of women 40 and older who reported having a mammogram within the past two years increased from 29 percent in 1987 to 70 percent in 2000. Since then, trends in mammography utilization by race and ethnicity stabilized through 2008 (overall 67.1 percent).

- White women 40 and older were more likely to report a mammogram in the past two years (68 percent) than any other racial/ethnic group. Screening rates were 55.3 percent in American Indian/Alaska Native women, 67.7 percent in African American women, 61.5 percent in Hispanic women, and 65.1 percent in Asian women.

- The lowest prevalence of mammography use in the past two years occurred among women who lack health insurance (35.6 percent), followed by immigrant women who have lived in the United States for fewer than 10 years (49.7 percent).

- Only 53 percent of women 40 and older reported having a mammogram within the past year. The Society recommends annual mammograms for women starting at age 40.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>% Mammogram within the past year*</th>
<th>% Mammogram within the past 2 years*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40-49</td>
<td>47.3</td>
<td>61.5</td>
</tr>
<tr>
<td>50-64</td>
<td>58.6</td>
<td>74.2</td>
</tr>
<tr>
<td>65+</td>
<td>53.2</td>
<td>65.4</td>
</tr>
<tr>
<td>Race/ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White (non-Hispanic)</td>
<td>54.2</td>
<td>68.0</td>
</tr>
<tr>
<td>African American (non-Hispanic)</td>
<td>52.2</td>
<td>67.7</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>46.8</td>
<td>61.5</td>
</tr>
<tr>
<td>American Indian and Alaska Native†</td>
<td>42.2</td>
<td>55.3</td>
</tr>
<tr>
<td>Asian American‡</td>
<td>52.2</td>
<td>65.1</td>
</tr>
<tr>
<td>Education (years)</td>
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</tr>
<tr>
<td>11 or fewer</td>
<td>40.1</td>
<td>53.9</td>
</tr>
<tr>
<td>12</td>
<td>49.2</td>
<td>64.3</td>
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<tr>
<td>13-15</td>
<td>55.2</td>
<td>69.1</td>
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<tr>
<td>16 or more</td>
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<td>77.9</td>
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<td>Health insurance coverage</td>
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<td></td>
</tr>
<tr>
<td>Yes</td>
<td>56.2</td>
<td>70.5</td>
</tr>
<tr>
<td>No</td>
<td>26.0</td>
<td>35.6</td>
</tr>
<tr>
<td>Immigration§</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Born in US</td>
<td>53.5</td>
<td>67.6</td>
</tr>
<tr>
<td>Born in US territory</td>
<td>49.6</td>
<td>63.6</td>
</tr>
<tr>
<td>In US fewer than 10 years</td>
<td>39.6</td>
<td>49.7</td>
</tr>
<tr>
<td>In US 10+ years</td>
<td>51.8</td>
<td>65.8</td>
</tr>
<tr>
<td>Total</td>
<td>53.0</td>
<td>67.1</td>
</tr>
</tbody>
</table>

*Percentages are age-adjusted to the 2000 US standard population. †Estimates should be interpreted with caution because of the small sample sizes. ‡Does not include Native Hawaiians and other Pacific Islanders. §Definition has changed such that individuals born in the US or in a US territory are reported separately from individuals born outside the US. Individuals born in a US territory have been in the US for any length of time.

American Cancer Society, Surveillance and Health Policy Research
Breast Cancer

In August 2010, the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) celebrated its 20th anniversary. The 20-year partnership between the American Cancer Society and the NBCCEDP has led to more than 3.7 million women being screened for breast and cervical cancer. Going forward, the Society will continue to work with the NBCCEDP to advocate for increases in program funding and provide outreach to ensure that women with inadequate health care coverage or none at all get the screening and treatment offered through the NBCCEDP.

- The BRFSS state median mammography rates have remained stable at around 60 percent over the past eight years.
- There is a screening disparity between women who have health insurance and those who don’t. Uninsured women have substantially lower rates of mammography use than women with insurance.
- Trend to 2015: Unlikely to meet objective

- CDC funding for the NBCCEDP in states, tribes, and territories declined slightly, by approximately $1 million, to $157 million in 2009. The total amount of funding by states grew $4 million to $139 million.
- Eighteen states funded the program at more than 50 percent of the CDC minimum in 2009.
- Three states contributed and achieved state funding for the first time.

Dashboard metrics.
Adult Rates and Trends:

- Adult obesity rates continued to rise in 28 states this past year. Thirty-eight states now have adult obesity rates above 25 percent; eight of these have rates above 30 percent. In 1991, no state had an obesity rate above 20 percent, and in 1980, the national average of obese adults was 15 percent.

- Adult obesity rates for African Americans and Latinos are higher than those for whites in nearly every state. Adult obesity rates for African Americans are greater than or equal to 30 percent in 43 states and the District of Columbia; in nine states, the rates exceed 40 percent. Adult obesity rates for Latinos are greater than or equal to 30 percent in 19 states.

Youth Rates and Trends:

- From 1999-2009, the prevalence of obesity among students nationwide increased from 10.7 percent to 12 percent; the prevalence of overweight students increased from 14.4 percent to 15.8 percent. It is projected that today’s generation of youth may be the first generation to live shorter, less healthy lives than their parents.

- Among African American youth, 21.0 percent are overweight, including 15.1 percent who are obese. Among Hispanic youth, 19.6 percent are overweight, including 15.1 percent who are obese. Among white youth, 13.6 percent are overweight, including 10.3 percent who are obese.

Challenges:

- It is difficult to combat perceptions that eating and exercise behaviors are only “individual” concerns and that environments in which we live, work, play, and go to school do not affect individual behavior.

- Many issues impact nutrition and physical activity behaviors: changes in the food supply, including increased portion sizes; marketing and advertising of “unhealthy” foods, particularly to kids; schools and worksites that are not conducive to good health; community design that hinders physical activity; economic constraints; family and home influences; and time constraints. Turning the obesity epidemic around will require comprehensive, coordinated, and sustained efforts by many players.

Bottom Line:

The obesity epidemic threatens to jeopardize the incidence and mortality decreases seen for many cancers since the early 1990s. Experience in tobacco control has taught us that policy and environmental changes are highly effective in deterring tobacco use. To avert an epidemic of obesity-related disease, similar purposeful changes in public policy and in the community environment will be required to help individuals maintain a healthy body weight and remain physically active throughout life.
### Progress toward the Nationwide Objectives at a Glance: Nutrition and Physical Activity

<table>
<thead>
<tr>
<th>By 2015</th>
<th>Progress</th>
<th>2015 Trends</th>
</tr>
</thead>
</table>
| **Overweight/Obesity:** Trends reversed and prevalence no higher than in 2005 | 2009 adult rate: 63.7/27.4% (BRFSS)  
2009 youth rate: 27.8/12.0% (YRBS) | 🚫         |
| **Nutrition:** 75% of population follows guidelines for fruit and vegetable consumption | 2009 adult rate: 23.8% (BRFSS)  
2009 youth rate: 22.3% (YRBS) | 🚫         |
| **Physical Activity:** 70% of population follows guidelines             | 2009 adult rate: 49.5% (BRFSS)  
2009 youth rate: 37.0% (YRBS) | 🚫         |

<table>
<thead>
<tr>
<th>By 2010</th>
<th>Progress</th>
<th>2010 Trends</th>
</tr>
</thead>
</table>
| **Overweight/Obesity:** Increasing trends stopped                      | 2009 adult rate: 63.7/27.4% (BRFSS)  
2009 youth rate: 27.8/12.0% (YRBS) | 🚫         |
| **Nutrition:** 45% of population follows guidelines for fruit and vegetable consumption | 2009 adult rate: 23.8% (BRFSS)  
2009 youth rate: 22.3% (YRBS) | 🚫         |
| **Physical Activity:** 60% of population follows guidelines             | 2009 adult rate: 49.5% (BRFSS)  
2009 youth rate: 37.0% (YRBS) | 🚫         |

- 👍  Likely to meet goal
- 🏃  Possible to meet goal
- 👎  Unlikely to meet goal
- ❓  Unknown
- ⚫  Dashboard metric
Overweight and Obesity

2015 Adult and Youth Objective
Reverse trend of increasing prevalence.

2010 Adult and Youth Objective
Stop increasing trends.

Adults
An estimated 34.2 percent of US adults 20 and older are overweight, 33.8 percent are obese, and 5.7 percent are extremely obese.

Between 1988-1994 and 2007-2008, the prevalence of obesity among women increased:

- From 22.9 percent to 33.0 percent among white women; from 38.2 percent to 49.6 percent among African American women; from 35.3 percent to 45.1 percent among Hispanic women

Between 1988-1994 and 2007-2008, the prevalence of obesity among men increased:

- From 20.3 percent to 31.9 percent among white men; from 21.1 percent to 37.3 percent among African American men; from 23.9 percent to 35.9 percent among Hispanic men

Youth
An estimated 16.9 percent of children and adolescents between the ages of 2 and 19 are obese.

Between 1988-1994 and 2007-2008, the prevalence of obesity among female youth increased:

- From 8.9 percent to 14.5 percent among white girls; from 16.3 percent to 29.2 percent among African American girls; from 13.4 percent to 17.4 percent among Hispanic girls

Between 1988-1994 and 2007-2008, the prevalence of obesity among male youth increased:

- From 11.6 percent to 16.7 percent among white boys; from 10.7 percent to 19.8 percent among African American boys; from 14.1 percent to 26.8 percent among Hispanic boys.
Nutrition and Physical Activity

Access to supermarkets increases access to healthy foods and has been associated with more healthful diets, greater consumption of fruits and vegetables, and lower rates of obesity.

Nutrition

**2015 Adult and Youth Objective**
*75% consume five or more servings of fruits and vegetables daily.*

**2010 Adult and Youth Objective**
*45% consume five or more fruits and vegetables daily.*

- In 2009, fewer than 1 in 4 adults (23.8 percent) reported eating fruits and vegetables five or more times a day; this percentage has remained essentially the same for more than a decade.
- Trend to 2010 and 2015: Unlikely to meet objectives

The 2009 Youth Risk Behavior Survey (YRBS) showed that only 22.3 percent of US high school students ate fruits and vegetables five or more times per day; again, like adults, this percentage has remained essentially unchanged for years.
- Trend to 2010 and 2015: Unlikely to meet objectives

Communities with a large proportion of ethnic minority residents tend to have fewer supermarkets that carry healthy, affordable, and high-quality foods.

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**Fruits and Vegetables* – Adults**

<table>
<thead>
<tr>
<th>Year</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994 BRFSS</td>
<td>22%</td>
</tr>
<tr>
<td>2003 BRFSS</td>
<td>23.6%</td>
</tr>
<tr>
<td>2007 BRFSS</td>
<td>24.4%</td>
</tr>
<tr>
<td>2009 BRFSS</td>
<td>23.8%</td>
</tr>
<tr>
<td>2010 Goal</td>
<td>45%</td>
</tr>
<tr>
<td>2015 Goal</td>
<td>75%</td>
</tr>
</tbody>
</table>

**Fruits and Vegetables* – Youth**

<table>
<thead>
<tr>
<th>Year</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001 YRBS</td>
<td>21.4%</td>
</tr>
<tr>
<td>2003 YRBS</td>
<td>22%</td>
</tr>
<tr>
<td>2007 YRBS</td>
<td>21.4%</td>
</tr>
<tr>
<td>2009 YRBS</td>
<td>22.3%</td>
</tr>
<tr>
<td>2010 Goal</td>
<td>45%</td>
</tr>
<tr>
<td>2015 Goal</td>
<td>75%</td>
</tr>
</tbody>
</table>

*Consume fruits and vegetables five or more times daily

---

* CDC, BRFSS

---

* CDC, YRBS

---

* "Consumes fruit or vegetable five or more times daily.*
Nutrition and Physical Activity

Federal Developments

The Patient Protection and Affordable Care Act of 2010
This act has the potential to address the obesity epidemic through a number of prevention and wellness provisions, including but not limited to:

- Nutrition Labeling of Standard Menu Items at Chain Restaurants with 20 or more locations, requiring calories on menus and menu boards, including drive-throughs, and food item tags; vending machine operators with 20 or more machines must also disclose the number of calories in each food item.

- Coverage of Preventive Health Services, including obesity screening and counseling

- The Prevention and Public Health Fund, supporting programs authorized by the Public Health Services Act for prevention, wellness, and public health activities

2010 Child Nutrition Reauthorization
Provisions in this bill would provide resources and training to improve the nutritional quality of school lunches, expand nutrition education for children, and strengthen school nutrition and physical activity wellness policies. It would also require the USDA to set science-based nutrition standards for foods sold outside the school meal program.

The American Recovery and Reinvestment Act (ARRA) of 2009
This act funded the Communities Putting Prevention to Work initiative, which is designed to establish policies and promote changes in systems and environments to support healthier diets, improvements in physical activity, and tobacco-free living.

State Legislative Trends
Twenty states and the District of Columbia have set nutrition standards for school lunches, breakfasts, and snacks that are stricter than existing USDA requirements. Six years ago, only four states had legislation that set nutrition standards that were stricter than existing USDA requirements.

Twenty-eight states and the District of Columbia have nutrition standards for competitive foods sold in schools on à la carte lines, in vending machines, in school stores, or through school bake sales. Five years ago, only six states had nutrition standards for competitive foods.

Every state has some form of physical education requirement for schools, but these requirements are often limited, not enforced, or do not meet adequate quality standards.

Thirteen states have passed Complete Streets legislation, which aims to ensure that all users – pedestrians, bicyclists, motorists, and transit riders of all ages and abilities – have safe access to a community’s streets.

Purposeful changes in public policy and the community environment in which individuals live, work, play, and go to school will be necessary to support them in living healthier lives.
Physical activity indirectly reduces the risk of developing the many types of obesity-related cancers because of its role in helping to maintain a healthy weight. Additionally, it improves the quality of life of cancer patients and is associated with a reduction in the risk of breast cancer recurrence, breast cancer-specific mortality, and all-cause mortality.

Physical Activity

2015 Adult and Youth Objective
70% follow guidelines

2010 Adult and Youth Objective
60% follow guidelines

- Based on the 2009 Behavioral Risk Factor Surveillance System (BRFSS), 49.5 percent of adults met moderate physical activity recommendations, a slight increase from 2007.
- The state median for vigorous physical activity is 29.4 percent.
- Trend to 2015: Possible to meet objective
- Trend to 2010: Possible to meet objective

- The 2009 YRBS data showed moderate physical activity is 37.0 percent, an increase from 34.7 percent in 2007.
- Trend to 2015: Possible to meet objective
- Trend to 2010: Possible to meet objective
The American Cancer Society cannot achieve the 2015 challenge goals and nationwide objectives entirely on its own. Instead, we must collaborate with others in productive ways. Even though the nationwide prioritization process, which resulted in our leadership roles and focus areas, did not establish specific programs of work for each site and/or risk factor, the Society still has a responsibility to be a catalyst, primarily through collaboration, to ensure that the resources of our cancer control partners address any gaps.

- Prostate Cancer
- Skin Cancer
- Comprehensive School Health Education

Collaborative Roles
Prostate Cancer

Prostate cancer is the most frequently diagnosed cancer in American men and the second most common cancer death.

**Trends:**
- The long-term incidence trend is difficult to interpret because it is substantially influenced by changes in prostate-specific antigen (PSA) testing. The mortality trend shows a 2.6 percent annual reduction for 2005-2007.

**Challenges:**
- For reasons that remain unclear, prostate cancer incidence rates are significantly higher in African American men than in white men.
- Mortality rates in African American men remain more than twice as high as those of white men.
- There is presently no sufficient data to recommend for or against routine prostate cancer testing.

**Bottom Line:**
The only well-established risk factors for prostate cancer are age, race/ethnicity, and family history of the disease. Early detection may increase survival and treatment options. High-risk men (African Americans or men with a strong family history) should discuss the potential benefits and limitations of prostate cancer early detection testing with a health care provider beginning at age 45. Average-risk men should have this discussion with a health professional beginning at age 50.
## Progress toward the Nationwide Objectives at a Glance: Prostate Cancer

<table>
<thead>
<tr>
<th>By 2015</th>
<th>Progress</th>
<th>2015 Trends</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Incidence:</strong> Reduce by 15%</td>
<td>Baseline 1992 to 2007: 28.0% reduction</td>
<td>?</td>
</tr>
<tr>
<td><strong>Mortality:</strong> Reduce by 50%</td>
<td>Baseline 1991 to 2007: 40.0% reduction</td>
<td>💪</td>
</tr>
<tr>
<td><strong>Early Detection:</strong> 90% follow detection guidelines</td>
<td>No surveillance system measures whether men have been offered PSA</td>
<td>?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>By 2010</th>
<th>Progress</th>
<th>2010 Trends</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mortality:</strong> Reduce by 40%</td>
<td>Baseline to 2007: 40.0%</td>
<td>💪</td>
</tr>
</tbody>
</table>

*Likely to meet goal  -  Possible to meet goal  -  Unlikely to meet goal  -  Unknown  -  Dashboard metric*
Prostate Cancer

Our diverse volunteer base increases our understanding of the entire community and enables us to better reach and serve all people.

Age-adjusted Incidence Rates

2015 Objective

15% Reduction

- Prostate cancer incidence has been extremely variable in the past 20 years, largely due to the widespread adoption of PSA screening.
- So little is known about exactly what causes prostate cancer that it is difficult to provide recommendations for prevention of the disease. The only well-established risk factors for prostate cancer are age, ethnicity, and family history of the disease.
- The long-term trend is unknown.

- African American men have one of the highest documented prostate cancer incidence rates in the world.
- In 2007, the incidence rate for African American men was 54 percent higher than the incidence rate for white men; the reasons for this substantial gap remain unclear.

Prostate cancer accounts for approximately 37 percent of all cancers diagnosed in African American men.
The large disparity in prostate cancer mortality rates between African American men and white men accounts for about 40 percent of the overall cancer mortality disparity between African American men and white men.

Age-adjusted Mortality Rates

2015 Objective
50% Reduction

2010 Objective
40% Reduction

- The latest joinpoint trend (2005-2007) shows a 2.6 percent annual decrease; if this trend continues, we will exceed the 2015 goal.
- The reasons for this trend are uncertain, but in part reflect improved treatment.
- Results from two recent screening trials suggest little or no mortality benefit and substantial overdiagnoses as a result of PSA screening.

- Although death rates have been declining among white men and African American men since the early 1990s, rates in African American men remain more than twice as high as those in white men.
Survival Rates

- The five-year relative survival rate is more than 99 percent for white men and 97 percent for African American men.
- More than 90 percent of all prostate cancers are discovered in the local and regional stage; the five-year relative survival rate for patients whose tumors are diagnosed at these stages approaches 100 percent.
- The dramatic improvements in survival are partly attributable to earlier diagnosis and improvements in treatment.

Early Detection

2015 Objective

90% follow guidelines.

- There is no surveillance system that measures whether men have discussed the potential benefits and limitations of prostate early detection testing, which is what the Society’s guidelines recommend. There is presently not sufficient data to recommend for or against routine prostate cancer testing.
- PSA screening rates have remained essentially flat over the past five years at just above 50 percent.
- However, screening rates among men without insurance are almost half those of men with insurance.
More than two million cases of skin cancer are diagnosed each year. Most are basal and squamous cell skin cancers, which are highly curable if detected early.

However, about 68,130 skin cancer cases in 2010 will be malignant melanoma – the most serious skin cancer. While melanoma is also highly curable if detected early (the five-year relative survival rate for local-stage disease is 98 percent), it will cause an estimated 8,700 deaths in 2010. Melanoma affects mostly whites, who are 10 times more likely to develop the disease than African Americans.

**Trends:**
- Melanoma incidence rates have been increasing for at least 30 years. In the most recent time period, rapid increases have occurred among young white women and white adults 65 and older.
- The death rate for melanoma has been decreasing in white men and women younger than 50; in contrast, in whites 50 and older, death rates have been increasing by 1.0 percent per year in men since 1990 and have been stable in women since 1989.

**Challenges:**
- Adults and adolescents do not regularly protect themselves from ultraviolet (UV) exposure when outside on sunny days.

**Bottom Line:**
The majority of skin cancers are caused by excessive exposure to UV rays. Reducing sun exposure, wearing protective clothing, and properly using adequate sunscreen are the best ways to reduce skin cancer risk. This is especially true for children, as childhood sunburns can increase the risk of skin cancer later in life.

Overall, there has been rather limited progress in improving sun protection practices and reducing sunburns among US youth between 1998 and today, despite widespread sun protection campaigns.
Progress toward the Nationwide Objectives at a Glance: Skin Cancer

<table>
<thead>
<tr>
<th>By 2015</th>
<th>Progress</th>
<th>2015 Trends</th>
</tr>
</thead>
</table>
| **Behavior Change**: 75% of people use at least two protective measures | **Adult 2008 NHIS**: 11.6% to 32.6%  
**Youth 2009 YRBS**: 9.3% to 17.4% | 🚫 |

👍 Likely to meet goal  🚹 Possible to meet goal  🚫 Unlikely to meet goal  🎉 Unknown  ⚫ Dashboard metric
Skin Protection – Behavior Change

2015 Objective

75% of people use at least two protective measures.

Progress

- The 2009 Youth Risk Behavior Survey (YRBS) found that only 9.3 percent of high school students used sunscreen with an SPF of 15 or higher “most of the time” or “always” when they were outdoors in the sun for more than an hour; this was down from the 10.3 percent as reported in the 2007 YRBS.

- Nationwide, according to the 2007 YRBS, 17.4 percent of high school students “most of the time” or “always” stayed in the shade, wore long pants, wore a long-sleeved shirt, or wore a hat that shaded their face, ears, and neck when outside for more than one hour on a sunny day.

- According to the 2008 National Health Interview Survey (NHIS), adults reported engaging in the following sun protection measures: 32.6 percent used sunscreen always or often; 14.3 percent used a hat always or often; 31.5 percent used shade always or often; 11.6 percent used long-sleeved shirts always or often; and 32.1 percent used long pants always or often. In addition, 15 percent of adults reported using an indoor tanning device, including sunlamp, tanning bed, or tanning booth at least once in the past 12 months.

The American Cancer Society is a core member of the National Council on Skin Cancer Prevention, which is comprised of more than 45 organizations that play a crucial role in promoting skin cancer awareness and prevention efforts nationwide. In 2010, in collaboration with the council, the Society supported development and promotion of the second annual “Don’t Fry Day,” which is the Friday before Memorial Day.
Skin Cancer

Most governmental and nongovernmental efforts to prevent skin cancer in the United States have sought to change the individual behaviors of parents and children, but have failed to emphasize sun protection policies, such as those used effectively in Australia.

- The use of indoor tanning booths or sunlamps is particularly prevalent among young adults and women who perceive a tanned appearance as healthy and attractive. In a national sample of adolescents, 17.7 percent of girls and 5 percent of boys reported using an indoor tanning booth in the previous year.

- At the state level, 21 states have enacted legislation limiting a minor’s access to indoor tanning facilities, including restricting access to the use of tanning facilities by age or requiring parental permission.

- The School Health Policies and Programs Study (SHPPS) conducted by the CDC in 2006 indicates that 2 percent of school districts required and 36 percent recommended that schools schedule outdoor activities to avoid times when the sun is at peak intensity. Five percent of school districts required and 32 percent recommended that schools establish procedures to encourage students to use sunscreen before going outside.

- If these current trends continue, we are unlikely to meet the 2015 objective.
The present generation of young people exhibits behaviors that are linked to increased cancer risk in the future, including tobacco use, poor diet, lack of physical activity, drug and alcohol use, and certain sexual behaviors.

If these young people can be influenced to change their behaviors, more than 60 percent of cancers known to be preventable and caused by habits formed in childhood could potentially be eliminated. The effort to improve youth health choices could yield additional health benefits, since many of the behaviors that increase cancer risk also increase the risk of heart disease, diabetes, and stroke later in life.

**Trends:**
- While the percentage of schools that require health education increased from 6.4 percent of elementary schools, to 20.6 percent of middle schools, to 35.8 percent of high schools, the yearly health education requirements from grade six through grade 12 differ. Thirty-seven percent of schools taught a required health education course in grade six, 34 percent in grade nine, and only 10.2 percent in grade 12. Thus, during the grades when the prevalence of health risk behaviors increases among students, schools progressively provide less health education.

**Challenges:**
- Lack of curriculum and lack of understanding what works are not the main barriers to comprehensive school health education. Instead, the primary obstacles are a lack of resources, trained personnel, and policies in school systems that address health in a coordinated and comprehensive way.
- At the local level, few required health education classes or courses are taught by a teacher who majored or minored in health education or health and physical education combined.

**Bottom Line:**
More than 53 million young people are enrolled in 14,000 school districts across the United States. Comprehensive school health education in grades K-12 can provide students the knowledge and skills necessary to help them adopt and maintain healthy lifestyles. If adopted and implemented nationwide, comprehensive school health education, coordinated with other health enhancing school programs and policies, could shape the future health of the nation.
## Progress toward the Nationwide Objectives at a Glance: Comprehensive School Health Education (CSHE)

<table>
<thead>
<tr>
<th>By 2015</th>
<th>Progress</th>
<th>2015 Trends</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHSE: 50% of school districts provide CSHE</td>
<td>2006 SHPPS data: 24%</td>
<td>✅</td>
</tr>
<tr>
<td>School Health Councils: 90% of school districts have active school health councils</td>
<td>2006 SHPPS data: 72.9% have some type of council</td>
<td>✅</td>
</tr>
<tr>
<td>School Health Coordinators: 90% of school districts have school health coordinators</td>
<td>2006 SHPPS data: 67.8%</td>
<td>✅</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>By 2010</th>
<th>Progress</th>
<th>2010 Trends</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHSE: 35% of school districts provide CSHE</td>
<td>2006 SHPPS data: 24%</td>
<td>✅</td>
</tr>
</tbody>
</table>

**Dashboard metric**

**Likely to meet goal**

**Possible to meet goal**

**Unlikely to meet goal**

**Unknown**

**Dashboard metric**
Comprehensive School Health Education

Comprehensive school health education (CSHE) refers to K-12 classroom instruction – just one component of the larger eight-component school health program that includes food services, the school environment, physical education, student services, staff wellness, student counseling, and community and parent involvement.

2015 Objective
50% of school districts

2010 Objective
35% of school districts

Progress
• The 2006 School Health Policies and Programs Study (SHPPS) data showed that 24 percent of school districts conduct comprehensive or coordinated school health education, up significantly from 14.9 percent reported in the 2000 SHPPS.

• The Society supported the review and revision of the National Health Education Standards, released in February 2007. Since its release, the Society provided implementation training to more than 40 states, the District of Columbia, and the Navajo Nation. The National Health Education Standards, originally developed in 1995 with the Society’s support, have significantly influenced the quality and quantity of health education taught in US schools in the past 15 years. The standards are now the recognized health education reference in the United States and have been referenced internationally. This is a significant contribution by the American Cancer Society to the increased quality and quantity of school health education nationwide.

• Forty states have adopted or adapted the standards as a framework for K-12 health education. Seventy-two percent of states required or encouraged school districts to follow health education standards or guidelines based on the National Health Education Standards. With renewed commitment, the Society continues to work with other national youth and school health organizations to promote the use and adoption of the National Health Education Standards.

• In 2009 and again in 2010, the Society, together with the CDC’s Division of Adolescent and School Health, implemented an academy for lead faculty from colleges and universities with undergraduate and graduate programs that prepare future health education teachers. The academy serves as a professional development opportunity to advance school health teacher preparation by offering educational sessions, CDC and Society school health program resources, as well as networking opportunities that will advance teaching practices. The academy fills an otherwise unmet professional development need for faculty engaged in school health education teacher/coordinator preparation.

• Trend to 2010 and 2015: Increases are expected in the percentage of school districts that require CSHE as more emphasis is placed on the health of children and youth, given their current health status. SHPPS 2012 data will be released by the Centers for Disease Control and Prevention’s Division of Adolescent and School Health (DASH) in October 2013.
Comprehensive School Health Education

Increasingly, educators and administrators recognize the value of health education and its potential impact on student health and achievement, and, ultimately, academic success. We can look to the next decade for an increased focus in this area.

School Health Councils

2015 Objective

90% of school districts with active councils

Progress

• Based on data from the 2006 SHPPS survey, school health councils exist in 72.9 percent of school districts.

• Recent federal regulations associated with the Federal Free and Reduced School Meal Authorization required that all school districts use representatives from both school and the community to develop school wellness policies related to nutrition and physical activity. Schools with school health councils, many formed due to the Society’s advocacy efforts, were well positioned to develop policies outlined in the regulations. Those that did not have councils had to create them to serve the district. In most cases, school health councils created school wellness policies that went beyond the federal requirement to address nutrition and physical activity by including other student health risks such as tobacco use, sun safety, and alcohol/drug prevention.

• Trend to 2015: The 2010 objective of 75 percent has essentially been met and the National Board of Directors established a new 2015 benchmark of 90 percent for this objective. The use of school health councils will likely continue to increase as a result of recent federal regulations associated with the Federal Free and Reduced School Meal Authorization.
School Health Coordinators

2015 Objective

90% of school districts with coordinators

Progress

• The 2010 objective has been exceeded, largely due to Society efforts to raise the awareness of and need for school health coordinators. The Society has worked closely with the CDC’s DASH to include survey questions that helped identify the prevalence of school health coordinators at the school district and school building level. Nearly 70 percent of school buildings now have a person who oversees or coordinates school health education.

• Since the inception of the American Cancer Society School Health Leadership Institutes in 1999, many Society Divisions and state departments of health and/or education have sponsored trainings targeting school health coordinators and other school and community members who share and influence decisions that impact school health programs.

• School Health Leadership Institutes conducted at the national, state, and regional levels over the past 10 years have reached school health leadership teams in more than 300 school districts that represent more than five million K-12 students – just less than 10 percent of the total US student population.

• Trend to 2015: The 2010 objective of 50 percent has been met, and the National Board of Directors established a new 2015 benchmark of 90 percent for this objective. While use of the Society School Health Leadership Institute model continues, the Society has influenced other national school health organizations and agencies to further support school health coordinators. Many more resources exist today that can assist in making the job of the school health coordinator more effective and more sustainable.

Comprehensive School Health Education

The present generation of adolescents is heavier, less physically active, and, especially among girls, smokes more than its parents did at the same age. This backslide in the status of our national health has tremendous negative implications for society.
Even though cancer is potentially the most preventable and the most curable of the major chronic, life-threatening diseases, it remains a leading killer worldwide, accounting for approximately one in eight deaths. According to the World Health Organization, people in low- and middle-income countries tend to develop chronic diseases “at younger ages, suffer longer – often with preventable complications – and die sooner than those in high-income countries.” Effective measures to reduce cancer morbidity and mortality require increased global awareness of the disease burden; the mobilization and appropriate allocation of resources; the formulation of evidence-based policies and proven interventions; and the commitment of organizations and institutions in the nonprofit, for-profit, and governmental sectors.

**Trends**

- In 2010, cancer is projected to become the leading cause of death worldwide, followed by heart disease and stroke.
- In 2008, there were an estimated 12.7 million new cases of cancer and 7.6 million cancer deaths.
- In 2008, 53 percent of the 12.7 million new cases of cancer and 63 percent of the 7.6 million cancer deaths worldwide occurred in developing countries.
- By 2030, it is estimated there will be 21.4 million new cases of cancer and 13.2 million cancer deaths.
- Tobacco will kill one billion people in the 21st century, a ten-fold increase from the 100 million deaths in the 20th century.
- Tobacco use currently causes approximately six million deaths per year worldwide, and this number is expected to double to 10 million by the year 2020.
- According to the WHO Tobacco Overview in 2005, African countries are experiencing the highest increase in the rate of tobacco use among developing countries, with consumption increasing by 4.3 percent per year.
Challenges:

- Cancer is absent or low on the health agendas of low- and middle-income countries.

- Noncommunicable diseases (NCDs), including cancer, heart disease, diabetes, and respiratory diseases, account for more than 60 percent of the world’s deaths, yet they have been largely neglected in international health and development work, despite the tremendous opportunities to save lives by addressing preventable causes of these diseases.

- NCDs are not addressed in the United Nations’ Millennium Development Goals. Given the large disease burden from the NCDs, policy should be enacted to address them.

- In 2008, cancer accounted for nearly $1 trillion in economic losses from premature death and disability. The economic toll from cancer is nearly 20 percent higher than from heart disease, the second leading cause of economic loss ($895 billion and $753 billion, respectively), according to an economic cost of cancer report by the American Cancer Society and Livestrong.

- Due to significant disparities between low- and high-resource countries in access to screening and treatment, more than 85 percent of the cases and deaths from cervical cancer occur in developing countries, making it the most common cancer-related cause of death for women in these countries.

Bottom Line:

Ultimately, cancer control goes hand in hand with efforts to promote human and economic development and to improve standards of health, education, and medical care throughout the world. As the largest and most successful voluntary health agency in the world, the American Cancer Society is one of the few organizations capable of providing meaningful leadership in the global fight against cancer. In September 2011, there will be an unprecedented opportunity for cancer and other chronic diseases to be elevated within the United Nations Millennium Development Goals, through a High Level Meeting on Noncommunicable Diseases. Civil society, with the active support of organizations like the American Cancer Society, will play a critical role in shaping the agenda for the meeting and ensuring that concrete outcomes are developed to acknowledge and address the growing cancer burden.
Global Cancer Deaths

- The WHO estimates that noncommunicable disease deaths will increase by 17 percent over the next 10 years and in the African region by 27 percent.

- Worldwide, cancer causes more deaths than AIDS, tuberculosis, and malaria combined.

Cancer causes the highest economic loss of all of the 15 leading causes of death worldwide. The economic toll from cancer is nearly 20 percent higher than heart disease, the next leading cause of economic loss ($895 billion and $753 billion, respectively).
As a leader in the global cancer control movement, the American Cancer Society fights cancer and tobacco through cancer advocacy and tobacco control programs. We work in partnership with cancer and tobacco control nongovernmental organizations, international organizations, and government agencies throughout the world. Our efforts cut across all regions, but special regional emphasis is placed on tobacco control programs in sub-Saharan Africa.

Global Tobacco Control

- Tobacco accounts for about 8.8 percent of all global deaths and 4.2 percent of disabilities. It accounts for about 30 percent of all cancers globally.

- By the end of 2010, the death toll of tobacco will be approximately six million, 72 percent of which will consist of deaths in low- and middle-income countries.

- If current trends continue, tobacco will kill seven million people annually by 2020 and more than eight million people annually by 2030, about 83 percent of whom reside in low- and middle-income countries. Occupational exposure to secondhand smoke kills 200,000 workers every year. One-hundred million people were killed by tobacco in the 20th century, and it is projected to kill more than one billion in the 21st century.

- It is estimated that the global economy loses $500 billion due to tobacco use annually.
The Society plays a significant role in global tobacco control by stimulating advocacy, supporting research, developing leadership, and disseminating information to save lives from cancer and reduce tobacco-related diseases. Our efforts have included advocating for effective tobacco control policies and supporting tobacco control research and information dissemination, as well as building the capacity of organizations and leaders to address tobacco control issues in their countries and communities, including:

• Providing tobacco control training and grants to more than 200 tobacco control seed grantees in more than 70 countries

• Actively supporting the Framework Convention on Tobacco Control (FCTC) ratification and implementation. Through the FCTC Advocacy Grants program, with Cancer Research UK and the Framework Convention Alliance, more than 50 advocacy grantees in more than 20 countries have received funding.

• Co-hosting the Global Smokefree Partnership initiative to promote smoke-free policies worldwide

In a part of the world that is notably affected by HIV/AIDS, malaria, and other infectious diseases, cancer is emerging as a serious public health threat. According to the International Agency for Research on Cancer, much of the rise can be attributed to widespread tobacco use and exposure to secondhand smoke. Adult smoking prevalence is less than 10 percent in men and 2 percent in women in many African countries, including Nigeria and Ethiopia, the two most populous nations in the continent. However, cigarette consumption is increasing in this region due to the adoption of western behaviors associated with economic growth and increased marketing by tobacco companies. The smoking pattern among teens is even more disturbing. According to the 2005 Global Youth Tobacco Survey, African teens have the second highest smoking prevalence of all six WHO regions, preceded only by that of the European region.

The Africa Tobacco Control Consortium (ATCC) was established in February 2009 to avert a preventable epidemic of tobacco-related death and disease in sub-Saharan Africa. The ATCC is supported by a $7 million grant awarded by the Bill & Melinda Gates Foundation. Its four objectives are centered on developing, implementing, protecting, and integrating policies to reduce tobacco use and exposure and increase the effectiveness and sustainability of the region’s nascent tobacco control movement.
The ATCC has gone through an extensive strategic planning process over the past year to develop work plans and define key activities that will aid in achieving these objectives, meeting with partner organizations in February 2010 in Naivasha, Kenya, and in May 2010 in Lagos, Nigeria. Key activities include the establishment of a small grants program to support national-level policy campaigns in key tobacco control intervention areas; creating and maintaining a tobacco control resource and technical assistance center to assist advocates and researchers on the continent; launching a fellowship program to develop new leaders in tobacco control in Africa; evaluating the research needs and developing a regional agenda to strengthen tobacco control research in Africa; and working on strategies to campaign for increased tax/price on tobacco products and inclusion of tobacco control on national development agendas.

The ATCC has also tackled key human resources issues, hiring 11 full-time staff to implement the consortium’s work plan, strengthening Africa-based partners’ organizational development, and devising strategies to ensure the sustainability of this initiative.

The ATCC staff has taken the lead in reaching out to French-speaking African tobacco control advocates at the 3rd Conférence International Francophone sur le Contrôle du Tabac (CIFCOT 3) in Niamey, Niger, and will ensure African civil society’s leadership and participation at treaty negotiations for the 4th Conference of the Parties to the Framework Convention on Tobacco Control (FCTC COP-4) in November 2010 in Punta del Este, Uruguay.

In addition to the Gates-funded ATCC project, the Global Health Tobacco Control team is working with the International Tobacco Control Research team on two potential projects in Africa to increase the number of researchers working in tobacco control, to raise the quantity and quality of local research outputs, and to improve links between researchers, advocates, and decision-makers to directly impact policy change. One of the projects being proposed is focused specifically on research and training on the economics of tobacco control, while the other project is looking at creating tobacco control as a specialized area in a master of public health program. Both projects are intended to work with and complement the efforts of the ATCC.
Global Cancer Advocacy

Cancer and other noncommunicable diseases are largely overlooked by the global health and development community. It is estimated that less than 1 percent of private and public funding for health is allocated to preventing and controlling cancer and other noncommunicable diseases in low- and middle-income countries. Here in the United States, the administration’s Global Health Initiative includes no meaningful funding for noncommunicable diseases, despite the existence of cost-effective solutions to prevent or treat these diseases, which can be integrated into existing global health programs.

The American Cancer Society has become actively involved in working with global partners, including the International Union Against Cancer (UICC), the International Diabetes Federation, the World Heart Federation, Livestrong Foundation, and others, to prioritize cancer and noncommunicable diseases on the global health agenda. We were among many nonprofits in the global health community to advocate for a special United Nations High Level Meeting in September 2011. This meeting will be instrumental in balancing global health funding and integrating low-cost interventions for cancer and other NCDs into existing health care systems.

- The American Cancer Society was recently granted special consultative status with the United Nations Economic and Social Council (ECOSOC). Being granted consultative status opens the door for the Society to actively engage with the ECOSOC and its subsidiary bodies, as well as with the United Nations Secretariat, programs, funds, and agencies. In addition, the Society will have UN ground passes, and be able to attend UN Commission meetings and table 500-word statements at those meetings.

- The American Cancer Society, through the publication of opinion letters sent to United Nations representatives and published in high-impact journals, issued a call for the General Assembly of the UN to hold a special High-Level Meeting on Noncommunicable Diseases in September 2011.

- The American Cancer Society will be actively involved in the preparations for the high-level meeting, and, having received special consultative status with the ECOSO, will be able to be represented at the meeting itself.
Regional Initiatives

The Society’s global cancer advocacy efforts cut across all regions, but special emphasis is placed on programs in sub-Saharan Africa and Latin America.

- Over the past several years, the Society has collaborated with NGOs and institutions in countries throughout the Latin American region. In the region, the Society has worked on increasing civil society engagement in cancer control through trainings and technical assistance; funding and building institutional capacity in cancer control advocacy; and policy planning, patient empowerment, tobacco control, and NGO management. The Latin America Regional Health Grants Program, a three-year regional initiative, provides training and technical assistance to strengthen the institutional capacity of a network of NGOs from Argentina, Brazil, Colombia, Costa Rica, Mexico, and Venezuela, ultimately enhancing the impact of their cancer control programs.

- The American Cancer Society and our partners in Africa are working to prioritize cancer and other noncommunicable diseases on the region’s health and development agenda, and to promote tobacco control throughout Africa. Together with regional stakeholders, the Society raises awareness about the growing burden of cancer in Africa and promotes evidence-based policies and programs to prevent the disease. The Society works with a number of partners in the public and private sectors, including the African Organization for Research and Training in Cancer (AORTIC), Cervical Cancer Action, International Union Against Cancer (UICC), International Union for Health Promotion and Education (IUHPE), The Corporate Council on Africa, World Economic Forum, World Health Organization, and a host of community-based civil society organizations, as well as a growing media network, to achieve our regional cancer advocacy objectives.
Information Sharing

The American Cancer Society disseminates global health information to support our global health priorities through:

- **Media Summits**: Journalist fellowships and trainings in India, Latin America, and Africa have helped 75 journalists produce more than 200 cancer and tobacco stories in leading media outlets.


- **Publications**: Through our own research initiatives in Global Health, the American Cancer Society contributes to the scientific knowledge base on the impact of cancer and tobacco use around the world. These include *The Tobacco Atlas* (Third Edition), *Global Tobacco Epidemic*, *Global Cancer Facts & Figures*, and *The Cancer Atlas*.

- **The Tobacco Atlas** (Third Edition), a joint venture between the Society and the World Lung Foundation, presents compelling statistics, maps, and graphics about tobacco use and control around the world in two languages other than English, making this crucial source of information available to more cancer and tobacco control organizations across the globe. The Spanish version was launched in April 2010 in Mexico City, with high-ranking health officials and 24 journalists attending the event, while the launch of the Mandarin version took place in August 2010 at the UICC Congress in Shenzhen, China, and was covered by about 40 journalists, reaching 14.5 million people in China.

- **The American Cancer Society and Livestrong** also collaborated on the publication of a landmark study on the economic impact of cancer. *The Global Economic Cost of Cancer* report provides the first global estimate of the economic burden associated with premature deaths and disability due to cancer. The report received extensive media coverage, with presence on The Associated Press and Reuters, and mentions in international newspapers and key American news outlets, such as ABC, MSNBC, NPR, CNN, and Fox News.

- **The Web and E-newsletters**: Approximately 20-25 percent of traffic to cancer.org comes from outside of the United States. Bilingual newsletters are sent to partners in 85 countries.

- **Social Media**: A global presence on Facebook, Twitter, YouTube, and blogs, with special events such as the 2010 UICC Congress and *The Global Economic Cost of Cancer* report publication eliciting particularly high number of mentions on Twitter. More than 800 individuals and organizations follow the ACS Global Programs on Twitter (@acsglobal) and about 700 more support our Facebook page (American Cancer Society Global).
Income Development
Summary:

• The Society continues to be the largest health charity, and in 2008 and 2009 moved ahead of the American Red Cross to become the largest secular charity in public support. This is excluding organizations that focus on donated goods, and pass-through organizations such as the United Way.

• From 2003 to 2008, the strength of the first Integrated Fundraising Plan enabled the Society to consistently out-perform the growth of the charitable health sector, typically at a two-to-one ratio, with a resulting growth in market share in each of these years.

• The year 2009 was an anomaly in the pattern established during the first Integrated Fundraising Plan, with preliminary results suggesting a decline in market share. This resulted primarily from the heavy concentration of Society revenue portfolio in Planned Giving and revenue from community business owners and nationwide corporations and their employees. These two segments, together representing about half of revenue, were most vulnerable to contraction in the market.

• In 2010, the Society held its ground from a revenue perspective, with public support expected to be up approximately 1-2 percent for the year. Few revenue strategies changed more than a percent compared to the previous year. The exceptions were DeterminNation, our new endurance event platform and the Choose You cause branding initiative.

• In 2010, the number of donors and participants in our fundraising activities continued to increase; however, the amount of each donor’s contribution slightly declined compared to the previous year.

• Cost per dollar raised was relatively stable from 2004-2008, although it increased in 2009 with the contraction of the fundraising market. It is expected to remain somewhat elevated or improve slightly in 2010.

Challenges:

• Nearly all strategies have been affected by the problems in the broader economy and a shrinking market size. Particularly hard hit are strategies relying on corporate and major gifts or gifts subject to market valuations, such as planned giving although the latter slightly improved in 2010. Corporate engagement with payroll deduction has also been impacted by the restructuring of multiple corporate partners.

• While most income strategies, including the larger ones such as Relay For Life and Planned Giving, have ample room for continued growth, the pace of growth has moderated from the extraordinary levels seen in past decades.
Next steps:

- The Society completed the development of our Integrated Fundraising Plan II in the spring of 2010 and worked to identify growth potential and investment needs with each Division during the summer. However, we recognize that the portfolio management process is iterative, and will evolve over time based on the changes in the economic and competitive climate, new opportunities that are identified, and the availability of resources to invest.

- The Society is confident in the strength of our approach, and will continue to apply principles to optimize the portfolio on an ongoing basis, to ensure the organization’s ongoing leadership in fundraising to support a world with less cancer and more birthdays.

- Growth in public support has been strong in each year since the Integrated Fundraising Plan began its phased rollout in 2003, through 2007. However, results in 2008 were down 3 percent, and 2009 results were down 10.9 percent as a result of a challenging economic environment in the public and private sectors alike. In 2010, the Society held its ground from a revenue perspective, with public support expected to be up approximately 1-2 percent for the year.
### Total Public Support Net Income (in millions)

<table>
<thead>
<tr>
<th>Source</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
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<tr>
<td>Total public support</td>
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<td>$1,039</td>
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<tr>
<td>Relay For Life</td>
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<td>$406</td>
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<td>Other community-based events</td>
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<tr>
<td>(Making Strides Against Breast Cancer®, Daffodil Days®, others)</td>
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<td>(direct mail, telemarketing)</td>
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<td>Employer-based strategies – independent payroll deduction campaigns</td>
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<td>Other (memorials, unsolicited, Team ACS, other)</td>
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* Estimate
The American Cancer Society enjoys a historic strength in mobilizing communities to fight back against cancer through grassroots fundraising – raising small gifts through millions of individual donations from private supporters. In the past decade, the Society has made strong and deliberate efforts to broaden our portfolio of fundraising approaches to capitalize on market opportunities, to manage risk, and to improve fundraising efficiencies.

Strategies outlined in the Society’s nationwide Integrated Fundraising Plan leverage both traditional and contemporary fundraising practices and are prioritized for high levels of growth nationwide. These strategies are highlighted below.

**Relay For Life**
Continue to grow the signature activity, Relay For Life, as the primary strategy for engaging communities in the fight against cancer. Generate a significant portion of the Society’s total annual giving and create volunteer leadership opportunities, a platform for advocacy, survivor/caregiver, and mission-related activities. Fuel growth in new nontraditional communities or in more established markets by engaging and involving special interest and affiliation-based audiences – including students, corporate campuses, recreation and hobby groups, and animal enthusiasts – as a way to increase participation and outreach.

**Making Strides Against Breast Cancer**
In large and mid-sized markets across the country, mobilize women, especially breast cancer survivors, to be champions in the fight against breast cancer through Making Strides events. Engage large corporations as flagship or other sponsors to recruit teams and participants to raise funds and awareness within their organizations, and to deliver collaborative messaging to employees and consumers in their communities and nationwide.

**DetermiNation**
Engage the rapidly growing and high-impact endurance athlete audience in communicating an inspirational personal vision of endurance and fitness, and a national spirit of commitment to winning the fight against cancer under the banner of DetermiNation. Provide a comprehensive and flexible training program to support athletes in crossing the finish line, raising funds, and increasing visibility of the Society’s brand within the endurance event marketplace. Motivate them to participate not only in their local marathon, triathlon, bike, and other endurance races, but to travel to exciting DestiNation events, which provide unique and meaningful opportunities to fight cancer across the country and throughout the year.

**Distinguished Events**
Provide opportunities for wealthy individuals and corporate leaders to engage their social circles, professional colleagues, and business contacts to raise funds in the fight against cancer. Generate significant revenue through corporate sponsorship, and invite individuals to further advance the Society’s mission through a distinguished giving commitment.

Income Development

In 2009, 6.9 million donors made more than nine million gifts, with an average gift size of $67. More than 6.6 million of these donors were individuals, approximately 325,000 were corporations, and about 6,000 were foundations.
Distinguished Giving

**Major Gifts** Develop meaningful long-term relationships with high-net-worth individuals and foundations, and provide them a platform for realizing their personal vision of the fight against cancer while investing in the Society’s most compelling mission opportunities. Build enduring relationships that motivate donors to support the American Cancer Society annually, alongside opportunities to fund unique, time-sensitive campaigns that accelerate the Society’s ability to accomplish our mission.

**Planned Giving** Develop meaningful personal relationships with individuals of capacity and their financial advisors, enabling them to leverage their assets and make ultimate gifts to the fight against cancer. When possible, position the Society as a philanthropic advisor and use direct response strategies to build awareness of planned giving opportunities among a broader audience.

Corporate & Systems Initiative
Develop cross-Division relationships with major US employers (Fortune 1,000 companies and others), and create mutually beneficial partnerships through a coordinated account management process. Offer companies customized mission and income offerings to stimulate payroll deduction programs, event sponsorships, matching gifts, cause marketing relationships, and corporate philanthropy.

Direct Response Marketing
Build significant visibility and revenue for the American Cancer Society through multi-channel direct response marketing, which leverages the mass media, outreach to consumer audiences, traditional mail and telephone communication, as well as online and social networking technologies. Design integrated strategies that enable new and existing customers to drive their own path of engagement, increase their generosity, and create long-term loyalty for the organization.

E-revenue
Build a powerful e-revenue competency to support existing and emerging fundraising efforts (e.g., Relay For Life, DetermiNation, Choose You), and create dynamic new opportunities for engagement made possible by technological advances across digital media. Provide an online foundation for donor engagement and care that enables the Society to access a broader group of potential donors, to achieve higher levels of giving by fundraising competitively, and to enhance our brand and relevance. Improve fundraising efficiency and the ease of data capture, using subsequent insight to drive improvement in constituent experience.

Strategy and Analytics
Improve fundraising success by monitoring trends in the competitive landscape, identifying key success factors in priority strategies, developing and communicating major strategic objectives, providing data and analysis to support planning for revenue and investment targets, and evaluating progress against established goals.
Historical Change
Since adopting the 2015 Challenge Goals in 1996-1998 and the nationwide objectives in 1999, the American Cancer Society National Board of Directors has annually reviewed progress toward these established outcomes. In response to the annual review, the Board changes or modifies outcome statements, as appropriate. Following is a historical look at the changes from 1996 through August 2010.

2015 Goals

<table>
<thead>
<tr>
<th>Outcome Statement/Origination Date</th>
<th>Rationale for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>50% reduction in age-adjusted cancer mortality rates by the Year 2015. <em>(Adopted 1996)</em></td>
<td>No change since adoption</td>
</tr>
<tr>
<td>25% reduction in age-adjusted cancer incidence rates by the Year 2015. <em>(Adopted 1998)</em></td>
<td>No change since adoption</td>
</tr>
<tr>
<td>Measurable improvement in the quality of life (physical, psychological, social, and spiritual) from the time of diagnosis and for the balance of life of all cancer survivors by the Year 2015. <em>(Adopted 1998)</em></td>
<td>No change since adoption</td>
</tr>
</tbody>
</table>

Note that statements outlined in blue are those currently in effect.
## Historical Change

### Principles

#### Information

<table>
<thead>
<tr>
<th>Outcome Statement/Origination Date</th>
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</tr>
</thead>
<tbody>
<tr>
<td>State-of-the-art information on issues related to incidence, mortality, risk factors, prevention, early detection, treatment, survivorship and quality of life (physical, social, psychological, and spiritual) will be available and accessible through all appropriate channels to all people. <em>(Adopted 2009)</em></td>
<td>Deleted 2015 timeframe and added the words “prevention” and “early detection” in 2009</td>
</tr>
<tr>
<td></td>
<td>Added the words “treatment” and “survivorship” in 2003</td>
</tr>
<tr>
<td>By 2015, state-of-the-art information on issues related to incidence, mortality, risk factors, treatment, survivorship and quality of life (physical, social, psychological, and spiritual) will be available and accessible through all appropriate channels to all people. <em>(Adopted 2003)</em></td>
<td>This objective has been mostly completed and was restated for 2004.</td>
</tr>
<tr>
<td>By 2004, objectively quantify, prioritize, and create plans to fulfill unmet cancer information needs of constituents. <em>(Adopted 2003)</em></td>
<td>This objective has been completed, and the work is ongoing. Specific metrics related to the leadership roles and focus areas address this objective, and NCIC continually collects and evaluates information-related data.</td>
</tr>
<tr>
<td>By 2002, identify the cancer-related information needs and utilization patterns of users of Society cancer information services in order to prioritize and develop or assemble information to fill those identified needs. <em>(Adopted 2000)</em></td>
<td>This objective has been mostly completed and was restated for 2004.</td>
</tr>
</tbody>
</table>

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### Measurement

<table>
<thead>
<tr>
<th>Outcome Statement/Origination Date</th>
<th>Rationale for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitoring systems that track relevant incidence, mortality, risk factor and screening prevalence, and quality-of-life dimensions should be available nationwide. <em>(Adopted 2003)</em></td>
<td>No change since adoption</td>
</tr>
<tr>
<td>By 2008, all states will have cancer registries that meet NAACR silver or gold certification standards. <em>(Adopted 2003)</em></td>
<td>This statement was deleted in 2009. The objective is largely met and will continue to be monitored as a key indicator of improvement in measurement standards</td>
</tr>
<tr>
<td>By 2005, tracking systems will be developed or supported to identify and monitor the disparities between population groups in cancer incidence, mortality, risk factor and screening prevalence, and quality of life. <em>(Adopted 2003)</em></td>
<td>This objective has been mostly completed, and the work is ongoing.</td>
</tr>
<tr>
<td>By 2005, systems will be developed or supported that track inputs, activities, and outputs toward achievement of Division-specific outcomes and ultimately nationwide objectives. <em>(Adopted 2003)</em></td>
<td>This objective has been mostly completed, and the work is ongoing through the Nationwide Dashboard and Division Scorecards.</td>
</tr>
<tr>
<td>By 2002, nationwide systems will be developed or supported to gather baseline, monitoring, and program evaluation and cost data for all relevant incidence, mortality, and quality-of-life dimensions. <em>(Adopted 1999)</em></td>
<td>This objective has been mostly completed, and the work is ongoing. This objective was restated in 2003 in the overarching measurement statement.</td>
</tr>
<tr>
<td>By 2002, develop internal tracking systems for the nationwide program of work. <em>(Adopted 2000)</em></td>
<td>This objective has been partially completed, and the work is ongoing. This objective was restated in a 2005 objective.</td>
</tr>
<tr>
<td>By 2002, conduct surveys to begin to track nationwide interim objectives that are not tracked using external data sources. <em>(Adopted 2000)</em></td>
<td>This objective has been mostly completed and was restated in a 2005 objective.</td>
</tr>
</tbody>
</table>

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### Disparities

<table>
<thead>
<tr>
<th>Outcome Statement/Origination Date</th>
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</thead>
<tbody>
<tr>
<td><strong>Eliminate differences in the incidence, prevalence, mortality, and burden of cancer and related adverse health conditions, beyond what would be expected under equitable circumstances that exist among specific population groups in the United States. These population groups may be characterized by gender, age, race/ethnicity, education, income, social class, disability, geographic location, or sexual orientation.</strong> <em>(Adopted 2009)</em></td>
<td>Deleted 2015 timeframe in 2009. Changed the wording to match the definition of cancer health disparities that has been adopted by the Society.</td>
</tr>
<tr>
<td>By 2015, eliminate the disparities in cancer burdens among population groups by reducing age-adjusted cancer incidence and mortality rates and improving quality of life in the poor and underserved. <em>(Adopted 2006)</em></td>
<td>Deleted the words “to the population average” to reduce ambiguity.</td>
</tr>
<tr>
<td>By 2015, eliminate the disparities in cancer burdens among population groups by reducing age-adjusted cancer incidence and mortality rates and improving quality of life in the poor and underserved to the population average. <em>(Adopted 1999)</em></td>
<td>Wording was refined in 2006 objective to reduce ambiguity.</td>
</tr>
<tr>
<td>By 2005, conduct or support comprehensive assessments that identify issues and needs for eliminating disparities to guide decisions on objectives, audiences, and interventions. <em>(Adopted 2003)</em></td>
<td>The work in this objective is ongoing through the leadership roles and focus areas.</td>
</tr>
<tr>
<td>By 2004, ensure that appropriate programs included in the Society nationwide program of work address cancer disparities and the needs of the underserved. <em>(Adopted 2003)</em></td>
<td>Addressing disparities was established as an overarching pillar for all leadership roles and focus areas. Specific metrics in the leadership roles and focus areas address this objective. This objective has been completed, and the work is ongoing.</td>
</tr>
</tbody>
</table>

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## Disparities (continued)

<table>
<thead>
<tr>
<th>Outcome Statement/Origination Date</th>
<th>Rationale for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>By 2001, develop five-year action plans by NHO that address the elimination of disparities within each site/risk factor and quality-of-life area. <em>(Adopted 2000)</em></td>
<td>This objective was partially completed in 2001, and restated in a 2004 objective.</td>
</tr>
<tr>
<td>By 2001, all charter agreements will incorporate an organizational diversity plan. <em>(Adopted 2000)</em></td>
<td>This objective was completed in 2001.</td>
</tr>
<tr>
<td>By 2001, diversity training for staff and volunteers will be available nationwide. <em>(Adopted 2000)</em></td>
<td>This objective was completed in 2001.</td>
</tr>
<tr>
<td>By 2001, a clearinghouse for sharing best practices and coordination will be developed. <em>(Adopted 2000)</em></td>
<td>This objective was completed in 2001.</td>
</tr>
</tbody>
</table>

## Collaboration

<table>
<thead>
<tr>
<th>Outcome Statement/Origination Date</th>
<th>Rationale for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efforts should be increased toward working collaboratively with other organizations and agencies to achieve common cancer control goals and objectives. <em>(Adopted 2009)</em></td>
<td>Changed the wording so statement is broader than just for the Society</td>
</tr>
<tr>
<td>Efforts should be increased at all levels of the American Cancer Society for working with other organizations and agencies to achieve our common cancer control goals and objectives. <em>(Adopted 1999)</em></td>
<td>Changed the wording in 2009 to a broader statement</td>
</tr>
<tr>
<td>By 2004, identify, enter into, and measure specific collaborations and partnerships with organizations and systems, especially those related to addressing identified cancer disparity issues. <em>(Adopted 2003)</em></td>
<td>This objective has been completed, and the work is ongoing. Collaborative relationships continue with numerous leadership organizations in the fight against cancer. A database of collaborative partnerships is now being maintained and regularly updated.</td>
</tr>
</tbody>
</table>

*Note that statements outlined in blue are those currently in effect.*
### Collaboration (continued)

<table>
<thead>
<tr>
<th>Outcome Statement/Origination Date</th>
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</tr>
</thead>
<tbody>
<tr>
<td>By 2002, identify collaborating partners and incorporate roles, based upon collaboration guidelines, in action plans at all levels of the Society. <em>(Adopted 2000)</em></td>
<td>This objective has been partially completed and was restated in a 2004 objective.</td>
</tr>
<tr>
<td>By 2002, collaboration training for staff and volunteers will be available nationwide at all levels of the Society. <em>(Adopted 2000)</em></td>
<td>This objective was mostly completed in 2002, and the work is ongoing.</td>
</tr>
</tbody>
</table>

### Access to Quality Treatment

<table>
<thead>
<tr>
<th>Outcome Statement/Origination Date</th>
<th>Rationale for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assure that all people diagnosed with cancer have access to appropriate, quality treatment and follow-up, achieving 0% disparities in treatment outcomes. <em>(Adopted 2009)</em></td>
<td>Deleted 2015 timeframe in 2009</td>
</tr>
<tr>
<td>By 2015, assure that all people diagnosed with cancer have access to appropriate, quality treatment and follow-up, achieving 0% disparities in treatment outcomes. <em>(Adopted 2000)</em></td>
<td>This objective was originally adopted in 2000.</td>
</tr>
<tr>
<td>By 2004, develop long-term action plans by NHO, in collaboration with the National Quality Forum and others, that (a) address access to care and (b) define indicators of quality treatment for each major cancer site. <em>(Adopted 2001)</em></td>
<td>This objective has been partially completed, and the work is ongoing. Access to care is a current focus for the Society. Collaborative partnerships continue with numerous leadership organizations and others on this issue.</td>
</tr>
</tbody>
</table>

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# Historical Change

## Nationwide Objectives

### Colorectal Cancer

<table>
<thead>
<tr>
<th>Outcome Statement/Origination Date</th>
<th>Rationale for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Incidence:</strong> By 2015, reduce the age-adjusted incidence rate of colorectal cancer by 40%. <em>(Adopted 1999)</em></td>
<td>No change since adoption</td>
</tr>
<tr>
<td><strong>Mortality:</strong> By 2015, reduce the age-adjusted mortality rate of colorectal cancer by 50%. <em>(Adopted 1999)</em></td>
<td>No change since adoption</td>
</tr>
<tr>
<td><strong>Early Detection:</strong> By 2015, increase to 75% the proportion of people aged 50 and older who have colorectal screening consistent with American Cancer Society guidelines. <em>(Adopted 1999)</em></td>
<td>No change since adoption</td>
</tr>
<tr>
<td><strong>Incidence:</strong> By 2010, reduce the age-adjusted incidence rate of colorectal cancer by 30%. <em>(Adopted 2006)</em></td>
<td>New objective established in 2006 as interim measure toward 2015 objective</td>
</tr>
<tr>
<td><strong>Mortality:</strong> By 2010, reduce the age-adjusted mortality rate of colorectal cancer by 40%. <em>(Adopted 2006)</em></td>
<td>New objective established in 2006 as interim measure toward 2015 objective</td>
</tr>
<tr>
<td><strong>Behavior Change:</strong> By 2010, 60% of people aged 50+ will have received colorectal screening consistent with American Cancer Society guidelines. <em>(Adopted 2006)</em></td>
<td>Updated the 2005-related objective to a 2010 objective following mid-course assessment</td>
</tr>
<tr>
<td><strong>Public Awareness:</strong> By 2005, 75% of people aged 50+ will be aware of and have knowledge about the need for colorectal screening. <em>(Adopted 2000)</em></td>
<td>This objective was moved to operations in 2006 and is being monitored as a key indicator in business plan activities.</td>
</tr>
<tr>
<td><strong>Behavior Change:</strong> By 2005, 50% of people aged 50+ will have received colorectal screening following Society guidelines as measured by the preferred tests of sigmoidoscopy, colonoscopy, or barium enema. <em>(Adopted 2000)</em></td>
<td>This objective was updated in 2006 to a new 2010 objective.</td>
</tr>
</tbody>
</table>

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# Historical Change

## Colorectal Cancer (continued)

<table>
<thead>
<tr>
<th>Outcome Statement/Origination Date</th>
<th>Rationale for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access to Screening:</strong> By 2005, 100% of states will have comprehensive insurance laws, which cover the costs of colorectal screening in fully insured and self-insured health plans. <em>(Adopted 2000)</em></td>
<td>Word change adding “or cooperative agreements” in 2001</td>
</tr>
<tr>
<td><strong>Access to Screening:</strong> By 2005, 100% of states will have comprehensive insurance laws or cooperative agreements that cover the costs of colorectal screening in fully insured and self-insured health plans. <em>(Adopted 2001)</em></td>
<td>This objective was moved to operations in 2006 and is being monitored as an existing Leadership Role metric.</td>
</tr>
</tbody>
</table>

## Lung Cancer and Adult and Youth Tobacco Use

<table>
<thead>
<tr>
<th>Outcome Statement/Origination Date</th>
<th>Rationale for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Incidence:</strong> By 2015, reduce the age-adjusted incidence rate of lung cancer by 45%. <em>(Adopted 1999)</em></td>
<td>No change since adoption</td>
</tr>
<tr>
<td><strong>Mortality:</strong> By 2015, reduce the age-adjusted mortality rate of lung cancer by 45%. <em>(Adopted 1999)</em></td>
<td>Restated in 2005 following mid-course assessment to make consistent with overall 2015 goal of a 50% reduction</td>
</tr>
<tr>
<td><strong>Mortality:</strong> By 2015, reduce the age-adjusted mortality rate of lung cancer by 50%. <em>(Adopted 2005)</em></td>
<td>Restated objective to make consistent with overall 2015 goal of a 50% reduction</td>
</tr>
<tr>
<td><strong>Adult Tobacco Use:</strong> By 2015, reduce to 12% the proportion of adults (18 and older) who use tobacco products. <em>(Adopted 1999)</em></td>
<td>Changed wording to “current cigarette smokers” in 2006 to make consistent with survey questions</td>
</tr>
<tr>
<td><strong>Adult Tobacco Use:</strong> By 2015, reduce to 12% the proportion of adults (18 and older) who are current cigarette smokers. <em>(Adopted 2006)</em></td>
<td>Restated objective to make consistent with survey questions</td>
</tr>
</tbody>
</table>

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**Historical Change**

**Lung Cancer and Adult and Youth Tobacco Use** (continued)

<table>
<thead>
<tr>
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<th>Rationale for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adult Smokeless Tobacco Use</strong>: By 2015, reduce to 0.4% the proportion of adults (18 and older) who are current users of smokeless tobacco. <em>(Adopted 2006)</em></td>
<td>New objective established in 2006 following mid-course assessment</td>
</tr>
<tr>
<td><strong>Youth Tobacco Use</strong>: By 2015, reduce to 10% the proportion of young people (under 18) who use tobacco products. <em>(Adopted 1999)</em></td>
<td>Changed wording to “high school students who are current cigarette smokers” in 2006 to make consistent with survey questions</td>
</tr>
<tr>
<td><strong>Youth Tobacco Use</strong>: By 2015, reduce to 10% the proportion of high school students (under 18) who are current cigarette smokers. <em>(Adopted 2006)</em></td>
<td>Restated objective to make consistent with survey questions</td>
</tr>
<tr>
<td><strong>Youth Smokeless Tobacco Use</strong>: By 2015, reduce to 1% the proportion of high school students (under 18) who are current users of smokeless tobacco. <em>(Adopted 2006)</em></td>
<td>New objective established in 2006 following mid-course assessment</td>
</tr>
<tr>
<td><strong>Adult Tobacco Use</strong>: By 2010, reduce to 18.5% the proportion of adults (18 and older) who are current cigarette smokers. <em>(Adopted 2006)</em></td>
<td>Updated the 2005-related objective to a 2010 objective following mid-course assessment</td>
</tr>
<tr>
<td><strong>Adult Tobacco Use</strong>: By 2010, reduce to 22% the proportion of adults (25 and older) with less than a high school education who are current cigarette smokers. <em>(Adopted 2009)</em></td>
<td>Restated the objective as low education level is often used as a proxy measure for socioeconomic status (SES) and is a more reliable measure. Restatement of the objective also clarifies the objective to match available data.</td>
</tr>
<tr>
<td><strong>Adult Tobacco Use</strong>: By 2010, reduce by 25% from 2000 baseline prevalence rate the proportion of low-SES adults (18 and older) who are current cigarette smokers. <em>(Adopted 2006)</em></td>
<td>Updated the 2005-related objective to a 2010 objective following mid-course assessment</td>
</tr>
<tr>
<td><strong>Youth Tobacco Use</strong>: By 2010, reduce to 15% the proportion of high school students (under 18) who are current cigarette smokers. <em>(Adopted 2006)</em></td>
<td>Updated the 2005-related objective to a 2010 objective following mid-course assessment</td>
</tr>
</tbody>
</table>

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## Lung Cancer and Adult and Youth Tobacco Use (continued)

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Adult Tobacco Use:</strong> By 2005, reduce to 19% the proportion of adults (18 and older) who use tobacco products. <em>(Adopted 2000)</em></td>
<td>This objective was restated in a 2010 objective following mid-course assessment.</td>
</tr>
<tr>
<td><strong>Adult Tobacco Use:</strong> By 2005, reduce by 25% from 2000 baseline prevalence rate the proportion of low-SES adults (18 and older) who use tobacco products. <em>(Adopted 2000)</em></td>
<td>This objective was restated in a 2010 objective following mid-course assessment.</td>
</tr>
<tr>
<td><strong>Youth Tobacco Use:</strong> By 2005, reduce to 15% or less the frequent use of cigarettes by young people (under 18). <em>(Adopted 2000)</em></td>
<td>This objective was restated in a 2010 objective following mid-course assessment.</td>
</tr>
<tr>
<td><strong>Tobacco Settlement:</strong> By 2005, 75% of states will direct available tobacco control funds consistent with CDC guidelines. <em>(Adopted 2000)</em></td>
<td>This objective was moved to operations in 2006 and is being monitored as an existing Leadership Role metric.</td>
</tr>
<tr>
<td><strong>Clean Indoor Air:</strong> By 2005, 50% of US population will reside in communities covered by comprehensive clean indoor air laws/policies. <em>(Adopted 2000)</em></td>
<td>This objective was moved to operations in 2006 and is being monitored as an existing Leadership Role metric.</td>
</tr>
<tr>
<td><strong>Tobacco-free Schools:</strong> By 2005, 100% of schools will have tobacco-free environments. <em>(Adopted 2000)</em></td>
<td>This objective was moved to operations in 2006 and is being monitored as a key indicator in business plan activities.</td>
</tr>
<tr>
<td><strong>Tobacco Excise Taxes:</strong> By 2005, all states will achieve a state excise tax level on cigarettes that is equal to the federal level, and 50% of states will achieve a state excise tax level on cigarettes that is equal to or greater than $1.00 per pack. <em>(Adopted 2000)</em></td>
<td>This objective was moved to operations in 2006 and is being monitored as an existing Leadership Role metric.</td>
</tr>
</tbody>
</table>

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## Breast Cancer

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Incidence:</strong> By 2015, reduce the age-adjusted incidence rate of breast cancer by 15%. <em>(Adopted 1999)</em></td>
<td>No change since adoption</td>
</tr>
<tr>
<td><strong>Mortality:</strong> By 2015, reduce the age-adjusted mortality rate of breast cancer by 45%. <em>(Adopted 1999)</em></td>
<td>Restated in 2005 following mid-course assessment to make consistent with overall 2015 goal of a 50% reduction</td>
</tr>
<tr>
<td><strong>Mortality:</strong> By 2015, reduce the age-adjusted mortality rate of breast cancer by 50%. <em>(Adopted 2005)</em></td>
<td>Restated objective to make consistent with overall 2015 goal of a 50% reduction</td>
</tr>
<tr>
<td><strong>Early Detection:</strong> By 2015, increase to 90% the proportion of women aged 40 and older who have breast screening consistent with American Cancer Society guidelines. <em>(Adopted 2009)</em></td>
<td>Changed the timeframe from 2010 to 2015. The mammography rates have remained stable at around 60% over the past five years and it is unlikely that we could meet the 90% screening level by 2010.</td>
</tr>
<tr>
<td><strong>Early Detection:</strong> By 2010, increase to 90% the proportion of women aged 40 and older who have breast screening consistent with American Cancer Society guidelines. <em>(Adopted 2006)</em></td>
<td>Updated 2008- and 2005-related objectives following mid-course assessment</td>
</tr>
<tr>
<td><strong>Early Detection:</strong> By 2008, increase to 90% the proportion of women aged 40 and older who have breast screening consistent with American Cancer Society guidelines. <em>(Adopted 1999)</em></td>
<td>Restated in a 2010 objective following mid-course assessment</td>
</tr>
<tr>
<td><strong>Behavior Change:</strong> By 2005, the recent screening rates of women aged 40+, women aged 65+, and low-SES populations (200% of poverty level and below) will be 70%. <em>(Adopted 2000)</em></td>
<td>Restated in a 2010 objective following mid-course assessment</td>
</tr>
<tr>
<td><strong>Access to Treatment:</strong> By 2005, through advocacy at all organizational levels, 100% of women will have access to appropriate treatment. <em>(Adopted 2000)</em></td>
<td>This objective was moved to operations in 2006 and is being monitored as an existing Leadership Role metric.</td>
</tr>
</tbody>
</table>

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## Historical Change

### Breast Cancer (continued)

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<tr>
<th>Outcome Statement/Origination Date</th>
<th>Rationale for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Surveillance:</strong> By 2002, include in all state registries Ductal Carcinoma In Situ (DCIS) surveillance data as a measurement for evaluating screening. <em>(Adopted 2000)</em></td>
<td>This objective was completed in 2002.</td>
</tr>
</tbody>
</table>

### Prostate Cancer

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<thead>
<tr>
<th>Outcome Statement/Origination Date</th>
<th>Rationale for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Incidence:</strong> By 2015, reduce the age-adjusted incidence rate of prostate cancer by 15%. <em>(Adopted 1999)</em></td>
<td>No change since adoption</td>
</tr>
<tr>
<td><strong>Mortality:</strong> By 2015, reduce the age-adjusted mortality rate of prostate cancer by 20%. <em>(Adopted 1999)</em></td>
<td>Restated in 2005 following mid-course assessment to make consistent with overall 2015 goal of a 50% reduction</td>
</tr>
<tr>
<td><strong>Mortality:</strong> By 2015, reduce the age-adjusted mortality rate of prostate cancer by 50%. <em>(Adopted 2005)</em></td>
<td>Restated objective to make consistent with overall 2015 goal of a 50% reduction</td>
</tr>
<tr>
<td><strong>Early Detection:</strong> By 2015, increase to 90% the proportion of men aged 50 and older who follow American Cancer Society detection guidelines for prostate cancer. <em>(Adopted 1999)</em></td>
<td>Changed wording by adding “age-appropriate” in 2001 for clarity</td>
</tr>
<tr>
<td><strong>Early Detection:</strong> By 2015, increase to 90% the proportion of men who follow age-appropriate American Cancer Society detection guidelines for prostate cancer. <em>(Adopted 2001)</em></td>
<td>Restated objective for clarity</td>
</tr>
<tr>
<td><strong>Mortality:</strong> By 2010, reduce the age-adjusted mortality rate of prostate cancer by 40%. <em>(Adopted 2006)</em></td>
<td>New objective established in 2006 as interim measure toward 2015 objective</td>
</tr>
</tbody>
</table>

Note that statements outlined in blue are those currently in effect.
# Historical Change

## Prostate Cancer (continued)

<table>
<thead>
<tr>
<th>Outcome Statement/Origination Date</th>
<th>Rationale for Change</th>
</tr>
</thead>
</table>
| **Behavior Change:** By 2010, increase the percentage of men who have been offered age-appropriate PSA screening to 75%. *Adopted 2006* | Updated 2005-related objective following mid-course assessment  
Eliminated this objective based on results of recent clinical trials |
| **Behavior Change:** By 2005, increase the percentage of age-eligible men who have been offered PSA screening to 75%. *Adopted 2000* | Wording change in 2001 for clarity |
| **Behavior Change:** By 2005, increase the percentage of men who have been offered age-appropriate PSA screening to 75%. *Adopted 2001* | Restated in a 2010 objective following mid-course assessment |
| **Surveillance:** By 2002, develop data collection systems to accurately measure the percentage of men screened for prostate cancer as measured by PSA tests. *Adopted 2000* | This objective was completed in 2002. |

*Note that statements outlined in blue are those currently in effect.*
### Nutrition and Physical Activity

<table>
<thead>
<tr>
<th>Outcome Statement/Origination Date</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Behavior Change:</strong> By 2015, increase to 75% the proportion of persons who follow American Cancer Society guidelines on diet and nutrition as measured by consumption of fruits and vegetables. <em>(Adopted 1999)</em></td>
<td>This objective was restated in 2000 for clarity.</td>
</tr>
<tr>
<td><strong>Behavior Change:</strong> By 2015, increase to 75% the proportion of persons who follow American Cancer Society guidelines with respect to consumption of fruits and vegetables as published in the American Cancer Society Guidelines on Nutrition and Physical Activity for Cancer Prevention. <em>(Adopted 2000)</em></td>
<td>Restated objective for clarity</td>
</tr>
<tr>
<td><strong>Behavior Change:</strong> By 2015, increase to 90% the proportion of youth (high school students) and to 60% the proportion of adults who follow American Cancer Society guidelines with respect to the appropriate level of physical activity as published in the American Cancer Society Guidelines on Nutrition and Physical Activity for Cancer Prevention. <em>(Adopted 2000)</em></td>
<td>This objective was revised in 2006 following mid-course assessment to a new target for youth and adults.</td>
</tr>
<tr>
<td><strong>Behavior Change:</strong> By 2015, increase to 70% the proportion of adults and youth who follow American Cancer Society guidelines with respect to the appropriate level of physical activity as published in the American Cancer Society Guidelines on Nutrition and Physical Activity for Cancer Prevention. <em>(Adopted 2006)</em></td>
<td>Revised objective with a new target for youth and adults</td>
</tr>
<tr>
<td><strong>Overweight/Obesity:</strong> By 2015, the trend of increasing prevalence of overweight and obesity among US adults and youth will have been reversed, and by 2015, the prevalence of overweight and obesity will be no higher than it was in 2005. <em>(Adopted 2006)</em></td>
<td>New objective established in 2006 following mid-course review</td>
</tr>
</tbody>
</table>

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### Historical Change

**Nutrition and Physical Activity** (continued)

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<thead>
<tr>
<th>Outcome Statement/Origination Date</th>
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</thead>
<tbody>
<tr>
<td><strong>Behavior Change:</strong> By 2010, increase to 45% the proportion of adults and youth who meet American Cancer Society guidelines for vegetable and fruit consumption, as published in the American Cancer Society Guidelines on Nutrition and Physical Activity for Cancer Prevention. (<em>Adopted 2006</em>)</td>
<td>Updated from a 2005-related objective following mid-course assessment</td>
</tr>
<tr>
<td><strong>Behavior Change:</strong> By 2010, increase to 60% the proportion of adults and youth who meet American Cancer Society guidelines for physical activity, as published in the American Cancer Society Guidelines on Nutrition and Physical Activity for Cancer Prevention. (<em>Adopted 2006</em>)</td>
<td>Updated from a 2005-related objective following mid-course assessment</td>
</tr>
<tr>
<td><strong>Overweight/Obesity:</strong> By 2010, the increasing trends in overweight/obesity for both US adults and youth will have stopped. (<em>Adopted 2006</em>)</td>
<td>New objective</td>
</tr>
<tr>
<td><strong>Public Awareness:</strong> By 2005, 90% of the public will be aware of and have knowledge about the role of a healthy diet and physical activity in preventing cancer. (<em>Adopted 2000</em>)</td>
<td>This objective was moved to operations in 2006 and is being monitored as a key indicator in business plan activities.</td>
</tr>
<tr>
<td><strong>Behavior Change:</strong> By 2005, 45% of the population will consume five servings of fruits and vegetables daily. (<em>Adopted 2000</em>)</td>
<td>Restated in a 2010 objective following mid-course assessment</td>
</tr>
<tr>
<td><strong>Behavior Change:</strong> By 2005, increase to 72% the proportion of youth (high school students) and to 30% the proportion of adults who follow American Cancer Society guidelines with respect to the appropriate level of physical activity as published in the American Cancer Society Guidelines on Nutrition and Physical Activity for Cancer Prevention. (<em>Adopted 2000</em>)</td>
<td>Restated in a 2010 objective following mid-course assessment</td>
</tr>
</tbody>
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## Skin Cancer

<table>
<thead>
<tr>
<th>Outcome Statement/Origination Date</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Behavior Change:</strong> By 2015, increase to 75% the proportion of people of all ages who use at least two or more of the following protective measures that may reduce the risk of skin cancer: avoid the sun between 10 a.m. and 4 p.m., wear sun-protective clothing when exposed to sunlight, use sunscreen with an SPF 15 or higher, and avoid artificial sources of ultraviolet light (e.g., sun lamps, tanning booths). <em>(Adopted 1999)</em></td>
<td>Revised wording in 2006 by substituting the words “properly apply” for “use”</td>
</tr>
<tr>
<td><strong>Behavior Change:</strong> By 2015, increase to 75% the proportion of people of all ages who use at least two or more of the following protective measures that may reduce the risk of skin cancer: avoid the sun between 10 a.m. and 4 p.m., wear sun-protective clothing when exposed to sunlight, properly apply sunscreen with an SPF 15 or higher, and avoid artificial sources of ultraviolet light (e.g., sun lamps, tanning booths). <em>(Adopted 2006)</em></td>
<td>Revised objective with 2006 wording change</td>
</tr>
<tr>
<td><strong>Public Awareness:</strong> By 2005, 50% of parents will be aware of and have knowledge about the importance of sun protection for their children. <em>(Adopted 2000)</em></td>
<td>This objective was eliminated in 2006 as there are currently no existing population-based measures of awareness and knowledge about sun protection in the general public.</td>
</tr>
<tr>
<td><strong>Organizational Awareness:</strong> By 2005, 50% of elementary schools, day-care centers, parks/recreation centers will be aware of and have knowledge about the importance of sun protection. <em>(Adopted 2000)</em></td>
<td>This objective was deleted in 2001 due to redundancy.</td>
</tr>
<tr>
<td><strong>Organizational Policy:</strong> By 2005, 50% of elementary schools, day-care centers, parks/recreation centers will have policies to foster skin protection. <em>(Adopted 2000)</em></td>
<td>This objective was eliminated in 2006 as there are currently no existing measures of numbers of organizations with policies that foster skin protection. School-based policies will continue to be monitored through the School Health Program and Policies Study periodically conducted by the CDC.</td>
</tr>
</tbody>
</table>

*Note that statements outlined in blue are those currently in effect.*
### Comprehensive School Health Education

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<tr>
<th>Outcome Statement/Origination Date</th>
<th>Rationale for Change</th>
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</thead>
<tbody>
<tr>
<td><strong>Comprehensive School Health Education (CSHE):</strong> By 2015, increase to 50% the proportion of school districts that provide a comprehensive or coordinated school health education program. <em>(Adopted 1999)</em></td>
<td>No change since adoption</td>
</tr>
<tr>
<td><strong>School Health Councils:</strong> By 2015, 90% of school districts will have active school health councils. <em>(Adopted 2009)</em></td>
<td>This objective was updated to a new timeframe and new target based on essentially meeting the related 2010 objective.</td>
</tr>
<tr>
<td><strong>School Health Coordinators:</strong> By 2015, 90% of school districts will have trained school health coordinators. <em>(Adopted 2009)</em></td>
<td>This objective was updated to a new timeframe and new target based on meeting the related 2010 objective.</td>
</tr>
<tr>
<td><strong>CSHE:</strong> By 2010, 35% of school districts will provide CSHE. <em>(Adopted 2006)</em></td>
<td>Updated from 2005-related objective following mid-course assessment</td>
</tr>
<tr>
<td><strong>School Health Councils:</strong> By 2010, 75% of school districts will have active school health councils. <em>(Adopted 2006)</em></td>
<td>Updated from 2005-related objective following mid-course assessment. This objective has essentially been met and was updated to a new 2015 objective in 2009.</td>
</tr>
<tr>
<td><strong>School Health Coordinators:</strong> By 2010, 50% of school districts will have trained school health coordinators. <em>(Adopted 2006)</em></td>
<td>Updated from 2005-related objective following mid-course assessment. This objective has been met and was updated to a new 2015 objective in 2009.</td>
</tr>
<tr>
<td><strong>CSHE:</strong> By 2005, 20% of school districts will provide CSHE. <em>(Adopted 2000)</em></td>
<td>This objective was updated to a 2010 objective following mid-course assessment.</td>
</tr>
<tr>
<td><strong>School Health Councils:</strong> By 2005, 50% of school districts will have active school health councils. <em>(Adopted 2000)</em></td>
<td>This objective was updated to a 2010 objective following mid-course assessment.</td>
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### Comprehensive School Health Education (continued)

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<tbody>
<tr>
<td><strong>School Health Coordinators</strong>: By 2005, 50% of school districts will have trained school health coordinators. <em>(Adopted 2000)</em></td>
<td>This objective was updated to a 2010 objective following mid-course assessment.</td>
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### Quality of Life

<table>
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<tr>
<th>Outcome Statement/Origination Date</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Access to Care</strong>: By 2015, the proportion of individuals without any type of health care coverage plan will decrease to 0%. <em>(Adopted 2006)</em></td>
<td>New objective adopted in 2006</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Costs</strong>: By 2015, the proportion of individuals diagnosed with cancer who report difficulties in obtaining medical care due to high out-of-pocket costs will decrease to 2%. <em>(Adopted 2006)</em></td>
<td>New objective adopted in 2006</td>
</tr>
<tr>
<td><strong>Pain Control</strong>: By 2015, all 50 states and the District of Columbia will have received a grade of B or higher on the Pain Policy Report Card, and at least 10 states will have received a grade of A. <em>(Adopted 2009)</em></td>
<td>Minor wording change for clarity</td>
</tr>
<tr>
<td><strong>Pain Control</strong>: By 2015, all 50 states and the District of Columbia will have received a grade of B or higher and 10 states will have received a grade of A on the Pain Policy Report Card. <em>(Adopted 2006)</em></td>
<td>New objective adopted in 2006</td>
</tr>
</tbody>
</table>

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### Historical Change

#### Quality of Life (continued)

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Symptom Control</strong>: By 2015, establish and implement a process to measure the effective control of pain, other symptoms, and side effects for those affected by cancer. <em>(Adopted 2009)</em></td>
<td>New objective established in 2009</td>
</tr>
<tr>
<td><strong>Measurement</strong>: By 2015, there will be national surveillance systems to monitor quality of life for those affected by cancer. <em>(Adopted 2006)</em></td>
<td>New objective adopted in 2006. Objective deleted in 2009 and restated in new symptom control measurement objective.</td>
</tr>
<tr>
<td><strong>End-of-Life Care</strong>: By 2015, increase use of best practice end-of-life care. <em>(Adopted 2009)</em></td>
<td>New objective established in 2009</td>
</tr>
<tr>
<td><strong>Physical Effects</strong>: By 2015, provide appropriate care for symptom control, emphasizing pain, rehabilitation, and side effects of treatment based upon an appropriate care plan using uniform standards of care for 90% of cancer survivors. <em>(Adopted 1999)</em></td>
<td>Changed wording in 2001 by adding “fatigue” to the statement</td>
</tr>
<tr>
<td><strong>Physical Effects</strong>: By 2015, provide appropriate care for symptom control, emphasizing pain, fatigue, rehabilitation, and side effects of treatment based upon an appropriate care plan using uniform standards of care for 90% of cancer survivors. <em>(Adopted 2001)</em></td>
<td>Objective deleted in 2006 as no population-based surveillance data sets currently exist to provide assessments of progress. New objectives were adopted in 2006 based on a new model and available data.</td>
</tr>
<tr>
<td><strong>Pain Control</strong>: By 2015, provide appropriate care for the control of pain based upon an appropriate care plan using uniform standards of care for 90% of cancer survivors. <em>(Adopted 1999)</em></td>
<td>Objective deleted in 2006 as no population-based surveillance data sets currently exist to provide assessments of progress. New objectives were adopted in 2006 based on a new model and available data.</td>
</tr>
<tr>
<td><strong>Physical Appearance</strong>: By 2015, the negative impact of cancer on physical appearance and body image will be substantially reduced in 75% of those affected cancer survivors. <em>(Adopted 1999)</em></td>
<td>Objective deleted in 2006 as no population-based surveillance data sets currently exist to provide assessments of progress. New objectives were adopted in 2006 based on a new model and available data.</td>
</tr>
</tbody>
</table>

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### Quality of Life (continued)

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<tr>
<th>Outcome Statement/Origination Date</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Social Support:</strong> By 2015, appropriate interventions for socioeconomic needs will be received by 90% of cancer survivors, and families and caregivers of those affected by cancer. <em>(Adopted 1999)</em></td>
<td>This objective was restated in 2001 for clarity.</td>
</tr>
<tr>
<td><strong>Support Network:</strong> By 2015, 90% of cancer survivors and families and caregivers of those affected by cancer will express satisfaction with the available social support network. <em>(Adopted 2001)</em></td>
<td>Objective deleted in 2006 as no population-based surveillance data sets currently exist to provide assessments of progress. New objectives were adopted in 2006 based on a new model and available data.</td>
</tr>
<tr>
<td><strong>Social Effects:</strong> By 2015, 75% of cancer survivors and their families will be assisted through advocacy, referral, and education in addressing financial, employability, insurability issues, and access to treatment and follow-up care. <em>(Adopted 1999)</em></td>
<td>This objective was restated in 2001 for clarity.</td>
</tr>
<tr>
<td><strong>Socioeconomic Support:</strong> By 2015, 75% of cancer survivors and their families will be assisted through advocacy, referral, and education in addressing financial, employability, insurability issues, and access to treatment and follow-up care. <em>(Adopted 2001)</em></td>
<td>Wording was added to this objective in 2002 for clarity.</td>
</tr>
<tr>
<td><strong>Socioeconomic Support:</strong> By 2015, 75% of cancer survivors and their families will be appropriately assisted at the community level through program/service delivery, advocacy, referral, and education in addressing identified needs related to financial, employability, insurability issues, and access to treatment and follow-up care. <em>(Adopted 2002)</em></td>
<td>Objective deleted in 2006 as no population-based surveillance data sets currently exist to provide assessments of progress. New objectives were adopted in 2006 based on a new model and available data.</td>
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### Historical Change

#### Quality of Life (continued)

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<tr>
<th>Outcome Statement/Origination Date</th>
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</thead>
<tbody>
<tr>
<td><strong>Psychological, Emotional, Spiritual Effects:</strong> By 2015, 90% of cancer survivors and families and caregivers of those affected by cancer will receive appropriate care or appropriate referral to services for identified psychological, emotional, and spiritual problems and/or needs. <em>(Adopted 1999)</em></td>
<td>Wording was changed in 2001 for clarity.</td>
</tr>
<tr>
<td><strong>Psychological, Emotional, Spiritual Effects:</strong> By 2015, 90% of cancer survivors and families and caregivers of those affected by cancer will receive appropriate care or appropriate referral to services for identified psychological, emotional, and spiritual distress and/or needs. <em>(Adopted 2001)</em></td>
<td>Objective deleted in 2006 as no population-based surveillance data sets currently exist to provide assessments of progress. New objectives were adopted in 2006 based on a new model and available data.</td>
</tr>
<tr>
<td><strong>Provider Education:</strong> By 2015, 90% of health care providers will assess psychological, emotional, and spiritual needs of cancer survivors and families and caregivers of those affected by cancer and provide appropriate care or appropriate referral to services. <em>(Adopted 1999)</em></td>
<td>Objective deleted in 2006 as no population-based surveillance data sets currently exist to provide assessments of progress. New objectives were adopted in 2006 based on a new model and available data.</td>
</tr>
<tr>
<td><strong>Service Delivery Systems:</strong> By 2008, 100% of Divisions will develop or have access to a comprehensive service delivery system that addresses the needs of cancer survivors, their families, and caregivers through Society programs/services, or referral to other organizations and resource development to fill gaps in services. <em>(Adopted 2002)</em></td>
<td>This objective was moved to operations in 2005 under the Leadership Roles.</td>
</tr>
<tr>
<td><strong>Public Awareness:</strong> By 2005, 60% of survivors, their families, and caregivers will be aware of and have knowledge about American Cancer Society quality-of-life education and support services. <em>(Adopted 2000)</em></td>
<td>This objective was moved to operations in 2005 under the Leadership Roles.</td>
</tr>
</tbody>
</table>

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### Quality of Life (continued)

<table>
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<tr>
<th>Outcome Statement/Origination Date</th>
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</thead>
<tbody>
<tr>
<td><strong>Health Care Provider Awareness:</strong> By 2005, 75% of relevant health care providers (e.g. cancer care providers, primary care providers) will be aware of and express satisfaction with and willingness to refer their patients to American Cancer Society quality-of-life education and support services. <em>(Adopted 2000)</em></td>
<td>This objective was moved to operations in 2005 under the Leadership Roles.</td>
</tr>
<tr>
<td><strong>Public Policy/System Change:</strong> By 2005, 75% of health care systems will have institutionalized quality standards for the management of pain. <em>(Adopted 2000)</em></td>
<td>Objective deleted in 2006 as no population-based surveillance data sets currently exist to provide assessments of progress. New objectives were adopted in 2006 based on a new model and available data.</td>
</tr>
<tr>
<td><strong>Society Patient Support Programs:</strong> By 2005, the number of cancer survivors, their families, and caregivers who participate in appropriate Society patient support programs or are referred to other community programs will increase by at least 50%. <em>(Adopted 2000)</em></td>
<td>This objective was moved to operations in 2005 under the Leadership Roles.</td>
</tr>
<tr>
<td><strong>Public Policy/System Change:</strong> By 2002, all Divisions and national will have three-year action plans to influence public policy for priority issues in quality of life, including pain control. <em>(Adopted 2000)</em></td>
<td>This objective was mostly completed in 2002.</td>
</tr>
<tr>
<td><strong>Assessment of Need:</strong> Every three years, the American Cancer Society will document the self-reported needs of cancer survivors, their families, and caregivers to determine Society roles, collaborative opportunities, and potential Society programs. <em>(Adopted 2000)</em></td>
<td>Objective deleted in 2006 as no population-based surveillance data sets currently exist to provide assessments of progress. New objectives were adopted in 2006 based on a new model and available data.</td>
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## Access to Care

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<tbody>
<tr>
<td><strong>Health Care Coverage:</strong> By 2015, the proportion of individuals without any type of health care coverage plan will decrease to 0%. <em>(Adopted 2009)</em></td>
<td>Objective moved in 2009 from the “Quality of Life” category to a new overall category titled “Access to Care.” The subtitle of this objective was changed to “Health Care Coverage.”</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Costs:</strong> By 2015, no more than 2% of individuals diagnosed with cancer will report difficulties in obtaining medical care due to high out-of-pocket costs. <em>(Adopted 2009)</em></td>
<td>Objective moved in 2009 from the “Quality of Life” category to a new overall category titled “Access to Care.” The intent of the objective remained the same, but with minor wording changes for clarity.</td>
</tr>
<tr>
<td><strong>Completion of Recommended Treatment:</strong> By 2015, establish and implement a process for measuring the completion of recommended treatment based on established guidelines, including participation in clinical trials. <em>(Adopted 2009)</em></td>
<td>New objective adopted in 2009</td>
</tr>
</tbody>
</table>

*Note that statements outlined in blue are those currently in effect.*
## Leadership Roles, Focus Areas, Supporting Pillars, Mission Outcomes

### Leadership Roles and Focus Areas

<table>
<thead>
<tr>
<th>Outcome Statement/Origination Date</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Information:</strong> Support better decisions by making available high-quality, timely, understandable information, especially to newly diagnosed cancer patients and their caregivers.</td>
<td>No change since adoption</td>
</tr>
<tr>
<td>Focus Areas:</td>
<td></td>
</tr>
<tr>
<td>• Being a trusted provider of unbiased, general information</td>
<td></td>
</tr>
<tr>
<td>• Being a trusted provider of interactive, personal information and guidance <em>(Adopted 2004)</em></td>
<td></td>
</tr>
<tr>
<td><strong>Research:</strong> Leverage the Society's scientific credibility and unique position to support innovative, high-impact research – through both direct funding and the ability to influence the amount and direction of research funding from other sources.</td>
<td>No change since adoption</td>
</tr>
<tr>
<td>Focus Areas:</td>
<td></td>
</tr>
<tr>
<td>• Extramural funding of innovative and high-impact research</td>
<td></td>
</tr>
<tr>
<td>• Intramural funding to conduct, collaborate, and publish high-impact research, assisting both internal and external cancer control strategies</td>
<td></td>
</tr>
<tr>
<td>• Influence amount and direction of funding and policy changes that support research <em>(Adopted 2004)</em></td>
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Leadership Roles and Focus Areas (continued)

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<th>Outcome Statement/Origination Date</th>
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</thead>
<tbody>
<tr>
<td><strong>Quality of Life:</strong> Improve quality of life of cancer patients, caregivers, and survivors by assisting primarily with service referral, community mobilization, collaboration, advocacy, and where appropriate, directly providing services.</td>
<td>No change since adoption</td>
</tr>
</tbody>
</table>

Focus Areas:
- Refer patients and caregivers to optimal local services via multiple channels.
- Influence investment by local communities in high-impact, quality-of-life services and policies through community mobilization, collaboration, and advocacy.
- Where necessary, to directly provide services where the Society is uniquely able to do so. *(Adopted 2004)*

| **Prevention and Early Detection:** Increase the prevention and early detection of cancer. *(Adopted 2004)* | No change since adoption |

| **Prevention and Early Detection** | Restated in 2010 for clarity |

Focus Area:
- Prevent and detect colorectal cancer, as early as possible. *(Adopted 2010)*
- Prevent and detect, as early as possible, colorectal cancer through increased screening rates, including addressing disparities. *(Adopted 2004)*

*Note that statements outlined in blue are those currently in effect.*
Leadership Roles and Focus Areas (continued)

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<tbody>
<tr>
<td><strong>Prevention and Early Detection</strong></td>
<td>Restated in 2010 for clarity</td>
</tr>
<tr>
<td>Focus Area:</td>
<td></td>
</tr>
<tr>
<td>• Reduce tobacco use to prevent lung and other cancers. <em>(Adopted 2010)</em></td>
<td></td>
</tr>
<tr>
<td>• Prevent lung cancer through legislative advocacy and smoking-cessation activities. <em>(Adopted 2004)</em></td>
<td></td>
</tr>
<tr>
<td><strong>Prevention and Early Detection</strong></td>
<td>Restated in 2010 for clarity</td>
</tr>
<tr>
<td>Focus Area:</td>
<td></td>
</tr>
<tr>
<td>• Prevent and detect breast cancer as early as possible. <em>(Adopted 2010)</em></td>
<td></td>
</tr>
<tr>
<td>• Reduce disparities in the early detection of breast cancer, primarily through advocacy and partnerships. <em>(Adopted 2004)</em></td>
<td></td>
</tr>
<tr>
<td><strong>Prevention and Early Detection</strong></td>
<td>New area of focus</td>
</tr>
<tr>
<td>Focus Area:</td>
<td></td>
</tr>
<tr>
<td>• Improve nutrition and physical activity to decrease the incidence of overweight-/obesity-related cancers. <em>(Adopted 2010)</em></td>
<td></td>
</tr>
</tbody>
</table>

*Note that statements outlined in blue are those currently in effect.*
### Leadership Roles – Supporting Pillars

<table>
<thead>
<tr>
<th>Outcome Statement/Origination Date</th>
<th>Rationale for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Advocacy:</strong> The leadership roles will be supported by a clear focus and investment in advocacy. Advocacy will be supported at the local, state, and national level with dedicated staff, direct funding, and volunteer involvement. <em>(Adopted 2004)</em></td>
<td>No change since adoption</td>
</tr>
<tr>
<td><strong>Disparities:</strong> The American Cancer Society recognizes the importance of disparities in each of its leadership roles and will focus its efforts on them. Disparities will be addressed through direct service delivery, advocacy efforts, and direct outreach to underserved communities. <em>(Adopted 2004)</em></td>
<td>No change since adoption</td>
</tr>
</tbody>
</table>

### Mission Outcomes

<table>
<thead>
<tr>
<th>Outcome Statement/Origination Date</th>
<th>Rationale for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prevention and Detection</strong></td>
<td>No change since adoption</td>
</tr>
</tbody>
</table>
| • Tobacco Focus: Decrease tobacco prevalence rates in adults and youth.  
  • Colorectal Focus: Increase colorectal screening among adults 50 and older.  
  • Breast Focus: Increase breast screening among women 40 and older.  
  • Nutrition/Physical Activity Focus: Decrease the prevalence of overweight and obesity. *(Adopted 2010)* | |

*Note that statements outlined in blue are those currently in effect.*
### Mission Outcomes (continued)

<table>
<thead>
<tr>
<th>Outcome Statement/Origination Date</th>
<th>Rationale for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Information and Quality of Life:</strong></td>
<td>No change since adoption</td>
</tr>
<tr>
<td>Begin to develop data-collection methods to monitor the improvement of health-related quality-of-life outcomes (physical, emotional, social and spiritual well-being) relative to: • Increasing cancer knowledge and empowering patients and caregivers to participate in decision-making, to communicate with their treatment team, and to cope with issues that arise throughout their cancer journey • Increasing patient and caregiver physical and psycho-social symptom management/well-being • Reducing barriers to receiving quality treatment <em>(Adopted 2010)</em></td>
<td></td>
</tr>
<tr>
<td><strong>Global Tobacco Control:</strong></td>
<td>No change since adoption</td>
</tr>
<tr>
<td>By 2015, prevent any increases in the smoking prevalence rate among both youth and adults in sub-Saharan Africa <em>(Adopted 2010)</em></td>
<td></td>
</tr>
</tbody>
</table>

*Note that statements outlined in blue are those currently in effect.*
We **save lives** and create more birthdays by helping you stay well, helping you get well, by finding cures, and by fighting back.

cancer.org  |  1.800.227.2345