Cancer Facts & Figures
for African American/Black People  2022-2024
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This publication attempts to summarize current scientific information about cancer. Except when specified, it does not represent the official policy of the American Cancer Society.

Basic Cancer Facts

Introduction

In 2020, there were 46.9 million Americans who identified as Black or African American, accounting for 14.2% of the total US population.\(^1,\^2\) The Black population is the third-largest racial/ethnic group following White and Hispanic people and primarily resides in the South (Figure 1). The population includes ancestors of individuals brought to the US as slaves who largely identify as African American, as well as nearly 10% who are recent immigrants, mostly of African or Caribbean descent. The Black immigrant population has increased 5-fold over the past four decades, from 816,000 in 1980 to more than 4.3 million in 2019.\(^3\)

Although racial classification is a social construct based on appearance, it remains useful for describing health patterns in the US because long-standing structural racism has contributed to inequalities in the social determinants of health. Although some cancer-associated genetic mutations are inherited, most health differences between population groups do not stem from biology, but from variations in socioeconomic status and access to medical care. Collectively, Black people have the highest death rates and shortest survival rates of any racial/ethnic group in the US for most cancers, largely driven by social mechanisms that are further explained on page 3. Notably, Black immigrants have lower cancer mortality than US-born Black people, highlighting the importance of where a person lives over race or biology.\(^4\)

Figure 1. Non-Hispanic Black Population as a Percentage of Total County Population, 2020


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This report presents statistics on cancer incidence, mortality, survival, and risk factors for Black people in the US. Additional information is given for selected cancer sites, chosen due to their large disparity and impact on the Black population. When possible, data are confined to non-Hispanic Black people, who account for approximately 94% of the total Black population, to limit racial misclassification. It is intended to provide information to cancer control advocates, community leaders, public health and health care workers, and others interested in cancer prevention, early detection, and treatment in the Black community.

### What Is Cancer?

Cancer is a group of diseases characterized by uncontrolled growth and spread of abnormal cells. If the spread is not controlled, it can result in death. Although the causes of cancer are not completely understood, numerous factors are known to increase risk, including many that are modifiable (e.g., tobacco use and excess body weight) and some that are not (e.g., inherited genetic mutations and immune conditions). These risk factors may act simultaneously or in sequence to initiate and/or promote cancer growth.

### Can Cancer Be Prevented?

A substantial proportion of cancer is preventable, including all cancers caused by tobacco use. Overall, at least 42% of newly diagnosed cancers are potentially avoidable, including the 19% caused by smoking and the 18% caused by a combination of excess body weight, physical inactivity, excess alcohol consumption, and poor nutrition. Many of the cancers caused by infectious organisms can also be prevented through behavioral changes, vaccination, or treatment of the infection. For more information on cancer risk factors, see page 22.

Screening can prevent colorectal and cervical cancers through the detection and removal of precancerous growths, as well as reduce mortality from cancers of the breast, colon, rectum, cervix, prostate, and lung and bronchus (among current or former heavy smokers) through early detection. A heightened awareness of changes in certain areas of the body, such as breast, skin, mouth, eyes, or genitalia, may also result in the early detection of cancer. For more information on cancer screening, see page 32.
Factors That Influence Cancer Disparities

Structural Racism

As noted earlier, the underlying source of health disparities among people of color is structural racism, which is discrimination perpetuated through interconnected institutions and reinforced through culture, history, ideology, and sanctioned practices. Structural racism impacts all facets of life to limit the accumulation of wealth and overall standard of living through unequal access to work, education, housing, healthy food, and quality health care.\(^6\),\(^7\)

One example of structural racism is redlining, a historically legal form of lending discrimination in which creditworthy applicants who lived in poor neighborhoods, usually with a large Black population, were refused loans for housing improvement and purchase. This practice facilitated segregation by preventing Black people from gaining home equity and entering middle or upper class neighborhoods, and continues to influence health today.\(^7\) Areas with historical redlining and/or current lending bias are associated with increased risk of late-stage cancer diagnosis\(^*\) and have 2 times higher breast cancer mortality rates than other areas.\(^10\)

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\(^*\)For those who have not been previously diagnosed with cancer.\(^\dagger\)All sites excludes basal and squamous cell skin cancers and in situ cancers except urinary bladder.\(^\ddagger\)Includes in situ cancers. Note: Percentages and “1 in” numbers may not be equivalent due to rounding.

Source: DevCan: Probability of Developing or Dying of Cancer Software, Version 6.7.9 ©2022, American Cancer Society, Inc., Surveillance and Health Equity Science
discriminatory practices include the diversion from historically Black neighborhoods of public transportation, grocery stores, and public green spaces, all of which limits the availability of affordable healthy food and opportunities for physical activity. Additionally, this environment increases the prevalence of chronic stress, infectious disease, and other exposures that contribute to poorer health.

Socioeconomic Status

As a result of this historical context and social structure, race is strongly correlated with socioeconomic status (SES) in the United States. During 2019-2020, 19% of Black people were living below the federal poverty level compared to 7% of White people, and only 28% had completed four years of college compared to 41% of Whites. Cancer risk and mortality increase with decreasing SES, regardless of race/ethnicity. This is largely because of higher prevalence of cancer risk factors due to marketing strategies that target low-income populations; environmental and community factors mentioned in the previous section; and unequal access to high-quality care. However, Black people have higher death rates than White people at every level of SES. Although racial disparities in cancer mortality have begun to narrow, socioeconomic disparities have widened over the past several decades.

Access to Care

Access to health care influences the use of prevention and early detection services (e.g., tobacco cessation counseling and cancer screening), as well as receipt of cancer treatment and survivorship care. One of the largest obstacles to high-quality care is cost, which is exacerbated for Black people by disproportionately low insurance coverage. In the US, insurance coverage is closely tied to employment. However, Black people are further disadvantaged by having a higher likelihood of inadequate health insurance even with employment. Compared to their uninsured counterparts, people with health insurance are more likely to have a usual source of...
### Table 3. Incidence Rates* for Selected Cancers in Black People by Sex and State, 2014-2018

<table>
<thead>
<tr>
<th>State</th>
<th>All Cancers</th>
<th>Lung &amp; Bronchus</th>
<th>Colon &amp; Rectum</th>
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</table>

Race is exclusive of Hispanic ethnicity. *Rates are per 100,000 and age adjusted to the 2000 US standard population. †Rates are suppressed when there are fewer than 25 cases. ‡Data from this registry is not included in US combined rates because they did not consent or because they did not meet NAACCR high-quality standards for all years during 2014-2018. §Colon & rectum incidence for this state includes appendix cancer.

Table 4. Death Rates* for Selected Cancers in Black People by Sex and State, 2015-2019

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<th>State</th>
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<th>Female</th>
<th>Male</th>
<th>Female</th>
<th>Male</th>
<th>Female</th>
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<td>14.8</td>
<td>37.9</td>
<td>28.0</td>
</tr>
</tbody>
</table>

Race is exclusive of Hispanic ethnicity. *Rates are per 100,000 and age adjusted to the 2000 US standard population. †Rates are suppressed when there are fewer than 25 deaths.

Figure 3. Trends in Death Rates* for Selected Cancer Sites among Black and White People, US, 1975-2019

Race includes Hispanic ethnicity. *Rates are age adjusted to the US standard population and are 2-year moving averages.

**Source:** National Center for Health Statistics, Centers for Disease Control and Prevention, 2021.

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Studies show that equal treatment reduces racial disparities. The 2010 passage of the Affordable Care Act (ACA) and subsequent expansion of Medicaid by many states has helped to mitigate the financial burden of health care and reduce the number of people who are uninsured, particularly among those with lower SES. People of color have had the largest gains, with the uninsured rate declining from 20% in 2010 to 12% in 2019 in Black people and from 14% to 9% in White people. However, people of color are still more likely to be uninsured and are disproportionately represented in states that did not expand Medicaid. (For more information about how the ACA influences people diagnosed with cancer, see the Advocacy section on page 36.) Even when Black people do have access to care it is more often of lower quality compared to White people.

**Comorbidities (Other Health Conditions)**

Discriminatory practices and disproportionate poverty also contribute to a higher prevalence of other chronic diseases, which may increase cancer risk independently and/or through shared risk factors, as well as reduce the likelihood of cancer survival. For instance, diabetes increases risk of cancer incidence and mortality, and is more common among Black people than any other racial/ethnic group. (For more information about diabetes, see page 29.) The death rate for diabetes is about two times higher in Black people than in White people among both men and women (Table 1). Black people also have higher

---

**Table 5. Comparison of Cancer Incidence Rates between Black and White People, US, 2014-2018**

<table>
<thead>
<tr>
<th>Cancer</th>
<th>Male Black Rate*</th>
<th>Male White Rate</th>
<th>Male Absolute Difference†</th>
<th>Male Rate Ratio‡</th>
<th>Female Black Rate*</th>
<th>Female White Rate</th>
<th>Female Absolute Difference†</th>
<th>Female Rate Ratio‡</th>
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<td>1.2</td>
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<td>&lt;0.1</td>
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<td>7.8</td>
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<td>5.9</td>
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<td>7.4</td>
<td>3.5</td>
<td>3.9</td>
<td>2.14</td>
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<td>72.7</td>
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<td>5.5</td>
<td>3.9</td>
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<td>1.40</td>
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<td>10.9</td>
<td>6.9</td>
<td>1.63</td>
<td>15.0</td>
<td>11.2</td>
<td>3.8</td>
<td>1.24</td>
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<td>1.8</td>
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<td>2.7</td>
<td>1.18</td>
<td>13.5</td>
<td>11.8</td>
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<td>1.14</td>
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<td>28.1</td>
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<td>1.11</td>
<td>127.1</td>
<td>132.5</td>
<td>-5.4</td>
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<td>0.95</td>
<td>2.4</td>
<td>2.6</td>
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Races are exclusive of Hispanic ethnicity. Sites listed in descending order by rate ratio. *Rates are per 100,000 and age adjusted to the 2000 US standard population. †Absolute difference is the rate in Black minus the rate in White people. ‡Rate ratio is the unrounded rate in Black divided by the unrounded rate in White people.

death rates for heart disease, stroke, and hypertension, which have shared risk factors with cancer, as well as HIV/AIDS, which increases risk of several cancers.

Not surprisingly, the coronavirus disease 2019 (COVID-19) pandemic has exacerbated health disparities among people of color.33-35 Black individuals were about 3 times more likely to be hospitalized with COVID-19 and twice as likely to die from the disease compared to White individuals in 2020.36, 37 The 20% of counties in the US that are disproportionately Black accounted for 58% of COVID-19 deaths nationally from 2019 through mid-April 2020, highlighting the contribution of structural racism and racial segregation to health outcomes.33 Worse disease outcomes among Black patients may have been contributed to by less access to paid sick and vacation leave. In addition, employment is closely tied to health insurance, and the pandemic abruptly erased 5 years of progress in narrowing the Black-White unemployment gap.38 The long-term impact of the pandemic, including increased cancer incidence and mortality because of health care disruptions like decreased cancer screening,39 will unfold slowly over many years to come.

Medical Mistrust and Health System Implications

Studies have shown that Black people have higher mistrust in the medical system compared to Whites, with one-quarter expressing high mistrust of physicians.40 This is likely due in part to a long history of racial bias and discrimination in the US health care system, including exploitation of Black people for medical advancement,41 unequal treatment at segregated hospitals, and provider bias.43, 44, 45 For example, over 50% of surveyed medical students and residents believed one or more false statements regarding differences in how Black people perceive pain (e.g., they have thicker skin or less sensitive nerve endings).46 These biases likely explain the underprescription of opioid medicines to Black patients even when they have the same pain level, treatment preferences, and history of opioid abuse as White patients.47

---

<table>
<thead>
<tr>
<th>Cancer</th>
<th>Male Black Rate*</th>
<th>Male White Rate*</th>
<th>Absolute Difference†</th>
<th>Rate Ratio‡</th>
<th>Female Black Rate*</th>
<th>Female White Rate*</th>
<th>Absolute Difference†</th>
<th>Rate Ratio‡</th>
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<td>Melanoma of the skin</td>
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<td>1.8</td>
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</table>

All sites                     | 221.4            | 186.2            | 35.2                 | 1.19       | All sites         | 152.1            | 135.4                | 16.7       |

Races are exclusive of Hispanic ethnicity. Sites listed in descending order by rate ratio. *Rates are per 100,000 and age adjusted to the 2000 US standard population. †Absolute difference is the rate in Black minus the rate in White people. ‡Rate ratio is the unrounded rate in Black divided by the unrounded rate in White people.

Source: National Center for Health Statistics, Centers for Disease Control and Prevention, 2021. ©2022, American Cancer Society, Inc., Surveillance and Health Equity Science
Mistrust in providers and the medical system is associated with lower cancer screening and quality of life in Black prostate cancer survivors\textsuperscript{32,48} and also contributes to the underrepresentation of Black individuals in clinical trials.\textsuperscript{49} Diverse clinical trial participation is necessary to inform clinicians about the efficacy of cancer therapies among the general population, as well as among specific groups.\textsuperscript{50-53} However, most clinical trial participants are middle-aged White people without other health conditions, which neither reflects the cancer population as a whole, nor informs the treatment of Black or other patients of color, older patients, or other medically underserved individuals. In 2020, Black people represented 14\% of the of the total population but only 7\% of US Food and Drug Administration cancer trials participants.\textsuperscript{54} In addition to medical mistrust, factors that contribute to low participation include study design (e.g., lack of diverse recruitment), medical provider bias, enrollment requirements (e.g., exclusion of people with other illnesses), and barriers to access.\textsuperscript{52,53,55,56} Although decades of effort to increase diversity in clinical trials have yielded little progress,\textsuperscript{57} there is new hope with the Henrietta Lacks Enhancing Cancer Research Act signed into law in 2021. This legislation requires both the study of policies that impact diverse enrollment and implementation of changes to address these barriers.\textsuperscript{58} For more information on how the American Cancer Society and the American Cancer Society Cancer Action Network\textsuperscript{54} work to reduce cancer disparities, see the Advocacy section on page 36.
Cancer Occurrence in Black People

How Many Black Americans Alive Today Have Ever Had Cancer?

More than 1.4 million Black Americans with a history of cancer were alive on January 1, 2018, most of whom were diagnosed years earlier.39

What Is the Risk of Developing or Dying of Cancer?

The risk of being diagnosed with cancer increases with age because most types of cancer require many years to develop. About 1 in 3 Black men and women will be diagnosed with cancer in their lifetime and 1 in 5 Black men and 1 in 6 Black women will die from the disease (Table 2).
How Many New Cancer Cases and Deaths Are Expected in 2022?

**New cases:** About 111,990 cancer cases in Black men and 112,090 in Black women are expected to be newly diagnosed in 2022 (Figure 2). The most commonly diagnosed cancers are prostate, lung and bronchus (hereafter lung), and colon and rectum (hereafter colorectal) in Black men and breast, lung, and colorectal in Black women. These four cancers account for more than half of all new cases among Black people.

**Deaths:** About 36,430 Black men and 37,250 Black women are expected to die of cancer in 2022 (Figure 2). Lung cancer is the most common cause of cancer death among Black men (22%), followed by prostate cancer (17%), whereas breast cancer is the leading cause of cancer death in Black women (18%), followed by lung cancer (17%). This is in contrast to the overall female population, among whom lung cancer is the leading cause of cancer death. Colorectal cancer is the third-leading cause of cancer death in Black men and women, similar to the general population.

Does Cancer Occurrence Vary by State?

There is wide variation in cancer occurrence by state, particularly for cancers closely tied to behavioral factors like smoking (Table 3 and Table 4). For example, lung cancer incidence rates for Black men residing in the Southern states of Arkansas, Mississippi, and Kentucky are nearly twice those in Colorado and Nevada due to historically higher smoking prevalence that continues today.

How Has Cancer Occurrence Changed over Time?

**Trends in Cancer Incidence**

Since the early 1990s, incidence rates for all cancers combined have generally declined in Black men and remained stable in Black women. Patterns among Black men largely reflect declines in cancers of the prostate, lung, and colorectum. Whereas, among women, declines in lung and colorectal cancer are offset by increasing incidence of uterine corpus and breast cancer, though the trend for breast cancer has recently slowed and is approaching stabilization.

**Trends in Cancer Mortality**

Overall cancer death rates increased from the mid-1970s until 1991 at a much steeper pace in Black people than in White people, especially among men (Figure 3), largely driven by the tobacco epidemic. From 2010 to 2019, the death rate declined faster in Black men than in White men (3% versus 2% per year) but the pace was similar among women (2% per year).

The overall higher cancer death rates in Black people are largely due to cancers of the breast and colorectum in women and cancers of the prostate, lung, and colorectum in men. The more rapid progress in recent years, especially among Black men, largely reflects steep declines for lung and other smoking-related cancers because of rapid reductions in smoking prevalence over the past 40 years. (For more information on smoking, see page 22.) As a result, the Black-White disparity narrowed among men (Figure 3).

Major Differences in the Cancer Burden between Black and White People

**Incidence and Death Rates**

The risk of developing cancer is higher in Black than in White people for many cancers, especially those associated with infectious agents, such as stomach, liver, and cervical cancers. Table 5 and Table 6 show cancer incidence, mortality rates, and rate ratios in Black versus White people. Rate ratios greater than 1 indicate a higher rate in Black people and rate ratios less than 1 indicate a higher rate in White people.

Overall, Black men have 6% higher cancer incidence but 19% higher cancer mortality than White men, reflecting lower survival rates. Even more striking, Black women have 8% lower cancer incidence than White women, but 12% higher cancer mortality. This is partly driven by breast and uterine corpus cancers, for which Black women have slightly lower or similar incidence but 41% and 97% higher mortality, respectively. Uterine corpus cancer incidence rates that are calculated using hysterectomy-adjusted population denominators (i.e., only including women with an intact uterus who are at risk for this disease) are higher in Black than White.
Figure 6a. Trends in Incidence Rates* among Black People for Selected Cancers by Sex, 1975-2018

Race includes Hispanic ethnicity. *Rates are delay adjusted and age adjusted to 2000 US standard population and 2-year moving averages.

Source: SEER Program, 9 SEER Registries, National Cancer Institute, 2021.

Figure 6b. Trends in Death Rates* among Black People for Selected Cancers by Sex, US, 1975-2019

Race includes Hispanic ethnicity. Rates are age adjusted to 2000 US standard population and 2-year moving averages.

women because Black women are more likely to have had a hysterectomy. Thus, the uterine cancer mortality disparity would be even higher if corrected for hysterectomy prevalence.

The largest racial disparities in incidence and mortality are for stomach and prostate cancers and myeloma, with death rates more than 2-fold higher in Black people than in White people. In addition, incidence rates for Kaposi sarcoma (KS) are almost 4 times higher in Black people (Table 5). In the US, KS is a relatively rare cancer that primarily occurs among people infected with the human immunodeficiency virus (HIV), which is more common among Black people. (For more information on HIV infection, see page 31.)

Stage at Diagnosis and Survival
Stage of disease is the extent or spread of cancer at the time of diagnosis and has a large influence on cancer survival. In this report, stage is broadly classified as localized, regional, or distant, the definitions for which are provided in the footnotes of Figure 4. For most cancers, Black people are more likely than White people to be diagnosed with an advanced (regional or distant) stage, when treatment is usually more extensive and less successful (Figure 4).

A common measure of cancer survival is relative survival, which is the percentage of people with cancer who are alive at a specified time following diagnosis (typically 5 years), divided by the percentage expected to be alive in the absence of cancer based on normal life expectancy. Although 5-year relative survival rates for all cancers combined are useful in monitoring trends over time and comparing survival differences between groups, they do not predict individual prognosis because they do not account for many important factors that influence survival, such as tumor characteristics and other patient illnesses.

The overall 5-year relative survival rate among Black people has increased from approximately 27% during 1960-1963 to 63% during 2011-2017. Still, Black people continue to have lower 5-year survival than White people (68%) overall and for each stage of diagnosis for most cancer sites (Figure 5). Some of the largest racial disparities in 5-year relative survival include cancers of the oral cavity and pharynx (Black: 51%; White: 69%) and urinary bladder (Black: 65%; White: 78%). Most of the differences in survival are due to socioeconomic barriers that limit access to timely, appropriate, and high-quality medical care as opposed to biological differences. For more information on how socioeconomic status and access to care contribute to racial disparities, see Factors That Influence Racial Health Disparities, page 3.

Selected Cancers

Female Breast
Incidence
Breast cancer is the most commonly diagnosed cancer among Black women, with an estimated 36,260 new cases expected to be diagnosed in 2022. Similar to the pattern among White women, incidence rates among Black women increased rapidly during much of the 1980s (Figure 6a), largely due to increased detection of asymptomatic lesions through newly introduced mammography screening. Recently, increases have slowed and are approaching stabilization in Black women, in contrast to continued increases among White women.

During 2014-2018, the overall breast cancer incidence rate was 127.1 cases per 100,000 in Black women compared to 132.5 in White women (Table 5), although rates are higher among Black women younger than 40 years of age. As a result, and also because of shorter life expectancy, the median age of diagnosis is younger for Black women, 60 years compared to 64 for White women.
Black women are twice as likely as women of other racial and ethnic groups in the US to be diagnosed with triple negative breast cancer (TNBC), so called because the tumor lacks estrogen receptors, progesterone receptors, and human epidermal growth factor receptor-2. Women with TNBC generally have poorer outcomes because of few effective treatments. Nevertheless, Black women are still about 30% more likely to die from these tumors than White women, partly because of lesser rates of surgery and chemotherapy. Black breast cancer survivors also have a much higher likelihood of being diagnosed with new cancers because young-onset receptor negative tumors, such as TNBC, are associated with a higher risk of subsequent malignancies than other breast cancer subtypes. Although breast cancer in men is rare, Black men have a higher incidence of all breast cancer subtypes than White men, including a two-fold higher risk of TNBC.

Black women are also more likely to be diagnosed with inflammatory breast cancer, a rare but aggressive subtype. Reasons for the Black-White variation in subtype distribution remain unclear, but do not appear to be completely explained by the differences in the prevalence of inherited genetic mutations. For more information about breast cancer subtypes, see Breast Cancer Facts & Figures at cancer.org/statistics.

Mortality

An estimated 6,800 deaths from breast cancer are expected to occur among Black women in 2022, making it the leading cause of cancer death in this population. Improvements in early detection and screening have led to a decrease in mortality for Black women since 1990. However, because the decline began later and was slower compared to White women, this progress led to a widening disparity that peaked in 2011-2012 (Figure 3). From 2010 to 2019, mortality rates continued to decrease in Black and White women by a little over 1% per year; from 1990, the breast cancer death rate dropped by 30% in Black women versus 41% in White women.

Breast cancer death rates in the most recent time period (2015-2019) are 41% higher in Black women compared to White women (Table 6). The racial disparity is largely due to more advanced stage at diagnosis; higher prevalence of obesity, other comorbidities, and unfavorable tumor characteristics (e.g., TNBC); and less access to high-quality treatment, likely due to financial barriers. Lack of private insurance and unfavorable tumor characteristics explain one-third and one-fifth of the disparity, respectively among women with early-stage disease younger than 65 years of age. Although there are some differences between Black and White women in the prevalence of genetic variations, they do not appear to explain the survival gap.

Prevention and Early Detection

Potentially modifiable factors that increase breast cancer risk include weight gain after the age of 18 and/or being overweight or obese (for postmenopausal breast cancers), menopausal hormone therapy (combined estrogen and progestin), alcohol consumption, and physical inactivity. Studies increasingly suggest that high consumption of non-starchy vegetables is associated with lower risk for hormone receptor-negative breast cancers. If confirmed, this would be especially relevant for Black women, who have a higher proportion of hormone receptor-negative breast cancer.

Screening mammography can detect breast cancer at an early stage, when treatment is often less intensive and more successful. However, effectiveness is influenced by both the quality of screening and the timeliness of follow-up. Black women are less likely than White women to have their imaging performed at a facility with the most current technology, such as digital breast tomosynthesis, and also have a longer time between abnormal results and follow-up. Despite similar self-reported screening prevalence, only 57% of breast cancers in Black women are diagnosed at a local stage compared to 67% in White women (Figure 4). A recent study found that over half of this disparity is due to differences in insurance coverage. For more information on breast cancer screening, see page 32.

Survival and Stage Distribution

The overall 5-year relative survival rate for breast cancers diagnosed in 2011-2017 was 82% for Black women compared to 92% for White women (Figure 5), partly due to more advanced stage at diagnosis, as mentioned earlier.
However, Black women have lower survival at every stage of disease, largely because of less access to high-quality health care, including receipt of care at low-resourced and/or unaccredited facilities. The greater burden of TNBC in Black women also contributes to disparate outcomes, although research suggests that Black women have lower survival than White women regardless of molecular subtype.


Colon and Rectum

Incidence

Colorectal cancer is the third most common cancer in Black men and women, with an estimated 20,700 cases expected to be diagnosed in 2022. Black people have the second-highest incidence of colorectal cancer in the US, following the Alaska Native/American Indian population. Incidence rates are about 20% higher in Black people than in White people among both men and women (Table 5). However, incidence was historically higher in White people and the crossover occurred in the early 1990s because of changing patterns in risk factors and slower dissemination of screening among Black people. From 2009 to 2018, incidence rates for colorectal cancer decreased by about 3% per year among Black people versus 2% per year among White people. Overall trends mask increasing incidence among people younger than 50 years of age, which is much steeper in White people (2% per year) than in Black people (0.5% per year).

Mortality

An estimated 7,200 deaths from colorectal cancer are expected to occur among Black people in 2022. Colorectal cancer is the third-leading cause of cancer death in both Black men and women. Similar to incidence rates, colorectal cancer mortality rates were historically higher in White people than in Black people (Figure 3), but have reversed and are now 44% higher in Black men and 31% higher in Black women compared to Whites (Table 6). This gap is two times larger than the disparity for incidence but has begun to shrink in recent years because of steeper declines in death rates from 2010 to 2019 in Black people (about 3% per year) than in White people (about 2% per year). One study estimated that 19% of the racial disparity in mortality can be attributed to less screening and 36% to lower stage-specific survival among Black people.

Prevention and Early Detection

Major modifiable factors that increase risk for colorectal cancer include excess body weight, type 2 diabetes, physical inactivity (colon only), long-term smoking, high consumption of red or processed meat, low calcium intake, moderate to heavy alcohol consumption, and very low intake of fruits and vegetables and whole-grain fiber. Vitamin D deficiency, which is more common among Black than White people, has also been associated with increased risk and may contribute to racial differences in disease occurrence and outcomes. Many of these risk factors are described in the section on Risk Factors for Cancer on page 22.

For adults ages 45 and older who are at average risk for the disease, colorectal cancer risk is also reduced through the use of screening tests that can detect and remove precancerous polyps, as well as detecting cancer at an early stage before symptoms develop. However, recommended colorectal cancer screening use in 2018 remained lower in Black people (65% up-to-date) than White people (68%) (Table 8). For more information on colorectal cancer screening, see page 32.

Survival and Stage Distribution

The 5-year relative survival rates for colorectal cancer improved from 45% in 1975-1977 to 59% in 2011-2017 among Black people versus 50% to 65% among White people. Some of the survival disparity is due to later-stage diagnosis among Black people, although this gap has narrowed: 34% of colorectal cancers in Black people are diagnosed at a localized stage compared to 35% in White people (Figure 4). Five-year relative survival rates remain lower in Black than in White patients for each stage of diagnosis (Figure 5).
Racial disparities in stage-specific survival largely reflect differences in treatment, comorbidities, and tumor characteristics.\textsuperscript{22, 96-99} Numerous studies have documented that Black people with colorectal cancer are less likely than White people to receive recommended surgical treatment, radiation, and chemotherapy.\textsuperscript{100-102} Additionally, Black people are more likely to have treatment delays, even within similar socioeconomic backgrounds,\textsuperscript{103} and are about 30\% more likely than White people to be diagnosed with proximal (right-sided) tumors, which have less favorable outcomes.\textsuperscript{104}


## Lung and Bronchus

### Incidence

Lung cancer will be diagnosed in an estimated 25,690 Black people in 2022, and is the second most common cancer in both men and women. During 2014-2018, incidence rates were 12\% higher in Black men than in White men but 16\% lower in Black women than in White women (Table 5). However, both Black men and women are more likely to be diagnosed with lung cancer at a younger age than Whites, with a median age at diagnosis of 67 versus 71, respectively.\textsuperscript{63}

Lung cancer occurrence reflects historical differences in smoking patterns, as over 80\% of lung cancer cases overall are caused by smoking.\textsuperscript{5, 105, 106} Similar to White men, incidence rates in Black men increased rapidly until the mid-1980s because of widespread smoking uptake.
during the first half of the 20th century, but have since declined steadily due to reductions in smoking. In contrast, rates in Black women increased until the late 2000s before declining because of later and slower smoking uptake and cessation compared to men (Figure 6a). Steeper smoking declines in Black people than in White people have resulted in a convergence in lung cancer incidence among young Black and White men and a crossover among women (Figure 7).\textsuperscript{106, 107} From 2009 to 2018, the annual decline in incidence was about 3% in Black and White men, 2% in Black women, and 1% in White women.

**Mortality**

Lung cancer is the leading cause of cancer death in Black men and the second-leading cause in Black women. An estimated 14,160 deaths from lung cancer are expected to occur among Black people in 2022. After increasing for decades, lung cancer death rates have declined since 1990 at a generally faster pace in Black men than in White men, reducing the racial disparity from an excess of 40% in Black men in 1990-1992 to 15% in 2015-2019. In women, the downturn began about a decade later than that in men and is also steeper in Black than White women (Figure 3). Consequently, although Black and White women had similar lung cancer mortality until the early 1990s, in 2015-2019 rates were 15% lower in Black women.

The more favorable trends among Black people reflect the steep decline in smoking initiation unique to Black youth from at least the mid-1970s until the early 1990s.\textsuperscript{108, 109} (For information on smoking trends, see page 22.) During 2015-2019, the lung cancer death rate declined by about 6% per year in Black men, 5% per year in White men, and 4% per year in Black and White women (Figure 6b). These accelerated trends reflect recent advances in lung cancer treatment, as well as reductions in smoking.

**Prevention and Early Detection**

Combustible tobacco is the most important risk factor for lung cancer, accounting for about 80% of lung cancer deaths in the US among all races/ethnicities combined.\textsuperscript{5} Risk increases with both quantity and duration of tobacco use. For more information on tobacco use, see page 22. Screening with low-dose spiral computed tomography has been shown to reduce lung cancer mortality by 20% to 39% among current or former (quit within 15 years) heavy smokers.\textsuperscript{110, 111} For more information on lung cancer screening, see page 33.

**Survival and Stage Distribution**

The 5-year relative survival rate for lung cancer is slightly lower in Black people than in White people overall, 20% versus 22%, with the largest difference for localized-stage disease (55% versus 60%, Figure 5). Localized-stage lung cancer is only diagnosed in 21% of Black people and 25% of White people because symptoms generally do not appear until the disease is advanced.

Numerous studies have shown that even when lung cancer is diagnosed early, Black people are less likely than White people to receive surgery, which is the most effective treatment for survival.\textsuperscript{112-116, 117} When treatment is equivalent, outcomes are similar between Black and White individuals.\textsuperscript{118}

**Myeloma**

**Incidence**

An estimated 7,810 new cases of multiple myeloma are expected to be diagnosed among Black people in 2022. Myeloma is a cancer of cells in the immune system called plasma cells. Incidence of myeloma is more than 2 times higher in Black people compared to White people (Table 5), and median age at diagnosis is younger (66 versus 70 years of age).\textsuperscript{63} Incidence continued to increase steadily in Black women by about 2% per year from 2009 through 2018, whereas rates in Black men may be stabilizing in recent years, resembling trends in White men.

**Mortality**

An estimated 2,530 myeloma deaths are expected to occur among Black men and women in 2022. Similar to incidence, mortality rates are about twice as high in Black people as in White people (Table 6). During 2015-2019, myeloma death rates declined by about 3% per year in Black women and 1% per year in Black men and White men and women due to improved treatment.\textsuperscript{119, 120}
Prevention

Excess body weight is the only known modifiable risk factor for myeloma; risk is about 20% higher in adults who are overweight or obese compared to people who are normal weight. Higher rates of obesity among Black people (see Excess Body Weight on page 24) may contribute to the racial disparity for myeloma, especially among women.

Myeloma is preceded by an asymptomatic premalignant condition known as monoclonal gammopathy of undetermined significance (MGUS); individuals with MGUS have a risk of progression to myeloma of about 1%-2% per year. MGUS is also more prevalent and diagnosed at earlier ages in Black people than people of any other racial/ethnic group. A family history of blood cancers is also associated with increased risk that is stronger among Black people than White people.

Survival and Stage Distribution

The 5-year relative survival rate has improved from 29% during 1975-1977 to 58% during 2011-2017 among Black people versus 24% to 55% among White people. The somewhat higher contemporary survival among Black people may reflect a lower prevalence of aggressive disease. Indeed, Black people have benefited less from recent improvements in treatment because of less access to care, lower utilization of new treatment, and more delays in treatment.

Prostate

Incidence

An estimated 41,600 cases of prostate cancer are expected to be diagnosed among Black men in 2022, accounting for 37% of all new cancers in Black men. Approximately 1 in 6 Black men will be diagnosed with prostate cancer in his lifetime compared to 1 in 8 White men. During 2014-2018, the average annual prostate cancer incidence rate was 172.6 cases per 100,000 Black men, 73% higher than the rate in White men (Table 5).

Similar to White men, incidence rates in Black men increased sharply from 1989 to 1992, then declined until the early 2010s, reflecting changes in use of the prostate-specific antigen (PSA) blood test. Rates were stable in Black and White men from 2014 through 2018, although this trend reflects localized-stage disease, which accounts for the majority of cases; rates for regional- and distant-stage disease increased during this time period by about 5% per year in Black and White men. The upturn in advanced disease likely reflects the reduction in screening following the US Preventive Services Task Force (USPSTF) 2012 recommendation against routine PSA testing. In 2018 the USPSTF revised the guideline again to recommend informed decision making among men ages 55-69 years.

Mortality

Prostate cancer is the second-leading cause of cancer death in Black men, with an estimated 6,040 deaths expected in 2022. Black men have the highest death rate for prostate cancer of any racial or ethnic group in the US, 2 times higher than White men (Table 6). Although there is some evidence that aggressive prostate cancer is more common in Black men, the larger disparity for mortality than incidence largely reflects less access to high-quality treatment.

The prostate cancer death rate in Black men has dropped by more than 50%, from a peak of 82.1 deaths per 100,000 in 1993 to 36.6 deaths per 100,000 in 2019, similar to the decline among White men. Factors that have likely contributed to the decrease include early detection through PSA testing, improved surgical and radiologic treatment, and the use of hormonal therapy for advanced-stage disease.

However, rapid declines since the mid-1990s have slowed in recent years, likely reflecting the uptick in advanced disease. From 2015 to 2019, the death rate declined by 1.3% per year among Black men and by 0.7% per year among White men (Figure 3).
Studies continue to document that Black men are relatively more likely to receive substandard treatment for prostate cancer.\textsuperscript{132, 141-143} Recently, it was reported that Black men diagnosed with advanced-stage prostate cancer were significantly less likely to receive any treatment compared to White men, even when accounting for similar insurance.\textsuperscript{144} When treatment is similar, prostate cancer 10-year survival is comparable\textsuperscript{135} or even higher among Black men.\textsuperscript{134, 135}

**Prevention and Early Detection**

The strongest known risk factors for prostate cancer are a family history of the disease, African ancestry,\textsuperscript{145} and certain inherited genetic conditions (e.g., Lynch syndrome and BRCA1 and BRCA2).\textsuperscript{146, 147} Smoking and excess body weight may increase risk of aggressive/and or fatal disease.\textsuperscript{148-152}

Prostate cancer usually has no symptoms until disease is advanced, but is a good candidate for early detection through screening because it is usually slow-growing. No organization presently endorses routine screening with the PSA test for men at average risk because of concerns about overdiagnosis (detection of disease that would never have caused harm) and serious treatment-related side effects. However, a recent modeling study estimated that screening Black men 45-69 years of age could reduce mortality by 26%-29% while limiting overdiagnosis.\textsuperscript{153} The USPSTF recommends that men ages 55-69 discuss the benefits of screening with their health care providers and make informed decisions based on family history, race/ethnicity, and comorbidities. The American Cancer Society similarly recommends informed decision-making beginning at age 45 for Black men and age 50 for other men. For more information on PSA testing, see page 33.

**Survival and Stage Distribution**

The overall 5-year relative survival rate for prostate cancer is 96% for Black men and 98% for White men (Figure 5). Eighty-four percent of all prostate cancers among Black men are diagnosed at a local or regional stage, for which the 5-year relative survival rate approaches 100%. When prostate cancer is diagnosed at a distant stage, 5-year survival drops to 30% in both Black and White men.

### Stomach

**Incidence**

An estimated 4,510 cases of stomach cancer are expected to be diagnosed in Black men and women in 2022. Stomach cancer incidence is about 2 times higher in Black men and women than White men and women (Table 5). However, higher rates are limited to cancers in the lower stomach, or non-cardia, whereas rates for cardia tumors, in the upper stomach near the esophagus, are similar by race.\textsuperscript{154} From 2009-2018, stomach cancer incidence rates declined more steeply in Black people (2% per year) than in White people (1% per year).

**Mortality**

Approximately 1,830 deaths from stomach cancer are expected to occur among Black people in 2022. Stomach cancer death rates are more than 2-fold higher in Black than White people, only in part due to higher incidence. The racial disparity in mortality is greater for men than for women, whereas the reverse is true for incidence (Table 5 and Table 6). During 2010-2019, stomach cancer death rates declined in Black men and women by 3% per year, similar to declines in White people.

**Prevention**

*Helicobacter (H.) pylori* infection is the most important risk factor for stomach cancer and is more than three times more common in Black than White people.\textsuperscript{155} For more information on *H. pylori*, see page 30. Other risk factors for stomach cancer include excess body weight (cardia cancer), smoking, high consumption of grilled and salt-preserved meat, and occupational exposures such as coal, rubber, and metal processing.\textsuperscript{156, 157}

**Survival and Stage Distribution**

Overall, 5-year relative survival for stomach cancer in Black people is 32%, comparable to that in White people (Figure 4). However, 5-year relative survival for non-cardia tumors, which account for more than half (55%) of cases in Black people but only 34% in White people, is 36% in Black people versus 44% in White people. Five-year relative survival rates for cardia tumors, which are less amenable to surgical treatment, are similar in Black and
White people (23% versus 24%, respectively). Similar to other cancers, research suggests that Black patients with stomach cancer are less likely to receive appropriate surgical treatment than White patients.\textsuperscript{158} Nearly 1 in 3 Black stomach cancer patients are diagnosed with distant-stage disease, including 40% for cardia and 30% for non-cardia, for which the 5-year relative survival rate is 5% for both cardia and non-cardia.

**Uterine Cervix**

**Incidence**

In 2022, an estimated 2,460 cases of invasive cervical cancer are expected to be diagnosed among Black women. The incidence rate of cervical cancer is 22% higher in Black women than in White women (Table 5). However, the disparity is much wider when rates exclude women who cannot develop cervical cancer because of a hysterectomy (removal of uterus and cervix), a procedure more common in Black women.\textsuperscript{159} One study found that after correcting for hysterectomy, incidence for cervical cancer was approximately 40% higher in Black than White women.\textsuperscript{160} From 2009-2018, cervical cancer incidence rates among Black and White women were stable.

**Mortality**

An estimated 780 deaths from cervical cancer are expected among Black women in 2022. Mostly as a result of screening, cervical cancer death rates have declined steadily since the 1970s (Figure 6b); rates in Black women continued to decline by 2% per year from 2010 through 2019, but have stabilized in White women in recent years. Despite this progress, Black women remain 65% more likely to die from cervical cancer than White women (Table 6), with an even larger disparity after rates are corrected for hysterectomy prevalence.\textsuperscript{159}

**Prevention and Early Detection**

Cervical cancer is caused by persistent infection with certain types of human papillomavirus (HPV) and is highly preventable through screening and vaccination. It is one of only two cancers (colorectal is the other) that can be prevented through screening. Most cervical abnormalities are detected as preinvasive lesions rather than invasive cancers because of the widespread uptake of screening with the Pap test and more recently the HPV test. For more information on cervical cancer screening and HPV prevention, see page 32 and page 29, respectively.

**Uterine Corpus (Endometrial)**

**Incidence**

An estimated 9,030 cases of cancer of the uterine corpus (body of the uterus) will be diagnosed in Black women in 2022. Cancer of the uterine corpus is often referred to as endometrial cancer because more than 90% of cases occur in the endometrium (lining of the uterine corpus). The uterine cancer incidence rate in Black women (28.1 per 100,0000) is similar to that in White women (27.8 per 100,000) without correction for hysterectomy prevalence (Table 5). However, hysterectomy correction results in an 80% increase in the rate for Black women versus a 58% increase for White women,\textsuperscript{168} equating to a 15% to 20% higher rate among Black women.

Historically, endometrial cancer incidence rates have been lower in Black than White women but a steeper and earlier increasing trend, beginning in the mid-1990s, has led to the recent convergence of rates. Increased risk may be related to the obesity epidemic, although a subtype that is less strongly associated with obesity appears to be driving the trend.\textsuperscript{168} From 2014 to 2018, incidence rates...
increased by about 2% per year in Black women but appeared to stabilize in White women.

Mortality

In 2022, an estimated 2,680 deaths from uterine corpus cancer will occur among Black women. The uterine corpus cancer death rate in Black women is nearly double that in White women (9.0 versus 4.6 deaths per 100,000, respectively; Table 6), likely due to unequal access to high-quality treatment. From 2010 to 2019, the death rate increased by about 2% per year in Black women, similar to increases in White women.

Prevention and Early Detection

An estimated 71% of all uterine corpus cancers are attributable to modifiable risk factors; excess weight alone is associated with 60% of all cases. Other risk factors include the use of postmenopausal estrogen (estrogen plus progestin does not appear to increase risk) and Tamoxifen, a drug used to prevent and treat breast cancer that increases risk slightly. Pregnancy and use of oral contraceptives or intrauterine devices are associated with reduced risk.

Survival and Stage Distribution

The Black-White disparity in 5-year relative survival for uterine corpus cancer is among the largest of any cancer: 63% in Black women compared to 84% in White women. Later-stage diagnosis, more aggressive tumors, and lower likelihood of timely optimal treatment contribute to the disparity. Close to half (44%) of uterine corpus cancers in Black women are diagnosed at an advanced stage or are unstaged (usually advanced) compared to 29% in White women (Figure 4). Survival is lower for Black women for every stage of diagnosis, with the largest difference for regional-stage disease (52% versus 72%; Figure 5). This may partly reflect a higher prevalence of aggressive uterine cancer subtypes (e.g., uterine serous cancer, uterine carcinosarcoma).

Risk Factors for Cancer

The American Cancer Society estimates that 42% of all cancer cases and 45% of cancer deaths in the US are attributed to potentially modifiable risk factors, including cigarette smoking, excess body weight, alcohol intake, poor diet, physical inactivity, and exposure to cancer-associated infectious agents. This section provides information about major cancer risk factors and their prevalence among Black people in the US. It is critical to recognize that social, economic, and cultural factors, as well as policy, can influence health-related behaviors, and although these choices are made by individuals, they are largely influenced by the communities and environments in which people live. For information about cancer risk factors beyond what is included in this section, visit cancer.org/statistics to review the most recent edition of Cancer Prevention & Early Detection Facts & Figures.

Tobacco

Cigarette Smoking

Tobacco use remains the most preventable cause of death in the US, increasing risk for at least 12 cancers: oral cavity and pharynx, larynx, lung, esophagus, pancreas, uterine cervix, kidney, bladder, stomach, colorectum, liver, and acute myeloid leukemia. Cigarette smoking may also increase risk of fatal prostate cancer and a rare type of ovarian cancer, and is estimated to cause about 30% of all cancer deaths in the US. Black communities are particularly at risk due to a history of targeted ads, specifically for menthol cigarettes. Tobacco-related cancer mortality is higher among Black people than White people because of historically higher smoking prevalence, but is also declining more rapidly because of steeper reductions in smoking initiation.
Historically, smoking prevalence was markedly higher in Black men compared to White men, but differences have narrowed during the past 20 years (Figure 8); in 2019, 18% of Black men currently smoked compared to 16% of White men.

Historically, Black and White women had similar smoking prevalence, but since about 1990 rates have been lower in Black women (Figure 8); in 2019, 13% of Black women currently smoked compared to 16% of White women.

Among adults who smoked in 2018, the rate of successful cessation in the past year was lower among Black (5%) than White (8%) people, even though Black people attempted to quit at higher levels (62% versus 53%). This inconsistency may reflect unequal access to cessation medications.

In 2020, 3% of Black high school students reported current cigarette use compared to 5% of White high school students (Figure 9).

Among Black people who smoke, more than 80% use menthol cigarettes compared to about 30% of White people, likely because of targeted marketing of menthol products in Black communities. Menthol may increase cigarette and cigar initiation and nicotine dependence among youth and young adults and make quitting more difficult.

Other Combustible Tobacco Products

People who smoke cigars have an increased risk of cancers of the lung, oral cavity, larynx, and esophagus compared to people who do not smoke cigars. Cigars, including little cigars or cigarillos, cost less than cigarettes; are often sold as singles and include flavorings; and are disproportionately marketed in Black communities. Waterpipes heat tobacco (often flavored) and smoke is passed through water, a process that cools the smoke and enables deeper inhalation among novice smokers. Although many individuals perceive waterpipe smoking to be less harmful than cigarettes because it is done in social settings (e.g., hookah bars), this form of tobacco use is known to increase the risk of lung, oral, and esophageal cancers, as well as noncancer respiratory illnesses.

Cigar, cigarillo, or filtered little cigar smoking prevalence in Black adults ages ≥18 years was 2 to 3 times higher than among White adults in the past decade, but the gap appears to be narrowing (2019: 5% in Black people; 4% in White people) (Figure 9).

Over the past decade, cigar, cigarillo, or little cigar smoking prevalence was consistently higher in Black students (9% in 2020) than in White (4%) or Hispanic (6%) students (Figure 9).

While regular pipe, waterpipe, or hookah smoking is similar in Black and White adults (1%), Black high school students (4%) report a higher prevalence of hookah use than White (2%) students (Figure 9).

E-cigarettes (Vaping Devices)

E-cigarettes, which emerged in the mid-to-late 2000s, are devices that aerosolize a liquid nicotine solution. Although evidence suggests that switching completely from conventional to e-cigarettes reduces exposure to numerous toxins and carcinogens, there is accumulating
evidence of negative short-term effects on airways and blood vessels. However, because these products are relatively new, risks associated with long-term use are unknown. Adolescent and young adult e-cigarette users are more likely than non-users to begin using combustible tobacco products.

- In 2019, 4% of Black adults were current e-cigarette users compared to 6% of White adults (Figure 9).
- E-cigarettes, alongside cigars, were the most commonly used tobacco product among Black high school students (9%) in 2020, although use was lower than among White (23%) or Hispanic (19%) students (Figure 9).

Secondhand Smoke

About 3% of all lung cancer cases in the US can be attributed to secondhand smoke exposure.

- Approximately 42% of Black nonsmoking people ages ≥20 years have serum markers for secondhand smoke compared to just 18% of White people.
- Secondhand smoke exposure is even higher among youth; 57%-58% of Black youth ages 3-17 had evidence of exposure compared to 36%-41% of White youth in 2017-2018.

Excess Body Weight, Alcohol, Diet, and Physical Activity

Aside from avoiding tobacco use, maintaining a healthy weight and limiting alcohol consumption are among the most effective strategies for reducing cancer risk. An estimated 18% of all cancers can be attributed to the combined effects of excess body weight, alcohol consumption, physical inactivity, and an unhealthy diet. The American Cancer Society’s 2020 diet and physical activity guideline provides recommendations to help individuals adopt healthy benefits. Those who most closely follow these recommendations are 10%-20% less likely to be diagnosed with cancer and 25% less likely to die from cancer. Community action strategies are also included in the guideline because of strong environmental influence on individual food and activity behaviors.

Excess Body Weight

An estimated 5% of all cancer cases in men and 11% in women can be attributed to excess body weight. Excess body weight (overweight or obesity) increases risk for many cancers: uterine corpus (endometrium), esophagus (adenocarcinoma), liver, stomach (cardia), kidney (renal cell), meningioma, multiple myeloma, pancreas, colorectum, gallbladder, ovary, female breast (post-menopausal), and thyroid. Although the evidence is less
Cancer Facts & Figures for African American/Black People 2022-2024

2020 American Cancer Society Guideline on Diet and Physical Activity for Cancer Prevention

1. Achieve and maintain a healthy body weight throughout life.
   - Keep body weight within the healthy range and avoid weight gain in adult life.

2. Be physically active.
   - Adults should engage in 150-300 minutes of moderate-intensity physical activity per week, or 75-150 minutes of vigorous-intensity physical activity, or an equivalent combination; achieving or exceeding the upper limit of 300 minutes is optimal.
   - Children and adolescents should engage in at least 1 hour of moderate- or vigorous-intensity activity each day.
   - Limit sedentary behavior, such as sitting, lying down, and watching television, and other forms of screen-based entertainment.

3. Follow a healthy eating pattern at all ages.
   A healthy eating pattern includes:
   - Foods that are high in nutrients in amounts that help achieve and maintain a healthy body weight
   - A variety of vegetables – dark green, red, and orange, fiber-rich legumes (beans and peas), and others
   - Fruits, especially whole fruits with a variety of colors
   - Whole grains

   A healthy eating pattern limits or does not include:
   - Red and processed meats
   - Sugar-sweetened beverages
   - Highly processed foods and refined grain products

4. It is best not to drink alcohol.
   - People who do choose to drink alcohol should limit their consumption to no more than 1 drink per day for women and 2 drinks per day for men.

Recommendation for Community Action
   - Public, private, and community organizations should work collaboratively at national, state, and local levels to develop, advocate for, and implement policy and environmental changes that increase access to affordable, nutritious foods; provide safe, enjoyable, and accessible opportunities for physical activity; and limit alcohol for all individuals.

For more information, visit:

clear, excess weight may also increase the risk of cancers of the mouth, pharynx, larynx, and male breast, as well as fatal prostate cancer and non-Hodgkin lymphoma (diffuse large B-cell lymphoma). The prevalence of obesity increased in all adults over the past four decades and is especially high among Black women (Figure 10).

Additionally, physical inactivity and excessive weight gain that begin during childhood often continue into adulthood, resulting in long-term cumulative exposure to excess body fatness and subsequent health consequences. Furthermore, overweight Black youth are more likely to become obese adults than their White counterparts (Figure 11), likely at least in part because of a lower-resourced community environment. For example, there is a higher prevalence of food deserts/swamps (i.e., areas with limited access to a variety of healthy and affordable food) and lower prevalence of safe greenspaces for physical activity in neighborhoods with a larger proportion of people of color.210, 211

   - The prevalence of obesity in Black women continued to rise through 2017-2018 (57%) and has been consistently higher than all other race/sex groups (Figure 10).
   - In contrast, obesity prevalence has stabilized among Black men since 2005-2006, and prevalence in 2017-2018 (41%) was not statistically significantly different than among White men (45%) (Figure 10).
Among both Black men and women, overweight prevalence was similar to their White counterparts. (Figure 11).

In 2017-2019, the prevalence of obesity among Black people was greater than 40% in 20 states and did not fall below 20% in any state. In contrast, prevalence among White people did not exceed 40% in any state and was less than 20% in Hawaii and the District of Columbia (Figure 12).

Obesity prevalence nearly doubled among Black youth ages 2-19 years between 1988-1990 (13%) and 2017-2018 (24%).

Black girls ages 2-19 years have had consistently higher obesity prevalence than all other race/sex groups since 1988-1994, even at young ages; for example, 26% of Black girls ages 6-11 years were obese compared to 15% of White girls, whereas there is no racial disparity for boys at any age (Figure 11).

Alcohol

An estimated 6% of cancer cases can be attributed to alcohol consumption, which increases the risk for cancers of the mouth, pharynx, larynx, esophagus (squamous cell carcinoma), liver, colorectum, female breast, and stomach. Risk increases with alcohol volume, and even a few drinks per week may slightly increase risk of female breast cancer. The use of alcohol and tobacco combined interacts to increase the risk of cancers of the mouth, pharynx, larynx, and esophagus far more than the independent effect of either drinking or smoking alone.

- In 2018, heavier drinking was lower in Black people (men and women: 3%) than in White people (men: 6%; women: 7%) (Table 7).
- Among high school students in 2019, about 15% of Black men and 19% of Black women reported current (past month) alcohol consumption, compared to 33% and 36% of White men and women, respectively (Table 7).
Figure 12. Prevalence of Obesity* (%), Adults 18 Years and Older, 2017-2019

Note: Race is exclusive of Hispanic ethnicity. *BMI >= 30 kg/m²

Source: Centers for Disease Control and Prevention, 2021.

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Diet
An estimated 4%-5% of cancer cases can be attributed to poor diet.\(^5\) Diet patterns high in processed and red meat, starchy foods, refined carbohydrates, and sugary drinks are associated with higher risk of developing cancer (predominately colon).\(^216\) Conversely, dietary patterns emphasizing a variety of fruits and vegetables, whole grains, legumes, and fish or poultry and few red and processed meats are associated with lower cancer risk.\(^217, 218\) Diet is also influenced by access to healthy food, which is influenced by socioeconomic and community factors.\(^12, 14, 210\)

- Among Black adults in 2019, 10% consumed three or more servings of vegetables per day and 24% reported eating two or more servings of fruits daily, somewhat lower than that for White adults (Table 7).

- Among Black high school students in 2019, about 12% consumed vegetables three or more times per day and 27% consumed fruit/100% fruit juices two or more times per day, similar to that among White students (Table 7).

- Overall dietary patterns as measured by the Healthy Eating Index (HEI) between 1999 and 2016 showed no improvements among Black people.\(^219\)

- Between 1999 and 2018, total energy consumed from ultra-processed foods among youth ages 2-19 years increased more in Black than White youth.\(^220\)

- Consumption of “fast food” on any given day was higher among Black (42%) than White (37%) adults in 2013-2016 and in Black (17%) than White (13%) youth in 2015-2018.\(^221\)

- Despite a decrease in prevalence of sugar-sweetened beverage consumption in youth and adults overall between 2003-2018,\(^222\) Black adults contributed more to total consumption in 2015-2018 than White adults (15% versus 9%).\(^223\)

Physical Activity
Physical activity decreases the risk of cancers of the colon (but not rectum), female breast, endometrium, kidney, bladder, esophagus (adenocarcinoma), stomach (cardia), and possibly lung.\(^224-226\) Approximately 3% of cancer cases can be attributed to lack of physical activity, although


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<td><strong>No leisure-time physical activity</strong></td>
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<td><strong>Met recommended levels of aerobic activity</strong></td>
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<td>Adults (≥18 yrs)**</td>
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<td>High School Students***</td>
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<td><strong>Alcohol consumption</strong></td>
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<td>High School Students‡</td>
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<td>Females</td>
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<td><strong>Consumed ≥2 fruit servings a day</strong></td>
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<td>Females</td>
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<td><strong>Consumed ≥3 vegetable servings a day</strong></td>
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<td>Adults (≥18 yrs)</td>
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<td>Females</td>
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<td>High School Students</td>
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<td>Females</td>
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Races are exclusive of Hispanic ethnicity. Estimates for adults are age adjusted to the 2000 standard US population. *Not physically active for a total of at least 60 minutes on at least 1 day out of the past week. **Includes 150 minutes of moderate-intensity activity or 75 minutes of vigorous-intensity activity each week. ***Were physically active at least 60 minutes per day on all 7 days prior to survey. †Men: >14 drinks per week, women: >7 drinks per week. ‡At least one drink of alcohol, on at least 1 day during the 30 days before the survey.


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this is likely an underestimate because it is only based on colon, female breast, and endometrial cancers. Conversely, people with cancer who are physically active are less likely to have adverse effects and to die from the disease than those who are inactive. Extended leisure-time sitting has also been associated with increased risk of cancer death, whereas replacing sedentary time with even short durations of moderate to vigorous physical activity appears to reduce cancer mortality.

- In 2018, Black adults reported no leisure-time physical activity more often than White adults (34% versus 22%, Table 7).
- Similarly, 47% of Black adults reported meeting recommended levels of aerobic activity compared to 58% of White adults (Table 7).
- Racial disparities in physical activity were larger among women than among men (Table 7).
- In 2015-2018, the prevalence of physical inactivity was 30% or higher in 23 states among Black adults versus only 5 states among White adults.
- Black high school girls (31%) and boys (22%) were twice as likely to report no physical activity compared to White girls (15%) and boys (11%) (Table 7).
- In 2019, 21% of Black high school students reported at least 60 minutes of daily physical activity in comparison to 26% of White high school students (Table 7).

Type 2 Diabetes

Type 2 diabetes is a chronic condition in which the body loses the ability to respond to insulin and shares several modifiable risk factors with cancer, including excess body weight, poor diet, and lack of physical activity. Evidence suggests that type 2 diabetes may independently increase risk for several cancers, including liver, endometrium, pancreas, colorectum, kidney, bladder, breast, and ovary. In 2017-2018, the prevalence of diabetes among Black adults (12%) was greater than that among White adults (8%). Although body weight differences contribute to this disparity, Black people have a higher prevalence of both diabetes and prediabetes than White people at lower body weights, suggesting that mechanisms other than obesity are involved. In 2019, Black people were twice as likely to die from diabetes as their White counterparts (38.3 versus 19.0 per 100,000).

Infectious Agents

About 3% of all cancers in the US are due to infections caused by agents such as human papillomavirus, Helicobacter pylori, and hepatitis B and C viruses. Fortunately, there are opportunities to prevent or treat most of these infections.

Human Papillomavirus (HPV)

HPV is the most common sexually transmitted disease in the US, with approximately 13 million people newly infected in 2018. Although most HPV infections are cleared by the body and do not cause cancer, virtually all cervical and anal cancers are caused by persistent HPV infection, as well as 70% of oropharyngeal cancers and 60%-70% of vaginal, vulvar, and penile cancers. Cervical cancer is the most common HPV-related cancer in women, and oropharyngeal cancer is the most common in men. The virus is spread primarily through direct sexual contact and is usually asymptomatic.

While there are more than 100 different types of HPV, only about 14 of these cause cancer. The HPV vaccine currently used in the US protects against 9 HPV types and has the potential to avert 90% of HPV-associated cancers. The American Cancer Society’s 2020 guideline recommends routine HPV vaccination of both girls and boys between 9-12 years of age (see sidebar, page 30). However, because vaccination does not prevent established infections from progressing to cancer or protect against all HPV subtypes, all women should receive cervical cancer screening according to recommendations, regardless of vaccination status. (For more information about cervical cancer screening, see page 32.)

- In 2013-2016, the prevalence of high-risk oral HPV was similar among Black (5%) and White (4%) adults, but prevalence of high-risk genital HPV was much higher in Black (39%) than White (22%) people. There is some evidence of variations in the prevalence of specific HPV genotypes in Black compared to White women.
American Cancer Society Recommendations for HPV Vaccine Use

- HPV vaccination works best when given to girls and boys between ages 9 and 12 years.
- Teenagers and young adults ages 13 through 26 years who have not been vaccinated or who have not received all of their shots should get the vaccine as soon as possible. Vaccination of young adults will not prevent as many cancers as vaccination of children and teens.
- The American Cancer Society does not recommend HPV vaccination for people older than 26 years of age.

- In 2019, slightly over half of Black girls (53%) and boys (55%) ages 13-17 were up to date with HPV vaccination, similar to coverage among White girls but higher than White boys (49%) (Table 8).

*Helicobacter Pylori (H. Pylori)*

Chronic infection with *H. pylori*, a bacterium that grows in the stomach and causes damage to the stomach lining, increases risk of adenocarcinoma of the stomach, the most common type of stomach cancer, as well as lymphoma of the stomach. In the US, about 65% of non-cardia gastric cancers (cancers in the lower part of the stomach) and 31% of all stomach cancers are attributable to *H. pylori* infection.  

*H. pylori* is thought to spread from person to person through fecal-oral and oral-oral routes and is facilitated by crowded living conditions and poor sanitation. The prevalence of *H. pylori* infection in the US is about twice as high in Black than White adults, with increased odds of infection associated with African ancestry.

*Hepatitis B Virus (HBV) and Hepatitis C Virus (HCV)*

Chronic infection with HBV or HCV increases risk of liver cancer and non-Hodgkin lymphoma.

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### Table 8. Prevalence (%) of HPV Vaccination (2019) and Cancer Screening (2018), US

<table>
<thead>
<tr>
<th>HPV vaccination (adolescents 13-17 years)</th>
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<td>Black</td>
<td>White</td>
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<tr>
<td>Females</td>
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<tr>
<td>≥ 1 dose</td>
<td>72</td>
<td>71</td>
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<tr>
<td>Up-to-date*</td>
<td>53</td>
<td>54</td>
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<tr>
<td>Males</td>
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<tr>
<td>≥ 1 dose</td>
<td>72</td>
<td>66</td>
</tr>
<tr>
<td>Up-to-date*</td>
<td>55</td>
<td>49</td>
</tr>
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</table>

| Breast cancer screening                   |        |        |
|                                          |        |        |
| Up-to-date (women 45+ years)**           | 66     | 64     |
| Mammogram within the past two years      |        |        |
| (women 50-74 years) (USPSTF guidelines)  | 74     | 73     |

| Cervical cancer screening (women 25-65 years) |        |
|                                              |        |
| Up-to-date†                                  | 88     | 86     |

| Colorectal cancer screening‡                |        |        |
|                                          |        |        |
| Adults 50+ years                          | 65     | 68     |
| Males                                    | 64     | 69     |
| Females                                  | 66     | 66     |
| Adults 45+ years                          | 57     | 58     |
| Males                                    | 58     | 59     |
| Females                                  | 57     | 57     |

| Prostate-specific antigen test (men 50+ years)*** |        |
|                                              |        |
| Within the past year                        | 33     | 37     |

Races are exclusive of Hispanic ethnicity. Estimates for screening are age adjusted to the 2000 US standard population and do not distinguish between examinations for screening and diagnosis. HPV: human papillomavirus.  

*According to recommendations; see sources for more information.*  

**Mammogram within the past year (ages 45-54 years) or past two years (ages ≥55 years). †Pap test in the past 3 years among women 25-65 years or Pap test and HPV test within the past 5 years among women 30-65 years. ‡For ages ≥45 and ≥50 years: FOBT/FIT, sigmoidoscopy, colonoscopy, computed tomography (CT) colonography, or sDNA test in the past 1, 5, 10, 5 and 3 years, respectively. For ages 50-75 years: FOBT/FIT, sigmoidoscopy, colonoscopy, computed tomography (CT) colonography, or sDNA test in the past 10 years with FOBT/FIT in past 1 year. ***Among men who have not been diagnosed with prostate cancer.

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HBV: About 7% of all liver cancers in the US are attributable to HBV, a virus that is transmitted through blood or mucosal contact with infectious blood or body fluids (e.g., semen, saliva). Most new HBV infections occur in unvaccinated adults with high-risk behaviors, such as injection drug use and multiple sex partners. HBV can also be passed from an infected mother to her child during childbirth.
Vaccination against HBV is the primary prevention strategy to reduce prevalence of the virus. Those who should be vaccinated include infants, youth under age 19 who have not been vaccinated, and unvaccinated adults who are at high risk of infection (e.g., health care workers, travelers to regions where HBV infections is endemic).  

In 2020, the US Preventive Services Task Force (USPSTF) maintained its previous screening recommendations for HBV after considering new evidence that treating HBV infections leads to better health outcomes. Screening is recommended by the USPSTF for people who have not been vaccinated against HBV, as well as those who are at increased risk of infection because they were born in a country with high prevalence or engage in risky behaviors, such as injection drug use or unprotected sex with multiple partners, regardless of vaccination status.  

- HBV infection rates have been steady since 2010. In 2019, the rate of newly reported chronic HBV infection was about 4 times higher among Black people (6.7 cases per 100,000) than White people (1.8 cases per 100,000).  
- HBV vaccination coverage in 2019 was 91% among Black adolescents and 94% among White adolescents.  

HCV: Nearly one-quarter of liver cancers in the US are attributable to HCV. HCV transmission is most common through intravenous drug use, but can also occur through needle-stick injuries in health care settings, mother-to-child transmission during birth, and less commonly through sexual contact with an infected partner. Most people with HCV will become chronically infected and remain unaware of their infection until liver disease develops. In contrast to HBV infection, there is no vaccine to protect against HCV infection.  

In 2020, the US Preventive Services Task Force updated their guidelines recommending one-time screening among all men and women ages 18 to 79 years. Those who test positive for HCV are advised to begin antiviral treatment to reduce the risk of negative health effects and to be counseled on how to prevent transmission to others.  

- During 2012-2016, approximately 2.4 million people in the US were living with current HCV infection.  
- From 2013 through 2016, HCV prevalence was twice as high in Black (2.3%) compared to White (1.0%) adults.  
- In 2017, only 18% of adults born between 1945 and 1965 had ever been tested (according to guidelines at that time), with similar screening prevalence in Black and White adults.  

Human Immunodeficiency Virus (HIV)  

HIV infection is almost twice as common in Black people as in White people and is associated with elevated cancer risk both directly and indirectly. HIV may be present in the body for a long time without showing symptoms; however, as the infection progresses and the immune system is weakened, acquired immunodeficiency syndrome (AIDS) develops. HIV is primarily transmitted through sexual intercourse and injection drug use. There are several AIDS-defining (serious illness that signals the progression of HIV-infection to AIDS) cancers, including Kaposi sarcoma, high-grade non-Hodgkin lymphoma, and cervical cancer. HIV-infected individuals are also at an increased risk of developing other cancers, including Hodgkin lymphoma, some head and neck cancers, and anal and liver cancers. The weakened immune system, along with shared routes of transmission with other cancer-causing infectious agents (e.g., HPV, HCV), increases the risk of cancers in this population. There are several primary prevention strategies for HIV, such as practicing safe sex and using sterile needles. Among people diagnosed with HIV, antiviral medications reduce viral load and associated cancer risk.  

- In 2018, the prevalence of diagnosed or undiagnosed HIV was 7 times higher in Black people compared to White people ages 13 years and older.  
- HIV-infected Black people are less likely to receive treatment than White people; in 2018, 63 out of 100 Black individuals received treatment compared to 70 out of 100 White individuals.
Cancer Screening

Early detection of cancer through screening reduces mortality from cancers of the colon and rectum, breast, uterine cervix, and lung. In addition to detecting cancer early, screening for colorectal and cervical cancers can prevent these cancers by identifying and removing precancerous lesions. The American Cancer Society guidelines for the early detection of cancer are available at: https://www.cancer.org/healthy/find-cancer-early/cancer-screening-guidelines/american-cancer-society-guidelines-for-the-early-detection-of-cancer.html. Black people generally have lower rates of cancer screening, likely related to less access to care and perhaps lower likelihood of physician recommendation and medical mistrust. For information on cancer screening beyond what is included in this section, please visit cancer.org/statistics to review the latest edition of Cancer Prevention & Early Detection Facts & Figures.

Breast Cancer Screening

Mammography is a low-dose x-ray procedure that can detect breast cancer at an early stage when treatment is often less intensive and more successful. The American Cancer Society guidelines recommend that women at average risk begin screening at 45 years of age, with an option to begin at age 40; see page 49 for detailed screening recommendations. The American Cancer Society recommends that women with an elevated breast cancer risk (e.g., those with BRCA1 or BRCA2 gene mutations or a family history) begin annual screening with magnetic resonating imaging (MRI) starting at age 30. This is especially important for Black women, who are more likely to be diagnosed at a younger age and with more aggressive breast cancer subtypes.64

- Among Black women ages 40 and older, mammography screening declined from a peak of 71% in 1999 to 65% in 2005, and has since remained relatively stable.249
- In 2018, 66% of Black women and 64% of White women ages 45 and older reported being up to date with breast cancer screening (Table 8). However, self-reported survey data overestimate screening prevalence, particularly for Black women.258, 259

Cervical Cancer Screening

Regular use of Pap and HPV tests followed by appropriate and timely treatment can help prevent cervical cancer occurrence and death.261 In 2020, the American Cancer Society recommended that women ages 25 to 65 receive cervical cancer screening with the primary HPV test (preferred), co-testing that combines an HPV test with a Pap test, or a Pap test alone. (For more information on cervical cancer screening guidelines, see page 49.)

- Cervical cancer screening prevalence declined in Black women ages 21 to 65 years from 90% in 2000 to 82% in 2015, and has since increased to 87% in 2018.249
- In 2018, self-reported up-to-date cervical cancer screening prevalence among women ages 24-64 years was 88% in Black women and 86% in White women (Table 8).
- Black women appear to be less likely to receive recommended follow-up after a positive cervical cancer screening test.262

Colorectal Cancer Screening

Colorectal cancer (CRC) screening can prevent cancer through the detection and removal of precancerous growths, as well as detect cancer at an early stage when treatment is usually less intensive and more successful. The American Cancer Society recommends that colorectal cancer screening begin at age 45 for people at average risk with either a stool-based test or structural exam (e.g., colonoscopy). (See more specific information on colorectal cancer screening recommendations on page 49.)

- Black women are less likely to have screening at high-quality facilities,64 and to have access to digital breast tomosynthesis screening (or 3-D mammography), which has a higher detection rate and lower recall compared to older technology (digital mammograms).260
From 2000 to 2018, colorectal cancer screening among adults ages 50 and older doubled from 32% to 65% in Black people and increased from 40% to 68% in White adults.263, 264

In 2018, 57% of Black adults ages 45 years and older were up to date with CRC screening, similar to prevalence in White adults (58%, Table 8).

Despite similar self-reported CRC screening prevalence, Black people are more likely to receive a lower-quality colonoscopy.265

Recent research suggests that the Black-White screening disparity has increased in recent years as rates continue to improve in White people (by 1% per year from 2008 to 2016) but have stabilized in Black people.90

**Lung Cancer Screening**

Clinical trial data have shown that annual lung cancer screening with low-dose computed tomography (LDCT) reduces lung cancer mortality among people with a high risk because of their smoking history.266, 267 As a result of strengthened evidence in recent years for broader eligibility, in 2021 the US Preventive Services Task Force (USPSTF) lowered the recommended age to begin screening from 55 to 50 years of age and the pack-year threshold from 30 to 20 years.268 This change is intended to expand the number of Black individuals eligible to be screened because Black people develop lung cancer at younger ages and with lower smoking intensity.269 The American Cancer Society is currently updating their lung cancer screening guideline, but in the interim recommends following the guidance of the USPSTF. (See more specific screening recommendations on page 49).

In 2020, approximately 7% of eligible adults received LDCT in the past year according to registry data, although self-reported rates are markedly higher.270

According to self-reported data, the prevalence of LDCT in White and Black people ages 55-80 years was similar, although most Black people screened for lung cancer were older, suggesting that disparities in lung cancer screening may exist in younger populations.271

**Prostate Cancer Screening**

The American Cancer Society recommends that asymptomatic men ages 50 years and older have an opportunity to make an informed decision with their health care provider about whether to be screened for prostate cancer using the prostate-specific antigen (PSA) test. For Black men and men at high risk of prostate cancer, the American Cancer Society recommends that these discussions begin at age 45. In 2018, the USPSTF recommended shared decision-making for PSA testing among men ages 55-69 years after recommending against routine screening in 2012.272

Among men ages 55-69 years, PSA testing declined from 48% to 37% (11% decline) between 2010-2018 among Black men and from 50% to 40% (10% decline) among White men.273

In 2018, 33% of Black men ages 50 years and older received a PSA test in the past year compared to 37% of White men (Table 8).

**How the American Cancer Society Helps Reduce Cancer Disparities**

Eliminating disparities in cancer is an overarching goal of the American Cancer Society. As we lead the fight for a world without cancer, we believe all people should have a fair and just opportunity to live a longer, healthier life free from cancer regardless of how much money they make, the color of their skin, their sexual orientation, gender identity, their disability status, or where they live.
Cancer Prevention and Early Detection

One of the ways we are leading the fight is by encouraging evidence-based cancer screening for early detection. We also work to promote healthy lifestyles by bringing attention to the effects of obesity, diet and physical activity, sun exposure, and tobacco and alcohol use on cancer risk. Aside from avoiding tobacco, maintaining a healthy weight and staying active throughout life, following a healthy eating pattern and avoiding or limiting alcohol consumption are among the most effective strategies for reducing cancer risk.

The American Cancer Society’s 2020 diet and physical activity guideline (see page 25) for cancer prevention provides recommendations to help individuals adopt healthy behaviors. Community action strategies are also included in the guideline because of the strong environmental influence on individual food and activity choices.

Furthermore, in addition to detecting cancer early, regular screening can prevent cervical and colorectal cancers by identifying and treating removable precancerous lesions. Despite the promise of cancer screening and the associated reductions in mortality, not all population groups have benefited equally.

The Community Health Advocates implementing Nationwide Grants for Empowerment and Equity (CHANGE) Program awards community grants to promote health equity within communities with limited income and/or insurance coverage and communities of color. Since 2011, over 600 CHANGE grants have been awarded, reaching individuals through more than 3.2 million outreach and education interactions, contributing more than 1 million breast, cervical, and colorectal cancer screenings at low or no cost, and implanting sustainable policy and system changes.

In addition, we are collaborating with various partners to improve cancer outcomes among Black people through cancer prevention and early detection education and sharing of resources for people with cancer and their caregivers. These partnerships are critical in leveraging our mutual commitments to saving lives and reducing cancer disparities.

- The American Cancer Society is partnering with The Links, Inc., to develop the Health Equity Ambassador Links (HEAL) program. We have trained almost 2,000 Links members as health equity ambassadors who deliver information in communities. With help from an Anthem Foundation grant, in 2021, The Links, Inc., has committed to having another 500 ambassadors trained, which is expected to reach over 100,000 individuals in the next two years.

- The National Black Justice Coalition collaborates with the American Cancer Society and our advocacy affiliate, the American Cancer Society Cancer Action Network\textsuperscript{SM} (ACS CAN) to reach Black LGBTQ+ communities and other constituents with important messages relating to cancer prevention and early detection.

- The American Cancer Society is contributing to ongoing dialogue and collaboration around health equity issues with Black-led social, civic, and faith organizations, including the African Methodist Episcopal Church; Alpha Kappa Alpha (AKA) Sorority, Inc.; Delta Sigma Theta Sorority, Inc.; Phi Beta Sigma Fraternity, Inc.; and Zeta Phi Beta Sorority, Inc.


Support for Quitting Tobacco

The American Cancer Society continues our long history of work to reduce tobacco use through research, education, and advocacy. Our tobacco control efforts focus on the adoption and implementation of smoke- and tobacco-free policies in all workplaces, public places, and other important venues such as multiunit residential settings. Our website, cancer.org, and 24/7 helpline provide information about the health benefits of quitting tobacco.
and resources for people who want to quit smoking or help someone else quit. In addition, we’re taking steps to reduce tobacco-related health disparities, including among the disproportionately high percentage of smokers who also have mental health or substance use disorders. See page 38 for specific examples of successful efforts in furthering tobacco control within the Black community.

**Patient and Caregiver Services**

The American Cancer Society provides people with cancer and their caregivers with resources that can help improve – and even save – lives, including information about cancer, transportation to treatment, lodging during treatment, and a whole host of other supportive services.

**Cancer Information**

Trained American Cancer Society staff connect people to answers about a cancer diagnosis, treatment, side effects, health insurance, our programs and services, and referrals to other services at our 24/7 helpline at 1-800-227-2345. Our website, cancer.org, offers easy-to-understand, evidence-based, and accurate cancer information. People with cancer and their caregivers can find detailed and reliable information about 70+ types of cancer, available treatments, managing side effects, and living as a cancer survivor. Some of our cancer information is available in easy-reading formats and 12 different languages.

**Program and Services**

**Survivorship:** The American Cancer Society survivorship work aims to help people adjusting to, living with, and moving beyond cancer from diagnosis through long-term survivorship to the end of life. Efforts focus on helping survivors manage their ongoing physical, psychosocial, functional, and socioeconomic problems and engage in healthy behaviors to optimize their wellness. Our posttreatment survivorship care guidelines are designed to promote survivor health and quality of life by facilitating the delivery of high-quality, comprehensive, coordinated clinical follow-up care. Our survivorship research efforts focus on understanding the impact of cancer on survivors’ lives and on developing and testing interventions to help survivors actively engage in their health care and improve their health and well-being through and beyond treatment. Through the National Cancer Survivorship Resource Center, a collaboration between the American Cancer Society and the George Washington University Cancer Institute funded by the Centers for Disease Control and Prevention, we created the Cancer Survivorship E-Learning Series for Primary Care Providers. This free e-learning program continues to teach clinicians how to care for survivors of adult-onset cancers.

**Support for caregivers:** Cancer not only affects the individual diagnosed, but also impacts an entire family unit and network of close friends who often must provide care for their loved one throughout diagnosis and treatment. One of the informational tools we offer is our Caregiver Resource Guide (https://www.cancer.org/treatment/caregivers/caregiver-resource-guide.html), which helps caregivers learn to care for themselves as they provide care for a loved one; better understand what their loved one is going through; develop skills for coping and caring; and take steps to help protect their own health and well-being. Another helpful resource is our Caregiver Support Video Series (cancer.org/caregivervideos), which provides educational support to caregivers as they assist with everyday needs of loved ones, as well as self-care techniques to improve their quality of life.

**Transportation to treatment:** When transportation to treatment is a concern, the American Cancer Society may be able to help provide rides. Thanks to volunteer drivers, our Road To Recovery® program offers free rides to people who would otherwise have difficulty getting to their cancer-related appointments.

**Lodging during treatment:** The American Cancer Society Hope Lodge® program provides a free home away from home for people facing cancer and their caregivers. More than just a roof over their heads, it’s a nurturing community that helps people access the care they need.

**Breast Cancer Support:** The American Cancer Society Reach To Recovery® program connects people facing breast cancer – from diagnosis through survivorship – with trained volunteers who are breast cancer survivors. Volunteers provide one-on-one support to help those facing...
breast cancer cope with their diagnosis, treatments, side effects, and more. Through our website (reach.cancer.org) and app, people facing breast cancer can create an online profile and match with a volunteer who has experienced a similar type of breast cancer, stage, and treatment.

Finding hope and inspiration: The American Cancer Society Cancer Survivors Network® provides a safe online community where cancer survivors and caregivers share their stories, ask questions, and get support from each other. At csn.cancer.org, members can participate on discussion boards or join chat rooms and build their own support network from among the members.

Research

Research is at the heart of the American Cancer Society’s mission. We have invested more than $5 billion in research since 1946, all to find the causes of cancer, ways to detect the disease earlier, more effective treatments, and ways to help people thrive during and after treatment. ACS is unique among nongovernmental, nonprofit organizations in having both intramural and extramural research programs, both of which will turn 76 years old in 2022. The top-tier research we fund and conduct covers everything from cell biology and immunology to nutrition to genetics to environmental and behavioral factors to inequalities in cancer occurrence and outcomes.

Some examples of the American Cancer Society’s current research include:

- Examining how social inequalities, including factors such as socioeconomic status and racial discrimination, contribute to racial/ethnic differences in cancer occurrence
- Utilizing our large and diverse population study, Cancer Prevention Study-3, to better understand how factors such as housing discrimination contribute to inequities in cancer prevention behaviors and cancer risk
- Developing a genetically based predictive tool for prostate cancer in order to make it easier for doctors to find and treat aggressive tumors within the prostate gland, particularly in Black men
- Exploring how women make decisions about ovarian cancer treatment in order to increase receipt of guideline-concordant treatment, particularly in Black women and those who do not have health insurance
- Monitoring progress in reducing racial and socioeconomic disparities in the cancer burden, including differences in prevention, early detection, treatment, survival, and mortality
- Examining the effectiveness of insurance coverage expansions under the Affordable Care Act in reducing disparities in receipt of cancer screening and treatment
- Partnering with Pfizer Global Medical Grants to reduce racial disparities in breast and prostate cancer specifically, as well as in the delivery of care for all Black people facing cancer

Advocacy

The American Cancer Society and the American Cancer Society Cancer Action Network® (ACS CAN), the American Cancer Society’s nonprofit, nonpartisan advocacy affiliate, are committed to ensuring that everyone has a fair and just opportunity to prevent, find, treat, and survive cancer. No one should be disadvantaged in their fight against the disease because of how much money they make, the color of their skin, or where they live. ACS CAN advocates for public policies to reduce disparities and improve health outcomes at all levels of government, some examples of which are listed below.

Much of ACS CAN’s work involves the protection of the health care law known as the Affordable Care Act (ACA), which has improved access to care for people facing cancer and their families by:

- Ending discrimination against people with cancer and other life-threatening diseases
- Expanding access to care for people with cancer or at risk for cancer
- Refocusing the health care system on disease prevention
ACS CAN advocates for all states to expand Medicaid coverage up to income levels specified in the Affordable Care Act. Expansion of this coverage has been shown to narrow racial disparities in health coverage and health outcomes. Most recently, ACS CAN joined with partners to expand eligibility for Medicaid in Oklahoma and Missouri through the ballot initiative process and will work to make sure the new laws are fully implemented. ACS CAN will continue to advocate for Medicaid expansion in the 12 states that have yet to expand, which cover about 41% of the Black population, and to advocate for a federal solution.

Clinical Trial Participation
ACS CAN is committed to increasing diversity in clinical trial participation. Communities of color and other medically underserved groups have higher cancer rates and are underrepresented in clinical trials. State Medicaid plans were some of the last major forms of insurance in the US that did not cover routine medical costs for people enrolled in clinical trials, effectively preventing many Medicaid enrollees from participation. ACS CAN led successful efforts in several states to ensure Medicaid covered these costs, and also advocated for federal legislation that ultimately became law and will take effect in 2022 for all Medicaid programs across the country.

In addition, ACS CAN drafted and successfully advocated for passage of the Henrietta Lacks Enhancing Cancer Research Act, which was signed into law in early January 2021. This bipartisan legislation will help remove barriers to participation in federally sponsored cancer clinical trials among communities that are traditionally underrepresented and ensure that people have more equitable access to cutting-edge treatment. ACS CAN is also strongly urging passage of the DIVERSE Trials Act, which would increase racial, socioeconomic, and geographic diversity in clinical trials and make it easier for all people facing cancer to participate by allowing trial sponsors to reimburse patients for ancillary costs, such as travel or lodging.

Increasing Funding for Research and Cancer Control
Each year, ACS CAN works hard to ensure that the agencies overseeing cancer research and prevention programs receive needed funding, and continues to lead the fight to maintain and increase investment in biomedical and cancer research and cancer programs at the National Institutes of Health (NIH), the National Cancer Institute (NCI), and the Centers for Disease Control and Prevention (CDC). This investment includes increased funding for cancer research at the National Institute on Minority Health and Health Disparities, which the American Cancer Society was instrumental in helping to establish.

Protecting state and federal funding for the CDC’s National Breast and Cervical Cancer Early Detection Program (NBCCEDP), which provides community-based breast and cervical cancer screening, diagnosis, and treatment to low-income, under- and uninsured women, is a high priority for ACS CAN. Ensuring adequate funding for the NBCCEDP will preserve a critical safety net for those who continue to lack access to lifesaving screening and diagnostic and treatment services for breast and cervical cancers. Current funding only serves 1 in 10 eligible women nationwide.

Colorectal Screening
Colorectal cancer screening by colonoscopy can uniquely prevent cancer, as well as detect disease early. ACS CAN led the fight in the passage of the Removing Barriers to Colorectal Cancer Screening Act of 2019, which closed a loophole in the Medicare program that could cost patients as much as $350 if polyps were removed during a screening colonoscopy. This loophole will be phased out beginning in 2022 and removed entirely by 2030 to ensure that Medicare beneficiaries have access to colorectal cancer screening without surprise out-of-pocket costs. Additionally, in 2022, the federal government clarified that a colonoscopy after a positive stool-based test should be provided at no cost for those patients covered by private insurance or Medicaid.
expansion plans. ACS CAN is working at the state (for state-regulated plans) and federal (for Medicare and traditional Medicaid) levels to ensure complete insurance coverage without cost sharing for colorectal cancer screening for all individuals.

Tobacco Cessation
ACS CAN was also a leading partner in the passage of the Family Smoking Prevention and Tobacco Control Act, which gives the Food and Drug Administration (FDA) the authority to regulate all tobacco products. The tobacco industry has intentionally and aggressively targeted communities of color with menthol in cigarettes, which increases smoking initiation, decreases successful quitting, and leads to greater addiction. Black people consistently report the highest prevalence of menthol cigarette use. ACS CAN has advocated for the FDA, Congress, and state and local authorities to prohibit the sale of flavored tobacco products, including menthol cigarettes. ACS CAN also advocates for smoking cessation treatment that is comprehensive, barrier-free, and widely promoted for Medicaid enrollees and is working to increase funding for prevention and cessation services at the state and federal levels.

Additional Resources
Center to Reduce Cancer Health Disparities (CRCHD)
The CRCHD is central to the National Cancer Institute’s efforts to reduce the unequal burden of cancer in our society and train the next generation of competitive researchers in cancer health disparities research. The CRCHD initiates, integrates, and engages in collaborative research studies to promote research and training in cancer health disparities and to identify new and innovative scientific opportunities to improve cancer outcomes in communities experiencing an excess burden of cancer. Visit crchd.cancer.gov for additional information.

Cancer Prevention and Control Research Network (CPCRN)
The CPCRN is a national network of academic, public health, and community partners who work together to reduce the burden of cancer, especially among underserved communities. Its members conduct community-based participatory cancer research across its eight network centers, crossing academic affiliations and geographic boundaries. Visit cpcrn.org for additional information.

Intercultural Cancer Council (ICC)
The ICC promotes policies, programs, partnerships, and research to eliminate the unequal burden of cancer among racial and ethnic minorities and medically underserved populations in the US and its associated territories. Visit iccnetwork.org for additional information.

National Medical Association (NMA)
The largest and oldest national organization representing physicians and patients of African descent in the US, the NMA is committed to improving the quality of health among socioeconomically disadvantaged individuals and individuals of African descent through its membership, professional development, community health education, advocacy, research, and partnerships with federal and private agencies. The American Cancer Society and the NMA have collaborated to develop and distribute culturally relevant consumer and professional materials that focus on the prevention, early detection, and treatment of breast, prostate, and colorectal cancers, as well as nutrition and physical activity. Visit nmanet.org for additional information.

African American Collaborative Obesity Research Network (AACORN)
The AACORN is a collaboration of academic scholars, emerging scholars, and community research partners dedicated to developing strategies to support healthy eating, physical activity, and healthy weights in Black communities. Visit aacorn.org for additional information.
Sources of Statistics

Estimated new cancer cases. The estimated number of new cancer cases diagnosed among non-Hispanic Black people in the US in 2022 was projected using a spatiotemporal model and time series projection based on incidence during 2004-2018 from 50 states and the District of Columbia that provided consent and met the North American Association of Central Cancer Registries’ (NAACCR) high-quality standards. The method for estimating incidence prior to projection considers geographic variations in sociodemographic and lifestyle factors, medical settings, and cancer screening behaviors, and also accounts for expected delays in case reporting. The number of new cases is then projected four years ahead using a temporal projection method.

Incidence rates. Incidence rates are calculated by dividing the number of people who are diagnosed with cancer by the number of people at risk for the disease in the population during a given time period. In this publication, incidence rates are reported as the average number of cases diagnosed per 100,000 people per year and are age adjusted to the 2000 US standard population. State-specific incidence rates were previously published in NAACCR’s publication Cancer Incidence in North America, 2014-2018. Incidence data for this publication were collected by registries participating in the Surveillance, Epidemiology, and End Results (SEER) program and the National Program of Cancer Registries as reported by NAACCR. Colorectal cancer incidence rates presented herein exclude appendix. All contemporary rates (2014-2018) presented herein exclude people of Hispanic ethnicity.

The most recent 5- and 10-year cancer incidence trends were based on delay-adjusted rates from the 21 SEER registries exclusive of Hispanic ethnicity. Delay adjustment accounts for delays and error corrections that occur in the reporting of cancer cases, which is substantial for some sites. These trends were previously published within the SEER*Explorer tool available on the SEER website or were calculated using SEER*Stat software (i.e., colorectal cancer trends exclude appendix).

Estimated cancer deaths. The estimated number of US cancer deaths among Black people was calculated by fitting the numbers of cancer deaths from 2005 through 2019 to a statistical model that forecasts the number of deaths expected to occur in 2022. Data on the number of reported cancer deaths were obtained from the National Center for Health Statistics (NCHS) at the CDC.

Mortality rates. Similar to incidence rates, mortality rates, or death rates, are defined as the number of people who die from cancer divided by the number of people at risk in the population during a given time period including those without cancer. Mortality rates herein are based on counts of cancer deaths compiled by the NCHS and population data from the US Census Bureau and are presented per 100,000 people and are age adjusted to the 2000 US standard population. Historic mortality data (prior to 1990) are inclusive of Hispanic ethnicity, whereas contemporary rates are confined to non-Hispanic Black and White populations.

Survival. This report describes survival in terms of 5-year relative survival rates, which adjusts for normal life expectancy by comparing survival among cancer patients to survival in people of the same age, race/ethnicity, and sex without cancer. Historical 5-year survival rates are based on data from the oldest 9 SEER registries, which go back to 1975 and include people of Hispanic ethnicity, while contemporary 5-year relative survival rates (2011-2017) are exclusive of Hispanic ethnicity based on data from 18 SEER registries. Some 5-year relative survival statistics presented in this publication were originally published on SEER*Explorer available at seer.cancer.gov.

Stage distribution. Stage at diagnosis (2014-2018) is based on SEER combined summary stages for local, regional, distant, and unstaged, which includes unknown or blank-stage data. Stage distribution is calculated as a percentage of total cases reported by NAACCR for Black and White people, exclusive of Hispanic ethnicity.
**Probability of developing or dying of cancer.**
Probabilities of developing or dying of cancer were calculated using the National Cancer Institute’s DevCan 6.7.9, which utilizes SEER 21 incidence and total US mortality data. These probabilities reflect the average experience of people in the US and do not take into account individual behaviors and risk factors. For example, the estimate of 1 Black man in 15 developing lung cancer in a lifetime underestimates the risk for people who smoke and overestimates the risk for people who have never smoked.

**Risk Factors.** The methods for the collection of population-based national survey data collected by the Centers for Disease Control and Prevention used to examine the prevalence of selected cancer risk factors and screening prevalence herein are described in further detail via the links below:

- National Health Interview Survey (NHIS): cdc.gov/nchs/nhis/index.htm for more information.

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Cancer Facts & Figures for African American/Black People 2022-2024


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For more information, contact:
Angela Giaquinto, Rebecca Siegel, or Ahmedin Jemal
Surveillance and Health Equity Science Department
## American Cancer Society Recommendations for the Early Detection of Cancer in Average-risk Asymptomatic People*

<table>
<thead>
<tr>
<th>Cancer Site</th>
<th>Population</th>
<th>Test or Procedure</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>Women, ages 40-54</td>
<td>Mammography</td>
<td>Women should have the opportunity to begin annual screening between the ages of 40 and 44. Women should undergo regular screening mammography starting at age 45. Women ages 45 to 54 should be screened annually.</td>
</tr>
<tr>
<td></td>
<td>Women, ages 55+</td>
<td>Transition to biennial screening, or have the opportunity to continue annual screening. Continue screening as long as overall health is good and life expectancy is 10+ years.</td>
<td></td>
</tr>
<tr>
<td>Cervix</td>
<td>Women, ages 25-65</td>
<td>HPV DNA test, OR Pap test &amp; HPV DNA test</td>
<td><strong>Preferred:</strong> Primary HPV test alone every 5 years with an FDA-approved test for primary HPV screening. <strong>Acceptable:</strong> Co-testing (HPV test and Pap test) every 5 years or Pap test alone every 3 years.</td>
</tr>
<tr>
<td></td>
<td>Women, ages &gt;65</td>
<td></td>
<td>Discontinue screening if results from regular screening in the past 10 years were negative, with the most recent test within the past 5 years.</td>
</tr>
<tr>
<td></td>
<td>Women who have been vaccinated against HPV</td>
<td></td>
<td>Follow age-specific screening recommendations (same as unvaccinated individuals).</td>
</tr>
<tr>
<td></td>
<td>Women who have had a total hysterectomy</td>
<td></td>
<td>Individuals without a cervix and without a history of cervical cancer or a history of CIN2 or a more severe diagnosis in the past 25 years should not be screened.</td>
</tr>
<tr>
<td>Colorectal†</td>
<td>Men and women, ages 45+</td>
<td>Guaiac-based fecal occult blood test (gFOBT) with at least 50% sensitivity or fecal immunochemical test (FIT) with at least 50% sensitivity, OR Multi-target stool DNA test, OR Flexible sigmoidoscopy (FSIG), OR Colonoscopy, OR CT Colonography</td>
<td>Annual testing of spontaneously passed stool specimens. Single stool testing during a clinician office visit is not recommended, nor are “throw in the toilet bowl” tests. In comparison with guaiac-based tests for the detection of occult blood, immunochemical tests are more patient-friendly and are likely to be equal or better in sensitivity and specificity. There is no justification for repeating FOBT in response to an initial positive finding. Every 3 years Every 5 years alone, or consideration can be given to combining FSIG performed every 5 years with a highly sensitive gFOBT or FIT performed annually Every 10 years Every 5 years</td>
</tr>
<tr>
<td>Endometrial</td>
<td>Women at menopause</td>
<td></td>
<td>Women should be informed about risks and symptoms of endometrial cancer and encouraged to report unexpected bleeding to a physician.</td>
</tr>
<tr>
<td>Lung</td>
<td>Current or former smokers ages 50-80 in fairly good health with 20+ pack-year history</td>
<td>Low-dose helical CT (LDCT)</td>
<td>The American Cancer Society is currently reviewing the new scientific evidence for lung cancer screening. In the interim we recommend following the updated guidelines from the US Preventive Services Task Force (uspreventiveservicestaskforce.org/uspstf/recommendation/lung-cancer-screening), which recommends annual LDCT screening in adults ages 50-80 who have a 20-pack year smoking history and currently smoke or have quit within the past 15 years.</td>
</tr>
<tr>
<td>Prostate</td>
<td>Men, ages 50+</td>
<td>Prostate-specific antigen test with or without digital rectal examination</td>
<td>Men who have at least a 10-year life expectancy should have an opportunity to make an informed decision with their health care provider about whether to be screened for prostate cancer, after receiving information about the potential benefits, risks, and uncertainties associated with prostate cancer screening. Prostate cancer screening should not occur without an informed decision-making process. African American men should have this conversation with their provider beginning at age 45.</td>
</tr>
</tbody>
</table>

CT-Computed tomography. *All individuals should become familiar with the potential benefits, limitations, and harms associated with cancer screening. †All positive tests (other than colonoscopy) should be followed up with colonoscopy.
The American Cancer Society’s mission is to save lives, celebrate lives, and lead the fight for a world without cancer.